

# **BROWN BAG SEMINAR**

**Thursday, June 18, 2015**

(third Thursday of each month)

Noon - 1 p.m.

633 17<sup>th</sup> 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  
May 16, 2015 through June 12, 2015

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# INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-950-181-01

IN THE MATTER OF THE CLAIM OF  
CHRISTOPHER PIERCE,

Claimant,

v.

CORRECTED ORDER

PELLA WINDOWS & DOORS, INC.,

Employer,

and

PINNACOL ASSURANCE,

Insurer,  
Respondents.

The respondents have moved for a corrected order in this matter which so as to amend the title of the May 4, 2015 order to that of an “order of remand”. The respondents contend, on the one hand, that they intend to appeal the May 4, 2015, order of the Panel, but, on the other hand, state that they do not intend to do so because it is not an appealable order. It is argued by the respondents that because the May 4 order remands the matter to the ALJ for further proceedings and findings, the order does not serve to grant or deny any benefits and is thereby rendered not appealable pursuant to §8-43-301(2) and § 8-43-307(1) C.R.S. They seek clarification as to the ‘final’ status of the May 4 order. In that regard the May 4, 2015, order is hereby corrected pursuant to § 8-43-302(a) to reflect that it is indeed an order of remand to the ALJ. We otherwise reenter the order without change to its original text as set forth below.

The claimant seeks review of an order of Administrative Law Judge Michelle Jones (ALJ) dated November 18, 2014, that denied and dismissed the claim for benefits. We set aside the order of the ALJ and remand the matter for additional proceedings.

The claimant sustained an injury at work on December 11, 2013. The respondents contested the claim on the basis the claimant was not an employee, but was instead, an independent contractor. The ALJ agreed and denied the claim. We find the ALJ failed to adequately consider the issue of whether or not the evidence established the claimant was

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customarily engaged in an independent trade or business related to the services performed for the employer.

The claimant worked for the employer previously as a service technician. The employer is a distributor of doors and windows manufactured by the Pella company. The claimant was employed to perform work repairing the windows and doors and fulfilling the requirements of the warranties on those products. Until 2009, he was a salaried employee. That year, the respondent employer laid off all their 16 service technicians and immediately rehired 8 of them as independent contractors to perform the same work. The claimant then continued in his job, but now designated by the employer as one of these independent contractors. The ALJ found the primary change in the claimant's circumstances occurred in the manner by which he was paid. Taxes were no longer deducted from his checks and he was not eligible for group health insurance coverage. Instead, the employer would send him one week in advance a schedule of service appointments with customers that would specify the number of hours the employer calculated the job would require. The price per job was either \$40 for a warranty service job or \$60 for non-warranty work. Although the employer would already know from the schedule provided the claimant how much he was owed each week, the employer did require the claimant to also send a weekly invoice to the employer. The claimant was required to make monthly payments to buy his van from the employer.

The claimant continued to work under this new arrangement until he fell from a second story window on December 11, 2013, while at work. He fractured his spine and lost the function of his legs. The parties agreed that in the event the claimant was deemed a covered employee, he would be entitled to compensation for the medical treatment he had received and for temporary total benefits from the date of injury at least up to the date of the September 18, 2014, hearing in the claim.

When the change from salaried employee to contractor was implemented, the claimant was required to sign several written agreements drafted by the employer. These included a Master Service Subcontract Agreement, a Declaration of Independent Contractor Status Form, and a Rejection of Coverage by Sole Proprietors Performing Construction Work on Construction Sites form. The claimant also was required to register a trade name with the Secretary of State's office. The Master Service document contained a list of terms pertinent to the circumstances existing between the employer and the claimant. The employer was to schedule all appointments and provide the claimant a copy of his schedule. The employer provided all the materials necessary for the service work. The employer was responsible for determining the amount to be paid for each job. The claimant was responsible for payment of all taxes and insurance. The

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claimant was required to satisfy the employer that he had in place a liability policy for damages to a customer's residence and acknowledged the employer did not provide workers' compensation or unemployment compensation insurance. The employer could inspect the claimant's work at any time and could require the claimant to meet the scheduled service dates and times, wear proper attire and to comply with the employer's job standards. The employer could terminate the Master Service Agreement "at any time and for any and no reason (termination for convenience) ...". The claimant was allowed to work for other employers but was prohibited from competing with the employer by contracting for work with other customers on Pella windows or doors.

The employer also provided to the claimant an addendum document at the same time as it presented the Master Service Agreement. The Independent Contractor Addendum, states that in the event an independent contractor does not provide workers' compensation insurance and its employee is injured, Pella is considered the "statutory employer" and is required to pay the benefits to the injured worker.

Pursuant to § 8-40-202(2)(a), C.R.S., any individual who performs services for pay for another shall be deemed to be an employee unless the person is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed. The putative employer may establish that the claimant was free from direction and control and engaged in an independent business or trade by proving the presence of some or all of the nine criteria set forth in § 8-40-202(2)(b)(II). *See also Nelson v. Industrial Claim Appeals Office*, 981 P.2d 210 (Colo. App. 1998).

The factors set forth in § 8-40-202(2)(b)(II) indicating that an individual is not an independent contractor include the individual being paid a salary or hourly rate instead of a fixed contract rate, and being paid individually rather than under a trade or business name. Conversely, independence may be shown if the person for whom the services are performed provides no more than minimal training to the individual, does not provide tools or benefits, does not dictate the time of performance, does not establish a quality standard for the individual's work, does not combine its business with the business of the individual, does not require the individual to work exclusively for a single person or company, and is not able to terminate the individual's employment without liability.

If the parties use a written document specifying the existence of the factors referenced in § 8-40-202(2)(b)(II), the document can create a rebuttable presumption of an independent contractor relationship between the parties. The ALJ concluded that on

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March 12, 2009, the parties executed a document agreeing to the conditions set forth in § 8-40-202(2)(b)(II). The ALJ therefore presumed the claimant was an independent contractor. It was held the claimant failed to overcome this presumption.

The ALJ also found the respondent employer had proved the existence of an independent contractor relationship. The ALJ found the claimant was not paid through an hourly rate but, instead, was paid by the job. The claimant was required to use a trade name. It was noted the employer provided minimal training. Other than a hammer the claimant obtained on his own, the employer provided most of the tools needed for the work. These included suction cup handles, glass cutter, extension ladders, scaffolding and silicone. However, the ALJ concluded these tools were actually those of the claimant. The ALJ noted that because the claimant could decline to accept the schedule of appointments arranged by the employer, there was no dictation of the time of performance. The employer was observed to have arranged for an inspector to ride with the claimant on occasion to review the claimant's work, but this was found to be only a quality inspection. The claimant was held to not be required to work exclusively for the employer. The ALJ reasoned the employer did not combine its business with that of the claimant and the employer was not allowed to terminate the claimant's contract without liability.<sup>1</sup>

On appeal, the claimant submits two arguments. He contends the ALJ did not apply the analysis used by the Supreme Court in *Industrial Claim Appeals Office v. Softrock Geological Services*, 325 P.3d 560 (Colo. 2014) pertinent to the issue of whether the claimant was engaged in an independent trade or business. The claimant also argues that if he was found to be an independent contractor, the statutory employer responsibility set forth in § 8-41-401(1) would make the employer liable for the claimant's injuries.

#### I.

Insofar as the second argument is concerned, the contention of the claimant is unavailing. Section 8-41-401(1) provides that any person or business that contracts out part or all of the work of that business is liable for any injuries sustained by subcontractors or their employees while performing the contracted work "except as otherwise provided in subsection (3) of this section." The claimant asserts he was a contractor of the employer, was injured while performing contracted out work, and the employer is therefore liable for his benefits. However, the respondents point to the

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<sup>1</sup> We note the evidence for this last finding to be elusive since the March 12, 2009, Master Service Agreement is explicit in its paragraph 19 that the employer may terminate the contract "without liability" "at any time and for any and no reason (termination for convenience) ...".

exception referenced in subsection (3) which appears to bar his claim under this statute. One of the exceptions listed in subsection (3) specifies that “a working ... sole proprietor who is not covered under a policy of workers’ compensation insurance, ... shall not have any cause of action of any kind under articles 40 to 47 of this title.” There is no dispute in this case that if the claimant is deemed an independent contractor, that he is a sole proprietor, that he personally is performing the work, and that he has not secured a policy of workers’ compensation insurance. The respondents’ point then, is well taken and § 8-41-401(1) does not apply in this case to make the respondent employer liable for the claimant’s injuries. The ALJ also made such a finding. Conclusions of Law, pg. 13. Accordingly, we need not consider the claimant’s objection to the ALJ’s analysis that *Findley v. Storage Tech.*, 722 P2d 322 (Colo. App. 1986) is inapplicable to this case.

## II.

The claimant’s argument in regard to the significance of the *Softrock* decision is more critical to the dispute between the parties. The claimant argues the employer has simply applied an artifice of an independent contractor relationship to cover a situation which is unchanged from the previous arrangement of an employer-employee contract. By doing so, it is asserted the employer can avoid the costs of workers’ compensation insurance, unemployment insurance and fringe benefits while requiring the claimant to perform precisely the same job as he did while an employee. The General Assembly sought to prevent the activity alleged by the claimant when it enacted § 8-40-202(2) pertinent to workers’ compensation, and § 8-70-115 relating to unemployment compensation benefits. Those sections use identical language to state under what circumstances “services for pay for another” can be considered covered employment eligible for benefits from the employer, and when they may be characterized as “independent” of the employer and not subject to the receipt of benefits. The presumption is that “any individual who performs services for pay for another shall be deemed to be an employee”. However, if it is shown the individual is “free from control and direction in the performance of the service,” ‘and’ the individual “is customarily engaged in an independent trade, occupation, profession, or business related to the service performed,” then the presumption of covered employment is overcome. The statute seeks to protect employees from the “vagaries of involuntary unemployment” (or disability from work injuries) while also allowing the existence of legitimate business models employing the contracting out of certain aspects of production or services.

