

BROWN BAG SEMINAR

Thursday, July 16, 2015

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

**2nd Floor Conference Room
(use elevator near Starbucks)**

1 CLE (including .4 ethics)

Presented by

Craig Eley

Prehearing Administrative Law Judge
Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation

Free

This outline covers ICAP and appellate decisions issued from
June 13, 2015 through July 10, 2015

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-894-819-02

IN THE MATTER OF THE CLAIM OF
LELAH PEDERSON,

Claimant,

v.

FINAL ORDER

JONATHAN P. BAYNE DDS, P.C.,

Employer,

and

NORTHERN INSURANCE CO OF NY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated December 29, 2014, that ordered permanent partial disability benefits based upon an apportionment applied by the Division Independent Medical Examiner (DIME). We affirm the decision of the ALJ.

In this claim the claimant suffered an occupational disease injury to her cervical spine with a date of onset on July 30, 2012. The claimant obtained significant treatment for her symptoms which included a fusion surgery at the C5-6 level. The respondents had contested the claim asserting it was a preexisting injury. The claimant, who worked as a dental hygienist, had pursued a prior compensation claim also involving her cervical spine. The date of onset for the previous injury was February 9, 2009, and it also involved her work as a dental hygienist for a different dentist. Her treating physician for the 2009 claim, Dr. Prior, found that the constant need for the claimant to bend her head forward while performing her work had aggravated a preexisting stenosis condition causing cervical radiculitis.

In regard to the 2009 claim, Dr. Prior placed the claimant at maximum medical improvement (MMI) on September 4, 2009. He performed range of motion measurements of the cervical spine and calculated a 9% permanent impairment rating due to range of motion deficits. Dr. Prior also derived a 6% diagnosis based rating pursuant to Table 53 of the AMA Guides. The total rating was 15% of the whole person. The

respondents in the 2009 claim requested a DIME review that was performed by Dr. Wunder. Dr. Wunder noted the claimant's statement that she had ceased working as a dental hygienist in May of 2009. At the time of the April 5, 2010, DIME appointment, the claimant reported she no longer had the symptoms of radiating neck pain that caused her to stop working. Dr. Wunder concluded the claimant did not merit a Table 53 rating due to the impermanency of her pain symptoms and any range of motion deficits were attributable to her original, preexisting, stenosis condition, which was not work related. Dr. Wunder therefore, assigned the claimant a 0% permanent impairment rating. A Final Admission of Liability was filed by the respondents according to this DIME report. The claimant then negotiated a full and final settlement of her claim for \$6,000.

When the claimant later returned to work as a dental hygienist her symptoms recurred. She then filed the present claim. As the result of an August, 2013, hearing, ALJ Stuber found her 2012 claim compensable. Her treating physician, Dr. Young, determined she was at MMI for the 2012 injury on March 3, 2014. Dr. Young calculated a permanent impairment rating of 21%. The respondents requested a DIME review that was performed by Dr. Ogrodnick. Dr. Ogrodnick deemed the claimant's impairment rating to be 17%. This rating included 9% from the diagnosis based table 53, and 9% due to range of motion deficits. However, Dr. Ogrodnick determined the Division's apportionment guidelines applied. He disagreed with Dr. Wunder's assessment that the claimant's range of motion deficit was attributable to a non-work preexisting stenosis condition. Dr. Ogrodnick concluded the claimant's work as a hygienist did serve to aggravate that condition. Therefore, the range of motion deficits measured by Dr. Prior in 2009 were observed to be work related. Because the range of motion deficits determined by Dr. Ogrodnick justified a 9% rating, just as they did when measured by Dr. Prior in 2009, that portion of the rating was deducted from Dr. Ogrodnick's rating attributable to the 2012 injury. Dr. Ogrodnick then calculated the claimant's permanent impairment rating from her 2012 claim to be only 9% as derived from Table 53. The respondents filed a Final Admission pursuant to that 9% whole person rating.

The claimant applied for a hearing to challenge the impairment rating determination of the DIME. The claimant asserted Dr. Ogrodnick was incorrect to apply the apportionment guidelines, and, by implication, the corresponding statute, § 8-42-104(5)(a) C.R.S. That statute provides:

- (5) In cases of permanent medical impairment, the employee's award or settlement shall be reduced:
 - (a) When an employee has suffered more than one permanent medical impairment to the same body part and has

received an award or settlement under the “Workers’ Compensation Act of Colorado” or a similar act from another state. The permanent medical impairment rating applicable to the previous injury to the same body part, established by award or settlement, shall be deducted from the permanent medical impairment rating for the subsequent injury to the same body part.

The claimant argued that because she did not receive an award for the 2009 9% rating the DIME subtracted from his 2012 17% rating, it was error to apply apportionment to achieve that 9% reduction.

However, the ALJ disagreed with the claimant’s contention. The ALJ pointed out that the statute provides for apportionment when the previous impairment rating is established either through an award ‘or’ a settlement. The previous 9% rating was provided by Dr. Prior and there was thereafter a settlement of the claim. Because these were the prerequisites specified by the statute, the ALJ determined apportionment was authorized by § 8-42-104(5)(a). The ALJ found the evidence did not otherwise establish by clear and convincing evidence that the DIME determination was mistaken. Consequently, the ALJ ruled the DIME impairment rating had not been overcome and would serve as the basis for an award of permanent impairment benefits.

On appeal, the claimant argues the ALJ had no jurisdiction to apply apportionment because the DIME’s finding in the earlier claim that the injury was not work related is binding on the ALJ in regard to the later claim. The claimant asserts the ‘respondents’ were allowed to win twice so as to reduce the claimant’s permanent impairment award, although for mutually exclusive reasons. Such a result is characterized by the claimant as illogical. The claimant contends the second DIME misapplied the AMA Guides to the Evaluation of Permanent Impairment revised 3d Edition to the first injury, when he noted that injury carried a rating for range of motion deficits, but failed to consider that the previous DIME had declined to include a rating for a diagnosis selected from Table 53, thereby precluding an apportionment of the earlier range of motion rating. Finally, the claimant argues Dr. Ogradnick cannot apportion out of his subsequent impairment rating a prior rating for which the claimant never received any compensation award.

The first two arguments of the claimant are two methods of describing the same principle. She contends the determinations of the first DIME, Dr. Wunder, are binding on the respondents and the ALJ insofar as they influence the outcome of the permanent impairment assigned by the second DIME, Dr. Ogradnick. As such, this argument

asserts the doctrine of issue preclusion applies. The concept of issue preclusion holds that a prior judicial decision pertinent to an issue may direct the result in a subsequent proceeding involving a similar issue. Here, the claimant contends the quasi-judicial determination of the first DIME physician, *see* §§ 8-42-107(8)(c) and 107.2(4)(c), accompanied by the judicial admission represented by the prior respondents' Final Admission of Liability, *see* § 8-43-203(2)(b)(I), is the equivalent of a prior judicial ruling. The Supreme Court, in *Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d 44 (Colo. 2001), set forth four conditions which must be present in a case to allow the principal of issue preclusion to determine the result in a later proceeding. While it is arguable that none of the four conditions are present here, there are two which are notably absent. These two include the requirement that the party against whom issue preclusion is asserted must have been a party to or is in privity with a party to the prior proceeding, and the party against whom issue preclusion is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. In this situation, the prior compensation claim featured as the employer a different dentist, Dr. Cockrell, DDS, and a different insurance carrier, Farmers Insurance Exchange. Accordingly, the employer in this matter, Dr. Bayne, and his insurance carrier, Northern Insurance Co. of New York, were not parties to the previous proceeding and had no opportunity to litigate the issue. Therefore, the earlier determination of Dr. Wunder that the claimant's symptoms were not work related, does not bar the respondents or the ALJ in this later claim from relying on the current DIME opinion of Dr. Ogrodnick that they were work related. While from the claimant's viewpoint it may seem illogical, or at least unfortunate, that she must litigate the same issue twice and run the risk of inconsistent results hurting her cause in both instances, the fact that she faced a distinct set of opponents in both cases requires that she face such a conundrum.

The claimant argues that the AMA Guides and the Division of Workers' Compensation's guidelines preclude a physician from assigning an impairment rating for a range of motion deficit unless the physician can first determine a rating derived from Table 53 of the AMA Guides. In the Division's publication "Impairment Rating Tips" (January, 2011), it is specified that "Spinal range of motion impairment must be completed and applied to the impairment rating only when a corresponding Table 53 diagnosis has been established." The claimant therefore, contends that because Dr. Wunder did not provide a Table 53 rating in the claimant's first claim, Dr. Ogrodnick is prevented from apportioning out the 9% range of motion rating calculated by Dr. Prior from that same claim. However, Dr. Wunder did not provide either a Table 53 rating or a range of motion rating. This was, he said, because he believed the claimant's symptoms were all from a preexisting condition not related to work. As a result, when Dr. Ogrodnick disagreed, and found the claimant's symptoms were work related, he used the

impairment rating provided by Dr. Prior to establish the base line for the degree of prior permanent impairment to be deducted for the purposes of apportionment. Dr. Prior calculated a 9% rating for range of motion deficits and a 6% diagnosis based impairment from Table 53. The prior rating then, used by Dr. Ogrodnick for apportionment, was derived consistently with the AMA Guides and the Division's directions in that regard. While it is never explained by Dr. Ogrodnick why he did not also subtract the 6% prior rating from Table 53, that issue was not a dispute raised by the respondents and was not before the ALJ.

The claimant argues the Division's guidelines to physicians do not allow apportionment of a prior rating for the same body part when there was no finding the impairment was also "disabling." She points out that Dr. Wunder, as well as Dr. Ogrodnick, concede that the claimant was asymptomatic on the date she underwent a DIME review with Dr. Wunder. Consequently, she contends Dr. Ogrodnick was in error when he apportioned the prior rating out of her subsequent rating since there was shown no disability to accompany the prior rating. The claimant misreads both the Division's Apportionment Calculation Guide and § 8-42-104(5)(a). That section refers solely to a previous "medical impairment rating applicable to the previous injury to the same body part." There is no reference to 'disability.' Only where the following subsection, § 8-42-104(5)(b), applies, in the case of apportionment of a non-work related previous medical impairment, is it made necessary to establish the impairment "is independently disabling." Similarly, the Apportionment Calculation Guide reflects this distinction between the two subsections. That Guide directs the physician to apply an apportionment only when it is found either that "the previous condition was work-related" or "the previous condition was non-work related and was disabling." Here, Dr. Ogrodnick concluded the claimant's prior medical impairment rating was work related and therefore calculated an apportionment. While Dr. Ogrodnick relied upon § 8-42-104(5)(a), the record also suggests even Dr. Wunder believed there was a 'disability' which might also have implicated the use of § 8-42-104(5)(b). Dr. Wunder noted "Should the patient, however, return to an occupation where static neck positions would occur, she would likely experience recurrence of her previous symptoms." Such an observation clearly suggests the doctor was recommending work restrictions to avoid return to the claimant's occupation as a dental hygienist. That restriction represents a substantial occupational 'disability' in the claimant's case.

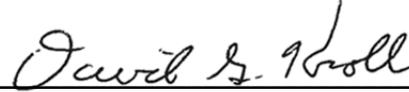
Finally, the claimant argues she did not receive any compensation for her first injury. As a result, she states it is incorrect to apply § 8-42-104(5)(a) to reduce her latter injuries' impairment rating. However, as the ALJ determined, the claimant did achieve a monetary settlement of her first claim. Section 8-42-104(5)(a) specifically includes a

settlement as a variety of compensation which justifies an apportionment. The concern is that the claimant should not be able to achieve a double recovery for an injured body part through the contrivance or a settlement of the prior claim rather than through an admission or a judicial determination. That was the case here, and the ALJ correctly applied the apportionment statute.

We find the DIME physician did not commit error when he applied the apportionment guidelines to calculate the permanent impairment rating in this matter. Accordingly, the ALJ was correct when he affirmed the DIME physician's impairment rating. We find no cause to question the ALJ's order in this matter.

IT IS THEREFORE ORDERED that the ALJ's order issued December 29, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Brandee DeFalco-Galvin

LELAH PEDERSON
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CERTIFICATE OF MAILING

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

_____ 5/19/2015 _____ by _____ RP _____ .

STEVEN U. MULLENS, P.C., Attn: KIMBERLY ROEPKE WHITING, ESQ., P O BOX 2940,
COLORADO SPRINGS, CO, 80901-2940 (For Claimant)
THE KITCH LAW FIRM, P.C., Attn: MICHELLE L. PRINCE, ESQ., 3064 WHITMAN
DRIVE, SUITE 200, EVERGREEN, CO, 80439 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-936-681-02

IN THE MATTER OF THE CLAIM OF

JOHN I. POWDERLY III,

Claimant,

v.

FINAL ORDER

CITY OF GOLDEN,

Employer,

and

SELF-INSURED c/o CIRSA,

Insurer,
Respondent.

The claimant seeks review of an order of Administrative Law Judge Cain (ALJ) dated December 2, 2014, that dismissed the claimant's claim for workers' compensation benefits with prejudice after repeated discovery violations. We affirm the ALJ's order.

The matter was set for hearing on the issues of compensability, medical benefits and various penalties. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The respondent had initially obtained an order allowing it to conduct discovery with a *pro se* claimant and sent the claimant interrogatories. On June 3, 2014, a Pre-hearing ALJ (PALJ) granted the respondent's motion to compel discovery requiring the claimant to "respond fully" to the respondent's first interrogatory. The claimant was specifically ordered to: (1) indicate how and when he was injured and the specific circumstances of the injury; (2) state "with whom the injury was discussed with the City of Golden and the "substance of any conversation;" (3) provide a full statement of what the claimant intended to offer as his testimony. The claimant was ordered to provide this information in the form of verified supplemental answers to interrogatories within 10 days of the prehearing order. The claimant was warned that failure to comply with the order compelling discovery carried the "potential for sanctions" including dismissal of the claim.

A hearing was rescheduled for July 2, 2014, in front of ALJ Cain. At the beginning of the hearing the respondent made an oral motion to dismiss the claim for failure to comply with the PALJ's order compelling discovery. ALJ Cain entered an order dated July 7, 2014, to suspend further proceedings. The ALJ found that the claimant had disregarded the PALJ's order compelling discovery and did not comply with the specific directives of the order. The ALJ also determined that the claimant's failure to comply was willful within the meaning of §8-43-207(1)(e), C.R.S. The claimant was again ordered to comply with the PALJ's order to compel and although the ALJ noted that the claim could have been dismissed, the ALJ concluded that the appropriate sanction was to suspend further proceedings until the claimant completely complied with the PALJ's order.

On October 21, 2014, the respondent filed a motion to strike the application for hearing and again sought dismissal for violation of the ALJ's orders. The respondent contended that the claimant filed what purported to be a supplemental response to the interrogatories, but he had not filed substantive responses.

The ALJ conducted a motions hearing on November 12, 2014, resulting in a oral order which was later committed to writing on November 14, 2014. This order stated that the claimant admitted that he has not provided the information as directed in the prior orders and that the claimant had placed himself at substantial risk of having his claim dismissed. However, the ALJ determined that the claimant should have one last chance to respond to the prior order. The claimant was directed to answer the interrogatories by November 14, 2014 at 5:00 pm. The claimant was specifically ordered to identify any conversations he had regarding the injury with supervisors and co-employees and "provide the substance of all discussions" with these persons. The claimant was again warned that the failure to timely and completely comply with this order would create a substantial risk that his claim would be dismissed.

