ISSUE

- Did Claimant prove by a preponderance of the evidence that physical therapy treatments provided in the spring of 2014 constituted reasonable and necessary maintenance 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 8 were received into evidence. Respondents' Exhibits A through C were received into evidence.

2. Claimant seeks an order requiring the Insurer to pay for 8 physical therapy (PT) visits that occurred from April to June 2014. These bills that were incurred at Performax Physical Therapy (Performax) and were for treatment of Claimant's left knee. The total amount billed for these services was $1043.

3. Claimant sustained admitted injuries on October 26, 2006 when she fell on both knees and also injured her back.

4. Claimant's treatment for her injuries included a left total knee arthroplasty (TKA) performed by Philip Stull, M.D. This surgery occurred on April 21, 2008.

5. On May 27, 2010 Insurer filed a Final Admission of Liability (FAL). The FAL admitted Claimant reached maximum medical improvement (MMI) on February 12, 2010. The FAL further admitted for permanent partial disability (PPD) benefits based on 26 percent whole person impairment, 28% of the right lower right lower extremity and 29% of the left lower extremity. The FAL also admitted for post-MMI "maintenance medical benefits" if "reasonable, necessary and related to the compensable injury."

6. Claimant credibly testified that Dr. Stull and Sharon Walker, M.D., were authorized treating physicians (ATP) with respect to her post-MMI medical care.

7. Claimant credibly testified that in March 2014 Dr. Walker referred her to Dr. Stull for examination of the left knee. At that time Claimant's left knee would hyperextend and "give out."

8. On March 21, 2014 Dr. Stull diagnosed "PCL deficiency (L) TKA." He prescribed PT "3 times per week for 8 weeks."

9. On April 11, 2014 Dr. Walker diagnosed "(L) TKA with loosening of joint; PCL deficiency." Dr. Walker referred Claimant to Performax for pool therapy and for "land PT quad strength."

10. On May 12, 2014 John Obermiller, M.D., issued a medical report assessing the reasonableness and necessity of the PT. Dr. Obermiller reviewed Dr. Stull's office note from March 21, 2014. Dr. Stull had written that 6 months previously he prescribed anti-inflammatories and "therapy" but Claimant was still "having some difficulties with left knee" including increased pain and "instability symptoms." Dr. Stull's impression was posterior cruciate (PCL) instability. Dr. Stull considered a surgical referral but stated he felt that "bracing and PT [were] warranted." Dr. Obermiller referred to the Medical Treatment Guidelines (MTG) and opined that the MTG would support PT "five times a week, for four to eight weeks, for an acute injury." However, Dr. Obermiller opined the available medical documentation did not provide "clear objective documentation of treatment rendered recent [sic]." Specifically Dr. Obermiller stated that there was "no clear documentation" of a need for PT for an injury that occurred in 2006. He further opined Claimant should be "well versed in a self-directed home-based exercise program." Based on the MTG and his review of the documentation Dr. Obermiller opined that the request for PT should not be "certified."

11. Claimant credibly testified she underwent 8 sessions of PT at Performax before she learned that further PT was denied. Claimant credibly testified that although the PT at Performax provided some relief of her symptoms it did not make a "major difference." As a result, she sought "advice" from Dr. Arthur. Dr. Arthur told the claimant she had a "loose ligament." She then saw Dr. Miner who recommended she undergo a left knee replacement surgery.

12. On September 30, 2014 Dr. Miner performed surgery described as a "single component (tibial component revision) left total knee arthroplasty." The pre-operative diagnosis included "failed left total knee arthroplasty due to: flexion extension instability, failure of the polyethylene insert with delamination and accelerated wear of the posterior aspect of the polyethylene insert." (Respondents' Exhibit A p. 5).

13. After the September 2014 revision surgery Claimant was again prescribed PT. Claimant attended PT. On January 5, 2015 Claimant advised Dr. Walker that she was improving and no longer experienced the "left knee giving way or locking or clicking." Claimant told Dr. Walker that she did not believe she needed formal PT any longer and wanted to "start using the gym for her therapy."

14. Claimant credibly testified she has experienced a good result from the September 2014 revision surgery.

15. On March 24, 2015 Lawrence Lesnak, D.O., performed an independent medical examination (IME) of Claimant. This IME was performed at the request of Respondents' counsel. Dr. Lesnak is board certified in physical medicine and rehabilitation and is level II accredited.

16. On March 24, 2015 Dr. Lesnak issued a written report concerning the IME. Dr. Lesnak took a history from Claimant, performed a physical examination and reviewed pertinent medical records. Dr. Lesnak wrote that he agreed with Dr. Obermiller that "there was no specific evidence which required formal physical therapy" prior to the September 30, 2014 surgery. Dr. Lesnak explained that "it appeared the patient was having some degree of hardware failure of her left knee prosthesis which ultimately led to surgical intervention." In these circumstances Dr. Lesnak opined that the PT performed in the spring of 2014 before surgery was not "reasonable or necessary, or related to the 10/26/2006 occupational injury."

17. Dr. Lesnak testified at the hearing. Dr. Lesnak stated that in the spring of 2014 Dr. Walker noted it was "likely" Claimant's left knee prosthesis had "loosened." He further noted that Dr. Arthur and Dr. Miner subsequently diagnosed Claimant with a loosening of the "polyethylene component" of her left knee prosthesis. Dr. Lesnak stated the polyethylene component of a prosthetic knee is a "plastic part" that serves as artificial menisci. Dr. Lesnak explained the polyethylene component wears out over time and when it does the patient can experience symptoms of instability in the knee. Dr. Lesnak opined that in light of the failure of the polyethylene component of the prosthesis the PT prescribed to Claimant in the spring of 2014 would not have been beneficial. Dr. Lesnak explained that PT would not help a patient with laxity of the prosthesis and he did not understand Dr. Stull's and Dr. Walker's reasons for prescribing PT. Dr. Lesnak expressed his opinions to a reasonable degree of medical probability.

