

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-614-149-07**

ISSUES

1. Whether the Trustee, Emilio Velarde, failed to comply with prior court orders to repay funds diverted from dependent SV and EV for purchase of Mexican real estate. Whether the Trustee also failed to comply with prior court orders to repay funds that the Trustee received and never transmitted to SV.

2. Whether the Trustee withdrew funds in 2014 from dependent EV's restricted account without court order. If so, whether those funds were used for EV's health, welfare, or education.

3. Method of repayment of funds owed to dependents SV and EV, including the Trustee's proposal at hearing.

FINDINGS OF FACT

1. Claimant worked for Employer when she was killed in a compensable motor vehicle accident on May 12, 2004. Respondents admitted liability for the death claim.

2. On June 9, 2006 ALJ Cain entered an order determining that SV and EV were dependent children of the Claimant and entitled to receive Workers' Compensation death benefits. ALJ Cain appointed SV and EV's uncle, with whom the minors were living, as Trustee for the death benefits.

3. The June 9, 2006 order provided that the court retained jurisdiction to modify the provisions for the payment of death benefits and over all related and ancillary matters concerning the payment of death benefits.

4. On March 24, 2008 ALJ Cain entered an order determining that the Trustee had purchased real estate in Mexico using the dependent children's trust funds.

5. On September 1, 2009 ALJ Margot Jones entered an order determining that the Trustee had failed to provide proper documentation to show that the Mexican real estate transaction benefited the dependent children. ALJ Jones ordered that the Trustee repay \$2,000 to SV's trust fund and \$3,000 to EV's trust fund to repay the funds used for the Mexican real estate purchase.

6. ALJ Jones further determined that the Trustee also had received \$2,000 in benefit payments for SV's health, welfare, and education and had failed to remit the \$2,000 in benefit payments to SV, who was living with SV's biological father in Mexico.

The Trustee did not transmit the money to Mexico as he should have. Therefore, ALJ Jones ordered that an additional \$2,000 be repaid to SV.

7. ALJ Jones ordered that the Trustee repay SV's trust at \$250 per month until the total \$4,000 owed to SV was repaid. ALJ Jones ordered that the Trustee repay EV's trust at \$250 per month until the total \$3,000 owed to EV was repaid.

8. The Trustee did not comply with the September 1, 2009 order. In November of 2010 the parties executed a Stipulation which was approved by order of the court. The Stipulation and Order reduced the monthly payments to \$75 per month into each of the minor dependents' accounts until the \$4,000 and \$3,000 was repaid. The Stipulation and Order also noted that the Trustee had established two restricted Chase Bank accounts (SV – account number 2971365172; EV – account number 2971365008) and that the bank may accept payments from the Trustee, the Insurer, or any other person. The Stipulation and Order also provided that the Bank would permit disbursement of these two accounts only upon further order of the Office of Administrative Courts. See Exhibit 2.

9. Again, the Trustee did not comply with the Stipulation and Order and did not make any payments into the restricted accounts.

10. On March 18, 2014 ALJ Cannici entered an order requiring that the Trustee sell the Mexican real estate within a reasonable time and deposit funds necessary to reimburse the dependents' accounts.

11. Again, the Trustee did not comply with this order. The Trustee has not sold the Mexican real estate nor has he made any repayments to SV or EV.

12. SV's date of birth is June 29, 1993. He is now over the age of 21, no longer presumed to be wholly dependent on decedent, and is no longer entitled to receive current death benefits.

13. EV's date of birth is February 20, 2003. She is twelve years old, remains a minor, and continues to be presumed to be wholly dependent on decedent and continues to be entitled to receive death benefits.

14. As of the date of hearing, Insurer was making quarterly benefit payments for EV in the amount of \$2,459.08. These benefit payments were split into two equal amounts. A quarterly payment of \$1,229.54 was made into Chase Bank account 3036806937 and was unrestricted. The Trustee was able to use this quarterly payment for EV's health, welfare, and educational needs as he saw fit and was not required to provide an accounting for the use of these funds. The second equal quarterly payment of \$1,229.54 was made into restricted Chase Bank account 2971365008. Per the November 2010 Stipulation and Order, no withdrawals of this account were to take place without court order.

15. Chase Bank, in error, failed to honor the restriction placed on account 2971365008. In 2014 the Trustee made several withdrawals from EV's restricted Chase Bank account 2971365008 without an order of the court approving the withdrawal.

16. On June 2, 2014, the Trustee withdrew \$800 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 3.

17. On August 30, 2014 the Trustee withdrew \$1,200 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 3.

18. On September 18, 2014 the GAL submitted a letter to Chase Bank regarding EV's restricted account 2971365008 noting that the statements the GAL reviewed showed withdrawals made without court order and asking for clarification. See Exhibit 3.

19. On December 8, 2014 the Trustee withdrew \$200 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 5.

20. On December 23, 2014 the Trustee withdrew \$700 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 6.

21. On December 24, 2014 the Trustee withdrew \$200 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 6.

22. On December 27, 2014 the Trustee withdrew \$140 from EV's restricted account. The Trustee admitted at hearing that he took these funds. See Exhibit 6.

23. The Trustee did not provide sufficient evidence to show that the funds withdrawn from the restricted account were used for EV's health, welfare, or educational benefits. The only evidence presented by the Trustee was that of the \$3,240 withdrawn between June and December of 2014, approximately \$300 was used to purchase EV a puppy.

24. On January 30, 2015 this hearing was commenced. The Trustee failed to appear at the January 30, 2015 hearing.

25. The hearing was continued to March 13, 2015. An Order to Show Cause was issued and ordered that the Trustee appear at a hearing on March 13, 2015 and that he provide bank statements for 2014 to address the withdrawn funds listed above.

26. The Trustee and his wife appeared at the March 13, 2015 hearing. The Trustee admitted taking \$3,240 in funds in 2014 from what was supposed to be a restricted account.

27. The Trustee and his wife, with whom EV still resides, proposed that the unrestricted quarterly payments of \$1,229.54 that they currently receive for EV's health, welfare, and education be restricted and used to pay back the amounts the Trustee owes for the Mexican real estate purchase, the failed benefit payments to SV, as well as the more recent 2014 withdrawals from EV's account.

28. The Trustee and his wife testified that they have sufficient income to provide for EV's health, welfare, and education without the quarterly payments.

29. The Trustee was ordered to provide documentation of income and expenses within 30 days of the March 13, 2015 hearing for consideration of the reasonableness of the proposal and to assist the GAL and ALJ in determining if the Trustee has sufficient income to care for the needs of EV.

30. Based on representations at hearing, the GAL proposed that a restriction be placed on the previously unrestricted Chase Bank account 3036806937 pending final order in this matter.

31. On March 17, 2015 an Order Regulating Chase Bank Accounts was signed by the ALJ. This order provided that Chase Bank may accept payments into the accounts from the Trustee, the Insurer, or any other person but that Chase Bank would not permit disbursement of any funds from either account 2971365008 or 3036806937 without further order of the Office of Administrative Courts.

32. The Trustee provided some information on income and expenses to the GAL on May 3, 2015. The information provided suggests that the Trustee is able to provide for EV's health, welfare, and education without use of the quarterly payments. The Trustee and his wife were found credible at hearing that they are able to provide for EV without use of the quarterly payments.

33. The Trustee is in clear violation of multiple prior orders of the Office of Administrative Courts, specifically, orders dated 3/26/08, 9/1/09, 11/9/10, 2/3/12, 5/1/13, and 3/18/14. However, the parties are not asking for penalties against the Trustee at this time and request that the issue of penalties be held in abeyance until all repayment obligations to SV and EV have been satisfied.

CONCLUSIONS OF LAW

Jurisdiction and Authority

Section 8-42-122, C.R.S., provides that in cases where the director deems dependents incapable of fully protecting their own interests, the director may order the deposit of death benefit payments in any type of account insured by the federal deposit insurance corporation, and "may otherwise provide for the manner and method of safeguarding the payments due such dependents in such manner as the director sees fit." This provision confers discretionary authority on the ALJ to provide for the

safeguarding of death benefits paid to dependents, and such authority is continuing. See *Truitt v. Industrial Commission*, 31 Colo. App. 166, 499 P.2d 623 (1972) (upholding commission's discretionary refusal to grant dependent claimants' request to have benefits released to their adoptive mother); § 8-43-201, C.R.S. (conferring original, concurrent jurisdiction on the director and administrative law judges to hear and decide all matters arising under the Act). The ALJ concludes that she retains jurisdiction to continue to provide for the safeguarding of the death benefits payable to the dependents. As found above, dependent EV was born on February 20, 2003 and is twelve years old. The ALJ concludes due to her minor age, EV is unable to fully protect her own interests and continued safeguarding of EV's benefits is appropriate. Further, the ALJ concludes that at the time funds due to SV were taken for the Mexican real estate purchase, and at the time funds intended for him were not transmitted to him by the Trustee, SV was also a minor and unable to fully protect his own interests. The ALJ concludes that continued orders on repayment of SV's benefits are appropriate and that jurisdiction continues over the funds due SV until repayment is satisfied.

Repayment of Funds

The Trustee has failed to repay any amount of money that was diverted from dependent SV and dependent EV's death benefits for purchase of the Mexican real estate. The Trustee also has failed to remit \$2,000 in benefits that he owed to SV for a period of time that SV was living in Mexico with SV's father. Finally, the Trustee also took additional funds from EV's restricted account in 2014 without court order or approval and did not use the funds for EV's health, welfare, or education. The ALJ finds unpersuasive the testimony surrounding \$300 spent on a puppy. This expenditure is not found reasonable or necessary for EV's health, welfare, or education.

The ALJ concludes that the Trustee owes the dependents the following amounts: SV - \$4,000; EV- \$6,240. The Trustee in the past has been ordered on several occasions to repay the funds owed to both SV and EV and has failed to comply with all prior orders regarding repayment. As found above, the Trustee has requested that the current quarterly payments that had been unrestricted for him to withdraw and use for EV's health, welfare, and education be restricted and used toward repayment. The Trustee has presented credible testimony and evidence that he is able to provide for EV without the necessity of the quarterly payments. After review, and after opportunity for the GAL to review, the ALJ finds the proposal to be a reasonable method to repay SV and EV.

Penalties

At this time the parties are withdrawing the request for penalties for failing to comply with prior orders of the court. This matter will be withdrawn, but the Trustee is warned that he is subject to future penalties should he fail to comply with any terms of this order.

ORDER

It is therefore ordered that:

Insurer:

1. Insurer shall continue to make a quarterly payment of \$1,229.54 into Chase Bank account 2971365008 and a quarterly payment of \$1,229.54 into Chase Bank account 3036806937.

Chase Bank:

2. Chase Bank shall keep the restriction on Chase Bank account 2971365008 and not allow any withdrawals of this account without an order of the court.

3. Chase Bank shall keep the restriction on Chase Bank account 3036806937 until May 1, 2017 and during the period of restriction shall only allow the following two authorized withdrawals:

a. On July 15, 2015, or within three business days thereof, Chase Bank shall allow the Trustee, Emilio Velarde, to make a one-time \$2,000 withdrawal.

b. On January 15, 2016, or within three business days thereof, Chase Bank shall allow the Trustee, Emilio Velarde, to make a one-time \$2,000 withdrawal.

4. Chase Bank shall transfer funds from restricted account 3036806937 to restricted account 2971365008 on the following dates, or within 3 business days thereof, and in the following amounts:

a. April 15, 2016 --- \$2,000 transfer

b. October 15, 2016 --- \$2,000 transfer

c. April 15, 2017 --- \$2,240 transfer

5. On May 1, 2017 Chase Bank shall lift the restriction on Chase Bank account 3036806937 and the Trustee, Emilio Velarde, shall again be allowed to withdraw funds from this account as needed for EV's health, welfare, and education.

6. Chase Bank shall continue to mail statements for restricted accounts 2971365008 and 3036806937 to the Guardian ad Litem.

Trustee, Emilio Velarde:

7. The Trustee, Emilio Velarde, shall withdraw \$2,000 from Chase Bank account 3036806937 on July 15, 2015, or within three business days thereof. The Trustee **SHALL** immediately transfer the \$2,000 withdrawal to SV. The Trustee must provide documentation sufficient to show the transfer was made to SV to the GAL by July 25, 2015. If the Trustee provides insufficient documentation to show that the transfer to SV occurred, it is presumed the transfer did not take place and the repayment schedule and this order may be altered and subject to reopening.

8. The Trustee, Emilio Velarde, shall withdraw \$2,000 from Chase Bank account 3036806937 on January 15, 2016, or within three business days thereof. The Trustee **SHALL** immediately transfer the \$2,000 withdrawal to SV. The Trustee must provide documentation sufficient to show the transfer was made to SV to the GAL by January 25, 2016. If the Trustee provides insufficient documentation to show that the transfer to SV occurred, it is presumed the transfer did not take place and the repayment schedule and this order may be altered and subject to reopening.

9. If the Trustee complies with this order, in its entirety, then on May 1, 2017 the Trustee will again be allowed to withdraw funds from Chase Bank account 3036806937 as needed and without an accounting for EV's health, welfare, and education.

Guardian ad Litem:

10. The GAL shall continue to receive and review statements for both restricted Chase Bank accounts.

11. The GAL shall review documentation from the Trustee to ensure the July 15, 2015 \$2,000 withdrawal of funds was transmitted to SV. The GAL shall attempt to independently confirm with SV that SV received the funds. The GAL shall petition the court if the GAL is not satisfied that payment was made to SV.

12. The GAL shall review documentation from the Trustee to ensure the January 15, 2016 \$2,000 withdrawal of funds was transmitted to SV. The GAL shall attempt to independently confirm with SV that SV received the funds. The GAL shall petition the court if the GAL is not satisfied that payment was made to SV.

13. The GAL shall ensure that Chase Bank makes transfers from restricted account 3036806937 to restricted account 2971365008 on, or within three business days of, April 15, 2016, October 15, 2016, and April 15, 2017 as outlined above. The GAL shall petition the court if the GAL is not satisfied that Chase Bank has made the appropriate transfers.

General:

The above orders will, within two years, satisfy repayment of \$4,000 to SV, and \$6,240 to EV. These funds were taken by the Trustee without authorization and were not used for SV or EV's health, welfare, or education. The repayment ordered and outlined above is a reasonable way to ensure the dependents receive death benefits to which they were entitled.

All matters not determined herein including, but not limited to, any future termination of EV's benefits upon a triggering statutory event and any future distribution of funds to EV from restricted account 2971365008 is reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 21, 2015

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUE

Whether Claimant has demonstrated by a preponderance of the evidence that the request for prior authorization of L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation by Michael J. Gesquiere, M.D. is reasonable, necessary and causally related to his May 25, 2009 industrial injury.

FINDINGS OF FACT

1. On May 25, 2009 Claimant suffered an admitted industrial injury during the course and scope of his employment with Employer. While Claimant was stepping down and back after retrieving an object from a pallet, he experienced a “pop” in his hip or groin area.

2. Claimant received medical treatment from Authorized Treating Physician (ATP) Michael Gesquiere, M.D. He was initially diagnosed with lumbar and groin strains. During 2009 he underwent a femoral hernia repair and hip surgery. Claimant subsequently obtained additional conservative treatment for his industrial injuries.

3. On July 12, 2011 ATP Brian Beatty, D.O. determined that Claimant had reached Maximum Medical Improvement (MMI). Relying on the *AMA Guides for the Evaluation of Permanent Impairment Third Edition (Revised)* (*AMA Guides*) Dr. Beatty assigned a 2% whole person impairment rating for injuries to Claimant’s ilioinguinal nerve.

4. Claimant challenged Dr. Beatty’s MMI and impairment determinations and sought a Division Independent Medical Examination (DIME). On January 4, 2012 John Aschberger, M.D. performed the DIME. Dr. Aschberger agreed that Claimant reached MMI on July 12, 2011. However, relying on the *AMA Guides* Dr. Aschberger assigned a 28 percent scheduled impairment to Claimant’s lower extremity for loss of range of hip motion and neurological condition. He also assigned an additional 5% whole person impairment for Claimant’s iliohypogastric nerve and ilioinguinal nerve impairments. Combining the ratings yielded a 16% whole person impairment.

5. On January 3, 2012 Claimant returned to Dr. Gesquiere for an evaluation. Dr. Gesquiere noted that Claimant suffered from chronic pain syndrome and opioid dependence. Claimant sought to decrease his reliance on narcotic pain medications. Dr. Gesquiere recommended neuromodulation therapy or a spinal cord stimulator in an attempt to decrease pain, improve function and reduce reliance on narcotic pain medications. Dr. Gesquiere subsequently renewed his recommendation for a spinal cord stimulator.

6. On May 18, 2012 Claimant underwent an independent medical examination with J. Tashof Bernton, M.D. Dr. Bernton determined that Claimant's functional status was excellent and his physical examination was "quite benign." He recommended that Claimant should cease treatment with narcotic medications. Dr. Bernton also disagreed with Dr. Gesquiere's request for a spinal cord stimulator.

7. On August 23, 2012 ALJ Friend denied Dr. Gesquiere's request for prior authorization for a spinal cord stimulator. Relying on the testimony and report of Dr. Bernton, ALJ Friend remarked that psychological factors played a role in Claimant's condition.

8. On October 9, 2012 Claimant underwent a spinal cord stimulator trial through his private insurance. Because he reported pain relief of approximately 80% to 90%, Dr. Gesquiere permanently implanted a spinal cord stimulator on December 17, 2012. However, by January 15, 2013 Claimant's pain had returned to an 8/10 level.

9. On June 4, 2013 Dr. Bernton again evaluated Claimant. Claimant reported right hip and groin pain, lower back pain and neck pain. He could not identify any functional improvement since the implantation of the spinal cord stimulator.

10. Following an August 14, 2013 hearing ALJ Henk issued a Summary Order. She concluded that Claimant failed to prove that Morphine ER, Klonopin, Norco or Nucynta were reasonable and necessary medications related to the May 25, 2009 accident.

11. On August 25, 2014 Dr. Gesquiere performed right L3-L4 facet joint blocks, an L3 medial branch nerve block, a right L4-L5 facet joint block and an L5 medial branch block. Claimant reported 50% relief from the blocks.

12. On September 29, 2014 Dr. Gesquiere requested prior authorization for right L3-4, L4-5 and L5-S1 radiofrequency nerve ablations. Insurer denied Dr. Gesquiere's prior authorization request.

13. On November 11, 2014 Dr. Bernton conducted a third independent medical examination of Claimant. He also testified through a post-hearing evidentiary deposition on April 10, 2015. Relying on the *Division of Workers' Compensation Medical Treatment Guidelines (Guidelines)* Dr. Bernton concluded that L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation was not reasonable, necessary and causally related to Claimant's May 25, 2009 industrial injury. Dr. Bernton remarked that the *Guidelines* require an 80% response from medial branch blocks in order to proceed with a radiofrequency ablation. A medial branch block is a procedure that involves whether blocking the small nerve that goes to the facet relieves pain. It is used to determine whether the facet is the pain generator. If a patient does not achieve at least 80% pain relief from medial branch blocks the permanent procedure of radiofrequency ablation is not recommended. Because Claimant received only 50% relief the medial branch blocks were non-diagnostic.

14. Dr. Bernton also explained that Claimant would not benefit from L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation. He detailed that Claimant has undergone multiple invasive procedures involving many pain generators. None of the procedures has produced lasting relief. Taking the next step to ablate the nerves would be “extraordinarily unlikely” to provide Claimant with significant relief. Dr. Bernton commented that Claimant would likely experience short-term pain relief that would “almost certainly” be on a “placebo response basis.” Similar to previous procedures Claimant would then return to baseline pain levels. He remarked that the likelihood that Claimant would obtain lasting relief from the radiofrequency ablation procedure was “miniscule.” Dr. Bernton summarized that psychological factors play a major role in Claimant’s condition, his response to blocks has been inconsistent and he has demonstrated a pattern of pain relief followed by the appearance of a new pain generator. He concluded that L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is not reasonable, necessary and causally related to Claimant’s May 25, 2009 industrial injury.

15. Claimant has failed demonstrate that it is more probably true than not that the request for prior authorization of L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation by Dr. Gesquiere is reasonable, necessary and causally related to his May 25, 2009 industrial injury. Initially, the record reveals that Claimant has undergone numerous conservative and diagnostic procedures in an attempt to reduce his lower back pain. Dr. Gesquiere permanently implanted a spinal cord stimulator on December 17, 2012. However, by January 15, 2013 Claimant’s pain had returned to an 8/10 level. Claimant subsequently could not identify any functional improvement since the implantation of the spinal cord stimulator.

16. Relying on the *Guidelines* Dr. Bernton persuasively concluded that L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is not reasonable, necessary and causally related to Claimant’s May 25, 2009 industrial injury. He remarked that the *Guidelines* require an 80% response from medial branch blocks in order to proceed with a radiofrequency ablation. If a patient does not achieve at least 80% pain relief from medial branch blocks the permanent procedure of radiofrequency ablation is not recommended. Because Claimant received only 50% relief the medial branch blocks were non-diagnostic.

17. Dr. Bernton also explained that Claimant would not benefit from L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation. He detailed that Claimant has undergone multiple invasive procedures involving many pain generators. None of the procedures has produced lasting relief. Taking the next step to ablate the nerves would be “extraordinarily unlikely” to provide Claimant with significant relief. Dr. Bernton commented that Claimant would likely experience short-term pain relief that would “almost certainly” be on a “placebo response basis.” He summarized that psychological factors play a major role in Claimant’s condition, his response to blocks has been inconsistent and he has demonstrated a pattern of pain relief followed by the appearance of a new pain generator. Based on the persuasive reports and testimony of Dr. Bernton, L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is not reasonable, necessary and causally related to Claimant’s May 25, 2009 industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers’ Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge’s factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). A preexisting condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the preexisting condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. *In re of Parker*, W.C. No. 4-517-537 (ICAP, May 31, 2006); *In re Frazier*, W.C. No. 3-920-202 (ICAP, Nov. 13, 2000).

5. It is appropriate for an ALJ to consider the *Guidelines* in determining whether a certain medical treatment is reasonable and necessary for a claimant’s condition. *Deets v. Multimedia Audio Visual*, W.C. No. 4-327-591 (ICAP, Mar. 18, 2005); see *Eldi v. Montgomery Ward*, W.C. No. 3-757-021 (ICAP, Oct. 30, 1998) (noting that the *Guidelines* are a reasonable source for identifying the diagnostic criteria). The *Guidelines* are regarded as accepted professional standards for care under the Workers’ Compensation Act. *Rook v. Industrial Claim Appeals Office*, 111 P.3d 549 (Colo.App. 2005). Nevertheless, the *Guidelines* expressly acknowledge that deviation is permissible.

6. The *Guidelines* reflect that a patient should obtain at least 80% relief with branch and facet blocks to proceed with a more permanent nerve procedure. If a patient obtains less than 80% relief from branch blocks a more permanent procedure such as radiofrequency ablation is not recommended. See W.C.R.P. Rule 17, Exhibit 1, p. 58.

7. As found, Claimant has failed demonstrate by a preponderance of the evidence that the request for prior authorization of L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation by Dr. Gesquiere is reasonable, necessary and causally related to his May 25, 2009 industrial injury. Initially, the record reveals that Claimant has undergone numerous conservative and diagnostic procedures in an attempt to reduce his lower back pain. Dr. Gesquiere permanently implanted a spinal cord stimulator on December 17, 2012. However, by January 15, 2013 Claimant's pain had returned to an 8/10 level. Claimant subsequently could not identify any functional improvement since the implantation of the spinal cord stimulator.

8. As found, relying on the *Guidelines* Dr. Bernton persuasively concluded that L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is not reasonable, necessary and causally related to Claimant's May 25, 2009 industrial injury. He remarked that the *Guidelines* require an 80% response from medial branch blocks in order to proceed with a radiofrequency ablation. If a patient does not achieve at least 80% pain relief from medial branch blocks the permanent procedure of radiofrequency ablation is not recommended. Because Claimant received only 50% relief the medial branch blocks were non-diagnostic.

9. As found, Dr. Bernton also explained that Claimant would not benefit from L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation. He detailed that Claimant has undergone multiple invasive procedures involving many pain generators. None of the procedures has produced lasting relief. Taking the next step to ablate the nerves would be "extraordinarily unlikely" to provide Claimant with significant relief. Dr. Bernton commented that Claimant would likely experience short-term pain relief that would "almost certainly" be on a "placebo response basis." He summarized that psychological factors play a major role in Claimant's condition, his response to blocks has been inconsistent and he has demonstrated a pattern of pain relief followed by the appearance of a new pain generator. Based on the persuasive reports and testimony of Dr. Bernton, L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is not reasonable, necessary and causally related to Claimant's May 25, 2009 industrial injury.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Dr. Gesquiere's request for prior authorization of L3-L4, L4-L5 and L5-S1 radiofrequency nerve ablation is denied and dismissed.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: May 21, 2015.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-819-962-06**

ISSUES

➤ Whether claimant has proven by a preponderance of the evidence that the medical treatment recommended by Dr. Lippman, Sr. is reasonable and necessary maintenance medical treatment related to her workers' compensation injury?

FINDINGS OF FACT

1. Claimant sustained an admitted injury on February 13, 2010 to her low back when she slipped on steps on work. Claimant was referred for medical treatment and eventually underwent surgery by Dr. Corenman consisting of a one level fusion at the L5-S1 level. Claimant was eventually placed at maximum medical improvement ("MMI") by Dr. Lippman on November 6, 2012. Dr. Lippman referred claimant to Dr. Lorah for an impairment rating. Dr. Lorah evaluated claimant and provided with an impairment rating of 19% whole person. Respondents filed a final admission of liability ("FAL") admitting for the impairment rating on December 12, 2012. The FAL also admitted for reasonable, necessary, related medical treatment by an authorized provider.

2. After being placed at MMI continued to treat with Dr. Lippman. Respondents agree that Dr. Lippman is a physician authorized to treat claimant for her industrial injury. Claimant also received a course of physical therapy post MMI through Valley View Hospital Rehabilitation from October 25, 2013 through November 20, 2013.

3. Claimant was referred by respondents to Dr. Fall for an independent medical evaluation ("IME") on December 4, 2014. Dr. Fall reviewed claimant's medical records, obtained a history from claimant and performed a physical examination in connection with her IME. Dr. Fall noted claimant was taking gabapentin, Zoloft, tramadol, and cyclobenzaprine. Dr. Fall diagnosed claimant as status post L5-S1 fusion, stable, with chronic low back pain and chronic depression. Dr. Fall noted that claimant did not relate to her any worsening of her condition since being placed at MMI. Dr. Fall opined that there was no medical indication for ongoing chiropractic treatment and instead recommended claimant increase her independent exercise program. Dr. Fall opined that claimant's prescription for Zoloft would be more appropriately prescribed through her private insurance. Dr. Fall recommended claimant discontinue the tramadol and utilize Aleve over the counter as a substitute. Dr. Fall also recommended claimant wean off the gabapentin. Dr. Fall opined that rare use of cyclobenzaprine as needed for muscle spasms may still be indicated under maintenance care.

4. Dr. Lippman issued a report dated January 15, 2015 that opined that claimant was still at MMI and recommended continued chiropractic care as the independent exercise program would not replace the chiropractic care. Dr. Lippman opined that the continued use of Zoloft was appropriate because claimant's depression was related to her injury. Dr. Lippman indicated he would be willing to try substituting Aleve for tramadol, and wean claimant off the gabapentin, but noted he did not want to make a lot of changes and jeopardize claimant's maintenance program. Dr. Lippman recommended continuing claimant's Flexeril.

5. Claimant testified at hearing in this matter that she continues to treat with Dr. Lippman post MMI approximately every 3 months. Claimant testified that if she doesn't keep up with her physical therapy she gets more pain. Claimant testified she has sought additional chiropractic care as maintenance treatment, but the medical care was denied by respondents. Claimant testified that her medications were discontinued and she has been taking medications when she can afford to take them. Claimant testified that without her medications, she experiences more pain. Claimant testified that without chiropractic care, she experiences more pain.

6. Dr. Fall testified by deposition in this matter. Dr. Fall testified consistent with her IME report. Dr. Fall testified that there was no medical evidence of functional gains from the chiropractic care and indicated that the chiropractic treatment was only passive treatment. Dr. Fall opined that the chiropractic care was not reasonable and necessary to cure and relieve claimant from the effects of her industrial injury and was not necessary to maintain her status at maximum medical improvement. Dr. Fall opined that the gabapentin was not necessary as claimant's records do not indicate a diagnosis of neuropathic pain or an indication of radiculopathy or neuropathic symptoms.

7. The ALJ finds the testimony of claimant to be credible and persuasive. The ALJ notes that claimant's condition is maintained by the treatment recommended by Dr. Lippman and credits claimant's testimony that her condition has worsened without the recommended treatment as persuasive.

8. The ALJ finds the January 15, 2015 report from Dr. Lippman to be more credible and persuasive than the report and testimony of Dr. Fall. The ALJ finds claimant has proven that it is more probable than not that she needs continued treatment to maintain MMI, including the chiropractic care and medications recommended by Dr. Lippman.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S., 2008. A preponderance of the evidence is that which leads the trier-of-fact, after

considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2008).

3. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant requires periodic maintenance care to prevent further deterioration of her physical condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995). Section 8-42-101, C.R.S., thus authorizes the ALJ to enter an order for future treatment if supported by substantial evidence of the need for such treatment. *Grover v. Industrial Commission, supra*. Even though an admission of liability is filed, the claimant bears the burden of proof to establish the right to specific medical treatment. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990).

4. As found, claimant has proven by a preponderance of the evidence that the treatment recommended by Dr. Lippman, including the chiropractic treatment and medications is reasonable and necessary to maintain claimant at maximum medical improvement and prevent further deterioration of her physical condition.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the medical treatment provided by Dr. Lippman related to her industrial injury including the chiropractic treatment and medications recommended by Dr. Lippman.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver,

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CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 22, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

ISSUES

1. Whether Claimant has overcome, by clear and convincing evidence, the DIME physician's opinion that her low back pain is not causally related to her May 13, 2010 work injury.

2. Whether Claimant has proven by a preponderance of the evidence that she suffered a compensable injury to her low back as a result of the May 13, 2010 work injury.

3. Whether the S1 selective nerve root block injection recommended by Dr. Checa is reasonable and necessary treatment related to Claimant's May 13, 2010 work injury.

4. Whether Claimant has proven, by a preponderance of the evidence, that she is entitled to compensation for disfigurement pursuant to § 8-42-108(1), C.R.S. (2010) and if so the amount of compensation.

5. The ALJ notes that in the December 19, 2014 Order, the ALJ found the Claimant had overcome the DIME opinion on MMI of the right knee and found that the S1 selective nerve root block injection was reasonable, necessary, and related treatment for Claimant's right knee injury. The ALJ acknowledges that performing the analysis sua sponte when the parties did not clearly endorse, identify, or argue the issues of MMI of the right knee and whether the injection was reasonable and necessary treatment of the right knee may have been improper in this case. Thus, the ALJ issues this Supplemental Order confining the analysis to the issues as directly identified and presented by the parties.

FINDINGS OF FACT

1. Claimant was employed by Employer for approximately five years as a bus driver with duties including transporting and assisting handicapped passengers.

2. On May 13, 2010 Claimant sustained a work related injury to her right knee while stooping over to tie down a wheelchair on her bus. At this time, Claimant experienced right knee pain. On the date of injury, Claimant did not mention any back pain.

3. The compensability of the right knee injury was contested by Respondents. Following hearing on August 16, 2011 the injury was found compensable. In the findings of fact, there is no mention of back pain or problems.

4. Following the May 13, 2010 injury, Claimant has undergone significant treatment to her right knee including injections, arthroscopic surgery in 2010, total knee arthroplasty in January of 2012, and right knee revision surgery in May of 2013.

5. Despite this significant treatment, Claimant still suffers from right knee pain and swelling on a regular basis. Claimant's right knee is significantly larger in visual size than her unaffected left knee.

6. As a result of her three right knee surgeries, Claimant has visible scarring to her right knee consisting of one vertical scar, approximately 8 inches in length by 1 inch in width, and two smaller arthroscopic scars approximately $\frac{3}{4}$ of an inch each in diameter. The scars remain discolored, raised, and uneven with Claimant's normal skin tone.

7. Doctors have performed significant testing on Claimant to try to determine the cause of her continued right knee pain and swelling.

8. Allergy testing showed Claimant was not allergic to the metal or cement used in her total knee replacement. X-ray testing on Claimant's right hip was negative and was found unlikely to be a pain generator.

9. On March 18, 2013 Claimant saw Ronald Hugate, M.D. Dr. Hugate noted that he was not sure what was going on with Claimant's knee. He noted that Claimant was worked up for infection and for metal or cement allergies which were all negative. He injected Claimant's right knee and noted that if she had significant relief he would continue to work her knee up including performing a bone scan of her components. If not, then he indicated he would start working up other sources of pain, including her back. Dr. Hugate noted that Claimant had a history of low back pain, and had an antalgic gait and station favoring her right knee. See Exhibit 3.

10. On April 22, 2013 Claimant again saw Dr. Hugate. Dr. Hugate noted a bone scan had been performed and showed increased uptake in the femoral and tibial components which he found unusual. He recommended Claimant undergo an open procedure to check the femoral and tibial components in her right knee to see if there was any evidence of loosening and also to consider upsizing her polyethylene. He noted Claimant was in such pain on a daily basis that she wanted to go ahead with the revision knee arthroplasty surgery, and noted her significant pain with weight bearing. See Exhibit 3.

11. In May of 2013 Claimant underwent right knee revision surgery where Dr. Hugate upsized the polyethylene. Following the right knee revision surgery, Claimant's right knee pain improved slightly but did not resolve. See Exhibit 3

12. Dr. Hugate still could not explain Claimant's continued right knee pain. He ordered a lumbar MRI which was performed on November 7, 2013 and demonstrated

mild degenerative disc disease and facet arthropathy without stenosis or neural element compromise.

13. On January 27, 2014 Claimant underwent right lower extremity EMG testing which suggested bilateral S1 radiculopathy.

14. On February 26, 2014 Claimant saw Michael Striplin, M.D. for an independent medical examination (IME). Dr. Striplin noted Claimant had undergone extensive physical therapy, arthroscopy of the right knee, a right total knee arthroplasty, and revision of the right total knee arthroplasty but continued to complain of right knee pain. Dr. Striplin noted that infection or allergy to a component of Claimant's knee prosthesis had been eliminated as a cause of her persistent symptoms. Dr. Striplin noted that Dr. Hugate suggested considering lumbar spine problems as a potential source of Claimant's continued pain and agreed that it might be appropriate, however, Dr. Striplin opined that any further lumbar spine evaluation should be accomplished outside the workers' compensation system because there was no indication that Claimant suffered a lumbar spine injury on May 13, 2010. Claimant reported to Dr. Striplin pain in her left lower back with radiation into the left lower extremity and that her back pain began 2.5 years prior. Dr. Striplin opined that Claimant reached maximum medical improvement (MMI) with regard to her right knee injury on November 28, 2013, six months after the revision of her right total knee arthroplasty. See Exhibit J.

15. Dr. Hugate still did not know what was going on with Claimant's right knee pain and referred Claimant to Giancarlo Checa, M.D., a pain specialist.

16. On March 20, 2014 Claimant saw Dr. Checa. Claimant at this time still had right knee pain and swelling. Dr. Checa was concerned with the continued pain and swelling one year out from surgery. Dr. Checa noted Claimant's gait was normal and heel to toe walk was normal and that Claimant's lumbar spine had normal flexion, extension, and lateral rotation. Dr. Checa noted Claimant's previous testing for metal allergy was negative. Dr. Checa diagnosed myalgia, sacroilitis, and radiculitis, and found no clinical evidence for chronic regional pain syndrome. Dr. Checa reviewed the January 27, 2014 EMG that implicated S1 radiculopathy. See Exhibit K.

17. Dr. Checa recommended a right S1 selective nerve root block injection to determine whether that nerve in Claimant's lower back was a pain generator and was responsible for the continued pain into Claimant's right leg and right knee. See Exhibit K.

18. On May 29, 2014 Brian Beatty, D.O. performed a Division Independent Medical Examination (DIME). Dr. Beatty noted Claimant's antalgic gait favoring her right knee, diffuse right knee pain, and mild diffuse swelling. He diagnosed Claimant with degenerative joint disease, right knee with arthroplasty, and with low-back pain of unknown etiology. Dr. Beatty opined that Claimant was at MMI with regard to her right knee injury as of May 29, 2014 based on the fact that Claimant was one year post-op

for a right knee revision arthroplasty with reasonable treatment, physical therapy, and rehabilitation. See Exhibit 6.

19. Dr. Beatty found that Claimant's low back pain was not directly or indirectly related to her May 13, 2010 work injury. Dr. Beatty believed Claimant had some mechanical issues that should be addressed with her personal physician. See Exhibit 6.

20. On June 2, 2014 Claimant saw Albert Hattem, M.D. Dr. Hattem opined that Claimant's S1 radiculopathy and any back condition were not causally related to her May 13, 2010 injury and that Claimant only injured her right knee and not her low back. Dr. Hattem noted that Claimant's gait was relatively normal and agreed with Dr. Striplin's opinion on MMI as of November 28, 2013. Dr. Hattem noted that if Claimant wanted treatment directed at her lumbar spine, then the treatment may be provided outside of workers compensation. See Exhibit N.

21. On June 25, 2014 Dr. Hugate saw Claimant for a follow up visit. Dr. Hugate noted that Claimant was a year out from her revision surgery and that Claimant continued to have right knee pain globally that was worse with activity and swollen on occasion. Dr. Hugate noted the knee was stable with pain to light touch and inferomedial swelling. Dr. Hugate noted he did not see anything intrinsically in the knee that could be causing Claimant's pain. He recommended strongly that Dr. Checa be authorized to perform diagnostic and/or therapeutic injections as necessary to help better define and treat Claimant's pain. See Exhibit 3.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, *et seq.*, C.R.S. (2010), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. See § 8-40-102(1), C.R.S. (2010). The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. See § 8-43-201, C.R.S. (2012). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo.App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the

testimony has been contradicted; and bias, prejudice, or interest. *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo.App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo.App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo.App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo.App. 2000).

Compensability

Claimant is required to prove by a preponderance of the evidence that the condition for which she seeks medical treatment was proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. Claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000).

The Claimant has failed to meet her burden of proof to show she suffered a compensable injury to her low back as a result of the May 13, 2010 work injury. The evidence is insufficient to show an injury to her low back was suffered as a result of the May 13, 2010 incident or as a result of altered gait due to her compensable knee injury. Claimant has failed to establish a causal connection between the low back pain she is suffering and her May 13, 2010 work incident.

Overcoming DIME

The assessment of a permanent impairment rating requires a rating physician to identify and evaluate all losses and restrictions which result from the industrial injury. *Egan v. Indus. Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998); *Colorado AFL-CIO v. Donlon*, 914 P.2d 396 (Colo. App. 1995). This includes an assessment of whether the various components of the Claimant's medical condition are causally related to the industrial injury. *Mosley v. Industrial Claim Appeals Office*, 78 P.3d 1150

(Colo. App. 2003). Consequently, a DIME physician's finding that a causal relationship does or does not exist between an injury and a particular impairment must be overcome by clear and convincing evidence. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo.App. 1998).

Claimant has failed to overcome by clear and convincing evidence the DIME physician's opinion that her low back pain complaints are not causally related to her May 13, 2010 work injury. The medical records, as found above, do not support a conclusion that a low back injury was suffered on May 13, 2010. Claimant did not initially complain of low back pain at the time of the injury or shortly thereafter. Further, although Claimant argues that altered gait as a result of her right knee injury caused her low back complaints, this argument is not found persuasive. Claimant has not presented clear and convincing evidence to demonstrate that she had an altered gait as a result of her right knee injury nor has she presented clear and convincing evidence to show that any altered gait caused her low back problems. Further, no medical provider has opined that an altered gait caused Claimant's low back problems. Rather, the medical records indicate that Claimant has both degenerative changes in her lumbar spine and that she has symptoms from a bilateral S1 radiculopathy. The opinions of DIME physician Dr. Beatty that Claimant did not suffer a low back injury as a result of the May 13, 2010 incident is found credible and persuasive and is supported by the opinions of Dr. Striplin and Dr. Hattem. Claimant has failed to meet her burden to show that her low back pain and the S1 radiculopathy is causally related to her work injury.

Additionally, the DIME physician's opinion is not, as Claimant argues, ambiguous. Rather, DIME physician Dr. Beatty could not relate her low back pain directly to her May 13, 2010 injury nor could he indirectly relate it to her May 13, 2010 injury. It is clear that his opinion is that the low back pain is not related to the May 13, 2010 injury. Claimant has been unable to overcome this opinion by clear and convincing evidence.

S1 selective nerve root block injection

Claimant, at hearing, sought a determination that the S1 selective nerve root block injection requested by Dr. Checa be found reasonable and necessary treatment. Respondents, at the outset of the hearing, clarified that their argument was that the S1 injection was related to the back and that unless Claimant overcome the causality of the back, then the injection would not be related to the claim. Claimant argued in her position statement that she was seeking a determination that the S1 nerve root block injection be considered reasonable and necessary to treat Claimant's lower back injury.

As found above, Claimant has bilateral S1 radiculopathy in her low back demonstrated by EMG testing. It has been recommended that an S1 selective nerve root block injection be performed at this time. The injection will help diagnose and treat the S1 radiculopathy which is not a work related injury. Although the injection may also help diagnose whether it is Claimant's non-work related S1 radiculopathy that is causing the continued pain into her right knee and may provide relief for the continued pain and

swelling into her right knee, the injection is aimed at treating an S1 radiculopathy which is not a work related condition.

The ALJ notes that in the prior order dated December 19, 2014 the ALJ found the injection to be a reasonable, necessary, and related treatment for the right knee injury. The ALJ issues this supplemental order to correct the prior order. The Claimant in this case sought a finding that the injection was reasonable and necessary to treat her lower back condition. The ALJ incorrectly opined that the treatment was reasonable and necessary to treat the right knee and that the right knee was not at MMI, when the issues of right knee MMI and right knee treatment were not clearly before the ALJ. Here, although the S1 injection recommended by Dr. Checa may be reasonable and necessary to treat Claimant's S1 radiculopathy, the radiculopathy is not a work related condition. The opinions of Dr. Beatty, Dr. Hattem, and Dr. Striplin that further treatment for the low back and S1 radiculopathy be done outside of the workers' compensation system is are found persuasive. Here, although the S1 radiculopathy may be a source of Claimant's continued right knee pain and although the S1 injection may incidentally improve her right knee symptoms, the injection is to treat a non work related bilateral S1 radiculopathy that Claimant would have whether or not she suffered a work related right knee injury. Further, after review of the transcript and all of the pleadings, the ALJ realized it was in error to issue an Order addressing MMI of the right knee as that was not clearly identified or presented at hearing. The issue of whether the right knee was at MMI and whether the S1 injection was reasonable and necessary treatment for the right knee was not clearly identified by Claimant as an issue at hearing, and in fact in the position statement was not a determination sought by Claimant. Rather, Claimant sought a determination that the injection be found reasonable and necessary to treat her low back and that her low back be found compensable. As the issues related to MMI and treatment of the right knee were not clearly before the ALJ, the prior order was in error.

Disfigurement

As a result of her May 13, 2010 work injury, Claimant has three visible scars on her knee that remain discolored and raised despite adequate healing time. Claimant's right knee and leg also is visibly larger in appearance, and appears swollen, compared to her unaffected left knee and leg. Claimant has met her burden to show that she sustained serious permanent disfigurements to areas of the body normally exposed to public view, which entitles her to additional compensation pursuant to § 8-42-108(1), C.R.S. (2010).

After viewing the visible scarring on Claimant's right knee and leg as well as the visible difference in size between her right and left legs, the ALJ finds that an award of \$3,300.00 is appropriate.

ORDER

1. Claimant has failed to overcome the DIME physician's opinion that her low back pain is not related to a May 13, 2010 work injury by clear and convincing evidence.

2. Claimant has failed to meet her burden to show she suffered a compensable injury to her lower back. The claim for lower back treatment, including the S1 selective nerve root block injection, is denied and dismissed.

3. Insurer shall pay Claimant \$3,300.00 for the disfigurements outlined above. Insurer shall be given credit for any amount previously paid for disfigurement in connection with this claim.

4. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 28, 2015

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-855-933-01**

ISSUES

- Whether claimant has proven by a preponderance of the evidence that his case should be reopened pursuant to Section 8-43-303, C.R.S. based on a change of condition?
- If claimant's claim is reopened, whether claimant has proven by a preponderance of the evidence that he is entitled to Temporary Total Disability ("TTD") benefits for the period beginning October 9, 2014 and ongoing?
- Whether claimant has proven by a preponderance of the evidence that the recommended left hip magnetic resonance image ("MRI") recommended by Dr. Purvis and Dr. Heil is reasonable medical treatment necessary to cure and relieve claimant from the effects of his industrial injury?

FINDINGS OF FACT

1. Claimant sustained an admitted injury while employed with employer on March 29, 2011. Claimant testified at hearing that he injured his low back on March 29, 2011 when he lifted a 40-pound bag of dog food and twisted. Claimant testified that he felt a pop in his low back, and later developed stinging symptoms in his low back.

2. Claimant testified that he initially sought treatment with Dr. Pulsipher at Surface Creek Family Practice. Claimant was initially evaluated by Dr. Pulsipher on April 1, 2011. Dr. Pulsipher noted that claimant reported no known injury, but claimant had been performing constant heavy lifting and had pain for the past 5 weeks. Dr. Pulsipher noted that claimant reported he was unable to hold his son for long periods of time due to the pain. Claimant returned to Dr. Pulsipher on April 4, 2011 and reported a flare up of his symptoms. Dr. Pulsipher performed manipulations and claimant was released to return to work with restrictions. Claimant again received treatment with Dr. Pulsipher on April 11, 2011 and April 18, 2011 consisting of manipulations of the lumbar spine.

3. Claimant subsequently sought a one-time change of physician to Dr. Smith. Claimant testified at hearing that he sought the change of physician because osteopathic adjustments he received from Dr. Pulsipher worsened his low back symptoms and caused him to have hip symptoms. During claimant's initial evaluation with Dr. Smith on April 29, 2011, Dr. Smith recommended physical therapy. Dr. Smith diagnosed claimant with a low back muscle strain with left hip and mid/upper back pain

after osteopathic manipulation. Dr. Smith also recommended strong anti-inflammatory medication.

4. Claimant subsequently underwent an MRI scan of his lumbar spine on May 18, 2011. The MRI report noted a mild diffuse bulge with slight flattening of the ventral thecal sac and mild degenerative change within facet joints at the L4-L5 level. The MRI report also noted a mild central bulge, a small central annular tear which effaced the central sac, and mild degenerative changes in the facet joints at the L5-S1 level. At the S1-S2 level, the radiologist noted a small central bulge and mild degenerative changes within the facet joints.

5. Dr. Smith recommended a course of conservative care including medications and physical therapy. As of September 6, 2011, claimant was continuing to complain of left hip pain, low back pain (left side greater than right), and pain radiating into the left leg. Dr. Smith referred claimant to Dr. Tipping for an opinion regarding maximum medical improvement ("MMI") and further recommendations for treatment. Dr. Smith also noted that claimant may require neurosurgical consultation and possible epidural injections at some point in the future.

6. Dr. Simon in Dr. Craig Tipping's office evaluated claimant on September 9, 2011. Dr. Simon noted that claimant was not at MMI. Dr. Tipping subsequently evaluated claimant on September 14, 2011. Dr. Tipping also noted that claimant continued to have symptoms, and was not at MMI. Dr. Tipping recommended a nerve conduction study and epidural steroid injections and perhaps selective nerve root injections.

7. Dr. Hehmann performed nerve conduction studies and noted on September 27 and November 22, 2011 that claimant had mild chronic denervation at L4-L5 and mild L5-S1 irritation, and recommended a second MRI scan and epidural steroid injections.

8. Claimant was evaluated by Dr. Faragher on February 8, 2012, who recommended diagnostic injections. On June 8, 2012, Dr. Faragher noted that claimant was having new symptoms of shooting pain in his lower back and left leg when he sneezed, laughed, or coughed, and noted a pinching feeling in his left hip down to the middle toe. Dr. Faragher recommended epidural steroid injections for the low back.

9. Claimant was referred by respondents for an Independent Medical Examination ("IME") with Dr. Mack on April 2, 2012. Dr. Mack reviewed claimant's medical records, obtained a history from claimant and performed a physical examination in connection with his IME. Dr. Mack issued a report and opined that claimant suffered a soft tissue injury to the lumbar spine on March 29, 2011 and opined that claimant's symptoms stemming from the March 29, 2011 accident had resolved. Dr. Mack opined that claimant's current subjective complaints of symptoms were related to claimant's chronic problems associated with claimant's tight hamstrings and weak core

musculature. Dr. Mack opined claimant was at MMI for his work injury as of December 20, 2011 when he underwent the second MRI scan that showed no additional changes from his prior examination.

10. Dr. Faragher eventually performed injections at the L5-S1 level and in the left sacroiliac joint on November 27, 2012. Claimant followed up with Dr. Faragher on December 27, 2012, and noted that his low back and leg pain had improved, but his left hip pain was now bothering him.

11. On January 16, 2013, Dr. Smith noted claimant was reporting more pinching down his left leg, but generally improved low back pain. On February 12, 2013, Dr. Smith reported that she and claimant had a frank discussion regarding his lack of improvement and worsening condition. Dr. Smith noted that she did not feel additional work up or epidural injection would improve his condition and recommended claimant be placed at MMI. Dr. Smith noted that claimant's condition had worsened since his initial injury and recommended continued medical treatment post MMI for his back, left hip and left lower extremity radiculopathy, including medications, therapy, injections and possible referrals. Dr. Smith again referred claimant to Dr. Tipping for an impairment rating.

12. On March 21, 2013, Dr. Tipping evaluated claimant and provided diagnoses of multilevel degenerative disc disease, chronic denervation at L4-L5, and neurogenic left hip pain secondary to denervation of L4-L5 nerve roots. Dr. Tipping provided an impairment rating of 14% whole person. Dr. Tipping opined 7% was attributable to claimant's loss of range of motion and 7% was attributable to a specific disorder under Table 53 of the *AMA Guides*. Dr. Tipping also provided permanent work restrictions that included no lifting greater than 20 pounds, no repetitive lifting greater than 10 pounds, no carrying greater than 20 pounds, and no pushing/pulling greater than 60 pounds.

13. Respondents filed a Final Admission of Liability on May 7, 2013 admitting to a 14% whole person impairment rating and to a general award of post-MMI medical benefits that are medically reasonable, necessary, and related to the industrial injury.

14. After claimant was placed at MMI, Respondents sent a letter to Dr. Smith inquiring about claimant's need for future medical care. Dr. Smith responded on February 26, 2014 that claimant would need ibuprofen, tramadol, and use of a TENS unit every day. Dr. Smith noted that claimant would need additional medical treatment for the remainder of his life.

15. Claimant testified at hearing that after he was rated by Dr. Tipping, he began noticing sharp, stinging pains in his hip and groin area from standing and walking. He testified that the pain in his groin had not been present before. He testified that he was getting sharper pains in the left and right side of his low back, instead of just

the left side as he had before. Claimant testified that these symptoms began to prevent him from walking long distances.

16. Claimant testified that he was referred to Dr. Purvis by Respondents after Dr. Smith closed her practice. Claimant testified he went to see Dr. Purvis because he had pain in his groin area and right lower back area that was not present prior to MMI. Dr. Purvis reported on her initial evaluation on June 17, 2014 that claimant was complaining of constant hip pain and worsening low back pain after the effects of Dr. Faragher's injection wore off. Dr. Purvis provided a left hip injection and prescribed tramadol and Motrin. Dr. Purvis marked on the Physician's Report of Worker's Compensation Injury that claimant was "unable to work," but noted in her narrative report that claimant should avoid lifting and twisting, and should avoid lifting more than 15 pounds.

17. Claimant returned to see Dr. Purvis on August 8, 2014, and Dr. Purvis noted that although the injection given at the prior visit was helpful, claimant had aches in his hip, "charlie horses" in his left leg, and was waking at night with pain. Dr. Purvis recommended neuromuscular therapy and again reported on the physician's report of Workers' Compensation Injury that claimant was unable to work. Dr. Purvis noted in her narrative report that claimant should avoid lifting 10 pounds repetitively and 20 pounds maximum, and avoid lifting and twisting.

18. On September 18, 2014, Dr. Purvis noted that claimant had been "up hunting and hiking around" the past five days, which had aggravated his low back pain. Claimant testified that in September 2014 he went on a hunting trip with his father and uncle. Claimant testified that he walked and did some light hiking in and around their camp, but did not go further than 100 yards away from the campsite. He testified that he did not do any hunting, lift heavy items, squat, carry gear, or carry any game. He testified he mostly assisted with cooking in the camp. Claimant testified he did not have an injury to his low back or incident of low back pain during the hunting trip. Claimant testified that he went to a hunting camp despite Dr. Purvis putting him on work restrictions because he wanted to help out his uncle and father, both of whom were over 60 years of age.

19. Dr. Purvis's September 18, 2014 note also references claimant having a new job at Western Convenience. Claimant testified that he was employed in a convenience store as an overnight clerk, and worked shifts from 10 p.m. to 5 a.m. Claimant testified that the job involved cleaning the store and stocking items, and that sweeping and mopping the store was the most physical task involved with the job. Claimant testified that he took the job despite being on work restrictions issued by Dr. Purvis because it was the only job he could find and he wanted to support his family.

20. Claimant testified that he had tried to perform a tile installation job in February 2014, prior to beginning his care with Dr. Purvis. He testified that he performed two days of work, but was unable to continue. Claimant testified that his

friend completed the job for him. Claimant testified that he took the tile job because he was behind on his bills and was trying to make money for his family. Claimant also testified that prior to seeing Dr. Purvis he helped a friend of his sand down a hood of a truck in the friend's garage.

21. Claimant returned to see Dr. Purvis on October 9, 2014. Dr. Purvis noted claimant was complaining of low back pain and crackling in his back when bending. Dr. Purvis noted that over the past two weeks claimant had left lower back tenderness and left leg pain and shakiness. Dr. Purvis noted claimant had left hip pain into the front groin area and the back of the hip, and burning down left front of left leg with numbness. Dr. Purvis noted that claimant came in for an earlier medical appointment as he could not wait until their scheduled appointment on October 22, 2014.

22. Dr. Purvis ordered a repeat lumbar MRI scan and referred claimant to a neurosurgeon. Dr. Purvis issued a letter dated October 20, 2014 noting that claimant was off work due to aggravation of his injuries.

23. Claimant testified at hearing that he worked for Western Convenience for approximately three weeks, and that he has not worked for Western Convenience (or any employer) since Dr. Purvis took him off work on October 9, 2014. Claimant testified that he is still an employee of Western Convenience, but is waiting to be released to work duty by a doctor before returning to work.

24. Claimant had the repeat MRI scan on October 16, 2014. The MRI scan showed changes at the L5-S1 as well as the S1-S2 levels that both appear slightly progressed in severity as compared to the previous study. This included a central protrusion with mild to moderate effacement of the central thecal sac at the S1-S2 level, which Dr. Fowler, the radiologist, noted appeared slightly more pronounced as compared to the prior MRI scan.

25. Claimant saw Dr. Fox on December 16, 2014. Dr. Fox noted that claimant had low back problems for the past four years and had been placed at MMI, but recently had increased discomfort in his back. Dr. Fox noted that claimant denied any specific recent injuries. Dr. Fox noted that he had reviewed the 2011, 2012, and 2014 MRI scans and opined that even though claimant had exacerbation in discomfort, he recommended continued nonoperative treatment. Dr. Fox noted, however, that if claimant's radicular symptoms worsen, claimant would need to be reevaluated.

26. Claimant returned to see Dr. Purvis on December 18, 2014. Dr. Purvis noted that Dr. Fox thought claimant had progressed since MMI especially in the disc area and fluid between the discs. Dr. Purvis also noted that claimant had ongoing hip pain, and ordered additional hip x-rays to compare to prior studies. Dr. Purvis referred claimant to an orthopedist for consultation regarding his hip pain and recommended neuromuscular therapy. Dr. Purvis again issued a no-work restriction for one month.

27. Claimant saw Dr. Heil on January 14, 2015. Dr. Heil noted that it was difficult to know where claimant's left hip pain was coming from, and recommended an additional left hip MRI scan.

28. Claimant returned to Dr. Purvis on January 20, 2015 with continued complaints of low back and left leg pain and left hip pain. Dr. Purvis recommended neuromuscular therapy, and placed claimant on a no-work restriction. Dr. Purvis noted that claimant's MMI date was unknown due to his ongoing pain complaints.

29. Respondents obtained an independent medical examination ("IME") of claimant with Dr. Cebrian on January 9, 2015. Dr. Cebrian reviewed claimant's medical records, obtained a history from claimant, and performed a physical examination, and issued a report dated February 13 2015. Dr. Cebrian opined in his report that claimant remained at MMI and that his condition had not worsened since being placed at MMI on February 12, 2013. Dr. Cebrian opined that claimant's functional limitations had not changed since MMI. Dr. Cebrian opined that claimant needed no additional medical treatment for the admitted work injury.

30. Dr. Cebrian testified by deposition on April 10, 2015. Dr. Cebrian testified consistent with his IME report. Dr. Cebrian opined in his deposition that claimant's work injury aggravated a pre-existing, underlying condition, but could not identify any prior back injuries, back treatment, or imaging records.

31. Dr. Cebrian testified that patients he treats can have altered gait secondary to back pain. Dr. Cebrian testified that an altered gait can lead to symptoms in the hips. Dr. Cebrian's report noted that claimant was reported to have an altered gait when he was examined by Dr. Mack on April 2, 2012. Dr. Cebrian testified that claimant's left hip symptoms could be the result of radiculopathy, because the MRI scans have shown the possibility of impingement of the left nerve root in claimant's lower back. Dr. Cebrian also testified that claimant's left groin symptoms were consistent with the finding of a cortical bubble on x-ray.

32. Claimant testified that he would like to return to physical therapy because it helped him in the approximately one year following the initial injury. Claimant testified that he has not had physical therapy recently because he was awaiting the result of the hearing. Claimant testified that the recommended MRI of his hip was denied by respondents.

33. Claimant testified that he had not filed a workers' compensation claim with his new employer, Western Convenience, because he did not sustain an injury, and did not experience any new symptoms as a result of his work as an overnight clerk.

34. Claimant testified that his current symptoms included low back pain, both left and right-sided. Claimant testified that his back pain began on the left side, but had worked its way to the right side. Claimant testified that he had left leg symptoms

involving left hip cramping and stinging pain down to his small toe. Claimant testified that he had pelvic pain and pain in his groin. Claimant testified that he did not have the cramping, the groin pain, or the right-sided back pain prior to MMI. Claimant testified that since reaching MMI, he had lost mobility and was unable to stand for extended periods of time, and had difficulty walking very far. He testified that at the time he reached MMI, he could walk between ¼ and ½ mile without pain. At the time of hearing, he could only walk ¼ mile and had to stop due to pain and cramping. The ALJ finds the testimony of claimant to be credible and persuasive.

35. The ALJ credits the medical reports and opinions of Dr. Purvis over the contrary opinions of Dr. Cebrian. The ALJ finds that Claimant has proven that is more likely than not that his current complaints are related to the March 29, 2011 work injury and his current disability is related to the March 29, 2011 work injury. The ALJ also finds that work restrictions issued by Dr. Purvis are related to the industrial injury. The ALJ credits the medical reports and opinions of Dr. Purvis and the testimony of claimant and finds that claimant has demonstrated that it is more probable than not that he is no longer at MMI. The ALJ credits the medical opinions of Dr. Purvis and the testimony of claimant and finds that claimant has proven that it is more probable than not that his condition has worsened and he is entitled to have his claimant reopened pursuant to Section 8-43-303, C.R.S. The ALJ finds that Claimant is in need of additional medical treatment to cure and relieve claimant from the effects of his industrial injury.

36. The ALJ credits the reports from Dr. Purvis and finds that claimant is restricted from all work activity as a result of a worsening of his condition related to the March 29, 2011 work injury. Dr. Purvis's no-work restriction began on October 9, 2014, when Dr. Purvis noted claimant's worsening symptoms and instructed him to stop working for his new employer, Western Convenience. The ALJ therefore finds that Claimant has proven by a preponderance of the evidence that he is entitled to TTD benefits commencing October 9, 2014 and continuing until terminated by law.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. At any time within six years after the date of injury, the ALJ may reopen an award on the ground of a change in condition. Section 8-43-303(1), C.R.S. A change in condition refers to "a change in the condition of the original compensable injury or to a change in claimant's physical or mental condition which can be causally connected to the original compensable injury." *Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 222 (Colo. App. 2008). The ALJ is not required to reopen a claim based upon a worsened condition whenever an authorized treating physician finds increased impairment following MMI. *Id.* The party attempting to reopen an issue or claim shall bear the burden of proof as to any issues sought to be reopened. Section 8-43-303(4).

4. As found, claimant has proven by a preponderance of the evidence that his condition has changed and he is entitled to have his claim reopened. As found, the opinions expressed by Dr. Purvis are found to be credible and persuasive and claimant has proven that his condition has worsened entitling claimant to reopen his claim.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Even though an admission of liability is filed, the claimant bears the burden of proof to establish the right to specific medical treatment. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990).

6. As found, claimant has demonstrated that the additional medical treatment recommended by Dr. Purvis, Dr. Fox and Dr. Heil, including the MRI of claimant's hip, is found to be reasonable medical treatment necessary to cure and relieve claimant from the effects of the industrial injury.

7. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1)

Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

8. As found, claimant has proven by a preponderance of the evidence that his injury resulted in a worsened condition that is evidenced by the increased work restrictions set forth by Dr. Purvis. As found, the claimant has proven by a preponderance of the evidence that he is entitled to an award of TTD benefits beginning October 9, 2014 and continuing until terminated by law.

