

BROWN BAG SEMINAR

Thursday, May 21, 2015

(third Thursday of each month)

Noon - 1 p.m.

633 17th Street

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

1 CLE (including .4 ethics)

Presented by

Craig Eley

Prehearing Administrative Law Judge
Colorado Division of Workers' Compensation

Sponsored by the Division of Workers' Compensation

Free

This outline covers ICAP and appellate decisions issued from

April 7 through May 15, 2015

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-870-626-01

IN THE MATTER OF THE CLAIM OF
JOHN ROSCOE,

Claimant,

v.

FINAL ORDER

LOOKOUT MOUNTAIN WATER
DISTRICT,

Employer,

and

COLORADO SPECIAL DISTRICTS
P&L POOL,
c/o COUNTY TECHNICAL
SERVICES, INC.

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Margot Jones (ALJ) dated October 22, 2014, that denied the respondents' request to modify the general admission of liability to decrease the claimant's average weekly wage. We affirm.

This matter went to hearing on the respondents' petition to modify. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant was a professional engineer with a background in mining and civil engineering, management road and dam construction and water development. When the claimant worked as a paid consultant his professional fees ranged from \$50/hour to \$100/hour. In 1988 the claimant was elected to the first Board of Lookout Mountain Water District (District). He later became president, serving consecutive terms as president until his admitted injury on October 11, 2011. On this date the claimant was inspecting a water facility site when he slipped, fell and fractured his skull.

The respondents filed a general admission of liability on November 23, 2011, admitting for an average weekly wage at the maximum rate of \$828.03 pursuant to §8-40-202 (1)(a)(II), C.R.S., which provides that the rate of compensation "of every

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nonsalaried person in the service of the state of any county, city town or irrigation, drainage or school district therein, or of any public institution or administrative board thereof,” including “nonsalaried elective officials...shall be at the maximum rate provided by article 40 to 47 of this title.”

The respondents subsequently filed a petition to modify the claimant’s average weekly wage asserting that the claimant did not meet the definition of §8-40-202(1)(a)(II), C.R.S., because he was actually a “salaried employee” and, therefore, his average weekly wage should be based upon the “wages” he actually received which the respondent calculated to be \$25.00 per week.

The ALJ found that the District adopted rules, pursuant to statute, §32-1-902 (3)(b), C.R.S., giving the Board discretionary authority to pay itself compensation, but only for attendance at Board meetings. Under this policy, the claimant was compensated \$100 per Board meeting he attended but could not exceed \$1600 per year. The Board meetings were held monthly. The District issued W-2s to the Board members, reflecting the sum of the \$100-per-meeting payment made to them. No income tax was withheld because the sum was too small to trigger any withholding requirements.

In addition to his attendance at the monthly board meetings, the claimant performed a myriad of other duties for the District including visiting water facility sites to pay contractors and determine whether a project had been completed. He met with state regulators, engineers, legal counsel, financial advisors, consultants and periodically attended conferences. As the Board president, the claimant signed all contracts, deed notes, debentures, warrants and other instruments on behalf of the District and was responsible for oversight of all legal and budgetary matters. The claimant reviewed written reports and design specifications and used his professional expertise to discuss these with paid contractors. The claimant spent an estimated 20 hours per week on the District’s business and was not paid for any of these activities.

The ALJ also found that the District’s workers’ compensation renewal documents with the insurer pool stated that all five directors on the Board were volunteers. In 2012, the respondents re-named a reservoir and dam after the claimant. The Board’s resolution in this regard recited that the claimant had “provided superior leadership and countless hours of volunteer time to maintain and improve the District’s ability to serve its residents in a responsible and cost effective manner and to plan for the future.”

Based on these findings, the ALJ concluded that the claimant was in fact a “nonsalaried” elective official for purposes of §8-40-202(1)(a)(II), C.R.S. and should be compensated based upon the maximum average weekly wage.

On appeal, the respondents renew the arguments made at hearing and contend that that the evidence compels the conclusion that the claimant was a salaried employee. We are not persuaded that the ALJ committed reversible error and affirm the ALJ’s order.

Because the respondents sought to modify the general admission of liability, they had the burden of proof on this issue. Section 8-43-201, C.R.S. provides, in pertinent part, a party seeking to modify an issue determined by a general or final admission...shall bear the burden of proof for any such modification. *See City of Brighton v. Rodriguez*, 318 P.3d 496 (Colo. 2014).

The statute at issue, §8-40-202(1)(a)(II), C.R.S. states that that a nonsalaried elective official shall be compensated based on the maximum rate. The court has recognized that the legislative intent in providing maximum compensation to public volunteers is to encourage public service. *Parker Fire Protection District v. Poage*, 843 P.2d 108 (Colo. App. 1992).

Section 8-40-201(19) C.R.S. defines the term “wages” to mean the money rate at which services rendered are recompensed under the contract of hire in force at the time of the injury, either express or implied, and shall not include gratuities received from employers or others.

Here, the ALJ found, and the respondents do not dispute, that the claimant volunteered to serve as an elective official for the District and was not compensated for the many services he performed. At the time of the claimant’s injury there was no enforceable agreement between the parties to pay any salary, only the stipend for attending the monthly Board meetings. Under these circumstances, we agree with the ALJ’s conclusion that the claimant was a nonsalaried elective official entitled to the maximum rate of compensation pursuant to §8-40-202(1)(a)(II), C.R.S.

If a party performs services without the expectation of remuneration the person is a “volunteer,” and not an employee within the meaning of the Workers’ Compensation Act. Thus, in *Hall v. State Compensation Insurance Fund*, 154 Colo. 47, 387 P.2d 899 (1963), the court held that a claimant providing charitable services to a hospital was not an employee despite the fact that the hospital provided free meals to the claimant. As stated by the Court of Appeals, the status of a volunteer is not negated by

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"the fact that the alleged employer may provide some benefit on a gratuitous basis." *Aspen Highlands Skiing Corp. v. Apostolou*, 854 P.2d 1357, 1360 (Colo. App. 1992), *aff'd* 866 P.2d 1384. The respondents' argument ignores the ordinary definition of the term "salary." The word can be described as "a fixed payment at regular intervals for services, esp. when clerical or professional." *Websters New World College Dictionary* (4th ed. 2010), or:

A salary is a form of periodic payment from an employer to an employee, which may be specified in an employment contract. It is contrasted with piece wages, where each job, hour or other unit is paid separately, rather than on a periodic basis. *Wikipedia the free encyclopedia*, (Jan. 8, 2015).

The payment made to the claimant here pursuant to § 32-1-902(3)(a)(II), C.R.S. is payable only when the claimant attends a meeting. The payment, therefore, does not coincide with the above descriptions of a salary as a periodic payment and, is instead, an episodic payment.

The workers' compensation statute itself ascribes a meaning to the word "salary" distinct from that assigned by the respondents. Section 8-42-102, C.R.S., discusses the standard to be used for a determination of the average weekly wage. Subsection (2)(a) describes the circumstances involving a payment by the month, (b) references payment by the week, (c) describes daily payment, (d) deals with hourly rates, (e) references piecework, tonnage and commissions, and (f) pertains to payment by the mile. Only in subparagraph (a), pertinent to monthly payments, is the payment characterized as a "salary." Because the claimant could attend meetings in a haphazard fashion, and be paid in a similar manner, his remuneration would not be consistent with the monthly definition of salary in this subparagraph (a).

As noted by the parties, there is very little case law directly on point with this issue. The claimant points to the case of *State Compensation Insurance Fund v. Keane*, 160 Colo., 292, 417 P.2d 8 (1966), in support of his contention that he is a "nonsalaried" volunteer. In *Keane*, the decedent was a deputy sheriff who received no compensation other than civil fees which he collected for the service of papers. Although the respondents in *Keane* argued that these fees should be characterized as a "salary" payable to the claimant, the court disagreed. The court recognized that it was the intent of the legislature to provide that the specifically enumerated nonsalaried volunteers be paid at the maximum rate of compensation. The court awarded dependent benefits based upon the maximum rate of compensation.