To that end, the Supreme Court, in *Softrock*, revised the standard previously used by the Panel and the Court of Appeals when analyzing whether or not an employee ‘is

customarily engaged' in an independent trade or business. That previous standard had sought to simply ask if the employee had customers other than the employer. If not, it was reasoned the employee was not 'engaged' in an independent business and would necessarily be a covered employee. However, in *Softrock* the Court declared "we also reject the ICAO's argument that whether the individual actually provided services for someone other than the employer is dispositive proof of an employer-employee relationship." 325 P.3d at 565. Instead, the fact finder was directed to conduct "an inquiry into the nature of the working relationship." Such an inquiry would consider not only the nine factors listed in § 8-202(2)(b)(II), but also any other relevant factors. The Court pointed as an example to the decision in *Long View Systems Corp. v. Industrial Claim Appeals Office*, 197 P.3d 295 (Colo. App. 2008). In *Long View* the Panel was asked to consider whether the employee "maintained an independent business card, listing, address, or telephone; had a financial investment such that there was a risk of suffering a loss on the project; used his or her own equipment on the project; set the price for performing the project; employed others to complete the project; and carried liability insurance." 325 P.3d at 565. This analysis of "the nature of the working relationship" also avoided a second problem presented by the single-factor test disapproved by the *Softrock* decision. That problem involved a situation where, based on the decisions of the employee whether or not to pursue other customers, the employer could be subjected to "an unpredictable hindsight review" of the matter which could impose benefit liability on the employer. 325 P.3d at 565.

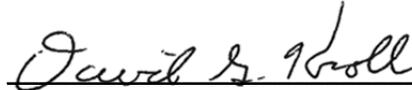
Here, the ALJ referenced the *Softrock* decision and surmised: "The issue is whether or not claimant was *required* to work exclusively for the employer. In this case, Claimant was not required to work exclusively for the employer." Conclusions of Law, pg. 10. We find this to be an inadequate consideration of the *Softrock* requirements. The ALJ must conduct an inquiry into the "nature of the working relationship." A review of the record in this matter as compared to the factors taken from the *Long View* decision reveals there is no, or insubstantial, evidence that the claimant had an independent business card, phone listing, business address, had any financial investment subject to a risk of loss, purchased his own tools or equipment on the project, set the price for performing the project or employed others. There was evidence he carried liability insurance as required by the employer. There was also evidence in the form of invoices and payments which suggested the employer knew the claimant was working full time and exclusively for the employer. The *Softrock* decision did not write out of the statute the need to show the claimant was "customarily engaged in an independent trade." Instead, it asked for a determination as to whether the decision to not take on other customers was a decision made entirely by the claimant and not expected by the employer. The ALJ then, must also analyze whether the employer would reasonably be

aware that the claimant was not engaged in an independent business, based on the working relationship it had with the claimant.

Because there is a paucity of evidence in the record pertinent to many of the factors mentioned by the *Softrock* decision to be considered, we set aside the November 18, 2014, decision of the ALJ and remand the matter for additional evidentiary proceedings to address evidence pertaining to the nature of the working relationship between the claimant and the employer. The ALJ shall then make additional findings in that regard as to whether the claimant is actually engaged in an independent trade, profession or business.

**IT IS THEREFORE ORDERED** that the ALJ's order issued November 18, 2014, is set aside and remanded for further proceedings and findings as described above.

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

5/11/2015 by RP.

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ., 7501 E. LOWRY BLVD., DENVER, CO, 80230 (Insurer)  
BURG SIMPSON ELDREDGE HERSH & JARDINE, P.C., Attn: JOHN M. MCCONNELL, ESQ., 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)  
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## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-944-222-01

IN THE MATTER OF THE CLAIM OF

ALICE SACKETT,

Claimant,

v.

CITY MARKET,

Employer,

and

SELF INSURED,

Insurer,  
Respondents.

FINAL ORDER

The respondent seeks review of an order of Administrative Law Judge Mottram (ALJ) dated October 23, 2014, that ordered the claim compensable, awarded temporary benefits and medical benefits. We affirm the order in large part but reverse the finding that the claimant's treatment by Dr. Scheffel was authorized medical care.

The claimant worked for the respondent employer as a checker at the employer's super market. On February 28, 2014, the claimant was checking produce inventory when she turned to look at items on a cart behind her and twisted her right knee. She testified she felt a twinge and within the next few hours her knee swelled and became painful. The claimant reported her injury to her supervisor and was offered her choice of two medical providers. She selected St. Mary's Occupational Health. However, when she had her husband drive her to that clinic at 4:30 p.m. that Friday afternoon, she discovered the clinic was closed until the following Monday. The claimant testified that due to the pain and swelling, she felt it advisable to go to the St. Mary's Hospital emergency room. The claimant was examined and provided anti-inflammatory and pain medication.

The following Monday, March 3, the claimant saw Dr. Craig Stagg at St. Mary's Occupational Health. Dr. Stagg prescribed an MRI exam, suggested work restrictions and the assistance of crutches. A follow up appointment was scheduled for March 7.

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The claimant spoke with the respondent's claims adjuster on March 5. He advised the claimant the respondent denied the compensability of the claim. A Notice of Contest was mailed by the adjuster on that date. The claimant then went to see her personal physician, Dr. Quackenbush, on March 6. A meniscus tear was suspected and Dr. Quackenbush referred the claimant to an orthopedic specialist, Dr. Peter Scheffel. The claimant saw Dr. Scheffel on March 25. The doctor suggested an MRI. After reviewing the MRI with the claimant, Dr. Scheffel suggested an arthroscopic surgery to view and possibly repair an abnormality revealed on the MRI. This surgery was completed by Dr. Scheffel on June 4. It featured the smoothing of cartilage behind the knee cap and the debridement of the soft tissue abnormality. The claimant achieved considerable relief from the surgery. Dr. Scheffel released the claimant to return to her regular duties at work on July 27. The claimant did return to work on that date and reported no knee pain or disability as of the date of the hearing on August 18, 2014.

Shortly after March 5, the claimant sought representation from an attorney. The claimant testified the attorney suggested she call Dr. Stagg, advise him the claims adjuster had contested the claim and request that Dr. Stagg refer her to her personal physician. The claimant then called St. Mary's Occupational Health, informed the staff and made this request. On March 31, Dr. Stagg wrote a letter to whom it may concern stating "Subsequently, her workers' compensation claim was contested (denied?). She has hired an attorney to assist her in that matter. At this point, Ms. Sackett is electing to proceed with care under the direction of her PCP. I feel this is appropriate. I would be glad to see her back once the administrative issue surrounding compensability within the workers' compensation system are resolved." On April 30, the claimant's attorney wrote a note to Dr. Stagg asking him "is this your referral to Ms. Sackett's primary care physician?" On May 19, Dr. Stagg replied in reference to this note: "The patient had asked to be referred to her primary care physician for her injury. I have referred her to her primary care physician at her request. I hope that clarifies that I did refer her to her primary care physician."

The respondent arranged for a second opinion IME by Dr. Douglas Scott. Dr. Scott examined the claimant on April 29. In his reports he set forth his opinion that the claimant had a previous knee injury twenty years previously. The claimant also suffered from degenerative joint disease and arthritis. The doctor believed the work incident on February 28, 2014, was only a temporary aggravation of the claimant's preexisting condition and resolved by the time he saw the claimant on April 29. Dr. Scott was of the opinion the claimant's surgery on June 4 was not made necessary by the February 28 work incident, but rather, by her preexisting degenerative joint disease.

In his order of October 23, 2014, the ALJ concluded the claimant did sustain a right knee injury at work on February 28, when she twisted her knee and that the medical treatment she received was related to that injury. The ALJ found the claimant was appropriately referred for medical treatment with St. Mary's Occupational Health. The ALJ determined the claimant's treatment at the emergency room on February 28 was compensable. He awarded temporary total benefits between March 6 and July 27, 2014, and denied the assertion the claimant had violated an employer safety rule. Finally, the ALJ ruled Dr. Scheffel was within the authorized chain of medical referrals and his treatment was therefore authorized.

On appeal, the respondent contends the ALJ committed error in finding the claimant's injury was compensable. The respondent argues the emergency room treatment was not authorized. Finally, the respondent asserts Dr. Scheffel was not an authorized doctor as the referral to Dr. Quackenbush was not within the authorized chain of referrals.

#### I.

The respondent argues the ALJ did not correctly apply the decision in *City of Brighton v. Rodriguez*, 318 P.3d 496 (Colo. 2014), for the reason that the claimant's injury was caused by a preexisting condition which was not aggravated by a special hazard of employment. The respondent points to the finding of the ALJ that the claimant's action of twisting her right knee on February 28 "aggravated accelerated or combined with claimant's pre-existing disease or infirmity (tricompartmental chondromalacia) and produced claimant's disability and need for medical treatment." Conclusions of Law ¶ 4. It is explained by the respondent that the action of twisting a knee while turning at work is a ubiquitous activity and not a special hazard. The respondent cites to several previous decisions by ALJs finding similar superficially benign actions to be characterized as ubiquitous which resulted in a denial of compensability and affirmance on appeal.

However, the cases referenced by the respondent feature findings of fact by an ALJ based on a totality of circumstances unique to each case. For example, the fact that an injury stemmed from the climbing of stairs in *Roberts v. Boulder County*, W.C. No. 4-673-066 (July 16, 2007), and was found not compensable does not serve as a rule of law precluding any findings of compensability when stair climbing is involved. See *Neiman v. Miller Coors*, W.C. No. 4-805-582 (July 30, 2010); *LeMay v. Colorado Springs School District 11*, W.C. No. 4-842-436 (October 20, 2011), *Melendez v. Weld County School District 6*, W.C. No. 4-775-869 (October 2, 2009), *Even v. The Mining Exchange*, W.C.

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No. 4-892-465 (April 29, 2013). All of these cases deal with injuries sustained while negotiating stairs but resulted in findings of compensable injuries.

In *City of Brighton*, the court noted the term “idiopathic” referred to “self-originated” conditions. A purely idiopathic injury is therefore not compensable because it does not ‘arise out of’ employment. Examples are heart disease and epilepsy. 318 P.3d at 503, footnote 2. The exception is said to occur when the direct cause of the injury is idiopathic but a ‘special hazard’ of employment also contributed to the injury. 318 P.3d at 503, footnote 3. However, when an activity from work is the proximate cause of the injury or need for treatment and disability, even though it combined with a preexisting condition to aggravate or accelerate that condition, the injury is compensable regardless of the absence of a special hazard of employment. See *National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 1259 (Colo. App. 1992); *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989); *Wernsman v. United Parcel Service*, W.C. No. 4-653-560 (July 7, 2006). This was the holding in *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). In *Vicory*, the claimant’s arm was so weakened by bone cancer that the act of pushing open a swinging door caused a fracture. Nonetheless, because the proximate cause of the injury was the activity of opening the door at work, the injury was compensable.