ORDER

It is therefore ordered that:

1. Claimant's claim is reopened pursuant to Section 8-43-303, C.R.S.
2. Respondents shall pay for the reasonable and necessary medical benefits necessary to cure and relieve claimant from the effects of the industrial injury provided by physicians who are authorized to treat claimant, including the hip MRI recommended by Dr. Heil.
3. Respondents shall pay claimant TTD benefits commencing October 9, 2014 and continuing until terminated by law.
4. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
5. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures

to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 20, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

ISSUES

- Did the respondents prove by a preponderance of the evidence that they are entitled to an order terminating the claimant's previously admitted right to receive post-MMI medical benefits?
- Did the claimant prove by a preponderance of the evidence that she is entitled to an award of specific post-MMI medical benefits including acupuncture and medication?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. Claimant's Exhibits 1 through 11 were admitted into evidence. Respondents' Exhibit A was admitted into evidence.
2. On June 2, 2011, the claimant suffered an admitted industrial injury to the low back when she was pulling products on a cart. The cart was off to her side which caused her to be in a twisting position.
3. The claimant testified as follows. At the time of the injury she felt a sharp pain in her low back and this pain went down her right leg. The pain eventually moved into the left leg. She had never had problems with either lower extremity prior to this incident.
4. The claimant was initially treated for this injury by John Fox, M.D. Dr. Fox is level II accredited. Dr. Fox examined the claimant on June 6, 2011. Dr. Fox noted tenderness over the right sacroiliac (SI) joint and that lumbar range of motion (ROM) was decreased and painful with right side bending. Dr. Fox assessed an SI strain, imposed a 10 pound weight restriction and prescribed medications. Apparently the claimant was also referred for physical therapy (PT).
5. On June 20, 2011 Dr. Fox noted that the claimant had transient improvement with PT but was getting worse overall with "frequent pinching pains in the left lower back."
6. On June 27, 2011 the claimant underwent a lumbar MRI. Mild facet arthropathy was noted at L4-5 and L5-S1. There was likely osteoarthritis of the SI joints.

7. Thereafter the claimant underwent additional PT, chiropractic treatment and acupuncture. The claimant reported some transient relief of symptoms as a result of these treatments.

8. On November 29, 2011 John Aschberger, M.D., examined the claimant. This examination was apparently the result of a referral from Dr. Fox. The claimant reported pain located mainly in the left low lumbar area. Dr. Aschberger assessed lumbosacral strain with a suggestion of a component of SI strain. He recommended PT for core stability and SI joint injections.

9. SI joint injections were performed on January 4, 2012. On January 9, 2012 the claimant reported to Dr. Aschberger that the injections resulted in "equivocal gain" and some relief of symptoms. The claimant also reported improvement in functionality.

10. On February 8, 2012 the claimant underwent a functional capacity evaluation (FCE). The claimant reportedly passed 66% of the validity criteria which suggested the possibility of poor effort and borderline invalid results. The claimant was placed in the light to medium duty category.

11. On March 12, 2012 Dr. Fox examined the claimant and reported decreased lumbar ROM in all directions with pain. He noted the claimant was not working because there was no light duty. He opined the claimant would soon be at maximum medical improvement (MMI) unless Dr. Aschberger had additional treatment suggestions.

12. On March 19, 2012 Dr. Aschberger recommended the claimant undergo an SI block and L4-S1 facet blocks on the left. On March 20, 2012 Dr. Fox noted the claimant had made no overall improvement and did not want to undergo the injections recommended by Dr. Aschberger.

13. On April 23, 2012 Dr. Aschberger examined the claimant. She was mildly tender at the left low back and SI areas with no paraspinal tightness. Dr. Aschberger assessed chronic low back pain with SI irritation and possible facet irritation. He opined the claimant was at MMI. He assessed an 8 percent whole person impairment based on 5% impairment of the lumbar spine and 3% reduced ROM in the lumbar spine.

14. On August 9, 2012 the claimant underwent a Division-sponsored independent medical examination (DIME) performed by Douglas Scott, M.D. Dr. Scott agreed with Dr. Aschberger's diagnosis of SI joint dysfunction with joint irritation and noted some findings suggestive of facet joint pain. He also agreed the claimant reached MMI on April 23, 2013. Dr. Scott assessed a 17% whole person impairment based on 5% for a specific disorder of the lumbar spine and 13% for lumbar ROM deficits. However, Dr. Scott expressed doubt about the validity of the ROM impairment stating that the diagnoses of SI joint disorder and/or facet pain would more likely influence lumbar extension than flexion. Therefore, Dr. Scott opined his 4% rating for reduced lumbar flexion might "not reflect a true permanent impairment in flexion." He

also opined, based on the FCE, that the claimant may have given poor effort on the ROM testing. Dr. Scott opined that “maintenance treatment” should include core strengthening exercises and use of a non-steroidal medication such as ibuprofen. He also suggested the claimant “reconsider” the SI joint and facet block injections recommended by Dr. Aschberger and stated these should be considered maintenance treatment.

15. On November 15, 2012 Dr. Fox examined the claimant. The claimant reported “quite a bit of pain in the left hip and left buttock.” The lumbar spine was tender with reduced ROM in “all directions.” The left SI region was also tender. Dr. Fox assessed a lumbar strain, sciatica and “left hip pain of uncertain etiology.” Dr. Fox also reviewed Dr. Scott’s DIME report noting the recommendations for additional land-based or pool therapy and “facet and/or sacroiliac injections performed as maintenance therapy.” Dr. Fox prescribed Flexeril and “pool therapy 2 times a week.” He also referred the claimant to Dr. Aschberger for potential facet and SI injections. Dr. Fox wrote that the claimant remained at MMI and all treatment “will be done as maintenance visits.”

16. On December 17, 2012 Dr. Fox noted that the claimant had seen Dr. Aschberger who was recommending epidural steroid injections. On December 17 Dr. Fox also completed a Physician’s Report of Workers’ Compensation Injury (Form WC 164) listing the “work related medical diagnosis (es)” as a sprain of the low back/lumbosacral, pain/hip and SI dysfunction.

17. Dr. Fox examined the claimant on January 17, 2013. The claimant reported that her back was no better and that she had not received any injections because the case was under litigation. The claimant advised Dr. Fox that she had “back pain 70% of the time.” Dr. Fox noted “focal tenderness in the right lower back.” The pain was between 6 and 8 on a scale of 10. Dr. Fox prescribed Flexeril.

18. The respondents sought a hearing to overcome the DIME physician’s impairment rating. On January 30, 2013 ALJ Cannici issued an order finding that the respondents overcame the DIME physician’s impairment rating by clear and convincing evidence. In support of this finding ALJ Cannici cited Dr. Scott’s opinion that the claimant may have given less than full effort during ROM testing and Dr. Aschberger’s testimony that there was no objective evidence that the industrial injury “caused lumbar flexion or right lateral flexion range of motion loss.” ALJ Cannici determined the claimant sustained 8% whole person impairment as a result of the industrial injury. On February 20, 2015 the respondents filed a Final Admission of Liability (FAL) admitting for PPD benefits consistent with ALJ Cannici’s order and also admitting for future medical benefits that are reasonable and necessary.

19. On February 19, 2013, the claimant returned to Dr. Fox. The claimant reported she had completed PT and requested additional PT. Dr. Fox also noted that Dr. Aschberger was planning to do injections as soon as they were authorized by the insurer. Dr. Fox’s plan was to proceed with injections once they were authorized. Dr. Fox referred the claimant to Robert Kawasaki, M.D., “for left L4-5 L5-S1 facet injections

and left SI joint injection.” Additionally Dr. Fox referred the claimant for more PT one to two times per week for one month. On February 19 Dr. Fox also completed a Form WC 164 listing the “work related medical diagnosis (es)” as a sprain of the low back/lumbosacral, pain/hip, SI dysfunction and low back pain with sciatica.

20. On March 8, 2013 Dr. Kawasaki performed left L4-5 and L5-S1 facet injections and a left SI joint injection. Dr. Kawasaki reported that the claimant’s “pre-injection VAS pain score of ‘10/10’ was reduced to 5-7 in recovery.”

21. Dr. Fox examined the claimant on March 19, 2013. The claimant reported her back pain was no better and she still complained of left hip symptoms. Dr. Fox assessed status post left facet injection and chronic low back pain. He opined she remained at MMI. Dr. Fox prescribed Tramadol and continued PT and pool therapy.

22. Dr. Aschberger examined the claimant on March 21, 2013. The claimant reported that she experienced no “lasting benefit” from the injections performed by Dr. Kawasaki. Dr. Aschberger noted the claimant was tender at the left low back “localized toward the SI area.” Dr. Aschberger noted he did not have the claimant scheduled for any follow-up visits.

23. Dr. Fox examined the claimant on April 2, 2013. The claimant reported significantly increased pain in her low hip and buttock since the March 8, 2013 injections. Dr. Fox noted diffuse tenderness in the lumbar region and recommended a repeat MRI. He also prescribed Percocet for severe pain but advised the claimant this was not an appropriate medication of long-term pain management.

24. On April 16, 2013 the claimant underwent a lumbar MRI. The radiologist reported that the MRI showed mild facet arthropathy from L3-L4 through L5-S1. Otherwise the MRI was normal.

25. On April 17, 2013 Dr. Fox examined the claimant and reviewed the MRI results. He noted the MRI showed mild facet arthropathy. He assessed mild facet arthropathy, post-facet injection and chronic low back pain. Dr. Fox opined that therapeutic options were limited given the lack of objective findings on the MRI. He referred the claimant for additional PT and chiropractic treatment and/or acupuncture.

26. On June 21, 2013 the claimant told Dr. Fox that her pain level had “significantly increased recently.” She also reported that PT was recently approved and restarted and acupuncture was pending authorization. The claimant was also approved to see “Dr. Kathy McCrea” (presumably Kathy McCranie, M.D.) with whom an appointment was scheduled on June 26, 2013. The claimant reported that tramadol was less effective than it used to be for treating pain and she requested stronger medication. Dr. Fox opined that the claimant remained at MMI and stated he would request that Dr. McCranie manage the claimant’s pain and medications.

27. Dr. McCranie performed a “physiatric evaluation” on June 21, 2013. The claimant reported a burning sensation in her left hip and that she was experiencing sharp pains down her left leg, left buttock and lumbar region. On a pain scale of 0 to

10 (with 10 being the worst pain) the claimant rated her worst pain at 10 (10/10) and her lowest pain at 6/10. The claimant advised Dr. McCranie that the injections performed by Dr. Kawasaki helped her left leg pain but she continued to have left buttock pain. Dr. McCranie noted the claimant had undergone over 100 PT sessions and that she was currently being treated with ultrasound, traction, dry needling and was taking Tramadol. Dr. McCranie's impressions included low back and posterior left thigh pain and "myofascial involvement of the lumbar and gluteal musculature." Dr. McCranie opined the claimant was a good candidate for trigger point injections.

28. On May 6, 2013 Carlos Cebrian, M.D., performed an independent medical examination (IME) of the claimant. Dr. Cebrian issued a report on July 17, 2013. Dr. Cebrian took a history from the claimant, reviewed pertinent medical records and conducted a physical examination. Dr. Cebrian assessed lumbar spine degenerative disease, subjective complaints "out of proportion to objective findings," right SI joint sprain and bilateral SI pain. Dr. Cebrian stated that the claimant continued to complain of significant pain 2 years after the injury and that her pain was shifting "from side to side." Dr. Cebrian opined this did not speak to "significant pathology nor a permanent condition." Dr. Cebrian also opined that "no future medical" was indicated for the injury of June 2, 2011 and that conservative therapies had failed to provide "sustained functional improvement or reduction in pain." Dr. Cebrian recommended the cessation of all maintenance care.

29. On July 22, 2013 Dr. McCranie administered trigger point injections to the left L5 paraspinals, the left S1 paraspinals, the left upper gluteal region and the left lateral gluteal region. Dr. McCranie also referred the claimant for massage therapy.

30. Dr. Fox examined the claimant on July 25, 2013. The claimant gave a history that she had "recently noted significant improvement in her symptom pattern." She was walking "irregularly" up to 2 miles at a time with minimal discomfort. The claimant had completed 4 visits of chiropractic/acupuncture treatment and felt it was "helping quite a bit." The claimant was also undergoing trigger point injections and massage therapy that began 3 days ago. Dr. Fox recommended continuation of trigger point injections and massage therapy, continued PT/acupuncture and prescribed Flexeril.

31. On July 29, 2013, the claimant returned to Dr. McCranie. The claimant reported some initial soreness after the trigger point injections but after that felt "incredible." The claimant stated that she felt "60% better" and that the trigger point injections "were better than any of the other injections she has had in the past." She rated her pain "on a 0-10 scale at a 6." Dr. McCranie administered trigger point injections to the left L5 paraspinals, the left S1 paraspinals and the left and right upper gluteal regions.

32. On August 5, 2013 the claimant returned to Dr. McCranie. The claimant reported she was doing "77% better" and reported her pain was 3/10. The claimant noted she had pain predominantly in the midline portion of the low back but overall felt the injections had helped bilaterally. The claimant desired to proceed with a third set of

injections. Dr. McCranie administered trigger point injections to the right and left upper gluteal musculatures and the right and left medial gluteal musculatures.

33. On August 9, 2013 the claimant called Dr. Fox's office and reported that the third set of trigger point injections was causing "a lot of pain." The claimant requested "stronger" medication and Dr. Fox wrote a prescription for Percocet.

34. On August 27, 2013 the claimant returned to Dr. McCranie. The claimant reported that after the last injections she developed a bruise which caused her to contact Dr. Fox who prescribed Percocet. However, the symptoms subsided and the claimant reported that her pain now varied between 4-5/10. Dr. McCranie noted the claimant had completed a series of three sets of trigger point injections. The claimant reported improvement from the injections, was decreasing use of Tramadol and was exercising regularly. Dr. McCranie discharged the claimant from treatment and referred her back to Dr. Fox for further maintenance care.

35. On August 28, 2013 the claimant returned to Dr. Fox. Dr. Fox noted that Dr. Cebrian did not believe further treatment was warranted and Dr. Fox opined that therapeutic options were "extremely limited." Dr. Fox noted the claimant was "still getting chiropractic/acupuncture treatments" and felt they were helping somewhat. Dr. Fox recommended the claimant complete scheduled chiropractic treatments and noted a gym membership had been requested. At this time Dr. Fox completed a Form WC 164 listing the "work related medical diagnosis (es)" as a sprain of the low back/lumbosacral, pain/hip, SI dysfunction and low back pain with sciatica.

36. On February 14, 2014 the claimant returned to Dr. Fox. She reported that she had obtained employment as a bank teller and was usually permitted to sit while working. However, she recently was required to stand and since that time had experienced an "exacerbation of her chronic low back pain." The claimant also reported that her injections had "worn off" and she had experienced increased pain since November 2013. The claimant completed a pain diagram showing left low back pain, left buttock pain and left posterior thigh pain. The pain was rated 7/10. Dr. Fox noted the claimant was taking Tramadol "when necessary." Dr. Fox observed the claimant had significant improvement in her symptoms after trigger point injections and requested that she be allowed to obtain additional treatments from Dr. McCranie. Dr. Fox also noted the claimant got relief from acupuncture and was requesting more of this type of treatment. Dr. Fox referred the claimant for acupuncture and to Dr. McCranie for "possible trigger point injections."

37. On March 4, 2014 Dr. McCranie prescribed the drug Tizanidra. The evidence does not contain any medical record concerning the claimant's March 4 visit to Dr. McCranie.

38. On April 28, 2014 Dr. Cebrian performed another IME of the claimant. Dr. Cebrian issued his report on May 31, 2014. In connection with this report Dr. Cebrian took an additional history, performed another physical examination and reviewed additional medical records. Dr. Cebrian reported that on physical examination there

was no swelling, bruising, redness or trigger points. ROM was reportedly full with pain on flexion and right lateral flexion. With movement the claimant reported pain on the left side of the lumbar spine. Dr. Cebrian assessed lumbar spine degenerative disease, subjective pain out of proportion to objective findings, right SI joint sprain-resolved, and diffuse myofascial pain.

39. In the May 31, 2014 report Dr. Cebrian opined that it is medically probable the claimant does not need any further treatment related to the June 2, 2011 claim. Dr. Cebrian again opined the claimant's reported symptoms are out of proportion to the objective findings, including the MRI findings. Dr. Cebrian recommended termination of all maintenance medical care noting that discharge "from the engagement of medical services will be therapeutic as there will not be the continued dependence on passive medical treatment." Dr. Cebrian opined that injections have not provided "sustained improvement" and medications have not provided increased function.

40. The claimant testified as follows. The maintenance treatments she received after MMI helped relieve her symptoms. The last trigger point injection in August 2013 relieved a lot of her pain. She has not received the acupuncture treatment recommended by Dr. Fox in February 2014 but desires to have it. She visited Dr. McCranie on March 4, 2014 and Dr. McCranie prescribed a "muscle relaxer." Dr. McCranie desired to try the muscle relaxer medication prior to performing additional trigger point injections because the claimant experienced substantial pain during the previous trigger point injections. The respondents have denied all medical treatment and prescriptions since March 4, 2014. The claimant desires to receive treatment from Dr. McCranie.

41. The respondents failed to prove it is more probably true than not that the claimant has no condition that is causally related to the industrial injury.

42. When the claimant was placed at MMI by Dr. Aschberger he diagnosed chronic low back pain, SI joint dysfunction and "possible facet irritation." The DIME physician, Dr. Scott agreed with the diagnosis of SI joint dysfunction and noted some findings consistent with facet joint pain. As shown by the WC Form 164's completed by Dr. Fox he agrees with the diagnosis of injury-related SI joint dysfunction and that the claimant suffers from persistent pain causally-related to the injury of June 2, 2011. Further, each of these physicians opined that the claimant needs one or more forms of post-MMI treatment to relieve the effects of the claimant's ongoing pain. Recommendations for post-MMI treatment have included PT, medications, SI joint and facet blocks, acupuncture, chiropractic and trigger point injections. The ALJ credits and gives substantial weight to the opinions of Dr. Aschberger, Dr. Scott and Dr. Fox insofar as they agree the claimant suffers from injury related medical conditions, including SI joint dysfunction, that are causally-related to the industrial injury and have resulted in ongoing symptoms since the date of MMI.

43. Dr. Cebrian's opinion that the claimant no longer suffers from any injury-related condition is not as persuasive as the opinions of Dr. Aschberger, Dr. Scott and Dr. Fox. Dr. Cebrian's opinion that the claimant does not now suffer from any injury-

related condition is contrary to the great weight of the credible medical opinions cited in Finding of Fact 42. Although Dr. Cebrian cited the absence of “objective findings” to support the existence of an ongoing medical condition, Dr. Aschberger, Dr. Scott, Dr. Fox and Dr. McCranie all have agreed the claimant’s clinical picture supports the conclusion that the claimant suffers from ongoing pain which warrants post-MMI treatment. To the extent Dr. Cebrian implies the claimant’s reports of pain are not credible because her symptoms have shifted from “side to side,” the ALJ finds his reasoning is unpersuasive. In this regard the medical records establish that within 18 days of the injury on June 2, 2011 the claimant reported both right and left sided symptoms. (Findings of Fact 4 and 5). Moreover, since Dr. Aschberger’s examination on November 29, 2011, the claimant has reported predominately, although not exclusively, left-sided back and lower extremity symptoms.

44. The respondents failed to prove it is more probably true than not that no additional treatment is or will be reasonable and necessary to relieve the ongoing effects of the industrial injury.

45. Dr. Cebrian’s opinion that no treatment is reasonable and necessary to relieve the effects of the injury is unpersuasive. Dr. Cebrian’s opinion appears to be based largely on his conclusion that none of the post-MMI treatments have provided the claimant any “sustained” pain relief or increased function. It is not clear from Dr. Cebrian’s reports what he believes would constitute sufficiently “sustained” relief to warrant post-MMI medical treatment.

46. Regardless, the claimant credibly testified that the post-MMI treatments have at least temporarily relieved some of her symptoms and the weight of the medical records corroborates her testimony. For instance, on March 21, 2013 the claimant told Dr. Aschberger that the injections performed by Dr. Kawasaki did not provide “lasting relief,” she did not say they provided no relief. In fact, on June 21, 2013 the claimant told Dr. McCranie Dr. Kawasaki’s injections “helped” her left leg pain. On June 21, 2013 the claimant told Dr. Fox that Tramadol was less effective in relieving her pain than “it used to be.” The ALJ infers from this entry that Tramadol was effective in relieving some of the claimant’s post-MMI pain although its effectiveness had declined by June 21, 2013. More significantly, on July 25, 2013 the claimant told Dr. Fox that her symptoms had significantly improved and she was able to walk up to 2 miles after 4 chiropractic/acupuncture visits and beginning the trigger point/massage therapy program prescribed by Dr. McCranie. On July 29, 2013 the claimant told Dr. McCranie she felt “incredible” after the first set of trigger point injections and they provided better results than any of the prior injections. On August 27, 2013 the claimant told Dr. McCranie that after the symptoms subsided from the last trigger point injections her pain was at a level 4-5/10, she was decreasing the use of Tramadol and was exercising regularly. On August 28, 2013 Dr. Fox noted the claimant was still undergoing chiropractic/acupuncture treatments and they were helping somewhat.

47. On February 14, 2014 Dr. Fox prescribed additional acupuncture and referred the claimant back to Dr. McCranie for “possible trigger point injections.” The ALJ infers from these referrals that Dr. Fox believes this course of treatment has a

reasonable prospect of relieving some of the ongoing effects of the claimant's injuries. The ALJ infers that Dr. Fox's opinion in this regard is based on his prior experiences demonstrating that these treatments provided significant relief of the claimant's symptoms. Dr. Fox's opinion in this regard is credible and persuasive.

48. The claimant proved it is more probably true than not that she is entitled to an award of specific medical benefits in the form of acupuncture treatment and the drug Tizandra.

49. For the reasons stated in Finding of Fact 42 the ALJ credits and gives substantial weight to the opinions of Dr. Aschberger, Dr. Scott and Dr. Fox insofar as they agree the claimant suffers from injury related medical conditions, including SI joint dysfunction, that are causally-related to the industrial injury and have resulted in ongoing symptoms since the date of MMI. The contrary opinion of Dr. Cebrian is not persuasive for the reasons stated in Finding of Fact 43.

50. On February 14, 2015 Dr. Fox credibly opined that the claimant should undergo additional acupuncture treatments. On that date the claimant reported her symptoms had been increasing since at least November 2013. The claimant had previously told Dr. Fox that she benefited from acupuncture treatments. The ALJ infers that the acupuncture prescribed by Dr. Fox offers a reasonable prospect for relieving the claimant's ongoing symptoms related to the industrial injury of June 2, 2011.

51. On March 8, 2014 Dr. McCranie prescribed the drug Tizanidra. The claimant credibly testified that Dr. McCranie wished to try this drug prior to any additional trigger point injections because the claimant had suffered severe pain when undergoing the injections. The ALJ infers from this evidence that Dr. McCranie believes use of Tizanidra may alleviate the claimant's symptoms without subjecting her to the pain associated with injection therapy. The ALJ finds that the prescription for Tizanidra offers a reasonable prospect of relieving the claimant's ongoing symptoms related to the industrial injury of June 2, 2011.

52. The ALJ further finds that the claimant failed to prove it is more probably true than not that trigger point injections constitute reasonable and necessary medical treatment. The ALJ infers from the claimant's testimony and Dr. McCranie's prescription for Tizanidra that Dr. McCranie believes performance of any additional trigger point injections should await the completion of the trial of Tizanidra. Dr. Fox has not actually prescribed additional trigger point injections. Instead Dr. Fox deferred to Dr. McCranie to determine whether the claimant needed injections.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of

litigation. Section 8-40-102(1), C.R.S. Generally, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201(1), C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201(1).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *CJI, Civil 3:16* (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201(1). The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions.

RESPONDENTS' REQUEST TO TERMINATE ALL MAINTENANCE MEDICAL BENEFITS

The respondents, relying principally on the opinions of Dr. Cebrian, contend that all medical maintenance benefits should be terminated because the need for such treatment is not reasonable, necessary or related to the industrial injury of June 2, 2011. The ALJ disagrees that the evidence supports termination of all maintenance medical treatment.

The respondents are liable to provide such medical treatment "as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee of the effects of the injury." Section 8-42-101(1)(a), C.R.S. Colorado courts have ruled that the need for medical treatment may extend beyond the point of MMI where the claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or prevent further deterioration of her condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995). An award for ongoing medical benefits after MMI is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. Thus an award of post-MMI medical benefits should be general in nature. *Hanna v. Print Expeditors Inc.*, 77 P.3d 863 (Colo. App. 2003).

In cases where the respondents file an FAL admitting for ongoing medical benefits after MMI they retain the right to challenge the compensability, reasonableness, and necessity of specific treatments. *Hanna v. Print Expeditors Inc.*, 77 P.3d 863 (Colo. App. 2003). When the respondents challenge the claimant's request for specific post-MMI medical treatment the claimant bears the burden of proof to establish entitlement to

the medical benefit. *Ford v. Regional Transportation District*, W.C. No. 4-309-217 (ICAO February 12, 2009).

In contrast, if the respondents file an FAL admitting for ongoing medical benefits after MMI but subsequently seek an order permanently terminating all such treatment they bear the burden to prove by a preponderance of the evidence that no treatment is or will be reasonably needed to relieve the effects of the injury or prevent deterioration of the claimant's injury-related condition(s). Section 8-43-201(1), C.R.S.; *Dunn v. St. Mary Corwin Hospital*, WC 4-754-838 (ICAO October 1, 2013); *Salisbury v. Prowers County School District RE2*, WC 4-702-144 (ICAO June 5, 2013).

The respondents may terminate all post-MMI medical treatment if they prove by a preponderance of the evidence that the claimant does not now suffer from any injury-related condition. Questions of causation present an issue of fact for determination by the ALJ. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). The respondents may also terminate all post-MMI medical treatment if they prove by a preponderance of the evidence that the claimant does not now and is unlikely in the future to need reasonable and necessary medical treatment to prevent deterioration of her condition or relieve ongoing effects of the injury. The question of whether the respondents proved that the claimant does not need and is not likely to need reasonable and necessary medical treatment to maintain or relieve the effects of her injury-related condition is also a question of fact for the ALJ. *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

Here, the respondents seek an order terminating the claimant's right to receive any post-MMI medical benefits. Consequently the respondents bear the burden of proof to show that the claimant does not now have any injury-related condition and/or that no medical treatment is currently needed or may reasonably be needed in the future to relieve the effects of the claimant's condition.

As determined in Findings of Fact 41 through 43, the respondents failed to prove the claimant does not now have any injury-related medical condition. The ALJ is persuaded by the opinions of Dr. Aschberger, Dr. Scott, and Dr. Fox that the claimant suffers from injury-related conditions that have continued to produce painful symptoms since the claimant was placed at MMI on April 23, 2012. Dr. Cebrian's contrary opinion is not credible and persuasive for the reasons stated in Finding of Fact 43.

As determined in Findings of Fact 44 through 47 the ALJ finds the respondents failed to prove the claimant does not now and is unlikely in the future to need medical treatment to relieve the ongoing effects of the June 2, 2011 industrial injury. Rather, in accordance with Finding of Fact 46 the ALJ is persuaded by the claimant's testimony, as corroborated by the medical records, that several post-MMI medical treatments have provided significant relief of her back and lower extremity symptoms. Moreover, the ALJ is persuaded by Dr. Fox's February 14, 2014 opinion that the claimant continues to need additional treatment to relieve the ongoing effects of the injury.

Conversely, for the reasons stated in Finding of Fact 46 though 47 the ALJ is not persuaded by Dr. Cebrian's opinion that the claimant does not need any additional treatment to relieve the effects of the injury. Indeed, Dr. Cebrian appears to believe that post-MMI medical treatment must result in "sustained" relief to be considered reasonable and necessary. However, Dr. Cebrian does not define what would constitute "sustained" relief. In any event, there is no legal standard requiring that post-MMI treatment provide "sustained" relief in order to be compensable. Indeed, medical treatment that results in "sustained" relief is more consistent with pre-MMI medical treatment designed to improve and stabilize the claimant's condition. Section 8-40-201(11.5), C.R.S. (MMI exists when injury-related mental and physical impairment is stable and no further treatment is expected to improve the condition). In contrast, post-MMI treatment is not designed to improve the claimant's overall condition. Instead it is designed relieve the ongoing effects of the industrial injury and/or prevent further deterioration of the claimant's condition after it has stabilized. *Grover v. Industrial Commission*, supra; *Stollmeyer v. Industrial Claim Appeals Office*, supra.

The respondents' request to terminate all post-MMI medical treatment is denied.

CLAIMANT'S REQUEST FOR AWARD OF POST-MMI MEDICAL BENEFITS

The claimant requests an award of post-MMI treatment in the form of "possible injections" and acupuncture treatments recommended by Dr. Fox on February 14, 2015. The claimant also requests an award of the Tizanidra, the medication prescribed by Dr. McCranie.

As noted above, when the claimant requests specific post-MMI medical benefits she bears the burden of proof to establish that the need for the treatment is causally related to the industrial injury and that the treatment is reasonable and necessary to relieve the effects of the injury or prevent deterioration of the condition.

As determined in Finding of Fact 42 the claimant proved it is more probably true than not that she needs additional medical treatment to relieve symptoms that are causally related to the injury of June 2, 2011.

As determined in Findings of Fact 50 and 51 the claimant proved it is more probably true than not that acupuncture and Tizanidra constitute reasonable and necessary medical treatment to relieve the ongoing effects of the June 2, 2011 industrial injury. For the reasons stated in Finding of Fact 52 the claimant failed to prove that at this time trigger point injections constitute reasonable and necessary medical treatment. Rather, determination of the reasonableness and necessity of trigger point injections is premature and must await the trial of Tizanidra.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The respondents' request to terminate post-MMI medical benefits is denied. The respondents shall continue to provide reasonable and necessary medical treatment to relieve symptoms of and prevent deterioration of conditions causally related to the industrial injury of June 2, 2011.

2. The insurer shall provide reasonable and necessary medical treatment in the form of acupuncture treatments and Tizanidra. Insofar as the claimant requests an award of trigger point injections that request is denied as of the date of the hearing, December 11, 2014. This order is not intended to prohibit or deny any future award of trigger point injections or other treatment subsequent to the date of the hearing.

3. Issues not resolved by this order are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 13, 2015

DIGITAL SIGNATURE:


David P. Cain
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

1. Whether Respondents timely designated Dr. Greendyke as Claimant's Authorized Treating Physician (ATP) in Idaho once it had some knowledge of facts that would lead a reasonably conscientious manager to believe that Claimant was relocating to Idaho and required continuing medical treatment.

2. Whether Respondents have presented substantial evidence to support a determination that additional medical treatment is not reasonably necessary to relieve the effects of Claimant's June 22, 2011 industrial injury or prevent further deterioration of his condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988).

FINDINGS OF FACT

1. On June 22, 2011 Claimant suffered an admitted industrial injury during the course and scope of his employment with Employer. Claimant injured his left hand while pulling a pallet jack.

2. On June 27, 2012 David W. Yamamoto, M.D. placed Claimant at Maximum Medical Improvement (MMI). He assigned Claimant a 15% left upper extremity impairment rating that converted to a 9% whole person rating. Dr. Yamamoto also recommended medical maintenance treatment.

3. On July 13, 2012 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Yamamoto's MMI and impairment determinations. Respondents noted that Claimant was entitled to receive medical maintenance benefits. Claimant did not seek a Division Independent Medical Examination (DIME) to challenge the admitted MMI date or impairment rating.

4. On January 16, 2013 Claimant visited David Conyers, M.D. for an evaluation. He recommended a left wrist arthroscopy with TFCC debridement and revision of the ulnar shortening.

5. On May 3, 2013 Claimant filed a Petition to Reopen his claim. On December 13, 2013 ALJ Broniak denied the Petition to Reopen.

6. By December 23, 2013 Dr. Yamamoto recommended continued maintenance treatment for up to 12 months. He also remarked that the left wrist surgery proposed by Dr. Conyers' could be undertaken as medical maintenance treatment.

7. On June 20, 2014 Claimant mailed a letter to Insurer stating that he was relocating to Idaho. He requested designation of an Idaho physician. Insurer received Claimant's request on June 23, 2014.

8. Claims Representative for Insurer Daysi Bloethner testified that she delegated the task of locating an Idaho physician to Insurer's Nurse Jo Walker and outside counsel. Nurse Walker explained that she contacted multiple Idaho physicians and sent medical records but was unable to locate a physician who was willing to treat Claimant.

9. On June 24, 2014 Nurse Walker contacted Occupational Medicine in Coeur D'alene, Idaho and spoke to Renee about the transfer of care. Renee remarked that she would need to consult with her manager regarding transfer of care and call back. On June 25, 2014 Nurse Walker received a message from Renee stating that Occupational Medicine would not accept the transfer of care because Claimant's injury was not acute.

10. On June 25, 2014 Nurse Walker contacted Dr. Ludwig's office regarding transfer of care and spoke to Tristin. Tristin commented that there would need to be an agreement to accept the Idaho fee schedule. Nurse Walker then requested a copy of the Idaho fee schedule.

11. On July 8, 2014, while waiting to hear back from Idaho Occupational Medicine Group, Nurse Walker again contacted Tristen from Dr. Ludwig's office. Because Tristen did not recall the prior discussion, Nurse Walker spoke to Dr. Ludwig's Nurse Lynne. Lynne explained that Dr. Ludwig would need to review Claimant's medical records prior to accepting a transfer of medical care.

12. On July 11, 2014 Nurse Walker sent the requested medical records to Dr. Ludwig's office. However, on July 15, 2014 Nurse Walker received a telephone call from Dr. Ludwig's office stating that he would not accept care because the injury occurred so long ago. Dr. Ludwig's office referred Nurse Walker to Scott Magnuson, M.D.

13. On July 15, 2014 Nurse Walker contacted Dr. Maguson's office and spoke to Georgia about becoming Claimant's new Authorized Treating Physician (ATP) in Idaho. Georgia responded that Claimant would need to have a primary care physician in order to be seen by Dr. Maguson. Dr. Magnuson subsequently declined to accept a transfer of care.

14. On July 17, 2014 Nurse Walker contacted U.S. HealthWorks in Spokane Valley and spoke to Julie. Julie noted that her physicians would not be willing to take Claimant's case because his injury was over one year old.

15. On July 23, 2014 Claimant sent a letter to Insurer stating that he relocated to a new Idaho address. The local change of address did not impact Insurer's efforts to locate a treating physician in Idaho.

16. On July 30, 2014 Nurse Walker contacted Dr. Keese but his office would not accept out of state claims. She also contacted Spokane Orthopedics but they did not take out of state claims. Finally, Nurse Walker contacted Dr. Mullen but his office would not treat wrist patients.

17. On July 30, 2014 Nurse Walker spoke to Tammy from Dr. Bowen's office. Dr. Bowen agreed to treat Claimant and requested medical records.

18. On August 1, 2014 Insurer designated Dr. Bowen as Claimant's ATP. Insurer scheduled an appointment for Claimant on August 19, 2014 at 10:15 a.m. in Post Falls, Idaho.

19. Ms. Bloethner commented that, shortly before the August 19, 2014 appointment, Claimant's attorney notified Insurer that Dr. Bowen's office had cancelled the appointment. Dr. Bowen did not wish to treat Claimant for non-medical reasons.

20. On August 26, 2014 Claimant sent a letter to Insurer stating that Dr. Bowen cancelled his medical appointment and refused to treat him. Insurer responded that Respondents were in the process of locating an Idaho physician to treat Claimant.

21. Ms. Bloethner testified that, shortly after learning that Dr. Bowen would not treat Claimant, Insurer located Dr. Greendyke at RiversEdge Orthopedics in Coeur d'Alenei, Idaho. However, Dr. Greendyke's office refused to schedule a medical appointment with Claimant until Insurer agreed to accept the Idaho fee schedule.

22. On August 26, 2015 Nurse Walker ceased attempting to locate an Idaho physician. She noted that "all possible prospects for finding doctor to accept transfer of [Claimant] have been exhausted." However, she remarked that she would pursue new prospects if additional information was obtained.

23. On August 26, 2014 Claimant sent a letter to Respondents stating that "pursuant to statute, the right of selection of the treating physician has passed to [Claimant]. Respondents were notified of the refusal to treat and Respondents have not designated a physician to treat Claimant." Insurer subsequently responded that the right of selection had not passed to Claimant because it had contacted multiple providers who had refused to provide medical treatment. Insurer also noted that it was continuing to attempt to locate an Idaho physician to treat Claimant.

24. Ms. Bloethner explained that she obtained approval from Insurer to accept the Idaho fee schedule and informed Dr. Greendyke's office on August 26, 2014. However, before an appointment could be scheduled Insurer and Dr. Greendyke's office sought to resolve the calculation of medical bills. Furthermore, Dr. Greendyke's office required Insurer to sign an agreement regarding the payment of medical bills.

25. For the period August 27, 2014 through September 13, 2014 Insurer and Dr. Greendyke's office communicated regarding the computation of medical bills. Insurer subsequently scheduled Claimant for a medical appointment with Dr. Greendyke

on September 29, 2014. On September 15, 2014 Insurer notified Claimant of the September 29, 2014 appointment with Dr. Greendyke.

26. On September 18, 2014 Claimant sent a letter to Insurer advising that he had located Michael Whiting, M.D. in Coeur d'Alenei, Idaho to provide treatment. Claimant also noted that Dr. Whiting was an authorized provider for the claim. Finally, Claimant requested transportation to the September 29, 2014 appointment with Dr. Greendyke.

27. On September 23, 2014 Insurer responded that it would not authorize treatment with Dr. Whiting. Ms. Bloethner also stated that Insurer did not have any medical records from Dr. Whiting.

28. Claimant acknowledged that he was aware of the September 29, 2014 appointment with Dr. Greendyke but did not attend the appointment. He explained that he did not receive a mileage check from insurer until two hours after the scheduled commencement of the appointment. However, Insurer sent Claimant a mileage check through overnight mail on September 25, 2014. Ms. Bloethner testified that she received confirmation that Claimant had received the mileage check on September 26, 2014 or three days prior to the scheduled appointment.

29. Respondents submitted medical reports from Jonathan Sollender, M.D. and Brian D. Lambden, M.D. Both reports explained that Claimant should not receive additional medical maintenance benefits. In a December 1, 2014 addendum to an independent medical examination report Dr. Sollender specifically noted that "Claimant should not be afforded any further maintenance care." Similarly, in a November 4, 2014 letter Dr. Lambden determined that "I do not believe medical maintenance care is necessary."

30. Respondents timely designated Dr. Greendyke as Claimant's ATP in Idaho once it had some knowledge of facts that would lead a reasonably conscientious manager to believe that Claimant was relocating to Idaho and would require continuing medical treatment. Despite the passage of more than two months before Respondents designated an Idaho ATP who would treat Claimant, the record reveals that Insurer engaged in significant reasonable efforts in an attempt to locate a physician who was willing to treat Claimant. Nurse Walker contacted numerous Idaho physicians during the summer of 2014 but they refused to provide medical treatment to Claimant because of the age of his industrial injury and for a variety of other reasons. Specifically for the period June 24, 2014 until August 26, 2014 Nurse Walker contacted at least eight physicians who declined to treat Claimant.

31. After learning about Dr. Bowen's refusal to treat Claimant, Respondents immediately searched for a replacement physician in Idaho. Respondents quickly found Dr. Greendyke, but he would not schedule an appointment for Claimant until Insurer agreed to accept the Idaho fee schedule, signed a written agreement and figured out how to compute payment of medical bills using proper coding. Ms. Bloethner did not have the authority to agree to the request but obtained authorization from a superior and

notified Dr. Greendyke's office that Insurer agreed to accept the Idaho fee schedule. For the period August 27, 2014 through September 13, 2014 Insurer and Dr. Greendyke's office communicated regarding the computation of medical bills. On September 15, 2014 Insurer notified Claimant that it had scheduled an appointment with Dr. Greendyke for September 29, 2014 but Claimant failed to attend. The record reveals that Insurer used reasonable efforts but encountered significant difficulties in locating an Idaho physician to treat Claimant. The record is replete with evidence that Insurer repeatedly attempted to obtain an ATP for Claimant in Idaho throughout the summer of 2014. Accordingly, the right of selection has not passed to Claimant and Dr. Greendyke is his ATP.

32. Respondents have presented substantial evidence to support a determination that additional medical treatment is not reasonably necessary to relieve the effects of Claimant's June 22, 2011 industrial injury or prevent further deterioration of his condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988). Initially, Respondents acknowledged that Claimant was entitled to receive maintenance medical benefits in the July 13, 2012 FAL. However, the persuasive evidence reveals that Claimant is no longer entitled to medical maintenance treatment. Both Drs. Sollender and Lambden persuasively concluded that Claimant should not receive additional medical maintenance benefits. In a December 1, 2014 addendum to an independent medical examination report Dr. Sollender specifically remarked that "Claimant should not be afforded any further maintenance care." Similarly, in a November 4, 2014 letter Dr. Lambden determined that "I do not believe medical maintenance care is necessary." Accordingly, Claimant is not entitled to additional medical maintenance benefits.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Change of Physician

4. If an employer is notified of an industrial injury and fails to designate an ATP the right of selection passes to the employee. *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565, 567 (Colo. App. 1987). An employer is deemed notified of an injury when it has “some knowledge of the accompanying facts connecting the injury or illness with the employment, and indicating to a reasonably conscientious manager that the case might involve a potential compensation claim.” *Bunch v. Industrial Claim Appeals Office*, 148 P.3d 381, 383 (Colo. App. 2006).

5. A claimant is not entitled to medical treatment by a particular physician. *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994); *Vigil v. City Cab Co.*, W.C. No. 3-985-493 (ICAP, May 23, 1995). Section 8-43-404(5)(a), C.R.S. permits the employer or insurer to select the treating physician in the first instance. Once the respondents have exercised their right to select the treating physician, the claimant may not change the physician without the insurer’s permission or “upon the proper showing to the division.” §8-43-404(5)(a), C.R.S.; *In Re Tovar*, W.C. No. 4-597-412 (ICAP, July 24, 2008). Because §8-43-404(5)(a), C.R.S. does not define “proper showing” the ALJ has discretionary authority to determine whether the circumstances warrant a change of physician. *Jones v. T.T.C. Illinois, Inc.*, W.C. No. 4-503-150 (ICAP, May 5, 2006). The ALJ’s decision regarding a change of physician should consider the claimant’s need for reasonable and necessary medical treatment while protecting the respondent’s interest in being apprised of the course of treatment for which it may ultimately be liable. *Id.*

6. Authorization to provide medical treatment refers to a medical provider’s legal authority to treat the claimant with the expectation that the insurer will compensate the provider. *Bunch*, 148 P.3d at 383; *One Hour Cleaners v. Industrial Claim Appeals Office*, 914 P.2d 501 (Colo. App. 1995). Authorized providers include those to whom the employer directly refers the claimant and those to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). Whether an ATP has made a referral in the normal progression of authorized treatment is a question of fact for the ALJ. *Suetrack USA v. Industrial Claim Appeals Office*, 902 P.2d 854 (Colo. App. 1995).

7. A respondent’s duty to designate a medical provider when a claimant moves to another location is triggered when the respondent has some knowledge of facts that would lead a reasonably conscientious manager to believe the claimant was relocating and would require continuing medical treatment. *See Bunch*, 148 P.3d at #JH833KJV0D1KQSV 2

383.; *In Re Ries*, W.C. No. 4-674-408 (ICAP, Jan. 12, 2011). The resolution of whether a respondent has timely fulfilled its duty to designate a medical provider in another state is one of fact for resolution by an ALJ. See *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997); *In Re Ries*, W.C. No. 4-674-408 (ICAP, Jan. 12, 2011).

8. As found, Respondents timely designated Dr. Greendyke as Claimant's ATP in Idaho once it had some knowledge of facts that would lead a reasonably conscientious manager to believe that Claimant was relocating to Idaho and would require continuing medical treatment. Despite the passage of more than two months before Respondents designated an Idaho ATP who would treat Claimant, the record reveals that Insurer engaged in significant reasonable efforts in an attempt to locate a physician who was willing to treat Claimant. Nurse Walker contacted numerous Idaho physicians during the summer of 2014 but they refused to provide medical treatment to Claimant because of the age of his industrial injury and for a variety of other reasons. Specifically for the period June 24, 2014 until August 26, 2014 Nurse Walker contacted at least eight physicians who declined to treat Claimant.

9. As found, after learning about Dr. Bowen's refusal to treat Claimant, Respondents immediately searched for a replacement physician in Idaho. Respondents quickly found Dr. Greendyke, but he would not schedule an appointment for Claimant until Insurer agreed to accept the Idaho fee schedule, signed a written agreement and figured out how to compute payment of medical bills using proper coding. Ms. Bloethner did not have the authority to agree to the request but obtained authorization from a superior and notified Dr. Greendyke's office that Insurer agreed to accept the Idaho fee schedule. For the period August 27, 2014 through September 13, 2014 Insurer and Dr. Greendyke's office communicated regarding the computation of medical bills. On September 15, 2014 Insurer notified Claimant that it had scheduled an appointment with Dr. Greendyke for September 29, 2014 but Claimant failed to attend. The record reveals that Insurer used reasonable efforts but encountered significant difficulties in locating an Idaho physician to treat Claimant. The record is replete with evidence that Insurer repeatedly attempted to obtain an ATP for Claimant in Idaho throughout the summer of 2014. Accordingly, the right of selection has not passed to Claimant and Dr. Greendyke is his ATP.

Medical Maintenance Benefits

10. To prove entitlement to medical maintenance benefits, a claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of his condition. *Grover v. Industrial Comm'n.*, 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment he "is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expeditors, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); see *Karathanasis v. Chilis Grill & Bar*, W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of

fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 919 P.2d 701, 704 (Colo. App. 1999).

11. The court of appeals has previously concluded that the burden of proof to establish compensability remained on the claimant even when an employer was attempting to withdraw an admission of liability. However, the Colorado Workers' Compensation Act has since been amended to change the burden of proof when respondents are attempting to withdraw admissions of liability. Specifically, respondents must now prove by a preponderance of evidence that the claimant did not suffer a compensable injury as defined under Colorado law. §8-43-201(1) (2013), C.R.S. Respondents admitted that Claimant was entitled to receive medical maintenance benefits as a result of his June 22, 2011 industrial injury. Accordingly, Respondents have the burden of proving by a preponderance of the evidence that additional medical treatment is not reasonably necessary to relieve the effects of Claimant's June 22, 2011 industrial injury or prevent further deterioration of his condition.

12. As found, Respondents have presented substantial evidence to support a determination that additional medical treatment is not reasonably necessary to relieve the effects of Claimant's June 22, 2011 industrial injury or prevent further deterioration of his condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988). Initially, Respondents acknowledged that Claimant was entitled to receive maintenance medical benefits in the July 13, 2012 FAL. However, the persuasive evidence reveals that Claimant is no longer entitled to medical maintenance treatment. Both Drs. Sollender and Lambden persuasively concluded that Claimant should not receive additional medical maintenance benefits. In a December 1, 2014 addendum to an independent medical examination report Dr. Sollender specifically remarked that "Claimant should not be afforded any further maintenance care." Similarly, in a November 4, 2014 letter Dr. Lambden determined that "I do not believe medical maintenance care is necessary." Accordingly, Claimant is not entitled to additional medical maintenance benefits.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. The right of selection has not passed to Claimant. Respondents timely designated Dr. Greendyke as Claimant's ATP.
2. Claimant is not entitled to receive medical maintenance benefits,
3. Any issues not resolved in this order are reserved for future determination.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) #JH833KJV0D1KQSV 2

days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: May 19, 2015.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

1. Whether the true opinion of the Division Independent Medical Examination (DIME) physician regarding permanent impairment is 16% whole person or 0% whole person.
2. Whether the opinion of the DIME physician has been overcome by clear and convincing evidence.
3. Whether a prior order finding the July 30, 2010 injury compensable precluded the DIME physician from providing a 0% whole person permanent impairment rating.

PROCEDURAL ISSUES

At the outset of hearing the parties reserved the issue of average weekly wage as well as wages from concurrent employment for future negotiation and potential settlement. The issue of whether the treatment provided by Ricardo Esparza, Ph.D. was authorized, reasonable, and necessary and whether the medical bills of Dr. Esparza should be paid by Respondents was found by the ALJ to not have been properly or fully identified as an issue for hearing and was reserved for future determination without prejudice.

FINDINGS OF FACT

1. Claimant works part-time for Employer as a supervisor in the pre-load area. Claimant's team is responsible for pulling packages from a conveyor belt, scanning and sorting them, and loading them into delivery trucks.
2. On July 30, 2010 while at work, Claimant crossed a conveyor belt with a flashlight in his left rear pocket. Claimant backed up to the belt, butt-first, and rolled across the belt on his back/butt. As he rolled across the belt, he felt a sharp pain in his left lower back/buttock area where the flashlight dug in. Claimant's lower back area went into spasm, and he dropped to one knee due to the pain.
3. Claimant reported the injury to Employer but understood from an August 2, 2010 meeting with Employer that Employer was denying his request for medical attention.

4. From August 3, 2010 through September 3, 2010 Claimant was treated by chiropractor Craig Pearson, D.O. Dr. Pearson's records reflect Claimant's pain complaints were in the left buttock and that Claimant had numbness in his left leg and foot. See Exhibit L.

5. Claimant continued to work his normal schedule for Employer as well as a second job as a realtor with no missed time due to the July 2010 incident. Claimant next sought medical treatment related to this incident on March 28, 2012.

6. On March 28, 2012, Claimant saw David Yamamoto, M.D. Claimant filled out a patient questionnaire where he reported left buttock pain and left leg/foot numbness and instability/imbalance. Claimant indicated on the patient questionnaire that when he rolled over the conveyor belt the flashlight compressed into his left buttock causing pain. See Exhibit K.

7. Dr. Yamamoto noted that Claimant had chronic pain in the left buttock, diagnosed sciatica and herniated disc syndrome, ordered a lumbar MRI, and opined the injury was work related. See Exhibit K.

8. Claimant underwent an MRI on July 11, 2012 that was interpreted by Craig Stewart, M.D. Claimant reported to Dr. Stewart falling two years prior with persistent left buttock pain. The MRI revealed multilevel moderate facet arthropathy of the lower lumbar spine with mild-moderate degenerative disc disease at L4-L5 and L5-S1. Dr. Stewart noted there was at most moderate bilateral neural foraminal narrowing at L5-S1 and noted that a small right central L5-L5 disc protrusion contributed to no definite nerve impingement. See Exhibit K.

9. The medical providers agree that the right sided disc protrusion shown on the MRI is not causing Claimant's left sided lower extremity symptoms.

10. On July 10, 2012 Rachel Basse, M.D. performed an Independent Medical Examination (IME). Claimant reported to Dr. Basse that at the time of the injury he had immediate severe pain in the left buttock and that he had continued pain deep in the left buttock, and aching, numbness, tingling, and pins and needles in the left leg from the knee through the foot. Dr. Basse opined that Claimant had left L5 radiculopathy and possible mild left S1 radiculitis. Dr. Basse opined that the July 2010 event is not one which she would expect to cause an injury to the lumbosacral spine. See Exhibit J.

11. On July 16, 2012 Claimant underwent an IME with John Hughes, M.D. Dr. Hughes diagnosed contusion of the sciatic nerve on the left and persistent neuropathy followed by the L5 nerve root distribution. Dr. Hughes opined that Claimant's left sciatic nerve contusion/bruise stemmed from the July 30, 2010 injury. See Exhibit A.

12. The compensability of the initial claim was contested by Employer and went to hearing.

13. On December 26, 2012 ALJ Harr issued an order determining that Claimant suffered a compensable injury on July 30, 2010. ALJ Harr found that Claimant showed it more probably true than not that he sustained an injury to his lower back that arose out of and within the course of his employment. ALJ Harr also found that Claimant had shown it more probably true that the medical attention provided by Dr. Pearson, Dr. Yamamoto, and by providers to whom Dr. Yamamoto referred Claimant was reasonable and necessary to cure and relieve the effects of the injury. See Exhibit A.

14. The issue of permanent medical impairment was not before ALJ Harr and was not litigated at the prior hearing. ALJ Harr made no findings regarding a permanent impairment rating. ALJ Harr's order specifically ordered that "issues not expressly decided herein are reserved to the parties for future determination." The issue of permanent partial disability and permanent medical impairment was thus reserved for future determination.

15. After the injury was found compensable, Claimant began treating with Dr. Yamamoto. Claimant saw Dr. Yamamoto on January 21, 2013, February 18, 2013, March 25, 2013, and May 13, 2013. At each of those appointments, Dr. Yamamoto provided the continued diagnoses of sciatica and herniated disc syndrome. Dr. Yamamoto also noted at all of these appointments that Claimant had normal active range of motion in his back. Dr. Yamamoto also made referrals to Peter Reusswig, M.D. and to Franklin Shih, M.D. See Exhibit K.

16. On February 22, 2013 Claimant saw Dr. Reusswig. Claimant reported to Dr. Reusswig that he had pain in his lower back and left leg. However, while describing the pain, Claimant reported the pain started in the mid left buttock, skipped his thigh, and restarted in his left knee and traveled down through his left shin and foot. Claimant saw Dr. Reusswig on March 15, 2013 and May 3, 2013 where he continued to report pain in the buttock on the left side, left leg pain, and left foot pain. See Exhibit 7.

17. On June 4, 2013 Claimant underwent an EMG/nerve conduction study performed by Dr. Shih. Claimant reported to Dr. Shih that he had discomfort in the left buttock and lower left extremity. Claimant also complained of depression and balance difficulties. Dr. Shih opined that Claimant's electrodiagnostic findings revealed some abnormalities but that the abnormalities were not related to Claimant's work injury of July, 2010. See Exhibit 8.

18. Dr. Shih assessed: multiple nerve conduction abnormalities consistent with diffuse peripheral neuropathy; low back and left lower extremity pain, complex, probable radicular syndrome; distal left peroneal nerve lesion with denervation noted in the extensor digitorum brevis; and left median nerve entrapment at the wrist. See Exhibit 8.

19. Dr. Shih opined that although Claimant's clinical presentation was consistent with lumbar radiculopathy, there was no electrodiagnostic evidence of

denervating *lumbar* radiculopathy and no evidence of pathology associated with a denervating lesion at the piriformis. Dr. Shih opined that the electrodiagnostic findings show that if there is pathology related to the lumbar or piriformis area, the pathology *was not* to the point of *causing damage* or denervation of the nerve. Dr. Shih recommended that Claimant follow up with his primary care physician for a routine medical workup to make sure there were no potential treatable causes of Claimant's diffuse peripheral neuropathy such as diabetes, thyroid dysfunction, vitamin deficiencies, etc. See Exhibit 8.

20. On June 19, 2013 Claimant again saw Dr. Yamamoto. At this appointment Claimant reported to Dr. Yamamoto that he had been depressed over the past two months, and preferred not to take an antidepressant or to get counseling. Claimant reported he did not want treatment for depression but that he wanted it noted in his chart that he had some mild depression as a result of the workers' compensation injury. Dr. Yamamoto assessed sciatica, herniated disc syndrome, and depressive disorder. Claimant saw Dr. Yamamoto on July 19, 2013, August 19, 2013, and September 18, 2013. Dr. Yamamoto continued to assess sciatica, herniated disc syndrome, and depressive disorder. See Exhibit K.

21. During this time, Claimant also continued to see Dr. Reusswig. On July 18, 2013, July 29, 2013, and August 13, 2013 Claimant continued to report to Dr. Reusswig that he had pain in the left buttock, left leg, left foot, and that he had continued left leg paresthesias. See Exhibit 7.

22. On September 30, 2013 Allison Fall, M.D. performed a medical records review at Respondents' request. Dr. Fall opined that Claimant's July 30, 2010 incident did not cause an injury to his lumbosacral spine and did not cause any lumbar radiculopathy. Dr. Fall pointed out that the electrodiagnostic evaluation was negative for radiculopathy or sciatic neuropathy from the piriformis and that the general peripheral neuropathy shown by the electrodiagnostic evaluation was not work related. Dr. Fall opined that Claimant was at maximum medical improvement (MMI). See Exhibit H.

23. At Claimant's very next appointment with Dr. Yamamoto, on October 18, 2013, Dr. Yamamoto continued his assessment of sciatica, herniated disc syndrome, and depressive disorder but assessed for the first time the diagnosis of low back pain. See Exhibit K.

24. On October 21, 2013 Respondents filed a Notice and Proposal to Select an IME for the issues of MMI and permanent impairment. On December 23, 2013 Respondents filed an application for a "24 month DIME" pursuant to 8-42-107(8)(b)(II), C.R.S. Dr. Hattem was eventually selected as the Division Independent Medical Examination (DIME) physician and March 19, 2014 was set as the date for the examination.

25. While the DIME application was pending, Claimant continued to treat with Dr. Yamamoto and Dr. Reusswig. Claimant continued to have pain in the left buttock and left knee to toes. Dr. Reusswig performed multiple injections into Claimant's left buttock and in February of 2014 opined that Claimant had left piriformis syndrome.

26. On December 23, 2013 Claimant underwent an ultrasound of his left gluteal region interpreted by William Berger, M.D. Dr. Berger's impression was negative soft tissue ultrasound exam. Dr. Berger noted the subcutaneous fat and imaged musculature appeared normal. See Exhibit K.

27. On January 8, 2014 Claimant saw Ricardo Esparza, Ph.D. for a psychological assessment on referral from Dr. Yamamoto. Dr. Esparza provided provisional diagnoses of: major depression, single episode, without psychosis; pain disorder associated with psychological factors in general medical condition; anxiety disorder; and relational problems associated with mental and medical condition. See Exhibit 5.

28. Claimant saw Dr. Esparza on January 22, 2014, January 30, 2014, February 5, 2014, February 25, 2014, March 5, 2014, March 19, 2014, April 3, 2014, April 22, 2014, May 20, 2014, June 20, 2014, and July 1, 2014. Dr. Esparza noted at these visits that Claimant continued to have ups and downs and continued to struggle with depression. At the final appointment, Dr. Esparza noted that Claimant had made an important psychological transition, recognized responsibility for his own happiness and had made a concerted attempt to move away from resentment, projections of blame, and sense of futility in trying to change reality. Dr. Esparza noted the plan was for Claimant to advise if he needed a follow up visit with none planned. See Exhibit 5.

29. On February 24, 2014 Claimant was placed at MMI by Dr. Yamamoto. Dr. Yamamoto's report inconsistently noted Claimant's complaints to be lower back pain and left leg pain/numbness, but also listed Claimant's symptoms were only in the left buttock and left leg area with no symptoms in the lower back. Dr. Yamamoto assessed: mechanical low back pain; left leg tingling and numbness, clinically suggestive of an S1 radiculopathy; history of left sciatic nerve contusion; and secondary depression. See Exhibit 2.

30. Dr. Yamamoto provided an 18% whole person permanent impairment rating. Dr. Yamamoto's rating included a 15% impairment from Table 53, provided a 1% whole person impairment from Table 49 for the S1 nerve root radiculopathy, and provided a 2% whole person impairment for depression. See Exhibit 2.

31. On March 19, 2014 Albert Hattem, M.D. performed a DIME. Claimant reported to Dr. Hattem that he had injured his left lower back on July 30, 2010 when a flashlight dug into his left buttock area. Claimant reported he had not missed any work as a consequence of the injury. Claimant reported at the evaluation that he had pain over the left buttock and left lateral leg from the knee to the foot. Claimant did not report low back pain. See Exhibit I.

32. Dr. Hattem diagnosed left buttock contusion. Dr. Hattem opined that Claimant was appropriately placed at MMI on February 24, 2014. Dr. Hattem noted diagnostically that a lumbar MRI demonstrated only age related mild to moderate degenerative changes and that an EMG/nerve conduction study revealed no evidence of lumbar radiculopathy. See Exhibit I.

33. Dr. Hattem noted that as of February 24, 2014 Claimant was 43 months post injury and had completed very extensive treatment including physical therapy, massage therapy, acupuncture, medication management, and multiple injections and that despite all the treatments, Claimant's left buttock pain persisted. Dr. Hattem opined that it was unlikely additional treatment would be beneficial. See Exhibit I.

34. Dr. Hattem opined that it was not plausible that such a minor incident occurring in July of 2010 with subsequent unrevealing diagnostic tests would cause 4 years of chronic unrelenting pain. Dr. Hattem opined that it was likely that other non work related factors were causing the ongoing subjective complaints. See Exhibit I.

35. Despite opining that the July 2010 incident was minor and that the lumbar MRI and EMG/nerve conduction tests revealed no evidence of lumbar impairment due to the injury, Dr. Hattem provided a 16% whole person impairment rating pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Third Edition, revised (AMA Guides). Dr. Hattem assigned a 7% impairment for 6 months of medically documented pain with moderate to severe degenerative changes on structural tests, and a 10% impairment for abnormal lumbar range of motion, and combined the ratings for a 16% whole person impairment. See Exhibit I.

36. Dr. Hattem differed from Dr. Yamamoto's impairment rating in three ways. Dr. Hattem did not believe a 1% whole person impairment for S1 radiculopathy impairment was appropriate as the EMG/nerve conduction study did not demonstrate that finding. Dr. Hattem also did not believe mental health impairment was appropriate and noted there was no evidence for a significant psychiatric disturbance. Dr. Hattem opined that Claimant's depression was not functionally limiting to warrant a permanent impairment rating. Finally, Dr. Hattem noted he believed a 7% table 53 impairment was more appropriate than the 5% table 53 impairment Dr. Yamamoto provided as the MRI demonstrated moderate degenerative changes. See Exhibit I.

37. On August 22, 2014 Dr. Hattem testified via deposition. Dr. Hattem indicated that when he first evaluated Claimant, he questioned causation of a lumbar spine injury but believed the issue had already been decided by ALJ order. Dr. Hattem testified consistent with his DIME report that the flashlight did not come into contact with Claimant's lumbar spine.

38. Dr. Hattem confirmed that Table 53 of the AMA Guides deal with permanent impairment ratings for specific disorders of the spine. Dr. Hattem opined that Claimant does not have permanent impairment of his lumbar spine caused by the

July 2010 incident and is not entitled to a Table 53 permanent impairment rating. Dr. Hattem opined that Claimant did not have an intervertebral disk or soft tissue lesion caused by the July 2010 incident. Dr. Hattem opined the source of Claimant's pain is a localized sciatic nerve-piriformis muscle injury, which is not ratable and does not cause impairment to Claimant's lumbar spine.

39. Dr. Hattem opined that his prior 16% whole person impairment rating was in error, not consistent with the AMA Guides, and that Claimant had no permanent impairment from the July 2010 incident warranting a rating for specific disorder of the spine.

40. Dr. Hattem also confirmed his opinion that Claimant was not entitled to a mental impairment rating and that any psychological problems Claimant was having were not related to rolling over a flashlight four years ago. Although Dr. Hattem believed that any psychological problems Claimant was having were not related to the July 2010 incident, Dr. Hattem also noted that even if they were related, the psychological problems were not limiting Claimant's function sufficient to warrant a permanent impairment rating. Dr. Hattem noted that Claimant had continued to work two jobs from the date of injury until present time without missing time due to depression. Dr. Hattem noted that although Claimant reported to Dr. Esparza that he was withdrawn, isolated, and depressed, that was not reflected in Claimant's ability to continue to function very highly.

41. The deposition opinion of Dr. Hattem that Claimant is not entitled to an impairment rating for his lumbar spine or for his psychological condition, and that Claimant's permanent impairment rating is 0% is the true opinion of the DIME physician.