The claimant provided a response to the interrogatories by the deadline given. However, at the merits hearing scheduled November 25, 2014, the respondent renewed its motion to dismiss for failure to comply with the prior orders. The ALJ determined that although the claimant had substantially complied with a portion of the order, the claimant did not comply with the portion of the order that required him to set forth a list of supervisors and employees of the City of Golden with whom he discussed the injury and provide a description of the substance of those conversations. The ALJ found that the claimant's failure to comply was willful and constituted a substantial disregard of his responsibility to provide discovery under prior orders. Workers' Compensation Rule of

Procedure (WCRP) 9 and §8-43-207(1)(e), C.R.S. The ALJ, therefore, concluded that the appropriate sanction for the claimant's failure was dismissal of the claim.

On appeal the claimant asks for his case to be reconsidered and states that he has answered all of the questions to the best of his ability and would like another opportunity to present his case. We perceive no reversible error.

WCRP 9-1 applies to discovery in workers' compensation procedures. Rule 9-1(E) provides that "[i]f 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." Further, § 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). WCRP 9-1(G) also provides that the failure to comply with an order to compel shall be presumed willful.

The conduct of discovery is a matter committed to the discretion of the ALJ. Whether to impose sanctions and the nature of the sanctions to be imposed are matters within the fact finder's discretion. *Shafer Commercial Seating, Inc. v. Industrial Claim Appeals Office*, 85 P.3d 619 (Colo. App. 2003). The fact finder is given flexibility in choosing the appropriate sanction and should exercise informed discretion in imposing a sanction that is commensurate with the seriousness of the disobedient party's conduct. *Id.* An ALJ's exercise of discretion in determining the appropriate discovery sanction is broad, and is binding in the absence of an abuse of discretion. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo. App. 2001). An abuse of that discretion is only shown where the order "exceeds the bounds of reason," such as where it is not in accordance with applicable law, or not supported by substantial evidence in the record. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993); *Rosenberg v. Board of Education of School District # 1*, 710 P.2d 1095 (Colo. 1985).

Additionally, we are bound by the ALJ's factual findings if they are supported by substantial evidence. §8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Application of this standard requires that we defer to the ALJ's credibility determinations and his assessment of the

sufficiency and probative weight of the evidence. Moreover, whereas here, a party fails to procure a transcript, the ALJ's factual findings are presumed to be supported by the evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

Here, the ALJ entered detailed findings explaining his decision to sanction the claimant by dismissing the claim. The ALJ noted that the history of the claimant's failure to set forth the substance of the conversations he had with supervisors and other employees, despite multiple discovery orders instructing him to do so, was a willful violation. The ALJ also found that his failure to set forth this information was a substantial disregard of his responsibility to provide for discovery. The ALJ's factual findings are supported by our review of the record. Under these circumstances, we do not disagree with the ALJ that dismissal of the claim was appropriate for the claimant's discovery violations.

The claimant's arguments notwithstanding, as stated by the Colorado Court of Appeals in *Sheid v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991), "[a] court is justified in imposing a sanction which terminates litigation at the discovery phase if a party's disobedience of discovery orders is intentional or deliberate or if the party's conduct manifests either a flagrant disregard of discovery obligations or constitutes a substantial deviation from reasonable care in complying with discovery obligations." *Sheid v. Hewlett Packard*, 826 P.2d at 399. As found by the ALJ, the claimant had multiple opportunities to comply with the discovery orders and that his failure to comply was willful. The record also discloses that the claimant was provided with notice and an opportunity to be heard regarding the respondent's motion to dismiss and to provide the basis for his failure to respond and comply with the discovery orders. *See Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076 (Colo. App. 1990).

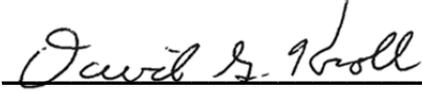
Under the particular facts and circumstances of this action, therefore, we are unable to conclude that the ALJ abused his discretion in dismissing the claimant's claim with prejudice. Consequently, we have no basis disturb the ALJ's order. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated December 2, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



Brandee DeFalco-Galvin



David G. Kroll

JOHN I. POWDERLY III
W. C. No. 4-936-681-02
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CERTIFICATE OF MAILING

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

_____ 5/28/2015 _____ by _____ RP _____ .

JOHN I. POWDERLY III, 5950 BLANCA CT, GOLDEN, CO, 80403 (Claimant)
NATHAN, BREMER, DUMM & MYERS, P.C., Attn: MARK H. DUMM, ESQ., 7900 EAST
UNION AVENUE, SUITE 600, DENVER, CO, 80237-2776 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-950-808-01

IN THE MATTER OF THE CLAIM OF

JOAN BRIGGS,

Claimant,

v.

FINAL ORDER

SAFEWAY, INC.,

Employer,

and

SELF INSURED,

Insurer,
Respondents.

The respondent seeks review of an order of Administrative Law Judge Mottram (ALJ) dated January 12, 2015, that ordered the claim compensable, awarded medical benefits and denied temporary disability benefits. We affirm.

The claimant worked for the respondent as a meat and fish clerk in the respondent's super market. On May 14, 2014, the claimant fell after finishing a sale to a customer and turning to retrieve a new set of gloves. There were no witnesses to the fall. The claimant believes she tripped and hit her head on a metal work table. She was found by a co-worker lying on the floor with blood coming from her left ear and from a cut on her tongue.

The claimant was taken to the emergency room at St. Mary's Hospital. The claimant was examined with a CT scan of her spine, an MRI of her brain and an EEG exam which showed temporal spikes consistent with a seizure. The claimant was provided with Keppra, an anti-seizure medication and advised not to drive for a three month period. The claimant was released from the hospital the next day. She returned to work two days later. She testified at the November 4, 2014, hearing that she stopped taking the Keppra due to its side effects. She stated she had not had any seizures prior to May 14, 2014, nor has she had any since.

JOAN BRIGGS

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The claimant was not referred to any physician by the employer. She saw her personal doctor, Dr. Rademacher on May 23, 2014. Dr. Rademacher referred her to a neurologist. The claimant testified that neurologist was Dr. McDanel. Dr. McDanel had read the claimant's EEG study while she was hospitalized. On August 4, 2014, Dr. McDanel authored a report concluding the claimant had suffered a "single unprovoked seizure." He noted the only possibly provoking factor was sleep deprivation near the time of her fall. He recommended continued prohibition of driving for three months and a return visit at that time to ensure the claimant had no further seizure incidents. The claimant does complain of more frequent headaches since May 14.

The ALJ concluded the claimant was injured when she hit her head on a metal table as she began to fall. The ALJ characterized the metal table as a hazard of employment and was not a ubiquitous condition. The ALJ relied on the testimony of the claimant and the emergency room findings that the claimant had present abrasions and a auricular hematoma as well as bleeding from the ear. These pieces of evidence were reasoned to all be consistent with an injury occurring when the claimant hit the metal table. The ALJ noted the testimony of Dr. Bernton presented by the respondent. Dr. Bernton testified the most likely scenario involved a new onset of epilepsy which caused the claimant to both fall and to sustain the symptoms for which she was treated. However, the ALJ resolved it was not necessary to determine whether or not the claimant did experience an unprovoked episode of a seizure or epilepsy. The ALJ ruled that because evidence indicated the claimant sustained her injuries through contact with the metal table, which was a special employment hazard, it was unnecessary to discern whether the reason she fell did itself arise out of the conditions of employment.

The ALJ found the respondent had failed to refer the claimant to a doctor or medical facility in the first instance. The claimant then, was required to make her own choice of physician. The ALJ found the treatment of Dr. Rademacher and Dr. McDanel to be reasonable and necessary and duly authorized. The emergency room treatment was also found compensable. However, the ALJ determined the claimant did not miss work due to her injuries. Her claim for temporary disability benefits was therefore denied.

On appeal, the respondent contends the ALJ committed error when he declined to rule as to the reason for the claimant's fall. The respondent complains the ALJ was incorrect in finding a metal table to be a special hazard of employment. The respondent also objects to the claimant's ability to choose two doctors for treatment instead of just one. Finally, the respondent asserts mistake in the authorization of doctors who treated only the seizure condition which the ALJ did not find was caused by the blow to the claimant's head.

I.

The record reveals the ALJ was asked to choose between two competing theories as to how the claimant came to be injured. The respondent argued the claimant suffered an episode of epilepsy or seizure which caused the claimant to fall. The seizure, it is asserted, was a personal or idiopathic condition not arising from work. The claimant, on the other hand, testified she felt she tripped over her own feet or items on the floor. As a result, she claims she fell and hit her head on the metal table. The ALJ reasoned it was not required that he make a finding in regard to the details of the cause for the fall. Instead, by finding the claimant's injuries resulted from hitting her head on the table, and construing the table to represent a special hazard of employment, the reason for the claimant's fall became superfluous. We agree with the ALJ's reasoning.

In the event the claimant's version is successfully proven, her injuries would have arisen out of and within the course of her employment making the claim compensable, § 8-41-301(1)(c). Conversely, should the respondent's theory have proven more persuasive, the fact of an idiopathic cause of an injury would not have precluded a compensable claim if a 'special hazard' of employment also contributed to the injury. *City of Brighton v. Rodriguez*, 318 P.3d 496, 503 n. 3 (Colo. 2014). The finding by the ALJ that a special hazard of employment did lead to the claimant's injuries made inconsequential the argument over how the claimant came to fall.

This was the holding in *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989). In *Ramsdell* the analysis required that to be a special employment hazard "the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered." In *Ramsdell* the claimant suffered a seizure and fell from a 25 foot high scaffolding. A "special hazard" of employment is one which increases either the risk of injury or the severity of injury when combined with the preexisting condition, which is the direct or precipitating cause of the injury. *Shaffstall v. Champion Technologies*, W.C. No. 4-820-016 (March 2, 2011). When a special hazard of employment contributes to the severity of the claimant's injury, the injury is ruled compensable in spite of the involvement of the preexisting condition. The special hazard need not be simply unusual or novel. In *National Health Labs v. Industrial Claim Appeals Office*, 849 P.2d 1259 (Colo. App. 1992), the claimant was injured when she experienced a seizure while driving. Driving however, is not an unusual activity. But because it involves a possibility for severe injury, it was observed to qualify as a 'special hazard' of employment.

Here, the ALJ viewed the respondent's exhibit H, a photograph of the metal table, and the description of the claimant. The table is depicted as approximately six feet long and two feet wide. It is attached to a metal sink and basin and to the wall behind it. The table is supported by stainless steel legs with a stainless steel counter top. It has on top of it a large cellophane roll and dispenser. The ALJ characterized the table as an item not ubiquitous and a hazard of employment. The respondent contends metal tables are routinely encountered in many locations outside of work including home kitchens. However, the photo of the steel table in exhibit H constitutes substantial evidence to support the ALJ's finding that the nature of the table is obviously industrial. It is considerably larger, heavier, fixed and more rigid than a table that would typically be seen in a residential kitchen. An employee running into or falling over such a solid piece of equipment could easily suffer an injury more severe than would be expected if they encountered a standard kitchen table. We must uphold the ALJ's determination of this issue if it is supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; see *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). The ALJ's finding that this metal table creates a "special hazard" of employment as one which increases either the risk of injury or the severity of injury is a reasonable observation. This standard of review requires us to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). We do not find error in the ALJ's conclusion a special hazard of employment was involved in the claimant's injury regardless of the reason she began to fall.

II.

The respondent argues the ALJ was in error when he authorized the treatment of two doctors selected by the claimant without requiring the respondent's agreement to the second doctor. When an employer does not tender the services of a physician at the time of injury, the claimant has the right to select a physician to treat her injuries. § 8-43-404(5)(a)(I)(A). A referral from the original physician in the normal progression of authorized treatment allows for the authorized treatment provided by the doctor accepting the referral. *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). When the referral reveals it is based on the independent medical judgment of the referring doctor, it may be construed as an authorized referral. *City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997).

However, even if the employer initially waived the right pursuant to § 8-43-404 (5)(a)(I)(A) in the "first instance" to choose the treating physicians by failing to provide a

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list of two physicians, such waiver does not preclude it from having any right to object to or participate in subsequent changes of physician. *See, Miller v. Rescare*, W.C. No. 4-793-307 (June 18, 2010); *Tournier v. City and County of Denver*, W. C. No. 3-892-574, 3-894-603, 3-921-234 (April 30, 1997). An employee may obtain permission from the respondent to have a different doctor authorized to provide treatment by making such a request in writing. § 8-43-404(5)(a)(VI). The respondent asserts the claimant chose Dr. Rademacher to treat her. In that event, the respondent argues the claimant is not allowed to then seek out a second treating physician without first securing the approval of the respondent. The respondent contends there was no evidence Dr. Rademacher referred the claimant to Dr. McDanel.

The ALJ's findings state the claimant sought treatment from Dr. Rademacher on May 23, 2014. The ALJ then noted Dr. Rademacher recommended the claimant be seen by a neurologist. Finding of Fact 6. The ALJ's following finding discloses that the claimant was examined by Dr. McDanel on August 4. While the ALJ does not specify the referral by Dr. Rademacher to a neurologist was a referral to Dr. McDanel, the findings of fact clearly requires that inference. The claimant testified that when Dr. Rademacher saw her and referred her to a neurologist he mentioned two such doctors. One was Dr. Dean and the second was Dr. McDanel. Tr. at 19 and 31. There is no other statement in the record that the claimant came to see Dr. McDanel other than through a referral from Dr. Rademacher. The record then, and a reasonable reading of the ALJ's findings, reveals that the claimant selected Dr. Rademacher to treat and he made a referral to Dr. McDanel for specialized treatment by a neurologist. These circumstances represent a referral in the normal progression of authorized treatment. We find no error in the authorization of both Dr. Rademacher and Dr. McDanel to treat the claimant.

The respondent contends that Dr. McDanel's treatment was limited to treatment of the claimant's seizure. It is argued that if the ALJ surmised it was not necessary to find the seizure was caused by the claimant's work, then there is no support for the ALJ's determination that Dr. McDanel's treatment was reasonable or necessary and related to the work injury. The ALJ's authorization of Dr. McDanel's treatment is asserted to be in error.

Dr. Rademacher states in his report of May 23, 2014, the claimant complained of a syncopal episode on May 14, 2014, which led her to fall at work. He observed that everything known in regard to her physical condition both prior and subsequent to the fall was normal. The one exception related to the EEG finding of left temporal spikes. The doctor noted: "With this in mind, it is felt that we should send her to the neurologist and have his evaluation. ... She has had no further seizure activity and has been feeling well

since she woke up from the syncopal like episode.” Dr. McDaneld saw the claimant on August 4, 2014. He reviewed the claimant’s history and her EEG test. He stated the reason for the evaluation was the episode of a single seizure on May 14. The doctor concluded no additional treatment was required. He recommended she abstain from driving for the next three months and follow up with him at that point.

Medical treatment provided as a strategy to perfect a diagnosis for symptoms that are partially related to work injuries has been deemed compensable despite the circumstance that the condition treated later turns out to be an injury distinct from the work injury. Treatment provided so as to ascertain the extent of the industrial injury is compensable. This is despite the discovery after the treatment is provided that it uncovered a separate cause for some of the injured worker’s conditions. In *Merriman v. Industrial Commission*, 120 Colo. 400, 210 P.2d 448 (1949), treatment for the claimant’s work related low back injury led to a recommendation for an “exploratory operation to determine the nature or extent of the claimant’s injuries.” The claimant had fallen on May 1, and was hospitalized two days later when he passed blood in his urine. The exploratory surgery revealed the claimant suffered from a diseased kidney which was then removed. The claimant then quickly recovered and returned to work. The court found the cost of the exploratory surgery was a compensable benefit of the worker’s compensation claim.