The ALJ’s holding in this case was similar. He found the claimant’s need for treatment occurred because “she twisted while standing in the cooler.” The ALJ rejected as unpersuasive the opposing theory of Dr. Scott. The ALJ referenced the claimant’s testimony and medical records to surmise it was a twisting action of the knee that occurred and caused the near immediate swelling and pain in the claimant’s leg. Accordingly, 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). 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). Here, when applying the foregoing legal principles, we conclude that the ALJ did not err in finding that the claimant sustained an injury that arose out of her employment.

## II.

The respondent contends the ALJ committed an abuse of discretion when he approved the claimant’s use of the emergency room on February 28 and determined that treatment compensable. It is argued the claimant only received pain medications in the

way of treatment and it was not required that she be transported by an ambulance. Thus, it is asserted the visit was not a bona fide emergency.

The court of appeals has recognized an exception for emergency treatment to the employer's right to choose the treating physician. *See Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990) (after emergency treatment ended claimant "required to notify her employer and give it a reasonable opportunity to furnish" subsequent treatment).

The question of whether there is an emergency situation and whether there has been a medical referral are ordinarily questions of fact for determination by the ALJ. *See Amorelli v. Amorelli Plumbing and Heating, Inc.*, W.C. No. 4-436-946 (Sept. 26, 2001) (question of whether employer timely tendered services of physician after notice of an injury is one of fact). Thus, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Gonzales v. Crowley County*, W.C. No. 4-250-651, (Nov. 27, 2000).

Here, the ALJ noted the claimant's injury occurred on a Friday afternoon and the St. Mary's Occupational Health clinic closed for the day and would not reopen until three days later. The claimant testified her knee had experienced considerable swelling as well as bothersome pain. The claimant also explained that she was scheduled to work for the employer over the weekend. Because the claimant was already traveling in a car with her husband, it did not become necessary to involve an ambulance. These circumstances constitute substantial evidence to support the ALJ's finding that treatment at the emergency room was reasonable and related treatment constituting an exception to the need to have medical treatment subject to prior authorization.

### III.

The respondent contends the ALJ committed error when he found the referral of the claimant from Dr. Stagg to Dr. Quackenbush and then to Dr. Scheffel, caused Dr. Scheffel to be within the authorized chain of referrals. The respondent argues Dr. Stagg was not making a referral using medical judgment. Instead, he was said to be simply acquiescing to the claimant's choice of physician when she told Dr. Stagg her claim had been denied by the insurance adjuster and she therefore wanted to be treated by her personal physician.

The respondent points to an analogous situation in *Clemonson v. Lovern's Painting*, W.C. No. 4-503-762 (October 21, 2005). In *Clemonson* the treating doctor, Dr.

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Sabin, had placed the claimant at maximum medical improvement (MMI) and had only recommended some additional physical therapy in the way of medical treatment. However, the claimant continued to complain of problems with his collarbone and his throat. He returned to see Dr. Sabin to get someone to fix his problem. He obtained a referral to Dr. Seeman. However, Dr. Sabin later testified that when he made the referral to Dr. Seeman he was under the impression that the Division of Workers' Compensation had directed the claimant to his office to obtain a referral to a specialist, and if that were not the case, no referral would have been made. The ALJ and the Panel concluded Dr. Sabin's referral was not the "result of Dr. Sabin's independent medical judgment.... Instead, the referral was based upon nonmedical decisions." *Clemonson* at 4. The referral was deemed by the ALJ and the Panel to not have been an authorized referral.

The March 31 note from Dr. Stagg appears similarly to be the product of a nonmedical decision. The note does not reference any medical condition or treatment that served as a motivation for making a referral to the claimant's personal care physician. Dr. Stagg states only that the insurer contested the claimant's claim, that she retained an attorney and she elected, due to the contest, to proceed through the use of her personal doctor. He thereupon agreed the claimant could see her PCP. He is explicit in his May 19 letter to the claimant's attorney that "I have referred her to her primary care physician at her request." Otherwise, Dr. Stagg indicates he would be happy to provide the necessary medical treatment himself. He had, in fact, recommended an MRI and set a follow up appointment. Dr. Scheffel proceeded to make the same suggestion of an MRI before any further treatment recommendations. Dr. Stagg's referral is quite clear that it is not a referral based upon a medical consideration, but rather a response to the claimant's and her attorney's request that she see her personal physician in this situation of a contested claim.

The fact that the respondent contested liability does not negate its right to designate the authorized treating physician. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). There is no indication in the record that Dr. Stagg was informed by the respondent that it would not authorize and pay for any of Dr. Stagg's treatments or recommendations. He received only communication from the claimant and her attorney regarding the contested status of her claim. Dr. Stagg's letters reveal that he was making the referral to the claimant's PCP because he did not see himself as the treating doctor in her case, due to the contest. His referral then, similar to the situation in *Clemonson*, was made in a situation where the referral was made for a nonmedical reason due to the misapprehension of the referring doctor. Because the referral was not made as a result of the referring physician's independent medical judgment, the referral is not considered valid. *Bestway Concrete v. Industrial Claim Appeals Office*, 984 P.2d 680

(Colo. App. 1999). Accordingly, we conclude that neither Dr. Quackenbush nor, in turn, Dr. Scheffel, provided authorized medical care through the March 31 or May 19 referral from Dr. Stagg.

**IT IS THEREFORE ORDERED** that the ALJ's order issued October 23, 2014, is affirmed insofar as it found the claimant's February 28, 2014, injury to be compensable, awarded temporary total benefits from March 6 through July 26, 2014, and authorized emergency room treatment on February 28. The ALJ's order is reversed to the extent the treatment provided by Dr. Quackenbush and Dr. Scheffel was deemed authorized.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
David G. Kroll

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

ALICE SACKETT  
W. C. No. 4-944-222-01  
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CERTIFICATE OF MAILING

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

\_\_\_\_\_ 4/21/2015 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

KILLIAN DAVIS RICHTER & MAYLE, PC, Attn: ERIN C. BURKE, ESQ., 202 N. 7TH STREET, GRAND JUNCTION, CO, 81501 (For Claimant)

RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: JEFF FRANCIS, ESQ., 1401 17TH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

**INDUSTRIAL CLAIM APPEALS OFFICE**

W.C. No. 4-932-057-02

IN THE MATTER OF THE CLAIM OF  
LAURA HOPPER,

Claimant,

v.

**FINAL ORDER**

RE/MAX PROPERTIES, INC.,

Employer,

and

FARMINGTON CASUALTY  
COMPANY,

Insurer,  
Respondents.

The respondents seek review of an order of Administrative Law Judge Walsh (ALJ) dated January 23, 2015, that held the respondents liable for workers' compensation benefits as the claimant's statutory employer. We set aside the ALJ's order.

This matter went to hearing on the issue of compensability, statutory employer, medical and temporary disability benefits, authorized provider, average weekly wage and penalties for uninsured employer. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The respondent-employer is a licensed real estate broker. The brokerage is owed by Joe Clement. The respondent-employer entered into an independent contractor arrangement with Jeff Ryder, who is a licensed real estate agent. Jeff Ryder hired the claimant as a personal administrative assistant. The claimant was paid by Jeff Ryder through his personal business account. The claimant worked for Jeff Ryder for approximately 20 months before she was injured.

On August 14, 2013, the claimant was assisting her co-worker move a chair at the office when her heel caught a rip in the carpet causing her to trip. The claimant's face hit the arm of the chair, knocking out her front tooth and breaking her upper mandible bone. The claimant received medical treatment but was not restricted from working. The

claimant was ultimately terminated on August 15, 2014. Jeff Ryder had no workers' compensation coverage for his employees.

The claimant sought workers' claim for compensation from the respondent-employer. The respondent-employer maintains workers' compensation coverage for its employees. The ALJ found that the respondent-employer contracted out its regular business to Jeff Ryder and his employees and, therefore, the respondent-employer qualifies as the claimant's statutory employer pursuant to §8-41-401 (1)(a)(I), C.R.S. The ALJ reasoned that §8-40-301(2), C.R.S., which excludes licensed real estate sales agents and licensed real estate brokers from the definition of "employee," is inapplicable to the claimant because she is not a licensed real estate agent. The ALJ determined that the respondent-employer, therefore, was liable for the claim. The ALJ also denied the claimant's request for temporary disability benefits and penalties against the respondents.

On appeal the respondents contend the ALJ erred in his application of the law. The respondents argue that the ALJ failed to consider the plain language of §8-41-401(5), C.R.S., which specifically precludes real estate brokers from being considered statutory employers. We agree with the respondents that real estate brokers may not be deemed statutory employers pursuant to §8-41-401(5). We, therefore, set the ALJ's order aside.

Section 8-41-401(1)(a), C.R.S. provides as follows:

Any person, company, or corporation operating or engaged in or conducting any business by leasing or contracting out any part or all of the work thereof to any lessee, sublessee, contractor, or subcontractor, irrespective of the number of employees engaged in such work, shall be construed to be an employer as defined in articles 40 to 47 of this title and shall be liable as provided in said articles to pay compensation for injury or death resulting therefrom to said lessees, sublessees, contractors, and subcontractors and their employees or employees' dependents, except as otherwise provided in subsection (3) of this section.

Section 8-41-401(5) provides

**(5) The provisions of this section shall not apply to licensed real estate brokers** and licensed real estate sales agents, as regulated in article 61 of title 12, C.R.S., who are excluded from the definition of employee pursuant to section 8-40-301 (2). (*emphasis added*).

LAURA HOPPER

W. C. No. 4-932-057-02

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Section 8-40-301(2), C.R.S. excludes a licensed real estate agent and a licensed real estate broker from the definition of employee if certain criteria are met. The parties do not dispute that those criteria are met here with regard to the real estate broker and the real estate agent.