42. On August 27, 2014 Dr. Fall performed a medical records review and issued a report. Dr. Fall opined that Dr. Hattem's March 19, 2014 DIME report erred in providing a 16% whole person permanent impairment rating for the lumbar spine. Dr. Fall opined that a Table 53 diagnosis must be given first before moving on to range of motion and that Dr. Hattem did not provide a diagnosis meeting the criteria of Table 53. Dr. Fall also opined that Dr. Hattem erred in the date of MMI and opined that Claimant was obviously at MMI at the time she previously saw him in September of 2013. See Exhibit H.

43. On March 20, 2015 Dr. Yamamoto testified at deposition. Dr. Yamamoto agreed that the EMG nerve testing did not demonstrate any evidence of radiculopathy from the spine. Dr. Yamamoto agreed that Claimant has piriformis syndrome caused by the work injury and that the pain generator for piriformis syndrome is in the left buttock area where the piriformis crosses over the sciatic nerve. Dr. Yamamoto testified that his diagnosis of mechanical low back pain could have been from stiffness as a result of the piriformis syndrome, but acknowledged it could have other causes.

44. Dr. Yamamoto opined that Table 53 does not permit an impairment rating for piriformis syndrome. However, Dr. Yamamoto opined that in Claimant's case,

Claimant had the buttock or piriformis injury and shortly thereafter developed lower back pain and stiffness and that the injury altered Claimant's movement creating a chronically stiff back which was ratable.

45. Dr. Yamamoto characterized his rating as a difference of opinion with Dr. Hattem. In Dr. Yamamoto's opinion Claimant met the criteria for a permanent impairment rating for his lumbar spine as Claimant had a clearly documented acute injury, initial complaint of buttock pain which was likely the piriformis syndrome, and had clearly documented stiffness of his low back. Dr. Yamamoto opined that Claimant may also have sacroiliac dysfunction that might need to be pursued and that it was a possibility that Claimant had both piriformis and sacroiliac dysfunction. Dr. Yamamoto noted that the sacroiliac joint is considered part of the spine.

46. No medical provider has diagnosed Claimant with sacroiliac dysfunction.

47. Dr. Fall testified at hearing. She opined that Claimant's ongoing pain is more likely than not related to the diffuse and non-work related peripheral neuropathy shown by EMG/nerve testing conducted by Dr. Shih. Dr. Fall opined that Claimant was not entitled to a permanent impairment rating for his lumbar spine and that his incident in July 2010 rolling on the flashlight did not cause lumbar spine impairment. She opined that nerve pain from the left buttock area was not part of the lumbar spine nor did the left buttock pain radiate up to the lumbar spine and opined that the objective medical evidence did not support a whole person impairment rating under Table 53 for specific disorders of the spine.

48. Dr. Fall noted Claimant's non work related conditions to include: fracture of the left leg through the growth plate and a shorter left than right leg; low thyroid; peripheral neuropathy; and peroneal nerve near the lower leg and ankle. Dr. Fall opined that those conditions, taken together would be expected to cause an altered gait.

49. Dr. Fall further opined that that Claimant was not entitled to a permanent impairment rating for mental impairment. She noted that when a person is not involved in activities of daily living or recreation due to pain, it is not ratable but that if they are not involved in activities of daily living or recreation due to depression, it is ratable. She found Claimant to be functional with no significant depression warranting a permanent impairment rating.

50. Dr. Fall's testimony and opinions are found credible and persuasive.

51. Dr. Hattem's testimony and opinions are found credible and persuasive.

52. Dr. Yamamoto's opinions are not found credible or persuasive, were difficult to pinpoint, and are not supported by the overwhelming medical evidence.

53. The conflict between Dr. Yamamoto's rating of permanent impairment and the zero rating provided by Dr. Hattem (and supported by Dr. Fall) amounts, at most, to a difference of medical opinion.

54. The testimony of Claimant at hearing is not found persuasive. Claimant was somewhat evasive, had trouble recalling details, and his testimony was inconsistent with several medical reports, including the location of injections that were performed by Dr. Reusswig on his left buttock and not his lower back.

55. The testimony of Mrs. Niziolek is also not persuasive regarding whether Claimant's injury caused permanent impairment to the lumbar spine warranting a rating and whether Claimant's diagnosed depression qualifies for a permanent impairment rating.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. See § 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. See § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

DIME Opinion

The DIME physician's findings concerning the date of MMI and the degree of medical impairment are binding on the parties unless overcome by clear and convincing evidence. See § 8-42-107(8)(b)(III) & (8)(c), C.R.S. If the DIME physician offers ambiguous or conflicting opinions concerning MMI or impairment, it is for the ALJ to resolve the ambiguity and determine the DIME physician's true opinion as a matter of fact. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, *supra*. In so doing, the ALJ should consider all of the DIME physician's written and oral testimony. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998). A DIME physician's finding of MMI and permanent impairment consists not only of the initial report, but also any subsequent opinion given by the physician. *Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005); *see also, Jarosinski v. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002). Once the ALJ determines the DIME physician's opinion concerning impairment, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. *Clark v. Hudick Excavating, Inc.*, W.C. No. 4-524-162 (November 5, 2004)

As found above, in his initial report, DIME physician Dr. Hattem questioned the relationship between the injury and Claimant's ongoing pain. However, he nonetheless provided an impairment rating. Dr. Hattem subsequently opined that Claimant was not entitled to an impairment rating under Table 53 as he did not have an intervertebral disc or soft tissue lesion or impairment to the lumbar spine caused by the July 2010 work injury. Dr. Hattem also continued his initial opinion that Claimant was not entitled to any rating for mental impairment. Dr. Hattem opined that his initial 16% whole person impairment rating was not consistent with the AMA Guides and at deposition opined that Claimant's true impairment rating was 0%. Dr. Hattem's deposition testimony that there was no impairment to the lumbar spine is his true opinion. Dr. Hattem is found credible and persuasive in explaining why he initially provided a rating, in error. In this matter, the true opinion of the DIME physician is 0% impairment with no permanent impairment to the lumbar spine and no permanent psychological impairment. Therefore, the burden of proof rests with Claimant to overcome the DIME physician's 0% whole person impairment rating by clear and convincing evidence.

Overcoming the DIME opinion

The DIME physician's findings concerning the date of MMI and the degree of medical impairment are binding on the parties unless overcome by clear and convincing evidence. Sections 8-42-107(8)(b) (III) & (8)(c), C.R.S. "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or

facts highly probable or the converse, and is free from serious or substantial doubt. *Leming v. Indus. Claim Appeals Office*, 62 P.3d 1015 (Colo. App. 2002). In other words, a DIME physician's findings may be not overcome unless the evidence establishes that it is "highly probable" that the DIME physician's opinion is incorrect. *Postelwait v. Midwest Barricade*, 905 P.2d 21 (Colo. App. 1995). To overcome a DIME physician's opinion, "there must be evidence establishing that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *Adams v. Sealy, Inc.*, W.C. No. 4-476-254 (ICAO, Oct. 4, 2001). A DIME physician must apply the AMA Guides when determining the claimant's medical impairment rating. See § 8-42-101(3.7), C.R.S.; §8-42-107(8)(c), C.R.S. Whether the DIME physician properly applied the AMA Guides, and ultimately whether the rating has been overcome by clear and convincing evidence are issues of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office*, 17 P.3d 202 (Colo. App. 2000). A mere difference of medical opinion does not constitute clear and convincing evidence to overcome the opinion of the DIME physician. *Javalera v. Monte Vista Head Start, Inc.*, W.C. Nos. 4-532-166 & 4-523-097 (ICAO, July 19, 2004).

Lumbar Spine- Table 53

Claimant has failed to overcome Dr. Hattem's DIME opinion by clear and convincing evidence. Claimant failed to show that it is highly probable that Dr. Hattem's determination of 0% impairment is incorrect. Additionally, the testimony of Dr. Yamamoto confirmed that the rating physician has discretion to provide a permanent impairment rating and that he merely had a difference of medical opinion with Dr. Hattem on whether or not Claimant suffered a permanent impairment to his lumbar spine that was ratable. Dr. Yamamoto admits that piriformis syndrome is not ratable under Table 53 for lumbar spine impairment. However, Dr. Yamamoto believes that the piriformis injury altered Claimant's movement and that shortly after the piriformis injury Claimant developed low back pain and stiffness, and that the mechanical low back pain is ratable. This is inconsistent with the medical reports showing that the pain reported by Claimant was consistently reported to be in the left buttock and left leg following the injury and low back pain and stiffness did not develop shortly after the July 2010 injury. As found above, Dr. Yamamoto did not diagnose mechanical low back pain until October 18, 2013, more than three years after the July 2010 work injury and a few weeks after Dr. Fall opined that Claimant had no injury to the lumbosacral spine. Further, Dr. Yamamoto's testimony included an opinion that Claimant may suffer from sacroiliac dysfunction which would be ratable as it is part of the lumbar spine. This opinion is not supported by any medical evidence and despite significant treatment, Claimant was never diagnosed with sacroiliac dysfunction.

Although Dr. Yamamoto believes that Claimant's mechanical low back pain *could* be caused by altered gait as a result of the left piriformis injury or that Claimant *might* have sacroiliac dysfunction, these opinions are not found persuasive and are not supported by the overall medical documentation in this case. Rather, the medical evidence and opinions of Dr. Hattem and Dr. Fall are persuasive that Claimant has no impairment of his lumbosacral spine warranting a Table 53 rating. Claimant has failed

to present credible and persuasive evidence to establish that Dr. Hattem's 0% impairment rating was incorrect. Dr. Fall agreed with Dr. Hattem's conclusions on the 0% impairment rating providing further support for the DIME physician's opinion. Although Dr. Yamamoto disagrees with Dr. Hattem's DIME conclusion, Dr. Yamamoto's opinion does not suggest that it is highly probable that Dr. Hattem's opinion is incorrect.

Psychological Impairment

Claimant also has failed to overcome the DIME opinion of Dr. Hattem by clear and convincing evidence as it pertains to a 0% permanent mental impairment rating. Although Claimant argues that the DIME physician should have provided an impairment rating for psychological impairment, Claimant failed to present clear and convincing evidence that the DIME physician erred by failing to do so. Here, Dr. Hattem opined that a significant factor showing Claimant was not functionally limited by depression to the point warranting a permanent impairment rating was that Claimant continued to work two jobs, with no missed time due to the injury or depression. Claimant worked for Employer in a supervisory capacity and also ran his own real estate business, showing his functional ability was high. As found above, consistent with the DIME opinion, Dr. Fall also opined that a 0% mental impairment rating was appropriate in this case as there was insufficient evidence to show that Claimant's depression was functionally limiting. Dr. Hattem was able to review the full reports of Dr. Esparza which did not change his opinion as to the appropriateness of a 0% permanent mental impairment rating. Claimant did not present evidence or testimony from Dr. Esparza or Dr. Yamamoto showing that Dr. Hattem erred in applying the AMA Guides for mental impairment to Claimant's function or Claimant's depression diagnosis. The difference in permanent mental impairment rating between Dr. Yamamoto and DIME physician Dr. Hattem and Dr. Fall is merely a difference of opinion on whether Claimant meets the AMA Guides for mental impairment and as to whether Claimant's diagnosed depression was functionally limiting sufficient to warrant a permanent impairment rating. DIME physician Dr. Hattem opined it was not and with no substantial evidence showing this to be in error, Claimant has failed to meet his burden.

Issue Preclusion

Issue preclusion is an equitable doctrine that bars re-litigation of an issue that has been finally decided by a court in a prior action. *Bebo Construction Co. v. Mattox & O'Brien, P.C.*, 990 P.2d 78 (Colo. 1999). Issue preclusion bars re-litigation of an issue if: (1) The issue sought to be precluded is identical to an issue actually determined in the prior proceedings; (2) The party against whom estoppel is asserted has been a party to or is in privity with the party to the prior proceeding; (3) There is a final judgment on the merits in the prior proceeding; and (4) The party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. *Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d 44 (Colo. 2001). Claimant argues that, because ALJ Harr determined that Claimant sustained a "low back injury" while rolling over the flashlight, Dr. Hattem was either bound to provide an impairment rating for the lumbar spine or was required to determine that the source of the claimant's pain and impairment was

from the lumbar spine or lumbar region. Claimant's argument is unpersuasive, not supported by law, and runs contrary to the established statutory and case law assigning the DIME physician authority to assess impairment and causation.

The issue before ALJ Harr was compensability. ALJ Harr found the July 2010 injury compensable, allowing Claimant to receive further treatment. The treatment Claimant received after this order eventually ruled out the lumbar spine as a source of Claimant's continued pain and ruled out a ratable lumbar spine condition. The issue in the current case is not identical to the issue of compensability determined by ALJ Harr. Rather, the issue in this case is whether Claimant is entitled to a permanent impairment rating under Table 53 of the AMA Guides for impairment of the lumbar spine. Although ALJ Harr ordered generally that the injury in July of 2010 to the lower back was compensable, he made no findings or order regarding permanent impairment to the lumbar spine. The parties at the prior hearing did not have a full and fair opportunity to litigate the issue of permanent impairment as Claimant had not yet received treatment and no medical provider was even close to being able to opine on whether the injury would eventually cause a permanent impairment to Claimant's lumbar spine. Claimant's argument that the DIME physician is required to find a permanent impairment to Claimant's lumbar spine based on an earlier award of general compensability would lead to an absurd result. Not every case where a compensable injury is suffered leads to permanent impairment or a permanent impairment rating. Claimant's argument that the issue here is identical to the issue determined by ALJ Harr and is thus precluded from determination is not persuasive.

ORDER

It is therefore ordered that:

1. The DIME physician's opinion in this matter is that Claimant has a permanent impairment rating of 0% whole person.
2. Claimant has failed to overcome the DIME opinion by clear and convincing evidence. Claimant failed to show by clear and convincing evidence that he is entitled to a Table 53 permanent impairment rating for his lumbar spine. Claimant also failed to show by clear and convincing evidence that he is entitled to a permanent psychological impairment rating.
3. Respondents shall be entitled to file a Final Admission of Liability admitting for a 0% whole person impairment rating.
4. Any issues not determined in this decision are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 14, 2015

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUE

The following issue was raised for consideration at hearing:

1. Whether Respondents proved by clear and convincing evidence that the Division Independent Medical Examiner's (DIME) determination regarding maximum medical improvement (MMI) is most probably incorrect.

FINDINGS OF FACT

Based upon the evidence presented at hearing, that ALJ enters the following findings of fact:

1. Claimant was employed by Employer for two and one half years as a commercial truck driver. On February 10, 2012, Claimant sustained an admitted injury to his left shoulder.
2. Claimant was walking around a truck trailer doing a pre-trip check on the vehicle before beginning a driving trip for Employer. As Claimant came around the back of the vehicle and started walking up towards the front, his feet went out from under him when he stepped on some black ice and fell on his left side.
3. Since it was Friday evening when the accident occurred, Claimant could not report the accident because there was no one at Employer to whom to report.
4. Claimant tried to complete his driving trip, which was supposed to go to Grand Junction, Colorado. However, he only made it to Rifle, Colorado. He was having too much pain from his fall. He called the team he was supposed to meet, and they exchanged trailers in Rifle, Colorado.
5. Claimant reported his injury and had his initial medical appointment with authorized treating physician, Michael Ladwig, M.D., on February 14, 2012. The initial diagnosis was contusion of the left humerus.
6. On February 21, 2012, Claimant was referred to have a MRI to rule out occult fracture of the left humerus.
7. The MRI, taken on March 6, 2012, was normal for the humerus, but a MR arthrogram was also done on March 6, 2012, on the left shoulder, which showed a full thickness tear distal supraspinatus tendon with 1 cm retraction, mild osteoarthric changes AC joint and glenohumeral joint,

and subchondral cyst formation at the junction of the rotator cuff tendons.

8. On March 8, 2012, Claimant was referred to Dr. John Papilion, orthopedic surgeon, by Dr. Ladwig. Claimant had his initial appointment with Dr. Papilion on March 20, 2012. Dr. Papilion found that Claimant failed conservative care, and that he was an excellent candidate for arthroscopy subacromial decompression and distal clavicle resection with arthroscopic rotator cuff repair.
9. Claimant had the surgery on June 11, 2012. The post-operative diagnoses were full thickness tear supraspinatus tendon, 2.5 cm, rotator cuff, left shoulder, chronic impingement, left shoulder, acromioclavicular joint arthropathy, left shoulder, and chronic biceps tendon rupture with degenerative tear superior labrum, left shoulder.
10. The operations performed consisted of examination under anesthesia, diagnostic video arthroscopy, arthroscopic debridement of the superior labrum and rotator cuff, arthroscopic subacromial decompression with release of coracoclavicular ligament, arthroscopic distal clavicle resection, arthroscopic rotator cuff repair with 4.7-mm Bic-Swivelocks x 4 with fibertape.
11. Claimant was placed in an abduction pillow shoulder immobilizer after the surgery. Claimant had to keep this device on all the time.
12. Claimant was prescribed Percocet upon discharge from the Lowry Surgery Center where the shoulder surgery was performed. The dosage prescribed was 1 – 2 pills by mouth every 4 – 6 hours, as needed.
13. Initially, Claimant took Percocet a few times during the day, one or two pills, depending upon how he felt. Claimant took at least two Percocet at night. When Claimant took the Percocet during the day, he would lie on the couch and nap.
14. Claimant was sleeping on a couch where he would not be able to roll over onto his left side because his arm was in the sling. In the last couple days of June 2012, Claimant fell at home.
15. On the night of the fall, Claimant took two (2) Percocet before or at bedtime. The Percocet prescription was a part of Claimant's medical care prescribed by an authorized treating physician.
16. Around midnight or one a.m., Claimant got up to go to the bathroom, and in the process of returning to the couch as he took a step to the right, he leaned over and fell on a living room chair and ottoman.

17. Claimant landed on his right side when he fell onto the cushioned chair with padded arms and a padded seat. Claimant came down on his right shoulder and hit his nose against the side of the cushion.
18. Claimant's use of the drug Percocet for pain following the first surgery made Claimant feel tired, groggy, and light headed such that he used the wall to steady himself going to and from the bathroom. Claimant's Percocet usage contributed to his fall in late June.
19. Claimant was wearing the shoulder immobilizer sling at the time he fell. Claimant did not feel any increased symptoms in his surgical left arm and shoulder after the fall or the next day.
20. Claimant began physical therapy on July 18, 2012. Claimant's fall occurred before this first physical therapy appointment. In the initial phase of physical therapy, Claimant progressed well. Claimant started to have problems occur as the physical therapy exercises became more difficult.
21. By September 10, 2012, Claimant was experiencing pain in his joint involving his upper arm. Claimant was also experiencing pain with overhead movement. By September 20, 2012, Claimant was experiencing popping in his shoulder. By September 27, 2012, Claimant reported soreness in the left shoulder that was not like the last physical therapy visit. His pain had increased.
22. By October 1, 2012, the pain was so bad that Claimant needed to sleep in a recliner. At the remaining physical therapy visits on October 4, 2012, October 15, 2012, October 22, 2012, October 25, 2012, October 31, 2012, November 1, 2012, November 5, 2012, November 8, 2012, and November 12, 2012, Claimant continued to report pain problems with certain motions of the shoulder.
23. Claimant had a follow up visit with Dr. Papilion on November 1, 2012, where he found that Claimant was almost five (5) months out from the repair of a tear in the rotator cuff and doing only fair. He noted persistent loss of motion and weakness that had plateaued in therapy.
24. Dr. Papilion ordered a post-surgical MRI, which was done on November 8, 2012. The repeat MRI showed a prior central rotator cuff repair but recurrent focal (12 x 10 mm) full-thickness tear of the anterior distal supraspinatus tendon overlying a suture anchor which may be bent or broken at the end sticking out.

25. Claimant had a follow up visit with Dr. Papilion on November 13, 2012, at which time Dr. Papilion found Claimant was a good candidate for repeat arthroscopy and rotator cuff repair.
26. Dr. Papilion's office scheduled the surgery to occur on December 7, 2012, but Respondents refused to authorize the surgery. In denying the request for authorization for surgery, Respondents relied on a record review performed by Dr. Allison Fall dated December 4, 2012. Dr. Fall opined that she was unable to state within a reasonable degree of medical probability that the second shoulder surgery was related to the work injury. She reasoned that the issue was the fall, which occurred three weeks after the first rotator cuff repair surgery. Dr. Fall opined that if this fall did cause the injury to the rotator cuff repair and caused a recurrent tear, this would be an intervening injury.
27. A second medical record review by J. Raschbacher, M.D. was performed on October 21, 2013. He opined that it would appear that a broken anchor would be more likely consistent with a fall rather than a spontaneous breakage or failure of the suture anchor. He did agree with Dr. Papilion that a certain number of rotator cuff repairs simply fail. He also stated that even if there was not a question of broken materials at the repair site, a fall in and of itself would be enough to cause a re-tear of the cuff. Dr. Raschbacher noted that Claimant's risk of surgical failure was higher because he smokes.
28. Claimant reported to Dr. Papilion that he fell three weeks after the first surgery on the right shoulder.
29. Claimant underwent a Division Independent Medical Examination with Dr. Thomas Fry on August 26, 2014. Dr. Fry assessed Claimant not at maximum medical improvement (MMI). Dr. Fry opined that it was unlikely that the fall three weeks post-surgery on the right shoulder re-injured the left shoulder, and the broken shoulder anchor and high surgical failure rate made it reasonable to assign Claimant's condition to a failure to heal from the original injury and surgery, and therefore a work related condition.
30. Dr. Papilion saw Claimant again on September 12, 2013. He found that Claimant had persistent symptoms with a recurrent tear 10 x 12 mm in the rotator cuff of his left shoulder. He also noted Claimant was having pain, loss of function, weakness, and that he was unable to lift. He continued to recommend a repeat examination under anesthesia, arthroscopy, and a revision rotator cuff repair of the left shoulder.
31. Dr. Papilion's deposition was taken by Claimant on March 18, 2014. Dr. Papilion was accepted as an expert in orthopedic surgery. Dr. Papilion

opined that the type of surgical repair that he performed on Claimant can fail without trauma.

32. Dr. Papilion described the shoulder immobilizer with an abduction pillow that Claimant was required to wear after surgery. Dr. Papilion opined that the anchor may not be broken, it could be dislodged. Dr. Papilion stated that a trauma would not necessarily be required for an anchor to pull out.
33. Dr. Papilion opined that a minor fall like that described by Claimant may have caused the rotator cuff to tear; because of its weakened state, in the early postoperative phase, the doctor opined that the shoulder's weakened state was susceptible to any kind of trauma, in physical therapy or a fall. Dr. Papilion's review of physical therapy notes caused him to credibly opine that the surgical failure occurred in the September time frame during the advancing physical therapy regiment.
34. Dr. Papilion provided letters dated September 26, and October 1, 2013, in response to letters sent by counsel. He found that Claimant was not at MMI. He stated that he was not convinced that the presumed second injury was responsible for the recurrent rotator cuff tear since physical therapy records document the advance of symptoms of pain, weakness, and loss of motion concurrent with the advance of physical therapy. Dr. Papilion opined that "There are percentages of rotator cuff repairs that do not heal and remain symptomatic, that require revision surgery." (Claimant Exhibit, pp. 2 – 3.) Dr. Papilion opined that the need for repair of the recurrent rotator cuff tear is related to the original work injury and subsequent surgical intervention.
35. On January 14, 2015, Dr. Hendrick Arnold opined, consistent with the opinions of Dr. Raschbacher and Dr. Fall, that it is within medical probability that the need for surgery is not related to the workers' compensation injury of February 10, 2012. Dr. Arnold found Claimant at MMI as of July 1, 2012. Drs. Arnold and Raschbacher acknowledged that a percentage of rotator cuff repairs fail spontaneously and require repeat surgery. Additionally, both doctors agree that Claimant needs repeat left shoulder surgery.
36. Dr. Arnold mentioned that medical records in 2013 reflect that Claimant had some substance abuse problems, however, Claimant took a drug test after the accident of February 10, 2012, that was negative. And, Claimant while employed by Employer for two and a half years gave random urine analysis samples that were negative for illegal drugs.
37. Claimant also maintained a commercial driver's license to drive for Employer. This license required physical examinations to maintain.

Claimant also took a pre-surgical physical on May 25, 2012, which he passed.

38. The ALJ finds the medical records and the opinions in this case by Dr. Papilion and Dr. Fry are the most credible and persuasive. Drs. Arnold, Fall and Raschbacher presented different theories regarding the cause of the rotator cuff re-tear, however, their opinions do not rise to the level of clear and convincing evidence that the DIME opinion of Dr. Fry on the issue of MMI is most probably incorrect. Respondents failed to present clear and convincing evidence that Claimant's fall at the end of June 2012 was a separate intervening event and therefore not work related.
39. The ALJ finds Drs. Fry and Papilion's opinions are most persuasive that the need for additional surgical repair of the recurrent rotator cuff tear is related to the original work injury and subsequent surgical intervention. Further, Dr. Papilion explains that Claimant's initial tear was large and statistically a significant percentage of repairs do go on to fail for various reasons. Also, the doctor notes that Claimant had increased pain when physical therapy was advanced as corroborated by the physical therapy records and Claimant's testimony of increasing problems as physical therapy exercises progressed.
40. The ALJ finds the DIME opinion of Dr. Fry that Claimant is not at MMI and that the recurrent tear of the left rotator cuff is work related has not been overcome by clear and convincing evidence.

CONCLUSIONS OF LAW

Having entered the foregoing findings of fact, the following conclusions of law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Section 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. A claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201(1), C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents and a workers' compensation case shall be decided on its merits. Section 8-43-201(1), C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).
3. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).
4. In this case, Respondents contend that they presented clear and convincing evidence through the medical reports of Drs. Fall, Raschbacher and Arnold that the MMI determination of the DIME physician was most probably incorrect. Sections 8-42-107(8)(b)(III) and (c), C.R.S., provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. The party seeking to overcome the DIME physician's finding regarding MMI bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, *supra*.
5. Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician's finding concerning MMI is incorrect. Where the evidence is subject to conflicting inferences a mere difference of opinion between qualified medical experts does not necessarily rise to the level of clear and convincing evidence. Rather it is the province of the ALJ to assess the weight to be assigned conflicting medical opinions on the issue of MMI. *Oates v. Vortex Industries*, WC 4-712-812 (ICAO November 21, 2008). The ultimate question of whether the party challenging the DIME physician's finding of MMI has overcome it by clear and convincing evidence is one of fact for the ALJ. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).
6. Under the statute, MMI is primarily a medical determination involving diagnosis of the claimant's condition. *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005); *Monfort Transportation v. Industrial Claim Appeals Office*, 942 P.2d 1358 (Colo. App. 1997). A determination of MMI requires the DIME physician to assess, as a matter of diagnosis, whether various components of the claimant's medical condition are causally related to the industrial injury. *Martinez v. Industrial Claim Appeals Office*, 176 P.3d 826 (Colo. App. 2007). A finding that the claimant needs additional medical treatment (including surgery) to improve his injury-related medical condition

by reducing pain or improving function is inconsistent with a finding of MMI. *MGM Supply Co. v. Industrial Claim Appeals Office*, 62 P.3d 1001 (Colo. App. 2002); *Reynolds v. Industrial Claim Appeals Office*, 794 P.2d 1090 (Colo. App. 1990); *Sotelo v. National By-Products, Inc.*, W.C. No. 4-320-606 (I.C.A.O. March 2, 2000). Thus, a DIME physician's findings concerning the diagnosis of a medical condition, the cause of that condition, and the need for specific treatments or diagnostic procedures to evaluate the condition are inherent elements of determining MMI. Therefore, the DIME physician's opinions on these issues are binding unless overcome by clear and convincing evidence. See *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

7. In this case, Respondents failed to meet their burden of proof to overcome by clear and convincing evidence Dr. Fry's DIME opinion that Claimant is not at MMI and that the current need for medical treatment and surgery for the left upper extremity is related to the work injury of February 10, 2012. The evidence supplied by Respondents through the reports of Drs. Raschbacher, Fall and Arnold amount to no more than a difference of opinion among experts and do not rise to the level of clear and convincing evidence. Claimant credibly testified regarding the mechanism of the late June 2012 fall onto a chair at home. Claimant was wearing an immobilizing arm sling and he fell on the right side. Relevant evidence was also revealed by Claimant's physical therapy records which showed Claimant's increasing pain and loss of function as physical therapy progressed. Furthermore, Dr. Fry, Arnold, Raschbacher, and Papilion agreed that rotator cuff repair surgery fails at a very high incident rate with or without a precipitating traumatic event.

ORDER

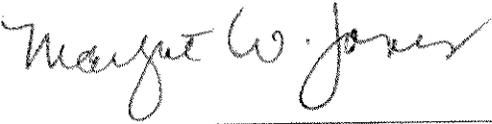
Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Respondents failed to sustain their burden of proof to establish that the DIME opinion regarding MMI is most probably incorrect.
2. Claimant is not at maximum medical improvement.
3. Respondents shall be liable medical treatment to cure and relieve Claimant of the effects of the left shoulder recurrent rotator cuff tear.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th St., Suite 1300, Denver, CO 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the petition to review by mail, as long as a certificate of mailing attached to your petition shows: (1) That you mailed it within twenty

(20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8 – 43 – 301 (2), C.R.S. (as amended, SB09 – 070). For further information regarding procedures to follow when filing a Petition to Review, see rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 28, 2015

DIGITAL SIGNATURE:


Margot Jones
Administrative Law Judge
Office of Administrative Courts

ISSUES

- Whether claimant has proven by a preponderance of the evidence that a follow up visit with Dr. Khan Farooqi is reasonable and necessary medical treatment related to claimant's admitted work injury?
- Whether claimant has proven by a preponderance of the evidence that her right shoulder and neck condition are causally related to the admitted work injury?
- Whether claimant has proven by a preponderance of the evidence that the medical treatment provided by Dr. Adams and Dr. Tice was reasonable and necessary to cure and relieve the claimant from the effects of the industrial injury?

FINDINGS OF FACT

1. Claimant sustained an admitted injury on September 30, 2011 while participating in training for employer when her all terrain vehicle ("ATV") hit a rock and rolled. Claimant testified at hearing that when the ATV began to roll, she dove off the ATV and landed on her hands. Claimant was taken from the accident scene to the base camp for the training, and was placed in a cervical collar and transported by ambulance to the emergency room ("ER") where claimant received treatment for an injury to her left foot and ankle.

2. Following claimant's injury, claimant was referred for medical treatment with Dr. Adams. Claimant received a course of medical treatment related to her left foot and ankle. Claimant was initially evaluated by Dr. Adams on October 7, 2011. Dr. Adams noted claimant was experiencing some mid back pain after the accident but not complaining of the pain during his examination. Dr. Adams noted claimant continued to have a lot of tenderness of the dorsum of her foot and both sides of the ankle.

3. Claimant was subsequently referred to Dr. Tice. Claimant was examined by Dr. Tice on November 16, 2011. Dr. Tice noted claimant had previously been examined for a back injury in July that was reasonably stable. Dr. Tice noted claimant was complaining of some neuropathic pain in her foot that Dr. Adams thought could be related to her back. Dr. Tice opined that the pain in her foot was likely not related to her back problem.

4. Claimant continued to treat with Dr. Huene and Dr. Khan-Farooqi for her foot and ankle injuries.

5. Claimant developed symptoms in the ulnar nerve distribution on her right hand. Claimant underwent an electromyogram (“EMG”) in connection with her symptoms under the auspices of Dr. Hehmann. The EMG was noted to be normal across the elbow and through the wrist, but Dr. Hehmann noted on examination that claimant definitely had an ulnar sensory distribution of loss of sensation. Claimant eventually sought a hearing and obtained an order in July 2013 finding the treatment for her ulnar nerve symptoms to be related to the work injury.

6. Claimant returned to Dr. Tice on October 1, 2013. Dr. Tice noted that Dr. Adams was concerned claimant was getting worse. Dr. Tice recommended surgical decompression and transposition of the ulnar nerve.

7. Claimant returned to Dr. Adams on October 24, 2013 with reports of pain radiating from her hand up into her shoulder. Claimant eventually underwent a right ulnar nerve decompression and transposition on November 11, 2013 under the auspices of Dr. Tice. Dr. Tice noted in his surgical report that claimant had a slight compression of the nerve at the cubital tunnel. Claimant returned to Dr. Adams on December 19, 2013 and noted she did not notice any improvement from before the surgery.

8. Claimant returned to Dr. Tice on January 29, 2014. Claimant reported symptoms that included ongoing numbness and weakness in the hand, some tenderness over the transposed ulnar nerve. Dr. Tice noted on examination that claimant had a history of shoulder and neck injury.

9. Claimant returned to Dr. Adams on February 17, 2014 and noted she was still experiencing numbness, tingling, loss of hand strength and pain that radiates up into her neck.

10. Claimant was evaluated by Dr. Tice on March 26, 2014. Dr. Tice noted claimant was having more trouble with hyperesthesias in her right hand and some pain in the shoulder and neck. Dr. Tice noted claimant had a history of shoulder and neck injury and left ankle injury. Dr. Tice noted claimant remained symptomatic from her shoulder pain and neck. Dr. Tice opined claimant’s ulnar decompression was doing fairly well.

11. Claimant returned to Dr. Tice on May 1, 2014. Dr. Tice noted claimant was doing better, but still had significant spasm and pin in her right shoulder on occasion. Dr. Tice further noted that the occupational therapist thought some of claimant’s problems were radicular in nature and coming from her neck. Dr. Tice noted that he felt claimant had a cervical strain and believed physical therapy with traction would be helpful for her.

12. Respondents referred claimant for an independent medical examination (“IME”) with Dr. Nicholas Olsen on June 12, 2014. Dr. Olsen reviewed claimant’s medical records, obtained a history from claimant and performed a physical examination

in connection with his IME. Dr. Olsen noted in his June 12, 2014 IME report that claimant did not complain of pain in her neck and shoulder following her injury and opined that claimant was at MMI as of March 26, 2014 when she returned to Dr. Tice for examination and he ordered x-rays of the right shoulder and neck, both of which were normal. Dr. Olsen did not recommend additional treatment for the claimant's neck or shoulder.

13. Dr. Tice responded to an inquiry from claimant's attorney on July 14, 2014. Dr. Tice opined in his report that he believed claimant was experiencing neck and shoulder pain that he related to a minor cervical sprain and also a dysethesia following claimant's right ulnar nerve transposition. Dr. Tice noted that claimant complained of pain in her neck, shoulder and arm following her injury and opined that claimant's neck and shoulder pain was related to her injury. Dr. Tice recommended treatment for the neck and shoulder including therapy and repeat EMG testing.

14. Claimant was examined by Dr. Burnbaum on August 27, 2014. Dr. Burnbaum examined claimant and opined that claimant had provided a good history for an ulnar nerve problem at the elbows, but claimant was not any better on examination. Dr. Burnbaum noted that things just do not add up, as claimant had weakness in multiple muscles throughout the arm, not in a C8 distribution. Dr. Burnbaum noted that there was nothing to suggest a brachial plexopathy or a root compression. Dr. Burnbaum recommended repeat nerve conduction studies.

15. Dr. Burnbaum performed nerve condition studies on October 24, 2014. The studies showed that the ulnar sensory nerve action potential amplitude was diminished on the right, as was the ulnar dorsal cutaneous sensory nerve action potential and even the median antebrachial cutaneous sensory nerve action potential. Dr. Burnbaum noted that he did an ulnar nerve motor study around the elbow, and while the nerve had been transposed, he was able to trace it and there was no ulnar motor slowing around the elbow. Dr. Burnbaum noted that the low-amplitude sensory nerve action potentials on the right for the ulnar nerve could be coming from the elbow and could be due to movement of the nerve at surgery, but because the median antebrachial cutaneous sensory nerve action potential was also diminished in amplitude, this brought up the possibility that it could be coming from higher up.

16. Claimant was examined by Dr. Matsumura on December 3, 2014. Dr. Matsumura noted claimant was placed at maximum medical improvement ("MMI") by Dr. Stagg on August 16, 2012 and deferred to his impairment rating provided at that time. Dr. Matsumura noted the medical records did not document claimant complaining of neck and shoulder pain following her accident. Dr. Matsumura opined that claimant's examination was not consistent with any specific cervical radiculopathy or myelopathy and opined that these complaints were not related to claimant's injury.

17. Claimant was examined by Dr. Hundley on December 23, 2014. Dr. Hundley noted claimant reported she complained of neck pain following her accident when her husband and an EMT brought her down to the ambulance where a cervical

collar was placed on claimant before they moved her to the ambulance. Dr. Hundley provided claimant with a diagnosis of cervicalgia and lesion of the ulnar nerve. Dr. Hundley recommended conservative treatment. Dr. Hundley noted that she believed claimant's neck and arm pain was related to the work injury based on the history provided by claimant and her examination.

18. Dr. Olsen issued a report in response to an inquiry from Respondents' counsel on January 13, 2015 which noted the new medical records from Dr. Burnbaum and Dr. Tice. Dr. Olsen again noted the significant delay in the development of right upper extremity pain complaints and opined that no further medical treatment was related to claimant's work related injury.

19. Dr. Tice issued a report in response to an inquiry from Respondents' attorney dated January 14, 2015. Dr. Tice indicated in his response that he disagreed with Dr. Matsumura and felt that claimant's condition was related to her work injury as she was thrown from her vehicle, and although she declined care for her neck at the time of the injury, it became apparent in the course of her treatment that her symptoms in her neck were related to her arm, which was work related, as she fell on an outstretched arm in the accident. Dr. Tice also noted that he disagreed with Dr. Matsumura that claimant's shoulder complaints were not related to her work injury. The opinions expressed by Dr. Tice in this January 14, 2015 report are found to be credible and persuasive.

20. Claimant testified at hearing that the pain in her neck and shoulder have been getting worse. Claimant testified she had symptoms in her shoulder and neck prior to her ulnar surgery and her symptoms have worsened in frequency and severity. Claimant testified she has been referred by Dr. Tice to Dr. Khan Farooqi for re-evaluation of her ankle because her ankle continues to roll. The medical records entered into evidence do not contain references to this referral.

21. Dr. Olsen testified by deposition in this matter. Dr. Olsen noted in his deposition that he examined additional medical records and reports after his examination of claimant on June 12, 2014. Dr. Olsen noted it was his opinion that claimant's cervical spine symptoms were not consistent with an ongoing cervical process. Dr. Olsen testified that while claimant was given a cervical spine collar before her ambulance ride, the ER physician cleared claimant's cervical spine and no diagnosis of an injury to the cervical spine was given by the ER physician.

22. Dr. Olsen opined that while claimant may have sustained a minor cervical strain as a result of the accident, her current symptoms, over three years after the accident, were not related to the accident. Dr. Olsen opined that claimant's right shoulder demonstrated a benign examination at the time of his IME and testified that the medical records did not demonstrate any indication that claimant suffered from a right shoulder injury when she fell off the ATV on September 30, 2011. Dr. Olsen further opined that claimant did not need any additional treatment to her left ankle. Dr. Olsen noted that his physical examination of claimant did not reveal any instability of the left

ankle and any intermittent rolling of her left ankle would not necessarily be related to the September 30, 2011 work injury.

23. The ALJ credits the opinions set forth by Dr. Tice in his reports over the contrary opinions expressed by Dr. Olsen and Dr. Matsumura in their reports and the testimony of Dr. Olsen and determines that claimant has demonstrated that it is more probable than not that the ongoing medical treatment recommended by Dr. Tice for claimant's neck and shoulder is reasonable and necessary to cure and relieve claimant from the effects of her industrial injury.

24. In coming to the conclusion the ALJ credits the testimony of claimant as being credible and persuasive regarding the physical complaints she experienced following her industrial injury and finds claimant's testimony supported by the medical records of Dr. Tice.

25. The ALJ further credits the testimony of claimant along with the medical reports from Dr. Tice and Dr. Hundley and find that the medical treatment provided by Dr. Tice and Dr. Hundley is reasonable and necessary to cure and relieve claimant from the effects of her industrial injury.

26. With regard to the referral from Dr. Tice to Dr. Khan-Farooqi for re-evaluation of the ankle, the ALJ notes that the medical records do not document that Dr. Tice made a referral to Dr. Khan Farooqi and, therefore, the ALJ dismisses this issue without prejudice.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the

testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it “aggravates accelerates or combines with” a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra*.

4. As found, claimant has proven by a preponderance of the evidence that her accident aggravated, accelerated or combined with a preexisting condition to produce her need for treatment to her right shoulder and cervical spine. As found, the claimant’s testimony at hearing is credible in this regard. As found, the ALJ credits the medical opinions expressed by Dr. Tice over the contrary medical opinions expressed by Dr. Olsen.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

6. As found, the treatment from Dr. Hundley and Dr. Tice has been reasonable and necessary to cure and relieve the Claimant from the effects of her industrial injury.

ORDER

It is therefore ordered that:

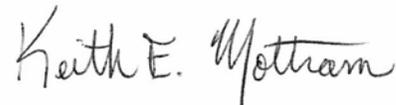
1. Respondents shall pay for the reasonable medical treatment necessary to cure and relieve claimant from the effects of her industrial injury, including the medical treatment to claimant’s cervical spine and right shoulder provided by Dr. Hundley and Dr. Tice.

2. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the

certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 27, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-895-762-05**

ISSUES

- Do the respondents have the burden of proof to overcome by clear and convincing evidence the DIME physician's finding that the claimant's left shoulder impairment was caused by the industrial injury?
- If the respondents were not required to overcome the DIME physician's finding concerning the cause of the left shoulder impairment did the claimant prove by a preponderance of the evidence that her left shoulder impairment was caused by the industrial injury?
- What is the claimant's impairment rating for right upper extremity?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. At the hearing Claimant's Exhibits 1 through 7 were admitted into evidence. At the hearing Respondents' Exhibits A through C were admitted into evidence.

2. The respondents filed an Application for Hearing listing the issues as permanent partial disability (PPD) benefits and "overcoming the DIME which found the left upper extremity to be work related." At the commencement of the hearing the ALJ inquired of respondents' counsel concerning the issues to be addressed. Respondents' counsel stated the respondents did not seek to overcome the Division-sponsored independent medical examination (DIME) physician's finding regarding maximum medical improvement (MMI). However, the respondents disagreed with the DIME physician's opinion that the claimant's left upper extremity impairment was caused by the admitted industrial injury. Respondents asserted that in these circumstances the claimant had the burden of proof by a preponderance of the evidence to show that the left upper extremity was caused by the industrial injury. On specific inquiry from the ALJ claimant's counsel stated the claimant did not have "any additional issues" but took the position that the respondents were required to overcome by clear and convincing evidence the DIME physician's finding that the left shoulder condition was caused by the industrial injury. Upon specific inquiry by the ALJ claimant's counsel represented the claimant was not seeking an order converting her upper extremity impairment ratings to whole person ratings.

3. The claimant testified as follows. On July 24, 2012 she worked in the employer's decor and flooring unit. She was responsible for the closing shifts that involved a lot of heavy lifting. She lifted cases of tile that weighed approximately 50

pounds. On July 24 she was lifting cases of 16-inch tiles from a pallet to a shelf that was at approximately waist level. She lifted one case to about the level of her knees and she dropped it with her right arm and tried to catch it with her left arm. However, the case fell to the ground and broke the tiles. After the incident the claimant's left shoulder hurt but the right shoulder hurt worse.

4. The claimant further testified as follows. After the incident she did not immediately report any injury to the left shoulder. However, the left shoulder always hurt. She also had pain in the left elbow that was "like an electric current." Eventually the left elbow pain resolved. The employer referred her to a "really small workman's comp" provider that treated her for "sore muscles." Eventually she reported to this provider that her right shoulder was very painful and she was referred to Dr. Otten. An MRI was performed on the right shoulder and she was diagnosed with a partial tear of the rotator cuff. She underwent physical therapy (PT) for the right shoulder and noticed she was "unable to assist" with her left upper extremity. A doctor and physical therapist told her she had a "compensation injury" to the left upper extremity because her right arm was weak. The right shoulder was surgically repaired in December 2013.

5. The claimant testified she did not have any left shoulder problems prior to the industrial injury of July 24, 2012. She also testified that after July 24 she was careful not to injure the left shoulder. Specifically, the claimant allowed her daughter to mow the lawn and to care of their horses.

6. The evidence does not include any medical records dated prior to October 2, 2012.

7. On October 2, 2012 Ryan Otten, M.D., examined the claimant at Workwell Occupational Medicine (Workwell). Dr. Otten recorded a history of present illness involving "longstanding pain located in the R shoulder." The claimant reported that the injury occurred on July 21 [sic] when she was lifting a case of ceramic tile and felt a "sudden sharp pain in the right shoulder." The claimant also reported a "brief period of time where she was experiencing left elbow symptoms, attributed to epicondylitis." The claimant also advised Dr. Otten that she had developed low back pain in the last few days. Dr. Otten's report does not contain any mention that the claimant reported left shoulder symptoms. Dr. Otten assessed right shoulder pain, a right rotator cuff strain r/o labral tear and a sprain of the lumbar spine. Dr. Otten ordered an MRI of the right shoulder, continued naproxen and PT. Dr. Otten released the claimant to "restricted duty" with no use of the right arm.

8. On October 10, 2012 the claimant underwent a right shoulder MRI. The MRI indicated a partial tear of the supraspinatus, anterior glenoid labrum tear, degenerative changes of the labrum and degenerative changes of the AC joint.

9. On October 12, 2012 Dr. Otten reviewed the MRI results and referred the claimant for a surgical consultation with Robert Fitzgibbons, M.D. Dr. Otten's note from this date does not mention any left shoulder complaints.

10. On October 23, 2012 Dr. Otten examined the claimant. He noted that the claimant reported that Dr. Fitzgibbons wanted her to resume PT. Dr. Otten's note from this date does not mention any left shoulder complaints. In addition to the prior restrictions Dr. Otten limited the claimant to working 4 hour shifts.

11. On November 7, 2012 Dr. Otten again examined the claimant. She reported that Dr. Fitzgibbons agreed to surgically repair the right shoulder. Dr. Otten's note from this date does not mention any left shoulder complaints.

12. On November 29, 2012 Dr. Otten again examined the claimant. He noted that the claimant was scheduled for right shoulder arthroscopy to be performed by Dr. Fitzgibbons on December 4, 2012. Dr. Otten's note from this date does not mention any left shoulder complaints.

13. On December 13, 2012 Dr. Otten examined the claimant for the purpose of reevaluating "her right shoulder strain, status post massive rotator cuff tear and repair and tenodesis done on December 4." Dr. Otten noted the claimant was to begin PT for the right shoulder on January 2, 2013. Dr. Otten's note from this date does not mention any left shoulder complaints.

14. In January 2013 the claimant was treated at Workwell by ANP-C William Ford. On February 7, 2013 ANP Ford noted the claimant's "primary problem" was pain in the right shoulder. However, he also noted that the claimant "again brings up her left shoulder, which I feel should be treated outside the Worker's Compensation System."

15. On February 14, 2013 the claimant underwent an imaging study of the left shoulder. The ALJ infers from the report that this was an x-ray study. The radiologist noted mild degenerative changes at the acromioclavicular and glenohumeral joints. The soft tissues "appeared normal." The radiologist opined the small AC spurs "may contribute to impingement type symptoms."

16. On February 22, 2013 the claimant was examined at Workwell by Marc-Andre Chimonas, M.D. Dr. Chimonas noted the claimant reported that she was in PT and felt her right shoulder range of motion (ROM) was improved. He also noted that she was "developing left shoulder pain" and was "having this worked up outside the workers compensation system."

17. On March 4, 2013 Dr. Fitzgibbons examined the claimant for a "follow-up visit after a right shoulder arthroscopic surgery." The claimant reported her right shoulder was improving. On this visit Dr. Fitzgibbons examined both the right and left shoulders. With respect to the left shoulder Dr. Fitzgibbons noted some positive findings on resisted strength testing.

18. On March 11, 2013 the claimant underwent an MRI of the left shoulder upon referral from Dr. Fitzgibbons. The radiologist reported an impression of a full thickness tear of the anterior aspect of the supraspinatus tendon with underlying moderate supraspinatus tendinosis.

19. On March 28, 2013 Dr. Otten noted the claimant went outside the workers' compensation system to have a workup on her left shoulder and had been diagnosed with a supraspinatus tear. The claimant was scheduled for surgery in May to repair this condition. The claimant requested Dr. Otten's opinion as to whether treatment including surgery on the left shoulder should be covered under workers' compensation. Dr. Otten wrote the claimant "was injured when using both arms to lift cases of 16 pound tiles." He noted the "primary discomfort at the time was in the right shoulder but she did complain of some left upper extremity pain." In these circumstances Dr. Otten opined to a reasonable degree of medical probability that the claimant injured her left shoulder rotator cuff at same time that she injured the right shoulder. He opined she should begin PT for the left shoulder and continue PT for the right shoulder.

20. In May 2013 Dr. Fitzgibbons surgically repaired the left supraspinatus tear.

21. On May 29, 2013 Allison Fall, M.D. performed an independent medical examination (IME) at the respondents' request. Dr. Fall is board certified in physical medicine and rehabilitation and is level II accredited. In connection with the IME Dr. Fall took a history, reviewed medical records and performed a physical examination. Dr. Fall issued a written report on May 29, 2013.

22. In the report Dr. Fall noted a history that on July 24, 2012 there were "seven 16-inch tiles, and [the claimant] was lifting and putting them on a shelf at chest level." She "picked up one, and it kind of moved, and her right hand gave out." The claimant reported she felt pain in the upper right arm and across her upper back. She also felt pain in the left elbow. The claimant told Dr. Fall that her left shoulder hurt "the whole time," but "they were concerned with the elbow."

23. Dr. Fall assessed status post work-related right shoulder injury with rotator cuff repair and biceps tenotomy, left lateral epicondylitis resolved and non-work-related left shoulder rotator cuff tear post repair. Dr. Fall opined to a reasonable degree of medical probability that the claimant's left shoulder condition and resulting surgery were not caused by the July 24, 2012 industrial injury. Dr. Fall noted that although the claimant initially had symptoms consistent with left lateral epicondylitis, that condition resolved. She explained there is no medical record documentation of an acute injury to the left shoulder on the day of the injury. Further, there is no documentation of left shoulder complaints until 2013. Dr. Fall opined the left shoulder condition is "most likely a degenerative condition for which [the claimant] underwent the" May 2013 surgery.

24. Dr. Fall opined the claimant was at MMI for the right shoulder and assessed a 4% upper extremity impairment which converted to 2% whole person impairment.

25. On July 10, 2013 Amber Sanders, M.A., authored a report concerning the claimant's treatment at the Longmont Clinic. Ms. Sanders noted she examined the claimant on "February 14." The claimant gave a history that she sustained a work-related injury "sometime before" when she lifted a heavy box with both hands. The box "slipped" and the claimant caught it momentarily before dropping it again. The claimant

reportedly experienced right shoulder pain and felt “less pain in the left elbow and left shoulder area.” After the right shoulder surgery the claimant became “more aware” of continuing left shoulder pain. Ms. Sanders wrote that she is “not an orthopedic surgeon or disability Dr.” However, Ms. Sanders wrote that she was “pretty incredulous that this kind of accident could an injury [sic] to her right shoulder requiring surgery, and yet not affect the left shoulder at all.”

26. Dr. Otten opined the claimant reached MMI on October 14, 2013. He assessed 6 percent impairment of the right upper extremity which converts to 4% whole person impairment. Dr. Otten noted the “compensability” of the claimant’s left shoulder condition was still disputed and he did not assign any impairment for the left shoulder. The claimant was released to return to work at regular duty.

27. On October 29, 2013 the respondents filed a Final Admission of Liability (FAL) for permanent partial disability (PPD) benefits based on Dr. Otten’s 6 percent right upper extremity impairment rating. The respondents did not admit any liability for PPD benefits based on the left upper extremity.

28. On April 23, 2014 Susan Santilli, M.D., performed a Division-sponsored independent medical examination (DIME). Dr. Santilli took a history from the claimant, reviewed medical records and performed a physical examination. The claimant reported that on July 24, 2012 she was “stacking boxes of tile at the end of the day when her right arm just dropped and then the left went as well.” After the incident all of the claimant’s upper body muscles were sore “across the chest/shoulders and upper back.” The claimant’s left elbow had been “pulled and she did have some therapy for that and this resolved.” A couple of months later the claimant underwent a right shoulder MRI that revealed a tear in the supraspinatus. The claimant underwent therapy for the right shoulder and ultimately had surgery to repair it in December 2012. The claimant reported that throughout this time her left shoulder hurt but not as much as the right. The claimant reported that Dr. Fitzgibbons thought the left shoulder pain was “due to overuse while the right was healing” but the claimant stated she had this pain before the right shoulder surgery.

29. Dr. Santilli noted that it was “difficult to find any pertinent medical records in the allotted timeframe that addressed [the claimant’s] initial presentation, her left elbow, or her progression.”

30. Dr. Santilli opined to a reasonable degree of medical probability that the claimant’s left shoulder rotator cuff injury was caused by the work-related incident of July 24, 2012 when she dropped the tiles. In support of this opinion Dr. Santilli wrote that after the July 24 incident the claimant had “left epicondylitis” that indicated there was a “left upper extremity injury at that time.” Dr. Santilli further explained that since the claimant was “holding the box of tile with both hands and caught it with both hands then similar forces were in play for both upper extremities.” Finally Dr. Santilli noted the claimant had no history of left shoulder problems prior to July 24, 2012 and no history of left shoulder injury after July 24, 2012.

31. Dr. Santilli opined the claimant reached MMI on October 14, 2013. She further opined that as a result of the injury the claimant sustained a right upper extremity impairment of 4% that converted to 2% whole person impairment. Dr. Santilli further opined the claimant sustained 3% left upper extremity impairment that converted to 2% whole person impairment. The combined whole person impairment was 4%.

32. On May 8, 2014 Dr. Fall authored a second report after reviewing Dr. Santilli's DIME report. Dr. Fall opined that Dr. Santilli "erred in her causation analysis regarding the left shoulder." Dr. Fall noted that Dr. Santilli's report indicated she did not review any medical records between the date of injury and the October 10, 2012 MRI. Dr. Fall opined that this was a critical failure in Dr. Santilli's causation analysis because the medical records from this time failed to document any reports of a left shoulder injury, and documented there were no initial left shoulder complaints indicating that there was a left shoulder injury "at that time." Dr. Fall also stated that Dr. Santilli made a "faulty assumption" that the claimant "caught" the box of tiles with both hands. Dr. Fall explained that the claimant did not report "catching the box of tile." Further, Dr. Fall stated that Dr. Santilli has no way of knowing what "forces" were applied to either shoulder. Dr. Fall also stated that the fact the claimant did not report any shoulder symptoms prior to the date of injury does not mean the injury caused the left shoulder condition. Dr. Fall explained that tears of rotator cuff muscles are "quite common" in the claimant's age group.

33. Dr. Fall testified at the hearing. Dr. Fall stated the claimant never told her that she caught the falling tiles with her left hand. Dr. Fall noted that the initial medical records indicate the claimant gave a history that her right arm gave out and that she had right shoulder and left elbow symptoms. Dr. Fall noted that the claimant was first seen by Dr. Fitzgibbons on October 16, 2012 and seen again on November 6, 2012. Dr. Fall noted that on both of these occasions Dr. Fitzgibbons examined the claimant's left shoulder and reported that she had no pain and full ROM. Dr. Fall opined that Dr. Fitzgibbon's records indicate the left shoulder was not a problem in October and early November 2012.

34. Dr. Fall testified that with an acute tear of the supraspinatus tendon the patient would experience symptoms. However, with a degenerative process most persons will not have symptoms. Dr. Fall was asked whether the claimant could have torn the left supraspinatus tendon while performing PT and she stated that there was no documentation of any such event.

35. A preponderance of the credible and persuasive evidence establishes that the claimant's left shoulder condition (tear of supraspinatus tendon/ rotator cuff tear) was not proximately caused by the admitted industrial injury of July 24, 2012.

36. Dr. Fall credibly and persuasively opined to a reasonable degree of medical probability that the tear of the claimant's left rotator cuff and consequent surgery were not caused by the industrial injury of July 24, 2012. Dr. Fall persuasively explained that if the claimant suffered an acute tear of the rotator cuff on July 24, 2012 she would have suffered acute symptoms. However, Dr. Fall persuasively argued that

the medical records do not document a temporal relationship between the date of injury and the claimant's first documented complaints of left shoulder symptoms in February 2013. She also persuasively opined that Dr. Fitzgibbon's reports of October 16 and November 6, 2012 document that he examined the left shoulder but there were no complaints of pain and no evidence of reduced ROM. Dr. Fall persuasively opined that the absence of left shoulder findings during Dr. Fitzgibbon's examinations in October and November 2012 shows the claimant's left shoulder was not problematic at that point in time. Dr. Fall also persuasively opined that the medical records do not document any injury to the left shoulder that occurred during PT for the July 24 injury. Dr. Fall persuasively opined that the claimant's left rotator cuff tear was most likely degenerative in nature and that such tears are common in persons of the claimant's age.

37. The claimant's testimony that she has suffered left shoulder symptoms ever since the July 24, 2012 injury is not credible and persuasive. The claimant's testimony that she suffered left shoulder beginning on July 24, 2012 and that these symptoms were always present is not corroborated by the contemporaneous medical records. Rather these records document complaints of right shoulder pain and left elbow pain (then diagnosed as left epicondylitis) that eventually resolved. Dr. Otten's reports between October 2, 2012 and December 13, 2012 do not document any reports of left shoulder pain. Dr. Fitzgibbon's reports in October and November 2012 do not document left shoulder pain or reduced ROM. The ALJ infers that if the claimant actually suffered constant left shoulder pain since the date of injury she would have reported it to her treating physicians and they would have recorded it. As stated above, soon after the date of injury the claimant reported right shoulder and left elbow symptoms and these were duly recorded in the medical records. When claimant developed low back pain she reported it to Dr. Otten and he duly recorded the report in his October 2, 2012 report. However, the first medically documented complaint of left shoulder symptoms does not appear until February 7, 2013, more than six months after the date of the injury.

38. Dr. Otten's opinion that the claimant's left shoulder condition is related to the injury of July 24, 2012 is not as persuasive as Dr. Fall's contrary opinion. Dr. Otten appears to reason that because the claimant reported "left upper extremity pain" at the time of the July 24, 2012 injury she must have sustained the left rotator cuff tear at that time. Dr. Otten's March 28, 2013 opinion does not persuasively explain why the claimant did not report *left shoulder* symptoms at the time of the injury and for many months thereafter. Dr. Otten's mention of "left upper extremity pain" presumably refers to the *left elbow* complaints that subsequently resolved. Dr. Otten does not persuasively explain how left elbow symptoms could be indicative of a torn rotator cuff.

39. Dr. Santilli's opinion that the claimant's left shoulder condition is related to the injury of July 24, 2012 is not as persuasive as Dr. Fall's contrary opinion. Although the report of left elbow symptoms at the time of injury might indicate there was some injury to the "left upper extremity" on July 24, Dr. Santilli did not persuasively explain how the presence of left elbow symptoms near the date of injury indicates or proves that the claimant simultaneously sustained a torn left rotator cuff. Dr. Fall persuasively

argued that Dr. Santilli's opinion does not account for the absence of any recorded left shoulder symptoms until many months after July 24. Dr. Santilli's opinion does not refute Dr. Fall's credible opinion that if the rotator cuff was torn on July 24, 2012 that left shoulder symptoms would have been present at that time, not six months later.

40. The opinion of Amber Sanders is not accorded any substantial weight on the issue of causation. Ms. Sanders concedes she is not a surgeon or "disability" doctor. Further it does not appear that Ms. Sanders is a physician at all. The ALJ finds that whatever qualifications Ms. Sanders has to issue opinions concerning medical causation her opinion is not as persuasive as Dr. Fall's well reasoned opinion. Further, it does not appear that Ms. Sanders reviewed any of the contemporaneous medical records when formulating her opinion on causation.

41. The weight of the credible and persuasive evidence establishes that the claimant sustained 4% impairment of the right upper extremity. Dr. Fall and Dr. Santilli agreed the claimant sustained 4% impairment of the right upper extremity. The ALJ finds their opinions to be credible and persuasive on the issue of the degree of right upper extremity impairment.

42. Evidence and inferences contrary to these findings of fact are not credible and persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Generally, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201(1), C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201(1).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201(1). The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions.

BURDEN OF PROOF ON SCHEDULED INJURY

As an initial matter the parties disagree concerning which of them has the burden of proof regarding causation and what the standard of proof is. The respondents argue that the cause of the claimant's left upper extremity rotator cuff tear presents a "threshold issue" of "compensability" and the claimant bears the burden of proof to establish causation by a preponderance of the evidence. The claimant argues that the issue of "causation" is determined by the DIME physician. Therefore, the claimant asserts that the respondents have the burden to prove by clear and convincing evidence that the DIME physician incorrectly found the left shoulder rotator cuff tear was caused by the July 24, 2012 industrial injury.

The ALJ disagrees with the respondents' assertion that the cause of the claimant's left upper extremity impairment presents a "threshold" issue of fact for determination by the ALJ under the preponderance of the evidence standard. The respondents cite *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000), and *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002), as authority for their position.

Faulkner does not stand for the proposition that the issue of causation is always decided as a "threshold issue" under the preponderance of the evidence standard. Rather, *Faulkner* holds that where the issue was "whether claimant had sustained any compensable injury arising out of and in the course of her employment" the issue was determinable by the ALJ under the preponderance of the evidence standard. 12 P.3d at 846. The *Faulkner* court also acknowledged that where the issue involves a whole person impairment rating arising under § 8-42-107(8)(c), C.R.S., an "IME physician's opinion concerning the cause of a particular component of the claimant's overall impairment" must be overcome by clear and convincing evidence. *Faulkner* is distinguishable from this case because here the respondents have admitted that the claimant sustained an injury arising out of and in the course of her employment. Consequently, the ALJ is not called upon to make a "threshold determination" concerning the "compensability" of the claim and *Faulkner* is not controlling.

Similarly, *Cordova* is not authority for the proposition that the issue of causation is always decided by the ALJ under the preponderance of the evidence standard. To the contrary, *Cordova* expressly recognizes that determinations of MMI and whole person impairment inherently require a DIME physician to determine whether there is a causal relationship between a particular condition and the compensable injury. 55 P.3d at 189-190. Thus, when the issues involve MMI or the cause of whole person impairment the DIME physician's opinion regarding causation must be overcome by clear and convincing evidence. *Cordova* merely stands for the proposition that when the issue involves reopening based on an alleged worsening of condition the issue is beyond the purview of the DIME physician and the ALJ may determine the cause of the worsening under the preponderance of the evidence standard.