Similarly in *University of Colorado v. Spencer*, Colo. App. No. 88CA1508 (October 2, 1989) *not selected for publication*, the court of appeals set aside the conclusion of the ALJ and the panel that a \$250 payment to an otherwise nonsalaried volunteer turned the claimant into a “salaried” employee for purposes of the statute. The claimant in *Spencer* was a student at the University of Colorado and appeared as an actor in a play produced by the University in conjunction with the Parks and Recreation Department. During the performance the claimant fell striking his head on a steel stake and sustained a severe brain injury. The court stated that the claimant had volunteered for this acting role and for five previous theatrical productions sponsored by the University. The claimant had never received any compensation for his services and did not expect to be paid for his work in the plays. After the claimant was selected for this acting role, the cast and crew members were advised that the play had been budgeted and that they would share in any “left-over monies” if the show was performed under budget. Approximately one month after his injury, the claimant received \$250 as his share of the play’s excess budget funds. The court stated that this amount reflected only a partial reimbursement of the claimant’s theatrical expenses. The court said that at the time of the injury there was no enforceable agreement between the parties to pay any salary and that the \$250 received by the claimant could not properly be classified as salary received for his services.

The *Keane* and *Spencer* cases are analogous to the present claim and we are not persuaded by the respondents’ arguments that this case is somehow distinguishable. We agree with the ALJ’s conclusion, that under the totality of the circumstances, the \$100 the claimant received for Board meeting attendance is a nominal benefit, essentially akin to a gratuity. In view of the other many duties that the claimant performed for the District without pay, this amount should not negate the claimant’s status as a nonsalaried volunteer. Christina Shea, a contractor who handles accounting and administration for the District, testified that the claimant was not required to perform any of the extra duties in order to get paid, but that he volunteered these services on behalf of the District. Tr. at 35. The claimant’s wife further stated that he performed his volunteer activities for the District because he cared about his community and based on the belief that he would not be paid. Tr. at 106.

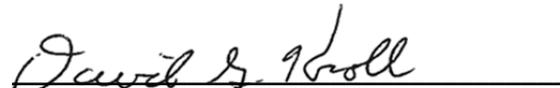
We, therefore, agree with the ALJ’s determination that the claimant was a “nonsalaried” elective official within the meaning of §8-40-202(1)(a)(II), C.R.S. and thus, properly compensated based on the maximum rate.

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IT IS THEREFORE ORDERED that the ALJ's order dated October 22, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


David G. Kroll

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CERTIFICATE OF MAILING

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

_____ 3/17/2015 _____ by _____ RP _____ .

LAW OFFICE OF ERICA WEST, Attn: ERICA WEST, ESQ., 837 E. 17TH AVE., #102,
DENVER, CO, 80202 (For Claimant)

DWORKIN, CHAMBERS, WILLIAMS, YORK, BENSON & EVANS, P.C., Attn: CAMERON
J. RICHARDS, ESQ., 3900 EAST MEXICO AVENUE, SUITE 1300, DENVER, CO, 80210
(For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-937-322-01

IN THE MATTER OF THE CLAIM OF

ELAINE WILSON,

Claimant,

v.

FINAL ORDER

DILLON COMPANIES, INC.,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Mottram (ALJ) dated October 15, 2014, that determined the claimant sustained a compensable injury after a fall in the employer's parking lot and awarded medical and temporary disability benefits. We affirm.

A hearing was held on compensability, medical and temporary disability benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant was employed by the employer as a barista for the coffee shop contained within the respondent's store #440. The claimant's normal work schedule was from 8:30 a.m. until 5:00 p.m., five days per week. The employer had designated two areas on the property for employee parking. The employees were asked to park in these areas so the customers have easier access to the store but employees have not been disciplined for parking close to the store. These areas were also available for customers to park and employees were not prohibited from parking off-site.

On December 11, 2013, the claimant completed her shift and clocked out at 5:03 p.m. The claimant then did some personal grocery shopping, paid for her groceries and left the store. The claimant testified that it was not unusual for her to do her grocery shopping after work and she received an employee discount for groceries purchased at the store. The claimant exited the store and began walking to her car, past the pharmacy drive through. There was a car at the drive through and the claimant needed to step off of

the curb to get to where her car was parked. The claimant slipped and fell on ice in the parking lot of the employer's premises. The claimant was taken by ambulance to the emergency room where she was diagnosed with a closed neurovascularly intact left tibia and fibula fracture and a rib fracture.

The respondent denied the claim contending that the claimant's act of grocery shopping was a personal deviation that took the claimant out of the course and scope of her employment. The ALJ found that although the claimant's shopping could constitute a personal deviation, the ALJ concluded that "any personal deviation had concluded by the time the claimant paid for her groceries and began walking to her car." The ALJ went on to conclude that the claimant's injury was compensable and ordered the respondent to pay for medical treatment and temporary disability benefits.

On appeal, the respondent argues that the ALJ erred in his analysis of the claim. The respondent also asserts that the ALJ abused his discretion in determining that the claimant's "personal deviation" ended after the claimant checked out and walked out of the store and that the ALJ erred in referencing the "exclusive remedy" provision in his order. We are not persuaded the ALJ committed reversible error.

In Colorado, only those injuries "arising out of" and "in the course of employment," are compensable under the Workers' Compensation Act. Section 8-41-301(1)(b), C.R.S. The course of employment requirement is satisfied when the claimant shows that the injury occurred within the time and place limits of the employment. *Popovich v. Irlanda*, 811 P.2d 379 (Colo. 1991). Here, the ALJ found that the claimant's injury met the course and scope test. The claimant sustained an injury in the employer controlled parking lot shortly after she clocked out from her shift. We are not persuaded by the respondent's arguments that the claimant's injury was not sustained in the course and scope of employment because the claimant was not necessarily required to park in the areas designated by the employer as employee parking or the fact that she could have parked off site. The panel has previously recognized that "[i]t is now 'practically' universally accepted that a parking lot adjacent to the employer's business is a part of the employer's premises." *Rodriguez v. Exempla Healthcare, Inc.*, W.C. No. 4-705-673 (April 30, 2008). In support of this holding, the Panel quoted Professor Larson as follows:

As to parking lots owned by the employer, or maintained by the employer for its employees, practically all jurisdictions now consider them part of the "premises," whether within the main company premises or separated from it. *This rule is by no means confined to parking lots owned,*

controlled, or maintained by the employer. The doctrine has been applied when the lot, although not owned by the employer, was exclusively used, or used with the owner's permission, or just used, by the employees of this employer. Thus, if the owner of the building in which the employee works provides a parking lot for the convenience of all tenants, or if a shopping center parking lot is used by employees of businesses located in the center, the rule is applicable. (emphasis in original).

Larson's Workers' Compensation Law, § 13.04 [2] [a] [b] (footnotes omitted); *see also State Compensation Insurance Fund v. Walter, supra* (upholding award of compensation to claimant injured while crossing public street between employer's parking lot and employer's shop); *Woodruff World Travel, Inc. v. Industrial Commission, supra* (parking lot was provided for use by employer's employees, employer was aware its employees used the lot, and lot constituted "an obvious fringe benefit to claimant"); *Friedman's Market, Inc. v. Welham*, 653 P.2d 760 (Colo. App. 1982) (fact that the respondent did not own or control the parking lot does not, as a matter of law, mandate a different result). Additionally, once a parking lot has achieved the status of "a portion of the employer's premises, compensation coverage attaches to any injury that would be compensable on the main premises." *Larson's Workers' Compensation Law*, § 13.04 [2] [b].

In the present case, the parking lot where the claimant fell was situated adjacent to the building where the claimant worked. Further it was undisputed that the employer's employees used this parking lot and that the employer knew its employees used such parking lot. Tr. at 76. Misty Herman, store manager, testified that the employees were asked to park in certain areas of the parking lot so that the customers had easier access to the doors. Tr. at 88. Herman further testified that although they requested that the employees comply with this parking policy, she did not have a way to monitor the employee's cars to insure compliance. Tr. at 89. Even though the employer may not have disciplined employees for failing to park in the designated areas, and even though the lot was open to the general public, the ALJ nevertheless concluded, with record support, that the parking lot was owned and maintained by the employer and the employer directed the employees where to park, indicating a degree of control over the employees' parking decision. *Friedman's Market, Inc. v. Welham, supra*. Injuries sustained in parking lots which are provided by the employer for the benefit of employees arise out of the employment because they are a normal incident to the employment relationship. *Seltzer v. Foley's Department Store*, W. C. No. 4-432-260 (September 21, 2000) (claimant's parking lot injury compensable even though it occurred

while claimant was off the clock, and at a place where the risk was shared by the general public).