. . . he was entitled to recover the amounts he expended for surgical and hospital treatment which was deemed by competent physicians reasonably necessary to relieve him from the effects of the accident, and he also was entitled to recover for the disability resulting from the operation. The above conclusion is not changed by the fact that the surgical treatment here involved, contrary to the preoperative diagnosis, was not performed to relieve from the effects of the accident, but rather, as subsequently discovered, was needful to relieve from the pre-existing disease. The commission made a finding, based upon competent evidence, that the operation was necessary as a result of the accident, and found, in effect, that all disability following the operation resulted naturally from the accident. The above circumstances clearly show the causal connection between the injury, the operation, and the disability, . . . *Merriman, supra*, 210 P.2d at 403.

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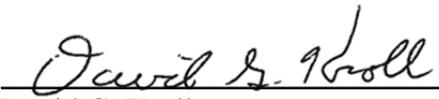
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Relying on *Merriman*, we have more recently held in *Vandenberg v. Ames Construction*, W.C. No. 4-388-883 (December 5, 2007) that surgery which discovered an unrelated appendicitis while seeking to find the cause of a blockage of a work injury related shunt placed in the claimant's abdomen, was compensable medical treatment. This was deemed to be the case because the surgery "was initially aimed at relieving these symptoms by trying to ascertain the cause of the accumulation of fluid. ... Thus the diagnostic procedures and the treatment rendered were partially aimed at relieving the effects of the industrial injury."

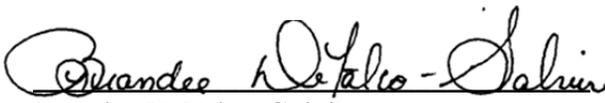
This same principle applies to the claim at hand. The claimant was found to have fallen at work due to a mysterious cause. There were no witnesses to her fall and the sequence of the injuries to her head was obscure. It was unclear as to whether she suffered a seizure prior to her fall or as a result of hitting her head on the metal table or the floor at the conclusion of the fall. The EEG test completed at the emergency room suggested for the first time the presence of a seizure as a possible genesis for the episode. The ALJ could reasonably infer the "diagnostic procedures and the treatment rendered were partially aimed at relieving the effects of the industrial injury." This was true regardless of the ultimate finding by the ALJ that the claimant's injuries were caused by hitting the metal table, without also finding the single episode seizure was caused by that event. The ALJ's finding the treatment by Dr. McDaniel to be compensable is consistent with the analysis in *Merriman*. We find no basis to depart from this finding by the ALJ.

IT IS THEREFORE ORDERED that the ALJ's order issued January 12, 2015, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Brandee DeFalco-Galvin

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CERTIFICATE OF MAILING

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

_____ 7/8/2015 _____ by _____ RP _____ .

WITHERS SEIDMAN RICE & MUELLER P.C., Attn: DAVID B. MUELLER, ESQ., 101
SOUTH THIRD STREET, SUITE 265, P O BOX 3207, GRAND JUNCTION, CO, 81502 (For
Claimant)

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-947-977-01

IN THE MATTER OF THE CLAIM OF
CODY DAVIS,

Claimant,

v.

ORDER

LITTLE PUB HOLDINGS, LLC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order, corrected order, and supplemental order of Administrative Law Judge Cannici (ALJ) dated November 3, 2014, November 25, 2014, and March 11, 2015, respectively, that ordered the claimant was entitled to medical benefits through March 19, 2014, and temporary total disability (TTD) benefits for the period of March 9, 2014, through April 6, 2014. We set aside the ALJ's termination of medical benefits as of March 19, 2014, and his termination of TTD benefits as of April 7, 2014, and remand for further findings and a new order on TTD benefits and temporary partial disability (TPD) benefits.

The claimant works as a bartender for the respondent employer. On March 8, 2014, the claimant was changing out an empty beer keg in order to hook up connecting hoses to a full keg. An empty beer keg weighs approximately 40 pounds. As the claimant leaned forward and lifted the empty keg, she twisted and experienced a twinge in her lower back. The claimant's back pain continued to increase throughout the rest of her work shift.

On March 9, 2014, the claimant was scheduled to open the employer's bar at 11:00 a.m. The claimant, however, was experiencing trouble walking, her mobility was not great, and her breathing was "awful." She contacted another employee to cover her shift. On March 10, 2014, the claimant went into work to perform inventory. The claimant reported to the general manager that she thought she had hurt her ribs or popped

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some ribs out of place changing the keg. She commented that she was unable to continue inventory duties because she was having difficulties sitting, breathing, and talking. The general manager provided the claimant with a list of two designated Workers' Compensation medical providers, and the claimant chose HealthOne.

While at HealthOne, FNP Halat completed a physical examination of the claimant. FNP Halat determined that the claimant was suffering from "shortness of breath, pain [and] left upper quadrant abdominal pain." FNP Halat contacted 911 to transport the claimant to Swedish Medical Center (Swedish) because she required more extensive evaluation than could be provided at the clinic. The claimant was admitted to Swedish because of abdominal pain, flank pain, vomiting, and nausea. A chest x-ray and an abdominal CT scan did not reveal any acute findings, and a subsequent CT scan of the lumbar spine was normal. Physicians suspected that the claimant's pain was secondary to a musculoskeletal strain. On March 14, 2014, the claimant was discharged from Swedish with a diagnosis of low back pain, secondary to muscle spasm.

The claimant returned to HealthOne on March 17, 2014, and Dr. Williams examined the claimant. He noted that the claimant's symptoms were consistent with her described mechanism of injury and diagnosed a lumbar strain and muscle spasms. He took the claimant off of work. After attending several other appointments at HealthOne during March and April 2014, the claimant was diagnosed with a lumbar strain and possible torn paraspinous muscles in her lower back. The claimant underwent conservative treatment, including medications and physical therapy. On April 4, 2014, Dr. Williams released the claimant to modified duty, with lifting, carrying, and pulling restrictions. The claimant returned to modified work on April 7, 2014.

The claimant subsequently visited her personal physician, Dr. D'Ambrosio, on June 9, 2014. The claimant reported severe pain in her lower back and posterior pelvis, and numbness and tingling radiating down the back of both legs. Dr. D'Ambrosio noted that the claimant suffers from fibromyalgia and chronic pain syndrome. Dr. D'Ambrosio recorded range of motion measurements that were identical to the deficits he previously had recorded on February 10, 2014. He previously noted that the claimant had severe restrictions on flexion, extension, and bending. He also previously commented that the claimant suffers from Sjogren's and other rheumatologic chronic pain symptoms. MRIs conducted on January 6, 2014, and June 20, 2014, which were both before and after the claimant's work incident, did not reveal any structural abnormalities, protrusions, or stenosis.

The respondent insurer filed a Notice of Contest. The claimant filed an Application for Hearing endorsing TTD, TPD, compensability, medical benefits, and other issues. The respondents filed their response also endorsing the issues of TTD, TPD, compensability, medical benefits, course and scope, causation, relatedness, preexisting condition, and other issues.

At the request of the respondents, the claimant underwent an independent medical examination with Dr. Fall. Dr. Fall opined that the claimant's presentation was consistent with her prior history of worsening back pain and stiffness, and that she did not suffer a new, specific work-related injury or an aggravation of a preexisting condition. Dr. Fall noted that the claimant's symptoms of nausea, vomiting, abdominal pain, and shortness of breath were not typical for a lumbar strain. Instead, these symptoms were more consistent with her preexisting condition. Accordingly, Dr. Hall concluded that the claimant's lower back symptoms constitute the natural progression of her preexisting condition.

On November 3, 2014, November 25, 2014, and March 11, 2015, the ALJ issued his order, corrected order, and supplemental order, respectively. In all three of his orders, the ALJ stated that the issues to be decided were compensability, medical treatment, average weekly wage, TTD, and TPD. The ALJ concluded that the claimant established it was more probably true than not that she sustained a compensable lower back injury on March 8, 2014. However, the ALJ determined that the March 8, 2014, incident constituted a temporary aggravation of her chronic, pre-existing condition. Consequently, he concluded that the claimant's work activities on March 8, 2014, aggravated, accelerated, or combined with her preexisting condition to produce a need for medical treatment, but that her temporary aggravation resolved by March 19, 2014. He ordered the respondents liable for medical benefits through March 19, 2014, as well as TTD benefits from March 9, 2014, through April 6, 2014. He found that the claimant had returned to modified work for the employer on April 7, 2014, and that her entitlement to TTD ceased at this point. In his Supplemental Order, the ALJ stated that if either party was dissatisfied with the order, then a Petition to Review may be filed within 20 days after mailing or service of the order. The ALJ referenced §8-43-301(2), C.R.S. for further information regarding procedures to follow when filing a petition to review.

The claimant timely filed her petition to review the ALJ's supplemental order on March 16, 2015, but did not file an accompanying brief in support. Rather, the claimant filed her brief in support on April 11, 2015. The claimant's brief in support was received by the Office of Administrative Courts on April 15, 2015.

I.

Initially, we address the respondents' request to strike the claimant's brief in support of the petition to review. The respondents argue that the claimant's brief in support is untimely since it was not filed contemporaneously with the petition to review the supplemental order issued by the ALJ. The respondents also argue that the claimant's brief in support should be stricken because it exceeds the 20 page limit set forth in Office of Administrative Courts Rule of Procedure 26(E). We deny the respondents' request.

Section 8-43-301(6), C.R.S. provides that a party dissatisfied with a supplemental order may file a petition for review, and the petition shall be accompanied by a brief in support:

(6) A party dissatisfied with a supplemental order may file a petition for review by the panel. The petition shall be filed with the division if the supplemental order was issued by the director or at the Denver office of the office of administrative courts in the department of personnel if the supplemental order was issued by an administrative law judge. The petition shall be filed within twenty days after the date of the certificate of mailing of the supplemental order. *The petition shall be in writing, shall set forth in detail the particular errors and objections relied upon, and shall be accompanied by a brief in support thereof.* The petition and brief shall be mailed by petitioner to all other parties at the time the petition is filed. All parties, except the petitioner, shall be deemed opposing parties and shall have twenty days after the date of the certificate of mailing of the petition and brief to file with the division or the Denver office of the office of administrative courts, as appropriate, briefs in opposition to the petition. (emphasis added)

The failure to file a brief in support of a petition to review is not a jurisdictional defect and, thus, neither is the failure timely to file a brief. *See Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986).

It is true, as the respondents' argue, that the claimant's brief in support of the ALJ's Supplemental Order was not timely filed. As noted above, §8-43-301(6), C.R.S. specifically provides that a party dissatisfied with a supplemental order may file a petition for review, and the petition shall be accompanied by a brief in support. Nevertheless, we take note that the ALJ's supplemental order references §8-43-301(2), C.R.S. rather than §8-43-301(6), C.R.S. with regard to the procedures to follow when filing a petition for review. Since §8-43-301(6), C.R.S. is the applicable section

regarding petitions to review of an ALJ's supplemental order rather than §8-43-301(2), C.R.S., we will not strike the claimant's brief in support as untimely.

The respondents also argue that the claimant's brief in support should be stricken because it exceeds the 20 page limit set forth in OACRP 26(E). However, we decline the respondents' request. *See People v. Rodriguez*, 914 P.2d 230 (Colo. 1996)(court has discretion to grant permission to file oversized brief).

II.

The claimant argues that the ALJ erred in allowing Dr. Fall to testify by deposition and at the hearing, and by relying upon her testimony to render a decision regarding compensability. The claimant contends that IMEs are only allowed in two distinct circumstances: a DIME examination under §8-43-502(2), C.R.S.; and, when a claim is admitted or has been adjudicated to be compensable under §8-43-404(1)(a), C.R.S. The claimant argues that since her claim is fully contested, her right to compensation does not exist and, therefore, she should not have been required to attend such an IME. The claimant further argues that when reading §8-43-404(1)(a), C.R.S. together with §8-43-502(2), C.R.S., the legislative purpose is clear-to allow respondents, when the IME opinion could determine whether the case is compensable, only to use the Division IME process where a disinterested third party picks a panel of physicians. The claimant contends that the respondents are only allowed to pick a physician to give a second opinion when it would only affect the extent of some benefits. We perceive no reason to depart from the Panel's reasoning in *Black v. Homestead Village*, W.C. No. 4-732-596 (July 6, 2009), which addressed this very argument.

Section 8-43-404, C.R.S. provides in pertinent part as follows:

(1)(a) If in case of injury the right to compensation under articles 40 to 47 of this title exists in favor of an employee, upon the written request of the employee's employer or the insurer carrying such risk, the employee shall from time to time submit to examination by a physician or surgeon or to a vocational evaluation, which shall be provided and paid for by the employer or insurer, and the employee shall likewise submit to examination from time to time by any regular physician selected and paid for by the division.

* * *

(3) So long as the employee, after written request by the employer or insurer, refuses to submit to medical examination or vocational evaluation or in any way obstructs the same, all right to collect, or to begin or maintain

any proceeding for the collection of, compensation shall be suspended. If the employee refuses to submit to such examination after direction by the director or any agent, referee, or administrative law judge of the division appointed pursuant to section 8-43-208 (1) or in any way obstructs the same, all right to weekly indemnity which accrues and becomes payable during the period of such refusal or obstruction shall be barred. (emphasis added)

We apply the plain and ordinary meaning of the statute, if clear. *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo.2004). Further, when construing provisions of the Act, we read the statute as a whole and, if possible, construe its terms harmoniously, reconciling conflicts where necessary. *Colorado Dep't of Labor and Employment v. Esser*, 30 P.3d 189 (Colo.2001).

In *Black*, the Panel held that the plain and ordinary meaning of §8-43-404(1)(a), C.R.S., when read in context, is that if a claim is filed under the Act seeking compensation in favor of the claimant, the claimant shall from time to time submit to examination by a physician chosen by the employer or the insurer. As explained by the Panel, this reading of §8-43-404(1)(a), C.R.S. would give it consistent, harmonious, and sensible effect with §8-43-404(3), C.R.S. which provides that the right to “begin” any proceeding for compensation will be suspended if the claimant refuses to submit to such examination. The claimant’s argument notwithstanding, we do not view this reading of §8-43-404(1)(a) and (3), C.R.S. as writing out the “if clause” contained in §8-43-404(1)(a), C.R.S. Rather, this reading of §8-43-404(1)(a), C.R.S., construes the statute as a whole, construes its terms harmoniously, and reconciles its conflicts, as we are required to do. *See Colorado Dep't of Labor and Employment v. Esser, supra*. Thus, as held by the Panel in *Black*, when reading §8-43-404(1)(a), C.R.S. together with §8-43-404(3), C.R.S., the legislative intent is revealed. That is, §8-43-404(1)(a), C.R.S. creates the obligation of a claimant seeking benefits under the Act to undergo an IME and §8-43-404(3), C.R.S. provides for the consequences if a claimant is unwilling to fulfill this obligation. We further note that the Division of Workers’ Compensation has interpreted §8-43-404(1)-(4), C.R.S. as allowing for RIMEs, or Respondent Independent Medical Examinations. On the Division’s website, it provides as follows regarding RIMEs: “This type of exam can be requested at any time during the course of the workers’ compensation claim.” *See* <https://www.colorado.gov/cdle/node/20906>. Consequently, as concluded in *Black*, we are not persuaded that the respondents’ only right to an IME is in a contested case pursuant to §8-43-502(2), C.R.S. *See also Easley v. Ruby Tuesday*, W.C. No. 4-934-489-03 (April 22, 2015)(rejecting identical argument).