Nevertheless, the ALJ agrees with the respondents that under the circumstances of this case the claimant has the burden of proof to establish the cause of her left shoulder impairment by a preponderance of the evidence. It is well-established that scheduled impairment ratings and non-scheduled whole person impairment ratings are treated differently under the Act. Specifically, scheduled ratings are not subject to the DIME procedure which applies only to whole person impairment ratings assigned under § 8-42-107(8)(c), C.R.S. Section 8-42-107(8)(a), C.R.S.; *Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000); *Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998). It follows that when only a scheduled impairment rating is at issue the DIME physician's opinion concerning the cause of a particular component of the scheduled impairment is not entitled to presumptive weight. Rather, the claimant bears the burden of proof to establish by a preponderance of the evidence that he has sustained a particular scheduled impairment caused by the industrial injury. See *Maestas v. American Furniture Warehouse*, WC 4-662-369 (ICAO June 5, 2007) (where issue is the *extent of scheduled impairment* caused by the industrial injury claimant has the burden of proof by a preponderance of the evidence).

Here, the only issue presented at the hearing was whether the claimant sustained permanent scheduled impairments of the left and right upper extremities as a result of the admitted industrial injury on July 24, 2012. The claimant did not argue that the claimant's impairment should be rated as whole person impairment and did not dispute the DIME physician's MMI determination. Consequently the claimant has the burden of proof to establish by a preponderance of the evidence that her left shoulder impairment was caused the industrial injury.

CAUSE OF SCHEDULED LEFT SHOULDER IMPAIRMENT

The respondents argue that the claimant failed to establish by a preponderance of the evidence that the left shoulder rotator cuff tear was caused by the injury. Therefore, the respondents argue that the claimant is not entitled to a scheduled impairment rating for the left upper extremity. As noted above, the claimant has incorrectly argued that the respondents were required to overcome by clear and convincing evidence the DIME physician's finding that the claimant's left upper extremity impairment was caused by the industrial injury. The ALJ agrees with the respondents' position concerning the left upper extremity scheduled impairment.

Because the claimant did not even contend that she sustained functional impairment beyond the arm at the shoulder, the ALJ must determine whether the claimant proved by a preponderance of the evidence establishes that the left upper extremity scheduled impairment was caused by the injury. *Maestas v. American Furniture Warehouse, supra*.

As determined in Findings of Fact 35 through 40, a preponderance of the credible and persuasive evidence establishes that the claimant's left shoulder rotator cuff tear was probably not caused by the July 2012 industrial injury. Rather, the ALJ credits the opinions of Dr. Fall that the left rotator cuff tear was probably not caused by the industrial injury but instead by naturally occurring degeneration of the rotator cuff.

Dr. Fall persuasively opined that there is an insufficient temporal relationship between the occurrence of the injury on July 24, 2012 and the later development of left shoulder symptoms to infer a causal relationship between these events. For the reasons stated in Findings of Fact 37 through 40, the ALJ is not persuaded by the contrary opinions expressed by Dr. Otten, Dr. Santilli and Ms. Sanders. It follows the claimant failed to meet his burden of proof to establish that he is entitled to a scheduled impairment rating for the left shoulder.

RATING FOR SCHEDULED RIGHT SHOULDER IMPAIRMENT

The respondents argue that the parties are bound by the DIME physician's determination that the claimant sustained a 4% scheduled impairment of the right upper extremity. However, for the reasons stated above the ALJ concludes the DIME physician's opinion concerning the degree of a scheduled impairment is not entitled to any special weight under the Act. *Delaney v. Industrial Claim Appeals Office, supra*; *Egan v. Industrial Claim Appeals Office, supra*. Instead the claimant has the burden to prove the degree of impairment caused by the right shoulder injury. *Maestas v. American Furniture Warehouse, supra*.

In accordance with Finding of Fact 41 the credible and persuasive evidence establishes the claimant sustained 4% impairment of the right upper extremity. Consequently the insurer shall pay PPD benefits under § 8-42-107(2)(a), C.R.S., based on 4% impairment of the right upper extremity.

The ALJ notes that in her position statement the claimant asserts that the respondents are liable to pay for medical treatment of the left upper extremity. The ALJ recognizes that the claimant endorsed the issue of medical benefits in her response to the application for hearing. However, as determined in Finding of Fact 2 claimant's counsel did not raise any issue of medical benefits at the hearing despite a direct inquiry by the ALJ concerning what issues the claimant wished to raise. The ALJ considers claimant's counsel's representation to the court as an express waiver of consideration of any issue except PPD and a judicial admission that the claimant was not seeking an award of medical benefits as a result of the hearing. Therefore, the ALJ will not address the question of "medical benefits."

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Insurer shall pay the claimant interest at the rate of 8% per annum on compensation benefits not paid when due, if any.
2. Insurer shall pay permanent partial disability benefits based on a scheduled impairment of 4% of the right upper extremity.
3. Issues not resolved by this order are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 6, 2015

DIGITAL SIGNATURE:


David P. Cain
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-903-810-04**

ISSUE

The following issue was raised for consideration:

Whether Claimant sustained his burden of proof to establish by a preponderance of the evidence that he is entitled to an order for a change of physician.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered:

1. Claimant injured his low back while working for Employer on November 1, 2012.
2. After Claimant's injury, Claimant was sent to Dr. Robert Nystrom at Concentra Medical Center in Thornton, CO for ongoing care and treatment. Dr. Nystrom became Claimant's authorized treating provider and treated him from November 2012 through December 2013. Claimant resides in Thornton, CO.
3. Claimant failed conservative treatment on his low back and underwent a L5-S1 anterior and posterior lumbar fusion by Dr. Andrew Castro on October 31, 2013.
4. On or around December 2013, Dr. Nystrom left employment at the Concentra facility located in Thornton, CO and moved his practice to a Concentra facility in Greeley, CO. Claimant alleges that he requested to continue to treat with Dr. Nystrom and that his request was denied. Claimant further alleges that Respondents continued to deny Claimant's request to continue care with Dr. Nystrom and instead authorized Dr. Albert Hattem to take over care. Claimant's testimony regarding his request of Respondents to continuing treatment with Dr. Nystrom was not deemed credible or persuasive. Claimant did not establish the date(s) that he communicated his desire to continue care with Dr. Nystrom or the method by which he communicated that desire to Respondents. The only documentary evidence of Claimant's request for a change of physician came on September 24, 2014, when Claimant filed the application for a hearing on the issue of a change of physician.
5. Claimant began treating with Dr. Hattem in the Concentra Stapleton office on March 14, 2014. Dr. Hattem's practice includes focus on patients who have a delayed recovery and more complex cases. Claimant was referred to Dr. Hattem because of these issues. Throughout his course of treatment with Dr. Hattem, Claimant continued to treat with his surgeon, Dr. Andrew Castro. Claimant treated with Dr. Hattem between March 14, 2014, and October 6, 2014, when Dr. Hattem placed Claimant at Maximum Medical Improvement (MMI).

6. On March 14, 2014, Dr. Hattem recommended Claimant continue physical therapy two times per week at the Thornton clinic. On April 14, 2014, Claimant reported to Dr. Hattem that he does not like to take medication, but takes occasional Ibuprofen. Dr. Hattem noted in his report that Claimant declined medications at that visit. On May 12, 2014, Claimant reported to Dr. Hattem that he did not believe physical therapy was providing significant benefit. Thus, Dr. Hattem held off on prescribing additional physical therapy at that time.

7. Dr. Hattem deferred to Dr. Castro's clinical judgment as to whether Claimant was a candidate for an epidural steroid injection on June 23, 2014. Also, on that date, Dr. Hattem scheduled Claimant for a trial of swimming pool therapy. Dr. Hattem informed Claimant at that time that his case was approaching MMI. Dr. Hattem stated in his report that once swimming pool therapy and potential injections are completed, Dr. Hattem would assign an impairment rating.

8. Dr. Hattem continued to prescribe pool therapy in July and August 2014. Claimant underwent an epidural steroid injection with Dr. Sacha, and responded non-diagnostically. Dr. Hattem opined on August 18, 2014, that Claimant's condition remained the same and that Claimant's case was approaching closure.

9. Also, on August 18, 2014, Dr. Castro noted that Claimant reported no significant benefits from his recent injection. Dr. Castro opined that he could not account for Claimant's ongoing symptoms. Dr. Castro also opined that Claimant would not benefit from further surgical intervention. Dr. Castro recommended Claimant follow up one year from his surgery date in October 2014.

10. Respondents sent correspondence to Dr. Hattem on September 24, 2014, inquiring whether Claimant reached MMI. Dr. Hattem sent return correspondence on September 29, 2014, opining that Claimant was not yet at MMI, but that Claimant would likely be at MMI on September 30, 2014, when Claimant was scheduled to return to Dr. Hattem.

11. Claimant requested a change of physician on September 24, 2014, when he filed the application for hearing in this matter raising the issue of change of physician. Dr. Hattem placed Claimant at MMI on October 6, 2014. Dr. Hattem recommended maintenance medical care for Claimant, including a follow-up visit with Dr. Castro, and ongoing refills of Claimant's Ibuprofen for 9-12 months. Claimant has not returned to Dr. Hattem for his medication refills since Dr. Hattem placed Claimant at MMI and made this recommendation for maintenance care.

12. Claimant contends that his application for hearing on the issue of change of physician concerns the provisions of Section 8-43-404(5)(a)(V) which, provides, that if the authorized treating physician moves from one facility to another, or from one corporate medical provider to another, an injured employee may continue care with the authorized treating physician, and the original facility or corporate medical provider shall provide the injured employee's medical records to the authorized treating physician

within seven days after receipt of the request for medical records from the authorized treating physician. Here, Claimant contends that an order should be entered to permit him to treat with Dr. Nystrom. Despite the nine months of treatment with Dr. Hattem and Dr. Castro between December 2013 and October 2014, and the MMI determination made by Dr. Hattem on October 6, 2014, Claimant contends that under Section 8-43-404(5)(a)(V) he should now be permitted to return to Dr. Nystrom for maintenance treatment.

13. Respondents filed a Final Admission of Liability on December 10, 2014, admitting for reasonable, necessary and authorized maintenance care.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are reached:

1. The purpose of the Workers' Compensation Act of Colorado (Act), Section 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

3. In this case, Claimant raises the issue of change of physician. Claimant relies on the provision of section 8-43-404(5)(a)(V) arguing that he only need prove that Dr. Nystrom was the authorized treating physician and that Claimant requested that he be permitted to continue care with Dr. Nystrom after the doctor's departure from the Thornton office.

4. However, by contrast, Respondents take the position that this case is one addressing a claimant's request to change physicians under Section 8-43-404(5)(a)(III)

and (IV). Respondents argue that an ALJ holds substantial discretion in determining whether a claimant has made a showing sufficient to authorize a change of physician. *Hoefner v. Russell Stover Candies and Sentry Insurance Company*, (W.C. No. 4-541-518, December 13, 2002). In *Hoefner*, the court held that a breakdown in the doctor-patient relationship may be sufficient to warrant a change of physician to assist in the claimant's recovery. The *Hoefner* court denied the claimant's change of physician request because it found that the authorized treating physician (ATP) rendered a comprehensive course of treatment that included diagnostic procedures, prescription medication, and physical therapy. *Id.*

5. Here, it is concluded that Claimant has not made a proper showing to support his request for a change of physician either under Section 8-43-404(5)(a)(V) or under Sections 8-43-404(5)(a)(III) and (IV). The evidence established that Claimant let nine months elapse between Dr. Nystrom's departure and his request to change physicians pursuant to Section 8-43-404(5)(a)(V). During that nine months, Claimant received care from Dr. Hattem and Dr. Castro regularly and medical notes do not reflect a request from Claimant to return to Dr. Nystrom. The evidence established that it was only as Dr. Hattem started reporting in the medical records that Claimant was approaching MMI that Claimant filed the application for hearing on the change of physician issue.

6. Further, under the change of physician provisions found in Section 8-43-404(5)(a)(III) and (IV) there was no credible or persuasive evidence presented at hearing that rises to the level of a proper showing justifying an order to change physicians. Instead, it is concluded that the authorized treating physicians for Claimant rendered a comprehensive course of treatment that included diagnostic procedures, injections, prescription medication, surgery and physical therapy. No credible or persuasive evidence was presented that Claimant had a breakdown in the therapeutic relationship with Dr. Hattem or that there was any other reason to conclude that Claimant could not recover from his injury under the care of Dr. Hattem. And, it is further concluded that Claimant did not establish that he made a timely request to change physicians in writing in the manner defined by statute.

ORDER

It is therefore ordered that:

Claimant's claim for a change of physician is denied and dismissed.

All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: ___May 7, 2015_____

DIGITAL SIGNATURE:


Margot W. Jones, Administrative Law
Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant established by a preponderance of the evidence that medical appointments and associated treatment with Dr. Meggan Grant-Nierman on February 2, 2015, and February 11, 2015, were reasonably necessary to relieve the effects of the March 16, 2013, industrial injury or prevent further deterioration of Claimant's condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988).
2. Whether Claimant established by a preponderance of the evidence that a general award of maintenance medical benefits is reasonably necessary to relieve the effects of her March 16, 2013, industrial injury or prevent further deterioration of her condition pursuant to *Grover v. Industrial Comm'n.*, 759 P.2d 705 (Colo. 1988).

FINDINGS OF FACT

Having considered the evidence presented at hearing, the Judge enters the following Findings of Fact:

1. Claimant works in Employer's dairy department in Salida, Colorado. She injured her back and left shoulder on March 16, 2013, while working with crates filled with containers of milk weighing 48 pounds in total. Each crate contained six gallon milk containers weighing eight pounds each. On the date of injury, seven crates, each one filled with gallon milk containers, were stack on each other and Claimant was retrieving the top crate.

2. Claimant presented at the emergency room at Heart of the Rockies Regional Medical Center on March 16, 2013, after her injury. The emergency room personnel noted Claimant, "...States that this afternoon at work she was lifting some milk crates when she hurt her back. States lifting/twisting motion. Symptoms have been increasing in severity throughout the night. [Patient] comes to the RN station appearing in extreme pain." It was also noted that Claimant had "Left sided traumatic flank pain, now pain into her left shoulder." The emergency room physician diagnosed low back pain. Claimant was given medications and instructed to follow-up with a physician.

3. Claimant received primary care for her work injury at First Street Family Health. She saw Dr. Joel Schaler on March 18, 2013. He reported, "...She works at

Safeway and was unloading crates of gallon milk containers. They wer [sic] stacked 7 high instead of the usual 5 high and each one weighs about 48 lbs. When she pulled off the top level and brought to the ground she experienced a sharp pain in the left mid back and shoulder. It hurts to sneeze, laugh, cough, and move. It hurts to sleep on her left side.” Dr. Schaler noted Claimant was “Tender over the AC joint region and upper pectoralis major...Tenderness along the lower left parathoracic musculature...” He diagnosed “sprain of unspecified site of back; sprains and strains of shoulder and upper arm.” Dr. Schaler prescribed medications, took Claimant off work, and recommended physical therapy.

4. Respondent admitted liability for Claimant’s March 16, 2013, work injury.

5. Claimant saw Dr. Meggan Grant-Nierman at First Street Family Health on March 20, 2013. First Street Family Health is an authorized medical provider. Dr. Grant-Nierman noted Claimant had recently been light headed, with shortness of breath. Claimant reported also being dizzy, pale, and “sweating with clamminess.” The doctor noted claimant “...Has been having a low grade fever from 99-101 each night for the last two weeks (even before the accident).” Dr. Grant-Nierman diagnosed hypoxemia and dyspnea, and recommended Claimant be admitted to the hospital. She was concerned about a potential pulmonary embolism or pneumonia, “...both of which can present with pleuritic chest pain, hypoxemia, fever, and tachycardia.”

6. Claimant was transported by Flight for Life to Penrose St. Francis Hospital in Colorado Springs. She was admitted on March 21, 2013. The history and physical report reflects that Claimant had a fever of 99-101.2 degrees typically in the evenings over the past two weeks. It also reflected that, on Saturday, 5 days prior to admission, Claimant injured her back at work. The report further reflects that Claimant works at a dairy and she was taking a crate from a high level down to a lower level and strained her lower back. The pain has been in the left flank area and it hurts to twist, bend, and move. In the “review of symptoms” section, the doctor noted, “...She is short of breath with pleuritic chest pain as above.” The admitting doctor diagnosed “acute respiratory failure. I think this is likely secondary to infection with pneumonia,” and also diagnosed “Sepsis syndrome. Likely has sepsis syndrome secondary to pneumonia.”

7. In a report dated March 21, 2013, Dr. Clyde Williams noted, “...The patient has a history of having fevers to 101 for 2 weeks, particularly at night and then she developed a left-sided chest pain about 4 days ago, which became progressive. She went to the hospital and was given an analgesic and anti-inflammatory agents. The next day because of the lack of improvement she went to see her doctor. He, likewise, apparently give [sic] her anti-inflammatory agents. Yesterday because of feeling so poorly she went to emergency room and was found to have an abnormal chest x-ray, and abnormal lab...Because of the concern about sepsis she was transferred to Penrose Hospital...” Dr. Williams diagnosed “Left-sided pneumonia with probable early sepsis with renal impairment, and elevated liver enzymes...”

8. Claimant was discharged from Penrose on March 31, 2013, with diagnoses including: “status post septic shock secondary to pneumonia; empyema; and

status post thoracotomy, chest tube placement, pleural decortication, and evacuation of empyema on March 26, 2013.” Claimant fully recovered from the effects of those problems approximately four months later. Claimant credibly testified that the symptoms she experienced as a result of her pneumonia and its complications were different, in both quality and duration, from the symptoms she experienced as a result of her work injury.

9. Claimant returned to First Street Family Health for treatment of her work injury. On May 16, 2013, Dr. Grant Nierman reported, “Follow up on left upper back and shoulder strain. Original injury was complicated by the development shortly after of pneumonia and sepsis. That has resolved and she is feeling better bit [sic] she continues to have pain in the left upper back inferior to the scapula and the left shoulder and neck. She says the whole area feels tight.” The doctor diagnosed “sprains and strains of shoulder and upper arm; sprain of unspecified site of back.” She recommended physical therapy.

10. Respondent arranged for Claimant to be examined by Dr. Mark Paz on September 17, 2013. Dr. Paz opined Claimant did not sustain a work-related injury. He opined that most, if not all, of Claimant’s work injury related symptoms were causally related to the left lower lobe pneumonia diagnosed on March 20, 2013. The ALJ finds this opinion not credible or persuasive.

11. Claimant participated in physical therapy beginning October 25, 2013. On that date, the therapist noted the reason for referral was, “...Pt injured @ work, lifting 6 gallons of milk from too high position; immediately noted ‘excruciating’ pain from R neck to L LB. Cont to experience sx’s in upper thoracic and LB...” The therapist noted: “...Plan of care developed and skilled treatment recommended for addressing injuries sustained while trying to lift 48# from too high @ work back in March. [Patient with] thoracic, cervical and SIJ pain...Primarily will address soft tissue dysfunction and chronic positioning while at work...”

12. On November 4, 2013, the therapist noted, “Pt reports SIJ pain is less w/past few visits in PT; educated on position of sacrum, ligaments, ms, etc...”

13. On November 19, 2013, the therapist noted, “...Feeling bad this afternoon after a full, heavy day at work due to holiday season coming up. Discuss w/pt re: prognosis for improvement limited if she continues to lift, carry, etc. at the current level...”

14. Dr. Grant-Nierman saw Claimant on January 22, 2014, and reported, “Has been doing PT for the back from the work comp episode back in March. PT is helping her she has one more appt with PT authorized at this point. Still working with a lot of heavy lifting at her job and still has quite a bit of upper thoracic pain but she is working through it, she is working with PT and doing home exercises at home. Feels she is making progress.” Dr. Grant-Nierman noted Claimant was “positive for paraspinal muscle tenderness.” She noted the treatment plan was “can do another few months of PT since she is seeing improvement but not completely there yet.”

15. On March 28, 2014, the therapist reported, "...Pt making good gains toward goals and decreasing pain; have scheduled two more visits spaced further apart to assess carryover."

16. Claimant attended her final physical therapy session on April 7, 2014, at which time the therapist noted, "...Last approved appt; pt continues to feel pain 0/10, but voicing apprehension over complete d/c from therapy. Told pt if she experiences an increase or relapse, to just communicate this at work..." The therapist contemplated the possibility that Claimant's symptoms could increase or relapse subsequent to discharge.

17. On April 22, 2014, Dr. Grant-Nierman noted Claimant's pain level was down and that she was feeling better. The doctor placed Claimant at maximum medical improvement (MMI) but indicated she should follow-up as needed, contemplating that Claimant should return to her for more treatment if it was needed.

18. Following MMI, Claimant continued performing a home exercise program, utilizing the techniques she was taught in physical therapy. However, she continued to experience pain and difficulty with the effects of the work injury. These problems were particularly noticeable during busy times at work, such as during holiday seasons. Claimant did not sustain a new injury.

19. Claimant underwent a Division independent medical examination (DIME) with Dr. Anjmun Sharma on September 9, 2014. He determined Claimant reached MMI on that date. He issued an 11% whole-person impairment rating for the injury to Claimant's lumbar spine. He opined that "...At this point in time, the patient does not require any maintenance care

20. Respondent filed a Final Admission of Liability on October 29, 2014 admitting liability consistent with Dr. Sharma's findings, but denying liability for medical benefits after MMI.

21. Claimant eventually found the residual effects of her work injury no longer manageable by herself and she returned to Dr. Grant-Nierman on February 2, 2015. She returned pursuant to Dr. Grant-Nierman's recommendation at MMI that Claimant should "follow-up as needed." The doctor noted this visit was in follow-up pertaining to the Claimant's work injury in March 2013. The doctor reported that Claimant's back pain was "miserable again." Claimant reported to the doctor that she has felt good doing physical therapy and now without physical therapy she has back pain at night and is not able to stay asleep. Claimant reported her back pain was at a 5 on a scale of 0 to 10 points. The doctor noted Claimant's shoulder range of motion was normal, but that "Traps paraspinals are very tender." Claimant was again diagnosed with a sprain of the back and the shoulder. The doctor recommended Flexeril medication and another round of physical therapy, but this time with dry needling. She recommended Claimant return for osteopathic manipulations and trigger point injections in order to relax some of the affected region.

22. Respondent arranged for Claimant to be examined by Dr. Paz again on February 10, 2015. Dr. Paz opined Claimant does not require medical maintenance subsequent to the date of MMI.

23. On February 11, 2015, Dr. Grant-Nierman noted, "Trigger points and pains/myalgias in the left upper shoulder / traps worsening over last several months, has done some massage and PT as well. Scheduled to do some dry needling in future." On examination, the doctor noted "TART changes in the entire left side paraspinal muscles in spasm with thicker ropey texture, tender up in the left trap there are several trigger points and tender spots and there is one just below the lower border of the scapula in the paraspinal muscle region." Dr. Grant-Nierman performed osteopathic manipulations and injections. She recommended heat and stretching, and to follow up with physical therapy for dry needling.

24. Respondent denied liability for the treatment Claimant received from Dr. Grant Nierman on February 2 and February 11, 2015. Claimant found that treatment beneficial in relieving the effects of her work injury, and she wishes to continue receiving post-MMI medical treatment from Dr. Grant-Nierman. The treatment Dr. Grant-Nierman provided on February 2 and February 11, 2015, and her recommendation for additional treatment, constitutes substantial evidence of Claimant's need for post-MMI medical treatment.

25. Dr. Paz testified at hearing. He testified it was still his opinion that Claimant did not suffer a work related injury, and that most, if not all, of Claimant's symptoms are attributable to the effects of pneumonia for which she was treated shortly after the industrial injury. He testified Claimant does not require any treatment after MMI. In light of the overwhelming medical evidence confirming that Claimant sustained an industrial injury on March 16, 2013, combined with the fact that Respondent admitted liability for that injury, the ALJ finds Dr. Paz' opinion that there was no work injury not credible and not persuasive. Because Dr. Paz is of the opinion that there was no work injury in the first place, it is logical to assume he would also hold the opinion, that Claimant requires no treatment after she reached MMI for such an injury. The ALJ finds that opinion not credible and not persuasive.

26. Claimant testified regarding her injury, her symptoms, the medical treatment she received, and her need for treatment after MMI. She testified regarding the pneumonia that was diagnosed and treated shortly after the work injury. She explained how the symptoms resulting from her work injury were different from the symptoms she experienced as a result of the pneumonia. Claimant testified regarding the beneficial effects of the post-MMI treatment provided by Dr. Grant-Nierman. The ALJ finds Claimant's testimony credible and persuasive.

27. The ALJ finds there is substantial evidence in the record supporting the reasonableness and necessity for future medical treatment. The ALJ finds Claimant has proved by a preponderance of the evidence she is entitled to a general award of post-MMI medical benefits.

CONCLUSIONS OF LAW

Having entered the foregoing findings of fact, the following conclusions of law are reached:

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S., *et seq.*, is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P. 3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. Claimant seeks an order finding that she established by a preponderance of the evidence that she is entitled to an general award of maintenance medical benefits. Specifically, Claimant seeks an order finding that Respondents are liable for treatment rendered by Dr. Grant Nierman on February 2 and February 11, 2015. Respondent contends that Claimant has no need for maintenance medical benefits because her condition and symptoms were not caused by the work incident, but were related to her pneumonia and sepsis syndrome.

5. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant requires periodic maintenance care to prevent further deterioration of his physical condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that a claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999); *Stollmeyer v. Industrial Claim*

Appeals Office, 916 P.2d 609 (Colo. App. 1995). Section 8-42-101, C.R.S., thus authorizes the ALJ to enter an order for future treatment if supported by substantial evidence of the need for such treatment. *Grover v. Industrial Commission*, *supra*.

5. In *Milco Construction v. Cowan*, 860 P.2d 539 (Colo. App. 1992), the Court of Appeals established a two-step procedure for awarding ongoing medical benefits under *Grover v. Industrial Commission*, *supra*. The court stated that an ALJ must first determine whether there is substantial evidence in the record to show the reasonable necessity for future medical treatment. If the claimant reaches this threshold, the court stated that the ALJ should enter a general order, similar to that described in *Grover*.

6. Claimant proved by a preponderance of the evidence that she is entitled to an award of maintenance medical treatment to relieve the effects of her industrial injury or prevent future deterioration of her condition. Substantial evidence showing the need for future medical treatment consists of Claimant's testimony regarding such treatment, as well as Dr. Grant-Nierman's recommendations for, and provision of, such treatment. Opinions to the contrary are rejected as unpersuasive.

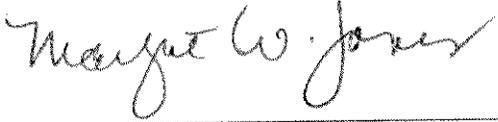
ORDER

The Judge orders, as follows:

1. Respondent shall pay for all of Claimant's reasonably necessary medical treatment by authorized providers after MMI. This includes the treatment Claimant has already received at First Street Family Health after MMI.
2. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 5, 2015

DIGITAL SIGNATURE:


Margot W. Jones, Administrative Law
Judge
Office of Administrative Courts
1525 Sherman St. 4th Floor
Denver, CO 80203

ISSUES

- Did the respondents prove by a preponderance of the evidence that the failure of claimant's counsel to appear at a hearing scheduled for October 1, 2014 constituted a "waiver" of the claimant's right to contest the issue of permanent partial disability benefits?
- Must a Division-independent medical examiner's opinion that a pre-injury medical impairment was "independently disabling" at the time of a subsequent industrial injury be overcome by clear and convincing evidence in order to avoid apportionment under § 8-42-104(5)(b), C.R.S.?
- Does a preponderance of the evidence establish that the claimant's pre-injury medical impairment was not "independently disabling" at the time of the industrial injury so as to preclude apportionment under § 8-42-104(5)(b), C.R.S.?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. At the hearing Claimant's Exhibits 1 through 5 and 10 through 13 were admitted into evidence. Respondents' Exhibits A through O were received into evidence.
2. On March 26, 2013 the claimant sustained an admitted industrial injury while performing his job as a forklift operator.
3. The claimant credibly testified that he was driving the forklift onto an elevator when the elevator door malfunctioned causing the forklift to come to an abrupt halt. The abrupt stop caused the forklift to tip forward and "ejected" the claimant upwards into the role cage where he struck the top of his head.
4. The claimant testified as follows concerning his neck problems prior to March 26, 2013. He began to experience neck pain in 2009. This neck pain came on "naturally" and did not result from an accident. In 2011 he underwent a "three-level" surgical procedure that was not a fusion. On October 29, 2012, five months prior to the industrial injury, he underwent a two-level cervical fusion. The claimant explained that he chose to undergo this surgery because his doctor told him he might be paralyzed if he had an automobile accident. As a result of the cervical fusion surgery he was off work approximately 3 months or until late January 2013. He then returned to work performing light-duty office work. Later he returned to full duty driving a forklift. Although somewhat uncertain, the claimant estimated that he performed full duty for

approximately one month prior to the March 26, 2013 industrial injury. On March 26 he was not under any work restrictions. At the time of the March 26 injury the claimant was working 40 hours per week plus overtime on the weekends.

5. The claimant testified that he was feeling “pretty good” after the October 2012 fusion surgery and was not worried about returning to work. He estimated his neck pain was in the range of 2-3/10 just prior to the March 26, 2013 injury. He opined that even though he had some residual neck pain after the cervical fusion surgery it was not causing any “disability” immediately prior to the March 26 injury. The claimant also opined that immediately prior to the March 26 injury he could have found other employment as a forklift driver if the employer had laid him off. Since the March 26 injury the claimant stated that he experiences neck pain in the 7-8/10 range every day. Despite this pain he has returned to work at regular duty. The claimant testified that after the March 26 injury the employer told him he would be terminated him if he did not return to work.

6. On January 18, 2010 the claimant underwent cervical MRI. The radiologist noted multilevel degenerative cervical changes with up to moderate central canal narrowing most pronounced at the C5-6 and C6-7 levels. There was also neural foraminal narrowing most pronounced bilaterally at C5-6 and on the right side at C3-4.

7. On January 28, 2010 the claimant underwent flexion and extension x-rays of the cervical spine. Dr. Stuart Kassan, M.D., reviewed the x-rays and noted mild degenerative changes in the mid and lower cervical spine.

8. On February February 25, 2010, Dr. Kassan noted the claimant was to see a Dr. Wong concerning spinal injections to identify which levels of the spine were most symptomatic. Dr. Kassan assessed cervical spine degenerative disc disease.

9. On March 12, 2010 Cliff Gronseth, M.D., examined the claimant for consideration of an epidural steroid injection. Dr. Gronseth assessed multilevel cervical disc degeneration. He performed a cervical interlaminar epidural steroid injection at C5-6.

10. On March 22, 2010 the claimant underwent a physical medicine examination by David Tanner, M.D. The claimant reported his neck pain was worsening. The frequency of pain was daily and reportedly interfered with the claimant’s “home activities and work.” Thereafter the claimant continued to undergo treatment including various injections.

11. On August 20, 2010 the claimant was seen by rheumatologist Judy Weiss, M.D., for evaluation of arthritis. The claimant reported pain in his hands, wrists, elbows shoulders, hips, left knee, ankles and feet. He also reported neck pain. At this time the claimant stated he was working long shifts in the employer’s brewery up to six days per week. Dr. Weiss opined the claimant sounds as if he could have rheumatoid arthritis.

12. On April 21, 2011 Michael D. Weiss, D.O., of Laser Spine Institute performed surgery described as destruction by thermal ablation of the paravertebral facet joint nerves at bilateral C4-5, right C5-6, and bilateral C6-7. The claimant also underwent a laminotomy and foraminotomy including partial facetectomy with decompression of the left nerve root at C5-6.

13. On August 26, 2011 the claimant advised Dr. Judy Weiss that he was still experiencing significant pain in his neck but was doing "much better in general."

14. On December 8, 2011 John Lankenau, M.D., and Shasta Vansickle, PA-C, evaluated the claimant for his neck pain of 18 months' duration. Dr. Lankenau noted that claimant had a laser surgery at C5-6 earlier in the year. Dr. Lankenau reviewed a cervical MRI and noted that it showed the claimant has congenitally short pedicles and is congenitally tight throughout his cervical spine. Dr. Lankenau also noted foraminal stenosis at C6-7 on the right and moderate stenosis at C3-4 on the right. At C5-6 there was a disk bulge contributing to the foraminal stenosis. Dr. Lankenau assessed multilevel cervical disc degeneration primarily at C5-6, foraminal stenosis at C5-6 bilaterally, left side greater than right, right-sided foraminal stenosis at C6-7 and right-sided foraminal stenosis at C3-4, neuritis and radiculitis of the cervical region, neck pain, and rheumatoid arthritis. Dr. Lankenau recommended additional injections or surgical options.

15. On October 29, 2012 Dr. Lankenau performed a two-level fusion surgery at C5-6 and C6-7. Dr. Lankenau noted the indications for the surgery included an increasing history of cervical radiculopathy dating back several years and the failure of conservative treatment. Dr. Lankenau also cited the most recent MRI results. Dr. Lankenau noted the claimant opted for surgical intervention based on continued symptoms and the failure of conservative treatment.

16. On January 3, 2013 Dr. Judy Weiss noted that the claimant had undergone a cervical fusion and was still experiencing "significant neck pain."

17. On January 3, 2013 Dr. Lankenau examined the claimant at Pinnacle Orthopedics. The claimant advised Dr. Lankenau that he still had neck pain, particularly after physical therapy. Dr. Lankenau opined that overall the claimant was "doing relatively well given how long he had his symptoms prior to surgery."

18. The medical records contain a note from Pinnacle Orthopedics dated February 28, 2013. (Claimant's Exhibit 1). The note contains no signature and the ALJ is unable to determine the author of the note. The notes states the claimant has returned to work and continues in physical therapy. The claimant reported that his neck pain and his arm strength were improved. The claimant's only complaint involved the right knee.

19. On March 26, 2013 the claimant was seen by Anne Schuller, PA-C at the employer's medical clinic. PA Schuller recorded a history of "work related injury." She assessed "cervicalgia."

20. PA Schuller again examined the claimant on April 2, 2013. The claimant reported that his neck pain persisted after he was seen on March 26, 2013. PA Schuller also noted a history of "Cspine fusion 4 months ago." The claimant reported that he was seen by Dr. Lankenau on April 2 and was told his "fusion graft [was] fractured." PA Schuller assessed a cervical strain and an abrasion on the scalp. She imposed restrictions of no driving forklifts, no kneeling, squatting or crawling and no lifting, carrying pushing and pulling in excess of 5 pounds.

21. Philip Smaldone, M.D., examined the claimant at the employer's clinic on April 19, 2013. The claimant reported he was essentially symptom free except at the extremities of right and left rotation at the cervical spine. Dr. Smaldone assessed a "neck strain" and nonunion versus fracture of the C5 graft. The claimant requested to return to work without restrictions on April 22, 2013 and Dr. Smaldone stated this would be appropriate given his clinical status.

22. The claimant underwent a cervical CT scan on May 13, 2013. This scan was apparently ordered by Dr. Smaldone. The CT scan revealed an uncomplicated anterior interbody fusion at C5-6 and C6-7. The scan showed that there was no fracture or other acute osseous abnormality and no alignment abnormality.

23. On June 18, 2013 Mark C. Watts, M.D., examined the claimant for a "routine neurosurgical followup." Dr. Watts noted he was examining the claimant because Dr. Lankenau was not currently available. Dr. Watts recorded a history that clinically the claimant did well after the October 2012 fusion and "returned to normal function." However the claimant was again injured in the forklift accident of March 26, 2013. The claimant reported neck pain up to the base of the skull. Dr. Watts stated that Dr. Lankenau had diagnosed a fracture based on x-ray. Dr. Watts reviewed the CT scan and opined there were "some elements that could potentially represent fracture, but this is so far out from the initial event, the fractures would likely be healing." Dr. Watts opined the claimant was "doing really well" but it was "uncertain how completely he recovered."

24. On August 28, 2013 Dr. Smaldone again examined the claimant. The claimant reported neck pain down the midline and trapezius pain with rotation of the head. This pain reportedly radiated down the bilateral upper back from the neck with flexion. The claimant also reported occasional left lateral arm numbness. The claimant stated that he could "perform the full function of his job with 6/10 pain." Dr. Smaldone placed the claimant at maximum medical improvement (MMI) and referred the claimant to Gary Zuehlsdorff, D.O., for an impairment rating.

25. On September 13, 2013 Dr. Zuehlsdorff examined the claimant for the purpose of assigning an impairment rating. Dr. Zuehlsdorff took a history from the claimant, reviewed medical records commencing with the March 26, 2013 date of injury and performed a physical examination. The claimant told Dr. Zuehlsdorff that he had worked for the employer for 36 years "first as a mechanic and now as a packaging specialist for over 20 years." Dr. Zuehlsdorff noted that in "November 2012" [sic] the claimant had undergone a two level fusion at C5-6 and C6-7 "that was a nonwork-

related incident.” The claimant told Dr. Zuehlsdorff that after the fusion surgery and prior to the March 26, 2013 industrial injury he “recovered to a level of about 3/10 neck pain with no longer any arm symptoms.” On September 13, 2013 the claimant reported his pain level was 7/10 and he was experiencing numbness in his right and left fourth and fifth fingers. The claimant also reported that he “was at his full-duty position and feels capable of remaining so.”

26. Dr. Zuehlsdorff assessed the claimant with the following conditions: (1) Head contusion with secondary cervical strain; (2) Past surgical history of cervical spine two-level fusion at C5-6 and C6-7 ACDF in November of 2012 [sic] with chronic pre-existing low level pain of 3/10 in the cervical region with elimination of bilateral upper extremity dysesthesias; (3) Subjective complaints of continuing pain at approximately 7/10 with bilateral upper extremity intermittent dysesthesias in the bilateral index and fifth fingers since date of work injury; (4) X-rays and MRI possibly concerning for a fracture but no definitive diagnosis of same.

27. Dr. Zuehlsdorff concurred with Dr. Smaldone that the claimant was at MMI.

28. Dr. Zuehlsdorff performed an impairment rating using the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides) and Division of Workers’ Compensation (DOWC) guidelines for apportionment of impairment. Dr. Zuehlsdorff determined that the claimant had 15% whole person impairment based on cervical range of motion (ROM) deficits. However, using DOWC guidelines he determined that 14% of the ROM impairment should be apportioned out to the non-industrial two-level fusion. Thus, Dr. Zuehlsdorff assigned 1% ROM impairment for the March 26, 2013 industrial injury. Dr. Zuehlsdorff also assessed 17% whole person impairment for specific disorders of the spine under Table 53 of the AMA Guides. However, Dr. Zuehlsdorff apportioned out 11% of the Table 53 rating based on the prior non-industrial fusion surgery. Thus, Dr. Zuehlsdorff assigned 6% whole person impairment as the specific disorder rating attributable to the March 26, 2013 industrial injury. Dr. Zuehlsdorff opined that claimant’s total impairment attributable to the March 26, 2013 work injury was 7% whole person impairment. Dr. Zuehlsdorff explained that under the DOWC guidelines apportionment was proper because the claimant had “pre-existing pain and discomfort from the previous injury, although non-work-related.”

29. The claimant underwent a Division-sponsored independent medical examination (DIME) performed by Susan Santilli, M.D. Dr. Santilli issued a DIME report on February 26, 2014. Dr. Santilli took a history from the claimant, reviewed medical records from both before and after the March 26, 2013 date of injury and performed a physical examination. The claimant reported to Dr. Santilli that on March 26, 2013 he was “performing his usual job” for the employer when he hit his head on the top of the forklift resulting in immediate pain. The claimant advised Dr. Santilli that after the neck surgery in October 2012 he had been doing well, was working full duty and was off pain medication. Prior to the March 26 injury the claimant rated his pain at 2/10. On February 26, 2014 the claimant rated his pain at 7/10 “which is where the pain level was

right after the [March 2013] work injury.” The claimant reported he was experiencing bilateral neck pain, numbness and tingling into the lateral two fingers on both hands and down both arms.

30. Dr. Santilli assessed the claimant with the following conditions: (1) Cervical strain with head contusion; (2) Past surgical history of cervical fusion at C5-6 and C6-7; (3) Possible cervical fracture at graft, but no definitive diagnosis of same has been made; (4) History of chronic neck pain and polyarthralgias.

31. Dr. Santilli opined the claimant reached MMI on September 13, 2013.

32. Dr. Santilli performed an impairment rating using the AMA Guides and Division of Workers’ Compensation (DOWC) guidelines for apportionment of impairment. Dr. Santilli determined that the claimant had 16% whole person impairment based on cervical ROM deficits. However, using DOWC guidelines she determined that 14% of the ROM impairment should be apportioned out to the non-industrial two-level fusion. Thus, Dr. Santilli assigned 2% ROM impairment for the March 26, 2013 industrial injury. Dr. Santilli also assessed 17% whole person impairment for specific disorders of the spine under Table 53 of the AMA Guides. However, she apportioned out 11% of the Table 53 rating based on the prior non-industrial fusion surgery. Thus, Dr. Santilli assigned 6% whole person impairment as the specific disorder rating attributable to the March 26, 2013 industrial injury. Dr. Santilli opined that claimant’s combined impairment rating attributable to the March 26, 2013 work injury was 8% whole person impairment. If the rating had not been apportioned Dr. Santilli indicated the claimant’s overall combined impairment rating is 30% whole person.

33. On March 12, 2014 Ellen K. Oakes, OTR of the Division of Workers’ Compensation (DOWC) Medical Services Delivery Section Independent Medical Examination Program sent to Dr. Santilli an Incomplete Notice – IME Report as well as a letter. The letter noted that Dr. Santilli had apportioned the claimant’s impairment rating based on a “previous non-work related condition.” The letter reminded Dr. Santilli that for cases with dates of injury on or after July 1, 2008 there were changes to Rule 12 requiring a rating physician to “establish that the injury meets certain criteria in order to qualify for apportionment.” Specifically Dr. Santilli was advised as follows: “These criteria [for apportionment] include the fact that the previous condition to the same body part was identified and treated, met the criteria for permanent impairment and was independently disabling at the time of the current injury.” Dr. Santilli was directed to clarify her apportionment and complete an apportionment worksheet.

34. On March 17, 2014 Dr. Santilli completed a “Division Independent Medical Examination Addendum” (Addendum). In the Addendum Dr. Santilli acknowledged the DOWC’s request for clarification of her apportionment of the claimant’s impairment rating. Dr. Santilli wrote that the claimant underwent a two-level fusion prior to the industrial injury and this “previous condition” was to the same body part (as the industrial injury), was identified and treated and was “independently disabling at the time of the current injury.” In support of the decision to apportion Dr. Santilli stated that prior to the March 26, 2013 industrial injury the claimant had ongoing neck pain that he rated

as 2/10. After the industrial injury the claimant reported constant 7/10 pain despite “working full duty as he did prior to the injury.” Dr. Santilli wrote that the “change in [the claimant’s] subjective pain reports has not caused a change in his work duty capacity.” Dr. Santilli reiterated that the claimant’s overall impairment is 30% whole person, but the apportioned rating for the industrial injury is 8% whole person impairment. Dr. Santilli included an Apportionment Calculation Guide and marked a box stating the claimant’s “previous condition was non-work related and was disabling.”

35. On July 31, 2014, Dr. Edwin Healey performed a medical records review at the request of the claimant. Dr. Healey is board certified in occupational medicine and neurology and is level II accredited. Dr. Healey’s review of the records included Dr. Zuehlsdorff’s impairment rating as well as Dr. Santilli’s DIME report and the Addendum. Dr. Healey was requested to address the issue of whether or not the apportioned impairment ratings issued by Dr. Zuehlsdorff and Dr. Santilli “are appropriated based on Rule 12-3B” promulgated by the DOWC. After reviewing the medical records Dr. Healey opined as follows:

Based on the Rule 12-3B, it is my opinion with a reasonable degree of medical probability, there should be no apportionment of the 30 percent whole person impairment provided by Dr. Santilli in the Division IME of 2/26/14 because [the claimant] did have a prior non-work related injury and even though he was still symptomatic, he was working without restrictions and was not disabled at the time of his 3/26/13 work injury. [The claimant] does meet the criteria for awarding an Impairment Rating for his 3/26/13 work injury without apportionment based on the current Workers Compensation Law and specifically Rule 12-3B.”

36. On May 20, 2014 the respondents filed a Final Admission of Liability (FAL). The FAL admitted for permanent partial disability (PPD) benefits based on Dr. Santilli’s apportioned impairment rating of 8% whole person.

37. A preponderance of the credible and persuasive evidence establishes that the claimant’s pre-injury neck condition, for which he underwent neck fusion surgery in October 2012, was not “independently disabling” at the time of the March 26, 2013 industrial injury. Specifically, the claimant’s condition prior to March 26, 2013 probably did not impair his capacity to meet personal, social or occupational demands.

38. Dr. Healey’s opinion that the claimant was not “disabled” by his pre-existing condition at the time of the March 26, 2013 industrial injury is credible and persuasive. Dr. Healey correctly pointed out that the claimant had returned to work without restrictions by March 26, 2013. He persuasively opined that the claimant’s ability to return to work prior to March 26 demonstrates that whatever symptoms he continued to experience from the prior condition did not disable him from performing his employment without limitation.

39. Dr. Healey's opinion that the claimant was not "disabled" by the prior condition as of March 26, 2013 is corroborated by the claimant's credible testimony. The claimant credibly testified that prior to the March 26 injury his pain level was at 2-3/10, that he had returned to full duty as forklift driver and was not under any work restrictions.

40. The ALJ infers from the claimant's credible testimony that by March 26, 2013 the residual symptoms caused by the claimant's preexisting neck condition were not limiting his ability to meet the physical demands of his employment or life in general. This inference is corroborated by the claimant's reports to various medical providers. Specifically, the February 28, 2013 note from Pinnacle Orthopedics noted the claimant's neck pain and arm strength were improved and his "only complaint" involved the right knee. On June 18, 2013 Dr. Watts noted the claimant did well and "returned to normal function" after the October 2012 fusion surgery. On October 13, 2013 the claimant told Dr. Zuehlsdorff that after the fusion surgery he "recovered" to a "level of 3/10 neck pain with no longer any arm symptoms." The claimant also advised Dr. Zuehlsdorff that despite 7/10 pain levels after the March 26, 2013 injury he continued to work full duty and felt capable of continuing." The claimant reported a similar history to Dr. Santilli who noted that after the October 2012 fusion surgery the claimant had been doing well, was working full duty and was off pain medication. The claimant also advised Dr. Santilli that prior to the March 26, 2013 his pain level was 2/10 but had been 7/10 since March 26. The ALJ infers from the reports to Dr. Zuehlsdorff and Dr. Santilli that the claimant has a high pain tolerance and probably was not functionally limited by the low 2-3/10 pain levels that he was experiencing prior to March 26, 2013.

41. Dr. Santilli's opinion, expressed in the Addendum, that the claimant's pre-existing condition that resulted in the fusion surgery was "independently disabling" at the time of the March 26, 2013 injury is not persuasive. In support of her opinion Dr. Santilli noted that prior to March 26, 2013 the claimant had ongoing neck pain rated at 2/10. However, Dr. Santilli did not explain or cite any examples of how this pre-injury pain impaired the claimant's capacity to meet personal, social or occupational demands. In fact, Dr. Santilli noted that prior to the March 26 injury the claimant was working full duty. Further, she stated the claimant's subjectively increased pain levels after March 26 had "not caused a change in his work duty capacity." Thus, Dr. Santilli's only discussion of how the pre-injury pain was "disabling" at the time of the March 26 injury tends to establish that the pre-injury pain did not impair the claimant's capacity to meet the demands of his employment.

42. Dr. Zuehlsdorff's opinion that the claimant's impairment rating should be apportioned based on the pre-injury neck pain and discomfort is also unpersuasive. Although Dr. Zuehlsdorff reported that apportionment is appropriate under DOWC Guidelines, he did not expressly render an opinion as to whether the claimant's pre-injury pain was "independently disabling" at the time of the March 26, 2013 injury. Thus, he violated the requirements of WCRP 12-3(B), which requires a rating physician to state an opinion on this subject when apportioning based on prior non work-related medical impairment. Moreover Dr. Zuehlsdorff failed to cite specific examples of how

the claimant's pre-injury pain and discomfort impaired his ability to meet personal, social or occupational demands.

43. On October 1, 2014 a hearing was scheduled in this matter before Administrative Law Judge Felter (ALJ Felter). The record does not contain the Application for Hearing or any response that was filed. However, a transcript of the proceedings before ALJ Felter is contained in the record.

44. At the commencement of the October 1, 2014 hearing ALJ Felter noted that the matter was set for 1:30 but the claimant's counsel was not present. ALJ Felter stated that he understood "from our docket section that everyone has been trying to reach" the claimant's counsel but counsel "has not appeared or not advised why she won't be here." ALJ Felter inquired of respondents' counsel whether he had further information." Respondents' counsel replied that someone "called my office at 10:15 and said her car broke down and she couldn't make it." Respondents' counsel advised ALJ Felter that he told his office to "call them back and tell them it doesn't mean you couldn't make it at a hearing that's three and a half, or three hours away, that doesn't make sense to me." Respondents' counsel stated that in his opinion "[y]ou could get a cab or do whatever you needed to do." Respondents' counsel also advised ALJ Felter that "they called again an hour ago to say she couldn't make it" and that he spoke to claimant's counsel's office "maybe 15 minutes ago" and asked for claimant's counsel's cell phone number. However, respondents' counsel was told that that "they don't know where she is" and they "can't get a hold of her."

45. Following this discussion ALJ Felter thanked respondents' counsel for the information and then stated the following: "What's your pleasure? My inclination is to strike the application for hearing, period." Respondents' counsel replied: "Okay. Whatever you think is appropriate, I guess." ALJ Felter then stated that there had to be good cause for a continuance and he didn't see good cause. ALJ Felter further stated that the case is "for now abandoned" and if another application is filed "we'll cross that bridge when we get to it then." ALJ Felter then ordered that the application for hearing was stricken. He further stated that "I couldn't strike it with prejudice anyway, under the circumstances."

46. On October 1, 2014 at 10:39 Daniel Luepschen sent a sent a facsimile (fax) transmission from claimant's counsel's office to the OAC. The fax stated that he conversed with "Merci this morning regarding the hearing" scheduled for 1:30. The fax further states that Mr. Luepschen "told her that [claimant's counsel] was experiencing mechanical issues with her vehicle and would be unable to attend the hearing today."

47. On October 1, 2014 at 11:03 Daniel Luepschen sent a second fax to the OAC stating that he was asked by Merci whether the claimant "would be doing a motion to continue the hearing" or withdrawing his Application for Hearing and filing it again at a later time. Mr. Luepschen added that he was conferring with respondents' counsel's "paralegal to determine which of these options" the respondents' counsel would prefer.

48. On October 13, 2014 claimant's counsel filed the current Application for Hearing listing the issues of penalties, PPD benefits and "Apportionment and overcoming the DIME by clear and convincing evidence."

49. Evidence and inferences inconsistent with these findings are not credible and persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Generally, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201(1), C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201(1).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *CJI*, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201(1). The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions.

WAIVER OF CLAIM FOR PPD BASED ON CLAIMANT'S COUNSEL'S FAILURE TO APPEAR AT HEARING

The respondents argue that the claimant "waived" his right to seek additional PPD benefits because his counsel appeared at the hearing before ALJ Felter on October 1, 2014. The respondents assert the evidence establishes that the claimant's counsel was aware of mechanical problems with her car at least 3 hours prior to the October 1 hearing but failed to take reasonable steps, such as taking public transportation or a cab, to attend the 1:30 p.m. hearing. The respondents further contend that claimant's counsel failed to submit "significant evidence" to document the mechanical problems with her car or to explain her failure to secure alternative transportation to the hearing. The ALJ rejects the respondents' waiver argument for several reasons.

The doctrine of waiver constitutes an “affirmative defense” to a claim. Therefore, the party asserting the defense has the burden of proof to establish the elements of a waiver. *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988); *Moler v. Colorado Springs Winwater*, WC 4-447-584 (ICAO February 8, 2006). Waiver is the voluntary, knowing and intelligent surrender of a known right. *Johnson v. Industrial Commission*, *supra*; *Pfaff v. Broadmoor Hotel*, WC 4-105-774 (ICAO October 15, 2003). Waiver may be explicit or established by conduct inconsistent with assertion of the right. However, a waiver implied from conduct should be free of ambiguity concerning the party’s intention to surrender the right. *Department of Health v. Donahue*, 690 P.2d 243, 247 (Colo. 1984); *Pfaff v. Broadmoor Hotel*, *supra*. A claim of waiver may itself be waived if not asserted in a timely fashion. *Lewis v. Scientific Supply Co.*, 897 P.2d 905 (Colo. App. 1995).

Reduced to its simplest form, the respondents essentially argue that the claim for additional PPD benefits should be dismissed for failure to prosecute the claim. This argument is predicated on the claimant’s failure to produce any good reason for her counsel’s failure to appear at the October 1, 2014 hearing.

In this regard the respondents could have requested ALJ Felter to issue an order to show cause why the claim should not be dismissed pursuant to § 8-43-207(1)(m), C.R.S. However, when presented an opportunity to argue that the failure to appear justified or would justify issuance of a show cause order and ultimately dismissal of the claim, respondents’ counsel simply deferred to ALJ Felter’s discretion to design a remedy for the failure to appear. ALJ Felter then elected to dismiss the application for hearing without prejudice. The ALJ concludes that by deferring to ALJ Felter’s discretion and failing to raise their “waiver” argument the respondents themselves waived the argument that the claimant failed to prosecute the claim and should now be barred from seeking additional PPD benefits. *Lewis v. Scientific Supply Co.*, *supra*.

Even if the respondents have not waived the argument that the claim for further benefits was “waived” by the claimant’s failure to appear at the October 1 hearing, the ALJ concludes that ALJ Felter’s ruling that the proper sanction was dismissal of the application for hearing is now the law of the case. Law of the case is a discretionary doctrine holding that courts must generally follow prior legal rulings in the same case. *In re the Estate of Walter*, 97 P.3d 188 (Colo. App. 2003). A second judge may reconsider the prior ruling of a judge if new facts, circumstances or law indicate that reconsideration is appropriate. *In re the Estate of Walter*, *supra*.

Here, ALJ Felter ruled that the appropriate sanction for claimant’s counsel’s failure to appear was dismissal of the application for hearing. He did so after offering the respondents the opportunity to argue for any sanction they considered appropriate. In these circumstances the respondents have not presented any compelling reason why the undersigned ALJ should revisit ALJ Felter’s ruling and impose the severe sanction of dismissal for her failure to appear and prosecute the claim on October 1, 2014.

Even if the respondents have not waived their argument, and even ALJ Felter’s ruling is not law of the case, the ALJ declines to find that claimant’s counsel’s failure to

appear constituted a waiver of the claimant's right to seek additional PPD benefits. Rather, the undersigned ALJ finds that the respondents failed to carry their burden of proof to establish that the failure of claimant's counsel to appear constituted a voluntary, knowing and intelligent waiver of the right to claim additional benefits.

The respondents' argument is that the claimant's counsel knew of mechanical problems with her car in enough time to arrange alternative means of transportation to the October 1 hearing. However, this argument is based on the unspoken assumption that when the breakdown occurred the claimant's attorney was at a location where she could timely summon appropriate assistance to repair or move the car, arrange alternative transportation from wherever she was located and still timely appear at the 1:30 hearing. Because the respondents have the burden of proof to establish waiver, it was not the burden of the claimant to establish these facts for them and her failure to do so cannot be held against her. Rather, the ALJ finds the evidence establishes only that claimant's counsel suffered a mechanical breakdown at an unknown time and place and through the OAC staff advised that the breakdown prevented her from appearing at the hearing. In the absence of persuasive evidence establishing that there was no breakdown, or that the breakdown occurred under circumstances that made attendance at the hearing feasible, the ALJ is unable to find that counsel's failure to appear unambiguously decided to waive the claim for additional PPD benefits. The ALJ further declines to infer that claimant's counsel voluntarily, knowingly and intelligently surrendered the claimant's right to appear at the hearing and present evidence in support of the claim.

APPORTIONMENT OF IMPAIRMENT RATING

The claimant contends that he overcame by clear and convincing evidence the DIME physician's (Dr. Santilli's) decision to apportion his impairment rating from 30 % whole person to 8% whole person impairment based on his pre-existing back condition. Relying principally on the opinion of Dr. Healey, the claimant specifically argues that at the time of the March 26, 2013 industrial injury his pre-existing neck condition was not "independently disabling" within the meaning of § 8-42-104(5)(b), C.R.S. The respondents, citing *Martinez v. Industrial Claim Appeals Office*, 176 P.3d 826 (Colo. App. 2007) contend that apportionment is a "medical determination" and the claimant failed to overcome by clear and convincing evidence the DIME physician's decision to apportion the impairment rating. The ALJ concludes the claimant was not required to overcome by clear and convincing evidence the DIME physician's opinion that the pre-existing neck impairment was "independently disabling." The ALJ further concludes that a preponderance of the evidence establishes the pre-existing impairment was not "independently disabling" at the time of the March 26 injury. Therefore, apportionment of the impairment rating was not proper and the claimant is entitled to PPD benefits based on 30% whole person impairment.

Section 8-42-104(5)(b) provides that in cases of permanent medical impairment "the employee's award or settlement shall be reduced:"

(b) When an employee has a nonwork-related previous permanent medical impairment to the same body part that has been identified, treated, and, at the time of the subsequent compensable injury was independently disabling. The percentage of the nonwork-related permanent medical impairment existing at the time of the subsequent injury to the same body part shall be deducted from the permanent medical impairment rating for the same body part.

Application of § 8-42-104(5)(b) to the facts of this case requires the ALJ to interpret the meaning of the term “independently disabling.” The ALJ notes that neither party cited any current cases that interpret the term. The ALJ is also required to determine whether a DIME physician’s opinion that a prior medical impairment was “independently disabling” must be overcome by clear and convincing evidence.

A court should effect the legislative intent of a statute by first looking to the “plain and ordinary meaning” of the language used in the statute. If the meaning is ambiguous or unclear the court may look to other aids to interpretation including the legislative history, the context in which the legislation was adopted and the consequences of various interpretations. *See Weld County School District RE-12*, 955 P.2d 550 (Colo. 1998); *Henderson v. RSI, Inc.*, 824 P.2d 91 (Colo. App. 1991).

When the General Assembly amends a statute a presumption arises that the legislature intended to change the law as it existed prior to the amendment. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). There is also a presumption that the General Assembly was cognizant of judicial precedents addressing the subject matter of the inquiry. *Weld County School District RE-12, supra*.

Section 8-42-104(5)(b) was adopted in 2008 and became effective on July 1 of that year. For the period July 1, 1999 to July 1, 2008 § 8-42-104(2)(b), C.R.S., provided that when benefits were awarded pursuant to “section 8-42-107, an award of benefits for an injury shall exclude any previous impairment to the same body part.” Section 8-42-104(2)(c) stated that this apportionment applied to awards of permanent partial disability. Prior to July 1, 1999 § 8-42-104(2), C.R.S., provided that in cases of “previous disability” the disability for a “subsequent injury” was to be determined by “computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.” This provision expressly applied to awards of permanent partial disability.”

In *Askew v. Industrial Claim Appeals Office*, 927 P.2d 1333 (Colo. 1996) the court interpreted the meaning of the term “previous disability” as that term was used in the pre-1999 version of § 8-42-104(2). The court observed that the Act did not define the term “previous disability.” However the court stated that § 8-42-107(8)(c), C.R.S., requires the use of the AMA Guides when determining impairment and that the rating of impairment “necessarily includes the decision to apportion such impairment.” The court then observed that the AMA Guides define the term “impairment” as “an alteration of an

individual's health status that is assessed by medical means." In contrast, the AMA Guides state that "disability" is assessed by nonmedical means and is "an alteration of an individual's capacity to meet personal, social, or occupational demands." The court emphasized that under the AMA Guides "a person who is impaired is not necessarily disabled." *Id.* at 1337.

In *Askew* the respondents sought to apportion an impairment rating for a back injury based on a pre-existing degenerative back condition. However, the facts demonstrated that prior to the industrial injury the degenerative back condition was asymptomatic and did not hinder the claimant's ability to meet any demands. The court reasoned that under the "plain language of § 8-42-104(2)" apportionment was improper. It reasoned that the claimant's preexisting degenerative condition may have been an "impairment" under the AMA Guides, but it was not a "disability" because it did not limit his capacity "to meet the demands of life's activities." *Id.* at 1337; *see also Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998).

Later, in *Public Service Co. v. Industrial Claim Appeals Office*, 40 P.3d 68 (Colo. App. 2001) the court applied the *Askew* analysis to affirm a denial of apportionment based on a prior industrial impairment that was not disabling at the time of the subsequent industrial injury. Significantly, the court determined that under the *Askew* decision the "apportionment principles triggered under § 8-42-104(2) do not concern causation, but instead pertain to the status of a claimant's preexisting impairment." Specifically the court was required to determine if the pre-existing impairment rose to the level of a disability that continued to affect the claimant at the time of the subsequent injury. Moreover, the *Public Service* court ruled that the question of whether prior impairment was "disabling" at the time of the subsequent injury presented a question of fact for the ALJ to determine under the preponderance of the evidence standard, and the ALJ was not required to give any "presumptive weight" to the DIME physician's opinion on this issue.

As noted above, the General Assembly amended § 8-42-104(2) effective July 1, 1999. The legislature deleted any reference to the term "disability" and provided an award of PPD benefits was to exclude "previous impairment to the same body part." In *Martinez v. Industrial Claim Appeals Office*, *supra*, the case cited by the respondents, the court of appeals held that the statutory change rendered immaterial the distinction between "the type of apportionment authorized under former § 8-42-104(2) and the type of apportionment required by the AMA Guides as part of the rating process." The court stated that under the July 1, 1999 version of the statute apportionment constituted a "pure medical determination, which when made by the DIME physician is subject to the clear and convincing standard of § 8-42-107(8)." 176 P.3d at 828.

Section 8-42-104 was again amended in 2008 to include the provisions of subsection (5)(b). Subsection (5)(b) conditions apportionment of "nonwork-related previous permanent medical impairment" on a finding that the previous medical impairment was "independently disabling" at the time of the subsequent industrial injury. The ALJ concludes that the 2008 adoption of subsection (5)(b) evidences the General Assembly's intent to alter the law of apportionment as it existed from July 1, 1999 to

July 1, 2008, by reincorporating into the statute the requirement that a previous medical impairment be “disabling” at the time of the subsequent industrial injury.

The ALJ further concludes that when the General Assembly used the term “independently disabling” in subsection (5)(b) it did so with full cognizance of the *Askew* decision and its progeny. Specifically, the ALJ infers the legislature was aware that *Askew* held the plain and ordinary meaning of the phrase “previous disability” referred to “an alteration of an individual’s capacity to meet personal, social, or occupational demands” as determined by nonmedical means. Consequently, the ALJ infers that in 2008 when the General Assembly reinserted the term “disabling” into subsection (5)(b) its intent was to condition apportionment of pre-existing non work-related medical impairment on a finding that such impairment limited the claimant’s capacity to meet personal, social or occupational demands at the time of the subsequent industrial injury. Moreover, the General Assembly intended to legislatively repeal the holding in *Martinez v. Industrial Claim Appeals Office, supra* that apportionment is strictly a “medical determination” and the DIME physician’s opinion on apportionment must be overcome by clear and convincing evidence. Rather use of the term “disability” in subsection (5)(b) signals an intent to readopt the *Askew* court’s view that, as provided in the AMA Guides, the existence of “disability” is determined by nonmedical means. Further the ALJ infers the General Assembly intended to adopt the *Public Service Co.* court’s view that the existence of “disability” is determined under the preponderance of the evidence standard and the DIME physician’s opinion is not entitled to any “presumptive weight” on this issue.