Moreover, while the claimant had clocked out from work, it is well settled that the "course of employment" embraces a reasonable interval before and after official working hours when the employee is on the employer's property. *Larson, Workers' Compensation Law* § 21.06(1); *Industrial Commission v. Hayden Coal Co.*, 113 Colo. 62, 155 P.2d 158 (1944) (interval of up to 35 minutes has been allowed for arrival and departure from work); *Ventura v. Albertson's Inc.*, 856 P.2d 35 (Colo. App. 1992). The ALJ specifically found that the claimant's injury here occurred a short time (approximately 15 minutes) after she had clocked out. Therefore, because it is supported by substantial evidence in the record, we are bound by the ALJ's factual finding that the claimant was injured during the time and place of her employment. Section 8-43-301(8), C.R.S.

The inquiry does not stop there, however, and the claimant must also satisfy the "arising out of" requirement for compensability. The "arising out of" element is narrower than the "course" element and requires the claimant to prove that the injury had its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Popovich v. Irlando*, supra. The "arising out of" test is one of causation. *See Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). The determination of whether there is a sufficient "nexus" or causal relationship between the claimant's employment and the injury is one of fact which the ALJ must determine based on the totality of the circumstances. *City of Brighton v. Rodriquez*, supra.

In order to satisfy the arising out of requirement, it is not necessary that the claimant actually be engaged in performing job duties at the time of the injury. *See Employers' Mutual Ins. Co. v. Industrial Commission*, 76 Colo. 84, 230 P. 394 (1924). Our courts have recognized that it is not essential for the compensability determination that the activities of an employee emanate from an obligatory job function or result in some specific benefit to the employer so long as the employee's activities are sufficiently incidental to the work itself as to be properly considered as arising out of and in the course of employment. *See also Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996) (an activity arises out of employment if it is sufficiently "interrelated to the conditions and circumstances under which the employee generally performs the job functions that the activity may reasonably be characterized as an incident of employment"). It is sufficient if the injury arises out of a risk which is reasonably incidental to the conditions and circumstances of the particular employment. *Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9 (Colo. App. 1995). Whether

a particular activity has some connection with the employee's job-related functions as to be “incidental” to the employment is dependent on whether the activity is a common, customary, and an accepted part of the employment as opposed to an isolated incident. *See Lori’s Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995)

In contrast, if an employee substantially deviates from the mandatory or incidental functions of her employment, such that she is acting for her sole benefit at the time of an injury, then the injury is not compensable. *Kater v. Industrial Commission*, 728 P.2d 746 (Colo. App. 1986); *see also Callahan v. Nekoosa Papers, Inc.*, W.C. No. 3-866-766 (May 8, 1989)(claimant working on his car in the employer's parking lot with his own tools was not engaged in an activity incidental to his employment). When a personal deviation is asserted, the issue is whether the activity giving rise to the injury constituted a deviation from employment so substantial as to remove it from the employment relationship. *Panera Bread, LLC v. Industrial Claim Appeals Office*, 141 P.3d 970 (Colo. App. 2006).

Here, the ALJ found that “even if Claimant’s shopping following the completion of her shift represented a personal deviation, that deviation ended once Claimant completed her check out and walked out of the store to her car” and the claimant was “back within the course and scope of her employment.” The respondent contends that the ALJ necessarily found that there was a substantial deviation removing the claimant from her employment duties and that this mandates conclusion that the claimant’s injury did not arise out of her employment. We disagree.

Here, as noted in the ALJ’s order, there is evidence from which the ALJ could have determined that it was common and customary and an accepted part of the employment for the employees to do personal shopping which would create a sufficient nexus to the claimant’s employment by virtue of his findings that the claimant received an incentive to shop at the grocery store through an employee discount and regularly did so following her shift. Thus, contrary to the respondent’s assertion, we do not read the ALJ’s findings to actually determine there was a substantial deviation. The ALJ merely determined that “even if” there was a personal deviation from employment, that deviation ended once the claimant checked out and walked out of the store to her car.

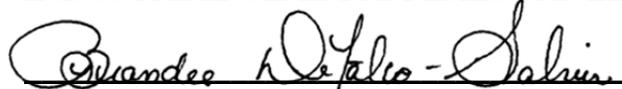
The question of when a personal deviation has ended and the claimant has commenced the return to employment duties is generally one of fact for determination by the ALJ. Further, the claimant bears the burden of proof on this issue. *Wild West Radio, Inc. v. Industrial Claim Appeals Office*, 905 P.2d 6 (Colo. App. 1995). Because the issue is factual, we must uphold the ALJ's order if supported by substantial evidence in the

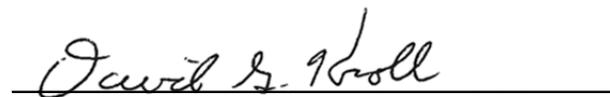
record. Section 8-43-301(8), C.R.S. The claimant testified that pursuant to the employer's request, she always parks on the east side of the building when she is working. Tr. at 24. The claimant would have taken the same path to her car whether she left immediately after her shift or after 15 minutes of shopping. Tr. at 69. The claimant's act of walking to her car to leave for the day was contemplated by her employment duties as employers are expected to provide a safe ingress and egress to the premises and the claimant would have had to exit the building regardless of whether or not she had stopped to do personal shopping. Moreover, the ALJ specifically found it was the black ice in the parking lot that caused the claimant to fall and not the fact that she was carrying grocery bags. Because the ALJ's findings in this regard are supported by substantial evidence and those findings in turn support the conclusion that any personal deviation the claimant might have engaged in had ended, we have no basis to disturb the ALJ's order. Section 8-43-301(8), C.R.S.

The respondent also takes issue with a footnote in the ALJ's order discussing the fact that the determination in this case was "consistent with the established principle of workers' compensation to provide for the quick and efficient delivery of benefits without consideration of fault, in exchange for waiving the right to pursue a judgment against an employer in a civil court." Although this appears to be superfluous commentary, in our view, it does not alter the ALJ's dispositive findings and conclusion that the claimant sustained an injury arising out of and in the course and scope of her employment when she fell in the employer's parking lot. We, therefore, perceive no reversible error in this regard.

IT IS THEREFORE ORDERED that the ALJ's order dated October 15, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


David G. Kroll

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W. C. No. 4-937-322-01
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CERTIFICATE OF MAILING

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

_____ 3/16/2015 _____ by _____ RP _____ .

WITHERS SEIDMAN RICE & MUELLER, PC, Attn: SEAN E. P. GOODBODY, ESQ., 101
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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. 4-880-213-03

IN THE MATTER OF THE CLAIM OF

KIM CAYLOR,

Claimant,

v.

STATE OF COLORADO,

Employer,

and

SELF INSURED,

Insurer,
Respondent.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Walsh (ALJ) dated January 8, 2015, that struck her Application for Hearing and Notice to Set and denied and dismissed all issues endorsed therein. We affirm.

The claimant sustained an admitted injury to her lower back on February 16, 2012. At the request of the respondent, the claimant underwent a Division Independent Medical Examination (DIME) with Dr. Chen. In her DIME report dated February 24, 2014, Dr. Chen stated that maximum medical improvement (MMI) and an impairment rating would be decided after the claimant underwent a MRI of her lumbar spine. The claimant subsequently underwent the MRI, and on April 21, 2014, Dr. Chen issued an addendum DIME report in which she determined that the claimant reached MMI on June 2, 2013, with a 13% whole person impairment rating.

On April 29, 2014, the Division of Workers' Compensation issued a Notice of Receipt of DIME Report to the parties noting that the DIME process had concluded. On May 16, 2014, the respondent filed a Final Admission of Liability (FAL), consistent with Dr. Chen's DIME report and addendum DIME report.

On May 30, 2014, the claimant filed an objection to the FAL and also a Notice and Proposal to Select an Independent Medical Examiner. The claimant did not file an Application for Hearing at this time. Subsequently, on June 25, 2014, the claimant filed

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an Application for Hearing and Notice to Set. In her Application, the claimant stated that she was going to cancel the DIME request related to the FAL filed on May 16, 2014. The claimant further stated that she was seeking to overcome the DIME opinions of Dr. Chen “in connection with the impairment rating and MMI for her back as well as Claimant’s entitlement to medical benefits and impairment for her chemical sensitivity if any, which was not addressed by Dr. Chen.”