These statutory employer provisions prevent employers from avoiding responsibility to pay workers' compensation benefits by conducting their business through a separate, uninsured employer. *See Finlay v. Storage Technology Corp.*, 764 P.2d 62, 64 (Colo. 1988). Whether a person or entity has the status of a statutory employer is generally a question of fact. *Thornbury v. Allen*, 991 P.2d 335, 339 (Colo.App.1999). Where the facts are undisputed, however, the determination of that status from the undisputed facts is a question of law that we review de novo. *Newsom v. Frank M. Hall & Co.*, 101 P.3d 1107, 1110 (Colo. App. 2004), *rev'd on other grounds*, 125 P.3d 444 (Colo. 2005). Our review is limited by statute and we may only correct, set aside, or remand an order if the findings of fact are not sufficient to permit appellate review, if conflicts in the evidence are not resolved, if the findings of fact are not supported by the evidence, if the findings of fact do not support the order, or if the award or denial of benefits is not supported by the applicable law. Section 8-43-301(8), C.R.S.

In interpreting these statutes, we must attempt to further the legislative intent. *Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323 (Colo. 2004). To discern the intent we must give the words in the statute their plain and ordinary meanings, unless the result is absurd. *Id.* In our view, the plain language of §8-41-401(5), C.R.S., states that the general provisions of §8-41-401, C.R.S., that create a statutory employer relationship, do not apply to a licensed real estate broker.

If the statutory language unambiguously sets forth the legislative purpose, we need not apply additional rules of statutory construction to determine the statute's meaning. *Kauntz v. HCA-Healthone, LLC*, 174 P.3d 813, 816 (Colo. App. 2007). Nonetheless, we may consider legislative history when there is substantial legislative discussion surrounding the passage of a statute, and the plain language interpretation of a statute is consistent with legislative intent. *Kisselman v. American Family Mut. Ins. Co.*, 292 P.3d 964 (Colo. App. 2011).

The respondents submitted the legislative history of HB 85-1052 which removed real estate brokers and real estate agents from the statutory employer provision. The ALJ did not review the legislative history, noting in his order that the provisions of §8-41-401(1) were clear, and therefore, he did not need to resort to the legislative history. ALJ

LAURA HOPPER

W. C. No. 4-932-057-02

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Order at 7 ¶¶ 11-12. The ALJ's order, however, does not address the specific exclusion in §8-41-401(5), C.R.S. With specific reference to that subsection, the legislative history contains testimony from witness, Craig Eley, regarding the issue of a real estate agent's employee not being able to reach beyond the direct employer if the proposed exclusion was passed into law. House Business Committee CD No. 1 at 44:34 through 50:40 (47.42). This testimony is consistent with the plain language of §8-41-401(5), C.R.S.

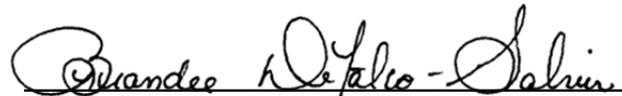
The claimant contends that §8-41-401(5), C.R.S., should be read narrowly and only operates to prohibit brokers or agents as employees from reaching up to a statutory-employer to claim workers' compensation benefits and does not address real estate brokers as "employers." We disagree. The first sentence of the subsection (5) states that the provisions "of this section" shall not apply to real estate brokers. "This section" is a reference to the general statutory employer provision in §8-41-401(1), C.R.S. If the general assembly had only intended to prevent agents and brokers from being considered "employees," they presumably would not have added the exclusionary language in the statutory *employer* section of the Act. Moreover, §8-41-401(5) does not prevent a broker or an agent from being a direct employer of an individual, as argued by the claimant. A real estate broker can have a direct employee, who does not meet the requirements in §8-40-301(2) and is liable for workers' compensation for those direct employees. In this case, Joe Clement testified that he had 22 direct employees and he had workers' compensation insurance for those employees. Tr. at 69. The exclusion in §8-41-401(5), C.R.S. is limited to brokers and agents as *statutory employers* in §8-41-401(1), C.R.S.

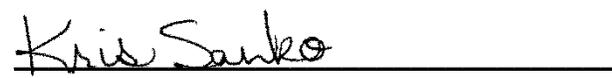
The ALJ found, and the parties do not dispute, that the respondent-employer in this case is a licensed real estate broker and that the claimant was not a direct employee of the respondent-employer. Under these circumstances, the plain language of §8-41-401(5) C.R.S. excludes the respondent-employer from the general provisions of the statutory employer statute. The ALJ erred in failing to apply §8-41-401(5), C.R.S., and his order must be set aside. Section 8-43-301(8), C.R.S.

**IT IS THEREFORE ORDERED** that the ALJ's order dated January 23, 2015, is set aside.

LAURA HOPPER  
W. C. No. 4-932-057-02  
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INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
Kris Sanko

LAURA HOPPER  
W. C. No. 4-932-057-02  
Page 7

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 5/26/2015 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

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RAY LEGO & ASSOCIATES, Attn: JONATHAN S. ROBBINS, ESQ./GREGORY W.  
PLANK, ESQ., 6060 S. WILLOW DRIVE, SUITE 100, GREENWOOD VILLAGE, CO, 80111  
(For Respondents)

## INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-924-286-03

IN THE MATTER OF THE CLAIM OF  
CRAIG LIGGINS,

Claimant,

v.

FINAL ORDER

MCDONALD WATERPROOFING INC.,

Employer,

and

PINNACOL ASURANCE,

Insurer,  
Respondents.

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated January 22, 2015, that granted the respondents' motion for summary judgment and denied and dismissed the claimant's claim for permanent total disability (PTD) benefits. We affirm.

The claimant was injured on July 16, 2013. The respondent insurer filed a general admission of liability on July 31, 2013. On September 22, 2014, before the claimant had been placed at maximum medical improvement (MMI) and before the respondent insurer had filed a Final Admission of Liability (FAL), the *pro se* claimant filed an application for hearing. In his application for hearing, the claimant endorsed the issues of PTD benefits, medical benefits, average weekly wage, disfigurement, compensability, and other issues, such as other injuries the claimant alleged he sustained on July 16, 2013.

The claimant eventually underwent a Division-sponsored independent medical examination (DIME). In his DIME report, the DIME physician placed the claimant at MMI on June 2, 2014, with a lower extremity impairment rating of 28, which converts to an 11 whole person impairment. On October 23, 2014, the respondent insurer filed a FAL based on the opinions of the DIME physician.

On October 29, 2014, the claimant filed an objection, but he did not file an application for hearing within 30 days from the date the FAL was filed.

Thereafter, the respondents filed a motion for summary judgment, arguing that the issue of PTD benefits listed in the claimant's application for hearing was unripe since the claimant had not been placed at MMI and the respondents had not filed their FAL at the time the application was filed. Further, the respondents argued that since the claimant failed to timely file an application for hearing within 30 days from the respondents' FAL, all indemnity issues were closed. In their motion, the respondents noted that under §8-43-203(2)(b)(II)(A), C.R.S., issues may proceed to hearing without the need to refile an application for hearing after a FAL is filed, but that this procedural exception applied only to pending issues which were ripe when endorsed. Since the respondents contended that the issue of PTD benefits was not ripe when the claimant filed his application for hearing, they requested that the ALJ enter summary judgment in their favor on the issue of PTD benefits.

The ALJ subsequently issued her order granting the respondents' motion for summary judgment. In her order, the ALJ initially found that at the time the claimant filed his application for hearing, the issue of PTD benefits was not ripe. She explained that the issue of PTD benefits does not become ripe until after the date of MMI has been established, and MMI had not yet been established for the claimant. Consequently, the ALJ implicitly struck the issue of PTD as not being ripe. More specifically, in her order, the ALJ cited §8-43-211(2)(d), C.R.S.<sup>1</sup>, and explained that "[i]f a party requests a hearing on an issue which is not ripe, the non-ripe issue should be stricken." The ALJ further concluded that the claimant's failure to file an application for hearing within 30 days after the date the FAL was filed resulted in automatic closure of the claim pursuant to the terms of the FAL. She concluded that under §8-43-203(2)(b)(II)(A), C.R.S., the claimant had 30 days after the respondents' FAL to file an application for hearing on any disputed issues which were ripe for hearing. The ALJ implicitly concluded that since the issue of PTD benefits was ripe after the respondents filed their FAL, the claimant's failure to file an application for hearing on this issue resulted in a jurisdictional bar to his claim for PTD benefits. The ALJ therefore denied and dismissed the claimant's claim for PTD benefits.

On appeal, the claimant argues that the ALJ erred in granting the respondents' motion for summary judgment. The claimant concedes that at the time he filed his application for hearing, the issue of PTD benefits was not ripe, but he argues that the ALJ instead should have stricken the issue rather than grant summary judgment on it. We perceive no reversible error.

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<sup>1</sup> Section 8-43-211(2)(d), C.R.S. was amended in 2013 and 2014, and now is reflected at §8-43-211(3), C.R.S.

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). 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).

Here, we conclude that the ALJ did not err in granting the respondents' motion for summary judgment. The claimant's argument notwithstanding, it is clear that in her order, the ALJ first struck the issue of PTD benefits in the claimant's application for hearing as being unripe. As mentioned above, the ALJ concluded that "[i]f a party requests a hearing on an issue which is not ripe, the non-ripe issue should be stricken." Conclusions of Law at 2 ¶8. The ALJ concluded that the issue of PTD was not ripe at the time the claimant filed his application for hearing because the claimant had not yet been placed at MMI. Conclusions of Law at 2 ¶10. *See Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006). The ALJ then found that on October 23, 2014, the respondents filed their FAL based on the opinions of the DIME physician. In his DIME report, the DIME physician placed the claimant at MMI as of June 2, 2014. Consequently, the respondents' FAL on October 23, 2014, and the DIME physician's opinion that the claimant had reached MMI on June 2, 2014, had removed any legal impediment to a determination of the claimant's eligibility for PTD benefits. Thus, the issue of PTD benefits was ripe at this time. *Id.* Pursuant to §8-43-203(2)(b)(II)(A), C.R.S., however, the claimant did not file an application for hearing listing the issue of PTD benefits within 30 days from the respondents' FAL. Thus, under §8-43-203(2)(b)(II)(A), C.R.S., the issue of PTD benefits was closed. *Id.* Since there are no disputed issues of material fact regarding the claimant's failure to file an application for hearing within 30 days from the respondents' FAL endorsing the issue of PTD benefits, the ALJ properly granted the respondents' motion for summary judgment on the issue of PTD benefits. OACRP 17; C.R.C.P. 56; *see also Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261 (Colo. App. 2004)(if a claimant does not contest the FAL and apply for hearing within 30 days, the case is automatically closed pursuant to §8-43-203(2)(b)(II) as to the issues admitted in the FAL); *see also Lacina v. Kenton H Behrent d/b/a K-Behrent Electric*, W.C. No. 4-413-054 (July 5, 2001), *aff'd* Colo. App. No. 01CA1339 (Sept. 26, 2002). Consequently, we will not disturb the ALJ's order on this ground.