The ALJ further concludes that the foregoing analysis is consistent with WCRP 12-3(A) and (B). WCRP 12-3(A) pertains to injuries “prior to July 1, 2008” and states the rating physician “shall apportion any preexisting medical impairment, whether work-related or non work-related, from a work-related injury or occupational disease using the” AMA Guides.

In contrast WCRP 12-3(B) applies to dates of injury “on or after July 1, 2008” and states the rating physician “may provide an opinion on apportionment of any preexisting work related or non work-related permanent impairment to the same body part” using the AMA Guides where “medical records or other objective evidence substantiate preexisting impairment.” The rule also provides that if the rating physician apportions based on a prior non work-related impairment the physician “must provide an opinion as to whether the previous medical impairment was identified, treated and independently disabling at the time of the work-related injury that is being rated.” Significantly, WCRP 12-3(B)(1) states the “effect of the Physician’s apportionment determination is limited to the provisions in section 8-42-104.”

The ALJ infers from WCRP 12-3(B)(1) that the rule reflects a recognition by the Director of the DOWC that the legal “effect” of a rating physician’s opinions concerning apportionment, including an opinion concerning whether a previous impairment was independently disabling at the time of the subsequent industrial injury, can have no more legal consequence than is contemplated by § 8-42-104. As determined above, the ALJ concludes that § 8-42-104(5)(b) contemplates that a DIME physician’s opinion

concerning whether or not prior medical impairment was “independently disabling” at the time of the industrial injury is not entitled to “presumptive weight” and is of no greater legal consequence than any other physician’s opinion on this subject.

A preponderance of the credible and persuasive evidence establishes that the claimant’s 30% whole person impairment rating cannot be apportioned based on his pre-injury condition because the prior condition was probably not “independently disabling” at the time of the March 26, 2013 injury. As determined in Findings of Fact 37 through 42, the credible and persuasive evidence establishes the claimant’s condition prior to the injury on March 26, 2013 was probably not “independently disabling.” Dr. Healey credibly opined that the claimant’s ability to return to full duty work without restrictions prior to the March 26 injury demonstrates the claimant’s condition was probably not “independently disabling” within the meaning of WCRP 12-3(B) and, therefore, § 8-42-104(5)(b). Dr. Healey’s report reflects his opinion that the claimant’s ability to perform regular employment without any restrictions shows the pre-injury condition was probably not impairing his capacity to meet personal, social or occupational demands. The claimant’s credible testimony, as corroborated by the history he gave to various medical providers, establishes that by March 26 he had returned to work at full duty and was experiencing relatively low levels of pain and doing well. Although Dr. Santilli opined, after prompting by the DOWC, that the claimant’s pre-injury condition was independently disabling at the time of the March 26 injury, that opinion is not persuasive for the reasons stated in Finding of Fact 41. Dr. Zuehlsdorff’s opinion that the claimant’s impairment rating should be apportioned is not persuasive for the reasons stated in Finding of Fact 42.

No party has sought to challenge Dr. Santilli’s DIME opinion that the claimant sustained ratable impairment as a result of the March 26, 2013 injury, and that her overall impairment rating for body parts injured in the March 26 incident is 30% whole person. This rating is therefore binding on the parties and the ALJ. Section 8-42-107(8)(c), C.R.S. The specific issue determined here is that apportionment of the DIME physician’s overall rating based on the claimant’s pre-existing non work-related medical impairment is not proper under § 8-42-104(5)(b) because the prior impairment was not “independently disabling” at the time of the March 26 injury. Therefore, the claimant is entitled to PPD benefits based on the DIME physician’s overall rating of 30% whole person impairment and without regard to apportionment.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.
2. The claimant’s right to raise the issue of PPD benefits was not waived by failure of her counsel to appear at the hearing on October 1, 2014.

3. The insurer shall pay the claimant PPD benefits in accordance with the statutory formula based on 30% whole person impairment.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 28, 2014

DIGITAL SIGNATURE:


David P. Cain
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

- Did the claimant prove by a preponderance of the evidence that any need for lumbar facet injections was proximately caused by the industrial injury of April 11, 2013?
- Did the claimant prove by a preponderance of the evidence that lumbar facet injections constitute reasonable and necessary medical treatment?
- Did the claimant prove by a preponderance of the evidence that any need for a left elbow MRI was proximately caused by the industrial injury of April 11, 2013?
- Did the claimant prove by a preponderance of the evidence that a left elbow MRI constitutes reasonable and necessary medical treatment?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. Claimant's Exhibits 1 through 13 were admitted into evidence. Respondents' Exhibits A through M were admitted into evidence.

2. The claimant testified as follows concerning the injury that occurred on April 11, 2013. She left the employer's store and went to the parking lot to retrieve a binder from her car. As she was returning to the store she stepped on some ice and slipped. She put out her left hand to break the fall but the hand slipped and she landed on her left elbow, left shoulder and left hip. The claimant described the fall as "really hard" and she didn't think about much of anything but her elbow because it hurt badly.

3. The claimant further testified that later on April 11, 2013 she told her supervisor about the injury and jokingly asked him to pull on her arm to get it back in place. The supervisor declined to pull on her arm but directed her to file a report. The employer then referred her to Concentra Medical Centers (Concentra) for treatment. At Concentra the claimant was seen by a physician. The claimant recalled that she told the Concentra doctor about symptoms involving her elbow, shoulder and hip. She also recalled that she mentioned that her back hurt. The claimant recalled that the Concentra physician referred her to Dr. Kavi Sachar, M.D., to evaluate the elbow because that was "the main concern."

4. The claimant testified that she was seen by Dr. Sachar April 12, 2013. Dr. Sachar evaluated the elbow and suggested surgery as soon as the swelling was reduced. The claimant did not recall discussing any symptoms with Dr. Sachar except

the elbow. The claimant testified that she returned to Dr. Sachar six days later to undergo elbow surgery. She recalled that on the date of the elbow surgery she reported to Dr. Sachar that she was experiencing back pain but he “convinced her” that he was “an arm and hand specialist only.” The claimant intended to return to Concentra for back treatment but the return visit was denied. The claimant explained that at that point she was desperate and her attorney helped find a physician to treat her.

5. On April 11, 2013 Kirk Holmboe, D.O., examined the claimant at Concentra. Dr. Holmboe recorded the claimant’s “chief complaints” as injury to the left elbow, left shoulder and left hip. He recorded a history that the claimant hit some ice and landed “directly on her left arm and her left hip.” The claimant reported increasing pain and swelling in her left elbow, some left shoulder pain and “minimal symptoms in her left hip and thigh.” The claimant reported a “past history” of a traumatic brain injury from a motor vehicle accident (MVA) and that she was still recovering from this injury. On examination Dr. Holmboe noted massive swelling and ecchymosis of the posterior aspect of the elbow. Shoulder range of motion (ROM) was not tested. Dr. Holmboe ordered an x-ray that showed a “significant comminuted displaced intraarticular fracture of the olecranon.” Dr. Holmboe advised the claimant that her elbow would require surgery and referred her to Hand Surgery Associates (HSA) for evaluation the next morning. Dr. Holmboe’s office note makes no mention of injury to the low back or that the claimant reported any low back symptoms.

6. On April 12, 2013, Kavi Sachar, M.D., examined the claimant at HAS. Dr. Sachar took a history that the claimant “slipped and fell on the ice at work landing on her left elbow.” Dr. Sachar’s impression was a “comminuted displaced left olecranon fracture.” Dr. Sachar and the claimant discussed performing surgery described as “open reduction internal fixation with wire.” The claimant decided to undergo surgery. Dr. Sachar’s note contains no mention that the claimant reported back pain or other back symptoms.

7. On April 16, 2013 Dr. Sachar performed surgery on the claimant’s left elbow.

8. On April 24, 2014 Dr. Sachar examined the claimant and took “three view x-rays of the left elbow.” The x-rays reportedly showed “excellent position of the hardware and olecranon ORIF.” Dr. Sachar referred the claimant for physical therapy (PT) on the left elbow. Dr. Sachar’s April 24 note contains no mention that the claimant reported back pain or other back symptoms.

9. On May 1, 2013 the claimant began PT for left her elbow at Select Physical Therapy (Select). On May 20, 2013, almost three weeks later, the physical therapist reported the claimant’s “neck is sore and she is having some pain in the right low back.” The therapist noted that the claimant was usually wearing a sling for her elbow but this hurt her neck. The therapist recorded that the claimant had been in an MVA “last August and had a fracture in the neck and a head injury.”

10. On May 22, 2013 Dr. Sachar examined the claimant. He noted that overall she was doing reasonably well "5 weeks post ORIF left olecranon." He also noted that the claimant reported "she has had neck and back pain since the time of the injury" and believed the sling made her neck slightly worse. Dr. Sachar also noted the claimant "has not been seeing a primary work comp physician at this time."

11. July 1, 2013, attended PT for treatment of her elbow. The physical therapist noted the claimant stated that she was continuing "to have problems with her (R) neck and low back as well that are not being addressed."

12. On July 8, 2013 the claimant was examined by neurologist Lynn Parry, M.D. The claimant reported "persistent" left arm, neck and low back problems after the injury of April 11, 2013. The claimant gave a history that on April 11 she slipped on ice while working and fell "full force onto her elbow." She was treated at Concentra "where she complained of elbow pain as well as neck pain." The claimant reported that she was involved in an MVA in September 2012 that caused a skull fracture and neck pain for which she received PT, radiofrequency treatment and massage therapy. Dr. Parry noted that she did not have any medical records for the 2012 and 2013 injuries.

13. On physical examination Dr. Parry noted the claimant lacked full extension of the left elbow and had "decreased pinprick" of the third and fourth digits. The claimant's upper and lower reflexes were abnormal. The claimant had a slightly antalgic gait on the right. She sat with her shoulders behind her pelvis which Dr. Parry described as "indicative of imbalance between anterior and posterior pelvic musculature." There was "mild tenderness" over the lumbosacral area and over the posterior pelvis in the region of the sacroiliac (SI) joints.

14. Dr. Parry wrote that the claimant has a "history of previous injuries to the neck and back which appear to have been aggravated" by the April 11, 2013 slip and fall. Dr. Parry opined that claimant "certainly could have sustained a flexion-extension injury to the cervical spine as well as a low back strain." Dr. Parry further opined the claimant was not at maximum medical improvement (MMI) on July 8, 2013 because she needed electromyography to assess possible ulnar nerve compression at the elbow and a cervical MRI to rule out possible myelopathy suggested by hyperreflexia. Dr. Parry also referred the claimant for additional PT.

15. Dr. Parry reexamined the claimant on October 9, 2013. Dr. Parry noted the claimant was standing almost continuously work and reported ongoing back pain. The claimant reported she could not lean on her left elbow without experiencing a shooting pain. Dr. Parry obtained and reviewed Dr. Holmboe's April 11, 2013 office note and Dr. Sachar's notes. Dr. Parry opined that because the claimant's "initial presentation was clearly focused on the elbow with an acute and fairly serious fracture" the claimant's back complaints had not been fully addressed. On physical examination the claimant demonstrated an inability to fully extend her elbow, tenderness along the lateral epicondyle and olecranon and decreased sensation in the fourth and fifth digits. The claimant continued to "demonstrate asymmetric pelvic stability with weakness on the left and tenderness over the left sacroiliac joint." Dr. Parry opined that when the

claimant fell she “also landed on her left hip and has problems in the back, specifically the left SI joint which would be consistent with her slip and fall.”

16. Dr. Parry reexamined the claimant on February 5, 2014. The claimant reported ongoing problems in the left arm, low back pain as well as right-sided arm pain and right-sided headaches. Dr. Parry noted the claimant had “decreased pelvic stability on the left but increased tenderness over the right sacroiliac joint.” Dr. Parry opined the “SI joint/pelvic instability” was a “ligamentous type injury” that is difficult to stabilize. Dr. Parry further opined the claimant still had “signs of ulnar nerve dysfunction” with limited motion and increased pain in the left upper extremity. Dr. Parry opined the claimant needed removal of the hardware in her arm.

17. On June 2, 2014 Thomas Fry, M.D., surgically removed the hardware in the claimant’s left elbow.

18. On June 12, 2014 the claimant came under the care of Kristin Mason, M.D. Dr. Mason is board certified in physical medicine and rehabilitation and is level II accredited. The claimant gave a history that she fell in April 2013. She put her hand out to brace herself but the left hand slipped causing her to land on the left elbow and left hip. The claimant reported she had “ecchymosis along the entire left side.” Dr. Mason noted the claimant suffered an olecranon fracture that was repaired by Dr. Sachar, and that hardware had recently been removed by Dr. Fry. The claimant complained of an “exacerbation of chronic neck pain” and “fairly widespread pain on the right side of her body which she feels is because she is out of whack.” The claimant was undergoing PT that included heat, dry needling, some manual treatment and use of a vibration bed. On physical examination Dr. Mason noted decreased flexion and extension ROM in the left elbow. The claimant had normal SI movement on the standing flexion test, mild tenderness over the bilateral trochanteric areas and tenderness over the right SI area. There was also tenderness of the “right paraspinal and periscapular areas. Forward flexion of the lumbar spine was limited. Left side bending was limited and painful compared to right side bending. Dr. Mason assessed the following: (1) Status post left elbow olecranon fracture with ORIF and later hardware removal; (2) Fairly widespread myofascial pain in the lumbar and periscapular areas; (3) Prior history of head injury with skull fracture and upper cervical radiofrequency for headaches; (4) Documentation of left SI dysfunction. Dr. Mason prescribed continued PT and a TENS unit to assist with pain management.

19. Dr. Mason reexamined the claimant on August 18, 2014. Dr. Mason noted that reports of Dr. Fry “referenced normal EMG for the medial ulnar nerves.” The claimant complained of upper back pain, lower back pain and elbow pain. The claimant advised that when she was slept on her sides she experienced hip pain that was “really more in the SI area.

20. Dr. Mason reexamined the claimant on September 8, 2014. The claimant reported her elbow was stiff and she could not rest the elbow on anything. The claimant was “concerned about the fact that she has had low back discomfort since the injury that has never really been addressed beyond physical therapy treating it.” Dr. Mason

referred the claimant for low back imaging including extension x-rays and an MRI scan. Dr. Mason opined the claimant's back problem had not been "addressed because she had a more significant injury to the left upper extremity but it has persisted."

21. The claimant underwent a lumbar MRI on September 27, 2014. The radiologist reported that there was no fracture. Further there were "multiple small left lateral protrusions at the L2-3, L3-4 and a lesser extent L4-5." The largest protrusion was at L2-3 but did not "overtly compress the exiting or descending nerve roots, though there "was "recess crowding as well as foraminal stenosis."

22. On September 27, 2014 the claimant underwent lumbar spine x-rays. The radiologist described these images as an "unremarkable lumbosacral spine series." There was no fracture, soft tissue swelling or foreign body. The radiologist commented that with "age mild spondylosis can be expected" but there was no severe spondylosis of arthropathy.

23. Dr. Mason reexamined the claimant on October 2, 2014. The claimant reported her pain was 7 on a scale of 10 (7/10). Her elbow was sensitive to pressure or touch. The low back bothered her in most positions, particularly at night. Dr. Mason reviewed the x-ray and MRI studies. Dr. Mason wrote that there were "shallow disc protrusions to the left at L2-3, L3-4 and L4-5 but I think her symptoms may be emanating from facets." Dr. Mason referred the claimant to Nicholas K. Olsen, D.O., for consideration of "injections."

24. Dr. Olsen examined the claimant on October 7, 2014. Dr. Olsen took a history that on April 11, 2013 the claimant fell on "her left side fracturing her left elbow" and also injuring her "neck and upper back as well as her lumbar complaints." Dr. Olsen assessed a "history" of a "slip-and-fall on ice in the parking lot on 4/11/13," a "lumbar sprain/strain secondary to" the fall and "clinical signs of lumbar facet arthropathy versus SI joint dysfunction." Dr. Olsen opined the claimant's "symptoms are most consistent with possible facet arthropathy versus SI joint dysfunction" and the claimant was "more symptomatic on the right side than on the left." Dr. Olsen recommended right sided L4-5 and L5-S1 facet joint injections to "investigate" the facets. He emphasized the "diagnostic aspect" of the facet injections and stated that if they did not "fully diagnose" the claimant's symptoms he might look at "other pain generators including the left side or possibly the right SI joint."

25. Dr. Mason's November 17, 2014, office note states the facet injections recommended by Dr. Olsen had been requested but denied by the insurer. The claimant reported her back pain was worse with time and her arm continued to be "hypersensitive." Dr. Mason assessed a "slip-and-fall on 4/11/13 with low back pain which had not been aggressively addressed during the opening part of her treatment and "ongoing sensitivity" of the elbow. Dr. Mason noted no pain behavior and recommended continued physical therapy for the elbow and back.

26. The claimant testified that she would undergo the injections recommended by Dr. Olsen, if approved, because they might help reduce her pain.

27. Dr. Mason reexamined the claimant on December 15, 2014. The claimant continued to complain of back pain. The claimant reported that she had “more weakness” in her arm especially with prolonged flexion of the elbow. Dr. Mason noted the hardware removal was done “back in June” but the claimant “really continued to have significant complaints.” Dr. Mason also stated that an EMG had been done in October 2013 that was “normal for radial and ulnar nerves.” On examination Dr. Mason noted the claimant was “fairly weak in the wrist extensor muscles” and was tender over the radial tunnel with some pain radiating into the forearm “on palpation of that area.” Dr. Mason assessed persistent left elbow pain with findings “currently suggestive of possible radial nerve involvement” and low back pain radiating into the hip that “has not been aggressively addressed.” Dr. Mason recommended the claimant undergo an MRI of the elbow to evaluate “whether there is any other structural damage since she really has not improved as expected following removal of the hardware.” On December 15 Dr. Mason also completed a form WC 164 in which she listed the work-related diagnosis of left elbow fracture with a question of radial neuropathy.

28. The claimant testified that she would have undergone the elbow MRI recommended by Dr. Mason but the request was denied.

29. On November 21, 2014 F. Mark Paz, M.D., conducted an independent medical examination (IME) of the claimant. This IME was performed at the request of the respondents. Dr. Paz is an expert in internal medicine and occupational medicine. He is level II accredited.

30. On December 29, 2014 Dr. Paz issued a written report setting forth his findings and opinions. In connection with the IME Dr. Paz took a history from the claimant, reviewed pertinent medical reports and performed a physical examination. The claimant gave a history to Dr. Paz that on April 11, 2013 she slipped and fell on ice. She reported she fell “to her left” and landed on her outstretched left upper extremity. She landed on her left side. The claimant resumed work but later reported the injury to her employer because of swelling and pain in her elbow. The claimant then selected Concentra for treatment. According to the claimant she was evaluated at Concentra for symptoms of low back pain and the elbow pain. The claimant further reported that the Concentra physician referred her to Dr. Sachar to treat the elbow but “he was unable to treat the low back pain.”

31. In the written report Dr. Paz opined that based on the claimant’s reported history, the review of medical records and the physical examination it is not medically probable that the claimant’s back symptoms are related to the industrial injury of April 11, 2013. In this regard Dr. Paz noted that the lumbar spine MRI is “consistent with degenerative changes” including degenerative disc disease and lumbar degenerative joint disease. Dr. Paz opined the degenerative changes most likely pre-date the injury of April 11, 2013, are most likely not related to it and were probably not aggravated by it.

32. In his written report Dr. Paz noted the claimant was complaining of left elbow symptoms from the posterior aspect of the elbow to the posterior surface of the proximal forearm. She also reported a “pins and needles” sensation with light touch

including the “weight of a jacket across the left upper extremity.” Dr. Paz noted that during the IME the claimant was sitting in a chair and he observed her “supporting her upper body with the left upper extremity, elbow flexed on the arm of the chair.” Dr. Paz opined the claimant’s elbow was “clinically stable” and that that no further treatment could reasonably be expected to improve the elbow condition.

33. Dr. Paz testified that he applied the causation analysis he learned in level II training to assess the cause of the claimant’s low back symptoms. He explained that the level II methodology for determining causation requires the physician to take a history and perform a physical examination. Based on the information gleaned from the history and examination the physician makes differential diagnoses and then determines the most likely diagnosis (es). Finally the physician, after considering the occupational circumstances and facts surrounding the injury, renders an opinion to a reasonable degree of medical probability whether or not it is likely the diagnosis is work-related.

34. Dr. Paz testified it is not medically probable that there is a causal relationship between the April 11, 2013 industrial injury and the claimant’s back symptoms. With regard to the mechanism of injury Dr. Paz opined that based on the claimant’s description of the injury to Dr. Holmboe on April 11, 2013, and to him at the IME, she fell on her left side injuring her left hip, not the back. Dr. Paz also explained that if the claimant had injured her back on April 11 she most likely would have experienced back pain on the day of the injury or the next day, not several weeks after the injury. Dr. Paz noted that on April 11, 2013 Dr. Holmboe examined the claimant and documented left hip pain but not low back pain. Further, Dr. Paz did not find medical documentation of low back pain complaints until May 22, 2013 when Dr. Sachar recorded them.

35. With regard to the diagnosis of the claimant’s back condition Dr. Paz testified that the treating physicians have not arrived at any consistent diagnosis. He pointed out that Dr. Parry appears to diagnose SI joint problems while Dr. Mason initially diagnosed a myofascial problem.

36. Dr. Paz testified that his examination of the claimant did not produce any “objective findings” to support a diagnosis of a back injury. Rather, on his examination the claimant had diffuse low back complaints. Moreover, Dr. Paz opined the claimant’s lumbar MRI is consistent with degenerative disc disease (DDD), a condition that is common among persons of the claimant’s age. Dr. Paz noted the medical records show the claimant’s complaints of back pain escalated over time which, although it may be consistent with degenerative back disease, is not consistent with an acute injury or aggravation of a pre-existing condition. Dr. Paz explained that acute back injuries are most painful at the time of or soon after the injury.

37. Dr. Paz testified that the significance of the claimant resting her left elbow on the chair during the IME was that it demonstrated an inconsistency between her report of the severity of symptoms and her actual ability. Dr. Paz stated that he did not believe the claimant was attempting to mislead him. Rather he believes that the

claimant has a low tolerance for pain and her ability to function may be greater than her reported symptoms indicate.

38. Dr. Paz testified it would not be unreasonable to do an MRI of the left elbow if the claimant was contemplating surgery to the elbow. However, he opined the claimant is very functional and questioned why the claimant would consider surgery in these circumstances.

39. The claimant failed to prove that her back symptoms, and thus the need for facet injections proposed by Dr. Mason and Dr. Olsen, are causally related to the industrial injury of April 11, 2013. A preponderance of the credible and persuasive evidence establishes that if the claimant has back symptoms they are most probably caused by pre-existing degenerative spine disease that has progressed independently of the April 11, 2013 industrial injury.

40. Dr. Paz credibly and persuasively opined that if the claimant sustained a back injury on April 11, 2013, the symptoms of the injury would have developed either on the day of the injury or within the next day. However, the medical records in this case fail to document any report of back pain until May 20, 2013, more than five weeks after the date of injury. Dr. Paz also credibly opined that the worsening of the claimant's back pain over time is more consistent with the natural progression of the degenerative conditions documented by the lumbar MRI performed in September 2014. Dr. Paz explained that symptoms of an acute back injury are most severe at the time of the injury, not later.

41. The claimant's testimony that she experienced back pain at the time of the injury and reported it to Dr. Holmboe on April 11, 2013 is not credible and persuasive. The claimant's assertion is contradicted by Dr. Holmboe's April 11, 2013 office note which fails to document any report of low back pain by the claimant. The claimant's suggestion that Dr. Holmboe failed to note her report of back pain because the elbow injury was much more serious and of greater concern is not persuasive. In fact, Dr. Holmboe documented the claimant's reports of left hip and thigh pain even though he expressly noted that these symptoms were "mild." The ALJ infers that if the claimant had mentioned even "mild" back pain to Dr. Holmboe he would have recorded the complaint on April 11.

42. Similarly, the claimant's testimony that she reported back symptoms to Dr. Sachar on the date of the elbow surgery, April 16, 2013, is not credible and persuasive. First, the record does not contain any credible and persuasive documentation from the date of surgery, other than Dr. Paz's mention of reviewing an operative report.. Consequently, the claimant's testimony cannot be corroborated or refuted by reference to these documents, if they exist. Moreover, Dr. Sachar's reports prior to May 22, 2013 do not document any reports of back pain. Neither do the physical therapy reports document back pain until May 20, 2013. The ALJ finds it improbable that if the claimant experienced back pain commencing on the date of injury and continuing, as she told Dr. Sachar on May 22, there would be no medical documentation of those reports until May 20, 2013.

43. To the extent Dr. Parry and Dr. Mason and Dr. Olsen assign the claimant's back symptoms to the injury of April 11, 2013, their opinions are not persuasive. As Dr. Paz credibly testified, none of these physicians performed a causation analysis. Rather, they simply assigned the onset of the claimant's back symptoms to the time of the injury consistent with what the claimant told them. However, for the reasons stated in Findings of Fact 40 through 42, the ALJ finds it improbable that the claimant experienced back pain on the date of the injury or soon thereafter. As Dr. Paz credibly explained, the assumption that the claimant experienced back pain on the date of the injury is not medically probable. Because Dr. Parry, Dr. Mason and Dr. Olsen rely on this incorrect assumption to arrive at their conclusions regarding causation, their opinions are not persuasive.

44. The claimant proved it is more probably true than not that the need for a left elbow MRI is causally related to the industrial injury of April 11, 2013. The claimant further proved it is more probably true than not that an MRI constitutes reasonable and necessary treatment for the injury.

45. On December 15, 2014 Dr. Mason credibly and persuasively opined that the claimant needs an MRI to determine if there is some previously undetected damage to the claimant's elbow that has caused her to experience ongoing elbow symptoms despite the hardware removal surgery on June 2, 2014. The ALJ infers from Dr. Mason's December 15 note that the purpose of conducting the MRI is to further diagnose and define the exact nature of the claimant's symptoms and to suggest a further course of treatment depending on the results.

46. Dr. Paz's opinion that an MRI is not reasonable and necessary is not as persuasive as the opinion of Dr. Mason. Even Dr. Paz indicates that an MRI might have some diagnostic value, but only if the claimant were to consider surgery. Dr. Paz does not think surgery would be advisable since he considers the claimant's condition to be stable. However, Dr. Mason credibly and persuasively questions the "stability" of the claimant's condition because the claimant has not improved as expected since the hardware removal. In these circumstances the ALJ concludes an MRI is a reasonable and necessary diagnostic procedure that offers a reasonable prospect of further defining the claimant's condition and determining what if any treatment offers a reasonable prospect of curing or relieving the effects of the elbow injury.

47. The claimant proved it is more probably true than not that the need for the MRI is causally related to the industrial injury of April 11, 2013. Dr. Mason's December 15, 2014 report credibly implies it is her opinion that the need for the left elbow MRI is causally related to the April 11, 2013 industrial injury. Dr. Mason listed the left elbow as an injury related diagnosis on the WC 164. Not even Dr. Paz credibly opined that the claimant's elbow symptoms are unrelated to the industrial injury. Rather, Dr. Paz takes the position that the left elbow injury is now "stable" and there is no need for an MRI unless the claimant is considering surgery. As found, Dr. Mason's opinions concerning the reasonableness and necessity of the MRI are more persuasive than Dr. Paz's opinion.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201(1), C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201(1).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201(1). The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions.

REQUEST FOR FACET INJECTIONS

The claimant argues the evidence establishes that she sustained a low back injury as a result of the April 23, 2013 low back injury. She further argues that the facet injections recommended by Dr. Mason and Dr. Olsen constitute reasonable and necessary treatment for the low back injury.

The claimant was required to prove by a preponderance of the evidence that the conditions for which she seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The claimant must prove a causal nexus between the claimed need for treatment and the work-related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). The mere occurrence of symptoms at work or elsewhere does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work or elsewhere may represent the natural progression of a pre-existing condition that is unrelated to the employment. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1995); *Breeds v. North Suburban Medical Center*,

WC 4-727-439 (ICAO August 10, 2010); *Cotts v. Exempla, Inc.*, WC 4-606-563 (ICAO August 18, 2005). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000).

Further, respondents are liable to provide only such medical treatment as is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

The ALJ concludes a preponderance of the credible and persuasive evidence establishes that the claimant's reported back symptoms are not causally related to the industrial injury of April 11, 2013. As determined in Findings of Fact 39 through 43 a preponderance of the credible and persuasive evidence establishes that the claimant's back symptoms are not temporally associated with the injury, and that the most likely cause of the symptoms is the natural progression of pre-existing degenerative back disease. As found, the ALJ is persuaded by the causation analysis performed by Dr. Paz. Contrary opinions and evidence are not credible and persuasive for the reasons stated in Findings of Fact 41 through 43.

Because the claimant's back symptoms are not causally related to the industrial injury, it is not necessary to reach the issue of whether the proposed facet injections constitute reasonable and necessary treatment.

REQUEST FOR ELBOW MRI

The claimant argues a preponderance of the evidence establishes that the left elbow MRI proposed by Dr. Mason on December 15, 2014. Relying on the opinions of Dr. Paz the respondents argue the evidence is insufficient to establish any need for an MRI is causally related to the injury, or that an MRI is reasonably necessary.

Diagnostic procedures constitute a compensable medical benefit if they have a reasonable prospect of diagnosing or defining the claimant's condition so as to suggest a course of further treatment. See *Watier-Yerkman v. Da Vita, Inc.*, WC 4-882-157-02 (ICAO January 12, 2015).

As determined in Findings of Fact 44 through 47 the claimant proved it is more probably true than not that an MRI constitutes a reasonable and necessary diagnostic procedure to further diagnose and define the reasons for her ongoing left elbow symptoms. As found, the ALJ credits the opinion of Dr. Mason that the proposed MRI is reasonable and necessary, and that the need for the procedure is related to the April 11, 2013 injury. As found, not even Dr. Paz disputes that the claimant's ongoing elbow symptoms are related to the injury. Dr. Paz merely opines that an MRI is not a reasonable procedure unless the claimant is contemplating surgery.

The respondents shall pay for a left elbow MRI and such further treatment of the elbow as is reasonable and necessary, if any.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claimant's request for lumbar facet injections as a form of medical treatment is denied.
2. The claimant's request for a left elbow MRI as a form of medical treatment is granted. The respondents shall continue to provide reasonable and necessary medical treatment for the claimant's left elbow injury of April 11, 2013.
3. Issues not resolved by this order are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 18, 2015

DIGITAL SIGNATURE:



David P. Cain
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

1. Whether the Claimant proved, by a preponderance of the evidence, that the medical treatment consisting of additional physical therapy recommended by Dr. Orent is reasonably necessary to cure and relieve the effects of the April 17, 2013 industrial injury.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. The Claimant is a bus driver who was working for the Respondent on April 17, 2013, the date of her injury. The Claimant was coming to work and walking through the parking lot when she was struck by a vehicle driven by another employee. She was initially diagnosed with a mild concussion, nasal laceration, left knee injury, left ankle injury and blunt abdominal trauma (Respondent's Exhibit B, p. 4).

2. After initial treatment at St. Anthony's Hospital, the Claimant has continually treated with physicians at Arbor Medical Centers since April 22, 2013 (Respondent's Exhibit B, p. 4). The Claimant underwent surgery with Dr. Hsin for repair of her lateral meniscus and patella on May 30, 2013. Before and after this surgery, the Claimant was involved in rehabilitative care including 38 visits for physical therapy with Physical Therapy of Lakewood from May 15, 2013 to March 14, 2014 (Respondent's Exhibit C). Over the course of her physical therapy there, the Claimant met or made significant progress towards many of her short term and long term goals, including tolerating 2 hours of sitting, increasing left knee range of motion, returning to commercial driving, and squatting and lifting, and walking without a limp (Respondent's Exhibit C).

3. The Claimant then began further physical therapy at Alpha Rehabilitation following an evaluation on March 31, 2014. Between March 31, 2014 and October 23, 2014, the Claimant had 49 physical therapy appointments (Respondent's Exhibit D, p. 146) concentrating on core strengthening (Respondent's Exhibit D). As of September 9, 2014, the physical therapist noted that she was hoping the Claimant "would benefit from additional PT – more aggressive strengthening, but unfortunately she's NA to work through the pain" (Respondent's Exhibit D, p. 123). As of October 9, 2014, the therapist noted that it is difficult for the Claimant to fully extend her knee, but there was progress with glute and quad strengthening (Respondent's Exhibit D, p. 142).

4. On May 22, 2014, Dr. Sander Orent authored a written opinion disagreeing with the IME of Dr. Bart Goldman regarding the Claimant's upper extremity, neck, and knee conditions. Dr. Orent specifically opined that the Claimant's mechanism of injury was clear and her head, neck and knee conditions were related to the work-

related injury. With regard to the knee, Dr. Orent noted that the Claimant failed conservative treatment and that Dr. Eickmann had opined if that were the case, she would require an arthroplasty and that would be related to the work-related MVA (Claimant's Exhibit 1, p. 9).

5. In a follow up report on October 9, 2014, Dr. Orent noted that the Claimant requires an arthroplasty because she has significant symptoms that have been unresponsive to conservative treatment. Dr. Orent also responded to comments made by an independent medial evaluator and the physical therapists that the Claimant did not need a knee replacement and that there was nothing further they could do for the Claimant. Dr. Orent opined that these statements are not correct and that the Claimant needs to "continue her therapy twice a week to maintain her strength" pending an affirmative decision on the proposed surgery. Dr. Orent noted the Claimant was a "highly-motivated individual" who is anticipated to have an excellent prognosis from a knee replacement especially as the Claimant has maintained her fitness well in spite of the fact that she has a knee that does not allow her to do much (Claimant's Exhibit 1, pp. 6-7).

6. In October of 2014, Dr. Orent requested prior authorization for 6 additional physical therapy sessions with Alpha Rehabilitation. This request was denied on October 27, 2014 (Respondent's Exhibit A, p. 1). After review of the request, Dr. James Lindberg stated that the Claimant has far exceeded the number of physical therapy visits allowed and should be able to do a home program to maintain her strength. He recommended denying further physical therapy (Respondent's Exhibit A, p. 3).

7. On November 6, 2014, Dr. Orent commented on the denial of a recommended arthroplasty for the Claimant as well as a denial for physical therapy based on exceeding the medical treatment guidelines. Dr. Orent stated "I do feel that as we await a final determination on an arthroplasty for [the Claimant] that she should continue in physical therapy twice a week for maximizing strength and function." As for the need for the arthroplasty, Dr. Orent opines that "this is as clear as these cases ever are in situations like this. Therefore, I would urge that we move forward with an arthroplasty unless the employer can in some way provide evidence that this patient had preexisting symptomatic disease there is no excuse for denying this procedure" (Claimant's Exhibit 1, p. 3).

8. In an undated letter that is stamped "received" by Respondents' counsel on November 24, 2014, Dr. Orent opines that, "the physical therapy is a poor substitute but it is all that we have as long as the arthroplasty is denied. We do find that continuing her physical therapy maintains her quadriceps strength and function and maximizes her ability to ambulate in the face of a denial of a surgical procedure. The benefit that I would anticipate is until this patient is approved for surgery that we will keep her as fit as possible. While I understand that you consider that this would be an indication for Maximum Medical Improvement I do not agree. I feel that this patient cannot be declared at Maximum Medical Improvement until she has undergone her arthroplasty.

9. On December 4, 2014 the Claimant saw Dr. Gary Zuehlsdorff on December 4, 2014 for an Independent Medical Examination. Dr. Zuehlsdorff reviewed the Claimant's medical records noting no prior treatment or knee conditions. The Claimant advised him of some medial left knee pain from 20 years ago when she jumped off a horse that resolved after a few months with no ongoing problems or treatment (Respondent's Exhibit B, pp. 4-5). The Claimant reported that her current knee pain ranged from 2-9/10 with an average pain level of 5/10. Dr. Zuehlsdorff noted that the Claimant was doing physical therapy twice a week but there was minimal relief for a short time with little progress as a result of the continued physical therapy (Respondent's Exhibit B, p. 8). Dr. Zuehlsdorff's physical examination of the knee revealed a swollen medial joint line area with moderate tenderness, diminished range of motion and some atrophy of the left leg as compared to the right. Any maneuver performed caused the Claimant pain primarily in the medial area (Respondent's Exhibit B, pp. 8-9). Regarding the need for additional physical therapy, Dr. Zuehlsdorff opined that given the high number of physical therapy appointments and what he found to be "minimal transient relief," he did not recommend pursuing further physical therapy. However, Dr. Zuehlsdorff does find that the Claimant is not at MMI for her left knee (Respondent's Exhibit B, p. 9). Dr. Zuehlsdorff recommended a follow up consultation with the orthopedist, Dr. Hsin and opined that injections or surgery that is short of a total knee replacement would be recommended (Respondent's Exhibit B, p. 10).

10. On January 12, 2015, Dr. Zuehlsdorff provided a written follow-up to his IME report of December 4, 2014. Dr. Zuehlsdorff noted that he had contacted Dr. Hsin to discuss the case and Dr. Hsin stated that "the patient would be a good candidate for a patellofemoral replacement that would include a resurface of the trochlea. He feels that this would give the patient and 80% chance for significant recovery." Based on his discussion with Dr. Hsin and his 15 years of experience reviewing patient records in the work comp arena, Dr. Zuehlsdorff opined that Dr. Hsin's recommendation "makes medical sense" and Dr. Zuehlsdorff recommends "moving forward with approval for the patellofemoral replacement/resurfacing of the trochlea procedure" (Claimant's Exhibit 2).

11. At the hearing, the Claimant testified that physical therapy increased the strength in her knee and made her more functional. The Claimant further testified that PT decreased her pain. She testified credibly that she is limited in what she can do and the massage and ultrasound that she receives along with doing the exercises at physical therapy help strengthen her leg and knee and provides more benefit. She had been doing a home exercise program since the physical therapy was discontinued, but this doesn't include the massage and ultrasound. The Claimant also testified that she wanted the PT and was willing to undergo the knee surgery recommended by her orthopedic surgeon, Dr. Hsin. The Claimant also stated, after discussing PT and surgery with her ATPs, that it was her understanding that the stronger the knee, the better likelihood that future surgery would be successful.

12. Dr. Zuehlsdorff also testified at the hearing. He is familiar with the Claimant, having reviewed her medical records and having performed an IME with

interview and physical examination. In his opinion, with reference to the Lower Extremity Medical Treatment Guidelines, no additional physical therapy is warranted in this case. He opines that further physical therapy would not result in sustained relieve of her symptoms. Dr. Zuehlsdorff testified that the Claimant is ultimately headed for surgery by Dr. Hsin and the additional physical therapy requested by Dr. Orent is akin to flogging a dead horse. He further opined that, based on the condition of the Claimant's knee, aggressive physical therapy could put the Claimant at risk for injury. He testified that he believes that Dr. Orent is angry that the Claimant isn't approved for surgery so that is why he is requesting more physical therapy for the Claimant.

13. On cross examination, Dr. Zuehlsdorff conceded that the Medical Treatment Guidelines pertaining to PT did outline the intent of PT, among other things, was to strengthen the knee. He further conceded that his opinions regarding Dr. Orent's PT request resulting from him being upset with the Respondent were purely speculative and not based on any personal knowledge. Dr. Zuehlsdorff stated in his report that he "asked directly...if there was any emergency or incident where she had to move quickly and assist children on and off the bus...she admitted that could be an issue." However, upon being asked on cross examination, he was unsure whether or not he actually discussed this issue with Claimant as his notes didn't reflect him asking such a question.

14. The Lower Extremity Injury Medical Treatment Guidelines state, "The Division recognizes that acceptable medical practice may include deviations from these guidelines, as individual cases dictated. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care" (Respondent's Exhibit E, p. 149). The Lower Extremity Injury Medical Treatment Guidelines, section B (5) states, "goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings" (Respondent's Exhibit E, p.150).

15. The ALJ finds that consideration of the Medical Treatment Guidelines is appropriate. However, Dr. Orent, having considered the Guidelines in this case, persuasively presented rationale for a deviation from the typical amount of physical therapy because it is reasonable and necessary to maintain or improve the Claimant's strength and physical conditioning pending a recommended and likely left knee surgery as currently recommended by Dr. Hsin.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S.

A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers' compensation claim shall be decided on its merits. Section 8-43-201, C.R.S.

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Medical Benefits – Reasonably Necessary

Respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. Respondents may, nevertheless, challenge the reasonableness and necessity of current or newly requested treatment notwithstanding its position regarding previous medical care in a case. *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002), (upholding employer's refusal to pay for third arthroscopic procedure after having paid for multiple surgical procedures). The question of whether a particular medical treatment is reasonable and necessary is one of fact for determination by the ALJ. *Kroupa v. Industrial Claim Appeals Office, supra; Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999). The claimant bears the burden of proof to establish the right to specific medical benefits. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990). Factual determinations related to this issue must be supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

Pursuant to W.C. Rule of Procedure 17-2 (A), 7 Code Colo. Regs. 1101-3, health care practitioners are to use the Medical Treatment Guidelines referenced as Exhibits at W.C. Rule of Procedure 17-7, 7 Code Colo. Regs. 1101-3 (the "Medical Treatment Guidelines") when furnishing medical aid under the Workers' Compensation Act. The ALJ may also appropriately consider the Medical Treatment Guidelines as an evidentiary tool. *Logiudice v. Siemens Westinghouse*, W.C. 4-665-873 (ICAO January 25, 2011). However the ALJ is not required to grant or deny medical benefits based upon the Medical Treatment Guidelines. *Thomas v. Four Corners Health Care*, W.C. 4-484-220 (ICAO April 27, 2009). The Medical Treatment Guidelines are not definitive, but merely guidelines, and the ALJ has the discretion to make findings and orders which follow or deviate from the Medical Treatment Guidelines depending upon the evidence presented in a particular case. *Jones v. T.T.C. Illinois, Inc.*, W.C. 4-503-150 (ICAO May 5, 2006), *aff'd Jones v. Industrial Claims Appeals Office*, N. 06CA1053 (Colo. App.

March 1, 2007)(not selected for official publication); *Nunn v. United Airlines*, W.C. 4-785-790 (ICAO September 9, 2011).

In this case, although number of physical therapy sessions the Claimant has undergone are in excess of the treatments recommended by the Medical Treatment Guidelines, the treatments have been effective to keep the Claimant stronger and functional and she remains able to perform her job duties. In addition, it is not contemplated that she continue to undergo physical therapy sessions indefinitely. Rather, Dr. Orent recommends the physical therapy prior to a recommended surgery to keep the Claimant in good physical condition so that she has a better anticipated result from the surgery. Because her knee condition otherwise limits what the Claimant can do, the physical therapy, massage and ultrasound keep the Claimant more functional and in better physical shape in preparation for a surgery that the Claimant is likely to ultimately undergo.

While the Medical Treatment Guidelines were appropriately considered, the opinion of Dr. Orent is credible and persuasive and provides a valid rationale for deviation from the Guidelines. Additional physical therapy, including the attendant massage and ultrasound, is found to be reasonably necessary relieve the Claimant from effects of the injury pending a recommended knee surgery.

ORDER

It is therefore ordered that:

1. Per Dr. Orent's assessment of the Claimant's current condition and in light of a pending recommendation by Dr. Hsin for knee surgery, it is reasonable and necessary to continue physical therapy to maintain the Claimant's physical conditioning pending proceeding with a likely surgical intervention.

2. Respondent shall be liable for additional physical therapy including massage and ultrasound treatments as recommended by Dr. Orent that is reasonably necessary to maintain and improve the Claimant's physical conditioning pending a contemplated knee surgery. Respondent shall pay for this medical treatment in accordance with the Official Medical Fee Schedule of the Division of Workers' Compensation.

3. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative

Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 6, 2015



Kimberly A. Allegretti
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION Nos. WC 4-918-977-03 and WC 4-940-536**

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffers from a worsened condition causally related to his October 11, 2010 work injury to allow a reopening of WC claim 4-918-977.
2. Whether Claimant has established by a preponderance of the evidence that the treatment provided by Kathy Gutierrez, nurse practitioner, PhD, is authorized.
3. Whether Claimant has established by a preponderance of the evidence that he suffers from a work related occupational disease of his cervical spine.
4. Whether Claimant has established by a preponderance of the evidence that he suffers from a work related occupational disease of his right upper extremity (carpal tunnel).

FINDINGS OF FACT

1. Claimant works for Employer as a duct pipe installer and supervisor and has been employed by Employer for approximately twelve years. Between 2004 and 2007 Claimant performed similar work for a different company and then returned to employment with Employer.
2. Claimant's duties include performing both supervisory work and actual labor work alongside and with those he supervises.
3. As a supervisor, Claimant is responsible every morning for loading up the materials needed at the job site. When he arrives at the site, his crews help unload the materials. Claimant then is responsible for meeting with his crew members, conducting a safety meeting with a safety coordinator, and meeting with the general contractor. Claimant is responsible also for preparing paperwork for the general contractor. Claimant is responsible for ordering materials from suppliers and is required on occasion to drive to pick up the materials from suppliers and to deliver them to the job sites. Claimant makes rounds to review the work performed by his crews, answers questions, and must perform measurements and "take offs" of the job sites so as to inventory materials onsite and materials still needed. Claimant responds daily to phone calls or problems reported by any of his crews and, if necessary, travels to the crew site to assist. Claimant's crews are sometimes all at the same site as him, and sometimes he has crews at different job sites where he will have to drive to the other site to assist.

4. Claimant also performs actual labor work. Claimant works in and around crawl spaces, ceilings, around cables, around lighting, and anywhere that is needed to insulate and install duct pipe. He cuts pieces of insulation or duct with shears, climbs up ladders, fastens the insulation or duct pipe with a staple gun, goes back down the ladders, moves the ladders as needed, and continues that process while performing actual labor work. Claimant is not in one fixed position while performing his work. Claimant also uses a variety of tools during the day, and does not use one tool all day long. Claimant spends approximately 5-6 hours per day doing actual labor and approximately 2-3 hours per day performing supervisory duties. While performing actual labor work, the work and positions vary greatly depending on the project.

5. On October 11, 2010 Claimant suffered a work related injury when a co-worker accidentally dropped a screw gun from 15 feet above Claimant, and the screw gun hit Claimant on his hardhat/head.

6. On October 12, 2010 Claimant saw Brian Beatty, D.O. Claimant described the day prior that he was hit on the head by a drill dropped from 15 feet above him, that he did not lose consciousness, and complained of neck stiffness with right shoulder pain and a mild headache. See Exhibit 8.

7. Dr. Beatty noted that an X-ray of the cervical spine was negative and diagnosed mild concussion, cervical strain, spinal somatic dysfunction, and headache. Dr. Beatty's objective findings on physical examination included for cervical range of motion: flexion 60 degrees; extension 30 degrees; right lateral flexion 45 degrees; left lateral flexion 25 degrees; right rotation 45 degrees; and left rotation 50 degrees. Dr. Beatty recommended medication, osteopathic manipulative treatment, and stretches. Dr. Beatty placed Claimant on modified duty work restrictions and indicated the plan for maximum medical improvement status would 4-6 weeks. See Exhibit 8.

8. On October 19, 2010 Claimant again saw Dr. Beatty and reported the headaches were better but that he still had some neck and right shoulder pain that radiated down to the right elbow and caused occasional hand numbness. Dr. Beatty continued the treatment plan, continued the modified duty work restrictions, and indicated in the plan that maximum medical improvement status would be 3-4 weeks on the handwritten form and 4-6 weeks on the typewritten report. See Exhibit 8.

9. On October 26, 2010 Claimant saw Dr. Beatty. Claimant reported that he was doing much better and that his headaches were intermittent and mild but that he still had some discomfort and a feeling of numbness over the inside of his right elbow. Dr. Beatty's objective findings on physical examination included improved cervical range of motion of: flexion 75 degrees; extension 55 degrees; side bending right 50 degrees; side bending left 50 degrees; right rotation 80 degrees; left rotation 80 degrees. Dr. Beatty continued the treatment plan, noted an additional diagnosis of right medial epicondylitis, released Claimant to full duty work status without restrictions, and indicated that maximum medical improvement status would be 2-3 weeks on the handwritten form and 3-4 weeks on the typewritten report. See Exhibit 8.

10. On November 16, 2010 Claimant missed a follow up appointment scheduled with Dr. Beatty. Claimant did not contact Dr. Beatty to reschedule. See Exhibit 8. At no time did Dr. Beatty or any other treating provider refuse to treat Claimant for either medical or nonmedical reasons.

11. Dr. Beatty opined that Claimant reached maximum medical improvement on November 16, 2010 and that Claimant suffered no permanent impairment as a result of the October 11, 2010 injury. See Exhibit I.

12. Claimant did not seek any medical treatment for approximately two years and three months following his October 26, 2010 appointment. During this time, Claimant continued to work full duty for Employer. Claimant's symptoms never subsided and persisted during this period of time, but Claimant was able to work full duty and deal with the persistent pain and symptoms. In 2013 Claimant's pain worsened and he again sought treatment.

13. On January 17, 2013 Claimant saw Dr. Beatty. Claimant reported neck pain with numbness into his right fingers that had developed over the last 10 months. Dr. Beatty diagnosed cervical strain, indicated it was unknown if it was work related, provided manipulation, a second Medrol dose pack, and indicated no plans to follow up unless Claimant's symptoms persisted. Dr. Beatty did not refuse to further treat Claimant. See Exhibit 8.

14. On February 7, 2013 Kathy McCranie, M.D. performed a medical record review at Respondents' request. Dr. McCranie opined that with the significant time gap between the Claimant's last visit to Dr. Beatty and Claimant's report of his symptoms returning, it was not medically probable that there was a relationship between Claimant's October, 2010 injury and the symptoms that Claimant reported beginning in March or the summer of 2012. Dr. McCranie indicated to further assess causality, an Independent Medical Evaluation could be considered. See Exhibit L.

15. On February 15, 2013 Claimant saw Kathy Gutierrez, ANP, PhD (refers to herself as Dr. Gutierrez) at Premiere Healthcare Associates, LLC. Claimant was not referred to Dr. Gutierrez by Dr. Beatty or by any other provider but chose to treat with her on his own. Dr. Gutierrez noted that Claimant was a new patient who wished to establish care. Claimant reported that he was injured in October of 2010 and was seen by Rocky Mountain Medical Group, his employers' work compensation provider. Claimant reported he went through physical therapy for two weeks which helped with the discomfort and that he did well for a time. Claimant reported after doing well for a time, the headaches started to reoccur with pain radiating down his neck and upper back. Claimant also reported right wrist pain with numbness and tingling of his 2nd and 3rd fingers. See Exhibit K.

16. Dr. Gutierrez diagnosed post-traumatic headache, unspecified, thoracic spine pain, left shoulder pain, and carpal tunnel syndrome right wrist. She planned to get cervical and thoracic spine films and prescribed a right wrist splint. See Exhibit K

17. On March 7, 2013 Allison Fall, M.D. performed an Independent Medical Evaluation. Dr. Fall opined that Claimant's October 2010 work injury was not causing his current complaints or symptoms and that his right upper extremity paresthesias and neck pain were of unknown etiology. Dr. Fall reviewed Claimant's job responsibilities and did not identify any repetitive tasks and, therefore, opined that it would be unlikely that a compression neuropathy would be related to his work activities. Dr. Fall noted on physical examination that Claimant reported pain along the left levator scapulae on extension of the cervical spine. Dr. Fall did not complete cervical spine range of motion testing, but noted upon visual inspection, cervical range of motion appeared unrestricted. See Exhibit 7.

18. On March 25, 2013 Claimant again saw Dr. Gutierrez. Claimant reported headaches, neck pain, and left shoulder pain. Claimant also reported right wrist pain with numbness and tingling of his 2nd and 3rd fingers. Dr. Gutierrez noted that the x-rays of the cervical spine were unremarkable and that the x-rays for the thoracic spine were also unremarkable. Dr. Gutierrez diagnosed left shoulder pain and carpal tunnel syndrome of the right wrist. She advised Claimant it was in his best interest to see a workers' compensation provider. See Exhibit K.

19. April 26, 2013 an EMG and nerve conduction study was performed by Hua Judy Chen, M.D. Dr. Chen identified electrodiagnostic evidence for mild to moderate right carpal tunnel syndrome. Dr. Chen opined there was no evidence of cervical radiculopathy. Dr. Chen indicated that an MRI of the cervical spine would still be needed to rule out central cord lesion. See Exhibit 9.

20. On May 8, 2013 Claimant again saw Dr. Gutierrez. Dr. Gutierrez diagnosed radiculitis, right shoulder pain, and brachial plexus lesion. Dr. Gutierrez suspected possible cervical spine involvement in upper extremity symptoms and noted the plan would be to schedule a cervical MRI in the near future. Dr. Gutierrez recommended avoiding overhead work and repetitive motion activities related to the right wrist. See Exhibit K.

21. On May 16, 2013 Claimant underwent an MRI of his cervical spine. The MRI showed at C4-5 a mild central disc bulge with mild effacement of ventral thecal sac and mild bilateral neural foraminal stenosis. At the C5-6 level it showed mild left lateral recess disc bulge that contained increased T2 signal intensity consistent with a small annular tear resulting in mild left neural foraminal stenosis. The MRI showed right neural foramina widely patent. At the remaining levels, the MRI was unremarkable. See Exhibit K.

22. On May 21, 2013 a Final Admission of Liability was filed by Respondents. The Final Admission denied liability for medical treatments and/or medications after

maximum medical improvement and noted that for the October 11, 2010 injury, Claimant had reached maximum medical improvement on November 16, 2010. See Exhibit A.

23. Claimant did not object to the Final Admission.

24. Following the filing of the Final Admission, Claimant continued to treat with Dr. Gutierrez. Claimant saw Dr. Gutierrez on June 10, 2013 and indicated he wanted to pursue a surgical consultation and was going to speak with an attorney regarding his workers' compensation status. See Exhibit K.

25. On December 16, 2013 Claimant underwent an Independent Medical Examination with John Hughes, M.D. Claimant reported the October 2010 injury to Dr. Hughes and indicated that he was discharged from care after a couple of weeks. Dr. Hughes noted that Claimant continued to be symptomatic and that his right sided neck pain persisted after Claimant stopped treating with Dr. Beatty. Dr. Hughes opined that Claimant's current symptoms and clinical findings were quite similar to those noted three years ago by Dr. Beatty. Dr. Hughes opined that Claimant's cervical spine injury of October, 2010 persisted and that over time had become medically stable. Dr. Hughes opined Claimant was at maximum medical improvement, performed range of motion testing, provided an 8% whole person impairment rating, and recommended maintenance care of Medrol dose pack and osteopathic manipulative treatment, as well as trigger point injections, and medically directed progressive physical exercise. See Exhibit 6.

26. Dr. Hughes assessed: high energy axial compressive trauma sustained on October 11, 2010; closed head injury with brief loss of consciousness, resolved; cervical spine sprain/strain with development of right cervicothoracic regional myofascial pain syndrome with documentation of improvement but with persistence; long-term persistence of right superomedial scapular myofascial pain with current findings of a trigger point and reduced left lateral flexion of the cervical spine, as noted initially by Dr. Beatty; and recent emergence of right carpal tunnel syndrome, unrelated to the work injury on October 11, 2010. See Exhibit 6.

27. Dr. Hughes provided range of motion testing that showed Claimant's range of motion was overall worse than the range of motion performed on October 26, 2010, just prior to being placed at maximum medical improvement. On physical examination Dr. Hughes' objective range of motion findings for the cervical spine included: flexion at 60 degrees; extension from 65-71 degrees; right lateral flexion from 35-44 degrees; limited left lateral flexion from 32-36 degrees eliciting right lateral neck pain; and both right and left rotation of the head and neck at 48 and 58 degrees maximally. See Exhibit 6.

28. Dr. Hughes opined that Claimant had developed new symptoms in his right upper extremity, and agreed with other providers that the diagnosis was carpal tunnel syndrome. He concluded that this condition was separate from the October 11,

2010 injury but that it was a work related medical condition. He recommended medical treatment consistent with the Colorado Medical Treatment Guidelines and opined that Claimant's carpal tunnel condition was not at maximum medical improvement. See Exhibit 6.

29. On January 24, 2014 Claimant filed a workers' claim for compensation listing an injury date of approximately June, 2012. Claimant listed body parts affected as head, neck, back, shoulders, arms, and hands. Claimant indicated "I may have aggravated my 10/11/10 injury," and that the injury occurred by crawling, reaching, and twisting. See Exhibit C.

30. On February 11, 2014 Respondents filed a Notice of Contest. See Exhibit E.

31. On February 24, 2014 Claimant filed a Petition to Reopen WC case 4-918-977 alleging a change in medical condition. See Exhibit F.

32. On July 9, 2014 Dr. Fall performed a second Independent Medical Examination. Claimant reported neck pain, elbow numbness, head pain, shoulder aches, arm ache, and constant headaches. Dr. Fall reviewed in detail Claimant's job duties with him and noted his job duties varied daily depending on the particular jobsite. Claimant reported that every job was different and involved different tasks, his body was often in different positions, he used a staple gun for 3-4 minutes at a time, he carried ladders on occasion, and he used a screw gun on occasion. Dr. Fall opined that Claimant had carpal tunnel syndrome but opined that it was not work related as Claimant did not have risk factors for developing carpal tunnel as an occupational disease since his work and positioning varied frequently. Dr. Fall also opined that Claimant did not have any permanent medical impairment from his October 2010 injury and agreed that Claimant had reached MMI for the October 2010 injury on November 16, 2010. Dr. Fall opined that findings on the cervical MRI were unrelated to the October 2010 work injury and were appropriate multilevel degenerative changes. On physical examination Dr. Fall's objective range of motion findings for the cervical spine revealed mildly reduced range of motion in all planes with the most significant limitation in right rotation, and noted the cervical range of motion revealed near normal range of motion with the exception of decreased right rotation. She noted that Claimant complained of pain along the right lateral cervical spine and across the upper trapezius with all range of motion. See Exhibit H.

33. On August 18, 2014 Claimant again saw Dr. Gutierrez. Claimant reported ongoing neck pain, right shoulder pain, and headaches. Claimant reported the discomfort had not changed since his first visit in February of 2013. Claimant indicated he felt strongly that the discomfort started at the time the screw drill fell onto his head and neck in October of 2010. See Exhibit K.

34. On December 15, 2014 Dr. Hughes performed a case review. Dr. Hughes noted Claimant's job duties as described by Claimant, noted Claimant had continued

neck pain and headaches, right shoulder pain, and burning-quality pain and numbness of all of his fingers, more right than left sided. Dr. Hughes opined that Claimant suffered from right sided carpal tunnel syndrome secondary to forceful and repetitive grasping at work, as described by Claimant. Dr. Hughes opined, after speaking with Claimant regarding Claimant's essential job functions, that the onset of right-sided carpal tunnel syndrome was a work related occupational disease. Dr. Hughes opined that forceful use of metal hand shears constitutes a quite forceful grasping and repetitive physical exposure that he believed met the criteria for injurious exposure in accordance with the Colorado Division of Workers' Compensation Cumulative Trauma Medical Treatment Guidelines. See Exhibit 6.

35. Dr. Hughes did not opine that Claimant suffered an occupational disease of his cervical spine nor did he offer an opinion causally connecting Claimant's cervical spine condition to repetition or repeated job duties.

36. At hearing Dr. Fall testified consistent with her report. Dr. Fall indicated that she took into consideration Claimant's description of his job duties that she reviewed with him in detail. Dr. Fall opined that there was insufficient medical evidence to substantiate a work related occupational disease of the right upper extremity (carpal tunnel). She opined that Claimant's duties would not cause carpal tunnel because Claimant's day is broken up with a wide variety of different tasks and because Claimant does not perform work where he has four to six hours of wrist flexion. Dr. Fall opined that after comparing Claimant's job duties to the Medical Treatment Guidelines Claimant did not meet the criteria for work related carpal tunnel syndrome. She opined within a reasonable degree of medical probability that the carpal tunnel was not work related.

37. Dr. Fall further opined that Claimant did not suffer from a work related occupational disease of the cervical spine. Dr. Fall opined that there was insufficient evidence of repetitive movements of Claimant's neck or holding neck in an awkward position. Dr. Fall opined that one would need to have sustained awkward posturing where a change of position was not possible to support an occupational disease of the cervical spine. Dr. Fall opined within a reasonable degree of medical probability that Claimant does not suffer an occupational disease of his cervical spine.

38. Dr. Fall's opinions and testimony are found credible and persuasive regarding the occupational disease of Claimant's right upper extremity (carpal tunnel) and occupational disease of Claimant's cervical spine. Her opinions are based on a detailed review of Claimant's daily job duties, consistent with Claimant's testimony, and show a complete analysis under the medical treatment guidelines. Her opinion that Claimant does not suffer from an occupational disease of the right upper extremity is more credible and persuasive than the differing opinion of Dr. Hughes. Her opinion that Claimant does not suffer from an occupational disease of his cervical spine is also credible and persuasive and is the only medical opinion addressing occupational disease of the cervical spine.

39. Dr. Fall further opined that Claimant's cervical condition from the October 11, 2010 injury is not objectively worse now than it was on November 16, 2010 when Claimant was placed at maximum medical improvement based on her physical examination findings and range of motion measurements. Dr. Fall opined that Claimant's symptomatology has been consistent from 2010 until now and has not worsened.

40. Dr. Fall's opinion on the worsening of Claimant's cervical condition is not found credible or persuasive and her opinion is not consistent with her own range of motion measurements which showed decreased right rotation in July of 2014 that was not present when Claimant was placed at maximum medical improvement in November of 2010.

41. Claimant's testimony that his pain never went away completely, was persistent following the 2010 injury, and that it got worse prior to seeking medical treatment in 2013 is found credible and persuasive. Claimant worked unrestricted following the 2010 injury for almost 2.5 years without any medical treatment when the pain increased to the point that he needed to seek treatment. Claimant's subjective reports of worsening are found credible and are supported by objective range of motion testing showing that in 2013 his range of motion for the cervical spine was significantly decreased from the range of motion he displayed at the time of maximum medical improvement in November of 2010.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, *et seq.*, C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. See § 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. See § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim*

Appeals Office, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Reopening and Change of Condition

Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of change in condition. The claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 220 (Colo. App. 2008); *Chavez v. Industrial Commission*, 714 P.2d 1328 (Colo. App. 1985). The question of whether the claimant met the burden of proof to establish a causal relationship between the industrial injury and the worsened condition is one of fact for determination by the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Reopening is warranted if the claimant proves that additional medical treatment or disability benefits are warranted. *Richards v. Industrial Claim Appeals Office*, 996 P.2d 756 (Colo. App. 2000); *Dorman v. B & W Construction Co.*, 765 P.2d 1033 (Colo. App. 1988).