On July 16, 2014, the respondent filed a response to the claimant’s Application for Hearing, alleging that the claimant’s Application was untimely under §8-43-203(2)(b)(II)(A), C.R.S. Then, on July 25, 2014, the respondent filed a Motion to Strike the claimant’s Application for Hearing, arguing that it was untimely since it was filed more than 30 days after the May 16, 2014, FAL. The ALJ subsequently denied the respondent’s Motion.

On August 29, 2014, the respondent filed a Motion for Summary Judgment, again arguing that the claimant’s Application for Hearing was untimely under §8-43-203(2)(b)(II)(A), C.R.S. The respondent contended that its FAL took positions on MMI and impairment based on the Dr. Chen’s DIME report and, the claimant failed to timely file her Application for Hearing as contemplated by §8-43-203(2)(b)(II)(A), C.R.S. ALJ Lamphere denied the respondent’s Motion, ruling that the respondent failed to file affidavits or other documentation which would demonstrate that there was no disputed issue of material fact, as required under OAC Rule 17.

A hearing eventually was held on December 4, 2014. During the hearing, the claimant withdrew the issues of overcoming the DIME as to MMI and permanent impairment. The claimant stated that the only issue was “‘consideration’ of the claimant’s preexisting chemical sensitivity for further treatment of the underlying February 16, 2012 low back claim.” The respondent again raised the issue of the claimant’s untimely Application for Hearing under §8-43-203(2)(b)(II)(A), C.R.S., and objected to proceeding on the merits of the claimant’s Application for Hearing. The ALJ subsequently entered his order finding that the claimant’s entitlement to medical benefits and impairment for her chemical sensitivity were closed by the FAL dated May 16, 2014, when the claimant failed to apply for a hearing on these issues within 30 days. The ALJ found that the issues of medical benefits and impairment for the claimant’s chemical sensitivity were in dispute at the time of the filing of the respondent’s May 16, 2014, FAL. Accordingly, the ALJ struck the claimant’s Application for Hearing and all issues endorsed therein were denied and dismissed.

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The claimant has appealed the ALJ's order. On appeal, the claimant argues that since she requested a second DIME, and that DIME process still was ongoing, at least until she withdrew that issue at the December 4, 2014, hearing, then this means the 30-day clock under §8-43-203(2)(b)(II)(A), C.R.S. had not begun to run, and her Application for Hearing was timely. In support of her argument that her Application for Hearing was timely, the claimant relies upon the italicized portion of §8-43-203(2)(b)(II)(A), C.R.S. below, which provides as follows:

An admission of liability for final payment of compensation must include a statement that . . . the claimant may contest this admission if the claimant feels entitled to more compensation, to whom the claimant should provide written objection, and notice to the claimant that the case will be automatically closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing, including the selection of an independent medical examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted. *If an independent medical examination is requested pursuant to section 8-42-107.2, the claimant is not required to file a request for hearing on disputed issues that are ripe for hearing until the division's independent medical examination process is terminated for any reason. Any issue for which a hearing or an application for a hearing is pending at the time that the final admission of liability is filed shall proceed to the hearing without the need for the applicant to refile an application for hearing on the issue.* (emphasis added)

The principal objective of statutory construction is to effect the legislative intent. The words and phrases in the statute are the best indicators of legislative intent, and for that reason should be given their plain and ordinary meanings. *Spracklin v. Industrial Claim Appeals Office*, 66 P.3d 176 (Colo. App. 2002). We refrain from reading nonexistent provisions into a statute. *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005). Further, the words and phrases of the statute cannot be read in isolation, but instead must be read as a whole so as to give them a consistent and harmonious meaning. *Department of Labor and Employment v. Esser*, 30 P.3d 189 (Colo. 2001).

Here, we agree with the ALJ that the claimant's entitlement to medical benefits and impairment for her chemical sensitivity were closed by the respondent's FAL dated May 16, 2014, when the claimant failed to apply for a hearing on these issues within 30

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days. Section 8-43-203(2)(b)(II)(A), C.R.S. The claimant's argument notwithstanding, the plain language of §8-43-203(2)(b)(II)(A), C.R.S. does not allow for her to contest a FAL by requesting a second DIME after completion of the first DIME that the respondent originally requested pursuant to §8-42-107.2, C.R.S. *See also* §8-42-107.2(2)(c), C.R.S. (if self-insured employer requests an IME and the examination is conducted before the self-insured employer admits liability pursuant to §8-43-203(2)(b), claimant may not request a second IME on that issue). Rather, the plain language of the statute expressly provides that the case will be automatically closed as to the issues admitted in the FAL if the claimant does not, within 30 days after the date of the FAL, *contest the FAL in writing and request a hearing* on any disputed issues that are ripe for hearing. *See Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998)(because best indicator of legislative intent is language of statute, court must afford words their plain and ordinary meanings, provided no absurdity results). In fact, §8-43-203(2)(b)(II)(A), C.R.S. allows for a DIME to occur only if one has not already been conducted pursuant to §8-42-107.2, C.R.S. It is undisputed here, that at the time the claimant requested the second DIME, she previously had undergone a DIME with Dr. Chen at the request of the respondent pursuant to §8-42-107.2, C.R.S. The respondent then filed its FAL on May 16, 2014, consistent with Dr. Chen's DIME and addendum DIME report. Thus, pursuant to §8-43-203(2)(b)(II)(A), C.R.S., the claimant was required to contest the FAL in writing and request a hearing on any disputed issues that were ripe for hearing within 30 days after the FAL. It was not until June 25, 2014, or 40 days after the respondent's FAL, however, that the claimant requested a hearing. As such, the claimant's Application for Hearing was untimely under §8-43-203(2)(b)(II)(A), C.R.S. *See Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261 (Colo. App. 2004)(a claimant has 30 days after the date the employer files an FAL to file an Application for Hearing under §8-43-203(2)(b)(II), C.R.S.); *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).

The claimant argues that when applying equitable principles, she should be allowed to have her case decided on its merits. The claimant reasons that her counsel was lead to believe that the parties would agree to a stipulation on the matter, but the respondent's counsel repeatedly failed to respond to any of her counsel's numerous letters and telephone calls about the matter. She asserts that the respondent's inaction was an effort to trick her counsel into waiting too long to file an Application for Hearing. The filing requirements under §8-43-203(2)(b)(II), C.R.S. are jurisdictional, however. By failing to timely apply for a hearing under §8-43-203(2)(b)(II)(A), C.R.S., this created a bar to consideration of the issues which were closed by the respondent's FAL. *See Leprino Foods Co. v. Industrial Claim Appeals Office*, 134 P.3d 475 (Colo. App. 2005).

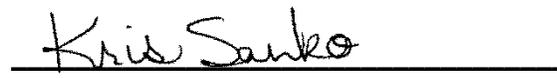
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Under these circumstances, we perceive no error in the ALJ's order which struck the claimant's Application for Hearing and denied and dismissed all issues endorsed therein.

IT IS THEREFORE ORDERED that the ALJ's order dated January 8, 2015, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


Kris Sanko

KIM CAYLOR
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CERTIFICATE OF MAILING

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

_____ 5/13/2015 _____ by _____ RP _____ .

STEVEN U. MULLENS, P.C., Attn: STEVEN U. MULLENS, ESQ., 1401 COURT STREET,
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RITSEMA & LYON, P.C., Attn: DEREK T. FRICKEY, ESQ., 111 S. TEJON ST., SUITE 500,
COLORADO SPRINGS, CO, 80903 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-798-331

IN THE MATTER OF THE CLAIM OF
DAVID CLICKNER,

Claimant,

v.

FINAL ORDER

COMFORT SYSTEMS
dba DESIGN MECHANICAL,INC.,

Employer,

and

FIDELITY & GUARANTY INSURANCE
COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Cannici (ALJ) dated December 3, 2014, that determined the claimant failed to overcome the Division Independent Medical Examination (DIME) physician's opinion on maximum medical improvement (MMI) and impairment. We affirm.

This matter went to hearing on the issue of compensability, with the respondents seeking to withdraw the admission of liability, and on the issue of the claimant overcoming the DIME physician's opinion on MMI and impairment. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant worked for the employer as a new construction installation plumber. On July 6, 2009, the claimant was working on a new construction project in Vail, Colorado. While working overhead on a ladder the claimant lost his footing and slid down several rungs of the ladder. The claimant was transported to the Vail Valley Medical Center emergency room where he received treatment for his lower back.