CRAIG LIGGINS  
W. C. No. 4-924-286-03  
Page 4

**IT IS THEREFORE ORDERED** that the ALJ's order dated January 22, 2015, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

  
\_\_\_\_\_  
Brandee DeFalco-Galvin

  
\_\_\_\_\_  
Kris Sanko

CRAIG LIGGINS  
W. C. No. 4-924-286-03  
Page 6

CERTIFICATE OF MAILING

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

\_\_\_\_\_ 6/5/2015 \_\_\_\_\_ by \_\_\_\_\_ RP \_\_\_\_\_ .

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ST., DENVER, CO, 80203 (For Claimant)

RUEGSEGGER SIMON SMITH & STERN, LLC, Attn: VITO RACANELLI, ESQ., 1401  
17TH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)

## INDUSTRIAL CLAIM APPEALS OFFICE

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

IN THE MATTER OF THE CLAIM OF  
LELAH PEDERSON,

Claimant,

v.

JONATHAN P. BAYNE DDS, P.C.,

Employer,

and

NORTHERN INSURANCE CO OF NY,

Insurer,  
Respondents.

FINAL ORDER

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. Ogrodnick 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. Ogrodnick. 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. Ogradnick for apportionment, was derived consistently with the AMA Guides and the Division's directions in that regard. While it is never explained by Dr. Ogradnick 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. Ogradnick, concede that the claimant was asymptomatic on the date she underwent a DIME review with Dr. Wunder. Consequently, she contends Dr. Ogradnick 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. Ogradnick concluded the claimant's prior medical impairment rating was work related and therefore calculated an apportionment. While Dr. Ogradnick 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.

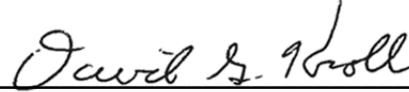
Finally, the claimant argues she did not receive any compensation for her first injury. As a result, she states it is incorrect to apply § 8-42-104(5)(a) to reduce her latter injuries' impairment rating. However, as the ALJ determined, the claimant did achieve a monetary settlement of her first claim. 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  
W. C. No. 4-894-819-02  
Page 8

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.

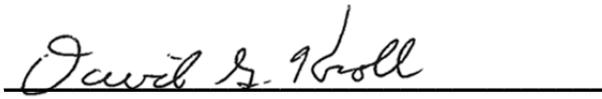
The claimant's arguments notwithstanding, as stated by the Colorado Court of Appeals in *Sheid v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991), "[a] court is justified in imposing a sanction which terminates litigation at the discovery phase if a party's disobedience of discovery orders is intentional 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)

14CA1422 Ragan v. ICAO 05-07-2015

COLORADO COURT OF APPEALS

DATE FILED: May 7, 2015  
CASE NUMBER: 2014CA1422

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Court of Appeals No. 14CA1422  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-920-457

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Rita A. Ragan, Re: Billie K. Ragan (Deceased),

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Metal Stud Forming Corporation; and Colorado Insurance Guaranty Association,

Respondents.

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ORDER AFFIRMED

Division V  
Opinion by JUDGE ROMÁN  
Ashby and Kapelke\*, JJ., concur

**NOT PUBLISHED PURSUANT TO C.A.R. 35(f)**  
Announced May 7, 2015

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

Lewis, Brisbois, Bisgaard & Smith, LLP, Kristin A. Caruso, Denver, Colorado,  
for Respondent Colorado Insurance Guaranty Association

No Appearance for Respondents Industrial Claim Appeals Office and Metal  
Stud Forming Corporation

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

Claimant, Rita A. Ragan, regarding Billie K. Ragan, also known as Billie Keith Ragan (deceased), seeks review of a final order of the Industrial Claim Appeals Office (Panel) affirming the entry of summary judgment denying and dismissing her claim for survivor benefits. We affirm.

### I. Background

The relevant facts in this case are undisputed. In January 1982, Billie K. Ragan (Mr. Ragan) suffered a heart attack within the course and scope of his employment with Metal Stud Forming Corporation (MSFC). MSFC admitted liability for Mr. Ragan's injuries. In 1990, Mr. Ragan, MSFC, and its workers' compensation insurer, Home Insurance Company, settled the claim and agreed that MSFC and Home Insurance would pay Mr. Ragan a lump sum payment of \$148,500 and provide him with "lifetime medical, surgical, and hospital benefits relating to his industrial injuries."

Thirteen years later, in 2003, Home Insurance was found to be insolvent and was ordered to liquidate its assets. The Order of Liquidation imposed a one-year deadline for filing claims after the June 13, 2003, entry of the order. Thus claims had to be filed on or before June 13, 2004. Following Home Insurance's insolvency, Mr.

Ragan's workers' compensation claim was adjusted by the Colorado Insurance Guaranty Association (CIGA) which paid for Mr. Ragan's related and reasonably necessary medical benefits.

In March 2013, Mr. Ragan suffered cardiac arrest and died. His widow, Rita Ragan (claimant), filed a claim with CIGA for workers' compensation death benefits. CIGA contested the claim on the grounds that it was time barred under the Order of Liquidation and the applicable provisions of the Colorado Insurance Guaranty Association Act (Guaranty Act), §§ 10-4-501 to -520, C.R.S. 2014. See § 10-4-508(1)(a)(III), C.R.S. 2014 (temporally limiting the filing of a covered claim). An administrative law judge (ALJ) agreed with CIGA and entered summary judgment denying and dismissing claimant's claim. The Panel affirmed and this appeal followed.

## II. Analysis

We note at the outset that claimant does not dispute that her claim is separate and distinct from Mr. Ragan's claim, and she acknowledges that her claim arose when Mr. Ragan died on March 18, 2013. See *Metro Glass & Glazing, Inc. v. Orona*, 868 P.2d 1178, 1180 (Colo. App. 1994) ("[U]nder the 'rule of independence,' disability payments awarded to an injured worker and death

benefits awarded to the employee's dependents are entirely independent of one another."); *State Comp. Ins. Fund v. Indus. Comm'n*, 724 P.2d 679, 680 (Colo. App. 1986) (where time elapses between an employee's date of injury and date of death, average weekly wage is calculated as of the date of the employee's death, not the date of injury).

Claimant nonetheless contends that the rule of independence should not apply here, that her claim should not be barred, and that the ALJ erred in granting summary judgment to CIGA. In particular, she argues that her right to collect workers' compensation death benefits should trump the provision of the Guaranty Act imposing a deadline for filing a claim. Because her claim arose long after Home Insurance's insolvency, she maintains it "would be absurd to construe section 10-4-508(1)(a)(III) as precluding a claim for benefits that could not possibly have been raised during the relevant time period." In the alternative, she argues that, as applied, section 10-4-508(1)(a)(III) violates the Due Process Clause of the Fourteenth Amendment because it deprives her of her property right to death benefits which she would have recovered but for the Guaranty Act's time bar. We disagree with

both contentions.

#### A. Standard of Review

“[S]ummary judgment may be sought in a workers’ compensation proceeding before the ALJ.” *Fera v. Indus. Claim Appeals Office*, 169 P.3d 231, 232 (Colo. App. 2007). Under Office of Administrative Courts Rule of Procedure (OACRP) 17, a party may move “for summary judgment seeking resolution of any endorsed issue for hearing.” Dep’t of Pers. & Admin. Rule 17, 1 Code Colo. Regs. 104-3. Like a motion for summary judgment pursued under C.R.C.P. 56, summary judgment may be granted in a workers’ compensation case if “there is no disputed issue of material fact and . . . the party is entitled to judgment as a matter of law.” OACRP Rule 17; *see also Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 802 (Colo. App. 1988) (noting that the Colorado Rules of Civil Procedure apply to workers’ compensation proceedings unless inconsistent or in conflict with the procedures and practices followed under the Workers’ Compensation Act).

We review an ALJ’s legal conclusions on summary judgment *de novo*. *See A.C. Excavating v. Yacht Club II Homeowners Ass’n*, 114 P.3d 862, 865 (Colo. 2005).

## B. Claim Is Time Barred

The Guaranty Act was adopted “to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and financial loss to claimants or policyholders because of the insolvency of an insurer, . . . and to provide an association to assess the cost of such protection among insurers.” § 10-4-502, C.R.S. 2014. CIGA “is a nonprofit, unincorporated legal entity” created by the Guaranty Act which “steps into the shoes of the insolvent insurer to pay claims within the coverage and limits of the insurance policy.” *Alexander v. Indus. Claim Appeals Office*, 42 P.3d 46, 47 (Colo. App. 2001); see also *Colo. Ins. Guar. Ass’n v. Harris*, 827 P.2d 1139, 1140 (Colo. 1992). The Guaranty Act obligates CIGA to pay on claims that would otherwise have been covered if the contracted insurer were solvent “to the extent of the covered claims existing prior to a determination of insolvency and arising within thirty days after the determination of insolvency.” § 10-4-508(1)(a)(I). But, the Guaranty Act expressly excludes from the definition of “covered claim”

any claim filed with the guaranty fund after

the earlier of:

(A) Twenty-four months after the date of the order of liquidation; or

(B) The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

§ 10-4-508(1)(a)(III).

Under the unambiguous provisions of the Guaranty Act, claimant's claim for survivor benefits — which did not arise until nine years after the 2004 deadline for filing claims established by the Order of Liquidation — is time barred. Where statutory language is unambiguous, we must apply it as written to give full effect to the General Assembly's intent in adopting it. *See Askew v. Indus. Claim Appeals Office*, 927 P.2d 1333, 1337 (Colo. 1996). "If courts can give effect to the ordinary meaning of words used by the legislature, the statute should be construed as written, giving full effect to the words chosen, as it is presumed that the General Assembly meant what it clearly said." *State v. Nieto*, 993 P.2d 493, 500 (Colo. 2000).