A change in condition, for purposes of the reopening statute, refers to a worsening of the claimant's work-related condition after MMI. *El Paso County Dept. of Social Services v. Donn*, 865 P.2d 877 (Colo. App. 1993). The pertinent and necessary inquiry is whether claimant has suffered any deterioration in his work related condition that justifies additional benefits. *Cordova v. Indus. Claim Appeals Office*, *supra*. The reopening authority under the provisions of Section 8-43-303, C.R.S. is permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the sound discretion of the ALJ. *Renz v. Larimer County Sch. Dist. Poudre R-1*, 924 P.2d 1177 (Colo. App. 1996).

Claimant has established by a preponderance of the evidence that his condition as a result of the October 11, 2010 work injury has worsened sufficient to reopen the claim. Although the multiple physicians agree that his symptoms persisted following his 2010 injury and continued until he again sought treatment in 2013, when Claimant

treated in 2013 he subjectively had worsened pain and objectively displayed reduced range of motion compared to the range of motion measurements performed in 2010 when he was placed at maximum medical improvement. It is true that Claimant's complaints of pain and symptoms in 2013 were very similar to the same complaints he provided to Dr. Beatty in 2010, and that the location of the complaints was similar. However, Claimant is credible that although the pain complaints and symptoms stayed in the same location and never went away completely following the 2010 injury, they also got worse in 2013 leading him to seek further treatment. This is objectively supported by range of motion testing showing Claimant's range of motion in 2013 was worse than when performed in 2010 by Dr. Beatty.

Claimant's testimony that his symptoms, although persistent from 2010 and located in the same areas of his body, worsened in 2013 is credible and persuasive and supported by the medical records. As found above, when Claimant initially treated with Dr. Beatty he showed reduced range of motion and was placed on modified duty work restrictions. A few weeks later, on October 26, 2010, Dr. Beatty noted Claimant's improvement, released Claimant to full duty work status without restrictions, and noted his cervical range of motion had improved to essentially normal. Although Claimant still had pain complaints at the October 26, 2010 appointment, Claimant was reported by Dr. Beatty to have reached maximum medical improvement on November 16, 2010 with no permanent impairment.

However, although Claimant had improved by October 26, 2010, he was not without pain. The pain and symptoms he reported on October 26, 2010 persisted and continued over the course of the next several years. Claimant continued working for approximately the next 2.5 years without restrictions before the persistent symptoms reached the point where Claimant again sought medical treatment. In February of 2013, Claimant reported to Dr. Gutierrez that he had initially improved after treating with Dr. Beatty, but that his symptoms persisted and were now worse. On December 16, 2013 at the Independent Medical Examination performed by Dr. Hughes, Claimant had range of motion that had gotten worse from the time he was placed at maximum medical improvement. A comparison of the objective range of motion testing of Claimant's cervical spine by Dr. Beatty and Dr. Hughes is compared below.

| | Beatty 2010 (MMI) | Hughes 2013 |
|-----------------------|--------------------------|---------------------|
| Flexion | 75 | 60 |
| Extension | 55 | 65-71 |
| Right lateral flexion | 50 | 35-44 |
| Left lateral flexion | 50 | 32-36 |
| Left rotation | 80 | 48 and 58 maximally |
| Right rotation | 80 | 48 and 58 maximally |

Additionally, Dr. Fall noted in her July 9, 2014 independent medical examination that objectively on physical examination Claimant had mildly reduced cervical spine range of motion in all planes with the most significant limitation in right rotation. As found above, this is a finding different from and worse than the range of motion findings performed by Dr. Beatty in November of 2010 when Claimant was placed at maximum medical improvement. After reviewing the evidence, including Claimant's credible testimony of worsening and the objective medical evidence of reduced range of motion, the ALJ concludes that Claimant has met his burden to show by a preponderance of the evidence that he has suffered a change of condition related to the October 11, 2010 work injury to warrant a reopening of WC case 4-918-977.

Authorized Treatment

Authorization to provide medical treatment refers to a medical provider's legal authority to treat the claimant with the expectation that the insurer will compensate the provider. *Bunch v. ICAO*, 148 P.3d 381 (Colo. App. 2006); *One Hour Cleaners v. Industrial Claim Appeals Office*, 914 P.2d 501 (Colo. App. 1995). Consequently, if the claimant obtains unauthorized medical treatment, the respondents are not required to pay for it. *Id.* Authorized providers include those to whom the employer directly refers the claimant and those to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997.)

Claimant has failed to establish in this case that the medical treatment rendered by Dr. Gutierrez is authorized medical care. As found above, there was no referral by an authorized provider to Dr. Gutierrez. Rather, Claimant sought treatment with Dr. Gutierrez on his own. As found above, Claimant was never denied medical care by Respondents or Dr. Beatty nor was he denied care for nonmedical reasons. Thus, the choice of physician never passed to him. Rather, Claimant simply decided to seek treatment elsewhere and chose not to return to Dr. Beatty. Therefore, Dr. Gutierrez is not an authorized medical provider in this claim and Respondents are not liable for payment for any treatment provided by her.

Occupational disease

An injury or occupational disease "arises out of" employment when it has 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 in connection with the contract of employment. *Panera Bread, LLC v. Indus. Claim Appeals Office*, 141 P.3d 970 (Colo. App. 2006). For an injury to arise out of employment, "the claimant must show a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract." *Madden v. Mountain W. Fabricators*, 977 P.2d 861 (Colo. 1999).

An occupational disease, as opposed to an occupational injury, arises not from an accident, but from a prolonged exposure occasioned by the nature of the

employment. *Colorado Mental Health Institute v. Austill*, 940 P.2d 1125 (Colo. App. 1997). C.R.S. § 8-40-201(14) defines “occupational disease” as: “A disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been generally exposed outside of the employment.”

Claimant has failed to establish by a preponderance of the evidence that he suffers from an occupational disease of the cervical spine. As found above, there is no credible evidence or medical opinion supporting an occupational disease to his cervical spine. Dr. Fall opined credibly that Claimant’s job duties did not show sustained awkward positioning to cause an occupational disease of the neck. Dr. Hughes also opined that Claimant’s symptoms in the cervical spine relate directly back to Claimant’s 2010 injury and Dr. Hughes does not relate any of Claimant’s cervical symptoms to an occupational disease or sustained awkward positioning.

Similarly, Claimant has failed to meet his burden to establish by a preponderance of the evidence that he suffers from an occupational disease of his right upper extremity (carpal tunnel). Dr. Fall’s analysis under the Medical Treatment Guidelines and opinion that Claimant’s job duties do not meet the criteria for an occupational disease of carpal tunnel is found credible and persuasive and more persuasive than the opinion provided by Dr. Hughes. Dr. Hughes placed a large emphasis on Claimant’s use of metal shears, however, as found above Claimant’s job duties varied greatly throughout each day and metal shears were not a major component of his job duties. Further, Dr. Hughes did not record how frequently the use of shears occurred throughout a work day, the repetitions per hour with the shears, or the force required to operate the shears. Given Claimant’s own description of his work duties throughout the day, and the description provided to Dr. Fall and used in her analysis, Claimant did not have prolonged exposure of awkward wrist flexion sufficient to meet the medical treatment guidelines during the course of his work day. Claimant often changed positions, moved around, and performed different duties throughout the day without awkward sustained posturing, sustained activity, or forceful tool use. Dr. Fall is credible that Claimant’s work duties as described are the type that would not cause carpal tunnel syndrome and that Claimant does not meet the threshold requirements for carpal tunnel syndrome as an occupational disease.

ORDER

It is therefore ordered that:

1. Claimant has met his burden to show that he suffers from a worsened condition causally related to his October 11, 2010 work injury. His petition to reopen WC No. 4-918-977 is granted.

2. Claimant has failed to meet his burden to show that the treatment provided by Dr. Gutierrez was authorized. Claimant's request for authorization and payment of treatment provided by Dr. Gutierrez is denied and dismissed.

3. Claimant has failed to meet his burden to show that he suffers from a work related occupational disease of his cervical spine. His request for treatment is denied and dismissed.

4. Claimant has failed to meet his burden to show that he suffers from a work related occupational disease of his right upper extremity (carpal tunnel). His request for medical treatment is denied and dismissed.

5. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 8, 2015

/s/ Michelle E. Jones

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th floor
Denver, CO 80203

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Respondents have proven by clear and convincing evidence that Claimant has reached MMI for his wrist injury on April 26, 2013; and
2. Whether Respondents have proven by clear and convincing evidence that Claimant's shoulder injury is not causally related to the work injury on April 26, 2013.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following findings of fact are entered.

1. At the time of hearing, Claimant was 36 years old and resided in Denver, Colorado. Claimant worked as a General Helper for Employer for several months. His duties included breaking-up cement and smashing cement pipes, which required regular use of sledgehammers and other heavy tools. Claimant worked long hours and at times Claimant worked up to 10 hours a day. Claimant is right-hand dominant.
2. On April 26, 2013, Claimant was injured at work while down in a pit shoveling hardened cement. He was injured when he jammed the shovel into the hardened cement floor and injured his right hand, wrist, arm and shoulder. His injury occurred at the workplace while performing his normal job duties.
3. Claimant told Hanna St. John on May 17, 2013, about his injured right shoulder and reported that he believed he injured the right shoulder at the time he injured his right wrist.
4. Claimant credibly testified that he had no previous right shoulder injury..
5. Claimant could not perform his work duties as General Helper for Employer with a right shoulder injury because his job requires heavy manual labor for up to 10 hours a day. Claimant was not able to swing a sledgehammer or break-up cement with an injured right shoulder.

6. Prior to being hired full-time as a General Helper for Employer, Claimant had a seven month "try-out" period. He performed his job functions so well he was hired full-time.
7. Claimant's right shoulder still hurts and he has limited range of motion and strength. He cannot perform his normal job duties with his injured right shoulder. Claimant's physicians recommend surgery on his right shoulder.
8. Claimant was first seen by Concentra Medical Centers on May 14, 2013, for his right wrist injury. Claimant denied any past injury to his right hand. His examination revealed he had a positive Finkelstein's test with increased pain with thumb extension. He was diagnosed with radial styloid tenosynovitis. He returned to work on May 14, 2013, with a splint.
9. On May 17, 2013, Claimant complained to Hanna St. John at Concentra Medical Centers of right shoulder pain and popping after returning to work.
10. On June 3, 2013, Dr. Kulvinder Sachar, M.D., hand surgeon, saw Claimant and diagnosed Claimant with right de Quervain's tenosynovitis.
11. On July, 9 2013, Dr. Sachar performed a right first dorsal compartment release of Claimant's right wrist.
12. On July 15, 2013, Dr. Sachar followed-up with Claimant regarding his right wrist injury.
13. On October 7, 2013, Claimant saw Hanna St. John and he complained of continued right shoulder pain since his work restrictions had changed for his right wrist and he was performing more of his normal job duties. Claimant had trouble lifting more than 10 pounds and his right shoulder continued to pop and click.
14. On October 15, 2013, Claimant was seen at Concentra for final examination and an impairment rating for his right wrist injury. He was seen by Dr. Burrows and given a 4% upper extremity impairment which equals 2% whole person.
15. On October 15, 2013, Claimant was also seen by Hanna St. John and complained of continued right shoulder pain and he was diagnosed with a shoulder sprain. Claimant was given restrictions of no lifting over 10 pounds.
16. On October 16, 2013, Claimant had a MRI on his right shoulder. The MRI indicated the supraspinatus, infraspinatus and subscapularis tendinosis with near full-thickness tear of the supraspinatus at the insertions. The MRI also indicated there was a superior posterior labral tear extending into the biceps anchor.

17. On October 21, 2013, Claimant saw Dr. Mark J. Montano, M.D. Dr. Montano reported that based on Claimant's explanation of the right shoulder injury, it was work-related. Claimant explained to the doctor that his right shoulder "worsened" when he was able to resume normal activities at work and use the right upper extremity. Dr. Montano referred Claimant to an orthopedic physician.
18. On October 23, 2013, Claimant was seen by Christine O'Neal because he was experiencing right shoulder pain. Claimant had been diagnosed with a labrum tear and a supraspinatus tear.
19. On October 29, 2013, Claimant was seen by Dr. Cary Motz, orthopedic surgeon at Concentra Medical Centers, for his right shoulder injury. Dr. Motz indicated his shoulder injury was work-related. Claimant was scheduled for surgery pending approval by insurance.
20. On November 8, 2013, Dr. Wallace Larson, M.D. performed a record review without examination of Claimant. The doctor confirmed that he, and the treating doctor, were in agreement that the right shoulder condition is not work-related. The doctor maintained there was no traumatic event to the right shoulder at the time of the work injury that would explain his right rotator cuff tear. Because the doctor could find no contributing event to explain the right rotator cuff tear, he opined that the right shoulder injury could not be work-related. Furthermore, he maintained that Claimant would have experienced pain in the right shoulder from the rotator cuff tear if it occurred during the work incident when Claimant's right wrist was injured.
21. On March 11, 2014, Dr. John Burriss felt Claimant reached maximum medical improvement (MMI) on October 15, 2013, with respect to his right wrist injury and confirmed his 4% upper extremity impairment rating.
22. On April 1, 2014, Claimant was evaluated by Dr. Montano at Concentra Medical Centers. Dr. Montano confirmed Claimant's diagnosis of a tear to the rotator cuff and noted limited range of motion of the shoulder with extension, abduction and external rotation. Dr. Montano recommended a return to work on April 1, 2014, with work restrictions that included no lifting over 10 pounds, no pushing or pulling over 20 pounds of force and no reaching above the shoulders.
23. On August 29, 2014, Claimant was seen by Dr. Douglas Scott, M.D., for a Division Independent Medical Examination (DIME). Dr. Scott is an occupational medicine specialist. Dr. Scott evaluated Claimant's right wrist/thumb, effusion of forearm joint and radial styloid tenosynovitis, right shoulder rotator cuff labrum tear, and supraspinatus tear. He also made findings regarding MMI, impairment ratings and apportionment.

24. Dr. Scott disagreed with Dr. Burris and believed Claimant was not at MMI for his right wrist injury as his range of motion and function of his right wrist had worsened since Dr. Burris's determination on October 15, 2013.
25. Dr. Scott recommended Claimant be referred back to Dr. Sachar for re-evaluation and considered for diagnostic testing or surgery.
26. Further, Dr. Scott disagreed with Dr. Burris's impairment rating on Claimant's right wrist. Using the *AMA Guides*, and evaluating the right wrist and thumb for active range of motion with a goniometer, Dr. Scott concluded Claimant had a total right thumb digital impairment of 27%, with a total hand impairment of 11%. Dr. Scott concluded Claimant's total upper extremity impairment equaled 10% at the right hand. Dr. Scott found 9% upper extremity impairment at the right wrist.
27. Dr. Scott also evaluated Claimant's right shoulder. He found Claimant's right shoulder was currently dysfunctional and that his condition was not stable. Dr. Scott felt Claimant needed right shoulder surgery to improve his range of motion and function. Dr. Scott concluded Claimant's shoulder was not at MMI.
28. Dr. Scott stated that Claimant should be referred back to Dr. Motz for a right shoulder evaluation for consideration of right shoulder arthroscopy to repair Claimant's full thickness tear of the rotator cuff.
29. Dr. Scott assigned 19% upper extremity impairment for Claimant's right shoulder injury.
30. Dr. Scott concluded, combining the 10% upper extremity impairment at the hand with 9% upper extremity impairment at the wrist with the 19% upper extremity impairment at the shoulder, equaled a total upper extremity impairment of the right upper extremity of 34%. Dr. Scott converted this 34% upper extremity impairment to a whole person impairment rating of 20%. Dr. Scott found apportionment was not applicable.
31. Dr. Scott noted he did not have any medical records that demonstrated Mr. Cannon had a pre-existing injury or prior dysfunction to the right shoulder.
32. Dr. Scott's DIME opinion was ambiguous regarding the relatedness of the right shoulder injury to the April 26, 2013, work injury. Dr. Scott notes in his DIME report that the relatedness of the right shoulder condition needed to be resolved through litigation. Dr. Scott's report indicates an awareness of Claimant's medical treatment and recites details from the medical records when Claimant did not make right shoulder complaints on April 26, 2013, and May 14, 2013, and when he reported right shoulder pain with popping

on May 17, 2013. Dr. Scott appeared to have a grasp of all the salient facts regarding Claimant's right shoulder and opined regarding Claimant's MMI status and impairment rating for the right shoulder and wrist.

33. Considering the totality of the medical records, Claimant's credible testimony, and Dr. Scott's conclusions that Claimant is not at MMI for his right shoulder, has impairment and requires additional treatment, it is found that the Dr. Scott's DIME opinion is that Claimant's right shoulder condition is work related. Thus, in this matter, it is Respondents' burden of proof to overcome the opinion of Dr. Scott on the issue of the relatedness of the right shoulder injury to the April 26, 2013, work injury by clear and convincing evidence.
34. Respondents failed to sustain that burden of proof. Respondents rely on Dr. Larsen's record review and opinion that Claimant's right shoulder injury was not work related. The DIME physician considered the same facts considered by Dr. Larsen and came to a contrary conclusion. Dr. Scott referenced Dr. Larsen's opinion and its basis and still concluded that Claimant right shoulder injury was work related. The doctors have a difference of opinion, however, Respondents did not present clear and convincing evidence that Dr. Scott is most probably incorrect on the issue of the relatedness of the right shoulder condition.
35. Further, it is found that Respondents did not present clear and convincing evidence that Dr. Scott's opinion on MMI was most probably incorrect.

CONCLUSIONS OF LAW

Having entered the foregoing findings of fact, the following conclusions of law are reached.

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. C.R.S. § 8-40-102(1) (2013). A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. § 8-42-101. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. C.R.S. § 8-43-201 (2013). A Workers' Compensation case is decided on its merits. C.R.S. § 8-43-201 (2013).

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings

as unpersuasive. See *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. In this case, Respondents filed an application for hearing challenging the DIME physician's determination of MMI and relatedness. The parties agreed that Dr. Scott, the DIME, concluded that Claimant was not at MMI for the right wrist and right shoulder injuries. As for the right wrist determination of MMI, the Respondents had the burden of proof to establish by clear and convincing evidence that the DIME physician's determination of MMI was most probably incorrect.

5. With regard to the determinations made by the DIME physician regarding the right shoulder, Respondents contend that the DIME did not find the right shoulder injury causally related to the April 26, 2013, work injury. Thus, Respondents argue that Claimant has the burden of proof by clear and convincing evidence to establish that the DIME physician's opinion on the relatedness of the right shoulder injury was most probably incorrect. Respondents further argue that since the right shoulder injury is not related to the April 26, 2013, work injury, the DIME determination of MMI for the right shoulder is incorrect and irrelevant.

6. Claimant argues that Respondents failed meet their burden of proof to establish that the MMI determination of the DIME physician was most probably incorrect. Claimant argues that the DIME determined that Claimant is not at MMI for the right wrist and shoulder injuries. Claimant contends that the DIME determined that the right shoulder is related to the April 26, 2013, work injury and thus it is Respondents' burden of proof by clear and convincing evidence to prove the DIME is most probably incorrect.

7. Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert, supra*. A mere difference of opinion between physicians fails to constitute error. See, *Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

8. The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office, supra*.

9. A party has a clear and convincing burden of proof to overcome the medical impairment rating determination of the DIME, Dr. Scott. Section 8-42-107(8), C.R.S. All of the reports and testimony of the DIME are to be considered in deciding what is the determination of the DIME. Then, the party who seeks to overcome that opinion faces a clear and convincing burden of proof. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998).

10. In this case, the DIME recognized, but failed to directly address, the issue of right shoulder relatedness. Where the DIME report contains ambiguities, it is the responsibility of the ALJ to resolve the ambiguities and determine what the DIME actually found. *MGM Supply Co. v. Industrial Claim Appeals Office*, 62 P.3d 1001, 1005 (Colo. App. 2002); *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000); *Villoch v. Opus Northwest, LLC*, W.C. 4-514-339 (ICAO, June 17, 2005); *Hill v. American Linen*, W.C. 4-375-880 (ICAO, December 2, 2004).

11. Here, it is concluded that the DIME physician's opinion regarding the relatedness of the right shoulder injury is ambiguous. However, based on the totality of the evidence, it is concluded that the DIME physician considered the salient facts, including: the fact that Claimant reported shoulder pain on his second visit to the doctor on May 17, 2013, 21 days after reporting the right wrist injury on April 26, 2013; that, thereafter, Claimant underwent active treatment of the right wrist, including surgery; and that, beginning October 7, 2013, and continuing on multiple visits throughout October, Claimant reported right shoulder pain and limited range of motion after Claimant resumed normal work duties requiring use of the right upper extremity. The DIME physician commented that the right shoulder relatedness question would be resolved through litigation.

12. The ALJ resolves the ambiguity in the DIME opinion on the relatedness issue concluding that Dr. Scott found the right shoulder injury related to the April 26, 2013, work injury. Therefore, it is further concluded that Respondents have the burden of proof by clear and convincing evidence to establish that the DIME physician is most probably incorrect in his determination that the right shoulder is related to the April 26, 2013, injury.

13. Respondents offered the deposition of Dr. Wallace Larsen in support of their position that Dr. Scott is incorrect about the relatedness of the right shoulder injury.

And, while Dr. Larsen does raise relevant questions about the relatedness of the right shoulder, his opinions do not rise to the level of clear and convincing evidence that Dr. Scott's opinion is most probably incorrect. Dr. Larsen's opinion relies on the absence of an immediate report of a right shoulder injury. Dr. Larsen's opinion also relies upon the doctor's opinion that Claimant's reported mechanism of injury would not cause injury to his right shoulder and that Claimant failed to immediately report pain in the right shoulder when it was the doctor's that a rotator cuff tear would cause immediate right shoulder pain.

14. Dr. Scott, as an occupational medicine specialist, in the DIME report, references Dr. Larsen's opinions about the relatedness of the right shoulder injury and opines that Claimant's right shoulder injury is not at MMI and requires additional treatment. Dr. Larsen's opinions and the medical records do not support the conclusion that there is clear and convincing evidence that Dr. Scott is incorrect about the relatedness of the right shoulder condition. Dr. Larsen's opinion is found to be no more than a difference of opinion between doctors and does not rise to the level of clear and convincing evidence of an error on Dr. Scott's part.

15. No credible or persuasive evidence was present to support Respondents' position that Dr. Scott's opinion regarding MMI is incorrect. Respondents, in argument, concede that Claimant has been afforded the treatment recommended by Dr. Scott for the right wrist injury. Dr. Scott opined that Claimant's right wrist and thumb had worsened and that Claimant should be referred to Dr. Sacher for re-evaluation. Respondents argued at hearing that Claimant had undergone the re-evaluation by Dr. Sacher recommended by Dr. Scott. Furthermore, Respondents' argument regarding MMI of the right shoulder was premised on the position that Claimant's right shoulder condition was not related to the April 26, 2013, work injury. No argument or evidence was presented that allowed the conclusion to be reached that, if Claimant's right shoulder condition was found to be work related, Claimant was at MMI. Since Claimant's right shoulder injury has been found to be related to the work injury, the credible and persuasive evidence establishes that he is not at MMI and Dr. Scott's opinion has not been overcome by clear and convincing evidence.

ORDER

It is therefore ordered that:

1. Respondents failed to sustain their burden of proof to establish by clear and convincing evidence that Dr. Scott's DIME opinion on MMI and relatedness were most probably incorrect.
2. Respondents shall be liable for medical treatment to cure and relieve Claimant of the effects of the April 26, 2013, work injury to Claimant's right wrist and right shoulder.
3. Respondents' claim is denied and dismissed.

All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 14, 2015

DIGITAL SIGNATURE:


Margot W. Jones, Administrative Law
Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

- Whether claimant has proven by a preponderance of the evidence that the medical treatment recommended by Dr. Lewis is reasonable and necessary to cure and relieve claimant from the effects of the industrial injury?
- Whether claimant has proven that respondents have waived the right to contest the proposed medical treatment by failing to contest the medical treatment in writing as required by W.C.R.P. 16-9(G)?

FINDINGS OF FACT

1. Claimant sustained an admitted injury on March 11, 2013 when he was putting away supplies and walked into a storage room and fell through an open grate into the basement. Claimant fell approximately six feet. Claimant was eventually diagnosed with a fracture of his ankle.

2. Claimant came under the care of Dr. Ting following his injury. Claimant reported to Dr. Ting complaints of back pain during his examinations. Claimant was provided with a cast boot for his ankle and prescribed medications and physical therapy. Due to claimant's continued complaints of pain, Dr. Ting referred claimant to Dr. Lewis.

3. Dr. Lewis' office initially evaluated claimant on February 9, 2014. Claimant was diagnosed with chronic cervicalgia, left craniocervical junction soft tissue mass and cervical spondylosis with facet arthropathy and chronic cervicalgia. Mr. Scruton, the physician's assistant in Dr. Lewis' office noted that he reviewed the magnetic resonance image ("MRI") studies of claimant's cervical, thoracic and lumbar spine that had been taken on September 19, 2013 and noted the findings of cervical spondylosis with disc osteophyte complexes along with the degenerative changes in claimant's lumbar spine. Mr. Scruton recommended treatment including a cervical epidural steroid injection.

4. The injections were denied by Respondents.

5. In response to an inquiry from respondents' counsel, Mr. Scruton indicated in a letter dated May 1, 2014 that claimant presented for interventional consideration with reported symptoms of neck and low back pain following claimant's injury. Mr. Scruton indicated that their focus would be the interventional management of claimant's condition and they would not make a determination regarding specific causality.

6. Respondents referred claimant for an independent medical examination ("IME") with Dr. Burnworth on December 3, 2014. Claimant reported to Dr. Brunworth

that his most significant problem was the persistent low back pain. Dr. Brunworth reviewed claimant's medical records, obtained a medical history and performed a physical examination in connection with her IME. Dr. Brunworth noted that based on the information available, it was her opinion that the accident caused an exacerbation of claimant's pre-existing degenerative disc disease. Dr. Brunworth noted that claimant's records reference a CT scan being performed in 2011, but continued to opine that the injury did cause an exacerbation of claimant's pre-existing condition. Dr. Brunworth recommended medical treatment involving physical therapy and chiropractic treatment.

7. The ALJ credits the opinion of Dr. Brunworth that the injury in this case caused an exacerbation of claimant's pre-existing condition. The ALJ finds that claimant has demonstrated that it is more likely than not that the injury aggravated, accelerated or combined with claimant's pre-existing condition to result in the need for medical treatment. The ALJ finds that claimant has proven that it is more likely than not that the injections recommended by Dr. Lewis and Mr. Scruton are reasonable and necessary medical treatment designed to cure and relieve claimant from the effects of the work injury.

8. The ALJ credits the medical records and finds that claimant was complaining of low back pain following his injury in his initial evaluations with Dr. Ting. The ALJ finds that claimant's increased neck and low back pain is causally related to his March 11, 2013 work injury.

9. The ALJ credits the medical reports from Mr. Scruton in Dr. Lewis' office and finds that claimant has proven that it is more probable than not that the proposed injections are reasonable and necessary to cure and relieve claimant from the effects of his injury. The ALJ notes that Dr. Brunworth indicated alternative treatment involving physical therapy and chiropractic care would be sufficient, but the ALJ is rejecting this opinion. Instead, the ALJ credits the opinions expressed by Dr. Lewis and Mr. Scruton regarding the course of treatment necessary to cure and relieve claimant from the effects of his work injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra*.

4. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Even though an admission of liability is filed, the claimant bears the burden of proof to establish the right to specific medical treatment. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990).

5. As found, claimant has proven by a preponderance of the evidence that the medical treatment recommended by Dr. Lewis is reasonable and necessary to cure and relieve claimant from the effects of his injury.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the medical treatment recommended by Dr. Lewis including the epidural steroid injections to claimant's cervical and lumbar spine.

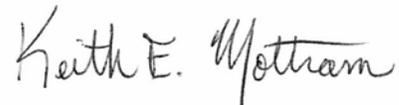
2. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the

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certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 21, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-942-437-01**

ISSUES

- Whether claimant has proven by a preponderance of the evidence that she has suffered a disability that is not contained on the schedule set forth at Section 8-42-107(2), C.R.S.?
- Whether claimant has proven by a preponderance of the evidence that she is entitled to a disfigurement award pursuant to Section 8-42-108, C.R.S.?

FINDINGS OF FACT

1. Claimant is a 58-year-old female and has been employed by employer for approximately seven years. Claimant currently works as manager of employer's store in Clifton, Colorado. Claimant sustained an admitted injury on January 20, 2014 when she was unloading supplies from a delivery truck and tripped over a box, landing on her right shoulder on the concrete floor.

2. Claimant sought medical treatment on the day of the injury at Montrose Memorial Hospital. Dr. Borgo noted that claimant had not had a prior right shoulder injury. Dr. Borgo noted that an initial x-ray did not show a fracture and claimant was provided with a sling and was prescribed percocet.

3. Claimant was referred by employer to Dr. Utt for medical care. On January 21, 2014, Dr. Utt noted that claimant had anterior swelling in the right shoulder along with anterior humeral and subacromial tenderness, limited abduction without pain, and tenderness in the upper arm in the deltoid region. Dr. Utt noted that claimant had symptoms in her neck, including tenderness in the paraspinal muscles and limited range of motion in her neck. Dr. Utt also noted upper back symptoms including tenderness in paraspinal muscles and in the midthoracic upper region, levels T1-T6 on the right.

4. On January 28, 2014, Dr. Utt noted that claimant had ongoing shoulder and upper back symptoms. Dr. Utt reported that claimant was having fairly intense pain and was unable to use her right upper extremity. Dr. Utt noted that the injury may have been more severe than just a sprain and was concerned about a rotator cuff tear, an occult fracture, or bicipital tendon injury. Dr. Utt recommended a magnetic resonance image ("MRI") of claimant's shoulder.

5. Claimant underwent the MRI on February 3, 2014. The radiologist noted mild arthropathy of the acromioclavicular joint with lateral downsloping of the acromion, a full-thickness rotator cuff tear involving the supraspinatus and underlying tendinopathy, and a nondisplaced fracture of the greater tuberosity.

6. Following the MRI, claimant was referred to Dr. Vance for an orthopedic consultation. Dr. Vance initially evaluated claimant on February 6, 2014. Dr. Vance had reviewed claimant's February 3, 2014 MRI, and noted that he would be unable to repair the rotator cuff because of the fracture at the preferred point of attachment. Dr. Vance noted that the fracture would need to heal before proceeding with rotator cuff repair surgery. Dr. Vance recommended work restrictions and continued using a sling.

7. Claimant returned to Dr. Utt on February 11 and March 11, 2014. Dr. Utt noted claimant continued to heal from her fracture.

8. On March 13, 2014, Dr. Vance noted that claimant's fracture appeared to have healed well, and he recommended proceeding with right shoulder surgery.

9. On April 9, 2014, Dr. Vance performed surgery, including diagnostic and operative arthroscopy of the right shoulder with intraarticular debridement including capsular release and debridement of rotator cuff and a subacromial decompression. Dr. Vance noted that although the February 3, 2014 MRI indicated a full-thickness rotator cuff tear, he observed only a partial thickness tear, and he debrided tissue to alleviate effects of the tear.

10. Claimant returned to Dr. Vance on April 17, 2014. Dr. Vance noted decreased range of motion in the shoulder and claimant was continuing to complain of quite a bit of pain. Dr. Vance recommended claimant continue with physical therapy and remain off work.

11. Dr. Utt noted on May 5, 2014 that claimant had a stiff shoulder and was making slow progress after surgery. Dr. Utt noted that claimant might have a difficult time getting back to her baseline and recommended claimant return to sedentary work with minimal use of her right arm and shoulder. Dr. Utt also noted that claimant had upper back pain on the right side, including her scapula. Dr. Utt noted that claimant had modest palpable thoracic tenderness and that her scapula was not symmetrical on the right.

12. Dr. Vance noted on May 15, 2014 that claimant continued to complain of constant pain in the scapula and bicep. Dr. Vance also noted that claimant had complained of scapular pain since the time of her injury. Dr. Vance noted that due to her being in a sling for an extended period of time with her fracture and following surgery, she may be in spasm with her continued shoulder pain. Dr. Vance provided a diagnosis of scapular dyskinesia.

13. Dr. Utt noted on May 19, 2014 that claimant continued to have significantly limited range of motion and pain in her right shoulder. Dr. Utt also noted that claimant had upper thoracic paraspinal tenderness on the right side. On June 23, 2014, Dr. Utt noted that claimant was complaining of right-sided upper-back pain as she improved her shoulder motion. Dr. Utt provided a diagnosis that included a thoracic strain. Dr. Utt

noted that claimant's right shoulder motion was improving, but still lacked full range of motion.

14. On June 26, 2014, Dr. Vance likewise noted claimant's complaints of scapular pain. Dr. Vance again provided a diagnosis scapular dyskinesia and adhesive capsulitis.

15. Dr. Utt noted on August 6, 2014 that claimant had improved shoulder pain, but still had range of motion issues. Nonetheless, Dr. Utt noted that claimant was nearing maximum medical improvement ("MMI").

16. On August 7, 2014, Dr. Vance noted that claimant's pain and shoulder range of motion had improved, but that she still had rotator cuff weakness on exam. Dr. Vance noted that claimant could return to work full-time and that no additional follow-up examinations would be required.

17. Dr. Utt placed claimant at MMI and released claimant to full duty on October 15, 2014. On November 3, 2014, Dr. Utt provided an impairment rating of 8% to the upper extremity, converting to 5% of the whole person. Dr. Utt's impairment rating was based on claimant's limited range of motion as measured during the examination.

18. Respondents filed an amended Final Admission of Liability ("FAL") admitting for the 8% upper extremity rating. Claimant filed a timely application for hearing endorsing the issues of PPD benefits and disfigurement.

19. Claimant testified at hearing that she engaged in physical therapy after surgery, with a focus on improving the range of motion in her shoulder. Claimant testified that although her range of motion improved, it never returned to her pre-injury range of motion. Claimant testified she was still limited in overhead movements involving her shoulder. Claimant testified that she had a loss of strength in her arm, and continued to experience pain in her shoulder blade area.

20. Claimant testified that when she performed the range of motion testing for Dr. Utt's impairment rating, she had difficulty performing overhead movements. She testified that she was unable to fully abduct her shoulder, and had to move her body in order to complete the abduction movement.

21. Claimant testified at hearing that her primary complaints were bicep pain and shoulder blade pain. Claimant testified she recalled discussing with Dr. Vance his diagnosis of scapular dyskinesia, and testified that she had never been diagnosed with scapular dyskinesia prior to this work injury. Claimant testified that her shoulder blade pain affected her function, because she had difficulty reaching and lifting overhead and difficulty reaching behind her back to fasten her bra. Claimant testified that she is unable to lift items overhead and that when her work duties involve placing items on high shelves, she now uses a ladder to perform those duties because she cannot lift

overhead. Claimant testified that she had difficulty reaching her right arm behind her head toward the opposite shoulder, had difficulty shrugging her shoulder up and down, and had difficulty shrugging her shoulder forward and backward because of pain in her shoulder blade area.

22. Respondents obtained an independent medical examination (“IME”) of claimant with Dr. Bernton. Dr. Bernton reviewed claimant’s medical records, obtained a history from the claimant and performed a physical examination. Dr. Bernton prepared a report in connection with his IME dated March 25, 2015. Dr. Bernton opined in his report that claimant did not have functional impairment “beyond the right arm at the shoulder” from the work injury.

23. Dr. Bernton testified at hearing consistent with his report. Dr. Bernton testified that claimant had rotator cuff pathology as the result of the work injury. He testified that the rotator cuff is composed of four tendons that connect to muscles that originate at and attach to the scapula. He testified that Dr. Vance had diagnosed claimant with scapular dyskinesia. Dr. Bernton testified that scapular dyskinesia is a change in the motion of the scapula.

24. The ALJ credits claimant’s testimony at hearing insofar as it is consistent with the medical records in this case that claimant continued experiencing problems with her right shoulder, including the right shoulder blade area, following the injury and surgery. This testimony is supported by the medical records that note claimant has scapular pain and dysfunction and difficulty with overhead range of motion.

25. The ALJ credits claimant’s testimony at hearing regarding her functional impairment, including her testimony regarding the pain in her shoulder blade area and her difficulty using the shoulder because of scapular pain. The ALJ finds this testimony is supported by the medical records which document claimant’s reports of subjective pain in areas not contained on the schedule of impairments set forth at Section 8-42-107(2), C.R.S. The ALJ finds that claimant has proven that it is more probable than not that she is entitled to a whole person impairment rating pursuant to Section 8-42-107(8), C.R.S.

26. As a result of claimant’s surgery, claimant has three arthroscopic scars on her right shoulder. Claimant’s scars measured ¼ inch by 1/8 inch on the front of her right shoulder, ¼ inch by 1/8 inch on the side of her right shoulder and ¼ inch by 1/8 inch on the back of her right shoulder.

27. The ALJ finds that claimant has proven that it is more probable than not that her injury has resulted in a disfigurement that is normally exposed to public view and is entitled to a disfigurement award pursuant to Section 8-42-108.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S., 2010. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers’ Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. The question of whether the claimant has sustained an “injury” which is on or off the schedule of impairment depends on whether the claimant has sustained a “functional impairment” to a part of the body that is not contained on the schedule. *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). Functional impairment need not take any particular impairment. Discomfort which interferes with the claimant’s ability to use a portion of his body may be considered “impairment.” *Mader v. Popejoy Construction Company, Inc.*, W.C. No. 4-198-489, (ICAO August 9, 1996). Pain and discomfort which limits a claimant’s ability to use a portion of his body may be considered a “functional impairment” for determining whether an injury is on or off the schedule. *See, e.g., Beck v. Mile Hi Express Inc.*, W.C. No. 4-238-483 (ICAO February 11, 1997).

4. As found, claimant has suffered a “functional impairment” to a part of the body that is not contained on the schedule. Therefore, claimant is entitled to a whole person impairment award pursuant to Section 8-42-107(8), C.R.S. The ALJ credits the testimony of the claimant at hearing and the medical records taken as a whole in finding that claimant has proven he suffered a functional impairment to a part of the body that is not contained on the schedule.

5. Pursuant to the medical records in this case, claimant was provided with an impairment rating of 8% of the upper extremity, which converts to a 5% whole person impairment rating.

6. Pursuant to Section 8-42-108, C.R.S., 2013 claimant is entitled to a discretionary award up to \$4,640.90 for his serious and permanent bodily disfigurement that is normally exposed to public view. Considering the size, placement, and general appearance of claimant's scarring, the ALJ concludes claimant is entitled to disfigurement benefits in the amount of \$174.03, payable in one lump sum.

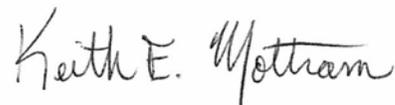
ORDER

It is therefore ordered that:

1. Respondents shall pay claimant PPD benefits based on a 5% whole person impairment rating.
2. Respondents shall pay claimant \$174.03 for disfigurement. Respondents are entitled to a credit for any disfigurement award already paid to claimant under this claim.
3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 21, 2015



Keith E. Mottram
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

ISSUES

- Whether Claimant has established by a preponderance of the evidence that his left knee injury was work related.
- If Claimant has met his burden on proving compensability, whether Claimant has established by a preponderance of the evidence that Concentra, Dr. Foulk, and their referrals are authorized.
- If Claimant has met his burden of proving compensability, whether Claimant has established he is entitled to TTD between February 18, 2014 and August 10, 2014.

➤ **STIPULATION**

The parties stipulated that the issue of TPD is reserved.

The parties stipulated that the Claimant's ASWW is \$1,000.00.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Claimant is a nine year employee of Employer.
2. Claimant testified that on February 5, 2014, he was pushing a Dodge Viper off a dynamometer when he when he felt strain in his left knee, resulting in soreness. Claimant testified that he reported his sore knee to his supervisor, Aaron Reek, but did not seek medical treatment and continued to work. Mr. Reek's communications do not support that Claimant reported any distinct event, but rather that Claimant's knee was "bothering him." There was no report of any "pop" to the knee.
3. Claimant also testified that on February 6, 2014, rather than pursuing a workers' compensation claim, he sought medical attention at North Suburban Medical Center. Claimant told the doctors at North Suburban that he had injured his left knee while pushing a vehicle on the street several days earlier. He also reported that the accident "occurred at home." Notes from the ER also state, "Initial pain and discomfort to left knee started when trying to push car out of snow . . . increasingly

worsening yesterday and today.” Notes from Claimant’s physical exam at North Suburban Medical Center report “No ligamentous laxity present.” Claimant was discharged with a diagnosis of “muscle strain left knee” and was advised to seek follow-up care if not well after one week.

4. Claimant returned to work on February 10, 2014 and when questioned by Employer reported his knee injury as work related. In his Report of Injury, Claimant reported two mechanisms of injury: (1) that his left knee was sore after pushing the Viper, and (2) that he “felt a very sharp pain in the back and side of left knee” when he stepped out of another vehicle later that same day. While Claimant reported that stepping out of the vehicle caused his greater pain, Claimant did not testify at hearing about that mechanism of injury. In addition, he did not report this mechanism of injury to his treatment providers at North Suburban Medical Center.
5. Claimant admitted on cross examination that he gave a recorded statement to Insurer. In that recorded statement, he testified that he was actually injured while exiting a vehicle, not while pushing the Viper. Claimant admitted on cross examination that he provided a different mechanism of injury to Insurer from what he testified to at hearing.
6. Claimant testified that his knee pain did not resolve within the week, and on February 11, 2014, rather than seeking treatment through the workers’ compensation system, he self-referred to Dr. Foulk, an orthopedist with whom he had treated three years earlier for a shoulder injury. Claimant reported to Dr. Foulk that his knee injury was not work related and that it occurred when he was pushing a stuck car. Claimant marked “No” in response to the question “Is this a work related injury?”
7. Claimant was cross-examined extensively about why he reported to North Suburban and Dr. Foulk that his injury did not occur at work. Claimant testified that he did so to avoid “the hassles” he anticipated with a workers’ compensation claim.
8. The ALJ is not persuaded by this testimony. Claimant reported to his Employer the day before seeing Dr. Foulk that the alleged injury was work related, therefore Claimant reporting to Dr Foulk after that date that the alleged injury was not work-related could not serve the purpose of avoiding the workers’ compensation system. Rather, the ALJ finds it more reasonable that Claimant would report most accurately to the physician with whom he had a previous relationship and whom he sought out for treatment.
9. At Dr. Foulk’s February 11, 2014 evaluation he diagnosed Claimant as suffering an anterior cruciate ligament tear, “based on his history and physical exam.” The ALJ notes that the history Claimant gave to Dr. Foulk is not consistent with his report of injury in that Claimant told Dr. Foulk that the injury occurred outside of work and failed to advise Dr. Faulk that his

major pain onset was upon exiting a vehicle later in the day. Further, Dr. Faulk's report does not include any notes from Claimant's examination which support his diagnosis.

10. On February 12, 2014, one day later, Claimant was examined at Concentra by Michelle Honsinger, PA. Claimant reported his injury as occurring at work, and that he felt some soreness in his knee after pushing a vehicle that increased to a sharp pain and twisting injury when he stepped out of another vehicle. Reports that there was a twisting injury are inconsistent with Claimant's Report of Injury to his Employer. PA Honsinger noted on physical examination of Claimant's left knee, "No obvious laxity." She diagnosed Claimant as having a knee strain, the same diagnosis he received from North Suburban Medical Center.
11. The ALJ finds Claimant's testimony to be inconsistent with his reports to his employer, reports to his treatment providers, and statements made to Insurer. On that basis, the ALJ finds Claimant to be not credible.
12. Based on the totality of the evidence, including Claimant's inconsistent reports of the mechanism(s) of his injury, Claimant's inconsistent reports of when the injury occurred, and Claimant's inconsistent and unexplained reports of where the injury occurred, the ALJ finds it more likely that Claimant did not sustain a work related injury to his left knee on February 5, 2014.
13. The ALJ finds that Claimant has not satisfied his burden of proving by a preponderance of the evidence that his injury is compensable.
14. In light of these findings, the ALJ need not address the remaining issues.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2014), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that he/she sustained an injury arising out of and within the course of his/her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the

reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A workers' compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

The ALJ finds Claimant not credible based on the inconsistency of his testimony as compared with his reports of his injury to treatment providers, his Employer, and Insurer. The ALJ also found Claimant's stated reason for some of his inconsistencies to be unreasonable. The ALJ therefore finds and concludes that Claimant failed to sustain his burden of establishing that he sustained an injury at work. On that basis, the ALJ finds and concludes that Claimant's injury is not compensable.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's claims for medical and compensatory benefits are denied and dismissed.

2. If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 5, 2015

/s/ Kimberly Turnbow

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Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUE

Whether the Claimant proved he suffered a compensable injury on April 28, 2014 while performing services arising out of and in the course of his employment with Employer.

FINDINGS OF FACT

1. The Claimant is a firefighter working for Employer for the past 25 years. For the last 3 years, the Claimant has been assigned as an EMT to Medic Unit 46, providing paramedic services (Hearing Tr., p. 11).

2. The Claimant testified, and the medical records confirm, that the Claimant had been experiencing symptoms of numbness and tingling in both of his hands. As of the morning of April 28, 2014, the Claimant testified that he had a "pins and needles" sensation in his hands while driving. Prior to this date, the Claimant had mentioned these symptoms to the mother of his child and she recommended that he see Dr. Mark Treihaft. The Claimant had made an appointment with Dr. Treihaft for evaluation of the numbness and tingling symptoms prior to April 28, 2014 (Hearing Tr., p. 12).

3. The Claimant's past medical history includes a fractured left elbow from 8 years prior, a C5-6 herniated disk and bilateral shoulder reconstructive surgeries, but no prior trauma or conditions related to his hands, wrists or forearms (Claimant's Exhibit 4, p. 27; Respondent's Exhibit C, p. 17).

4. On April 28, 2014, the Claimant's medic unit was dispatched to a cardiac event involving a good-sized gentleman in his 60's. The patient was placed on the floor and an airway was established and the Claimant started performing chest compressions. While performing chest compressions, the Claimant was kneeling with his arms at a 90 degree angle with his hands, one over the other, pressing down hard. As this was occurring, the Claimant's hands went completely numb, but he didn't want to switch out with another paramedic because this could harm the patient and he was still able to grip and push. After a time, another EMT took over the chest compressions and the Claimant moved to the bag. Between the chest compressions and bagging the patient, the Claimant was working on the patient for about 20 minutes (Claimant's Exhibit 1, p. 1 and Exhibit 7, p. 47; Respondent's Exhibit D, p. 30 and Exhibit A, p. 3).

5. There was some inconsistency between the Claimant's stated level of pain while he performed chest compressions on the patient on April 28, 2014. The Claimant first testified on cross-examination that the pain level was up to a "nine," but he agreed that he had previously responded to Interrogatories and stated that his pain level was

between four and six (Hearing Tr., p. 25; Claimant's Exhibit 11). The ALJ finds the prior statement made in response to the Interrogatories to be more reliable.

6. There was also some inconsistency in the evidence as to how long the Claimant's symptoms persisted after performing the compressions. The Claimant testified that prior to the April 28th incident, his symptoms were only intermittent and afterwards, they were constant and his hands never returned to the level they were as of the morning of April 28th (Hearing Tr., p. 16). The Claimant initially testified that it took 4-5 minutes to get his hands from completely numb back to a tingling feeling. He did not recall stating to his physicians that his symptoms returned to baseline after 4-5 minutes (Hearing Tr., pp. 16-17). Dr. Scott's June 6, 2014 medical record indicates that the Claimant's numbness and tingling lasted for 4 minutes after arriving back at the emergency room and "then the numbness and tingling returned to the constant baseline tingling" (Claimant's Exhibit 7, p. 49; Respondent's Exhibit A, p. 5). After listening to a portion of the audio recording of the IME visit with Dr. Scott, the Claimant agreed that he told Dr. Scott that his symptoms returned to baseline about 4 minutes after arriving at the ER (Hearing Tr., pp. 26-27). The ALJ finds that, consistent with his prior statements to Dr. Scott, the Claimant's symptoms did return to his baseline on April 28, 2014 after the Claimant had returned to the ER following the chest compression incident.

7. The Claimant saw Dr. Marc Treihaft on May 9, 2014 for evaluation of his bilateral numbness and tingling. Dr. Treihaft noted that the Claimant reported the symptoms had been ongoing for three weeks. Dr. Treihaft further noted that the Claimant's numbness involved digits one to four and it woke the Claimant up at night and bothered him while playing bagpipes or driving his car. Nowhere in the narrative report of the evaluation and the EMG and nerve conduction studies is there any mention of an incident on April 28, 2014 or any mention that the Claimant's symptoms increased or changed as of April 28, 2014 (Claimant's Exhibit 4; Respondent's Exhibit C). Based on the diagnostic testing, Dr. Treihaft opined that the Claimant had "moderately severe carpal tunnel syndromes" (Claimant's Exhibit 4, p. 28 and 29; Respondent's Exhibit C, p. 12 and 18). Although there was no mention of a specific incident on April 28, 2014 involving applying chest compressions, Dr. Treihaft does note that "work-relatedness was reviewed. He will speak with HR at the fire department" (Claimant's Exhibit 4, p. 28; Respondent's Exhibit C, p. 18).

8. Per the Employer's First Report of Injury, the Claimant notified his Employer of an injury on May 12, 2014 reporting that he had carpal tunnel and that he was injured on April 28, 2014 from "performing chest compressions on a prolonged resuscitation (APR)" (Respondent's Exhibit E, p. 36).

9. The Claimant was initially evaluated for bilateral hand numbness and tingling by Dr. Elizabeth Bisgard on May 13, 2014. She noted that the Claimant was well known to her through his annual physicals and his work with Employer. Dr. Bisgard noted that the Claimant reported that "about three months ago he developed some numbness and tingling in his bilateral hands. It was happening intermittently. It would occasionally wake him up at night, and he would notice it when driving or playing the

bagpipes, but it never interfered with his activities. He was tolerating the symptoms. They were not progressing.” Then, Dr. Bisgard reported that after the April 28, 2014 prolonged resuscitation event doing chest compressions for about twenty minutes, the Claimant’s hands were completely numb and although the sensation gradually returned to his hands, “since that episode he has had constant numbness and tingling” (Claimant’s Exhibit 1, p. 1; Respondent’s Exhibit D, p. 30). Dr. Bisgard did not have the EMG and nerve conduction studies as of this visit, but was expecting them from Dr. Treihaft’s office later that day. Dr. Bisgard recommended an evaluation and anticipated surgery very shortly. Dr. Bisgard opined that, “in reviewing his history and outside factors, although he had some symptoms prior to April 28, 2014, clearly there was a substantial change after a prolonged period of resuscitation on an individual. Therefore, it is my opinion based on a reasonable degree of medical probability that this is a work-related carpal tunnel syndrome” (Claimant’s Exhibit 1, pp. 2-3; Respondent’s Exhibit D, p. 31-32).

10. The Claimant saw Dr. Douglas Scott on May 22, 2014 and Dr. Scott prepared a written IME report dated June 6, 2014. Dr. Scott noted a mechanism of injury consistent with the Claimant’s testimony in this case and with his report to Dr. Bisgard and other treating physicians. Dr. Scott noted that the Claimant had reported bilateral hand numbness and tingling for three weeks and noted that Dr. Bisgard (in her May 13, 2014 evaluation) noted that the symptoms had started three months prior which would put the onset of symptoms in February of 2014 (Claimant’s Exhibit 7; Respondent’s Exhibit A). Dr. Scott noted that the Claimant reported to him that “for about 3 month before the April 28, 2014 resuscitation incident, his hands had pins and needles sensation with aching” (Claimant’s Exhibit 7, p. 49; Respondent’s Exhibit A, p. 5). Based in large part on the Claimant’s statements to Dr. Scott that the numbness he experienced during the 20 minutes of chest compression subsided within 4 minutes of arriving at the emergency room with the patient and he returned to his baseline, Dr. Scott opined that the carpal tunnel syndrome was not work-related. Dr. Scott opined that on April 28, 2014, the Claimant may have suffered from a temporary exacerbation of his underlying and pre-existing median nerve neuropathy at both carpal tunnels (Claimant’s Exhibit 7, p. 52; Respondent’s Exhibit A, p.8).

11. The Claimant was evaluated by Dr. In Sok Yi on June 30, 2014 for “progressive numbness and tingling in both of his hands, left side worse than right” with an onset of four to five months prior. Dr. Yi noted that the Claimant reported that the numbness and tingling became worse after a 5/28/2014 (sic) incident. Dr. Yi diagnosed bilateral carpal tunnel syndrome as verified by nerve conduction studies. Dr. Yi recommended a left endoscopic carpal tunnel release and to continue to treat the right upper extremity conservatively (Respondent’s Exhibit B, p. 11).

12. On July 11, 2014, Dr. Bisgard authored a written opinion after reviewing Dr. Treihaft’s report and Dr. Scott’s report. Dr. Bisgard noted that she disagreed with Dr. Scott’s causality assessment. Dr. Bisgard opined that performing CPR requires a great deal of force applied repeatedly while the hands are in an awkward position. Dr. Bisgard also opined that, although the Claimant was experiencing carpal tunnel symptoms prior

to April 28, 2014, the resuscitation was the incident that put the Claimant over the edge. Dr. Bisgard maintains that but for the April 28, 2014 incident, the Claimant would not be needing the carpal tunnel surgery at this time (Claimant's Exhibit 2, p. 18; Respondent's Exhibit D, p. 21).

13. The Claimant ultimately underwent surgery for the bilateral hands, with Dr. Yi performing the right endoscopic carpal tunnel release six days following the left endoscopic tunnel release. As of August 12, 2014, the numbness and tingling was significantly better and there was an improvement in palmar opposition strength (Claimant's Exhibit 6, p. 38; Respondent's Exhibit B, p. 10).

14. The Claimant was seen by PA-C Thahn Chau on August 29, 2014 and evaluated for duty and he was released to return to full duty work on September 3, 2014 (Claimant's Exhibit 3, pp. 25-26; Respondent's Exhibit D, pp. 19-20).

15. At a follow up visit on September 15, 2014, Dr. Yi noted the numbness and tingling was gone and although the Claimant still had some soreness in the left hand, he was able to return regular work (Claimant's Exhibit 6, p. 37; Respondent's Exhibit B, p. 9).

16. Dr. Douglas Scott testified at the hearing regarding his evaluation of the Claimant. He noted that he had reviewed additional medical records since his report including a letter from Dr. Bisgard dated July 11, 2014 and the post-operative records of Dr. Yi (Hearing Tr., p. 33). After reviewing the results of the nerve conduction study, Dr. Scott opined that the abnormal findings on the study preexisted the April 28, 2014 incident based on the Claimant's description of the earlier onset of his symptoms and because the Claimant exhibited a level of both sensory and motor nerve neuropathy which indicates a progressive preexisting condition (Hearing Tr., pp. 38-40). Dr. Scott testified that in order for a worker to experience occupational carpal tunnel syndrome, adequate repetition, duration and force must be present (Hearing Tr., p. 42). Dr. Scott opined that the chest compression incident described by the Claimant "doesn't involve forceful hand gripping or grasping" so it is not the right kind of force. Nor does the 20 minute time frame described meet the duration requirement or even come close to the 6-hour time frame (with no rest period) found in the studies on work related carpal tunnel syndrome (Hearing Tr., p. 44-46). Dr. Scott also disagreed with Dr. Bisgard's statement that the Claimant fell under the "fragile egg model" of a person with preexisting symptoms when the April 28, 2014 incident "caused the ultimate breaking of the egg that resulted in his need for surgery." Dr. Scott primarily disagreed because the Claimant's symptoms went back to his baseline (Hearing Tr., pp. 54-55). Rather, Dr. Scott finds that the Claimant experienced a temporary exacerbation of his condition in the period of time that he performed chest compressions and for some minutes after that. However, Dr. Scott finds that the temporary exacerbation of symptoms resolved on its own when the Claimant stopped performing the activity that was exacerbating his symptoms (Hearing Tr., pp. 56-57). On cross-examination, Dr. Scott agreed that carpal tunnel syndrome can be cause by a singular injury such as a wrist fracture, as well as by compression of the median nerve due to cumulative trauma (Hearing Tr., p. 60).

However, Dr. Scott nevertheless found that no part of the Claimant's moderate to severe carpal tunnel syndrome was caused by the chest compression incident on April 28, 2014 (Hearing Tr., p. 62).

17. The Claimant testified that prior to April 28, 2014, he was able to perform his work and leisure activities, including playing bagpipes, with some discomfort, but after that, the Claimant's abilities were more limited (Hearing Tr., p. 70).

18. As a consequence of the inconsistency between the Claimant's stated level of pain while he performed chest compressions on a patient on April 28, 2014, ranging from 4-6/10 to a 9/10, and the inconsistency in the evidence as to how long the Claimant's symptoms persisted after performing the compressions, the Claimant's testimony at hearing was not found to be as reliable as his earlier statements. In viewing this along with the nerve conduction studies and a physical examination, Dr. Scott opined at the hearing that the Claimant's bilateral carpal tunnel syndrome was not work-related. This is in contrast with Dr. Bisgard who had previously opined that the April 28, 2014 incident pushed the Claimant over the edge with respect to his symptoms and caused the need for his surgeries. The opinions of these two physicians are weighed in the overall context of the Claimant's medical records and the other testimony and evidence presented at hearing, and the opinion of Dr. Scott is found to be more persuasive than that of Dr. Bisgard.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado (Act), C.R.S. §§ 8-40-101, *et seq.*, is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. C.R.S. § 8-40-102(1). The Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. § 8-43-201. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of Respondents, and a workers' compensation claim shall be decided on its merits. C.R.S. § 8-43-201.

Assessing weight, credibility, and sufficiency of evidence in a Workers' Compensation proceeding is the exclusive domain of administrative law judge. *University Park Care Ctr. v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the

testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Compensability

Whether a compensable injury has been sustained is a question of fact to be determined by the ALJ. *Eller v. Industrial Claim Appeals Office*, 224 P.3d 397 (Colo. App. Div. 5 2009). The Claimant's right to compensation initially hinges upon a determination that "at the time of the injury, the employee is performing service arising out of and in the course of the employee's employment." C.R.S. § 8-41-301(1)(b). The "arising out of" test is one of causation which requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of employment arises out of the employment. *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). The evidence must establish the causal connection with reasonable probability, but it need not establish it with reasonable medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission*, 30 Colo. App. 224, 491 P.2d 106 (Colo. App. 1971); *Industrial Commission v. Royal Indemnity Co.*, 124 Colo. 210, 236 P.2d 2993. A causal connection may be established by circumstantial evidence and expert medical testimony is not necessarily required. *Industrial Commission of Colorado v. Jones*, 688 P.2d 1116 (Colo. 1984); *Industrial Commission v. Royal Indemnity Co.*, 124 Colo. 210, 236 P.2d 293 (1951).

Compensable injuries are those which require medical treatment or cause disability. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). All results flowing proximately and naturally from an industrial injury are compensable. See *Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970). In order to prove causation, it is not necessary to establish that the industrial injury was the sole cause of the need for treatment. Rather, it is sufficient if the injury is a "significant" cause of the need for treatment in the sense that there is a direct relationship between the precipitating event and the need for treatment. A preexisting condition does not disqualify a claimant from receiving workers' compensation benefits. Rather, where the industrial injury aggravates, accelerates, or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury. *Joslins Dry Goods Co. v. Industrial Claim Appeals Office*, 21 P.3d 866 (Colo. App. 2001); *H and H Warehouse v. Vicory*, supra; *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986). However, where an industrial injury merely causes the discovery of the underlying disease to happen sooner, but does not accelerate the need for the surgery for the underlying disease, treatment for

the preexisting condition is not compensable. *Robinson v. Youth Track*, 4-649-298 (ICAO May 15, 2007).

The totality of the evidence does not support that the Claimant suffered a compensable injury on April 28, 2014 while performing chest compressions for approximately 20 minutes on a patient who had gone into cardiac arrest. There is no controversy that the Claimant did indeed perform the chest compressions on the patient as he testified, consistent with prior medical records. However, the weight of the evidence establishes that the onset of the numbness and tingling in the Claimant's bilateral hands was approximately February of 2014. The symptoms persisted and progressed to the point that the Claimant had made an appointment with Dr. Treihafft for evaluation prior to the incident on April 28, 2014 although the appointment was not until May 9, 2014.

On April 28, 2014, the Claimant did experience a change in the numbness and tingling symptoms in his bilateral hands while he was performing chest compressions. Yet, the Claimant had previously reported to physicians that the symptoms subsided shortly after returning to the emergency department and the Claimant's symptoms returned to his baseline.

The Claimant ultimately underwent surgery for the bilateral hands, with Dr. Yi performing the right endoscopic carpal tunnel release six days following the left endoscopic tunnel release, even though Dr. Yi had only initially recommended surgery for the left hand and continued conservative care for the right. In any event, the surgeries were successful and by September of 2014, the Claimant no longer had the tingling and numbness symptoms.

Dr. Bisgard also opined that, although the Claimant was experiencing carpal tunnel symptoms prior to April 28, 2014, the resuscitation was the incident that put the Claimant over the edge. Dr. Bisgard maintained that but for the April 28, 2014 incident the Claimant would not have needed the carpal tunnel surgery at this time. In contrast, Dr. Scott opined that the abnormal findings on the Claimant's nerve conduction study preexisted the April 28, 2014 incident based on the Claimant's description of the earlier onset of his symptoms and because the Claimant exhibited a level of both sensory and motor nerve neuropathy which indicates a progressive preexisting condition. Dr. Scott also disagreed with Dr. Bisgard's statement that the Claimant fell under the "fragile egg model" of a person with preexisting symptoms when the April 28, 2014 incident "caused the ultimate breaking of the egg that resulted in his need for surgery." Dr. Scott primarily disagreed because the Claimant's symptoms went back to his baseline. Thus, Dr. Scott opined that the Claimant experienced a temporary exacerbation of his condition in the period of time that he performed chest compressions and for some minutes after that, but the temporary exacerbation of symptoms resolved on its own when the Claimant stopped performing the activity that was exacerbating his symptoms. Dr. Scott found that no part of the Claimant's moderate to severe carpal tunnel syndrome was caused by the chest compression incident on April 28, 2014.

When the opinions of Dr. Scott and Dr. Bisgard were weighed in the overall context of the Claimant's medical records and the other testimony and evidence presented at hearing, and the opinion of Dr. Scott was more persuasive than that of Dr. Bisgard. The Claimant has failed to meet his burden of proving that he suffered a compensable injury while performing services arising out of and in the course of his employment in this case. The work duties performed by the Claimant on April 28, 2014 did not cause, aggravate, accelerate, or combine with a preexisting disease or infirmity to produce the need for treatment.