The record reflects that the claimant has a long history of previous lower back issues and has sought treatment for his low back at various times since at least 2005. Dr. Gibson treated the claimant since 2008. Dr. Gibson testified at hearing that in his opinion the claimant's July 6, 2009, industrial injury aggravated the claimant's pre-existing lower back condition. The claimant's authorized treating physician, Dr. Olson, was also of the

opinion that the July 6, 2009, incident triggered the claimant's low back condition despite the fact that the claimant had chronic degenerative disc disease. The claimant eventually underwent an anterior discectomy and lumbar fusion at L3-L5 in November of 2011.

Dr. Steinmetz performed an IME and recommended that the lower back injury should be investigated because of the claimant's significant pre-existing back problems. According to Dr. Steinmetz, the claimant did not aggravate his pre-existing lower back condition in the July 6, 2009, incident.

Dr. Olson placed the claimant at MMI on May 3, 2013, and it was later determined that the claimant sustained an 11 percent whole person impairment. The respondents requested a DIME which was performed by Dr. Raneen Sheno. The DIME physician concluded that the July 6, 2009, incident did not cause, aggravate or exacerbate the claimant's underlying lumbar spine condition. The DIME physician also mentioned several red flags suggestive of secondary gain for ongoing disability benefits and narcotic medications. She summarized that the claimant's permanent lumbar spine impairment is a pre-existing condition and not related. Thus, the DIME physician concluded that the claimant reached MMI on July 6, 2009 and sustained zero percent impairment.

Dr. Rauzzino conducted a medical records review of the claimant's case and came to the conclusion that the claimant suffered "chronic and progressive degenerative changes and pain that pre-existed any minor trauma that he may have sustained."

The ALJ denied the respondents' request to withdraw the admission of liability concluding that the claimant did, in fact, sustain an incident at work on July 6, 2009, that required medical treatment. The ALJ went on to find that the claimant failed to produce clear and convincing evidence to overcome the DIME physician's opinions on MMI and impairment. The ALJ rejected the opinions of Dr. Gibson and Dr. Olson which he characterized as mere differences of opinion. The ALJ stated:

Although doctors disagreed with Dr. Sheno's DIME conclusions, their opinions do not suggest that it is highly probable that her opinion is incorrect. More specifically, the opinions of Dr. Gibson and Olsen (sic) do not constitute unmistakable evidence free from serious or substantial doubt that Dr. Sheno's MMI or impairment determinations are incorrect.

ALJ Order, Conclusions of Law No. 11.

On appeal the claimant alleges that the ALJ applied the incorrect legal standard for clear and convincing evidence. The claimant contends that the ALJ's use of the word "*unmistakable*" elevates the evidence standard above just considering whether it is highly probable that the DIME physician's opinions are incorrect. The claimant also contends that the ALJ failed to consider certain evidence and, alternatively, that the claimant was only required to show the DIME physician was incorrect by a preponderance of the evidence. We perceive no reversible error.

If a DIME physician has rendered an opinion regarding MMI or medical impairment, those opinions must be overcome by clear and convincing evidence. §§ 8-42-107(8)(b)(III), -107(8)(c), C.R.S.; *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App.2002); *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998); see also *Leprino Foods Co. v. Indus. Claim Appeals Office*, 134 P.3d 475, 482 (Colo. App. 2005) ("DIME physician's opinions concerning MMI and permanent medical impairment are given presumptive effect . . . [and] are binding unless overcome by clear and convincing evidence").

"Clear and convincing evidence means evidence which is stronger than a mere 'preponderance,' it is evidence that is highly probable and free from serious or substantial doubt." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995). Therefore, the party challenging a DIME physician's conclusion must demonstrate that it is "highly probable" that the DIME impairment rating or MMI findings are incorrect. *Qual-Med*, 961 P.2d at 592. The courts have held that the DIME physician's determination that an impairment is or is not caused by the industrial injury is also subject to the clear and convincing evidence standard. See *Cordova v. Industrial Claim Appeals Office*, *supra*; *Qual-Med, Inc. v. Industrial Claim Appeals Office*, *supra*.

The claimant's arguments notwithstanding, the court of appeals specifically has recognized that a party has met the burden of establishing that a DIME impairment rating and diagnosis are incorrect if the claimant has demonstrated that the evidence contradicting the DIME is "*unmistakable* and free from serious or substantial doubt." *Leming v. Indus. Claim Appeals Office*, 62 P.3d 1015, 1019 (Colo. App. 2002) (*emphasis added*); see also, *American Compensation Insurance Co. v. McBride*, 107 P.3d 973 (Colo. App. 2004). Although the claimant contends that these court of appeals cases are distinguishable, or that the court erroneously used "*unmistakable*" to describe the clear and convincing standard, we disagree. Furthermore, we are bound by published opinions of the court of appeals. C.A.R. 35(f). The Colorado courts have long recognized that "clear and convincing evidence" is "stronger than a preponderance of the evidence and which is unmistakable and free from serious or substantial doubt." *Dileo v. Knowlton*,

613 P.318 Colo. 1980); see *Donaldson v. District Court for Denver*, 847 P.2d 632 (Colo. 1993); *J.S. v. Chambers*, 226 P.3d 1193, 1194 (Colo. App. 2009); *In re Jane Doe 2*, 166 P.3d 293, 294 (Colo. App. 2007). *Metro Moving & Storage, Co. v. Gussert*, *supra*, the principal case discussing the clear and convincing evidence standard in workers' compensation, specifically cites to *Dileo v. Knowlton* to describe the evidence needed to satisfy the standard. We, therefore, are not persuaded by the claimant's attempts to distinguish the clear and convincing evidence standard in workers' compensation from the clear and convincing evidence standard of proof cited by the courts in other areas of the law.

Whether a party has met the burden of overcoming a DIME by clear and convincing evidence "is a question of fact for the ALJ's determination. *Metro Moving & Storage*, 914 P.2d at 414. We must uphold the factual determinations of the ALJ if the decision is supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

Here, the ALJ made extensive findings detailing the evidence he found persuasive. The ALJ found the DIME physician's opinions credible, especially in light of Dr. Steinmetz' and Dr. Rauzzino's similar opinions that the 2009 industrial injury did not alter the claimant's underlying condition. The claimant cites to other evidence to support his contention that he did sustain impairment as a result of the 2009 incident. The existence of contrary evidence, however, does not provide a basis for relief on appeal. *Cordova v. Industrial Claim Appeals Office*, *supra*. Moreover, the ALJ was not required to make findings concerning every piece of evidence or to explicitly discuss every theory which he found unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P. 3d 385 (Colo. App. 2000).

We also reject the claimant's assertion that the ALJ was required to reject the DIME's opinion because the DIME physician failed to properly apply the AMA Guides. It is well settled that deviations from the AMA Guides do not necessarily require the conclusion that a DIME physician's rating is incorrect. Instead, the ALJ may consider a technical deviation from the AMA Guides in determining the weight to be given the DIME physician's findings but such deviation does not compel automatic rejection of the DIME opinion. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003); *Metro Moving & Storage Co. v. Gussert*, *supra*. The ALJ's order indicates that he considered the fact that the DIME physician's zero percent rating did not involve the application of the AMA Guides in view of the DIME physician's determination that the claimant's impairment was not related to the industrial injury. The ALJ found the DIME physician's opinion credible and persuasive as was the ALJ's sole prerogative as fact

finder. *Rockwell Int'l v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990)(ALJ as fact-finder is charged with resolving conflicts in expert testimony).

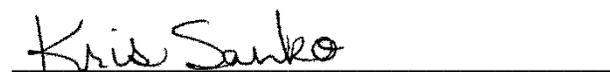
As we understand the claimant's final argument, he contends that because the ALJ denied the respondents' request to withdraw the final admission of liability, this meant that the DIME opinion had been overcome and that the DIME physician's opinion with regard to MMI and impairment should have been evaluated under a "preponderance of the evidence standard." We find no error in the ALJ's application of the burden of proof. Whether the claimant sustained a compensable injury in the first instance is subject to the preponderance of the evidence standard. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000) ("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 courts have declined to extend the DIME provisions to initial compensability determinations. *See Cordova v. Industrial Claim Appeals Office, supra*. (DIME physician's opinion concerning whether or not condition worsened so as to justify reopening not entitled to "special weight" under DIME procedure). Therefore, the ALJ's determination that the claimant sustained a compensable injury does not equate to a finding that the DIME physician's opinion concerning MMI and the extent of the claimant's impairment from the compensable injury has been overcome.