Moreover, §8-43-502(4), C.R.S. provides that nothing in §8-43-502, C.R.S. “shall preclude any party from obtaining an [IME] from a physician who is not a member of the medical review panel.” The plain language of §8-43-502(4), C.R.S. makes it clear that each party retains the right to obtain an IME of the claimant by medical experts outside of the membership of the medical review panel described in §8-43-502, C.R.S. The purpose of statutory construction is to effect the legislative intent. Because the best indicator of legislative intent is the language of the statute, words and phrases in a statute should be given their plain and ordinary meanings. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). Consequently, we reject the claimant’s argument that the respondents are only entitled to an IME in these two distinct circumstances. As such, we will not disturb the ALJ’s order on these grounds.

III.

The claimant next argues that the ALJ erred in awarding temporary compensability for only 10 days and in denying benefits after this period when there was no finding by an authorized treating physician of maximum medical improvement (MMI) or any other statutory reason to terminate TTD benefits. The claimant therefore seeks additional medical benefits past March 19, 2014, as well as additional TTD benefits. We agree that the ALJ erred in terminating medical benefits and TTD benefits under the particular circumstances presented here.

A.

Section 8-42-101(1), C.R.S. requires the employer to provide medical benefits to cure or relieve the effects of the industrial injury, subject to the right to contest the reasonableness or necessity of any particular treatment. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). The employer’s obligation continues until the claimant reaches MMI. This is true because MMI is defined as the point in time when the claimant’s condition is “stable and no further treatment is reasonably expected to improve the condition.” Section 8-40-201(11.5), C.R.S. However, the claimant may receive medical benefits after MMI to maintain MMI or prevent a deterioration of her condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Further, §8-42-107(8)(b)(I) & (II), C.R.S. provide that the initial determination of MMI is to be made by an authorized treating physician, and if either party disputes that determination, the claimant must undergo a Division-sponsored independent medical examination (DIME). That statute also provides that the ALJ lacks authority to determine MMI until there has been a medical determination of MMI by an authorized treating physician or an IME on the issue. *See Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995).

Initially, we note that on page 9 of their brief in opposition, the respondents argue that the claimant “has not appealed the ALJ’s determination that her entitlement to medical benefits related to the compensable injury ceased on March 19, 2014.” We disagree, however. On page 19 of her brief in support, the claimant argues that “what is error is [the ALJ’s] termination of benefits based on his determination that Claimant returned to her baseline on March 19, 2014. This is *de facto* a finding of MMI which the ALJ had no authority to find.” And, on pages 20-21, the claimant argues “[t]he medical treatment by the authorized physicians, etc. and the TTD awarded must continue past the 3/18/14 stop date until terminated by operation of law.” We conclude that the claimant has adequately raised on appeal the issue of medical benefits.

Here, the ALJ found that the claimant’s March 8, 2014, incident constituted a temporary aggravation of her preexisting condition that returned to baseline by March 19, 2014. The ALJ concluded, therefore, that the claimant’s “entitlement to medical benefits ceased by March 18, 2014 (sic) when her pain symptoms returned to baseline levels.” Conclusions of Law at 10 ¶10. Because the claimant is entitled to medical treatment until MMI, the ALJ’s finding necessarily reflects his implicit determination that the claimant had reached MMI for the effects of the industrial injury on March 19, 2014. The ALJ essentially concluded that no further treatment was reasonably needed to cure or relieve the effects of the industrial injury after this time. However, there has been no medical determination of MMI by an authorized treating physician or an IME. To the contrary, Dr. William’s last medical record dated April 18, 2014, states that the MMI date is unknown at this time because the claimant is still in active treatment. Ex. Q at 223. Dr. Williams continued to recommend physical therapy and pain medications, starting massage therapy, and seeking treatment from Dr. Chan for pain management. Ex. Q at 222. Under these circumstances, the issue of MMI was not properly before the ALJ and is not supported by the record. *Story v. Industrial Claim Appeals Office, supra*; §8-43-301(8), C.R.S. Consequently, the ALJ erred in implicitly finding the claimant to be at MMI as of March 19, 2014, and terminating the claimant’s entitlement to medical benefits as of this date. *See Lissauer v. Arapahoe House, W.C. No. 4-208-121 (Nov. 26, 1997), aff’d Arapahoe House v. Industrial Claim Appeals Office, Colo. App. No. 97CA2132 (July 9, 1998) (NSOP) (ALJ’s finding that a temporary aggravation ended was an impermissible finding of MMI); see also Kaltenborn v. Industrial Claim Appeals Office, 97CA0174 (July 31, 1997) (NSOP)(ALJ did not have authority to determine MMI under §8-42-107(8)(b), C.R.S., and because ALJ relied upon the finding that the claimant had returned to “baseline” in determining that psychological treatment after July 12, 1993 was not reasonable or necessary to cure and relieve the effects of the injury, ALJ erroneously terminated medical benefits). Accordingly, we set the ALJ’s ruling aside in this regard. Nevertheless, this determination does not prohibit the respondents*

from challenging the reasonableness, relatedness, and necessity for any particular treatments.

B.

Additionally, §8-42-105, C.R.S. provides that upon the occurrence of one of four enumerated conditions, TTD benefits shall cease. Section 8-42-105(3), C.R.S. provides that TTD benefits shall continue until the first occurrence of any one of the following: (a) the employee reaches maximum medical improvement; (b) the employee returns to regular or modified employment; (c) the attending physician gives the employee a written release to return to regular employment; or (d)(I) the attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee and the employee fails to begin such employment. *See United Airlines v. Industrial Claim Appeals Office*, 312 P.3d 235 (Colo. App. 2013); *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The termination of TTD benefits under any one of the four enumerated conditions is mandatory. *Burns v. Robinson Dairy, Inc.*, 911 P.2d 661 (Colo. App. 1995).

Moreover, with regard to TPD benefits, §8-42-106(1), C.R.S. provides:

In case of temporary partial disability, the employee shall receive sixty-six and two-thirds percent of the difference between the employee's average weekly wage at the time of the injury and the employee's average weekly wage during the continuance of the temporary partial disability, not to exceed a maximum of ninety-one percent of the state average weekly wage per week.

Section 8-42-106(2), C.R.S. provides that TPD benefits shall continue until either of the following occurs: “(a) The employee reaches maximum medical improvement; or (b)(I) The attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.”

Here, we conclude the ALJ erred in terminating TTD benefits as of April 7, 2014, and continuing, and not issuing any findings or conclusions regarding the claimant's entitlement to TPD benefits. The ALJ found the claimant had returned to work for the respondent employer in a modified capacity on April 7, 2014. In support of this determination, the ALJ found that on April 4, 2014, Dr. Williams had released the claimant to modified employment with lifting, carrying, and pulling restrictions, and that the claimant informed Dr. Williams she had returned to work on April 7, 2014.

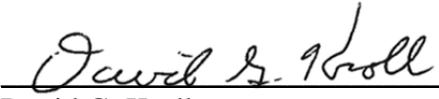
Conclusions of Law at 11-12 ¶13; Ex. Q at 203-205, 208. The ALJ also referenced the employer's records which reflected that the claimant had earned wages during the two-week pay period beginning on April 6, 2014, through April 19, 2014. Conclusions of Law at 11-12 ¶13; Ex. 10. While Dr. Williams' medical record dated April 8, 2014, does in fact state the claimant had been released to modified duty and that the night before was her first night back to work, it also states that her pain level became unbearable that night and that she lasted for about two hours and was unable to continue on. Dr. Williams then took the claimant off of work from April 8, 2014, through April 11, 2014. Ex. Q at 208-210, 212. On April 11, 2014, Dr. Williams reexamined the claimant and released her to modified duty working four hours per day. Ex. Q at 213-216. Another medical record dated April 18, 2014, states the claimant is on restricted duty, and another medical record dated April 18, 2014, states the claimant was "taken of[f] work schedule as of April 17, 2014." Ex. Q at 221-225. And, during the hearing, the claimant testified she has not worked at all since mid-April 2014. Tr. at 83-83. Because these medical records and this evidence do not support the ALJ's termination of TTD benefits from April 7, 2014, and continuing, we set his order aside in this regard. Additionally, the ALJ did not enter any findings or conclusions regarding the claimant's entitlement to TPD benefits. During the hearing, however, the claimant testified that before her work incident, she worked what was considered full time. She explained that she typically worked five days per week, averaging approximately 32-35 hours per week. Tr. at 81-82. As noted above, however, on April 4, 2014, Dr. Williams reexamined the claimant and released her to modified duty working four hours per day. Ex. Q at 213-216. Accordingly, we necessarily remand the matter to the ALJ for further findings and a new order regarding the claimant's entitlement to TTD and TPD benefits.

IT IS THEREFORE ORDERED that the ALJ's order, corrected order, and supplemental order dated November 3, 2014, November 25, 2014, and March 11, 2015, respectively are set aside regarding the termination of medical benefits and TTD benefits;

IT IS FURTHER ORDERED that the matter is remanded for further findings and a new order on the claimant's entitlement to TTD and TPD benefits.

CODY DAVIS
W. C. No. 4-947-977-01
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INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

CODY DAVIS
W. C. No. 4-947-977-01
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CERTIFICATE OF MAILING

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

_____ 6/17/2015 _____ by _____ RP _____ .

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY
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RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: CONNIE HULST, ESQ., 1401
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ALJ CANNICI, OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA MCGOVERN,
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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-907-349-03

IN THE MATTER OF THE CLAIM OF
VICTOR ENGLAND,

Claimant,

v.

FINAL ORDER

AMERIGAS PROPANE,

Employer,

and

INDEMNITY INSURANCE COMPANY
OF NORTH AMERICA,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Turnbow (ALJ) dated February 12, 2015, that ordered the parties' settlement in this matter reopened and directed the respondents to pay temporary disability benefits. We affirm.

On December 29, 2012, the claimant suffered a compensable right shoulder injury. He was diagnosed with a rotator cuff tear based upon an MRI image. The claimant subsequently underwent multiple total shoulder arthroplasty surgeries. The last surgery on May 1, 2013, used a thicker plate to attach the hardware to the claimant's scapula with screws. The claimant continued to experience difficult pain in his shoulder despite his second surgery. The respondents' arranged for a second opinion independent medical exam (IME) to be performed by Dr. Lambden. In his IME report the doctor estimated the claimant would be at maximum medical improvement (MMI) within two or three months. The claimant testified that the level of his pain did not decrease but he felt that eventually it would do so.

The respondents offered to settle the claimant's case on a full and final basis for \$35,000. The claimant obtained counsel and agreed to the settlement. The parties executed a settlement using the form required by the Division of Workers' Compensation on September 12, 2013. In the agreement, the claimant waived all rights to future indemnity and medical benefits. The claimant also waived the right to reopen the claim except on grounds of fraud or mutual mistake of material fact.

The claimant did not achieve improvement of his condition or of the pain in his shoulder. In October, 2013, he sought further treatment with his personal physician at a Kaiser-Permanente clinic. He saw Dr. Gallagher who obtained an X ray on October 15. He read the X ray to disclose a fracture in the scapula in the vicinity of a surgical screw. Dr. Gallagher performed a surgical repair of the fracture on November 20, 2013. The surgery did not accomplish a successful repair and the fracture remained. After the claimant sought to reopen his claim, the respondents had the claimant seen by his prior authorized physician, Dr. Papilion. Dr. Papilion made a referral to Dr. Hatzidakis who performed a second fracture repair surgery in September of 2014. A third surgery had been recommended.

The claimant filed a petition to reopen his settlement in March, 2014. In his August 22, 2014, application for a hearing he alleged a reopening was justified due to a mutual mistake of material fact surrounding the absence of any information regarding a fracture of the scapula until after the settlement was executed. The claimant requested additional medical benefits and temporary total disability benefits from September 12, 2013, and continuing.

After a hearing completed on December 18, 2014, the ALJ submitted a February 12, 2015, order. The ALJ found credible the testimony of Dr. Gallagher that the X ray evidence showed a screw used to adhere the claimant's shoulder hardware to the scapula was located in the site of the fracture. The doctor's opinion was that the stress generated through the screw caused the fracture. He indicated the medical records showed the first documentation of the fracture was the X ray dated October 15, 2013. Dr. Gallagher explained the fracture would have taken several months to develop. It would have progressed from a very small adhesion to an open fracture. Dr. Papilion expressed an opinion in a May 27, 2014, report that was consistent with Dr. Gallagher's observation the scapular fracture was related to the original work injury. Both he and Dr. Gallagher were convinced the fracture originated prior to September, 2013, the date of the settlement. It was not however, visible for detection until October, 2013. Dr. Lambden conducted a second IME after discovery of the fracture. He believed, as did Dr. Gallagher, that the surgical screw caused the fracture which then progressed in severity. Dr. Lambden also stated the claimant could not have been seen to have ever reached MMI, even after his last September, 2014, fracture surgery by Dr. Hatzidakis.

In her order, the ALJ found persuasive the testimony of Dr. Gallagher and gave weight to the testimony of Dr. Lambden that was consistent with that of Dr. Gallagher. The ALJ concluded that at the point of settlement in September, 2013, the claimant had

an existing, undiagnosed, and undiscovered fracture in his scapula. The ALJ noted that neither party sought or paid consideration for the unknown fracture for the reason that no one knew it existed. Accordingly, the ALJ surmised the parties entered into the settlement without being fully informed concerning the extent, severity and likely duration of the claimant's shoulder injury. This was found to constitute a mutual mistake of material fact which justified setting aside the September 12, 2013, settlement of the parties and reopening the claim. The ALJ recalculated the average weekly wage and deemed the claimant disabled from returning to work since the date of the settlement. Temporary total benefits were awarded from that date and continuing. The respondents were allowed a credit for the settlement proceeds paid to the claimant. Dr. Papilion and Dr. Hatzidakis were adjudged to be authorized treating physicians and their treatment was found compensable.

On appeal, the respondents contend there was insufficient evidence to support a finding of a mutual mistake, that the mistake was "unknown" and therefore excluded by the settlement document from consideration for reopening, that the ALJ was mistaken in finding the mistake was not mutual and therefore not granting the respondents' motion for a denial of the reopening at the close of the claimant's case, and for failing to apply the parol evidence rule to exclude much of the claimant's evidence. We disagree.

I.

The respondents assert the claimant failed to produce evidence of a mistake, that it was material, or that it was mutual. At the conclusion of the claimant's presentation of evidence, the respondents moved for a decision in their favor on the basis that the claimant had failed to produce sufficient evidence to prove any of these elements of a case for reopening. The ALJ took that motion under advisement and denied it in her final written order. Despite the insistence of the respondents, we note there is substantial evidence in regard to each of these factors.

A mistake may be found where parties settle a claim without being fully informed concerning the "extent, severity and likely duration" of the injury. *Gleason v. Guzman*, 623 P.2d 378 (1981). In this regard the mistake must pertain to a past or present fact not an opinion or prophecy about the future. *Gleason v. Guzman*, 623 P.2d 378 (1981). Further, a mutual mistake is one which is reciprocal and common to both parties to an agreement. *Maryland Casualty Co. v. Buckeye Gas Products Co.*, 797 P.2d 11 (Colo. 1990); *Cary v. Chevron U.S.A., Inc.*, 867 P. 2d 117 (Colo. App. 1993).