ORDER

Based on the above factual findings and legal conclusions, it is therefore ORDERED that:

1. The Claimant has failed to meet his burden of proving a compensable injury by a preponderance of the evidence by establishing that his bilateral carpal tunnel syndrome was caused by a work injury occurring on April 28, 2014.
2. The Claimant's claim for benefits under the Workers' Compensation Act of Colorado is therefore denied and dismissed.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 18, 2015



Kimberly A. Allegretti
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-958-846-01**

ISSUES

- Whether claimant has proven by a preponderance of the evidence that she suffered an industrial injury arising out of and in the course of her employment with employer?
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that the injury resulted in claimant obtaining medical treatment that was reasonable and necessary to cure and relieve claimant from the effects of the injury and from a provider who was authorized to treat claimant?
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits beginning July 24, 2014 and continuing?
- If claimant has proven a compensable injury, what is claimant's average weekly wage ("AWW")?

FINDINGS OF FACT

1. Claimant was employed with employer as a housekeeper beginning her employment on or about August 2006. Claimant testified at hearing that on March 1, 2013 she was descending a flight of stairs when she slipped on a piece of ice and fell to the ground. Claimant testified she fell onto her left side. Claimant testified when she fell she was carrying a basket with cleaning supplies and rags. Claimant testified that after she fell, she had pain in her whole body.

2. Claimant's testimony regarding her fall was supported by the testimony of Mr. Maldonado, a co-worker. Mr. Maldonado testified that he was informed by Ms. McPike that a guest had witnessed claimant fall and Ms. McPike requested Mr. Maldonado to go check on claimant. Mr. Maldonado testified that when he found claimant in the room, claimant was crying. Mr. Maldonado testified that claimant reported on the date of the injury that she did not want to seek medical care. Mr. Maldonado further testified to being in a meeting with claimant and Ms. McPike in which claimant's fall was discussed. Mr. Maldonado confirmed that Ms. McPike was the person employees would report work injuries to.

3. Claimant testified that the day after her work injury, she reported her injury to Ms. Suhouski with Mr. Maldonado performing interpretation for her. This testimony was supported by the testimony of Mr. Maldonado who noted that during the meeting,

claimant reported that she still had pain in her shoulder from her fall. On cross-examination, Mr. Maldonado testified that claimant did not request medical treatment following her fall. The ALJ finds the testimony of Mr. Maldonado to be credible and persuasive.

4. While respondents maintain claimant testified inconsistently regarding how she fell on March 1, 2013, the testimony and medical records do establish that claimant fell at work on March 1, 2013. This fact is supported by the testimony of claimant and Mr. Maldonado. Claimant however, did not receive medical treatment following her fall until 2014.

5. Claimant was examined by Dr. Sauerbry on March 4, 2014 with complaints of left shoulder pain. Claimant noted that she had problems with pain in the shoulder for a couple of years now. Claimant reported she was a housekeeper and did a lot of heavy work that aggravated her pain, but noted it was not a workers' compensation injury. Dr. Suerbrey recommended claimant get a magnetic resonance image ("MRI") of the shoulder.

6. Notably, when claimant reported to Memorial Hospital for the MRI, she reported she injured her shoulder in a fall 1 year ago, and complained of persistent pain and decreased range of motion. The MRI revealed a small localized full thickness tear of the anterior distal supraspinatus tendon along with moderately severe partial thickness tearing of the infraspinatus tendon and remainder of the supraspinatus tendon, along with mild articular surface tearing of the subscapularis tendon. A slap II tear, degenerative acromioclavicular joint with mild to moderate compromise of the acromial outlet and subacromial subdeltoid bursitis was also noted in the MRI findings.

7. Respondents note in their position statement that while claimant reported to the MRI physician, Dr. Lile, that she injured her shoulder in a fall, the records do not indicate that claimant fell at work. However, the testimony of claimant and Mr. Maldonado establish that claimant was involved in a fall in March 2013 and the fall was reported to Ms. McPike.

8. Claimant returned to Dr. Sauerbrey on June 25, 2014. Dr. Sauerbrey recommended claimant undergo surgery on her shoulder.

9. Claimant presented the testimony of her adult children, Jose and Erica at hearing. Claimant's children have performed translation services for claimant at various times with her medical providers and her employer. Jose testified at hearing that he translated for claimant at her appointment with Dr. Sauerbrey on March 4, 2014. Jose testified that his girlfriend took claimant to her appointment for the MRI on March 19, 2014.

10. Erica testified that he went with claimant to employer and reported the injury to "Laura" on or about June 25, 2014. Erica testified that Laura could not find the report regarding the fall and would contact Erica when she found the report.

11. Jose testified he returned with claimant in July 2014 and spoke with Laura and "Christine" regarding claimant's fall. Jose testified that Christine gave claimant an insurance card for the medical appointments and told Jose to have claimant use her sick leave and not come to work.

12. The ALJ credits the testimony of Erica and Jose and finds that when claimant reported the injury to employer on or about June 25, 2014 and advised employer that claimant was seeking medical treatment, claimant was not provided with a list of 2 physicians to choose from.

13. The ALJ notes the W.C.R.P. 8-2 requires the employer to provide claimant with a list of physicians designated to treat the injured worker within 7 days of the date they receive notice of the injury. W.C.R.P. 8-2(E) establishes that if the employer does not provide a list of providers to the injured worker, the injured worker may select a physician of their choosing.

14. The ALJ finds that after claimant's fall on March 1, 2013, claimant initially denied that she wanted to seek medical treatment. Therefore, employer was not required to provide claimant with a choice of medical providers as employer was not aware of the compensable nature of the injury. However, upon being informed by claimant that she was seeking medical treatment in July 2014, employer was then required to provide claimant with a designated provider list pursuant to W.C.R.P. 8-2. Because employer failed to provide claimant with the designated provider list, the claimant is then allowed to choose a physician to treat her injury. The ALJ finds that this occurred as of June 25, 2014 when she reported to employer that she had injured her shoulder in the fall and was seeking medical treatment.

15. Claimant was examined by Dr. Speer on July 24, 2014. Dr. Speer noted that claimant reported she fell down stairs at work in March 2012 and landed on her right shoulder. Following a letter from claimant to Dr. Speer dated October 9, 2014, Dr. Speer issued an addendum to his report to reflect changes regarding when claimant fell at work.

16. Respondents note that the records from Dr. Speer report an injury occurring in March 2012, and not 2013 as testified to by claimant. However, again, the evidence establishes that claimant fell at work in March 2013 and reported the incident to her employer, following which she reported the injury to Ms. McPike and Mr. Maldonado. This fact is established by the testimony of claimant and Mr. Maldonado, and was not credibly contradicted by respondents at hearing. The ALJ therefore finds that the discrepancies in the medical records regarding the date of the fall at work are simply discrepancies in the medical records and do not disprove the fact that the fall occurred on March 1, 2013 as testified to by claimant and Mr. Maldonado.

17. It was unclear from the testimony as to how claimant came to be seen by Dr. Speer. The ALJ ascertains from the records, however, that Dr. Speer became claimant's choice of physician to treat with as of the July 24, 2014 appointment.

18. Respondents filed a Notice of Contest on August 25, 2014. Claimant's August 28, 2014 appointment with Dr. Speer was cancelled because insurer had not decided if the claim would be accepted or not. Claimant did not return to Dr. Speer and the ALJ finds that Dr. Speer, by cancelling the August 28, 2014 medical appointment, refused to provide treatment for claimant due to non-medical reasons.

19. On September 16, 2014, Dr. Sauerbrey sent a request to insurer requesting authorization for shoulder surgery consisting of a rotator cuff repair and subacromial decompression.

20. Claimant underwent an independent medical examination ("IME") with Dr. Fall on January 8, 2015. A copy of the audio recording of the IME was entered into evidence at hearing. Dr. Fall issued a report dated January 8, 2015 as a result of the IME.

21. Dr. Fall reviewed claimant's medical records, obtained a history from claimant and performed a physical examination in connection with her IME. Dr. Fall noted in her report that claimant was quite nonspecific and was not able to describe how she fell and the exact mechanism of injury that would lead to a rotator cuff and SLAP tears. Dr. Fall opined that the mechanism of injury described by claimant would not result in the numerous findings on the MRI. Dr. Fall opined that the MRI findings were consistent with age-related degenerative findings. Dr. Fall opined that she was not able to state within a reasonable degree of medical probability that the MRI findings of the shoulder were related to a fall or that the symptoms were related to the fall from March 2013.

22. Dr. Fall testified by deposition in this case consistent with her IME report.

23. The ALJ credits the testimony of claimant and Mr. Maldonado and the medical reports from Dr. Sauerbrey and Dr. Speer and finds that claimant has proven that it is more likely than not that she sustained a compensable injury to her left shoulder on March 1, 2013 when she fell at work. The ALJ rejects the opinions expressed by Dr. Fall that are contrary to this finding.

24. The ALJ finds that claimant did not request medical treatment from employer until reporting her injury in June 2014 and advising employer that she was seeking medical treatment. The ALJ finds that employer reported her injury to employer on March 1, 2013, but credits the testimony of Mr. Maldonado and finds that claimant advised employer on that date that she was not seeking medical treatment. The ALJ therefore finds that the medical treatment claimant received from Dr. Sauerbrey in 2014, while reasonable and necessary to treat claimant's injury, was not authorized.

25. The ALJ finds that the medical treatment claimant received from Dr. Speer was reasonable and necessary to cure and relieve claimant from the effects of the injury.

26. The ALJ credits the testimony of claimant and Jose and the supporting wage records and finds that claimant was advised by employer to stay at home from work due to her shoulder injury beginning July 24, 2014 and take sick leave. This testimony is supported by the wage records entered into evidence that establish that claimant began taking sick leave during this period of time. The ALJ credits this testimony and finds that claimant has proven that it is more likely than not that she is entitled to TTD benefits commencing July 24, 2014 and continuing until terminated by law.

27. Claimant testified at hearing that while working for employer, she held concurrent employment with another hotel beginning in May 2008. This is supported by the wage records and W-2 forms that document claimant's concurrent employment with employer and Steamboat Ski & Resort Corporation.

28. Claimant argues that the wage records from employer document that claimant was paid \$3,723.46 for the time period between January 1, 2013 through February 22, 2013 and that claimant's AWW should be based off of this calculation. The ALJ is not persuaded. Notably, the wage record documents that claimant every two weeks. Therefore, the "year to date" amount does not mean that this covers only the time worked beginning January 1, 2013, but instead the wages paid, including wages paid for time earned prior to January 1, 2013 and covering 8 weeks.

29. It is claimant's burden of proof to establish the AWW. Based on what was entered into evidence at hearing, the ALJ finds the most appropriate way to calculate the AWW with regard to claimant's earnings for employer is to divide the earnings in the paystub by 8 weeks. This results in an AWW for claimant for her work with employer of \$465.43.

30. With regard to claimant's work with her concurrent employer, that ALJ determines that the most appropriate method for calculating the AWW is by using the W2 forms for 2012. The ALJ cannot ascertain with certainty claimant's AWW at the time of her injury based upon the records and claimant's testimony regarding the nature of her pay was not sufficient to establish that a different method should be used.

31. Claimant was paid \$22,053.02 in wages by Steamboat Ski and Resort for 2012. This equates to an AWW of \$424.10. Combining claimant's AWW for her work with employer and her concurrent employer comes to an AWW of \$889.53.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of

the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with "a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra*.

4. As found, claimant has proven by a preponderance that she suffered compensable injury arising out of and in the course of his employment with employer when she fell at work on March 1, 2013. As found, the testimony from claimant and Mr. Maldonado are credible and persuasive on this point. As found, the medical records from Dr. Lile in connection with the MRI performed on March 19, 2014 is found to be credible and persuasive regarding the cause of claimant's complaints of shoulder pain.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-43-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once respondents have exercised their right to select the treating physician, claimant may not change physicians without first obtaining permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996).

6. "Authorization" refers to the physician's legal authority to treat, and is distinct from whether treatment is "reasonable and necessary" within the meaning of Section 8-42-101(1)(a), C.R.S. 2008. *Leibold v. A-1 Relocation, Inc.*, W.C. No. 4-304-#J8YIBU140D11XE v 2

437 (January 3, 2008). Section 8-43-404(5)(a) specifically states: "In all cases of injury, the employer or insurer has the right in the first instance to select the physician who attends said injured employee. If the services of a physician are not tendered at the time of the injury, the employee shall have the right to select a physician or chiropractor." "[A]n employee may engage medical services if the employer has expressly or impliedly conveyed to the employee the impression that the employee has authorization to proceed in this fashion...." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985), *citing*, 2 A. Larson, *Workers' Compensation Law* § 61.12(g)(1983).

7. As found, claimant did not report to employer that the fall caused claimant to need medical treatment until June 2014. As found, claimant's medical treatment with Dr. Sauerbrey prior to this date is not authorized. As found, claimant's medical treatment with Dr. Speer in July 2014 was authorized and reasonable and necessary to cure and relieve claimant from the effects of her work injury.

8. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

9. As found, claimant left work as of July 24, 2014 as a result of her injury. As found, claimant has proven by a preponderance of the evidence that she is entitled to TTD benefits commencing July 24, 2014.

10. The ALJ must determine an employee's AWW by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of the injury, which must include any advantage or fringe benefit provided to the Claimant in lieu of wages. Section 8-42-102(2), C.R.S.; *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995).

11. As found, claimant's AWW for her work with employer and her concurrent employer equates to an AWW of \$889.53.

#J8YIBU140D11XE v 2

ORDER

It is therefore ordered that:

1. Respondents shall pay for the reasonable and necessary medical treatment provided to claimant by Dr. Speer.
2. Claimant's request for payment of the medical treatment from Dr. Sauerbrey is denied as being not authorized under the Colorado Workers' Compensation Act.
3. Respondents shall pay claimant TTD benefits commencing July 24, 2014 and continuing until terminated by law or statute based on an AWW of \$889.53.
4. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
5. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 22, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-962-660-01**

ISSUES

1. Whether Insurer has demonstrated by a preponderance of the evidence that Claimant rejected Workers' Compensation coverage pursuant to §8-41-202(1), C.R.S. prior to his July 22, 2014 motor vehicle accident.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he suffered compensable injuries during the course and scope of his employment with Employer on July 22, 2014.

FINDINGS OF FACT

1. Claimant owns and operates two plumbing businesses. Elite Drain Solutions dba Broken Arrow is a plumbing and drain cleaning business that he started in 2006. Employer is a commercial plumbing business that Claimant started in 2013 and services commercial accounts. Claimant was at all relevant times the President of Employer.

2. Richard Mann has been a self-employed insurance agent for Insurer since 2006. Mr. Mann sells all types of commercial and business insurance including home, auto and life lines. Mr. Mann earns a commission based on the premiums received by Insurer.

3. Mr. Mann has written numerous insurance policies for Claimant since 2007. They include a general liability and business automobile policy for Broken Arrow as well as personal lines for Claimant. Claimant has never asked Mr. Mann to write a Workers' Compensation policy for Broken Arrow.

4. In writing insurance policies for Broken Arrow Mr. Mann dealt primarily with Claimant's brother P.K. In March 2013 Claimant contacted Mr. Mann and advised him that he was starting Employer. Claimant clarified that Employer was a completely separate entity from Broken Arrow and his brother P.K. was not part of the new company. He sought to obtain a general liability policy for Employer.

5. In April 2013 Claimant contacted Mr. Mann and stated that he needed a Workers' Compensation insurance policy for Employer. Claimant noted that he required the policy so that he could submit bids on commercial projects.

6. Mr. Mann gathered information from Claimant, obtained approval for a Workers' Compensation policy with Insurer and received an estimated quote. Claimant advised Mr. Mann that Employer had one employee Ryan Unruh. Mr. Unruh was a plumber and the policy was based on his payroll earnings of approximately \$35,000 per year.

7. After Mr. Mann obtained approval, he asked Claimant whether he wanted to be included on the Workers' Compensation policy. Mr. Mann told Claimant that he was permitted to "opt out" of Workers' Compensation coverage as a corporate officer. He then explained that Claimant's insurance premium would increase by approximately \$3,000 per year if he wanted to be included on the policy. Claimant declined Workers' Compensation coverage for himself.

8. Mr. Mann completed an Application for Insurance that included Rejection of Coverage by Corporate Officers in parts A and B for Claimant to sign. Mr. Mann completed insurance documents based on the information Claimant had provided. The documents listed Claimant as President with 100% ownership of Employer and Ryan Unruh as the sole employee.

9. On April 26, 2013 Mr. Mann transported the documents to Claimant's place of business for review. Mr. Mann advised Claimant that if he did not sign the rejection forms he would automatically be covered under Employer's Workers' Compensation insurance policy. Claimant elected to sign the documents and exclude himself from Workers' Compensation coverage. Mr. Mann explained that he personally observed Claimant sign the Application for Insurance and Rejection of Coverage. Mr. Mann subsequently returned to his office, told notary Coylene Mann that he had personally observed Claimant sign the Rejection of Coverage documents and had Claimant's signature notarized.

10. Claimant denies that he signed parts A and B of the Rejection of Coverage documents. He testified that there were several inaccuracies in the documents including that he was only a 40% and not a 100% owner, the phone number on the documents was not Employer's business phone and the business description was incorrect. Moreover, he contends that the Rejection of Coverage was ineffective because his signature was not properly notarized. Claimant testified that he thought he had Workers' Compensation coverage through Employer.

11. Mr. Mann submitted the Application electronically to Insurer's Commercial Lines Division in St. Joseph, Missouri. He sent a hard copy of the Rejection of Coverage documents to Insurer's office through certified mail.

12. Tina Turner is a Commercial Underwriter for Insurer in St. Joseph, Missouri. Her job duties include analyzing risks, determining insurance eligibility and developing pricing for policies. Ms. Turner was the Underwriter for Employer's Workers' Compensation policy number 05-XU0827-90-0000.

13. Insurer electronically received Employer's Application for Insurance on April 26, 2013. Insurer received Employer's Rejection of Coverage documents, parts A and B, through certified mail on May 3, 2013.

14. Insurer issued a policy of Workers' Compensation Insurance for Employer that covered the period from April 26, 2013 to April 26, 2014. The Rejection of Coverage paperwork was delayed and not processed until after the policy was issued.

The policy thus reflected a total payroll of \$83,500 that consisted of Mr. Unruh's employee salary of \$35,000 and \$48,500 for Claimant as the payroll amount required for a corporate officer. The initial policy premium, based on a payroll of \$83,500, was \$5,213.

15. Ms. Turner explained that Insurer does not issue Workers' Compensation policies that only cover owners of companies. If Claimant was the only person listed on the Application for Insurance it would have been rejected.

16. On May 3, 2013 Insurer issued a Policy Information Page that included a "Change Endorsement" and "Partners, Officers and Other Exclusion Endorsement." The documents revealed that effective May 3, 2013 Claimant was excluded from the policy as a corporate officer and his payroll was deducted from the premium basis for the policy. The total estimated payroll for the policy was thus reduced from \$83,500 to \$35,000. The original premium of \$5,213 was then reduced by \$2,826 to \$2,387. The exclusion was processed on June 4, 2013 and was sent to Employer on June 6, 2013.

17. Insurer issued monthly billing statements to Employer. On July 1, 2013 Insurer issued a billing statement in the amount of \$1,789.50 that reflected the June 4, 2013 premium deduction based on Claimant's exclusion from the policy. Employer has continued to pay the premiums for the Workers' Compensation policy

18. In April 2014 Insurer issued a renewed Workers' Compensation Policy for Employer that covered the policy period of April 26, 2014 through April 26, 2015. The payroll of \$35,000 and the corresponding premium of \$2,353 documented on the Declaration Page were consistent with the payroll and premium charged after the Claimant had been excluded from the prior year policy.

19. On July 22, 2014 Claimant was involved in a motor vehicle accident while traveling north on I-25 in Thornton, CO. Donald Vaughn was driving the vehicle and Claimant was a passenger. Mr. Vaughn was insured by Safeco. Claimant explained that they were traveling to consider purchasing a new vehicle for Employer and visit a jobsite in Fort Morgan, Colorado.

20. Claimant was initially hospitalized at Exempla Good Samaritan Medical Center. Safeco Auto Insurance and Freedom Life Insurance Company were listed as the primary and secondary insurers for coverage of the hospital bills. Claimant's wife Jacquelyn Quint was listed as a subscriber for the Freedom policy. Subsequent Good Samaritan forms dated September 18, 2014 and September 22, 2014 list Safeco and Freedom as the insurers responsible for Claimant's July 22, 2014 injuries. There is no documentation in the Good Samaritan records stating that Claimant had a Workers' Compensation policy in force with Insurer that would cover Claimant's medical bills related to the motor vehicle accident.

21. Claimant was transferred to Boulder Community Hospital for care and treatment beginning on July 24, 2014. Insurers listed as responsible for coverage and payment of Claimant's injuries at Boulder Community Hospital included National

Foundation Life Insurance and CIGNA Insurance. There is no documentation in the Boulder Community Hospital records that Claimant had a Workers' Compensation insurance policy with Insurer that would cover his medical bills related to the July 22, 2014 motor vehicle accident.

22. Insurer has demonstrated that it is more probably true than not that Claimant rejected Workers' Compensation coverage pursuant to §8-41-202(1), C.R.S. prior to his July 22, 2014 motor vehicle accident. In April 2013 Claimant contacted Mr. Mann and stated that he needed a Workers' Compensation insurance policy for Employer so that he could bid on commercial projects. After Mr. Mann obtained policy approval, he asked Claimant whether he wanted to be included on the Workers' Compensation policy. Mr. Mann told Claimant that he was permitted to "opt out" of Workers' Compensation coverage as a corporate officer. He then explained that Claimant's insurance premium would increase by approximately \$3,000 per year if he wanted to be included on the policy. Claimant declined Workers' Compensation coverage for himself. Mr. Mann credibly explained that on April 26, 2013 he transported the insurance documents to Claimant's place of business for review. Mr. Mann advised Claimant that if he did not sign the rejection forms he would automatically be covered under Employer's Workers' Compensation insurance policy. Claimant elected to sign the documents and exclude himself from Workers' Compensation coverage. Mr. Mann credibly remarked that he personally observed Claimant sign the Application for Insurance and Rejection of Coverage. Moreover, Ms. Turner corroborated Mr. Mann's testimony that Claimant exercised his right as a corporate officer to reject Workers' Compensation coverage for himself. On May 3, 2013 Insurer issued a Policy Information Page that included a "Change Endorsement" and "Partners, Officers and Other Exclusion Endorsement." The documents revealed that effective May 3, 2013 Claimant was excluded from the policy as a corporate officer and his payroll was deducted from the premium basis for the policy.

23. In contrast, Claimant denies that he signed parts A and B of the Rejection of Coverage documents. He contends that the Rejection of Coverage was ineffective based on inaccuracies and an improperly notarized signature. Claimant remarked that he believed he possessed Workers' Compensation coverage on the date of his motor vehicle accident. However, the record demonstrates that he knowingly and intentionally rejected Workers' Compensation coverage for himself as a corporate officer of Employer. The written form rejecting coverage utilized by Insurer was substantially equivalent to the form required by Workers' Compensation Rule 3-4. Claimant was a corporate officer and sought to reject Workers' Compensation coverage for himself. Claimant took the affirmative step to reject Workers' Compensation coverage to avoid burdensome premiums. When Claimant rejected coverage the total estimated payroll for Employer's Workers' Compensation policy was reduced from \$83,500 to \$35,000. The original premium of \$5,213 the decreased by \$2,826 to \$2,387. Furthermore, Employer has continued to pay insurance premiums based on Claimant's exclusion from the Workers' Compensation policy. Finally, Claimant's actions after the motor vehicle accident reflect that he did not believe he had Workers' Compensation coverage through Insurer. Claimant made multiple claims with other insurers attempting to obtain coverage and payment of his medical bills from Good Samaritan Exempla Hospital and

Boulder Community Hospital. Accordingly, Claimant did not possess Workers' Compensation coverage through Insurer on July 22, 2014. His claim for benefits is thus denied and dismissed.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-41-202(1), C.R.S. permits a corporate officer to reject Workers' Compensation coverage. The section provides, in relevant part,

Notwithstanding any provisions of articles 40 to 47 of this title to the contrary, a corporate officer of a corporation or a member of a limited liability company may elect to reject the provisions of articles 40 to 47 of this title. If so elected, said corporate officer or member shall provide written notice on a form approved by the division through a rule promulgated by the director of such election to the worker's compensation insurer of the employing corporation or company, if any, by certified mail.

Section 8-41-202(2), C.R.S. specifies that the preceding election shall continue in effect so long as the corporation's or company's insurance policy is in effect or until the officer provides written notice to the insurer to revoke the election to reject coverage.

5. Workers' Compensation Rule of Procedure 3-4(A), addresses the election to reject coverage and provides as follows:

An officer of a corporation or a member of a Limited Liability Company who elects to reject the provisions of the Act under §8-41-202, C.R.S., shall complete the Division prescribed form and send it or a substantial equivalent, to the insurance carrier for the corporation's or company's other employees, if any, by certified mail.

6. A corporate officer and owner who exercises his right to reject coverage under §8-41-202, C.R.S. is not considered an employee under the Act. *Kelly v. Mile Hi Single Ply, Inc.* 890 P.2d 1161 (Colo. 1995). Although the Workers' Compensation Act is intended to provide exclusive remedies for all employees injured on the job, the General Assembly has authorized corporate officers the option to reject Workers' Compensation coverage. *Kelly*, 890 P.2d at 1164. The exception was introduced in response to small business owners' complaints that the self-coverage requirement under the Act unduly burdened their operations. The 1983 amendment provided small business owners with two benefits: (1) the right to reject compensation coverage and to avoid its premiums; and (2) the corresponding right to choose their coverage without unnecessary duplication from the compensation scheme. *Id.*

7. As found, Insurer has demonstrated by a preponderance of the evidence that Claimant rejected Workers' Compensation coverage pursuant to §8-41-202(1), C.R.S. prior to his July 22, 2014 motor vehicle accident. In April 2013 Claimant contacted Mr. Mann and stated that he needed a Workers' Compensation insurance policy for Employer so that he could bid on commercial projects. After Mr. Mann obtained policy approval, he asked Claimant whether he wanted to be included on the Workers' Compensation policy. Mr. Mann told Claimant that he was permitted to "opt out" of Workers' Compensation coverage as a corporate officer. He then explained that Claimant's insurance premium would increase by approximately \$3,000 per year if he wanted to be included on the policy. Claimant declined Workers' Compensation coverage for himself. Mr. Mann credibly explained that on April 26, 2013 he transported the insurance documents to Claimant's place of business for review. Mr. Mann advised Claimant that if he did not sign the rejection forms he would automatically be covered under Employer's Workers' Compensation insurance policy. Claimant elected to sign the documents and exclude himself from Workers' Compensation coverage. Mr. Mann credibly remarked that he personally observed Claimant sign the Application for Insurance and Rejection of Coverage. Moreover, Ms. Turner corroborated Mr. Mann's testimony that Claimant exercised his right as a corporate officer to reject Workers' Compensation coverage for himself. On May 3, 2013 Insurer issued a Policy Information Page that included a "Change Endorsement" and "Partners, Officers and Other Exclusion Endorsement." The documents revealed that effective May 3, 2013 Claimant was excluded from the policy as a corporate officer and his payroll was deducted from the premium basis for the policy.

8. As found, in contrast, Claimant denies that he signed parts A and B of the Rejection of Coverage documents. He contends that the Rejection of Coverage was

ineffective based on inaccuracies and an improperly notarized signature. Claimant remarked that he believed he possessed Workers' Compensation coverage on the date of his motor vehicle accident. However, the record demonstrates that he knowingly and intentionally rejected Workers' Compensation coverage for himself as a corporate officer of Employer. The written form rejecting coverage utilized by Insurer was substantially equivalent to the form required by Workers' Compensation Rule 3-4. Claimant was a corporate officer and sought to reject Workers' Compensation coverage for himself. Claimant took the affirmative step to reject Workers' Compensation coverage to avoid burdensome premiums. When Claimant rejected coverage the total estimated payroll for Employer's Workers' Compensation policy was reduced from \$83,500 to \$35,000. The original premium of \$5,213 the decreased by \$2,826 to \$2,387. Furthermore, Employer has continued to pay insurance premiums based on Claimant's exclusion from the Workers' Compensation policy. Finally, Claimant's actions after the motor vehicle accident reflect that he did not believe he had Workers' Compensation coverage through Insurer. Claimant made multiple claims with other insurers attempting to obtain coverage and payment of his medical bills from Good Samaritan Exempla Hospital and Boulder Community Hospital. Accordingly, Claimant did not possess Workers' Compensation coverage through Insurer on July 22, 2014. His claim for benefits is thus denied and dismissed. *See Boyle v. Red Mountain Builders, Inc.* W.C. No. 4-778-626 (ICAP, Feb. 18, 2010).(reasoning that the claimant properly rejected Workers' Compensation coverage as an owner/corporate officer of the employer pursuant to §8-41-202(1), C.R.S. and Rule 3-4 despite the lack of notarized signature).

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Workers' Compensation benefits is denied and dismissed.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: May 28, 2015.

DIGITAL SIGNATURE:

A handwritten signature in cursive script that reads "Peter J. Cannici". The signature is contained within a rectangular box.

Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

- Whether Claimant proved by a preponderance of the evidence that she suffered a compensable injury that arose out of and in the course and scope of her employment with Employer?
- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that she is entitled to medical treatment to cure and relieve the effects of the industrial injury?
- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits from September 30, 2014 and continuing until terminated by operation of law?
- If Claimant has proven a compensable injury, who are authorized treating physicians?

STIPULATION

The parties stipulate that Claimant's average weekly wage is \$572.53.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Reports of Injury

1. Claimant is a 26 year old female who works as a pharmacy technician for Respondent.
2. She alleges she injured her back at work on September 29, 2014. At hearing, Claimant testified that the injury occurred after the store had received its order for the day when she bent to pick up five handled shopping baskets, turned, and felt and heard a "pop" in her left lower back.
3. Claimant reported the mechanism of her injury differently to her numerous medical providers. For example, Claimant made the following varied reports:
 - On September 29, 2014, when Claimant first reported to Concentra, she reported that her injury occurred while she "was lifting and and [sic] unpacking boxes when she twisted to the left and felt a snap in her lower

back. . . . Patient states she has a history of sciatica to left lower back but has not bothered her in years.”

- When she reported to Dr. So, Claimant did not include any mention of turning or twisting. Rather, she stated that she “went to pick up some baskets took a step heard a pop in [her] lower left back and also felt it.” Additionally, this report indicates that Claimant was injured as she approached the baskets, before she picked them up.
 - On October 10, 2014, Claimant reported to Dr. Gary Ghiselli that she was taking some very light baskets from the pharmacy to the front of the store when she noticed a twinge in her back with radiation down into the anterior portion of her of her left leg.
 - On October 13, 2014, Claimant reported to Dr. Rossi at Concentra that she “was unloading an order when she bent down to pick up a basket and put it outside when she had a sudden snap in her back.”
 - In her Worker’s Claim for Compensation dated October 28, 2014, Claimant described that just before the accident; Claimant was “setting 10 delivery totes on the floor that weighed 10 to 50 pounds each.”
 - On October 30, 2014, Claimant reported to Physiotherapy Associates that, “She was lifting several baskets at work from the floor, took a step, to the side and heard a pop, felt stabbing pain in her back.”
 - On November 21, 2014, Dr. Jeffrey Sabin evaluated Claimant. To him she reported her injury occurred while “she was moving heavy baskets she felt a pop in her back followed by pain.”
4. Claimant testified she had never been in so much pain and that her legs were going numb. Claimant testified on cross-examination that her immediate pain was 5/10, and that by the end of her shift her pain was 11/10. Claimant testified that she continued to work out her shift hunched over, took numerous breaks to sit, and “had never been in so much pain.” The ALJ finds it unreasonable that Claimant could continue working with pain approaching 11/10.
 5. While Claimant acknowledged that a pharmacist was working in the same area at the time, she did not present any persuasive evidence that anyone, including the pharmacist, witnessed her injury or her working in such excruciating pain. Despite being in the “worst pain she ever felt,” Claimant finished her shift before reporting the alleged injury to her store manager. The ALJ finds it unreasonable that Claimant’s excruciating pain went un-witnessed, especially given the proximity of the pharmacist.
 6. Respondent called Sarah King who testified by telephone. Ms. King is the store director or manager to whom Claimant reported her injury. Ms. King testified that

Claimant reported to her that she had picked up baskets and hurt her back. Ms. King testified that she handled shopping baskets Claimant picked up weighed 1.6 pounds each, and that Claimant did not appear to be in distress when she reported her injury. The ALJ credits the testimony of Ms. King as being more consistent with the evidence than that of Claimant.

7. Claimant testified she did not receive a choice of provider form, however, a copy was mailed to her on October 1, 2014.

Previous Back Problems

8. Claimant testified that she had previously experienced sciatica in her low back for which she treated with Chiropractor Dr. Peter So. Claimant testified that her last treatment had been five years before her work injury, lasted only a couple of months at most, and that she had no lower back problems between that treatment and her alleged work injury.
9. Dr. So's records are inconsistent with Claimant's testimony. His medical records reflect that
 - Claimant treated with Dr. So on April 23, 2008 for acute left sided lower back pain radiating into her buttocks, and that the pain was aggravated by walking, getting up, and standing. Claimant also treated on April 26, 2008, and May 3, 2008 for those problems.
 - On January 7, 2011 Claimant began treating with Dr. So again for left-sided L5-S1 complaints with radiating back of leg pain. Claimant continued treatment on January 10, 2011; January 12, 2011; January 14, 2011; January 18, 2011; January 21, 2011; January 29, 2011; February 12, 2011; February 26, 2011; March 18, 2011; April 4, 2011; and April 11, 2011, for a total of twelve times.
 - On July 27, 2012, Claimant returned to Dr. So for treatment of right-sided L5-S1 symptoms.
10. On cross examination, Claimant recalled seeing Dr. So three times in early 2008 for pain with walking, sitting, and standing. However, she did not recall seeing him for twelve visits in 2011 for the same complaints. She admitted seeing Dr. So in 2012.
11. Claimant testified that she did not tell any of her treatment providers that she had chiropractic care for the same back issues within approximately two years of her alleged work injury. Despite her extensive chiropractic care in 2011 and her chiropractic visit in July 2012, Claimant told her treatment providers that she last had treatment for low back pain five years prior to her alleged work injury.
12. Claimant acknowledged that she was involved in a motor vehicle accident (MVA) on October 12, 2014 – less than two weeks after her date of injury -- in which her

car sustained \$2000 in damages. Claimant did not report the MVA to any of her treatment providers. She testified that she did not sustain any injuries as a result of the accident.

13. Claimant's testimony was again contradicted by that of Ms. King, who testified that she saw Claimant the day after the MVA when Claimant came into Ms. King's office with medical paperwork including a release to work with restrictions. Ms. King testified that during that meeting Claimant said she was in a lot of pain because of the MVA. Ms. King did not recall the details of the MVA, but was clear that Claimant attributed her pain to the MVA and not to her alleged work injury.

Course of Treatment

14. Claimant's first treatment was at Concentra the night of September 29, 2014. On September 30, 2014, Claimant returned to Concentra where Dr. Lori Rossi reported that Claimant presented with worsening back pain; that muscle relaxants and NSAID did not provide relief; and that radiculopathy increased when Claimant sat for any extended period of time.
15. Claimant sought treatment from Dr. So on October 1, 2014, and reported difficulty standing, walking, bending, and lifting. Dr. So's impression was lumbar strain or sprain; nonalopathic lesions, lumbar and sacral; and sciatica. Claimant returned on October 17, 2014 and on October 20, 2014, with little improvement.
16. On October 3, 2014, Dr. John McArthur reported Claimant's lumbar spine x-rays were essentially normal, with no evidence of acute injury or significant degenerative change. Dr. Steven Abrams reviewed flexion and extension views of the lumbar spine that he read to reflect a minimal grade 1 anterolisthesis of L5 over S1, without instability. Dr. Rossi referred Claimant to orthopedic specialist Dr. Gary Ghiselli.
17. On October 10, 2014, orthopedic specialist, Dr. Ghiselli, reported Claimant presented with a previous back history with exacerbation of pain after a rather insignificant injury at work. Dr. Ghiselli noted significant pain behaviors during portions of his physical examination. He opined Claimant more than likely had a preexisting spondylolisthesis with a possible spondylosis at the L5 level. "There will be difficulty attributing this injury to anything that happened while lifting up like grocery baskets, and it is more than likely has a preexisting condition as she has been treated for back problems in the past with chiropractic treatment approximately 5 years ago...I think it would be difficult [for the] workers' comp system to accept this as a work-related injury." He recommended physical therapy.
18. On October 15, 2014, Dr. Rossi responded to questions from Respondent's counsel and agreed "with Dr. Ghiselli's assessment."

19. On October 23, 2014, Respondents filed a Notice of Contest based on (1) medical reports from Dr. Rossi and Dr. Ghiselli that the claim was not work related and (2) Claimant's reports of a medical history of back problems approximately 5 years prior for which she saw a chiropractor.
20. Claimant participated in physical therapy at Physiotherapy Associates from October 30, 2014, through January 27, 2015. Her therapist noted that Claimant "made very minimal progress since beginning PT and is limited by pain which is preventing the progression of exercises." Claimant was instructed to continue her home exercises and update Ms. Condas in three weeks on her status.
21. Claimant's primary care physician, Stephanie Kuenn PA-C, referred her to Dr. Sabin. On November 21, 2014, Claimant saw Dr. Sabin who noted a history of "moving heavy baskets" when she felt a pop in her back followed by pain. She rated her pain at about five to six over ten. Dr. Sabin reviewed two x-rays which showed "well-preserved disc spaces" and "minimal anterolisthesis L5-S1." Dr. Sabin recommended continued core strengthening and stabilization through physical therapy and yoga.
22. On December 19, 2014, Claimant again saw Dr. Sabin and reported her pain level as six and a half over ten in her left lower back. She reported that she attended physical therapy with little improvement. She described her pain as localized back pain with activity and right buttock and thigh pain. Dr. Sabin's impression was spondylolisthesis L5-S1; and exacerbation of lower back pain following injury at work.
23. On December 20, 2014, an MRI of Claimant's low spine was read to reflect degenerative changes with a small disc herniation at L5-S1 and mild bilateral foraminal impingement but no spinal stenosis or listhesis.
24. On December 29, 2014, PA Menshenfriend noted that Claimant "continues to complain of alternating buttock and leg symptoms."
25. On January 23, 2015, Dr. Sabin's office called Claimant "after a failed transforaminal epidural injection." Claimant had earlier undergone an epidural steroid injection of the right L5 nerve root on January 13, 2015 with Dr. Engen. Dr. Sabin did not see any surgical indication and felt conservative management was most appropriate. Claimant was instructed to follow up with her primary care physician if she wanted to continue pain management.
26. On February 11, 2015, Dr. Sabin noted that Claimant's MRI reflected a small left-sided bulge but without nerve root compromise or spinal stenosis. He clarified that her complaint was back pain and not radiculopathy. Also, he noted that the Claimant underwent epidural steroid injections at L5-S1 without success. He was unable to identify any surgical indications, and noted that Claimant was okay to return to work from his standpoint and that her "restrictions" were self-imposed. He opined Claimant was likely at maximum medical improvement and

he planned to discharge her back to her primary care physician. Claimant's attorney requested a letter from Dr. Sabin so he could transfer her care to another physician.

27. Claimant testified that medical treatment after her work injury included physical therapy, injections, massage, acupuncture, and medications all of which provided very little, if any, relief. In fact, her condition worsened even though she did not return to work. Claimant's attorney referred Claimant to Dr. Knight for additional injections.
28. Dr. Jack Rook performed a medical examination at Claimant's request. He related Claimant's condition to work. Dr. Rook, however, relied on Claimant's (1) reports of her prior back problems resolving five years prior to her work injury; (2) her report that the mechanism of her injury involved twisting; and (3) her failure to report her MVA. Claimant represented to Dr. Rook that she did not experience low back pain or symptoms for five years prior to the incident on September 29, 2014, despite Dr. So's records and Claimant's admission at hearing that she actually received chiropractic treatment for low back pain and sciatica in 2008, 2011 and 2012. Dr. Rook relied on Claimant's false report that "there were no other traumatic events . . . such as a motor vehicle accident." Dr. Rook opined that Claimant's December 20, 2014 MRI was abnormal and demonstrated disc herniation at L5-S1 that most likely happened on the date of the incident when she heard her back "pop." Dr. Rook's opinion was contradicted by Dr. Sabin's interpretation of the MRI: that it reflected a small left-sided bulge without nerve root compromise or spinal stenosis and the fact that Claimant's epidural steroid injection provided no relief. Dr. Rook's opinion regarding Claimant's disc herniation was also contradicted by Dr. Rossi who testified by telephone that a disc herniation does not make an audible sound.
29. Dr. Rossi testified at hearing. Dr. Rossi evaluated and treated Claimant two times in 2014. She referred Claimant to Dr. Ghiselli and other medical providers. Dr. Rossi analyzed causation and agreed with Dr. Ghiselli's opinion that it is difficult to attribute Claimant's injury to lifting grocery baskets at work and it is more likely that her problems are due to her preexisting back condition for which she treated with a chiropractor. Dr. Rossi testified to several important factors for an accurate causation analysis including: knowledge of the full extent of Claimant's history of back problems and treatment in 2008, 2011, and 2012, because the more recent the complaints and treatment, the more likely Claimant's preexisting condition did not resolve and her condition relates back to her non-work condition; five years ago, on April 23, 2008; Claimant reported her pain was aggravated by walking, getting up and standing and those are the same aggravating factors now; the mechanism of injury is not significant enough to cause a new injury because lifting baskets that cumulatively weigh 8 pounds and turning is inconsistent with the force necessary to cause Claimant's problems in a twenty something year old individual; it is very unlikely that the small left-sided disc bulge is the cause of her problems because the MRI reflected no nerve root compromise or spinal stenosis; objective tests were all normal; and Claimant's

condition has not improved as expected despite all of the treatment and the fact Claimant has not returned to work.

30. Dr. Rossi disagreed with Dr. Rook's causation analysis. She testified that Dr. Rook did not understand Claimant's medical history correctly because Claimant incorrectly represented to him that she did not experience low back pain or symptoms for five years prior to the September 29, 2014, work incident when in fact Claimant treated in 2011 and 2012. Also, Claimant did not tell Dr. Rook about her October 2014 auto accident. And, Dr. Rook related Claimant's back problems to the small disc bulge; however, the MRI does not reflect nerve root compromise and injections were not diagnostic. Finally, discs are a deep structure and do not make a popping sound when compromised; rather that sound is more typical of a tendon.
31. The ALJ finds that Claimant did not respond to any treatment including muscle relaxants, NSAIDs, acupuncture, massage, physical therapy, epidural steroid injections, transforaminal steroid injections, and not working.
32. The ALJ finds Claimant's reports of her injury to be inconsistent, exaggerated, and not supported by persuasive evidence.
33. The ALJ credits the testimony of Ms. King over that of Claimant with respect to Claimant's condition when she reported her alleged work injury, and Claimant attributing her pain to her MVA. The ALJ finds that Ms. King's testimony is more consistent with the evidence, particularly the fact that no one witnessed Claimant working in excruciating pain on the day of her alleged work injury; and Ms. King's testimony that the baskets Claimant testified she picked up weighed only 1.6 pounds each.
34. The ALJ finds Claimant inconsistently reported the mechanism of her alleged injury to her treatment providers; failed to accurately report her prior chiropractic treatment; and failed to report her MVA which occurred two weeks after her alleged work injury. The ALJ further finds that Claimant's inaccurate and incomplete reporting were material to the diagnosis and treatment she received.
35. Based on the totality of evidence, the ALJ finds that Dr. Rook's opinion on the relatedness of Claimant's injury to her employment is not persuasive because it is based on incorrect and incomplete information. The ALJ finds the opinions of Dr. Rossi to be based on a fuller and more accurate understanding of Claimant's medical situation. Therefore, the ALJ finds the opinions of Dr. Rossi to be more credible and persuasive than the opinions of Dr. Rook.
36. The ALJ finds Claimant failed to demonstrate that her job duties caused an injury to her back or aggravated her back condition. The ALJ finds it more likely than not that Claimant's problems are due to her preexisting back condition.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

1. The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201. A Workers’ Compensation case is decided on its merits. Section 8-43-201.
2. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).
3. An employee is entitled to worker’s compensation benefits if injured performing service arising out of and in the course of employment. C.R.S. §8-41-301(1)(b)(c); *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). Injuries “arise out of” the employment when the activity giving rise to the injuries is sufficiently interrelated to the conditions and circumstances under which the claimant generally performs his or her job, that the activity may reasonably be characterized as an incident of employment. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207 (Colo. 1996). In other words, the job or the injury placed the individual in a position where injury resulted. The “course of employment” requirement is met when the injuries occur during the time and place limits of the employment. *Popovich v. Irlando*, supra. There must be a direct causal relationship between the employment and the injuries. See C.R.S. §8-41-301 and *Ramsdale v. Horn*, 781 P.2d 150 (Colo. 1989).
4. Claimant failed to demonstrate that her job duties caused an injury to her back or aggravated her back condition. The ALJ credits the opinions expressed by Dr. Rossi and Dr. Ghiselli over the contrary opinion expressed by Dr. Rook in coming to this conclusion. Claimant’s medical history supports the likelihood that her

problems are due to her preexisting back condition for which she treated with a chiropractor. Claimant failed to accurately report her medical history to most of her providers and to her independent medical examiner, Dr. Rook. Claimant incorrectly represented that she did not experience low back pain or symptoms for five years prior to the September 29, 2014, work incident when in fact Claimant treated in 2008, 2011, and 2012. Also, Dr. Rook was not aware of Claimant's October 2014 auto accident. Dr. Rossi pointed out that the more recent the complaints and treatment, the more likely Claimant's preexisting condition did not resolve and her condition relates back to her non-work condition. Finally, Claimant reported in 2008 that her pain was aggravated by walking, getting up, and standing and those are the same aggravating factors that she complained of following her alleged work accident.

5. The mechanism of injury does not support a work injury. Dr. Ghiselli, reported Claimant presented after a rather insignificant injury at work. Dr. Rossi testified that lifting baskets that weigh 8 pounds and turning is inconsistent with the force necessary to cause back problems in a twenty something year old individual.
6. The objective medical evidence does not correlate to the finding of an injury. Dr. Rossi credibly opined that it is very unlikely that the small left-sided disc bulge identified on MRI is the cause of Claimant's problems because, as Dr. Sabin noted, the MRI reflected no nerve root compromise or spinal stenosis. Also, discs are a deep structure and do not make a popping sound when compromised. In addition, all objective tests were essentially normal including x-rays, injections, and MRI. Claimant's orthopedist, Dr. Sabin, placed Claimant at maximum medical improvement and discharged her from his care despite her subjective complaints. Finally, Claimant's condition did not improve as expected despite all of her treatment and the fact Claimant had not returned to work. Physical therapy, injections, massage, acupuncture, and medications including muscle relaxants and NSAIDs provided very little, if any, relief and do not support a new injury.
7. Claimant's clinical examinations do not support a new injury. Medical records reflect mid and low back/buttock discomfort along with left upper leg numbness in 2008 that are similar to Claimant's complaints on October 1, 2014, when chiropractor Dr. So noted acute/constant moderate to severe low back, hip, and groin pain and tingling sensation in left her upper leg.
8. Claimant's seemingly exaggerated presentation to her physicians, failure to provide an accurate history, and unimproved symptoms despite medical treatment over a long period of time support a finding of non-work relatedness. For example, on a scale of 1 – 10, Claimant's pain was a 5 when her back popped and an 11 at the end of the day. Claimant failed to accurately disclose her medical history to her physicians and only reluctantly acknowledged she continued to treat for low back and buttock pain after 2008, after she was shown Dr. So's medical records on cross examination. Claimant admitted that she was in a car accident on October 12, 2014; however, she failed to mention the

accident to Dr. Rook. Claimant testified that she was not injured in the auto accident; however, she admitted that damage was done to her vehicle and she filed a small claims action against the other driver.

9. Ms. King's credibly testified that Claimant did not appear to be in a lot of pain on the date of the alleged work incident, however, several days later, Claimant returned to work after a non-work related motor vehicle accident and appeared to be in a great deal of pain and also told Ms. King that she was rear-ended and was in a lot of pain.
10. Dr. Rossi, Dr. Ghiselli, and Dr. Sabin could not identify a pain generator because all objective tests were essentially normal. Claimant testified that all activities aggravate her pain including standing, walking, and getting up and sitting.
11. In summary, the ALJ finds and concludes that Claimant failed to meet her burden of proof and demonstrate her condition resulted from a specific injury to her back at work.
12. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999).
13. The employer/insurer has the right in the first instance to select the physician who attends the injured worker, however, the employer/insurer is required to designate two authorized medical providers at two distinct locations and provide that information to Claimant within seven business days following notice or knowledge of the injury. Failure to provide Claimant with a choice of two authorized medical providers allows Claimant to make the choice of medical provider with whom he wants to treat.
14. In this case, Claimant testified she did not receive a choice of provider form, however, on October 1, 2014; Respondents mailed Claimant a choice of medical provider form along with medical authorization releases. Claimant chose to treat and did treat at Concentra. The medical providers at Concentra and their referrals, including Dr. Rossi and Dr. Ghiselli, are authorized.
15. On November 21, 2014, Claimant saw Dr. Sabin to whom she was referred by her primary care physician, Stephanie Kuenn PA-C. Dr. Sabin is not authorized. Dr. Sabin reported that Claimant was likely at maximum medical improvement, he planned to discharge her back to her primary care physician, and that Claimant's attorney wanted a letter so that he could transfer her care to another physician. Then, as Claimant testified, her attorney referred Claimant to Dr. Knight for additional injections. Dr. Knight is not authorized.

16. Claimant does not require medical treatment for a work related back injury. Medical benefits for Claimant's alleged back injury are neither reasonably necessary nor related to the September 29, 2014 alleged work injury. Therefore, the ALJ finds and concludes that Claimant failed to meet her burden of proof and demonstrate she needs medical care to cure and relieve the effects of a work related injury.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's claim for compensatory benefits is denied and dismissed.
2. The medical providers at Concentra and their referrals, including Dr. Rossi and Dr. Ghiselli, are authorized. Dr. Sabin is not authorized. Dr. Knight is not authorized.
3. Claimant does not require medical treatment for a work related back injury. Therefore, medical benefits are denied and dismissed.
4. Any and all issues not determined herein are reserved for future decision.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 25, 2015

/s/ Kimberly Turnbow
Kimberly B. Turnbow
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-963-355-01**

ISSUE

Whether Claimant has demonstrated by a preponderance of the evidence that she suffered a compensable injury to her left knee during the course and scope of her employment with Employer on September 17, 2014.

FINDINGS OF FACT

1. Claimant worked for Employer as a Medical Supply Chain Technician. In February 2011 Claimant tripped over a step stool while working for Employer and injured her left knee. She subsequently underwent an arthroscopic procedure for her injury with Mark S. Failing, M.D. He noted that Claimant's left knee demonstrated "considerable arthritic changes."

2. On September 17, 2014 Claimant was walking around a corner while coworker Ryan Modica was pushing a supply cart around the same corner. The cart struck Claimant in the lower extremities below the knees. Claimant reacted in pain. She suffered a contusion, bruising and laceration on her right shin. Claimant remarked that the impact hyperextended her left knee.

3. Mr. Modica explained that he was pushing a flatbed cart that was approximately eight to ten inches above the ground. The cart was made of plastic and had front wheels similar to those on a shopping cart. Mr. Modica described the incident as a bump and did not strike Claimant's shins with any significant force.

4. On September 17, 2014 Claimant mentioned the cart incident to Employer's Manager of Supply Chain Denise Rowley. Nevertheless, Claimant performed her regular job duties during the following week.

5. On September 28, 2014 Claimant reported that she had injured her left knee as a result of the September 17, 2014 incident. Claimant specified that the flatbed cart struck her on the left knee. Based on Claimant's continuing pain Employer referred her to Authorized Treating Physician (ATP) John Fox, M.D. for an evaluation.

6. On September 29, 2014 Claimant visited Dr. Fox for an examination. Dr. Fox recommended an MRI and released Claimant to full duty employment.

7. On October 3, 2014 Claimant returned to Dr. Fox for an evaluation. Claimant reported that a "co-worker hit her in the left shin with a cart and she has had significantly increased pain ever since." Dr. Fox noted that Claimant also reported "pain radiating down the shin and numbness in her toes." Dr. Fox attributed Claimant's left lower extremity condition to her work activities. He placed Claimant on restricted work duty, prescribed a knee brace and again ordered a left knee MRI.

8. On October 14, 2014 Claimant underwent an MRI of her left knee. The MRI revealed the following: (1) a degenerative medial meniscus without evidence of tearing; (2) a probable degenerative tear of the anterior horn of the lateral meniscus; (3) three compartment chondromalacia and (4) a small joint effusion.

9. On October 15, 2014 Claimant returned to Dr. Fox for an examination. After reviewing the MRI Dr. Fox remarked "MRI of the left knee showed extensive degenerative changes including some degenerative tearing of the lateral meniscus. No acute abnormalities were appreciated."

10. In addressing causation Dr. Fox commented:

I discussed causality with the patient and it is difficult if not impossible to state with any degree of certainty how much of her pathology is attributed to her prior knee injury. At any rate, patient states that she was essentially asymptomatic until the recent incident where she was hit by a cart. None of the pathology seen on the MRI seems to be attributable to the most recent incident but appears to be more chronic in nature and could have been at least partially accelerated by her prior [2011] knee injury.

11. Dr. Fox referred Claimant to Cornerstone Orthopedics for an evaluation. On October 28, 2014 Claimant underwent an examination with William Ciccone, M.D. Dr. Ciccone remarked that Claimant's left knee MRI revealed a "degenerative medial meniscus without evidence of tear with probable degenerative tearing of the anterior horn of the lateral meniscus with three compartment chondromalacia." In addressing Claimant's September 17, 2014 accident Dr. Ciccone commented that she "seemed to suffer a small injury to her pre-tibial area. She did not have significant injury to her knee."

12. Claimant returned to Dr. Ciccone for examinations on November 21, 2014 and December 5, 2014. In evaluating Claimant's left knee condition he noted that "I believe a lot of her symptoms are coming from the degenerative changes within her knee." Dr. Ciccone also commented that Claimant's "pain is really diffuse in nature and appears to be more arthritic."

13. On February 13, 2015 Claimant visited Dr. Failing for an evaluation. He diagnosed chondromalacia of the left knee.

14. On February 27, 2015 Claimant visited Todd M. Milner, M.D. for an examination. Dr. Milner noted that Dr. Failing had referred Claimant for a "second opinion evaluation of chronic and worsening left knee pain, stiffness and declining mobility." Claimant reported her prior left knee treatment that included a 2011 arthroscopic procedure. The procedure revealed "considerable arthritic changes." Dr. Milner commented that "over the past couple of years [Claimant's] chronic diffuse left knee pain has become markedly worse." He also remarked that Claimant "has had dramatically worsening left knee pain and stiffness over the past couple of years." Dr.

Milner summarized that radiographic evidence, a clinical examination and an arthroscopic evaluation revealed “advanced osteoarthritic change of the knee.”

15. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable injury to her left knee during the course and scope of her employment with Employer on September 17, 2014. The consistent reports of Claimant’s physicians reveal that her left knee symptoms were not related to her September 17, 2014 accident but constituted a chronic worsening of her left knee condition.

16. Although Dr. Fox initially attributed Claimant’s left knee symptoms to her work activities a subsequent MRI revealed extensive degenerative changes. After reviewing the MRI Dr. Fox noted that “none of the pathology on the MRI was attributable to the September 17, 2014 accident but “appear[ed] to be more chronic in nature “ Dr. Ciccone also determined that Claimant’s diffuse left knee symptoms were caused by arthritic changes. Finally, Dr. Milner summarized that radiographic evidence, clinical examination and an arthroscopic evaluation revealed “advanced osteoarthritic change of the knee.” He detailed that Claimant has experienced chronic, diffuse left knee pain over the past two years that “has become markedly worse.” The persuasive medical evidence thus reveals that Claimant has suffered degenerative, worsening and diffuse left knee pain over the past two years. Although there was a temporal correlation between the September 17, 2014 incident and Claimant’s left knee symptoms, any increased pain constituted the logical and recurrent consequences of her pre-existing left knee condition. Accordingly, the September 17, 2014 incident did not aggravate, accelerate, or combine with Claimant’s pre-existing left knee condition to produce a need for medical treatment. .

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers’ Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge’s factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.*, 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner*, 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts*, W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. The mere fact a claimant experiences symptoms while performing work does not require the inference there has been an aggravation or acceleration of a preexisting condition. *See Cotts v. Exempla, Inc.*, W.C. No. 4-606-563 (ICAP, Aug. 18, 2005). Rather, the symptoms could represent the “logical and recurrent consequence” of the pre-existing condition. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Chasteen v. King Soopers, Inc.*, W.C. No. 4-445-608 (ICAP, Apr. 10, 2008). As explained in *Scully v. Hooters of Colorado Springs*, W.C. No. 4-745-712 (ICAP, Oct. 27, 2008), simply because a claimant’s symptoms arise after the performance of a job function does not necessarily create a causal relationship based on temporal proximity. The panel in *Scully* noted that “correlation is not causation,” and merely because a coincidental correlation exists between the claimant’s work and his symptoms does not mean there is a causal connection between the claimant’s injury and work activities.

7. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable injury to her left knee during the course and scope of her employment with Employer on September 17, 2014. The consistent reports of Claimant’s physicians reveal that her left knee symptoms were not related to her September 17, 2014 accident but constituted a chronic worsening of her left knee condition.

8. As found, although Dr. Fox initially attributed Claimant's left knee symptoms to her work activities a subsequent MRI revealed extensive degenerative changes. After reviewing the MRI Dr. Fox noted that "none of the pathology on the MRI was attributable to the September 17, 2014 accident but "appear[ed] to be more chronic in nature " Dr. Ciccone also determined that Claimant's diffuse left knee symptoms were caused by arthritic changes. Finally, Dr. Milner summarized that radiographic evidence, clinical examination and an arthroscopic evaluation revealed "advanced osteoarthritic change of the knee." He detailed that Claimant has experienced chronic, diffuse left knee pain over the past two years that "has become markedly worse." The persuasive medical evidence thus reveals that Claimant has suffered degenerative, worsening and diffuse left knee pain over the past two years. Although there was a temporal correlation between the September 17, 2014 incident and Claimant's left knee symptoms, any increased pain constituted the logical and recurrent consequences of her pre-existing left knee condition. Accordingly, the September 17, 2014 incident did not aggravate, accelerate, or combine with Claimant's pre-existing left knee condition to produce a need for medical treatment.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Workers' Compensation benefits is denied and dismissed.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: May 22, 2015.

DIGITAL SIGNATURE:


Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-964-402-01**

ISSUES

- Whether claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course of his employment with employer?
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that he is entitled to an award of temporary total disability ("TTD") benefits from October 17, 2014 through December 16, 2014, subject to offsets.
- The parties stipulated that if the claim is found compensable, the Respondents shall designate a physician to treat claimant for his work injury?
- The parties stipulated to an average weekly wage ("AWW") of \$565.31.

FINDINGS OF FACT

1. Claimant is employed as a mechanic for employer. Claimant testified at hearing that he has been employed with employer for 18 ½ years. Claimant testified that his job duties include working on cars and performing general mechanic duties including repairing transmissions and engines. Claimant testified that on a daily basis he will lift items weighing more than thirty five (35) pounds.

2. Claimant testified that he had noticed a hernia in his abdomen previously that would pop out on occasion. Claimant testified that when he noticed his hernia pop out, he would pop it back in manually. Claimant testified that the hernia developed after doing some front end work on a car in April 2014.

3. Claimant testified that on October 16, 2014, he was working on a Jeep that was brought in to change out the front end axels. Claimant testified he pulled out the back axle by himself and experienced abdominal pain when he lifted the rear axle. Claimant testified he then asked of assistance with the front axle from a co-worker. Claimant testified he was hurting pretty good, but continued to work.

4. Claimant testified that his pain level increased significantly after October 16, 2014 and he began vomiting around 7:00 p.m. that evening after he got home. Claimant sought treatment at an Urgent Care facility and was referred to the Emergency Room ("ER") at Community Hospital. Claimant subsequently underwent surgery on October 17, 2014 under the auspices of Dr. Morse.

5. The medical records from the ER note that claimant reported with a history of abdominal pain for one day in the epigastric region. Claimant reported a history of a ventral hernia from a previous surgery and bowel resection and noted that he was unable to reduce the hernia yesterday as usual. Claimant reported he was finally able to push it back in, but had increased pain. The prior surgery was noted to be a right colon resection with appendectomy performed in 2011 for a benign colon tumor.

6. Dr. Morse issued a letter dated November 18, 2014 that noted that claimant had undergone an incisional hernia repair. Dr. Morse noted that claimant described that the hernia occurred at the site of a previous surgical incision, but that did not mean that the hernia was a direct result of the original surgery. Dr. Morse noted that claimant described the hernia occurring with acute strangulation while lifting at work. Dr. Morse opined that per the history provided by claimant, he believed the injury should be covered by workers' compensation.

7. Respondents obtained a medical records review independent medical examination ("IME") from Dr. Thurston on March 13, 2015. The IME report noted claimant's history and Dr. Thurston opined that claimant did not sustain an "accident" or work-related injury. Dr. Thurston noted that claimant had an incisional hernia resulting from incomplete healing following his 2011 surgery. Dr. Thurston further noted that the surgical report indicated that there was scarring and adhesion that would have occurred over days, weeks or even months, and would not have happened in one day.

8. The ALJ credits the medical opinions of Dr. Morse over the contrary medical opinions expressed by Dr. Thurston and along with claimant's testimony at hearing and finds that claimant has demonstrated that he sustained a compensable injury arising out of and in the course of his employment with employer. The ALJ credits claimant's testimony that his hernia was significantly worsened resulting in the need for surgery after his lifting at work on October 16, 2014 as credible and persuasive. The ALJ further credits the medical opinion expressed by Dr. Morse that claimant provided this accident history to him as occurring while lifting at work

9. Claimant testified at hearing that he was taken off of work following his surgery and returned to work on December 17, 2014. However, the medical records from Dr. Morse entered into evidence by Claimant at hearing contain a report releasing claimant to return to regular work as of December 1, 2014.

10. The ALJ finds that claimant has proven that it is more likely than not that he is entitled to TTD benefits commencing October 17, 2014 and continuing until December 1, 2014. The ALJ denies claimant's request for an order allowing for TTD benefits through December 16, 2014.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers’ Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it “aggravates accelerates or combines with “a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra*.