The ALJ's order reflects the proper application of the law. The ALJ's findings are supported by substantial evidence in the record and those findings, in turn, support the ALJ's conclusion that the claimant failed to overcome the DIME physician's opinions by clear and convincing evidence.

IT IS THEREFORE ORDERED that the ALJ's order dated December 3, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL


Brandee DeFalco-Galvin


Kris Sanko

DAVID CLICKNER
W. C. No. 4-798-331
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CERTIFICATE OF MAILING

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

_____ 4/30/2015 _____ by _____ RP _____ .

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-934-489-03

IN THE MATTER OF THE CLAIM OF

ANN M. EASLEY,

Claimant,

v.

RUBY TUESDAY,

Employer,

and

SAFETY NATIONAL CASUALTY CORP.,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated October 7, 2014, that ordered her claim not compensable and denied and dismissed her request for benefits. We affirm.

The claimant originally began working for the respondent employer as a part-time worker, averaging 30-35 hours per week. The claimant initially began working primarily as a salad bar attendant/dishwasher. As a salad bar attendant, the claimant's job duties included replenishing the salad bar and monitoring temperatures. She also did a minimal amount of salad bar prep work if supplies of cut vegetables were insufficient. As a dishwasher, the claimant's duties included loading and unloading dishes to and from a dish rack. Occasionally, the claimant might be required to move a rack of dishware/glasses or carry stacks of plates short distances. The racks weighed up to 32 pounds. The claimant spent approximately 50% of each shift replenishing the salad bar and 50% washing dishes.

The claimant testified that on June 1, 2012, she was carrying a stack of 12-15 plates and dropped them as a result of pain she was having in both wrists. The claimant testified that she had developed pain in her hands and wrists prior to June 1, 2012, but the pain worsened over time causing her to drop the stack of plates she was carrying on June 1, 2012.

The claimant testified that she discussed the pain she was having in her wrists with the kitchen manager, Ms. Livingston. The ALJ found, however, that it was probable that the claimant did not report her wrist pain as emanating from her work duties based upon her later testimony that she was unaware of the relationship between her carpal tunnel syndrome and work duties. The ALJ also found as not persuasive, the claimant's testimony that she did not know what to do with regard to reporting her claim further. The ALJ found that the claimant has a prior history of two other workers' compensation injuries.

On August 17, 2012, the claimant went to the emergency room (ER) complaining of bilateral hand pain which had worsened over the preceding three weeks. She reported she was a hostess who picked up items with her wrists all of the time and she was concerned she had carpal tunnel syndrome (CTS). The claimant was given a differential diagnosis of tendinitis and/or CTS, provided with splints, and instructed to follow up with orthopedics. She also was instructed not to use her arms at work for the next week.

The claimant testified she reported her ER visit and gave the ER paperwork to Mr. Elsrode, the general manager for the respondent employer. Mr. Elsrode, however, testified that while it was possible the claimant gave him the ER paperwork, she never reported her wrist condition to him as being work related, never requested to see the employer's workers' compensation doctor, and never requested time off work.

The claimant did not seek additional treatment until she returned to the ER on March 30, 2013, where she was evaluated by Dr. Campbell. The claimant reported to Dr. Campbell that she was working as a waitress and doing dishes, and was dropping dishes because she was having trouble with her grip. Dr. Campbell's ER note reflects that the claimant's work, as reported, "certainly goes with possible carpal tunnel." Dr. Campbell instructed the claimant to follow up with a hand surgeon. The claimant did not report to the respondent employer the outcome of her appointment with Dr. Campbell. Rather, the claimant elected to follow up with Dr. Watson, an orthopedic specialist she chose on her own.

The claimant testified that she continued to work in pain until April 29, 2013, at which time she was terminated.

Thereafter, on November 11, 2013, the claimant filed a Workers' Compensation Claim for Compensation, alleging that her CTS was caused by repetitive use of her hands and arms over time. The ALJ found that this was the first notice to the respondent

employer that the claimant was alleging a work-related injury/occupational disease to her wrists and hands.

On March 9, 2014, Mr. Blythe, a professional vocational evaluator, performed a Job Demand Analysis (JDA). Mr. Blythe observed that the job duties of a hostess required lifting more than 10 pounds an average of once per hour. The job duties of a salad bar attendant/dish washer required lifting more than 10 pounds an average of 27 times per hour. Overall for both jobs lifting 7-32 pounds was rated at rare, occurring less than 10% of the claimant's work day. Further, neither job required force and repetition, forceful gripping, awkward posture, use of a computer mouse, use of vibrating tools, or a cold working environment. Consequently, Mr. Blythe opined that the claimant's work duties did not trigger risk factors associated with the development of cumulative trauma disorder as provided for in the Colorado Medical Treatment Guidelines (Guidelines).

Dr. Sollender performed an independent medical examination (IME) at the request of the respondents. Dr. Sollender reviewed the JDA report prepared by Mr. Blythe, and the claimant's medical records. Dr. Sollender stated that while he agreed with the diagnosis of CTS, the claimant's job duties, as set forth in the JDA, did not involve any of the primary or secondary risk factors identified as likely causes for the development of CTS. Thus, Dr. Sollender opined that the claimant's CTS probably was not job related.

After the hearing, the ALJ issued his order determining that the claimant's CTS was not caused or aggravated by her work duties at the respondent employer. The ALJ found the JDA to be the most accurate reflection of the force, repetition, and duration required of the claimant when completing the tasks associated with her job. The ALJ found that none of the primary or secondary risks from the Guidelines were present in the claimant's jobs.

I.

The claimant has appealed, arguing that the ALJ erred in allowing Dr. Sollender to testify at hearing, and he erred in relying on Dr. Sollender's testimony to render a decision on compensability. The claimant contends that under the Workers' Compensation Act, there are only two types of independent examinations that a claimant can be required to undergo: one with a Division-sponsored independent medical examiner (DIME) under §8-43-502(2), C.R.S.; and the other when a claim is admitted or has been ruled compensable under §8-43-404(1)(a), C.R.S. The respondents contend the claimant failed to preserve this issue for appeal. While we disagree with the respondents' argument that the claimant failed to preserve this issue for appeal, we nevertheless reject the claimant's contention regarding the exclusion of Dr. Sollender's testimony.

A.

We initially address the respondents' argument that the claimant failed to preserve this argument for review. Prior to hearing, the claimant filed a Motion to Prohibit Dr. Sollender From Testifying About Claimant's IME With Him. In her Motion, the claimant asserted the same argument that she now is making before us. She contended that the claimant is only required to undergo two types of independent examinations under the **Act**- one a DIME pursuant to §8-43-502(2), C.R.S. and the other when a claim is admitted or has been ruled compensable under §8-43-404(1)(a), C.R.S. In the record, there is a June 24, 2014, order from the ALJ summarily denying the claimant's Motion. During the hearing, the claimant did not object to Dr. Sollender's testimony, nor did she seek reconsideration of her Motion.

In *Kilpatrick v. Industrial Claim Appeals Office*, Court of Appeals No. 2015 COA 30 (March 12, 2015), the Colorado Court of Appeals addressed a situation similar to that presented here. In *Kilpatrick*, the claimant served the employer with an interrogatory inquiring whether anyone working for or associated with insurer or the employer's counsel had given any gifts "of monetary value" to anyone working for the prehearing unit of the Division of Workers' Compensation, the Office of Administrative Courts, or the Panel. The employer declined to provide the requested information, asserting the request was overly burdensome and harassing. The claimant then filed a motion to compel, arguing that he could not obtain the information "automatically" through public financial disclosure. The claimant's motion was denied by a prehearing ALJ. The claimant did not seek review of the prehearing ALJ's denial of his motion to compel before the hearing ALJ.