Although claimant admits that her claim is separate and distinct and did not arise until well after the deadline for filing

claims had expired, she argues that she should nonetheless have been allowed to prosecute the claim because barring it would violate the legislature's "clear intent" to liberally construe the Workers' Compensation Act "to effect its remedial and beneficent purpose of delivering benefits to injured workers and their dependents." See *Specialty Rests. Corp. v. Nelson*, 231 P.3d 393, 401 (Colo. 2010) ("[W]e liberally construe the Workers' Compensation Act in favor of the injured employee to effectuate its remedial and beneficent purposes."). She suggests that in her situation the Workers' Compensation Act's promise to pay survivor benefits should take precedence over the Guaranty Act's limit on claims.

But, there is no statutory support for claimant's construction. The Guaranty Act divides the association into three separate accounts: workers' compensation insurance; automobile insurance; and, "all other insurance," to which the Guaranty Act applies. See § 10-4-506, C.R.S. 2014. Nowhere does the Guaranty Act state that workers' compensation claims should be given precedence over any other type of claim. To the contrary, the legislature has declared that "the health, welfare, and safety of the people of the state of Colorado would be enhanced by the expeditious handling of liability

claims,” including, among the many types of claims identified, automobile, medical malpractice, fire, and commercial liability. § 10-4-101, C.R.S. 2014.

Moreover, the Guaranty Act serves an important public interest that would be hampered if we were to adopt claimant’s construction: ensuring that claimants have a mechanism for recovering benefits despite the financial collapse of an insurer. See § 10-4-502. Permitting claims that arise after the expiration of the filing deadline would impose on CIGA uncertainty concerning the number and cost of claims. See *Alexander*, 42 P.3d at 49. As CIGA notes, because it does not collect premiums, it lacks the means to pay out unpredictable claims.

These goals have been relied upon to reject other challenges to the Guaranty Act’s effects. See *Mosley v. Indus. Claim Appeals Office*, 119 P.3d 576, 580 (Colo. App. 2005). In that case, a claimant argued that CIGA should have been penalized for failing to pay her claim timely. Her contention was rejected, however, because section 10-4-517, C.R.S. 2014, of the Guaranty Act grants immunity to CIGA and precludes the imposition of penalties against it. As pertinent here, the court noted that requiring CIGA to pay

penalties would thwart the Guaranty Act's goals by "increas[ing] premiums for individual policyholders and deplet[ing] CIGA funds to pay for covered claims of all claimants whose insurers had become insolvent." *Mosley*, 119 P.3d at 580. Similarly here, adopting claimant's statutory construction giving workers' compensation survivor benefits precedence over other barred claims could negatively affect CIGA's ability to pay those other "covered claims."

Courts in other jurisdictions that have addressed similar challenges to their states' guaranty acts have, without exception, upheld comparable temporal filing limits, finding them valid and necessary to advance the goals of the guaranty acts. *See, e.g., Union Gesellschaft Fur Metal Industrie Co. v. Ill. Ins. Guar. Fund*, 546 N.E.2d 1076, 1078-79 (Ill. App. Ct. 1989) (filing deadline for claims covered by insolvent insurer upheld even though claimant did not know of its claim until after deadline's expiration); *Satellite Bowl, Inc. v. Michigan Prop. & Cas. Guar. Ass'n*, 419 N.W.2d 460, 462 (Mich. Ct. App. 1988) (protection provided by the guaranty association is not absolute and the deadline for filing claims enhances the association's ability to recover reimbursement); *Lake Hosp. Sys., Inc. v. Ohio Ins. Guar. Ass'n*, 634 N.E.2d 611, 615 (Ohio

1994) (deadline for filing claims with guaranty association was statutorily mandated and could not be ignored even though claim did not arise until after deadline had expired because doing so would “would unnecessarily prolong distribution of the insolvent insurer’s assets to the detriment of other claimants and the guaranty association”). Claimant contends we should ignore these out-of-state cases because none of them are precedential here, but she has not cited to any case, in Colorado or elsewhere, that reached a contrary holding.

Nor are we convinced that *Subsequent Injury Fund v. King*, 961 P.2d 575 (Colo. App. 1998), mandates a different outcome, as claimant suggests. In that case, a division of this court rejected the Subsequent Injury Fund’s (SIF) argument that it was not liable for survivor benefits sought by two widows. Relying on the rule of independence, SIF argued that because the widows’ claims did not arise until their husbands’ deaths from lung cancer, an amended version of the applicable statute — which removed SIF’s obligations, and which was in effect at the time of the men’s deaths but not when they became ill — should apply. The court rejected this argument. Instead, the court held that the rule of independence did

not apply because the amended statute expressly continued coverage for occupational diseases, which, like that of the widows' husbands', arose before the deadline. *Id.* at 578.

Claimant argues that the rule of independence should likewise be inapplicable here. Unlike *King*, though, claimant here cannot rely upon a statutory provision expressly extending coverage over her claim; there is no provision that unequivocally states that illnesses occurring prior to a certain date would be covered as did the statute at issue in *King*. *Id.* at 577. In *King*, the court reasoned that “it would be anomalous” to interpret the applicable statutes, sections 8-46-104 and 8-41-304(2), C.R.S. 2014,

as imposing liability on the SIF for disability and medical benefits over \$10,000 for those diseases that occurred before April 1, 1994, but not for the benefits resulting when the disease leads to a death after that date. The fact that § 8-46-104 distinguishes only between injuries and occupational diseases rather than disability and death, further convinces us that such an interpretation would be misguided.

*Id.* at 578. The analysis thus rested on the amended statute's coverage for occupational diseases, not on whether the widows' claims fell under the rule of independence. Here, there is no

analogous statutory basis to make the rule of independence inapplicable.

Accordingly, we conclude that the ALJ and the Panel properly held that claimant's claim for survivor benefits was barred by section 10-4-508(1)(a)(III).

### C. No Due Process Violation

Claimant argues in the alternative that even if the statute mandates that her claim is barred, the application of such a time bar to her claim violates her rights to due process under the Fourteenth Amendment. We disagree.

“The fundamental requisites of due process are notice and the opportunity to be heard.” *Franz v. Indus. Claim Appeals Office*, 250 P.3d 755, 758 (Colo. App. 2010) (quoting *Hendricks v. Indus. Claim Appeals Office*, 809 P.2d 1076, 1077 (Colo. App. 1990)). Workers' compensation benefits are a constitutionally protected property interest which cannot be taken without the due process guarantees of notice and an opportunity to be heard. *See Whiteside v. Smith*, 67 P.3d 1240, 1247 (Colo. 2003).

Constitutional due process protections are only implicated if an individual has “present property interests — not possible

governmental interference with potential property interests.” *Watso v. Colo. Dep’t of Soc. Servs.*, 841 P.2d 299, 305 (Colo. 1992). “Once the state has legislatively created a certain entitlement and a person can demonstrate a legitimate claim to that entitlement, only then is the Fourteenth Amendment implicated to ensure that the person is not deprived of her entitlement absent due process of law.” *Hillside Cmty. Church v. Olson*, 58 P.3d 1021, 1025 (Colo. 2002). “To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it.” *Adams Cnty. Sch. Dist. No. 50 v. Dickey*, 791 P.2d 688, 694 (Colo. 1990) (quoting *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972)).

As claimant concedes, her claim for survivor benefits “did not mature” until her husband’s death. The Guaranty Act only obligates CIGA to cover claims “existing prior to a determination of insolvency [or claims] arising within thirty days after the determination of insolvency.” § 10-4-508(1)(a)(I). CIGA argues that because claimant’s survivor benefits did not accrue until 2013, ten years after the “determination of insolvency,” she did not and does not have a constitutionally protected property interest.

Claimant counters that “her rights had already been established” before her husband’s death and that his fatal, work-related cardiac arrest “was reasonably foreseeable to come into fruition.”

But, “[a] protected interest in property exists when a person has a legitimate claim of entitlement to the property.” *Whatley v. Summit Cnty. Bd. of Cnty. Comm’rs*, 77 P.3d 793, 798 (Colo. App. 2003). In our view, claimant’s unaccrued, potential claim was not a protected property interest at the time of Home Insurance’s insolvency declaration. Although Mr. Ragan’s heart condition made him susceptible to cardiac arrest, we disagree that it was “reasonably foreseeable” that he would die of his work-related condition. He could have died as a result of an accident, other illness, or tragic event, none of which would have been attributable to the chronic heart problems caused by his compensable 1982 heart attack. We therefore conclude that until Mr. Ragan died and his cause of death was determined, claimant had nothing more than the possibility of a claim, not a protected property interest in a covered claim under the Guaranty Act. *See Watso*, 841 P.2d at 305; *Dickey*, 791 P.2d at 694.

Even if we assume claimant had a protectable property interest in her claim, we conclude she has not established a due process violation. Colorado courts have repeatedly held that workers' compensation claimants are not a suspect class and that workers' compensation benefits are not a fundamental right. See *Dillard v. Indus. Claim Appeals Office*, 134 P.3d 407, 413 (Colo. 2006); *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 12); *Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). Consequently, we have generally applied a rational basis test to constitutional challenges to the Workers' Compensation Act. See *Dillard*, 134 P.3d at 413; *Calvert v. Indus. Claim Appeals Office*, 155 P.3d 474, 477 (Colo. App. 2006) ("Because receipt of workers' compensation benefits does not implicate a fundamental right, our review under a substantive due process analysis is governed by the rational basis standard.").

Under a rational basis test, "due process requires only that legislation or state action enacted under the police power be reasonable, and not arbitrary or capricious." *Bellendir v. Kezer*, 648 P.2d 645, 646 (Colo. 1982). A statute will therefore "stand if it bears a rational relationship to a legitimate governmental objective

and is not unreasonable, arbitrary, or capricious.” *Alexander*, 42 P.3d at 48.

When determining whether a statute or application is constitutional, we begin with the presumption of validity. “Therefore, the burden is on [the] claimant, as the challenging party, to prove the statute is unconstitutional beyond a reasonable doubt.” *Peregoy v. Indus. Claim Appeals Office*, 87 P.3d 261, 265 (Colo. App. 2004).