There is no "litmus-type" test for determining whether a mistake pertains to a past or present fact as opposed to a prediction or prognosis about the claimant's future condition, and this issue "is essentially factual in character." *Gleason v. Guzman*, 623 P.2d 384. Consequently, we must uphold the ALJ's finding of a mutual mistake if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Maryland Casualty Co. v. Buckeye Gas Products Co.*, *supra*. In applying the substantial evidence test, we are obliged to defer to the ALJ's resolution of conflicts in the evidence, her credibility determinations and the plausible inferences which she drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

The ALJ reviewed the medical records extant at the point the settlement was negotiated in September, 2013. She took particular note of the IME report of Dr. Lambden dated July 30, 2013. In that report the doctor gives the opinion there is no reason the claimant will not increase his activity level with his right shoulder in the near future. The recommendation for medical treatment was limited to physical therapy for another 4 to 8 weeks and pain medication during this period. Dr. Lambden anticipated the claimant would reach MMI within 2 to 3 months. Dr. Papilion authored a report on the same date and also recommended only physical therapy with a follow up appointment scheduled six weeks hence. The doctor noted no instability and an intact neurovascular exam. These medical reports were available to both parties and there were no contemporaneous medical records which contained any contrary opinions. The presence of these medical reports constitute substantial evidence for the ALJ's conclusion that both parties negotiated a settlement under the belief the claimant's condition would soon improve, that MMI would be achieved in a matter of months and the intervening medical treatment would include only conservative therapy.

However, shortly after the settlement, an X ray and then a CT scan revealed the claimant's condition was markedly worse than it was described in July by either Dr. Lambden or Dr. Papilion. Dr. Gallagher testified the claimant's scapular fracture most probably occurred as a result of the claimant's shoulder revision surgery. He also described how this fracture likely occurred in the spring of 2013. (Dr. Gallagher deposition, pg. 23). The medical documents in the file and the testimony show the claimant went on to require two additional surgeries with a third planned. Dr. Lambden testified the claimant was not at MMI in November of 2014. Tr. at 107. This information represents substantial evidence that the mutual knowledge of the parties was mistaken when the settlement was negotiated in September, 2013. The ALJ found the claimant had a present but undiagnosed fracture of his scapula. This fracture caused considerable disability and a large amount of additional medical treatment. The record

supports the ALJ's findings there was a mutual mistake as to the claimant's condition in September, 2013. The mistake was also material.

The respondents are correct to complain the ALJ should not have cited to a statement of the respondents' attorney made in a position statement as evidence of knowledge, or a lack of it, at the time of settlement. The statement is argument and does not rise to the level of a judicial admission. The attorney was not under oath or subject to cross examination. If counsels' argument becomes a substitute for evidence, there would be little need for judicial hearings. However, this error by the ALJ is harmless. As observed above, the record contains substantial admissible evidence to support the finding of a mutual mistake.

II.

The respondents argue the terms of the September 12, 2013, settlement agreement were unambiguous and clear. Therefore, they reason the parol evidence rule should be applied to prevent the admission of any extrinsic evidence addressing the intent of the parties. They point out the settlement agreement uses the Director's required settlement language and the ALJ did not find the settlement contract language to be ambiguous. The respondents note paragraph 6 of the settlement agreement advises the claimant there may be "unknown" injuries or conditions as a consequence of the work injury but that the claimant is waiving any claim for these unknown conditions by settling.

While the respondents point to paragraph 6 of the agreement and its reference to "unknown" injuries or conditions, the ALJ observed that paragraph 4 of the agreement provides the settlement agreement may be reopened on the grounds of "fraud or mutual mistake of material fact." This provision is consistent with the identical language in the reopening statute, § 8-43-303(1) C.R.S. The ALJ deemed the reference to a mutual mistake was clear and unambiguous. The claimant's evidence was found to be applicable to this term of the agreement. He sought to prove a mutual mistake of material fact. That evidence was not characterized as parol evidence submitted to contradict an unambiguous provision. It was instead, seen as evidence offered consistently with the unambiguous statement in the contract that a mutual mistake may allow a reopening.

A settlement agreement is a contract, and its interpretation is a question of law. *Cary v. Chevron U.S.A., Inc.*, 867 P. 2d 117 (Colo. App. 1993). If the language used in the agreement is plain, clear and no absurdity is involved, the agreement must be enforced as written. *Three G. Corp. v. Daddis*, 714 P.2d 1333 (Colo. App. 1986). Parol

evidence is only admissible if the agreement is so ambiguous that the parties' intent is unclear. *Cheyenne Mountain School Dist. #12 v. Thompson*, 861 P.2d 711 (Colo. 1993). The mere fact that the parties purport to interpret the agreement differently does not, in itself, create an ambiguity. See *Burns v. Burns*, 169 Colo. 79, 454 P.2d 814 (Colo. 1969); *Brunton v. International Trust Co.*, 114 Colo. 298, 164 P.2d 472 (1945).

We have previously reached a conclusion similar to that of the ALJ in this case in *Higley v. The Southland Corp.*, W.C. 3-876-696 (October 2, 1998). The parties in *Higley* had entered into a final settlement of the claim which provided the claimant waived her rights to future benefits with the exception of future medical benefits. The respondents later requested a hearing to contest the claimant's continuing need for housekeeping services as a medical benefit. The terms of the settlement agreement included a sentence stating: "The Respondents, however, retain their rights to contest the reasonableness and necessity and causal relationship of Claimant's medical treatment." The claimant sought to introduce evidence through testimony of her former attorney that the respondents agreed in order to obtain the settlement that they would continue to provide housekeeping services. The ALJ refused to allow this testimony due to the parol evidence rule. We affirmed the ALJ and noted the terms of the contract allowing the respondents the continuing right to contest medical benefits was unambiguous. The parol evidence represented by the attorney's testimony which sought to challenge that clear contract language was appropriately characterized as inadmissible parol evidence. However, we added that:

In reaching our conclusion, we recognize that the claimant's reasons for entering into the agreement might be relevant to a petition to reopen the settlement on grounds of "fraud or mutual mistake of a material fact." See § 8-43-204(1), C.R.S. 1998. However, neither party has petitioned to reopen the settlement. Therefore, the ALJ did not err in refusing to consider testimony concerning the claimant's reasons for settling the claim to interpret the terms of the settlement. *Higley* at 4.

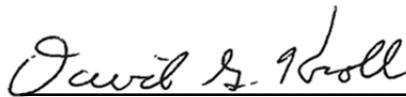
In this matter the claimant is seeking to submit evidence pertinent to an 'unknown' condition, but a condition which could establish a 'mutual mistake of material fact.' Because this latter term is an unambiguous part of the contract, the ALJ was not in error for allowing the claimant to submit his evidence relevant to that term.

The respondents rely on the decision in *Bopp v. Garden Square Assisted Living*, W.C. No. 4-893-767 (February 6, 2014), *affirmed*, (Colo. App. No. 14CA0348, 2015) for authority that the term “unknown” injuries in settlement documents would encompass an injury similar to the claimant’s scapular fracture in this matter and prevent it from being a basis for a claim for further benefits. However, a reading of the *Bopp* case reveals the claimant did not seek to reopen a settlement. Instead, she sought to file a separate claim for an injury the respondents argued was received in a quasi-scope of employment situation. The claimant had alleged she was injured obtaining chiropractic care on April 18, 2012, while treating for her original 2009 work injury. The claimant settled the 2009 injury on July 13, 2012. The claimant’s 2012 injury claim was dismissed when it was held to be a part of the 2009 injury claim and was therefore settled with that case. *Priceline Service, Inc. v. Industrial Claim Appeals Office*, 64 P.3d 936 (Colo. App. 2003). The claimant did not contend her 2012 injury was ‘unknown.’ She simply asserted it was a separate injury.

The respondents’ remaining arguments have been considered and are not found persuasive.

IT IS THEREFORE ORDERED that the ALJ’s order dated February 12, 2015 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

VICTOR ENGLAND
W. C. No. 4-907-349-03
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CERTIFICATE OF MAILING

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

_____ 6/25/2015 _____ by _____ RP _____ .

THE ELLIOTT LAW OFFICES, Attn: MARK D. ELLIOTT, ESQ./ALONIT KATZMAN,
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LEE + KINDER LLC, Attn: KATHERINE LEE, ESQ./JOSHUA D. BROWN, ESQ., 3801 E.
FLORIDA AVENUE, SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-915-606-03

IN THE MATTER OF THE CLAIM OF
ROBERTO GODOY,

Claimant,

v.

ORDER OF REMAND

CUSTOM MADE MEALS CORP.,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Michelle Jones (ALJ) dated March 30, 2015, that granted the respondents' motion for summary judgment and denied and dismissed the claimant's claim for permanent total disability (PTD) benefits. We set aside the ALJ's order and remand the matter for further proceedings.

The following facts are not disputed. On June 6, 2014, a Division Independent Medical Examination (DIME) physician issued a report concluding that the claimant was at maximum medical improvement (MMI) with a 30 percent whole person impairment rating. The respondents timely filed an application for hearing and notice to set, seeking to overcome the DIME report. While this issue was in dispute, the parties agreed to hold the issue of permanent total disability in abeyance, pending the completion of the litigation of the respondents' June 23, 2014, application for hearing on the issue of overcoming the DIME. The hearing was set for October 22, 2014. However, the respondents conceded the issue for hearing by filing a final admission of liability admitting for the DIME physician's MMI and impairment rating. On August 25, 2014, the respondents confirmed with claimant's counsel that the issues set for hearing were resolved by the final admission of liability. The claimant's counsel indicated that he planned to "App. for PTD after I get a Voc. eval." (Exhibit E). The respondents filed a hearing cancellation notice on August 25, 2014. The claimant failed to object or to apply for a hearing within 30 days of the August 22, 2014, final admission.

The claimant eventually filed an application for hearing listing the issue of permanent total disability on October 13, 2014, 53 days after the date of the August 22, final admission. The claimant also filed an “Objection Out of Time to FAL” on October 23, 2014.

The respondents filed a motion for summary judgment, arguing that the claimant’s failure to file an application for hearing within 30 days of the August 22, 2014, final admission closed all of the issues by operation of law. Section 8-43-203(2)(b)(II)(A), C.R.S. In response, the claimant made equitable arguments concerning the unfairness of the requirement to object within 30 days and contended that his constitutional due process rights were violated. The claimant also pointed to the agreement made with a Pinnacol Attorney to hold the issue of permanent total disability in abeyance.

The ALJ agreed with the respondents and granted the motion for summary judgment. The ALJ determined that the claimant’s failure to file an application for hearing within 30 days of the August 22, 2014, final admission resulted in automatic closure of the claim and the claimant was jurisdictionally barred from pursuing the permanent total disability claim. The ALJ, therefore, denied and dismissed the claimant's claim for permanent total disability benefits.

On appeal, the claimant again makes the same equitable arguments concerning the unfairness of the requirement to object and points to the agreement with a Pinnacol Attorney to hold the issue of permanent total disability in abeyance. Because there is a disputed issue of material fact concerning the scope and extent of this agreement between the parties, we agree with the claimant that the matter should be set aside and remanded for further proceedings.

Office of Administrative Courts Rule of Procedure Rule (OACRP) 17, allows an ALJ to enter summary judgment where there are no disputed issues of material fact. Moreover, to the extent that it does not conflict with OACRP 17, C.R.C.P. 56 also applies in workers' compensation proceedings. *Fera v. Industrial Claim Appeals Office*, 169 P.3d 231 (Colo. App. 2007); *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988)(the Colorado rules of civil procedure apply insofar as they are not inconsistent with the procedural or statutory provisions of the Act).

Summary judgment, however, is a drastic remedy and is not warranted unless the moving party demonstrates that it is entitled to judgment as a matter of law. *Van Alstyne v. Housing Authority of Pueblo*, 985 P.2d 97 (Colo. App. 1999). All doubts as to the existence of disputed facts must be resolved against the moving party, and the party

against whom judgment is to be entered is entitled to all favorable inferences that may be drawn from the facts. *Kaiser Foundation Health Plan v. Sharp*, 741 P.2d 714 (Colo. App. 1987). In the context of summary judgment, we review the ALJ's legal conclusions de novo. *See A.C. Excavating v. Yacht Club II Homeowners Association*, 114 P.3d 862 (Colo. 2005).

Section 8-43-203(2)(b)(II), C.R.S., provides as follows:

(A) An admission of liability for final payment of compensation must include a statement that this is the final admission by the workers' compensation insurance carrier in the case, that the claimant may contest this admission if the claimant feels entitled to more compensation, to whom the claimant should provide written objection, and notice to the claimant that the case will be automatically closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing, including the selection of an independent medical examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted.

Accordingly, the failure to file a written objection to final admission and an application for hearing on the disputed issues within 30 days closes the claim on all admitted issues. *Dyrkopp v. Industrial Claim Appeals Office* 30 P.3d 821 (Colo. App. 2001). The automatic closure of issues raised in an uncontested final admission of liability (FAL) is part of a statutory scheme designed to promote, encourage, and ensure prompt payment of compensation to an injured worker without the necessity of a formal administrative determination in cases not presenting a legitimate controversy. Once a case has automatically closed by operation of the statute, the issues resolved by the final admission are not subject to further litigation unless they are reopened pursuant to §8-43-303. C.R.S. *See Leeway v. Industrial Claim Appeals Office*, 178 P.3d 1254 (Colo. App. 2007). The statute further provides, “[a]ny issue for which a hearing or an application for a hearing is pending at the time that the final admission of liability is filed shall proceed to the hearing without the need for the applicant to refile an application for hearing on the issue.”

Here, we agree with the claimant that the ALJ erred in granting the respondents' motion for summary judgment. Although the claimant makes only general allegations that there was a stipulation to hold the issue of permanent total disability in abeyance, the

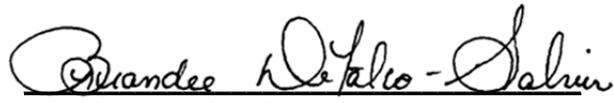
respondents concede there was such an agreement. In the motion for summary judgment, the respondents state that they “accept a finding that an agreement was reached between the parties to hold permanent total disability in abeyance pending the conclusion of the litigation on the respondents’ June 23, 2014, hearing application.”

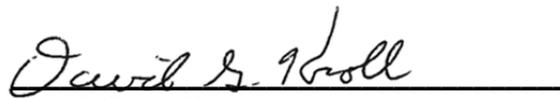
As we understand the claimant’s argument, he is contending that the effect and provisions of the agreement to hold the issue of permanent total disability in abeyance were misconstrued by the ALJ. Thus, the matter turns upon the interpretation of the agreement between the parties. The agreement, however, is not in the record and it is unclear whether the agreement between the parties was oral or written. Whether the terms of the agreement operated to preserve the issue of permanent total disability and for how long, is a factual determination for the ALJ. This is a factual issue that remains in dispute. This factual question should be determined following an evidentiary hearing at which the parties have had a full opportunity to adduce the evidence of the agreement to hold the issue in abeyance. *See Hoff v. Industrial Claim Appeals Office*, 2014 COA 137, (Colo. App. 2014) (when more than one inference could be drawn from evidence adduced at a hearing, the issue must be determined by the trier of fact and cannot be determined as a matter of law).

Because there is a factual dispute concerning the scope and extent to the terms of the agreement to hold the issue of permanent total disability in abeyance, the claimant is entitled to an evidentiary hearing regarding that issue. Therefore, summary judgment was not appropriate and we set aside the order insofar as it determined the claim was closed and denied the claimant to right to pursue his claim for permanent total disability benefits without a petition to reopen.