Subsequently, the claimant appealed. One of the issues raised by the claimant on appeal was that he was entitled to discover the alleged financial contributions the respondent insurer or its employees made to prehearing ALJs, ALJs, or Panel members. The respondents argued that the claimant failed to preserve the issue for appeal by failing to object to certain evidence, failing to make offers of proof, and failing to seek review of the denial of his motion to compel before either the ALJ or the Panel. The Court disagreed with the respondents. The Court reasoned that, in general, an objection adequately preserves an issue for appellate review "so long as it calls the court's attention to the specific point it addresses." *Id* at 8 ¶14. Here, prior to the hearing, the claimant filed her Motion to exclude the testimony of Dr. Sollender on the same grounds that she raises on review. The claimant's Motion was denied by ALJ Lamphere. While during the hearing the claimant did not object to the testimony from Dr. Sollender and did not seek reconsideration of the denial of her Motion regarding Dr. Sollender, we believe that the reasoning in *Kilpatrick* is instructive, and the claimant's Motion adequately preserved

the issue for appellate review. Tr. at 105-07. The claimant's Motion called the ALJ's attention to the specific argument that is being raised here on review.

B.

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

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

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

* * *

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

We apply the plain and ordinary meaning of the statute, if clear. *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023, 1029 (Colo.2004). Further, when construing provisions of the Act, we read the statute as a whole and, if possible, construe its terms harmoniously, reconciling conflicts where necessary. *Colorado Dep't of Labor and Employment v. Esser*, 30 P.3d 189, 193 (Colo.2001).

In *Black*, the Panel held that the plain and ordinary meaning of §8-43-404(1)(a), C.R.S., when read in context, is that if a claim is filed under the Act seeking compensation in favor of the claimant, the claimant shall from time to time submit to examination by a physician chosen by the employer or the insurer. As explained by the Panel, this reading of §8-43-404(1)(a), C.R.S. would give it consistent, harmonious, and sensible effect with §8-43-404(3), C.R.S. which provides that the right to “begin” any proceeding for compensation will be suspended if the claimant refuses to submit to such examination. The claimant’s argument notwithstanding, we do not view this reading of §8-43-404(1)(a) and (3), C.R.S. as writing out the “if clause” contained in §8-43-404(1)(a), C.R.S. Rather, this reading of §8-43-404(1)(a), C.R.S., construes the statute as a whole, construes its terms harmoniously, and reconciles its conflicts, as we are required to do. *See Colorado Dep't of Labor and Employment v. Esser, supra*. Thus, as held by the Panel in *Black*, when reading §8-43-404(1)(a), C.R.S. together with §8-43-404(3), C.R.S., the legislative intent is revealed. That is, §8-43-404(1)(a), C.R.S. creates the obligation of a claimant seeking benefits under the Act to undergo an IME and §8-43-404(3), C.R.S. provides for the consequences if a claimant is unwilling to fulfill this obligation. We further note that the Division of Workers’ Compensation has interpreted §8-43-404(1)-(4), C.R.S. as allowing for RIMEs, or Respondent Independent Medical Examinations. On the Division’s website, it provides as follows regarding RIMEs: “This type of exam can be requested at any time during the course of the workers’ compensation claim.” *See* <https://www.colorado.gov/cdle/node/20906>. Consequently, as concluded in *Black*, we are not persuaded that the respondents’ only right to an IME is in a contested case pursuant to §8-43-502(2), C.R.S.

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

that the respondents are only entitled to an IME in these two distinct circumstances. Thus, we will not disturb the ALJ's order on these grounds.

II.

The claimant next argues that the ALJ erred in allowing Mr. Blythe's JDA to be relied upon by Dr. Sollender because it was not an analysis of the claimant performing her job duties, but, rather was an analysis of another worker performing the claimant's job duties. The claimant further contends that the JDA performed by Mr. Blythe relied on the respondent employer's description of the claimant's job duties, in violation of W.C.R.P. 17, Exhibit 5 of the Guidelines. In turn, the claimant contends that Dr. Sollender and the ALJ erred in relying upon Mr. Blythe's JDA since it was invalid. We disagree.

Initially, we note that the ALJ has wide discretion to control the course of a hearing and make evidentiary rulings. Section 8-43-207(1)(c), C.R.S.; *IPMC Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). We may not interfere with the ALJ's evidentiary rulings in the absence of an abuse of discretion. *See Denver Symphony Ass'n v. Industrial Commission*, 34 Colo. App. 343, 526 P.2d 685 (1974). The standard on review of an alleged abuse of discretion is whether, under the totality of the circumstances, the ALJ's ruling exceeds the bounds of reason. *Rosenberg v. Board of Education of School District # 1*, 710 P.2d 1095 (Colo. 1985).

In support of her argument that the JDA was invalid, the claimant relies upon the Medical Treatment Guidelines, Rule 17, Exhibit 5 pertaining to cumulative trauma conditions. This section states, in pertinent part, as follows:

6. SPECIAL TESTS are generally well-accepted tests and are performed as part of a skilled assessment of the patients' capacity to return to work, his/her strength capacities, physical work demand classifications, and tolerance. The procedures in this subsection are listed in alphabetical order.

* * *

c. Jobsite Evaluations and Alterations: Ergonomic alterations must be done early to assure that appropriate changes are accomplished early in the treatment program.

Whenever a case is identified as a work-related cumulative trauma condition, job alterations are an expected treatment. These may be in the form of: 1) instructing the worker how specific duties might be performed

to meet ergonomic standards; 2) actual job worksite or duty changes; and/or 3) a formal jobsite evaluation at the worksite.

Jobsite evaluation and alteration should include input from a health care professional with experience in ergonomics or a certified ergonomist; the employee, and the employer. *The employee must be observed performing all job functions in order for the jobsite evaluation to be a valid representation of a typical workday.*

* * *

Job descriptions provided by the employer are helpful but should not be used as a substitute for direct observation.

A jobsite evaluation may include observation and instruction of how work is done, what material changes (desk, chair) should be made, and determination of readiness to return to work. Refer to Jobsite Alterations, Section H. 4, for specific ergonomic recommendations. (emphasis added)

The claimant's argument notwithstanding, Exhibit 5 of the Guidelines pertains to the tests that are performed as part of determining an injured employee's capacity to return to work, and the changes that are needed for furthering such a return to work. This section does not dictate the requirements that a claimant's or a respondent's vocational expert must follow when performing a Job Demands Analysis. As such, we perceive no error in the ALJ's decision to allow Mr. Blythe's JDA to be relied upon by Dr. Sollender, or in the ALJ's decision to rely upon the JDA.

Regardless, merely because a vocational expert observes another employee performing the job functions at issue does not result in the inadmissibility of the expert's report on the issue. Rather, any differences go only to the weight the ALJ assigned to the evidence and does not affect the ALJ's ability to rely upon it. *See Finch v. Target Corp.*, W.C. No. 4-899-106-02 (April 7, 2015)(inaccuracies in vocational expert's job demands analysis goes only to the weight the ALJ assigned the evidence and does not affect the ALJ's ability to rely upon it); *cf. Weathers v. Wal-Mart*, W.C. No. 4-858-594-02 (June 20, 2014)(differences between how the claimant performed her job and the admitted videotape of another employee performing the job affected only the weight to be afforded the videotape rather than its admissibility). Further, the claimant was able to provide extensive testimony regarding her job duties, and any alleged inaccuracies regarding the JDA. Tr. at 17-22, 24, 33, 127-129. The ALJ was free to reject all or part of the claimant's testimony regarding any alleged inaccuracies in Mr. Blythe's JDA, as he did here. *See Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385

(Colo. App. 2000)(ALJ must make specific findings only as to evidence found persuasive and determinative and is not required to address evidence not found persuasive). We further note that at the time Mr. Blythe performed his JDA, it was impossible for him to observe the claimant performing her job functions. The claimant was terminated on April 29, 2013, and Mr. Blythe conducted his JDA in March 2014. Ex. H at 175. Consequently, we will not disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated October 7, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Kris Sanko

ANN M. EASLEY
W. C. No. 4-934-489-03
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CERTIFICATE OF MAILING

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

_____ 4/22/2015 _____ by _____ RP _____ .

LAW OFFICE OF ROGER FRALEY, JR., Attn: ROGER FRALEY, JR., ESQ., 6377 S.
REVERE PARKWAY, SUITE 400, CENTENNIAL, CO, 80111 (For Claimant)
THOMAS POLLART & MILLER, LLC, Attn: CHARLOTTE VEAUX, ESQ./AMANDA J.
BRANSON, ESQ., 5600 S. QUEBEC STREET, SUITE 220-A, GREENWOOD VILLAGE, CO,
80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-939-951-01

IN THE MATTER OF THE CLAIM OF
CARLOS FLORES,

Claimant,

v.