The Guaranty Act’s time limit for filing claims has already been found to have a rationale that does not violate the Constitution. In *Alexander*, a division of this court upheld the application of the Guaranty Act’s filing deadline to bar a claim for workers’ compensation benefits even though the claim arose two years after the deadline expired. In rejecting the claimant’s contention that excluding his claim under section 10-4-508(1)(a) violated his rights to equal protection, the court found that the rational bases for the time limits outweighed the risk that some claimants might find their claims time barred:

[A] limitation provision such as that in [section] 10-4-508(1)(a) serves legitimate governmental purposes, such as ensuring

finality and the prompt recovery of reimbursement by the guaranty association from the estates of insolvent insurers, and is reasonably related to such purposes. Accordingly, we reject claimant's contention that the exclusion in [section] 10-4-508(1)(a) violates equal protection or substantive due process rights.

*Alexander*, 42 P.3d at 49. We find this reasoning persuasive.

Claimant urges us to distinguish *Alexander* on two grounds: (1) it addressed an equal protection challenge to the Guaranty Act rather than a due process challenge; and (2) it did not involve a claim for survivor benefits. Neither of these distinctions renders *Alexander* inapposite here. As quoted above, *Alexander* found that the provision violated neither the equal protection clause nor the due process clause. Moreover, even if *Alexander* primarily discussed equal protection, its finding of a rational basis would still be persuasive because the analysis for equal protection is essentially identical with that for due process. See *Snook v. Joyce Homes, Inc.*, 215 P.3d 1210, 1216 (Colo. App. 2009); *People v. Harper*, 111 P.3d 482, 484 (Colo. App. 2004) (“[T]he analysis mandated under substantive due process ‘essentially duplicates’ the analysis required under rational basis equal protection”

(quoting *Chapman v. United States*, 500 U.S. 453, 465 (1991))). As for the contention that *Alexander* dealt with a worker's claim for benefits rather than a survivor's claim for death benefits, we conclude that this is a distinction without a difference. The Guaranty Act applies to all types of "covered claims" collectively, and we perceive no basis for employing such a distinction between claims.

### III. Conclusion

Accordingly, we hold that claimant's claim for survivor benefits was excluded under the Guaranty Act, and that the exclusion of her claim did not violate her right to due process of the law. We therefore conclude that the Panel did not err in affirming the ALJ's granting of CIGA's motion for summary judgment.

The order is affirmed.

JUDGE ASHBY and JUDGE KAPELKE concur.

14CA1657 Savage v ICAO 05-28-2015

COLORADO COURT OF APPEALS

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

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

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Cory Savage,

Petitioner,

v.

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

Respondents.

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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

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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

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

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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.

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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

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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.

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Court of Appeals No. 14CA1757  
Industrial Claim Appeals Office of the State of Colorado  
WC No. 4-920-458

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DATE FILED: April 23, 2015  
CASE NUMBER: 2014CA1757

Teller County, Colorado, and Teller County WC Pool,

Petitioners,

v.

Industrial Claim Appeals Office of the State of Colorado and Michael Smith,

Respondents.

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ORDER AFFIRMED

Division I  
Opinion by JUDGE BOORAS  
Taubman and Gabriel, JJ., concur

Announced April 23, 2015

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Dworkin, Chambers, Williams, York, Benson & Evans, P.C., David J. Dworkin,  
Mary B. Pucelik, Denver, Colorado, for Petitioners

No Appearance for Respondent Industrial Claim Appeals Office

Wheelock Law, P.C., Cullen A. Wheelock, Gerald R. Blixt, Colorado Springs,  
Colorado, for Respondent Michael Smith

¶ 1 Teller County and the Teller County WC Pool challenge an award of workers' compensation benefits to Michael Smith, a volunteer with the Teller County Search and Rescue (TCSAR). We affirm.

### I. Background

¶ 2 Claimant, Michael Smith, is the president and the incident commander of TCSAR. He served TCSAR in other capacities for several years before his election as president. TCSAR is composed entirely of volunteers, including claimant, who receive no compensation for their service. TCSAR is on call at all times, and is under the jurisdiction of the Teller County Sheriff's Department. As president of TCSAR, claimant attends numerous meetings, including meetings of the fire chiefs, to prepare for disasters such as floods and fires.

¶ 3 On May 10, 2013, claimant left his home in Florissant to attend a fire chiefs meeting in Divide. Before departing, he contacted Teller County dispatch to "mark in service," thus notifying Teller County that he was en route to Divide for the fire chiefs meeting. As he was traveling to the meeting, he was struck head on by an approaching vehicle and sustained severe injuries.

¶ 4 He filed a claim for workers’ compensation benefits, asserting that as a volunteer, he fell within the scope of the definition of “employee” set forth in section 8-40-202(1)(a)(I)(A), C.R.S. 2014. Teller County contested the claim, however, arguing that the meeting claimant attended was not mandatory, and that he could not meet all of the statutory requirements necessary for a volunteer to be considered an employee under the Workers’ Compensation Act (Act).

¶ 5 After conducting a hearing, the administrative law judge (ALJ) found that when the accident occurred claimant “was actively engaged in duties that would constitute activities that are ‘proper for the performance’ of duties with the search and rescue organization.” In addition, the ALJ expressly found that claimant was the unit representative for a number of emergency response organizations, that he was “charged with coordinating assignments,” and “attend[ed] meetings across Colorado.” The ALJ further found that claimant’s attendance at the meeting in question benefitted Teller County “by preparing the search and rescue organization to competently engage in search and rescue operations.” Based on these findings, the ALJ concluded that

claimant was an employee for purposes of section 8-40-202(1)(a)(I)(A), and therefore entitled to benefits.

¶ 6 Teller County petitioned for review, arguing that claimant’s attendance at the meeting was volitional, not mandatory, and therefore should not be considered a sanctioned, covered activity. The Industrial Claim Appeals Office (Panel) disagreed, noting that it was “a custom and practice” in the county for the TCSAR president to attend the meetings. Consequently, the Panel concluded, claimant’s attendance at the meeting was within the course and scope of his duties. The Panel therefore affirmed the ALJ’s order.

## II. Analysis

¶ 7 Teller County contends that (1) claimant’s actions did not fall within the statutory definition of “employee” because he was driving to a meeting — not “actually performing duties” or “engaged in” an organized drill or training — when the accident occurred; (2) the Panel’s inclusion of “planning and preparation” activities under the definition of employee broadened the scope of the provision beyond the General Assembly’s intent; (3) the Panel engaged in improper fact finding in affirming the ALJ’s decision; and (4) claimant’s claim should have been barred by the “coming and going” rule. We are

not persuaded by these arguments to set aside the Panel’s order.

A. Statutory Definition of Employee

¶ 8 The Act defines “employee” to include:

volunteer rescue teams or groups, volunteer disaster teams, volunteer ambulance teams or groups, and volunteer search teams in any county, city, town, municipality, or legally organized fire protection district or ambulance district in the state of Colorado . . . while said persons are actually performing duties as volunteer firefighters or as members of such volunteer rescue teams or groups, volunteer disaster teams, volunteer ambulance teams or groups, or volunteer search teams . . . and while engaged in organized drills, practice, or training necessary or proper for the performance of such duties.

§ 8-40-202(1)(a)(I)(A).

¶ 9 We interpret statutory provisions de novo, and give “considerable weight’ to the Panel’s interpretation of the statute it administers.” *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 35. We look first to the statute’s plain language, giving that language its common meaning. *People v. Jenkins*, 2013 COA 76, ¶ 12. If the language is clear and unambiguous, we look no further and enforce it as written. *Id.*

¶ 10 The plain meaning of the statute makes clear that “employee”

includes volunteer firefighters and volunteer search and rescue workers in certain circumstances. At oral argument, Teller County conceded that, although the statute uses the conjunctive, the statutory requirements for inclusion as an “employee” are satisfied by either “actually performing duties” or being “engaged in organized drills, practice or training” when an accident occurs. See *Waneka v. Clyncke*, 134 P.3d 492, 494 (Colo. App. 2005) (“When interpreting a statute, a reviewing court may substitute ‘or’ for ‘and,’ or vice versa, to avoid an absurd or unreasonable result.”). We agree that volunteer firefighters and volunteer search and rescue workers are “employees” under the statute when they are actually performing duties or when engaged in organized drills, practice, or training.

¶ 11 Attending fire chief meetings was part of claimant’s position and duties as president of TCSAR. As a commander with the Teller County Sheriff’s Office acknowledged, coordinating with the fire chiefs is “important,” as is coordination between TCSAR and the Sheriff’s Office, and that lack of coordination and planning would lead to ineffective preparation and response.

¶ 12 Other cases involving volunteers have reached similar

conclusions. In one case, a division of this court upheld the Industrial Commission's finding of compensability for injuries sustained by a search and rescue volunteer while traveling by private plane to a meeting. *See Colo. Civil Air Patrol v. Hagans*, 662 P.2d 194, 196 (Colo. App. 1983). The division noted that the commander testified that the volunteers were on duty "from the time they leave home to attend a meeting until they return." *Id.* Thus, traveling to attend a meeting has satisfied the "actually performing duties" component.

¶ 13 We also reject Teller County's contention that claimant's accident should not be covered because he was acting alone and not as a member of a group or team when he was heading to the meeting. Teller County offers no case law authority for this interpretation of the statute, and we know of no circumstance in which a volunteer was denied benefits simply because no other volunteers were engaged in the same injury-causing activity. On the contrary, whether a volunteer's injuries have been compensable has rested on a determination of the nature of the activities, rather than the number of volunteer participants. *See, e.g., Nw. Conejos Fire Prot. Dist. v. Indus. Comm'n*, 39 Colo. App. 367, 369, 566 P.2d

717, 719 (1977) (upholding benefits for volunteer firefighter's injuries sustained while acting as a flagman at motorcycle races).

B. The Panel's Interpretation of "Employee" Is Not Overly Broad

¶ 14 Teller County argues that the Panel's reliance on *Hagans* is misplaced because the claimant in *Hagans* was required to attend the training meeting, whereas claimant here chose to attend the meeting without any direction from the Sheriff's Office. The Panel held that this distinction was inconsequential, though, because claimant had a custom and practice of attending these meetings as president of TCSAR.