4. As found, claimant has proven by a preponderance that he suffered compensable injury arising out of and in the course of his employment with employer on October 16, 2014. As found, the ALJ credits the testimony of claimant along with the medical opinions expressed by Dr. Morse in finding the claimant has proven a compensable injury arising out of and in the course of his employment with employer.

5. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM*
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Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

6. As found, claimant has proven by a preponderance of the evidence that his injury resulted disability that impaired his wage earning capacity as demonstrated by claimant's inability to resume his prior work.

7. Section 8-42-105(3)(c), C.R.S. provides that TTD benefits shall continue until the attending physician gives the employee a written release to return to regular employment.

8. As found, Dr. Morse issued a release returning claimant to regular employment as of December 1, 2014. While claimant testified at hearing that he did not return to work for employer until December 17, 2014, the written release from Dr. Morse indicates claimant was released for regular employment as of December 1, 2014 and respondents are therefore able to cut off TTD benefits pursuant to Section 8-42-105(3)(c), C.R.S. as of December 1, 2014.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the reasonable medical treatment necessary to cure and relieve claimant from the effects of his industrial injury.

2. Respondents shall pay claimant TTD benefits for the period of October 17, 2014 through December 1, 2014 based on the stipulated AWW of \$565.31.

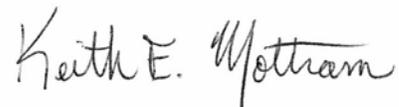
3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

4. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or

service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 22, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

**OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-964-736-01**

ISSUES

- Whether claimant has proven by a preponderance of the evidence that she is entitled to an award of temporary total disability (“TTD”) benefits commencing October 18, 2014 and continuing until terminated by law or statute?
- Whether respondents have proven by a preponderance of the evidence that claimant committed a volitional act that led to her termination of employment?
- The parties stipulated prior to hearing that claimant’s average weekly wage (“AWW”) for her injury is \$1,141.37. The parties’ stipulation includes claimant’s cost of converting her employer funded health insurance.

FINDINGS OF FACT

1. Claimant was employed with employer as an assistant manager. Claimant had been employed with employer for approximately 16 years, having worked previously for employer in a different state. Claimant testified that she was working the overnight shift starting on October 11, 2014 at 7:30 p.m. Claimant testified that at approximately 12:30 a.m. to 1:00 a.m. on October 12, 2014, she was pulling a pallet up a ramp when she injured her low back.

2. Claimant testified she finished pulling pallets off the truck, then went to the assistant manager’s office to lie down for a while, but lying down did not alleviate her pain. Claimant tested her boss, Mr. Meade at approximately 3:00 a.m. to 3:30 a.m. regarding her injury. Claimant testified Mr. Meade called claimant back and she informed Mr. Meade that she had hurt her back. Claimant testified Mr. Meade told claimant not to go to the doctor right away and to wait for a support manager to relieve her.

3. Claimant testified Mr. Meade arrived at the store at approximately 7:00 a.m. to 7:30 a.m. Claimant testified she was sitting on an electric cart when Mr. Meade arrived and he inquired how she was feeling. Claimant testified she informed Mr. Meade she was still hurting. Claimant testified after Mr. Meade relieved her, she went home, took pain medications and laid down, but she could not sleep.

4. Claimant testified that she was scheduled to go back to work at 7:30 p.m. on Sunday (October 12, 2014) for a shift that would last until 8:00 a.m. Monday morning. Claimant testified she called Mr. Meade at 4:00 p.m. to report that she could not return to work. Claimant testified that Mr. Meade returned her call approximately

15-20 minutes later, and told claimant that she would do this all the time when inventory needed to be done or Black Friday and claimant should think about whether or not she wants to be an assistant manager. Claimant testified that Mr. Meade called back later and told claimant to turn her keys and discount car in to human resources. Claimant asked Mr. Meade if he was firing her, and Mr. Meade said "yes".

5. Claimant then drove to employer's store and dropped off her badge, keys and discount card on the assistant manager's desk.

6. Claimant testified as to several more conversations between her and Mr. Meade in which Mr. Meade called and inquired as to how claimant was doing, and she informed Mr. Meade that she was still in pain and expressed anger over Mr. Meade firing her. Claimant testified as to multiple instances in which Mr. Meade inquired as to why she was not at work, and she claimant explained it was because she had been fired.

7. Claimant testified on cross-examination that when Mr. Meade called her and inquired as to why she was not at work, she realized she had not been fired and still had a job with employer. Claimant testified that she told Mr. Meade that she was going to take a shower and would then come into work. Claimant testified that while she was in the shower, she realized Mr. Meade was playing mind games with her and decided she was not going to go into work. Claimant testified that she felt Mr. Meade was argumentative, was playing mind games and was raising his voice, and she took offense with how she was treated by Mr. Meade.

8. Respondents presented the testimony of Ms. Palmer, the human resources manager for employer. Ms. Palmer testified that she investigated the situation involving Mr. Meade and claimant. Ms. Palmer spoke with Mr. Meade regarding the incident and then spoke with claimant regarding the incident. Ms. Palmer testified she terminated claimant after determining that claimant had abandoned her job. Ms. Palmer testified that she could have offered coaching for claimant that would not have resulted in her termination, but decided to terminate claimant because she this involved a gross display of job abandonment.

9. According to the termination notice completed by employer claimant was terminated when she "did not show up to work on the night of October 12, 2014. When contacted by the store (claimant) stated that she placed her name badge and other work items on the desk in the assistant mangers office. We accept her resignation without a two week notice." Ms. Palmer testified at hearing that this was completed by Ms. Simon with employer

10. Ms. Palmer testified on cross-examination that she was aware that claimant was injured on October 12, 2014. Ms. Palmer further testified that claimant had called in sick for the shift from 7:30 p.m. October 12, 2014 until 8:00 a.m. October 13, 2014.

11. The ALJ notes that although Ms. Palmer indicated to Mr. Meade in on October 15, 2014 that they needed to document everything, very little documentation was kept with regard to Ms. Palmer's investigation and her interviews with Mr. Meade. Ms. Palmer testified that she put her notes into an e-mail draft, but was unable to find the e-mail.

12. Regardless, Ms. Palmer testified on cross-examination that Mr. Meade's behavior was unprofessional. Ms. Palmer testified that Mr. Meade had informed her that he had lost his temper and had told claimant he wanted to fire her.

13. Claimant presented to Dr. Mordi on October 13, 2014 at 8:23 a.m. with reports of injuring her back while pulling a pallet jack. Dr. Mordi diagnosed claimant with a low back strain and provided claimant with medications including Flexeril and a Medrol dosepak. Claimant also restricted from any lifting or carrying and was instructed to follow up in 10 days.

14. Ms. Palmer testified at hearing that employer could have provided work within the restrictions set forth by Dr. Mordi. However, respondents refused to offer claimant coaching or work within her restrictions, and instead terminated claimant from her employment with employer based on job abandonment.

15. The ALJ credits claimant's testimony at hearing that she was experiencing pain in her low back following the October 12, 2014 work injury as persuasive. The ALJ credits claimant's testimony that the pain was significant enough that in the morning of October 12, 2014 she was utilizing an electric cart while finishing her shift for employer. The ALJ finds this testimony supported by the medical records of Dr. Mordi that document claimant reporting pain in her low back on October 13, 2014 significant enough that Dr. Mordi provided claimant with work restrictions that included no lifting.

16. The ALJ credits claimant's testimony and the medical records of Dr. Mordi and determines that claimant was restricted from working in her regular job with employer as a result of her work injury.

17. Respondents maintain in their position statement that it is inconsistent for claimant to have driven to employer's store to drop off her badge and keys if she were in pain. Respondents fail to explain how this is inconsistent if claimant was instructed to drop of her keys and badge by her supervisor for her to follow this instruction. Respondents maintain that claimant could not have been in the amount of pain she claimed to be in if she was willing to travel to employer's store to drop off her badge and keys. However, compensability is not at issue here, and the ALJ fails to see how claimant following the instructions of her supervisor would be inconsistent in this case.

18. While employer maintains that claimant was terminated for job abandonment, based on the fact that claimant had a conversation with Mr. Meade at approximately 8:13 p.m. in which claimant was told to come to work and she informed

her supervisor (Mr. Meade) that she would take a shower and then come to work, Ms. Palmer testified that she was aware that claimant had attempted to call in sick prior to this phone call.

19. Moreover, according to the written statement contained in the file by Mr. Clavery, he saw claimant at the store at approximately 6:00 p.m. on October 12, 2014 when she told him that she had put her stuff on the desk. This is consistent with claimant's testimony that Mr. Meade had terminated her, and she had taken her things to the store as instructed. The ALJ determines that claimant's employment was terminated by Mr. Meade in his conversation with claimant prior to 6:00 p.m. on October 12, 2014. The ALJ further finds that it was reasonable for claimant to believe Mr. Meade had taken necessary steps to terminate her employment and to follow his instructions, as her supervisor, to turn in her badge, keys and discount card.

20. Ms. Palmer testified that as a result of claimant not coming into work, another assistant manager, Mr. Clavery, had to work a 24 hour shift. Ms. Palmer testified that if Mr. Meade had known claimant was not going to show up for work, Mr. Meade could have worked claimant's scheduled shift so Mr. Clavery would not have worked a full 24 hour shift.

21. However, Mr. Meade was aware on the evening of October 12, 2014 that his conversations with claimant had resulted in her advising him that she believed she was fired. Moreover, Mr. Meade was aware that claimant had attempted to call in sick for her scheduled shift. There was no credible evidence presented that Mr. Meade made any attempts to cover claimant's shift when he was aware that she had called in sick and was under the impression that she was fired, other than to pressure claimant into coming into work. Moreover, Mr. Meade was aware that claimant was alleging a work injury on her prior shift.

22. The fact that Mr. Meade did not make arrangements for claimant's shift to be covered when she called in sick does not result in a finding that claimant committed a volitional act that led to her termination of employment. If Mr. Meade had made arrangements for claimant's shift to be covered when she initially called in sick, the issue with Mr. Clavery working a 24 hour shift would not have occurred. More importantly, Ms. Palmer testified that claimant had attempted to call in sick prior to missing her shift. Under the facts of this case, the ALJ does not find that claimant's actions of not appearing for work after attempting to call in sick following a work injury (which resulted in significant confusion as to whether claimant was terminated) establish that the injured worker committed a volitional act that resulted in her termination of employment.

23. Respondents presented no credible evidence that indicated claimant would be prohibited from calling in sick for her October 12 to October 13, 2014 shift. While employer noted that inventory was taking place during this time, there was also evidence that claimant's shift could have been covered by an assistant manager for a

different store. Additionally, while some evidence was presented that claimant had previously missed time from work during inventory or Black Friday, no credible evidence was presented as to whether this was a regular occurrence or to what degree it had occurred. Respondents effectively maintain that if claimant attempts to call in sick, and is pressured by her supervisor to appear for work, then agrees to appear for work, but ultimately decides to stay home, *after having previously called in sick*, claimant has abandoned her job. In the present case, the ALJ disagrees.

24. The ALJ credits the testimony of claimant and determines that Mr. Meade in the present case pressured claimant to appear at work after claimant called in sick. This testimony is supported by the telephone records entered into evidence and by the testimony of Ms. Palmer, who testified she was aware claimant had attempted to call in sick for her October 12, to October 13, 2014 shift. Claimant was then terminated after she failed to appear for her shift for which she had called in sick. The ALJ determines that respondents have failed to establish that claimant committed a volitional act that resulted in her termination of employment.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers’ Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. Likewise, Respondents have the burden of proving any affirmative defenses raised at hearing by a preponderance of the evidence. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers’ Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers’ Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2008).

3. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), C.R.S., requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

4. The ALJ credits the medical records from Dr. Mordi along with the testimony of claimant and determines that claimant has established that it is more probable than not that she is entitled to an award of TTD benefits beginning October 13, 2014 when she was placed on restrictions by Dr. Mordi.

5. Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S., contain identical language stating that in cases "where it is determined that a temporarily disabled employee is responsible for termination of employment the resulting wage loss shall not be attributable to the on-the-job injury." In *Colorado Springs Disposal v. Industrial Claim Appeals Office*, 58 P3d 1061 (Colo. App. 2002), the court held that the term "responsible" reintroduced into the Workers' Compensation Act the concept of "fault" applicable prior to the decision in *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Hence, the concept of "fault" as it is used in the unemployment insurance context is instructive for purposes of the termination statutes. *Kaufman v. Noffsinger Manufacturing*, W.C. No. 4-608-836 (Industrial Claim Appeals Office, April 18, 2005). In that context, "fault" requires that the claimant must have performed some volitional act or exercised a degree of control over the circumstances resulting in the termination. See *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1995) *opinion after remand* 908 P.2d 1185 (Colo. App. 1995).

6. As found, respondents have failed to establish that claimant committed a volitional act that resulted in her termination of employment. As found, claimant was terminated for job abandonment after she called in sick to her employer. As found, no credible evidence was presented that claimant voluntarily abandoned her job. Instead, claimant attempted to call in sick, was informed by her supervisor she was fired, dropped off her keys and badge, was then informed by her supervisor she had not been

fired and should show up for work. After claimant agreed to show up for work, then decided not to show up for work, and having already called in sick, claimant was terminated. Under the facts of this case, the ALJ fails to find that claimant committed a volitional act by abandoning her job with employer.

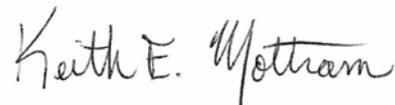
ORDER

It is therefore ordered that:

1. Respondents shall pay claimant TTD benefits commencing October 13, 2014 and continuing until terminated by law or statute based on the stipulated AWW.
2. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
3. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 28, 2015



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

ISSUES

- Whether claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course of his employment with Employer?
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that the medical treatment he received was reasonable and necessary to cure and relieve the claimant from the effects of the work injury and was provided by a physician authorized to treat claimant for his injury?
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that he is entitled to an award of temporary partial disability ("TPD") for the period of September 12, 2014 through October 25, 2014??
- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that he is entitled to an award of temporary total disability ("TTD") from October 26, 2014 and continuing?
- If claimant has proven a compensable injury, what is claimant's average weekly wage?

FINDINGS OF FACT

1. Claimant was employed with employer working in construction. Claimant testified that in September 2014 he was doing frame work for houses when he was picking up windows and felt pain in his low back. Claimant testified that his date of injury was September 11, 2014.

2. Claimant testified he told his two supervisors, "Carlos" and Mr. Alcaraz about his injury. Claimant testified he did not seek medical treatment on the day of the injury. Claimant returned to employer the day following the injury, but did not work all day. Claimant eventually sought medical treatment at the emergency room ("ER") on September 13, 2014 and reported he had moderate back pain that radiated into his left buttock. Claimant reported to the ER that he injured his back lifting, turning and bending. Claimant noted that the pain was similar to prior episodes. The ER physician, Dr. Walker, referred claimant for physical therapy.

3. Mr. Ringstad testified at hearing that the first he became aware of claimant's injury was when he was contacted by someone from the ER who reported to him that claimant was in for medical treatment. Mr. Ringstad testified at hearing that claimant reported his injury to him in person on Tuesday, September 16, 2014. Mr. Ringstad testified that he was unaware of an injury to claimant prior to September 13, 2014 when he was contacted by the ER.

4. Respondents presented the testimony of Mr. Alcaraz, claimant's supervisor. Mr. Alcaraz testified that claimant did not suggest to him on September 11, 2014 that he had injured his back. Mr. Alcaraz further testified that he was not working with claimant on September 11, 2014 as he was on a different job site that day. On cross examination, although Mr. Alcaraz consistently maintained that he did not work with claimant on September 11, 2014, he could not recall which dates he did work with claimant or which dates he worked on particular job sites. Mr. Alcaraz further established that employer was in the process of moving windows as claimant described in his direct examination during September 2014, but could not identify specific dates that such work would have been performed. Mr. Alcaraz's testimony is found to be less than credible as he appeared to have a very selective memory with regard to when work was being performed. Mr. Alcaraz would only offer testimony regarding specific dates that was designed to bolster respondents' case, while claiming ignorance to any questions involving dates that would allow the fact finder to ascertain the truth involving claimant's alleged injury. Mr. Alcaraz's testimony appeared designed to confuse the issues involving claimant's injury and frustrate the process of developing the truth. For this purpose, Mr. Alcaraz's testimony is completely disregarded by the ALJ.

5. Claimant was evaluated at Mountain View Therapy on September 16, 2014. Claimant reported complaints of constant pain in his mid to left lumbar area with occasional sharp shooting pain down his left leg. Claimant reported he had fallen about 4 months ago following which he treated at the ER for back pain and returned to work without seeing a physical therapist. Claimant reported to the therapist that he experienced sharp pain down his left leg after lifting a heavy window frame and returned to the emergency room. Claimant reported his pain was worse following the lifting incident.

6. Claimant was referred for medical treatment with Dr. O'Meara. Dr. O'Meara evaluated claimant on October 22, 2014. Dr. O'Meara noted claimant's prior back injury in April 2014 and noted that claimant reported he was injured again on September 13, 2014 in the same area of the low back when he was lifting windows. Dr. O'Meara noted that claimant could remain at full duty "while we determine causality". Dr. O'Meara noted that based on the records provided and the history, it was unclear whether or not "this is truly related to the workplace or simply a recurrent low back strain."

7. Dr. O'Meara's records indicate claimant was a "no show" for his visit on October 27, 2014 and claimant was discharged from care based on the claim being a "non-occupational injury"

8. Respondents authorized claimant to continue medical care with the Telluride Medical Center. Claimant was evaluated by Ms. Cattell, a physician's assistant, on October 27, 2014. Ms. Cattell noted claimant reported radiation of pain down the left leg to the foot after he was hurt at work when he was lifting windows. Ms. Cattell noted that claimant denied any previous injury to his low back and also complained of numbness down his right leg. Claimant reported he did not feel he could work anymore due to his pain. Ms. Cattell took claimant off of work for the period of October 27, 2014 through November 11, 2014.

9. Claimant returned to Ms. Cattell on November 10, 2014. Claimant reported to Ms. Cattell that he continued to undergo physical therapy and felt his back was slowly improving. Claimant was taking Percocet for the pain. Ms. Cattell recommended claimant continue physical therapy and remain off work.

10. Claimant returned to Ms. Cattell on December 1, 2014. Ms. Cattell noted claimant continued to complain of pain down his left leg to the foot. Claimant was provided with an injection of Tordol and continued with a prescription for Percocet. Ms. Cattell continued claimant off of work.

11. Claimant returned to Ms. Cattell on December 15, 2014. Ms. Cattell noted claimant reported through a translator that he had injured his back earlier in the year and attempted to work through it after being evaluated at Montrose Memorial Hospital. Claimant then reinjured his back in September and was again seen again at Montrose Memorial Hospital. Ms. Cattell noted that claimant had been taking medications and performing physical therapy for 8 weeks with no improvement and she felt it was reasonable to refer claimant for a magnetic resonance image ("MRI"). Claimant was again taken off of work.

12. Claimant was referred by respondents for an independent medical examination ("IME") with Dr. Fall on February 17, 2015. Dr. Fall reviewed claimant's medical records, obtained a medical history and performed a physical examination of claimant. Claimant reported to Dr. Fall that he had previously injured his back a few months prior to September 11, 2014 when he slipped on ice and fell backwards. Claimant reported to Dr. Fall that he was injured in September 2014 when he lifted a window while at work. Dr. Fall noted that claimant exhibited significant pain behaviors and had positive Waddell signs. Dr. Fall opined that claimant's current symptoms were not consistent with the alleged mechanism of injury and not consistent with physical examination findings. Dr. Fall opined that she was unable to state within a reasonable degree of medical probability that claimant suffered an injury at work on September 11,

2014, and that if an incident did occur, it was a temporary aggravation of a pre-existing condition.

13. Claimant testified at hearing consistent with her report. Dr. Fall noted that claimant complained of right hand pain that had no correlation to his alleged work injury. Dr. Fall noted claimant's description of his injury was vague and non-specific. Dr. Fall noted that the evaluation showed no evidence of a lumbar strain and no need for medical treatment. Dr. Fall opined that an MRI was not medically necessary as there were no objective findings on examination.

14. The ALJ credits the medical records in this case, along with claimant's testimony at hearing that he suffered an onset of back pain after lifting windows on September 11, 2014 as being persuasive to the issue of whether claimant suffered a compensable injury at work. The ALJ notes that conflicting evidence was presented at hearing as to whether claimant was working with Mr. Alcaraz on September 11, 2014, but the ALJ resolves this conflict in favor of claimant and against respondents.

15. In finding the claim compensable, the ALJ credits the medical records from the treating physicians including Ms. Cattell regarding the cause of claimant's condition over the conflicting opinion expressed by Dr. Fall in her report and testimony. The ALJ notes that while Ms. Cattell was not apparently aware of claimant's prior accident in April 2014, claimant did report this incident to her eventually in December 2014.

16. The ALJ notes that claimant has provided a consistent accident history to his medical providers of his injury occurring at work while lifting windows. The ALJ further finds that despite Mr. Alcaraz's testimony that claimant was not working with him on September 11, 2014, there was work involving windows being performed in September 2014 for employer. The ALJ credits claimant's testimony that he had a new onset of symptoms following the incident lifting the windows and determines that claimant has established that he suffered a compensable injury on September 11, 2014.

17. The ALJ notes that claimant had a prior injury occurring in April 2014. However, claimant was treated for this injury and was not under active medical care at the time of the September 11, 2014 work injury. The ALJ credits that medical records and determines that claimant has demonstrated that it is more probable than not that the incident lifting windows on September 11, 2014 aggravated, accelerated or combined with claimant's pre-existing condition to cause the need for medical treatment.

18. The ALJ notes that claimant sought care with the ER following his injury. The ALJ does not find that the treatment with the ER was true "emergency" medical care. The ALJ notes that claimant had previously sought medical care through an ER and does not find respondents responsible for the care through the ER. Claimant

returned to work the day after his injury and did not seek medical treatment until the weekend, several days after his injury. Under these circumstances, the ALJ finds claimant's treatment with the ER to be unauthorized medical treatment.

19. The ALJ does find claimant's treatment with Dr. O'Meara and Telluride Medical Center ("Ms. Cattell") to be within the authorized chain of referrals. The ALJ credits the testimony at hearing that claimant was allowed to treat with the Telluride Medical Center in Telluride pursuant to his request from employer.

20. The ALJ finds that the employment records document that in the 14 weeks that include claimant's date of injury, claimant earned \$8,198.50. The ALJ determines that claimant's AWW is properly established at \$585.61. The ALJ does not include claimant's earning prior to the June 27, 2014 pay period as it appears from the medical records that claimant had undergone medical treatment to his right foot during this period of time including a surgery to his foot on or about early June 2014, which could explain the lower earnings reflected in the June 13, 2014 paycheck.

21. The ALJ finds that claimant has failed to demonstrate by a preponderance of the evidence that he is entitled to an award for TPD benefits for the period of September 12, 2014 through October 25, 2014. The ALJ notes that claimant was not under work restrictions during this time and the wage records establish that for part of that period of time, claimant was able to continue working full time (earning more than his AWW for the paycheck issued October 17, 2014). Claimant has failed to establish that any wage loss during the September 12, 2014 through October 25, 2014 pay period would be related to his injury.

22. The ALJ finds that claimant was taken off of work completely by Ms. Cattell effective October 27, 2014 and finds that claimant has demonstrated that he is entitled to TTD benefits commencing October 27, 2014 and continuing until terminated by law or statute. The ALJ credits the reports of Dr. Cattell in making this finding.

23. The ALJ notes that the period of TTD endorsed by claimant was for October 26, 2014 and continuing, but finds that Ms. Cattell did not take claimant off of work until October 27, 2014.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo.

306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra*.

4. As found, claimant has established by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course of his employment with employer. As found, claimant has proven that lifting windows on September 11, 2014 caused an injury that aggravated, accelerated or combined with claimant's preexisting condition to produce the disability and need for treatment.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

6. "Authorization" refers to the physician's legal authority to treat, and is distinct from whether treatment is "reasonable and necessary" within the meaning of Section 8-42-101(1)(a), C.R.S. 2008. *Leibold v. A-1 Relocation, Inc.*, W.C. No. 4-304-437 (January 3, 2008). Section 8-43-404(5)(a) specifically states: "In all cases of injury, the employer or insurer has the right in the first instance to select the physician who attends said injured employee. If the services of a physician are not tendered at the

time of the injury, the employee shall have the right to select a physician or chiropractor.”

7. In *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990), the Colorado Court of Appeals held that in cases of medical emergency, the injured worker does not need to seek authorization from the employer or insurer before obtaining medical treatment from an unauthorized provider. However, a question may be raised as to whether a bona fide emergency exists that would justify treatment at an emergency room. See *Timko v. Cub Foods*, W.C. No. 3-969-031 (June 29, 2005).

8. In the present case, as found, claimant has failed to establish by a preponderance of the evidence that his treatment at the ER on September 13, 2014 was a bona fide emergency.

9. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

10. As found, claimant has proven by a preponderance of the evidence that he sustained an injury that led to a medical incapacity in his ability to work as evidenced by the work restrictions set forth by Ms. Cattell beginning October 27, 2014. As found, respondents are liable for TTD benefits beginning October 27, 2014 and continuing until terminated by law or statute.

11. To prove entitlement to temporary partial disability (TPD) benefits, claimant must prove that the industrial injury contributed to some degree to a temporary wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). As found, claimant has failed to establish that his work injury contributed to some degree of a temporary wage loss for the period of September 12, 2014 through October 25, 2014.

12. The ALJ must determine an employee's AWW by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of the injury, which must include any advantage or fringe benefit provided to the Claimant in lieu of wages. Section 8-42-102(2), C.R.S.; *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995).

13. As found, claimant's AWW for his September 11, 2014 work injury is established to be \$585.61 based on the payroll records entered into evidence.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the reasonable medical treatment necessary to cure and relieve claimant from the effects of the industrial injury from Dr. O'Meara and Telluride Medical Center.
2. Claimant's claim for payment of the medical bills from the ER at Montrose Memorial Hospital is denied and dismissed.
3. Respondents shall pay claimant TTD benefits commencing October 27, 2014 and continuing until terminated by law or statute based on an AWW of \$585.61.
4. Claimant's request for TPD benefits is denied and dismissed.
5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATED: May 6, 2015

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Keith E. Mottram

Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

ISSUES

1. Did the claimant establish by a preponderance of the evidence that the claimant's left knee revision surgery on September 8, 2014 was causally related to her industrial injury of December 14, 2007.

2. Did the claimant establish by a preponderance of the evidence that the claimant's need for medical care of her bilateral foot and ankle conditions was causally related to her industrial injury of December 14, 2007.

FINDINGS OF FACT

1. The claimant was injured in an admitted industrial injury on December 14, 2007, wherein she suffered an injury to her *left* knee caused by a twisting motion.

2. The claimant was seen by the respondent-employer's designated medical providers. Dr. Daniel Olson cared for the claimant most of that time with referrals to Dr. Davis and Dr. Xenos.

3. It was eventually determined medically that the claimant was in need of a total *left* knee replacement.

4. By an Order dated April 4, 2013 there was a determination made that the claimant's need for a total left knee replacement was reasonable, necessary, and related to her industrial injury of December 14, 2007.

5. The claimant eventually underwent the total *left* knee replacement surgery by Dr. Xenos on February 25, 2013 and was doing well post-operatively but did struggle with pain and range of motion issues early on.

6. Subsequent to this total knee replacement surgery on January 3, 2014 the claimant's *right* knee buckled causing the claimant to fall and injure her *left* knee.

7. As a result of this fall the claimant ultimately underwent a revision surgery to the left knee by Dr. Xenos. This surgery occurred on September 8, 2014.

8. Dr. Xenos opined that the damage to the left knee, and the need for revision surgery, as a result of the January 3, 2014 fall was totally distinct from, and unrelated to, the industrial injury of December 14, 2007.

9. The ALJ finds Dr. Xenos opinions to be credible and persuasive.

10. The ALJ finds that there is insufficient medical or lay evidence to establish that any bilateral foot or ankle conditions suffered by the claimant are causally related to the claimant's industrial injury of December 14, 2007.

11. The claimant has failed to establish that it is more likely than not that her need for revision surgery on her left knee is causally related to her industrial injury of December 14, 2007.

12. The claimant has failed to establish that it is more likely than not that her need for treatment for her bilateral foot or ankle conditions is causally related to her industrial injury of December 14, 2007.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2012), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

2. A workers' compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. The respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2009; *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). The question of whether medical treatment is reasonable and necessary is one of fact for determination by the ALJ. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002); *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999).

5. The claimant bears the burden of proof to establish the right to specific medical benefits. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990). Additionally, the claimant has the burden of proving an entitlement to benefits by a preponderance of the evidence. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). A preponderance of the evidence is that quantum of evidence that makes a fact or facts more reasonably probable or improbable, than not. *Page v. Clark*, 519 P.2d 792, (1979).

6. Even if a claimant suffers a compensable injury in the first instance, the ALJ may still deny a claim for workers' compensation benefits if the claimant fails to establish that the current and ongoing need for medical treatment or disability is proximately caused by an injury arising out of and in the course of the employment. See *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. Ct. App. 1997). The claimant has the burden to prove that any medical benefits sought are reasonable, necessary, and related to the work injury.

7. The question of whether a need for treatment is causally connected to an industrial injury is a question of fact. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

8. Dr. John Xenos the claimant's treating surgeon opines that the claimant's need for left knee revision surgery on September 8, 2014 was totally distinct from and unrelated to her industrial injury of December 14, 2007.

9. The ALJ concludes that Dr. Xenos' opinions are credible and persuasive.

10. The ALJ concludes that the facts demonstrate that the left knee revision surgery performed by Dr. Xenos on September 8, 2014 was not related to the claimant's industrial injury of September 8, 2007.

11. The ALJ concludes, as found above, that the claimant's need for bilateral foot and ankle treatment is insufficiently supported in the record based upon a totality of the evidence submitted.

12. The ALJ concludes that the claimant has failed to establish by a preponderance of the evidence that the claimant's need for left knee revision surgery performed on September 8, 2014 was related to her industrial injury of December 14, 2007.

13. The ALJ concludes that the claimant has failed to establish by a preponderance of the evidence that the claimant's need for bilateral foot and ankle treatment is related to her industrial injury of December 14, 2007.

ORDER

It is therefore ordered that:

1. The claimant's request for medical benefits for the surgery performed by Dr. Xenos on September 8, 2014 is denied and dismissed.

2. The claimant's request for medical benefits for bilateral foot and ankle treatment is denied and dismissed.

3. All matters not determined herein, and not closed by operation of law, are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATE: May 7, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

The issue presented at hearing was whether the claimant's left shoulder injury resulted in functional impairment at a site on her body not set forth on the schedule of injuries, C.R.S. §8-42-107(2); that is, "beyond the arm at the shoulder" and therefore payable as whole person rating under C.R.S. §8-42-107(8).

FINDINGS OF FACT

1. On January 7, 2013, the claimant suffered an admitted industrial injury to her left shoulder arising out of and in the course of her employment with the respondent-employer.

2. On August 29, 2014, Dr. Terrence Lakin placed the claimant at maximum medical improvement (MMI) and assigned her a 19% scheduled impairment for her left shoulder impairment which he converted to an 11% whole person rating. She was assigned permanent restrictions as follows:

- a. to limit above shoulder height activity to occasional;
- b. avoid crawling activities;
- c. upper extremity repetitive motion activity manipulating light weight objects between waist and chest height demonstrates left upper extremity tolerance to occasional, 5 min. at a time, up to 20 min. in any one hour time period;
- d. frequent level tolerance using right upper extremity;
- e. lifting/carrying capabilities between sedentary and sedentary light levels at and below shoulder height; and,
- f. unable to lift sedentary level weight overhead.

3. On October 1, 2014, the respondent-insurer admitted to Dr. Lakin's 19% scheduled impairment.

4. On October 30, 2014, the claimant filed an application for hearing on the issue of conversion of her 19% scheduled impairment to an 11% whole person rating.

5. At hearing the claimant credibly testified that she experienced constant sharp and burning pain from her left shoulder. Her pain radiates into her clavicle, the left side of her neck, down the left side of her back over her scapula, and from the clavicle into her left armpit and to the side of her left breast. She also testified that she is unable to do left arm activities above her shoulder. She is unable to do every day activities such as combing or washing her hair with her left upper extremity because of the pain in her shoulder. Her pain in the shoulder and into her trunk is constant and is aggravated by use of her arm. At night, the pain in her neck and shoulder wake her up and she finds it hard to find a comfortable position.

6. Dr. Carlos Cebrian testified for the respondents that he did not find any specific basis for a whole person rating and that the claimant had no ratable functional impairment beyond her injury at the claimant's left upper extremity; however, his IME report noted the claimant's complaints beyond the shoulder consisting of upper back, neck and headaches and his physical examination did find evidence of tenderness to palpation over the left trapezius with pain into her scapular region.

7. Dr. Cebrian identified the claimant's Exhibit 13 as an accurate representation of the trapezius muscle. The illustration shows the trapezius covers the neck up to the base of the head, extending bilaterally to shoulder joints and down below the scapulae to mid-back. When asked to show where the claimant's tenderness was located on Exhibit 13, Dr. Cebrian marked a large circle over the top of the trapezius extending well beyond the shoulder toward the neck.

8. Dr. Cebrian interpreted the abbreviation "sig" made by Dr. Lakin in the record multiple times: "sig trigger point left trap with radiating pain" as "significant". He further testified that trigger points are medically objective evidence.

9. The claimant's symptoms or referred pain from her left shoulder injury beyond the arm at the shoulder are corroborated by the medical records following her injury and after her two surgeries and other medical treatment modalities.

10. On physical exams February 13, March 6, March 27, April 8, April 13 and April 30, 2013, Dr. Lakin noted “sig[nificant] trigger point left trap[ezius] with radiating pain.”

11. On March 12, 2013, the claimant saw Charles A. Hanson, an orthopedic surgeon, who examined her and noted that in addition to burning and stabbing pain on her left shoulder, she was experiencing pain on her posterior paracervical area with headaches. The surgeon’s physical exam showed tenderness in the left posterior paracervical area. He diagnosed impingement tendonitis, subacromial bursitis and subdeltoid bursitis causing consistent burning and stabbing pain and recommended a left shoulder decompression with possible but doubtful rotator cuff repair.

12. On June 7, 2013, Dr. Hanson performed a left shoulder decompression with incision of coracoacromial ligament and excision of the anterior inferior half of the very distal clavicle, acromioclavicular joint and acromion.

13. After her surgery, the claimant’s symptoms beyond her shoulder continued. On July 12, 2013, Dr. Lakin noted on physical exam occasional pain over the left scapular region.

14. On August 21, 2013, Dr. Lakin in his physical examination of the claimant’s neck noted “extremely tight left trapezius with trigger points” in his muscular skeletal exam he noted tight paracervical muscles, left more than right into left parathoracic.

15. On September 12, 2013, the claimant continued with tenderness and muscle stiffness from the left side of her neck into her shoulder.

16. On October 3, 2013, on physical exam Dr. Lakin continued to document tightness in the claimant’s trapezius and paracervical muscles with trigger points.

17. The claimant’s symptoms beyond her left shoulder persisted. On November 7, 2013, she presented complaining she had been awakened at night by her pain two days before and her pain, described as severe, continued from the base of her neck into her left shoulder. The physical exam by Terry Schwartz, PA-C, confirmed Dr. Lakin’s previous examinations. It showed the claimant: “very tender Lt paraspinal muscles, across superior aspect of shoulder, even to light touch.” His impression included: “...acute spasms in cervical and Lt shoulder.” He recommended ice down for

her shoulder and neck. He ordered Toradol for pain, Valium up to three times per day to stop her neck and shoulder spasms.

18. On December 16, 2013, the claimant was seen by Dr. Lakin, who continued to note on physical exam of her neck, significant tenderness in the claimant's neck and left paraspinal muscles across into the superior aspect of her shoulder, even to light touch.

19. On January 6, January 29, and February 18, 2014, Dr. Lakin's physical exam findings regarding the claimant's symptoms of her left paraspinal muscles did not change.

20. On January 9, 2014, Dr. D. K. Caughfield performed an electrodiagnostic study. The claimant was complaining of lateral left neck pain into her shoulder and into her arm. The physical examination and impression showed a persistent symptomatic acromioclavicular across body impingement.

21. On January 28, 2014, Stephen Davis, M.D., of Bentonville, Arkansas, conducted a record review of the claimant's condition. His review noted the claimant's November and December 2013, symptoms of neck pain radiating to the left shoulder.

22. On March 17, 2014, the claimant underwent a second surgery on her left shoulder: left shoulder arthroscopic debridement for a partial thickness articular sided subscapularis tear and type 1 SLAP tear, a second left shoulder arthroscopic clavicle resection and subacromial decompression.

23. Two months after her second surgery, on May 19, 2014, the claimant's symptoms beyond the shoulder continued. She presented at physical therapy "very emotional and upset, stating that she had increased cervical, UT [upper thoracic] pain as well as bilat shlds ... She complained of joint stiffness and even an ear ache from her neck hurting so bad."

24. The ALJ finds the claimant's testimony of symptom's beyond the arm at the shoulder and into her trunk credible. They are corroborated by the medical records before and after her surgeries.

25. The ALJ finds that the credible medical evidence of record establishes that it is more likely than not that the functional situs of the claimant's impairment extends beyond the shoulder area and, *inter alia*, into the neck and trapezius.

CONCLUSIONS OF LAW

1. The purpose of the Act is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. An ALJ's factual findings concern only evidence that is dispositive of the issues involved; an ALJ need not address every piece of evidence that might lead to a conflicting conclusion and has rejects evidence contrary to findings of fact. See *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Determining whether a claimant sustained a "loss of an arm at the shoulder" within the meaning of §8-42-107(2)(a), C.R.S. or a whole person medical impairment compensable under §8-42-107(8)(c), C.R.S., is one of fact for determination by the ALJ. In resolving this question, the ALJ must determine the situs of the claimant's "functional impairment, " and the situs of the functional impairment is not necessarily the site of the injury itself. *Langton v. Rocky Mountain Health Care Corp.* 937 P.2d 883 (Colo. App. 1996); *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). Whether the claimant has sustained functional impairment beyond the arm at the shoulder depends on the particular circumstances of the individual case. *Walker v. Jim Fuoco Motor Co.*, 942 P.2d 1390 (Colo. App. 1997). Functional impairment need not take any particular form. The claimant's pain, including referred pain, limiting the claimant's use of a portion of her body beyond the

arm at the shoulder may appropriately constitute "functional impairment." See *Salaz v. Phase II et. al.*, W.C. No. 4-240-376 (November 19, 1997), *aff'd.*, *Phase II v. Industrial Claim Appeals Office*, (Colo. App. No. 97CA2099, September 3, 1998)(not selected for publication); *Mader v. Popejoy Construction Co., Inc.*, W.C. No. 4-198-489 (August 9, 1996), *aff'd.*, *Mader v. Popejoy Construction Co., Inc.*, (Colo. App. No. 96CA1508, February 13, 1997) (not selected for publication).

5. As found above, the ALJ concludes that the claimant has established by a preponderance of the evidence that the claimant suffers a functional impairment beyond a loss of the arm at the shoulder and is entitled to a whole person rating.

ORDER

It is therefore ordered that:

1. The respondent-insurer shall pay the claimant permanent partial disability benefits based upon the 11% whole person impairment rating provided by Dr. Lakin.
2. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
3. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATE: May 15, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

The issues for determination are:

1. Whether the claimant has established by a preponderance of the evidence that her extremity impairment rating should be converted to a whole person rating; and,
2. Whether the claimant has established by a preponderance of the evidence that she is entitled to a general award of post-maximum medical improvement maintenance medical care.

FINDINGS OF FACT

1. The claimant is a dental hygienist for the respondent-employer, and has been in his employ for 20 years.
2. On October 23, 2013 the claimant suffered an injury while dismissing a patient and tripping. She fell into a wall in front of her causing her to dislocate her right shoulder.
3. The claimant was seen at Emergicare initially, but then was seen by Dr. Duffy approximately two and a half hours later.
4. Dr. Duffy reduced the claimant's shoulder.
5. The claimant then entered a regimen of physical therapy to help strengthen her shoulder.
6. The claimant experienced pain at the back of her neck and also in the trapezius area.
7. The claimant was also treated with dry needling and chiropractic care.
8. The dry needling was able to relieve the claimant knots in her deep muscle tissue which other modalities of treatment failed to do.
9. The claimant has symptoms including pain at the base of the neck; pain down the right side of the shoulder to where the muscles meet the shoulder blade and

inside the shoulder blade; pain in the back area; and, pain under the scapula. The claimant also experiences occasional headaches due to the way she has to hold her arm while working on patients.

10. The claimant continues to have difficulty reaching up to adjust the overhead light for use with her patients. So much so that the claimant purchased an expensive light that is attached to her head in lieu of reaching overhead.

11. The claimant has not been given any work restrictions.

12. When the claimant's neck is painful it limits her ability to turn her head to the right. The dry needling was helpful in relieving the neck pain. The claimant believes that the dry needling was one of the few modalities of treatment that helped relieve her pain that no other modality can provide.

13. The claimant currently takes over the counter ibuprofen. The claimant's pain is a fairly consistent 3 of 10 with 10 being the worst.

14. The claimant's current pain is worse than it was when she was undergoing the dry needling.

15. The claimant is able to undertake all of her activities of daily living. She only has trouble with overhead objects if they are heavy.

16. The claimant had an independent medical evaluation done by Dr. Timothy Hall.

17. Dr. Hall opined that the claimant's functional limitations extend beyond the shoulder joint. Dr. Hall observed that most of the claimant's symptoms are in the parascapular, upper back, trapezius, and lateral neck. This has resulted in some range of motion reduction in her neck as well as side bending to the right.

18. Dr. Hall also opined that the claimant would benefit from post-MMI maintenance medical treatment involving dry needling.

19. The ALJ finds Dr. Hall's opinions to be credible.

20. The ALJ finds that the claimant has established that it is more likely than not that her functional impairment extends beyond the shoulder joint.

21. The ALJ finds that the claimant has established that it is more likely than not that she requires maintenance medical care to be determined by her authorized treating physician.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. The question of whether the claimant sustained a loss of an arm at the shoulder within the meaning of Section 8-42-107 (2) (a), C.R.S. or a whole person medical impairment compensable under Section 8-42-107 (8) (c), C.R.S. is one of fact for determination by the ALJ. In resolving this question the ALJ must determine the situs of the claimant's functional impairment, and the situs of the functional impairment is not necessarily the situs of the injury itself. *See Langton v. Rocky Mountain Health Care Corp.* 937 P.2d 883 (Colo.App. 1996); *Staunch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo.App. 1996).

5. The "loss of arm at the shoulder" is on the schedule of injuries listed under

Section 8-42-107 (2), C.R.S. *Maree v. Jefferson County Sheriff's Department*, W. C. 4-260-536 (August 6, 1998). Depending on the particular facts of the claim, damage to the structures of the shoulder may or may not reflect a functional impairment which is enumerated on the schedule of injuries under Section 8-42-107 (2), C.R.S. *Id.*

6. An impairment rating issued under the AMA Guides is relevant, but not dispositive of whether the claimant sustained a functional impairment beyond the schedule. *Staunch v. PSL Swedish Healthcare System, supra*. Further, pain and discomfort, which limits the claimant's ability to use a portion of the body, may be considered functional impairment for purposes of determining whether an injury is on or off the schedule. *See Vargas v. Excel Corp., W. C. NO. 4-551-161 (April 21, 2005)*. Functional impairment of the shoulder joint beyond the "the arm at the shoulder" is probative evidence of whole person impairment. *Id.*

7. As found above, the ALJ concludes that the claimant's testimony was credible and supported by the medical record.

8. As found above the ALJ concludes that Dr. Hall's opinions are credible and entitled to great weight.

9. The ALJ concludes as found above, that as a result of her work-related injury the claimant has functional impairment of the shoulder, and the claimant has functional impairment in areas beyond the shoulder. As a result of her work-related injury, the claimant has functional impairment that is located beyond the arm; it is located in the shoulder and in areas beyond the shoulder. As a result of her work-related injuries the claimant's functional impairment is not limited to the arm at the shoulder.

10. The ALJ concludes that the claimant has established by a preponderance of the evidence that her upper extremity impairment ratings should be converted into a whole person impairment rating.

11. Medical benefits after MMI may be ordered when they are necessary to cure or relieve the employee from the effects of the injury. § 8-42-101, C.R.S.; *Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988)*. Before an Order for Grover medical benefits may be entered, there must be substantial evidence in the record to support a determination that future medical treatment will be reasonably necessary to relieve the injured worker from the effects of the work-related injury or occupational disease. *Grover Id.*

12. The employee need not demonstrate the need for any specific medical benefit at the time of the hearing and respondents remain free in the future to contest the reasonable necessity of any future treatment specifically requested. *Milco Construction v. Cowan, 860 P.2d 539 (Colo. App. 1992)*; *Hanna v. Print Expeditors, Inc.*

77 P.3d 863 (Colo. App. 2003).

13. In the instance case, the more credible medical and lay evidence establishes that the claimant is in need of a general order of medical maintenance care to maintain her MMI status.

14. As found above, the ALJ concludes that the claimant has established by a preponderance of the evidence that she is entitled to post-MMI maintenance medical care.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The respondent-insurer shall pay the claimant permanent partial disability benefits based upon the DIME physician's whole person rating of 5%.
2. The respondent-insurer shall pay for the claimant's maintenance medical care as determined by the claimant's authorized treating physician.
3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
4. All matters not determined herein, and not closed by operation of law, are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATE: May 5, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

The issue to be determined by this decision is the following:

Whether the claimant established, by a preponderance of the evidence, that she sustained an occupational disease to her bilateral upper extremities arising out of and in the course of her employment.

FINDINGS OF FACT

1. The claimant has worked for the respondent-employer since at least 2005 in the Meat and Seafood Department. The claimant works five days a week, 8 hours a day. Usually she works the 7:00 A.M. to 8:00 P.M. shift but will also work the 10:30 A.M. to 7:00 P.M. shift as well.

2. The claimant's duties in the Meat and Seafood Department include opening boxes and plastic tubs, lifting and carrying food products, stocking shelves, scanning items for inventory purposes, cleaning, wrapping food and, on occasion, cutting meat and seafood. Much of this work is done in a walk in cooler and around refrigerated cases where food products are displayed. In a typical day, the claimant will spend an hour stocking, 1 to 1½ hours scanning, 2 hours opening boxes, and 30 to 45 minutes cleaning. The rest of the time is spent stocking shelves in all parts of the store, cleaning up the Meat and Seafood Department, stocking meat and seafood all on an as needed basis. In doing her work the claimant will spend approximately four hours in the walk in cooler. On any given day she will spend approximately ten minutes in the walk in freezer.

3. The claimant's duties in opening up boxes, some of which weigh up to 30 to 35 pounds, involve picking them up and then using a box cutter to open them. In using the box cutter, the claimant would use her left hand to steady the box and use her right hand to cut the box open. She would then take out the packages in the boxes which could be prepackaged lunch meat, hamburger, roasts, chicken, and seafood. The individual packets could weigh anywhere from a few ounces up to several pounds. The claimant would then take these packages out to the retail area and put them in the refrigerated display cases. Nearly all of the food products the claimant distributed to the display cases were refrigerated and/or frozen.

4. In distributing the prepackaged lunch meats to the refrigerated display cases, she would put the lunch meat in a cart and pull it to the retail display case. In putting the lunch meat in the display case the claimant would use her hand to push back a spring loaded plate and then lock it into place. After doing this, the claimant would then, using her hands, grasp the individual packages of lunch meat and put them into the display case in front of the spring loaded plate after which she would unlock the spring mechanism. In performing this job the claimant would have her hand in the refrigerator which has a temperature of 32 to 40 degrees. In addition to distributing the other products, the claimant would have to put the meat onto a "U boat" and then push/pull it out to the retail floor after which she would use her hands to put the individual packages of meat and seafood into the refrigerated display cases. Like the lunch meat packages, the meat and seafood was cold. In addition, the display case for meat and seafood has a temperature of 32 to 40 degrees and the claimant had to put her hand into these units while stocking the food. The claimant would have to stock the lunch meat and other meat products several times per shift.

5. In using a scanner, the claimant would hold it with her right hand and hold the printer with her left. She would then squeeze the trigger to complete the scan of the product. She would do this on a repetitive basis. The scan gun weighed around two pounds and the printer around one pound.

6. The claimant's job cleaning involved using her hands to wipe down counter tops and display cases, clean glass, counter fronts, along with sweeping and mopping. In wiping down display cases, the claimant would have to exert a significant amount of force in order to get sticky fluids off a surface.

7. According to Section G of the Job Description for the claimant's job, as promulgated by the respondent-employer, she is required to use her hands 81-100% of her shift. Also 61-80% of her shift involves bending and twisting her wrists along with squeezing of her hands. The claimant's job also requires her to lift up to 25 pounds 41-60% of her shift.

8. The claimant started noticing symptoms in her bilateral upper extremities in approximately September 2012. She was initially seen by her primary care physician, Dr. Heather Autry on September 18, 2012 for right wrist pain, the claimant told Dr. Autry on this date that she does a lot of heavy lifting at her job at the respondent-employer which aggravates her symptoms. Dr. Autry diagnosed DeQuervains tenosynovitis. Dr. Autry gave the claimant an injection and told the claimant to use a thumb spica splint with activity, and to use NSAIDS along with ice.

9. On December 10, 2012 the claimant returned back to Dr. Autry with complaints of left wrist pain. The claimant told Dr. Autry that her left wrist pain flared up while “babying her right wrist.” Dr. Autry diagnosed DeQuervains tenosynovitis and injected the left wrist.

10. The claimant was seen on January 15, 2013 by Dr. Randall Hoffman for left wrist pain. Dr. Hoffman diagnosed DeQuervains tenosynovitis and was given an injection. She was seen by Dr. Hoffman in follow up at which time her wrist symptoms had cleared up.

11. On September 3, 2014 the claimant was seen by Dr. Kurt Weaver with pain in both wrists. The claimant told Dr. Weaver that her work at the respondent-employer involves lots of grasping and manipulating. Dr. Weaver diagnosed the claimant with Carpel Tunnel Syndrome and DeQuervains tenosynovitis. In a note dated September 15, 2014, Dr. Weaver opined that the claimant’s DeQuervains tenosynovitis had a relationship to her work since it happens when people use their wrist and thumb too much in certain ways like grasping or grabbing objects.

12. On September 4, 2014 the claimant reported to the respondent-employer that she had bilateral wrist problems as a result of repetitive motion from stocking spring loaded cold cut holders, lifting “luggers,” and heavy boxes.

13. On September 5, 2014 the claimant presented herself to Memorial Occupational Health where she was evaluated by Dr. Stephen Castle. The claimant gave Dr. Castle a history of having worked for the respondent-employer for the past 9 years over which time her work demands have increased. She described hand intensive activities including stocking the sliced lunch meats in spring loaded cases which she constantly has to push back. She also told Dr. Castle that she cuts meat and loads/unloads boxes. Dr. Castle noted that the claimant has used wrist braces in the past, and over the last year developed numbness into her thumb, index, and middle fingers of both hands. Dr. Castle performed a physical examination and in his report gave work related medical diagnoses of bilateral carpel tunnel syndrome and bilateral DeQuervains tenosynovitis. Dr. Castle put the claimant on modified duty and referred the claimant for an EMG and occupational therapy.

14. On September 23, 2014 the claimant presented to Dr. William Griffis for an EMG/NCV the results of which revealed electrodiagnostic evidence of bilateral carpel tunnel syndrome and bilateral cubital tunnel syndrome. Dr. Griffis indicated in his record of this date that, from a clinical standpoint, the claimant also has bilateral DeQuervains tenosynovitis.

15. On October 6, 2014 the claimant was seen by orthopedic surgeon Dr. Karl Larsen for evaluation of bilateral wrist pain and hand numbness and tingling. The claimant told Dr. Larsen that she cuts fish and meat as well as stocks food products. The claimant related the onset of symptoms to heavy knife gripping, cutting, and other activities at work. The claimant told Dr. Larsen that she has had hand and wrist symptoms since around October, 2012. Dr. Larsen examined the claimant and found an obvious fullness over the front dorsal compartment bilaterally with a more nodular appearance to the right side than the left side. Dr. Larsen also found a positive tinel's sign, right much worse than left over the superficial radial nerve. Dr. Larsen's diagnosis was bilateral carpal tunnel syndrome, cubital tunnel syndrome, and DeQuervains tenosynovitis. Because the claimant did not have lasting resolution of her symptoms with the use of braces and injections, Dr. Larsen recommended carpal and cubital tunnel surgery as well as a first dorsal compartment release on the right side. Dr. Larsen indicated in his report that once the right side settles down after the surgery, the claimant can then have surgery on her left side.

16. On October 30, 2014 the claimant had the surgery on her right extremity as recommended by Dr. Larsen. In a post operative visit on November 12, 2014 the claimant was doing well as evidenced by the resolution of her numbness and tingling. However, Dr. Larsen noted that the claimant was still having some tenderness over her first dorsal compartment.

17. At request of respondent, the claimant underwent an evaluation with Dr. Carlos Cebrian on November 20, 2014. As part of his evaluation, he reviewed the claimant's medical records dating back to 2007. Dr. Cebrian took a history which included what the claimant's job duties were at the respondent-employer. After evaluating the claimant, Dr. Cebrian diagnosed her as having bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and bilateral DeQuervains tenosynovitis. Dr. Cebrian further opined that the claimant's diagnoses involving her arms, wrists and hands are not related to her work at the respondent-employer. In reaching his conclusion Dr. Cebrian relied upon Rule 17, Exhibit 5 of the DOWC Cumulative Trauma Guidelines (Guidelines).

18. On December, 23, 2014 the claimant had the surgery in her left extremity as recommended by Dr. Larsen.

19. On January 20, 2015 the claimant was evaluated by Dr. Jack Rook. Dr. Rook reviewed various medical records from various health care providers including Colorado Springs Health Partners, Memorial Occupational Health, Dr. Cebrian's evaluation, North Springs Surgical Associates, and TCM Healing Points Acupuncture

Clinic. Dr. Rook took a history which included the claimant's job duties at the respondent-employer, and performed a physical examination. Dr. Rook diagnosed the claimant as having bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and bilateral DeQuervains tenosynovitis. Dr. Rook opined that the claimant's diagnoses are related to her job duties at the respondent-employer. Dr. Rook in formulating his opinion relied upon Rule 17, Exhibit 5 of the Guidelines.

20. The claimant testified that the surgeries helped and that the symptoms in her right and left hands have improved considerably such that she was released to full duty work on February 23, 2015. In her testimony, the claimant went over her job duties all of which involve extensive and constant use of her hand and arms. Specifically, the claimant testified that she spends several hours a day opening boxes and luggers using a box cutter after which she takes the product out to the display cases for stocking. When stocking the lunch meat, the claimant has to push a spring loaded plate back with one hand, lock it into place, and then load the packages on a shelf. She also has to cut meat and fish on occasion using a dull knife. The claimant also testified that in performing her cleaning duties she uses a scrub brush and a scraper tool, which requires significant force, to properly clean the display cases. She also has to use a broom and mop. Cleaning can take up to an hour or so each day. The claimant testified that she uses her hand and arms on a repetitive basis all day long. She also testified that she has to work in a walk in refrigerator for four hours per day and the meat and fish products she handles are either refrigerated or frozen. The claimant testified that prior to 2012 she did not have problems with her hand and wrists. The claimant testified that in 2007 she played tennis and had some shoulder problems but they resolved after a few months of care. The claimant testified as to the hobbies and activities she engages in outside her work place which include gardening, raising chickens, and hiking. In tending her garden, the claimant has to plant seeds and water the area but her partner does the heavy work. The claimant also said that she raises chickens. In doing so, she uses a scoop to feed them on a daily basis and every two months sets out hay which the chickens spread themselves. She also collects eggs once a day which involves minimal use of her hands. The claimant no longer plays tennis and has no other hobbies or non-work activities which entail, any extensive use of her hands. Regarding house work, the claimant acknowledges she mops, sweep, and dusts. However, she does this once a week and splits the duties with her partner on a 50/50 basis.

21. Dr. Carlos Cebrian testified that in his opinion the claimant's carpal tunnel syndrome, cubital tunnel syndrome, and DeQuervains tenosynovitis is not related to her work at the respondent-employer. Dr. Cebrian based his opinion on his application and

interpretation of the Guidelines. Dr. Cebrian explained that the Guidelines require a multistep algorithm to determine if it is likely that the claimant's job duties would lead to the development of carpal tunnel syndrome, cubital tunnel syndrome, and a DeQuervains tenosynovitis. Dr. Cebrian went through the claimant's diagnoses and then using the Guidelines determined what the primary and secondary risk factors were for each of the claimant's diagnoses. Then, looking at the risk factor definitions he went through the claimant's job duties as given by the claimant in her testimony and in the medical records. Once that was done, he used the Guidelines to determine if the nature of the claimant's job duties met any of the primary or secondary risk factors for the development of the claimant's diagnoses. Based on this analysis Dr. Cebrian did not find the claimant's job duties either qualitatively or quantitatively met the criteria set forth in the Guidelines for the development of carpal tunnel syndrome, cubital tunnel syndrome, or DeQuervains tenosynovitis.

22. Dr. Cebrian went on to opine that the claimant's problems are the result of genetics, age, and other non-work related factors. Upon cross examination Dr. Cebrian agreed that the Guidelines are essentially guidelines and not everyone neatly falls under them. He believes while the guidelines are important a physician has to look at all the factors and use his or her best judgment in coming up with an opinion as to etiology or causation. Dr. Cebrian's testimony was in accordance with his report dated November 21, 2014. Finally, Dr. Cebrian agreed that the care the claimant had, including surgery, regardless of etiology, was reasonable and necessary.

23. Dr. Rook testified by Deposition and opined that the claimant's upper extremity diagnoses are due to her job duties at the respondent-employer. Dr. Rook in reaching his opinion used the Guidelines. Dr. Rook said that the claimant's duties as described to him by the claimant and through the respondent-employer's documents involve using her hands, bending her wrists, twisting her wrists, and squeezing her hands 81 to 100% of her work day. Dr. Rook testified that the claimant's job duties fulfill at least one or two primary risk factors and at least one of the secondary risk factors for each of the diagnoses given for the claimant's upper extremities. Dr. Rook went on to testify that the primary risk factors for these diagnoses are a combination of force, repetition, and pressure for up to six hours per day. If there is wrist posturing for four hours per day this is also a primary risk factor. Dr. Rook believes that using a mop, cutting open a box, pushing a spring loaded shelf, and cutting fish or meat with a dull knife involves constant movement of the wrists and fingers. In addition, Dr. Rook believes that working in a cold environment for four hours a day is a secondary risk factor for the claimant. Couple this with the temporal relationship between the work and the onset of symptoms leads Dr. Rook to the conclusion that the claimant's cumulative

trauma disorders are as a result of her work at the respondent-employer. Dr. Rook also testified that he took the claimant's non-work activities, such as sewing and gardening into account and does not believe any of these are contributing factors as they do not involve extensive use of the upper extremities.

24. The ALJ finds the analysis and opinions of Dr. Cebrian to be the more credible and persuasive medical evidence and gives it greater weight than medical opinions to the contrary.

25. The ALJ finds that the claimant has failed to establish that it is more likely than not that she suffers from an occupational disease of her bilateral upper extremities that arose out of and in the course of her employment with the respondent-employer.

CONCLUSIONS OF LAW

1. The claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999).

2. In determining whether the claimant suffered a compensable injury in this case, the credibility of the witnesses and the probative value of the evidence must be assessed in order to determine whether the claimant has met her burden of proof. *Dover Elevator Co. v. Indus. Claim Appeals Office*, 961 P.2d 1141 (Colo. App. 1998). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interest. *See Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936).

3. The test for distinguishing between an accidental injury and an occupational disease or condition is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corp.*, 867 P.2d 77, 81 (Colo. App. 1993). "Occupational disease" is defined by § 8-40-201(14), C.R.S. as:

[A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside the employment.

4. A claimant is required to prove by a preponderance of the evidence that the alleged occupational disease was directly or proximately caused by the employment or working conditions. *Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999). Moreover, § 8-40-201(14), C.R.S. imposes proof requirements in addition to those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819, 824 (Colo. 1993). A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

5. W.C.R.P. Rule 17, Exhibit 5 sets forth the treatment guidelines for Cumulative Trauma Conditions. Rule 17 set forth care that is generally considered reasonable for most injured workers. Further, while an ALJ is not required to utilize Rule 17 as the sole basis for making determinations as to whether medical treatment is reasonable, necessary and related to an industrial injury, it is appropriate for the ALJ to consider Rule 17 in making such determinations. § 8-43-201(3), C.R.S.

6. The credible and persuasive evidence presented at hearing established that there is not a causal relationship between the claimant's alleged conditions and her work exposure, especially in light of the credible analysis and opinions of Dr. Cebrian. Accordingly, the claimant failed to prove a compensable occupational injury based in part on the following reasons:

A. The claimant has the burden to establish a causal relationship between her alleged injury and her employment.

B. As found, the totality of the evidence in this case demonstrates that the claimant's job duties are numerous and varied throughout each shift. The claimant does not perform job duties which involve significant computer or mouse work, handheld vibratory tools, handheld tools weighing in excess of two pounds, or lift up to ten pounds more than sixty times per hour. Further, the claimant failed to prove that her job duties required her to sustain continuous awkward posture for significant periods of time. Rather, the totality of the evidence was persuasive that the claimant performed several different types of job tasks that required the use of one, or the other, or both upper extremities at different times. Of note, repetition alone is not a risk factor under Rule 17. As such, a review of her job duties reflects that there was not requisite force or repetition to cause her conditions.

C. Pursuant to Rule 17, a specific set of steps should be followed to determine if the claimant's conditions are work related. In this instance, Dr. Cebrian performed a causation analysis pursuant to the Division's Rule 17 and his conclusions are credible and persuasive and establish that the claimant's conditions are not work related.

D. As found, there is insufficient persuasive credible evidence that the claimant's treating physicians performed a causation analysis consistent with and required by Rule 17 in this case with regard to any of her diagnoses.

E. As found, the totality of the evidence is that claimant's job duties do not meet any primary or secondary risk factor known to be physiologically related to the claimant's diagnoses.

8. Given the foregoing, the ALJ determines and finds that the claimant has not met her burden of proof in establishing that she suffered a compensable occupational injury. Accordingly, the claimant has not demonstrated that the hazards of her employment caused, intensified, or, to a reasonable degree, aggravated her bilateral upper extremity conditions. *Anderson*, 859 P.2d at 824.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

The claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: <http://www.colorado.gov/dpa/oac/forms-WC.htm>.

DATE: May 27, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
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Colorado Springs, CO 80906