FINAL ORDER

AMERICAN FURNITURE WAREHOUSE,

Employer,

and

SELF-INSURED,

Insurer,
Respondents.

The respondent seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated November 4, 2014, that denied its request for a fifty percent reduction in the claimant's temporary benefits pursuant to §8-42-112(1)(a) and (b), C.R.S. We affirm.

A hearing was held on whether the respondent was entitled to reduce the claimant's temporary disability benefits by fifty percent pursuant to §8-42-112(1)(a) and (b), C.R.S. for the claimant's willful failure to obey a safety rule of, or for the willful failure to properly utilize a safety device provided by, the respondent employer. Finding there was insufficient evidence to establish that the claimant willfully failed to use the safety device or willfully violated a safety rule of the respondent employer, the ALJ denied and dismissed the respondent's request for the fifty percent reduction in temporary benefits.

The claimant was employed as a lift operator for the respondent employer. The claimant was required to stock shelves using equipment provided by the respondent employer, including a lift truck. A lift truck is a large mechanical operation that allows an employee to be lifted off the ground to reach the upper shelves in the respondent employer's warehouse. The respondent employer's safety rule requires the operator of the lift truck to attach himself to a harness and to tether the harness to the lift truck. The harness and tether then provide the operator with fall protection. The operator of the lift truck is to never detach the tether from the lift truck whenever the lift was in operation,

the lift was elevated; while it was being driven; a gate on the lift was still open; and if the employee perceived a risk of a fall.

On January 18, 2014, the claimant was working on a lift truck. He raised the lift to a mezzanine level in the employer's warehouse. The mezzanine level was 20 feet off the ground. The lift was driven up next to the mezzanine level, leaving a gap of less than 12 inches between the lift and the mezzanine platform. The claimant worked at that point by stepping off the lift, onto the mezzanine, then retrieved boxes and stepped back on to the lift where he deposited the boxes. While moving a box to the lift, the claimant fell through the narrow space between the lift and the mezzanine. He was not tethered to the lift truck at the time because the tether was not long enough to allow him to reach the boxes on the mezzanine. The ALJ observed the claimant is a big person and is obese. The ALJ found credible the claimant's testimony that he did not believe he was at risk of falling and so did not employ the tether.

The ALJ found the employer's safety rules did not specifically apply to the circumstances faced by the claimant when he fell. The claimant was not on the lift truck, but was returning to the lift from the mezzanine. The employer's witnesses testified there was a tether hook available right above the mezzanine gate the claimant was using. That testimony indicated the tethering rule would apply, and would require tethering in any situation where there was a 'risk of a fall.' However, the ALJ found credible the claimant's testimony that he had not received the training pertinent to the type of gate he was using on the mezzanine and he had only been working at that gate for 30 minutes prior to his fall. The ALJ also concluded the claimant was not performing his task in any particular hurry and did not have in mind that tethering was required when he misstepped and fell. The ALJ found the claimant did not willfully violate the employer's safety rule when he was injured on January 18.

On appeal, the respondent contends that a 'willful' violation of a safety rule is established where the claimant knew of the rule and deliberately performed the forbidden conduct. Here, the respondent argues the safety rule required tethering to either the lift truck or to an overhead tether hook whenever there was a chance of falling. The ALJ's finding that it was not clear that a large obese man could fall through a gap less than 12 inches wide is asserted to be error when it was used to find the claimant did not deliberately disobey the applicable safety rule. The respondent reasons: "This rationale leads to the proposition that some safety rules are meant only for skinny workers. Fat workers need not tether up; they may get wedged, but they won't fall. Such a suggestion is preposterous, ..."

Section 8-42-112(1), C.R.S., provides for a fifty percent reduction in benefits if the employee is injured due to a willful violation of a safety rule or the employee's willful failure to use safety devices provided by the employer. The term "willful" connotes deliberate intent, but mere carelessness, negligence, forgetfulness, remissness or oversight does not satisfy the statutory standard. *Bennett Properties Co. v. Industrial Commission*, 165 Colo. 135, 437 P.2d 548 (1968). The respondent, however, is not required to present direct evidence concerning the claimant's state of mind or prove the claimant had the rule "in mind" when he did the prohibited act. Rather, a "willful" violation may be inferred from evidence the claimant knew the safety rule and did the prohibited act. *Id.*

The respondent bears the burden of proof to establish that the claimant's conduct was willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). The question of whether the respondent carried the burden of proof was one of fact for determination by the ALJ. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990). Thus, we are required to uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. In applying this standard, we must defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences he drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

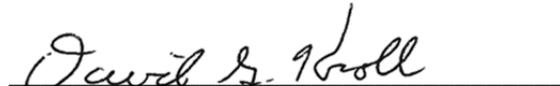
Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory testimony or contrary inferences. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). This standard of review requires that we consider the evidence in a light most favorable to the prevailing party, and defer to the ALJ's resolution of conflicts in the evidence, credibility determinations and plausible inferences drawn from the record. *Metro Moving and Storage Co. v. Gussert, supra.*

We perceive no error in the ALJ's order. Here, substantial evidence supports the ALJ's determination that the respondent failed to satisfy its burden of proving the claimant willfully failed to use the respondent employer's safety device or willfully violated the respondent employer's safety rule. The ALJ concluded, with record support, that the claimant had not received specific instruction on the safety procedures that might apply to the particular gate he was using on the mezzanine. The ALJ's observation then, that the rule which applied, i.e. secure a tether when there is a risk of a fall, was a reasonable finding. The respondent's argument that the perception of a person of a diminutive size that there is a risk for falling must always apply, even to someone of a

much larger stature, is not reasonable. A doorway featuring a six foot clearance would not indicate to a 5' 8" individual the need to duck. However, a 6'2" tall person better do so. If the shorter person was disciplined for violating a safety rule in that case which directed him to duck, that would be 'preposterous'. The ALJ's finding that the belief of the claimant that it was unlikely he would fall through a gap less than a foot wide is a reasonable basis for concluding the claimant did not willfully violate the safety rule. The perception that a risk of accident or injury is very remote is implicitly involved in the employee's determination that there is a 'risk of a fall'. As detailed above, it was the respondent's burden to prove the claimant's conduct was willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office, supra*. The ALJ's determination that the claimant's misperception is a case of negligence rather than willfulness is supported by substantial evidence. Section 8-43-301(8), C.R.S. *See May D & F v. Industrial Claim Appeals Office, supra*. Consequently, we will not disturb the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order dated November 4, 2014, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL



David G. Kroll



Brandee DeFalco-Galvin

CARLOS FLORES
W. C. No. 4-939-951-01
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CERTIFICATE OF MAILING

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

_____ 4/30/2015 _____ by _____ RP _____ .

KEATING WAGNER POLIDORI FREE, P.C., Attn: BRADLEY UNKELESS, ESQ., 1290
BROADWAY, SUITE 600, DENVER, CO, 80203 (For Claimant)
MCCREA and BUCK, LLC, Attn: JAMES B. BUCK, ESQ., 600 GRANT STREET, SUITE
825, DENVER, CO, 80203 (For Respondents)

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

CHRISTOPHER PIERCE

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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

CHRISTOPHER PIERCE

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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.¹

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

¹ 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.

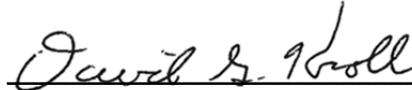
Here, the ALJ referenced the *Softrock* decision and surmised: "The issue is whether or not claimant was *required* to work exclusively for the employer. In this case, Claimant was not required to work exclusively for the employer." Conclusions of Law, pg. 10. We find this to be an inadequate consideration 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

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

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RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: ALEXANDRA E. COLEMAN, ESQ., 1401 17TH STREET, SUITE 900, DENVER, CO, 80202 (For Respondents)
ALJ MICHELLE E. JONES, % OFFICE OF ADMINISTRATIVE COURTS, ATTN: RONDA MCGOVERN, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE

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

IN THE MATTER OF THE CLAIM OF
ALICE SACKETT,

Claimant,

v.

FINAL ORDER

CITY MARKET,

Employer,

and

SELF INSURED,

Insurer,
Respondents.

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.

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.

ALICE SACKETT

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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.

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

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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)

14CA1422 Ragan v. ICAO 05-07-2015

COLORADO COURT OF APPEALS

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

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

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.

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

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.

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

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.

ORDER AFFIRMED

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

Announced April 23, 2015

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.