IT IS THEREFORE ORDERED that the ALJ’s order dated March 30, 2015, is set aside and the matter is remanded for further proceedings.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


David G. Kroll

ROBERTO GODOY
W. C. No. 4-915-606-03
Page 6

CERTIFICATE OF MAILING

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

_____ 7/9/2015 _____ by _____ RP _____ .

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AFFORDABLE LEGAL SERVICES, Attn: JOHN W. SWANSON, ESQ., 1555 SOUTH
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RUEGSEGGER SIMON SMITH & STERN, LLC, Attn: THOMAS M. STERN, ESQ., 1401
17TH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

MICHELLE E. JONES, ESQ., % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA
MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-937-000-01

IN THE MATTER OF THE CLAIM OF

JEANETTE JORDAN,

Claimant,

v.

FINAL ORDER

RIO BLANCO WATER
CONSERVANCY DISTRICT,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Mottram (ALJ) dated January 5, 2015, (and clarified on February 20, 2015) that ordered the respondents to pay a penalty pursuant to § 8-43-203(2)(a), C.R.S. but denied consideration of a penalty pursuant to § 8-43-304(1), C.R.S. We affirm the order.

The claimant injured her left wrist when she fell at work on July 23, 2013. She worked as a hydro-operator. The ALJ found the claimant informed her supervisor of her injury on that day when she left him a written note. The claimant then traveled to the emergency room and obtained an X ray. The emergency room staff took the claimant off work through the following Friday, July 26. The claimant was released to return to work without restriction on Monday, July 29. When the claimant returned to work on July 29, another supervisor, Mr. Eddy, advised her she was to be laid off due to a restructuring. The claimant returned to the authorized doctor, Dr. Britton, on July 30. The doctor diagnosed a wrist sprain and recommended a 5 pound lift restriction.

Mr. Eddy testified he informed the employer's workers' compensation insurer of the claimant's injury on July 23. After July 29, Mr. Eddy notified the insurer's claims adjuster that the claimant was now missing work due to the employer's restructuring. The adjuster however, made a notation the claimant returned to work on July 24. The adjuster further miscoded the claim paper work to state the claimant was discharged for cause and the claim did not feature lost time from work. A new adjuster took over the claim in

December, 2013. She filed a general admission of liability form for medical benefits only on December 19, 2013. Following the claimant's wrist surgery on May 14, 2014, the adjuster submitted an admission for temporary disability benefits as of that date.

On June 3, 2014, after obtaining counsel, the claimant filed an application for a hearing stating:

Penalties: (1) Employer violation of CRS § 8-43-101(1)(a) commencing 7/23/2013 – continuing, failure to properly report lost time injury to Division or injurer [sic], (2) Employer violation of CRS § 8-43-103(1) commencing 7/23/13 – continuing; failure to properly report lost time injury to Division or insurer. (3) Insurer violation commencing approximately 8/12/13: failure to admit liability for lost time injury until 4/29/14, implicating § 8-43-203. (4) Employer fraud/false statement implicating § 8-43-402 commencing 7/23/13 – continuing.

A hearing on the application was convened on November 12, 2014. After taking the testimony of the claimant, Mr. Eddy, and the claims adjuster, the ALJ found the employer did not comply with the requirements of §§ 8-43-101(1) and 8-43-103(1) by failing to notify the Division of the claimant's lost time injury within 10 days of the point the employer became aware the claimant was missing more than three shifts from work. The hearing officer then determined the insurer had violated § 8-43-203(1) due to its failure to notify the claimant and the division whether the insurer was denying or accepting liability for the injury within 20 days of the date the employer was to file its report pursuant to § 8-43-101(1). This violation was observed to run from August 22 through the date the general admission of liability was filed on December 19, 2013. The ALJ concluded the insurer had not taken sufficient steps to ascertain whether or not the claimant's injury truly was a no lost time claim. If it had done so, the ALJ surmised the insurer would have avoided its delay in filing its admission of liability. Accordingly, the ALJ assessed the insurer the maximum penalty allowed by § 8-43-203(2) of one day's compensation for each day of violation. The penalty totaled \$9,919.42, with 50% paid to the claimant and 50% to the Subsequent Injury Fund as provided by that section.

The ALJ did not consider any penalty that could have been assessed pursuant to § 8-43-304(1). The ALJ noted this statute was not referenced by either the claimant or the respondents in the application for a hearing, in a Case Information Sheet or at the outset of the hearing. At the hearing, the respondents' counsel advised the ALJ the respondents

had no affirmative defenses. Tr. at 8. However, three weeks after the conclusion of the hearing, in the parties' post hearing position statements, both parties referenced § 8-43-304. The claimant made no request for a penalty pursuant to § 8-43-203(2), but only for a penalty according to § 8-43-304(1) (\$742,000, 50% payable to the workers compensation cash fund). The respondents asserted they had cured the alleged violations when they filed their December 19 admission of liability. Due to the provisions of § 8-43-304(4), they contended the burden of proof to justify a penalty was on the claimant and required proof to the extent of 'clear and convincing' evidence. However, the ALJ resolved that because the issue of § 8-43-304 liability was not raised prior to the hearing, and the record did not reveal the issue to have been tried by consent during the hearing, neither the issues of § 8-43-304 penalties nor defenses were properly before him for decision.

On appeal, the claimant contends the ALJ committed an abuse of discretion when he declined to consider penalties pursuant to § 8-43-304(1) in regard to violations of §§ 8-43-101(1) and 8-43-103(1) by the employer. The claimant argues § 8-43-304(1) was implicitly raised when she alleged in her application for hearing the violations of §§ 8-43-101(1) and 8-43-103(1).

We do not agree the ALJ abused his discretion in noting the issue of penalties under § 8-43-304(1) was not before him for decision. Section 8-43-304(4) provides that in any application for hearing for any penalty pursuant to § 8-43-304(1) "the applicant shall state with specificity the grounds on which the penalty is being asserted." More importantly, Office of Administrative Courts Procedural Rules for Workers' Compensation Hearings, Rule 8(A), specifies the application for a hearing "shall be on a form provided by the OAC, ..." The OAC Application form contains the direction to the parties that if penalties are sought from an ALJ the party must check the box opposite "Penalties" and then must "Describe with specificity the grounds on which a penalty is asserted, including the order, rule or section of the statute allegedly violated, and the dates on which you claim the violation began and ended." A statement of the particular penalty remedy sought is a critical element of the grounds for the penalty claim. The direction that the specific grounds for the penalty be identified in the application would include a specification of the penalty sought to be applied.

The statute contains reference to a variety of penalty sections. These include § 8-43-218 (parties must cooperate with division claim managers, the penalty includes the rejections of hearing applications or responses and monetary fines); § 8-43-408(1) (failure to insure, increased liability for benefits); § 8-43-404(3), (commission of injurious practice, suspension of indemnity benefits); § 8-43-408(4) (failure to pay

ordered benefits or a bond, penalty for 50% of the amount of the order); § 8-43-203(2) (failure to timely file an admission or contest, one day's compensation for each day of violation); § 8-43-404(1)(3) (failure to attend medical appointment, suspension of indemnity benefits or request for benefits); § 8-47-102 (failure to obey subpoena or order of the director, incarceration until compliance is achieved); § 8-43-401(2) (failure to pay medical or permanent benefits within 30 days, 8% or 10% of the delayed payment); § 8-43-304(1.5)(repeated violations by an insurer, fine as determined by the Director or ALJ); § 8-43-304(1) (violations of the act or orders, \$1,000 per day); § 8-43-102 (claimant's failure to report injury, loss of one day's compensation for each day report delayed); § 8-43-402 (making a false statement to obtain a benefit or an order, felony conviction and loss of all right to indemnity benefits); among others.

Many of these overlap and may be subject to different defenses to their applications. Some require specific mental intent, (§ 8-43-402) while others apply simply to negligence and use an objective standard (§ 8-43-304(1)), and most premise the amount of the penalty on factors unique to the matter at hand. In that regard, establishing the amount of the penalty may subject the issue to consideration of the 8th Amendment to the U.S. Constitution's limit on excessive fines. *Davis v. K Mart*, W.C. 4-493-641 (April 28, 2004), referencing *Northern Telecom v. Industrial Claim Appeals Office*, (Colo. App. 02 CA 2052, December 24, 2003)(not selected for publication). *Associated Business Products v. Industrial Claim Appeals Office*, 126 P.3d 323 (Colo. App. 2005). Some feature discrete statute of limitations periods, *compare* § 8-43-203(2)(a) and (c) (penalty must be filed within seven years), *with* § 8-43-304(1) and (5) (penalty must be filed within one year). It is a defense to a penalty claim pursuant to § 8-43-304(1) that another penalty applies, whereas such a defense apparently is not applicable to § 8-43-304(1.5). Due to this maze of both subtle and dramatically varying standards, the need for a party to plead specifically the penalty section to be applied is imperative.

In this matter, by way of illustration, the claimant's pleading alleges violations by the respondents of § 8-43-101(1) and § 8-43-103(1). Both instruct the employer to provide notice of an injury to the director within 10 days of the loss of more than three days' work. The pleading then references § 8-43-203 which sets forth a penalty of up to one day's compensation if there is a failure to admit or deny within 20 days after a report "should have been filed with the division pursuant to § 8-43-103(1)." The respondents and the ALJ could very reasonably interpret the pleading's reference to violations of § 8-43-103(1) as prerequisites to the claim for a penalty pursuant to § 8-43-203. They would not necessarily be advised that the claim was for a separate penalty based solely on the violation of § 8-43-103 through application of § 8-43-304(1).

In *Carson v. Academy School District 20*, W.C. 4-439-660, (April 28, 2003), we held the need to plead the appropriate statutory section justifying the penalty claim was required. In *Carson*, the claimant described in her application for a hearing a penalty claim due to bad faith adjusting involved in the failure to pay some medical bills and for some lost time from work. There was no citation to any penalty statute. In his order following the hearing the ALJ imposed penalties under § 8-43-401(2)(a) for the late payment of medical bills, penalties via § 8-43-304(1) for the tardy payment of temporary benefits and penalties through § 8-43-203(1)(a) for failing to timely admit for these same temporary benefits. The respondents appealed arguing the lack of statutory reference to any of these penalty sections up to the very day of the hearing. We reversed the assessment of penalties.

Significantly, each legal theory for the imposition of penalties, whether predicated on § 8-43-401(2)(a) or § 8-43-304(1) for violation of the Act or Rules of Procedure, is subject to specific and unique defenses depending on the particular theory and statute employed. Here, the important point is that Liberty was entitled to reasonable notice of the specific *legal bases* of the claims for penalties in order that it be given a fair opportunity to prepare the appropriate defenses.

...

Although Liberty might or might not have recognized that these actions, if proven, could constitute violations of various provisions of the Act or rules, it was not required to assume that the claimant was raising such legal theories as the basis of the claim for penalties. Neither was Liberty required to foresee that at the time of the hearing the ALJ would shift the entire legal basis of the inquiry away from "bad faith adjusting" and focus on whether or not Liberty violated any of the previously unidentified statutes and rules. (*Carson*, at 4-5)

The respondents in this matter faced the same disability as did the respondents in *Carson*. As of the date of the hearing on November 12, 2014, the respondents did not raise any defenses pertinent to § 8-43-304(1). After the hearing's conclusion, they determined it was necessary to argue to the ALJ in their position statement that they had cured the violation involved. This was premised specifically on § 8-43-304(4).

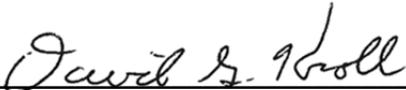
However, just as the respondents did not have notice of the penalty claim pursuant to § 8-43-304(1), the claimant did not have notice of the defense pursuant to § 8-43-304(4). The ALJ correctly concluded a penalty by way of § 8-43-304(1) had not been placed into issue at the hearing and was not subject to a decision.

We previously have determined that the requirement for specificity serves two functions. First, it notifies the putative violator of the basis of the claim so that the violator may exercise its right to cure the violation. The specificity requirement also ensures the alleged violator will receive notice of the legal and factual basis for the penalty claim so that their rights to present evidence, confront adverse evidence, and present argument in support of their position are protected. *See Major Medical Insurance Fund v. Industrial Claim Appeals Office*, 77 P.3d 867 (Colo. App. 2003); *Jakel v. Northern Colorado Paper Inc.*, W.C. No. 4-524-991 (October 6, 2003); *Gonzales v. Denver Public School District No. 1*, W.C. No. 4-437-328 (December 27, 2001); *Stilwell v. B & B Excavating Inc.*, W.C. No. 4-337-321 (July 28, 1999). The fundamental requirements of due process are notice and an opportunity to be heard. Due process contemplates that the parties will be apprised of the evidence to be considered, and afforded a reasonable opportunity to present evidence and argument in support of their positions. Inherent in these requirements is the rule that parties will receive adequate notice of both the factual and legal bases of the claims and defenses to be adjudicated. *See Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo. App. 1990); *Carson v. Academy School District # 20*, W.C. No. 4-439-660 (April 28, 2003); *Marcelli v. Echostar Dish Network*, W.C. No. 4-776-535 (March 2, 2010).

The claimant's pleading regarding a penalty claim was deficient to the extent it did not identify § 8-43-304(1) as the statutory penalty section for which she sought a penalty pertinent to the employer's or insurer's failure to submit an injury report to the director within 10 days pursuant to § 8-43-101 and § 8-43-103. We find no basis for finding error on the part of the ALJ when he held that issue was not raised for purposes of the November 12, 2014, hearing and was not properly before the ALJ for determination.

IT IS THEREFORE ORDERED that the ALJ's order issued January 5, 2015, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

JEANETTE JORDAN
W. C. No. 4-937-000-01
Page 9

CERTIFICATE OF MAILING

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

_____ 6/23/2015 _____ by _____ RP _____ .

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY
BLVD., DENVER, CO, 80230 (Insurer)

WITHERS SEIDMAN RICE & MUELLER, P.C., Attn: DAVID B. MUELLER, ESQ., 101
SOUTH THIRD STREET, SUITE 265, GRAND JUNCTION, CO, 81501 (For Claimant)

RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: MICHELE STARK CAREY, ESQ.,
1401 SEVENTEENTH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

14CA1657 Savage v ICAO 05-28-2015

COLORADO COURT OF APPEALS

DATE FILED: May 28, 2015
CASE NUMBER: 2014CA1657

Court of Appeals No. 14CA1657
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-929-714-01

Cory Savage,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; First Fleet, Inc.; and
Travelers Indemnity Company,

Respondents.

ORDER SET ASIDE AND CASE
REMANDED WITH DIRECTIONS

Division VI
Opinion by JUDGE ASHBY
Furman and Booras, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced May 28, 2015

Winston Law Firm, Kirk M. Anderson, Colorado Springs, Colorado, for
Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Ray Lego & Associates, Jonathan S. Robbins, Gregory W. Plank, Greenwood
Village, Colorado, for Respondents First Fleet, Inc. and Travelers Indemnity
Company

In this workers' compensation action, claimant, Cory Savage, seeks review of a final order of the Industrial Claim Appeals Office (Panel), setting aside an award of medical benefits to him. Because we conclude that substantial evidence supported the administrative law judge's (ALJ) order awarding him benefits, we set aside the Panel's order.

I. Background

Claimant worked as a truck driver for employer, First Fleet Incorporated. He drove two regular routes between Colorado and Kansas, and between Colorado and Nebraska.