¶ 15 Teller County argues that looking to custom and practice expands the statutory language of "performing duties" beyond its plain meaning. However, contrary to Teller County's contention, a custom and practice of engaging in a particular activity can be considered part of a volunteer's regular duties, and injury during such activities can be compensable. Following decisions from other jurisdictions, a division of this court observed that "as a result of custom and practice, other activities, such as participation in patriotic celebrations, have become part of the normal activities of volunteer fire departments, and when injuries have occurred in the

course of these activities, compensation has been allowed.” *Nw. Conejos Fire Prot. Dist.*, 39 Colo. App. at 369-70, 566 P.2d at 719-20 (where fire department’s participation in patriotic celebration was customary, the activities came within the scope of employment of a volunteer fireman by “pattern or custom”).

¶ 16 Nor are we persuaded by Teller County’s argument that covering volitional acts will deprive it of its right to determine who is an employee. An agency can acquiesce in the compensability of certain acts by knowingly permitting them to occur. For example, in *Capano v. Bound Brook Relief Fire Co. #4*, 811 A.2d 510 (N.J. Super. Ct. App. Div. 2002), the court affirmed an award of benefits to a ninety-three-year-old volunteer firefighter who underwent hip replacement surgery after falling while putting a log in a wood-burning stove. The claimant was no longer assigned any active duties, but instead “typically arrive[d] at the firehouse early each evening, clean[ed] up a little, and then ‘watch[ed] TV and talk[ed] with the other members.’” *Id.* at 511. His visits were characterized as “essentially social.” *Id.* Although the claimant had never been ordered or instructed to stoke the firehouse’s wood-burning stove, his injuries were held compensable because the fire department

acquiesced in his activity and benefitted from the claimant's habit of keeping the fire burning. *Id.* at 513.

¶ 17 Similarly, in this case, the ALJ found, with record support, that claimant attended numerous meetings as president of TCSAR and regularly attended the fire chiefs meeting. On the day of the accident, he followed his usual custom and practice of “marking in service” as he was leaving his home for the meeting. Claimant testified that the meeting would include training and planning for the forthcoming fire season. A commander with the Teller County Sheriff's Office confirmed that it was “important” for TCSAR “to coordinate with the fire chiefs on a regular basis,” and also to coordinate with the Sheriff's Office. Nothing in the record suggests claimant was ever instructed not to attend the various planning, training, and preparedness meetings. Because the commander acknowledged that prior coordination achieved at meetings assists Teller County's preparedness and responsiveness “during missions,” Teller County admittedly benefitted from claimant's attendance at these meetings. Under the circumstances, we agree with the Panel that claimant and Teller County had a custom and practice by which claimant attended meetings in his capacity as

president of TCSAR.

¶ 18 We therefore conclude that claimant was performing duties pursuant to a custom and practice in which Teller County acquiesced when he was involved in the accident. The Panel’s interpretation of section 8-40-202(1)(a)(I)(A) finding such activity falls within the definition of “employee” is not inconsistent with the clear language of the statute or the legislature’s statutory intent. *See Pena v. Indus. Claim Appeals Office*, 117 P.3d 84, 88 (Colo. App. 2004) (“We give deference to the Panel’s interpretation of workers’ compensation statutes and will set that interpretation aside only if it is inconsistent with the clear language of the statute or the legislative intent.”). The Panel thus did not err in finding claimant an “employee” at the time of his accident.

#### C. Fact Finding by the Panel

¶ 19 Teller County also argues that the Panel engaged in improper fact finding which warrants setting aside the Panel’s order. Specifically, Teller County contends that the Panel improperly found that claimant “was ordered by the Sheriff’s predecessor to attend the meetings and the current Sheriff never countermanded that order.” Teller County argues that the record does not support this

finding and that this fact was not addressed in the ALJ's order. We are not persuaded to set aside the Panel's order on this basis.

¶ 20 Teller County relies on *City of Loveland Police Department v. Industrial Claim Appeals Office*, 141 P.3d 943 (Colo. App. 2006), for the principle that a reviewing court errs by

“parsing . . . the record and testimony presented and making its own findings of fact in lieu of those made by the ALJ.” . . . Where the record supports the findings of the factfinder, the court of appeals is not at liberty to make an independent evaluation of the evidence and substitute its judgment for that of the factfinder.

*Id.* at 950 (quoting *Bodaghi v. Dep't of Natural Res.*, 995 P.2d 288, 303 (Colo. 2000)). Rather, a reviewing court is bound by the ALJ's factual findings if those findings are supported by substantial evidence in the record; questions of law and application of the law to undisputed facts are reviewed de novo. *See Winter v. Indus. Claim Appeals Office*, 2013 COA 126, ¶ 7.

¶ 21 Teller County maintains that there is a discrepancy between the Panel's recitation of the facts and the record itself. The Panel stated that “claimant testified that Commander Bright's predecessor as the [TCSAR] contact at the sheriff's department had advised . . .

claimant to attend the Fire Chief's meeting." The actual exchange to which Teller County points in support of its contention that the Panel misconstrued the evidence was as follows:

A (claimant): If I may speak frankly, we were informed by the representative of the Sheriff's Office that we were covered if we were going to the [County Search and Rescue Board] meetings.

Q (Teller County's counsel): Who told you that?

A: At the time it was Greg Griswold, [who] was the OEM [Office of Emergency Management liaison] for the Sheriff's Office.

Q: When you say "at the time," when was that time?

A: That was ever since I've been on the unit till I guess it was approximately six years ago. And then there was Jerry Kerr that took his position, and Jerry Kerr informed us of the same thing.

But, earlier in the hearing, claimant also testified:

Q (Teller County's counsel): The Sheriff's Department does not tell you you have to attend fire chief meetings; right?

A (claimant): They actually have told us -- the former representative of the Sheriff's Office told us that we have to have a representative at the fire chiefs meetings.

Q: The representative of Teller County has not told you — the current representative of Teller County has not told you you have to be present at these fire chief meetings; correct?

A: Not since this past year or since Sheriff Ensminger has taken over, it's never been discussed.

In our view, this passage, which Teller County does not cite, squarely supports the Panel's recitation of the facts. The Panel did not identify the portion of the transcript on which it relied to set forth facts which Teller County finds objectionable. We note, however, that the passage which Teller County cites discusses claimant's understanding, based on conversations with previous Sheriff's Office contacts, that he was "covered" when he attended meetings, not whether he was instructed to attend the meetings by a representative from the Sheriff's Office. Based on this record, we disagree that the Panel exceeded its authority or improperly engaged in fact finding.

¶ 22 We note, too, that even if the Panel overstepped its authority, it *affirmed* the ALJ. In our view, the Panel was simply stating the facts as background information. In contrast, reviewing courts

have been chastised for “parsing . . . the record” to make their own findings of fact when those findings on appeal were used to set aside the order of an administrative agency. *See Bodaghi*, 995 P.2d at 303. Therefore, any impermissible factfinding the Panel engaged in — and we do not perceive any — explained the underlying facts and record; it did not cull facts with the purpose of disagreeing with the ALJ’s findings and conclusion.

#### D. Coming and Going Rule Inapplicable

¶ 23 Finally, Teller County asserts that claimant’s claim should have been barred by the “coming from and going to rule,” which ordinarily denies workers benefits if they are injured coming from or going to work. *See Madden v. Mountain W. Fabricators*, 977 P.2d 861, 863 (Colo. 1999). “In general, a claimant who is injured while going to or coming from work does not qualify for recovery because such travel is not considered to be performance of services arising out of and in the course of employment.” *Id.* As Teller County acknowledges, however, exceptions to this general rule abound, and we agree with the Panel and the ALJ that when the accident occurred, claimant fell within a special circumstances exception to the *Madden* “coming from or going to” rule.

¶ 24 *Madden* held that

the proper approach is to consider a number of variables when determining whether special circumstances warrant recovery under the Act.

These variables include but are not limited to: (1) whether the travel occurred during working hours, (2) whether the travel occurred on or off the employer's premises, (3) whether the travel was contemplated by the employment contract, and (4) whether the obligations or conditions of employment created a "zone of special danger" out of which the injury arose.

*Id.* at 864. The Panel relied on *Hagans*, 662 P.2d 194, to conclude that claimant's travel fell within an exception to *Madden*. Indeed, *Hagans'* facts fall squarely within the variables later identified in *Madden*.

¶ 25 In *Hagans*, injuries sustained by a search and rescue volunteer while he was traveling to a mandatory training meeting were compensable. Teller County argues that *Hagans* is factually distinguishable because the fire chiefs meeting to which claimant was traveling was not mandatory.

¶ 26 However, the *Hagans* division recognized that an employer can "expressly or impliedly" agree that the employment relation shall continue during the period of coming and going. *Id.* at 196.

Likewise, *Madden* acknowledged that travel contemplated by employment could occur as the result of either an express or implied request by the employer. *Madden*, 977 P.2d at 864. The “common link” between situations that satisfy *Madden*’s third variable is that the travel “is a substantial part of the service to the employer.” *Id.* at 865.

¶ 27 Here, claimant and Teller County had a custom and practice under which claimant regularly attended the fire chiefs meetings and notified Teller County that he would be doing so by “marking in service.” While attendance was not technically “mandatory,” Teller County knew claimant regularly attended these meetings, and acquiesced in his participation. *See Capano*, 811 A.2d at 513. Teller County, through the Sheriff’s Office commander, conceded that it benefitted from claimant’s attendance at these meetings because his participation enabled coordination between departments and facilitated smoother disaster responses. From the commander’s testimony and the ALJ’s factual findings, it is clear that attending these meetings comprised a great deal of claimant’s time and involvement as president of TCSAR. Under the circumstances, we conclude that claimant’s attendance at the fire

chiefs meeting, including travel to the meeting, was contemplated as part of claimant's duties. Thus, the travel fell under the third *Madden* variable.

¶ 28 Accordingly, we conclude that claimant was an employee acting within the course and scope of his employment at the time of the May 10, 2013, automobile accident. The Panel therefore did not err in affirming the ALJ's award of benefits to claimant.

### III. Conclusion

¶ 29 The order is affirmed.

JUDGE TAUBMAN and JUDGE GABRIEL concur.