On September 21, 2013, claimant was driving near Colby, Kansas, when he felt ill and pulled over to the side of the road. He intended to sleep in the bunk in the truck's cab with the engine idling and, upon pulling over, contacted his wife to tell her of his plan. Because she was unable to reach him later that evening, claimant's wife contacted employer to inquire about his whereabouts. The police located claimant and his truck the next morning. He was unconscious, incontinent, and had vomited.

Claimant was transported by ambulance to the hospital in Colby. He was incoherent and was intubated on one hundred

percent oxygen to assist his breathing. Claimant's diagnoses upon admission included an altered mental state, dehydration, and gastroenteritis.

Later that day, claimant was flown to Memorial Hospital in Colorado Springs. Upon arrival at Memorial Hospital at approximately 5:00 p.m., his carbon monoxide [CO] level was measured at 4.1, which is "minimally elevated." According to one physician's report, the normal range of CO level for a non-smoker such as claimant is "from 0.5 to 1.5." The physician on call at the hospital observed that the "[number one] concern at this point was a remote carbon monoxide poisoning from [twelve] hours of idling in his truck cab." Memorial Hospital's differential diagnosis or "working diagnosis" was "acute-on-chronic carbon monoxide poisoning." A physician retained by employer opined that a CO reading of 4.1 in a patient several hours after being intubated on one hundred percent oxygen was significant, and that claimant's symptoms were consistent with CO exposure. The physician also noted that given CO's half-life of 320 minutes on room air and 80 minutes on one hundred percent oxygen, "[e]ven a conservative estimate of 3 half-lives since the patient was removed from the cab

would back extrapolate his estimated carboxyhemoglobin level at the time he was taken out of the cab at 32 (4 x 2 x 2 x 2).”

Employer disputed that claimant’s illness was caused by CO toxicity. Inspections of the truck performed approximately ten days after claimant first experienced symptoms found no elevated levels of CO in the cab or any sign of a leak or tear in the exhaust line. After reviewing these test results, employer’s retained physician observed: “Clearly, if there is no toxic exposure, there cannot be intoxication. . . . If there was no reasonable probability of carbon monoxide exposure, then that is not the medically probable cause of the clinical episode.”

Based on the medical and other evidence, the ALJ found that CO toxicity caused claimant’s injuries. Although the test results suggested the truck was not the source of the CO, the ALJ found that the totality of the evidence showed it more likely than not that claimant’s illness was caused by CO exposure in the truck’s cab. He therefore awarded claimant his medical benefits.

On review, the Panel set aside the ALJ’s order. The Panel held that under the supreme court’s test in *City of Brighton v. Rodriguez*, 2014 CO 7, claimant bore the burden of establishing a direct link

between his CO poisoning and the truck's cab. Because claimant had not shown that his illness was "directly tied" to the truck cab, the Panel ruled that claimant failed to meet his causation burden. It therefore reversed and set aside the ALJ's order. Claimant now appeals.

II. Analysis

Claimant contends that the Panel overstepped its authority in setting aside the ALJ's order. He argues that the Panel engaged in improper fact finding, and incorrectly concluded that he failed to establish the requisite causal link between his CO poisoning and his work. He also argues that the Panel misinterpreted and misapplied *Brighton*. We agree with both arguments.

A. Applicability of *Brighton's* "But-For" Test

In 2014, the Colorado Supreme Court issued its ruling in *Brighton*, abrogating a line of cases that had barred recovery if the cause of a claimant's injury, often a fall, was "unexplained."

Brighton, ¶ 35 n.9. *Brighton* compensated a worker who had fallen down some stairs even though it was unknown what caused her to fall. Similar to the circumstances here, the employer argued that because the worker could not provide evidence of "the precise

mechanism for the fall,” she could not prove the necessary causal connection between her injury and her work activities. The ALJ determined that the worker’s fall was consequently “unexplained” and denied benefits. But the supreme court held that because her “fall would not have occurred but for the fact that the conditions and obligations of her employment — namely, walking to her office during her work day — placed her on the stairs where she fell, her injury ‘arose out of’ employment and is compensable.” *Id.* at ¶ 36.

The supreme court explained that workplace injuries fall into one of three categories: “(1) *employment risks*, which are directly tied to the work itself; (2) *personal risks*, [or purely idiopathic injuries] which are inherently personal or private to the employee him- or herself; and (3) *neutral risks*, which are neither employment related nor personal.” *Id.* at ¶¶ 19, 22 (emphasis in original). The supreme court placed unexplained falls in this third category, and held that such injuries arise out of employment and are compensable if it can be shown the injury “would not have occurred *but for* employment.” *Id.* at ¶ 25.

In setting aside the ALJ’s order, the Panel held that claimant’s injury did not fall within the third — neutral — category. Relying

on the report of employer's engineer, who was unable to find evidence of a CO leak in the truck, as well as evidence that no subsequent drivers of the truck experienced similar symptoms, the Panel observed that no other "employee in the same circumstances encountered by the claimant did sustain a similar injury." It reasoned that because testing found no evidence of elevated CO levels in the cab, it could not say that claimant would not have fallen ill *but for* his exposure in the cab and, therefore, the *Brighton* "but for test" did not apply.

Because it determined the *Brighton* "but-for" test was inapplicable, the Panel analyzed the cause of claimant's injury under the second category, "personal" or "idiopathic" risks. It therefore held that claimant needed "to show a direct tie to the work itself, or evidence to show that *but for* the requirement of work an employee in similar conditions would also suffer these symptoms." Because he could not meet this burden, the Panel ruled claimant's claim noncompensable.

The Panel analogized claimant's situation to *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). In *Finn*, a claimant found lying on the ground with a skull fracture and

bruises was denied compensation because the claimant “failed to show how or when he received the fracture and the Commission drew no inference from his testimony to supply a causal connection.” *Id.* at 109, 437 P.2d at 544. *Brighton* expressly noted that *Finn*’s reasoning “is entirely consistent with this Court’s precedent regarding the non-compensability of idiopathic injuries.” *Brighton*, ¶ 34. Focusing on this language, the Panel held that claimant’s injury was similarly caused by an idiopathic condition as in *Finn*, and therefore noncompensable.

However, the Panel’s analysis disregards crucial analysis contained in *Brighton*. *Brighton* noted that “[d]emanding more precision about the exact mechanism of a fall is inconsistent with the spirit of a statute that is designed to compensate workers for workplace accidents regardless of fault.” *Id.* at ¶ 30. Although *Brighton* did not overturn *Finn*, *Brighton* cautioned that *Finn* “applies only to cases involving idiopathic — and thus not unexplained — falls. Indeed, this statement from *Finn* is merely a restatement of the ‘special hazard’ doctrine.” *Brighton*, ¶ 35.

Further, the supreme court expressly noted that *Finn* applied only to idiopathic injuries because evidence supported, and the ALJ

specifically found, that the claimant's injury in *Finn* was caused, essentially, by a preexisting condition, placing the injury in the "personal risk," not the "neutral risk," category.

While the employee speculated that he might have been hit by a forklift, he could not remember precisely how he had been injured and there were no witnesses to his accident. Notably, however, the fact-finder specifically credited testimony implying that the employee's injury was caused by some sort of idiopathic condition: "A supervisor who had seen the claimant a few minutes before the accident found him twisted behind some boxes, his feet thrashing as he repeatedly lifted his head which fell striking his face on the floor.... [T]he onset of the injury was *triggered by some 'mysterious innerbody malfunction.'*"

Brighton, ¶ 33 (quoting *Finn*, 165 Colo. at 108, 437 P.2d at 543.)

Here, in contrast, the ALJ expressly found that claimant did not suffer from an idiopathic condition. Rather, the ALJ found, with record support, that claimant was the victim of CO poisoning. Unlike the claimant in *Finn* who was found thrashing and repeatedly lifting and striking his head, the record here contains no evidence that claimant's CO poisoning was caused by an internal bodily malady. Therefore, contrary to the Panel's conclusion, claimant's injuries should have been analyzed under the third,

neutral risk category. His injuries therefore are compensable if the ALJ's factual findings support the conclusion that *but for* claimant's exposure in the truck's cab, he would not have suffered CO poisoning.

B. Substantial Evidence Supports the ALJ's Factual Findings

Having found that this matter should properly be analyzed under *Brighton's* "but-for" test, applicable to injuries caused by "neutral risks," we apply the test to the ALJ's factual findings. Claimant contends that substantial evidence supported the ALJ's factual findings and that the Panel consequently erred by disregarding those findings when it set aside the ALJ's order. We agree.

1. Standard of Review

A claimant bears the burden of establishing that his or her injury is compensable. *See City of Boulder v. Streeb*, 706 P.2d 786, 789 (Colo. 1985). "Proof of causation is a threshold requirement which an injured employee must establish by a preponderance of the evidence before any compensation is awarded. The question of causation is generally one of fact for determination by the ALJ." *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo.

App. 2000). Therefore, a claimant must establish that his or her injury both arose out of and occurred in the course of his or her employment. *See In re Question Submitted by the U.S. Court of Appeals for the Tenth Circuit*, 759 P.2d 17, 20 (Colo. 1988).

While we analyze the ALJ's and the Panel's legal conclusions de novo, *see Brighton*, ¶ 12, we apply the substantial evidence test to the ALJ's factual findings, *see Ward v. Dep't of Natural Res.*, 216 P.3d 84, 94 (Colo. App. 2008). "The determination of whether an employee's injuries arose out of employment is a question of fact for resolution by the ALJ." *Brighton*, ¶ 11. Accordingly, the ALJ's causation finding will be upheld if supported by substantial evidence in the record. § 8-43-301(8), C.R.S. 2014; *Cabela v. Indus. Claim Appeals Office*, 198 P.3d 1277, 1280 (Colo. App. 2008).

"Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995).

2. Record Supports the ALJ's Factual Findings

The ALJ expressly found it more likely than not that CO

toxicity was the cause of claimant's injuries. Claimant's medical records — which identify CO toxicity as a differential diagnosis, and confirm that claimant had minimally elevated levels of CO in his blood hours after being placed on one hundred percent oxygen — support the ALJ's factual finding that claimant suffered from CO poisoning. Indeed, on review, the Panel agreed that the evidence supported this finding and acknowledged it was bound by it.

But, the Panel then relied on the engineering reports that tested the truck after claimant's incident to surmise that it was "a mystery as to how [claimant's CO] exposure came about." The Panel noted that there was a "paucity of evidence" contradicting the engineers' report. The record established that despite running the truck engine for approximately three hours during the testing, no elevated CO level was recorded in the cab and no leaks were found in the exhaust line. Employer argued then, as it does now, that these test results "eliminated" the truck as the source of claimant's CO exposure. The Panel relied on the test results to conclude that the mere fact that claimant suffered from CO poisoning does not, "ipso facto," lead to the conclusion that the truck was the source of the CO because the ALJ pointed to "no other evidence . . . [in]

support [of] an inference the truck was the source of the carbon monoxide exposure.”

But the ALJ rejected the test results and explained why he found that the test results did not overcome other evidence establishing that claimant suffered from CO poisoning arising from his time spent in the truck. The ALJ noted that the engineers made “no attempt to recreate weather conditions,” did not test the truck with a trailer attached as it had been when claimant fell ill, and did not run the truck for “the extreme length of time” it had been running and idling immediately before claimant was found unconscious in the truck by the side of the road by police and EMTs. Because these variables impacted the engineers’ ability to precisely reproduce the conditions at the time claimant fell ill, the ALJ found that even though the tests did not uncover a CO leak, the results did not overcome other evidence tending to show that claimant had been exposed to CO in the truck.

In particular, the ALJ noted, with record support, that claimant’s elevated CO level, present several hours after he had been intubated on one hundred percent oxygen, made it more likely than not that CO poisoning caused his symptoms. The ALJ also

found, and the evidence established, that claimant remained in the truck's cab for several hours before he was rescued by emergency personnel and recovered quickly when he was removed from the truck and treated with oxygen. From this evidence, the ALJ drew the reasonable inference that *but for* claimant's apparent exposure to CO in the truck, he would not have suffered CO poisoning. See *Brighton*, ¶ 24.

These findings go to the credibility of the witnesses and the evidence, which is solely within the ALJ's discretion and cannot be disturbed absent a showing that they had been overwhelmingly rebutted by hard, certain evidence to the contrary. See *Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46 ("It is solely within the ALJ's discretionary province to weigh the evidence and determine the credibility of expert witnesses."); *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000) ("[W]e may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it."); *Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990) (weight to be

accorded expert testimony is “exclusively within the discretion” of the ALJ). Moreover, we are bound to accept reasonable inferences the ALJ draws from the evidence presented. *See Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1031 (Colo. 2004) (“[T]he ALJ’s factual findings are binding on appeal if they are supported by substantial evidence or plausible inferences from the record.”).

Here, the evidence substantially supports the ALJ’s finding that claimant suffered poisoning from CO exposure in the cab of his truck. Because the evidence supports this factual finding, we are bound by it. *Id.* We therefore conclude that the Panel erred in setting aside and reversing the ALJ’s order.

III. Conclusion

The order is set aside and the case remanded with directions to reinstate the ALJ’s order.

JUDGE FURMAN and JUDGE BOORAS concur.

15CA0086 Savidge v ICAO 06-11-2015

COLORADO COURT OF APPEALS

DATE FILED: June 11, 2015
CASE NUMBER: 2015CA86

Court of Appeals No. 15CA0086
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-620-669-14

Kathleen Savidge,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Air Wisconsin Airlines,
Inc.; and Insurance Company of the State of Pennsylvania,

Respondents.

ORDER AFFIRMED

Division III
Opinion by CHIEF JUDGE LOEB
Márquez* and Roy*, JJ., concur

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

Announced June 11, 2015

Steven U. Mullens, P.C., Steven U. Mullens, Colorado Springs, Colorado, for
Petitioner

No Appearance for Respondents

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art.
VI, § 5(3), and § 24-51-1105, C.R.S. 2014.

In this workers' compensation action, claimant, Kathleen Savidge, seeks review of a final order of the Industrial Claim Appeals Office (Panel). The Panel affirmed the order of an administrative law judge (ALJ) who declined to rule on the parties' dispute. The Panel also ruled that claimant's appeal was moot. We affirm.

I. Background

Claimant sustained an admitted, work-related injury to her arm in 2004. She reached maximum medical improvement (MMI) in 2005, but required ongoing medical maintenance care which employer, Air Wisconsin Airlines, Inc., provided. Claimant also suffers from several non-work-related ailments and receives Medicare and social security benefits for those conditions.

In 2011, the parties entered a settlement agreement by which employer agreed to pay claimant \$85,000 in exchange for claimant's settlement of her workers' compensation claim and waiver of all future benefits. The parties also agreed that employer would fund a Medicare Set-Aside Account (MSA) — a fund to pay for any future medical expenses arising out of claimant's work-related injury which Medicare, by statute, cannot cover. The agreement stated

that “[t]he MSA is to be administered by the Claimant.” Thirteen months later, the Centers for Medicare & Medicaid Services approved the proposed set-aside amount of \$101,785.

By then, however, claimant’s condition had worsened and she no longer felt capable of administering the MSA. She therefore asked employer to retain a third party administrator to manage the MSA. Employer refused and instead filed an application for hearing seeking to enforce the agreement.

The ALJ concluded, though, that issues concerning the MSA were “not within the purview of the ALJ’s jurisdiction.” He further noted that the provision was included in a portion of the settlement agreement, paragraph 9(B) that, by regulation, is separate from a workers’ compensation settlement agreement and is not subject to approval by the division of workers’ compensation (DOWC). *See* Dep’t of Labor & Emp’t Rule 7-2(A)(1), 7 Code Colo. Regs. 1101-3. Therefore, he denied and dismissed the parties’ request for relief under the MSA.

Both parties petitioned for review. But, after the petitions for review had been filed, employer agreed to “have the MSA professionally administered as requested by Claimant at the

hearing before the Court.” Employer therefore noted that the dispute concerning the administration of the MSA had become moot and withdrew its petition to review. Claimant, however, refused to withdraw her petition to review.

On review, the Panel held that the ALJ had correctly determined that he lacked jurisdiction to address the parties’ dispute over administration of the MSA. The Panel also held that because claimant “no longer has an injury in fact[, she] has no standing to maintain her appeal.” The Panel therefore “left undisturbed” the ALJ’s order.

II. Analysis

On appeal, claimant contends that the ALJ erred in concluding that he lacked jurisdiction to address the parties’ dispute over administration of the MSA. She argues that the agreement concerning the fund should be considered part of the parties’ settlement agreement, even though workers’ compensation rule of procedure 7-2(A)(1) expressly states that such agreements are not subject to DOWC approval. In addition, she urges this court to disregard an earlier Panel decision, *Pankratz v. Hancock*

Fabrics, W.C. No. 4-653-869 (March 25, 2011), that also concluded an ALJ lacked jurisdiction to approve or amend an MSA agreement.

We need not reach these arguments, however, because we agree with the Panel that the issue is moot. “A question is moot if its resolution cannot have any effect upon an existing controversy.”

Duran v. Indus. Claim Appeals Office, 883 P.2d 477, 485 (Colo. 1994); see also *In re Marriage of Wiggins*, 2012 CO 44, ¶ 16; *Reserve Life Ins. Co. v. Frankfather*, 123 Colo. 77, 79, 225 P.2d 1035, 1036 (1950).

Claimant does not dispute that the issue she raises is moot. Rather, she contends that the issue is one of great public importance which should be addressed regardless of its mootness here. Mootness has been disregarded if a controversy raises a matter that greatly impacts the public. See *Forbes v. Poudre Sch. Dist. R-1*, 791 P.2d 675, 676 n.2 (Colo. 1990) (“Because the question of the scope of the Board’s authority to order probation under the Teacher Tenure Act is a matter of great public importance and the exercise of that authority may occur on other occasions, we reject this argument.”).

We are not persuaded that the issue raised here rises to the level of great public importance meriting disregard of its mootness. Claimant argues that if she “submits her medical bills to the U.S. Social Security Administration (SSA) for payment when it is actually [employer’s] obligation to pay those bills, then this matter may end up in federal court with the SSA questioning why claimant is seeking to defraud the SSA.” She reasons that if the question of an ALJ’s jurisdiction over such disputes is not resolved, “it may trigger a severe and unintended consequence for claimants well beyond this workers’ compensation proceeding.”

However, the dispute between the parties concerned *by whom*, not *whether*, the MSA would be administered. The intent of administering the MSA, as we understand it, is specifically to ensure bills pertaining to claimant’s workers’ compensation injury are *not* submitted to SSA. Here, as claimant requested, employer agreed to have the MSA professionally administered. Any risk of the SSA bringing a fraud claim at this time is speculative.

Accordingly, the substantive issue raised in the application for hearing has been resolved. There being no dispute in controversy

to address, resolution of claimant's question will "have no effect on this legal controversy." *Duran*, 883 P.2d at 485.

The order is affirmed.

JUDGE MÁRQUEZ and JUDGE ROY concur.

14CA2023 McMeekin v ICAO 06-18-2015

COLORADO COURT OF APPEALS

DATE FILED: June 18, 2015
CASE NUMBER: 2014CA2023

Court of Appeals No. 14CA2023
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-384-910

Jane McMeekin,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Memorial Gardens,
and Reliance National Indemnity,

Respondents.

ORDER AFFIRMED

Division IV
Opinion by JUDGE GRAHAM
Webb and Terry, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(f)
Announced June 18, 2015

Steve U. Mullens, PC, Steven U. Mullens, Colorado Springs, Colorado, for
Petitioner

No Appearance for Industrial Claim Appeals Office

Thomas Pollart & Miller LLC, Brad J. Miller, Greenwood Village, Colorado, for
Respondents Memorial Gardens and Reliance National Indemnity

In this workers' compensation action, Jane McMeekin (claimant) seeks review of the order of the Industrial Claim Appeals Office (Panel) setting aside an order of an Administrative Law Judge (ALJ) awarding attorney fees to her. The ALJ assessed \$1323.10 in attorney fees against Memorial Gardens, and its insurer, Reliance National Indemnity (collectively employer) after finding that it endorsed an unripe issue on its hearing application in violation of former section 8-43-211(2)(d), Ch. 219, sec. 29, 1991 Colo. Sess. Laws 1319.¹ A Panel majority determined that the issue was ripe when employer endorsed it for hearing. We agree with that determination, and accordingly affirm.

I. Background

Claimant sustained an admitted work injury in 1997. Employer admitted liability for permanent partial disability benefits and medical maintenance benefits. Ongoing or future medical benefits after maximum medical improvement (MMI) (Grover

¹ The statute has since been renumbered and amended. See § 8-43-211(3), C.R.S. 2014. In its current form, the statute makes the sanction of attorney fees discretionary and only after the requesting party proves it first attempted to have the unripe issue stricken. It also excludes pro se parties from its application and expressly limits the reasonable attorney fees and costs to only those directly caused by the listing of the unripe issue.

medical benefits) may be awarded to relieve the injured worker from the effects of the work-related injury and to keep the worker at MMI. *See Grover v. Indus. Comm'n*, 759 P.2d 705, 710 (Colo. 1988).

In a prior appeal, a division of this court affirmed the denial of employer's 2011 request to end claimant's medical maintenance treatment. *See Memorial Gardens & Reliance Nat'l Indem. v. Indus. Claim Appeals Office*, (Colo. App. No. 12CA0951, Dec. 26, 2013) (not published pursuant to C.A.R. 35(f)). The division also affirmed the dismissal of several issues related to attorney fees, finding such issues interlocutory and not reviewable because the ALJ had not determined the fee amount to be awarded.

On remand, the ALJ entered an award of fees in the amount of \$2646.20. The ALJ previously determined that employer had endorsed two unripe issues for hearing, entitling claimant to her attorney fees and costs under former section 8-43-211(2)(d). The issues concerned apportionment² and authorized provider.³

² Employer denied liability for claimant's medical maintenance treatment on the grounds that it was necessitated by conditions other than the industrial injury. *See Hanna v. Print Expeditors Inc.*, 77 P.3d 863, 866 (Colo. App. 2003) (ALJ may order payment for future medical treatment if there is substantial evidence in the record that such treatment is reasonably necessary to relieve the

On review of that order, the Panel determined that only the authorized provider issue was unripe and would support an attorney fee award. It, therefore, remanded the case to the ALJ to determine the amount of attorney fees to be awarded for that single unripe issue.

On further remand, the ALJ rejected claimant's request for \$26,462 in attorney fees. That amount included all fees and costs claimant incurred in preparing for and participating in the hearing that adjudicated employer's request to terminate medical maintenance benefits. The ALJ determined that the crux of the earlier case revolved around the ripe medical benefit issue. The ALJ noted that the issue of authorized treating physician and its ripeness represented a subsidiary issue discussed in only a single paragraph of four sentences in claimant's ten-page post-hearing

claimant from the effects of the industrial injury).

³ The term "authorized provider" refers not only to those providers to whom an employer directly refers a claimant, but also those providers referred by the authorized provider. See *Town of Ignacio v. Indus. Claim Appeals Office*, 70 P.3d 513, 515-16 (Colo. App. 2002). Further, under the Workers' Compensation Act, only treatment given by an authorized provider is compensable. See *Cabela v. Indus. Claim Appeals Office*, 198 P.3d 1277, 1280 Colo. App. 2008).

position statement and consequently found that claimant established no entitlement to the attorney fees and costs that were related to the ripe issues resolved. As a result, the ALJ awarded claimant only five percent of the attorney fees and costs she had requested, which totaled \$1323.10.

Employer and claimant petitioned for review by the Panel. Employer argued that the ALJ erred both in determining that the issue of authorized treating provider was unripe and awarding any attorney fees and costs. Claimant argued that she was entitled to the entire amount of attorney fees and costs she incurred in litigating her medical maintenance benefits even though only one endorsed issue was unripe. A majority of Panel members revised their previous analysis and reversed their determination that the authorized treating physician issue was unripe. Consequently, the Panel majority set aside the attorney fees and costs awarded to claimant and did not reach the issue related to the appropriate amount of fees and costs to be awarded.

Claimant appeals on both the ripeness issue and her claim to an award of the total attorney fees and costs she incurred in defending her medical maintenance benefits.

II. Ripeness

Claimant first contends that the Panel majority erred in determining that the issue of authorized provider was ripe for adjudication at the time employer endorsed it on its hearing application. Because we are persuaded by the Panel majority's analysis, we reject this contention.

Ripeness presents a legal question we review de novo. *Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 16.

Former section 8-43-211(2)(d) required the assessment of reasonable attorney fees and costs against any party requesting a hearing, or filing a notice to set, on issues which were not ripe for adjudication at the time of the request or filing. The statute authorized an award of only the reasonable attorney fees and costs incurred by the opposing party in preparation for such hearing or setting.

“Generally, ripeness tests whether an issue is real, immediate and fit for adjudication. . . . [A]djudication should be withheld for uncertain or contingent future matters that suppose a speculative injury which may never occur.” *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006). The existence of any

legal impediment to a determination of an issue renders an issue not legally ripe for adjudication. *Id.*

The ripeness inquiry weighs “whether the case involves uncertain or contingent future events that may not occur as anticipated, or indeed may not occur at all,” against the hardship posed by the withholding of court consideration. 13B Charles Alan Wright et al., *Federal Practice & Procedure* § 3532, at 365, 369 (3d ed. 2008). In the workers’ compensation realm, ripeness and groundlessness involve different considerations.⁴ As the Panel concluded, issues lacking merit do not necessarily lack ripeness, and a frivolous or meritless claim may nonetheless be ripe for adjudication.

Claimant urges that even if the Panel majority correctly found no legal impediment to resolving the authorized provider issue, that issue implicated only uncertain or speculative contingent matters and presented no real dispute at the time employer endorsed it for hearing. In support, she denies any inextricable connection

⁴ The Workers’ Compensation Act no longer authorizes an award of attorney fees and costs for the defense of a frivolous or meritless claim in proceedings before the ALJ. See Ch. 219, sec. 32, § 8-43-216, 1991 Colo. Sess. Laws 1321 (repealed effective March 1, 1996, as provided in subsection (3) of the statute).

between the authorized provider issue and the ripe issue of medical benefits and maintains that the Panel's reliance on hypothetical scenarios highlights both the distinct and uncertain nature of that issue. She contends that tying the authorized provider issue to the ongoing medical benefits issue, as employer has done, fails to establish its ripeness. Rather, she posits that employer's bootstrapping frustrates the Act's goal of delivering benefits quickly and efficiently at a reasonable cost and without the need to litigate, *see* section 8-40-102(1), C.R.S. 2014, because it neutralizes section 8-43-211(2)(d) as a sanction and allows an employer contesting causation to raise the authorized provider issue without any concern as to ripeness.

Instead, we agree with the Panel majority that the issue of authorized provider can include not only whether a specific provider falls within the chain of referral, but also whether the scope of the referral covers a particular treatment. *See Kilwein v. Indus. Claim Appeals Office*, 198 P.3d 1274, 1276 (Colo. App. 2008) (scope of referral limited to a trial treatment run and care provided beyond trial was unauthorized). In its hearing application, employer stated that it was challenging medical maintenance benefits on the ground

that claimant's current condition did not require the narcotic medications her authorized treating physician prescribed.

Employer requested that "everything be cut off based on the causation defense and based on the fact that it's not reasonable and necessary." Consistent with the Panel majority's analysis, we conclude that employer's challenge to claimant's medication regime encompassed the issue of whether claimant's treating physician had exceeded the scope of his authorization by treating symptoms not caused by the work injury. Employer's endorsement of the apportionment issue, which the Panel ultimately found to be ripe, buttresses this interpretation of employer's hearing application.

Unlike issues that are not ripe, the authorized provider issue here would not become more certain or less speculative with time. *See Olivas-Soto*, 143 P.3d at 1180; *BCW Enters., Ltd. v. Indus. Claim Appeals Office*, 964 P.2d 533, 538-39 (Colo. App. 1997) (insurer entitled to attorney fees under former section 8-43-211(2)(d) where claimant sought penalties for bad faith failure to pay benefits while appeal of issue was still pending; hence bad-faith issue was not yet ripe). On the contrary, the parties acknowledge that no impediment to adjudication of that issue existed when it was endorsed. But, in

addition, the factual circumstances concerning the issue, which claimant characterizes as speculative and contingent, would not become more certain or definite with time.

The dissenting opinion notwithstanding, we believe that the issue of authorized provider could not have been more ripe for hearing. *Franz v. Indus. Claim Appeals Office*, 250 P.3d 1284 (Colo. App. 2010), is instructive. There, a division of this court concluded that the issue for hearing involving the selection of a new authorized treating physician was ripe and would not support an attorney fee award even though an appeal of an order authorizing a change of physician was pending. *Id.* at 1289. The division based its conclusion on the fact that the medical utilization review process giving rise to the change of physician order was final and complete upon the selection of a new physician. *Id.* at 1288. It determined, therefore, that the issue of selecting a replacement physician following the first replacement's refusal to treat the claimant was ripe for adjudication regardless of the possibility the change of physician order could be reversed. *Id.*

In contrast to *Franz*, the facts here involve no contingency, even one so remote as the appeal pending in that case. Moreover,

employer risked waiving the authorized provider issue if it did not endorse it in its hearing application. *See Kuziel v. Pet Fair, Inc.*, 948 P.2d 103, 105 (Colo. App. 1997) (issue not asserted before the ALJ or included in the application for hearing was waived).

We also agree with the Panel majority that the more plausible conclusion to be drawn from the record is that employer presented the authorized provider issue as part of its case concerning the work relatedness of claimant's medical maintenance regime. But even if employer abandoned the issue, that action did not establish the absence of a real and immediate controversy at the time of the hearing application. The Panel majority correctly observes that former section 8-43-211(2)(d) limits its temporal focus to the date of the hearing application and does not apply to issues at any other stage in the hearing process. Relying on the statutory changes that eliminated attorney fees as a sanction for frivolous and groundless issues, it also correctly recognized that an issue supported by little or no evidence was beyond the scope of former section 8-43-211(2)(d).

As a result, we conclude that any failure to pursue the authorized provider issue for adjudication indicated at most only a

strategic decision. Even the Panel's dissenting member recognized that the authorized treating provider issue became significant only if employer succeeded on its claim that the medical maintenance treatment was unrelated to the work injury. Therefore, contrary to the dissent's analysis, any decision to abandon the issue, whether based on a reassessment of the likelihood of success on the merits, time constraints, or an absence of evidentiary support, did not measure ripeness for purposes of former section 8-43-211(2)(d).

III. Amount of Attorney Fees Recoverable

Claimant next contends that she was entitled to an award of all the attorney fees and costs she reasonably incurred in responding to the hearing in which unripe issues were endorsed. Because we have affirmed the Panel majority's order determining that employer endorsed no unripe issues for hearing, we do not need to decide this issue. For the same reasons, we need not decide whether former section 8-43-211(2)(d) authorizes an award of appellate attorney fees and costs.

The order is affirmed.

JUDGE WEBB and JUDGE TERRY concur.