18. On cross-examination Dr. Lesnak testified that he agreed with Dr. Obermiller that the PT performed in the spring of 2014 was not reasonable and necessary. However, Dr. Lesnak stated that he did not necessarily agree with Dr. Obermiller's reasoning. Dr. Lesnak explained that the MTG for lower extremity pain do not apply to post-MMI maintenance treatment. Therefore, Dr. Lesnak, unlike Dr. Obermiller, did not use the MTG in arriving at his conclusion that the PT was not reasonable and necessary.

19. Claimant failed to prove it is more probably true than not the PT she received at Performax from April through June 2014 was reasonable and necessary to relieve the effects of the industrial injury or prevent deterioration of her condition.

20. Dr. Lesnak credibly and persuasively opined that in the spring of 2014 Claimant's left knee symptoms of pain and instability were related to failure of the polyethylene component of the prosthetic knee. He also credibly opined that PT would be of no benefit for this condition and that bracing and surgery were the indicated treatments.

21. Dr. Lesnak's opinion that Claimant was suffering from laxity caused by failure of the polyethylene component is corroborated by the fact that in the spring of 2014 both Dr. Walker and Dr. Stull diagnosed Claimant with PCL instability. Dr. Arthur and Dr. Miner agreed Claimant should undergo surgery. In September 2014 Dr. Miner performed a revision surgery because of a "failed left total knee arthroplasty due to:

flexion extension instability, failure of the polyethylene insert with delamination and accelerated wear of the posterior aspect of the polyethylene insert."

22. Dr. Lesnak's opinion that PT was not a reasonable and necessary treatment in the spring of 2014 is underscored by Claimant's own actions. Claimant admitted the PT was not alleviating her condition and consequently she sought consultations with Dr. Arthur and Dr. Miner. Indeed, Claimant elected to undergo revision surgery by Dr. Miner in September 2014. Claimant also admitted that the surgery produced a good result.

23. Neither Dr. Stull nor Dr. Walker offered any credible and persuasive explanation of why PT was a reasonable and necessary treatment for Claimant's knee condition in the spring of 2014. Neither did either of them offer a credible and persuasive refutation of Dr. Lesnak's argument that PT was not an effective treatment for instability caused by failure of the polyethylene component of the knee prosthesis.

24. 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. 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 the 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.

REASONABLENESS AND NECESSITY OF PHYSICAL THERAPY

Claimant contends a preponderance of the evidence establishes that the PT she received from Performax in the spring of 2014 constituted reasonable and necessary treatment for her left knee condition. Respondents, relying on the opinions of Dr. Lesnak and Dr. Obermiller argue the PT was not reasonable and necessary considering that Claimant's diagnosis was PCL laxity and failure of the prosthesis.

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 date 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).

In cases where the Respondents file a final admission of liability admitting for ongoing medical benefits after MMI they retain the right to challenge the compensability, reasonableness, and necessity of specific treatments. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003); *Teegardin v. J.C. Penney Co.,* WC 4-748-106-02 (ICAO January 17, 2014). When the Respondents challenge Claimant's request for specific medical treatment Claimant bears the burden of proof to establish entitlement to the benefits. *Ford v. Regional Transportation District,* W.C. No. 4-309-217 (ICAO February 12, 2009). The question of whether Claimant proved that specific treatment was reasonable and necessary to relieve or maintain her condition after MMI is one of fact for the ALJ. *See Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

As determined in Findings of Fact 19 through 23, Claimant failed to prove it is more probably true than not that the PT provided by Performax in the spring of 2014 constituted reasonable and necessary maintenance treatment. Rather, the ALJ credits the opinions of Dr. Lesnak that Claimant was suffering from instability caused by failure of the left knee prosthesis and that PT was not a reasonable and necessary treatment for that condition. The ineffectiveness of PT was emphasized by Claimant's decision to seek consultations with Dr. Arthur and Dr. Miner because the PT was not providing sufficient relief from her ongoing symptoms. Moreover, Claimant ultimately underwent surgery and admitted that she experienced a good result. Dr. Stull and Dr. Walker did not credibly and persuasively refute Dr. Lesnak's opinion that PT was notan appropriate treatment for Claimant's condition.

ORDER

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

1. The claim for payment of physical therapy expenses in the amount of $1043 is denied.

2. 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: July 8, 2015

DIGITAL SIGNATURE:

David P. Cain

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

ISSUES

- Did Claimant prove by a preponderance of the evidence that a topical cream containing the drug ketamine constitutes reasonable and necessary post-maximum medical improvement medical treatment designed to relieve ongoing symptoms associated with complex regional pain syndrome?

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. Respondents' Exhibits A through D were admitted into evidence.

2. Claimant sustained a compensable injury to her right ankle in 2007. Subsequently she underwent at least 7 surgical procedures designed to alleviate ongoing ankle and right lower extremity pain.

3. On April 9, 2011 the Insurer filed a Final Admission of Liability including an admission for ongoing medical benefits after maximum medical improvement (MMI).

4. On March 24, 2014 J. Tashof Bernton, M.D., an authorized treating physician, examined Claimant. He assessed "chronic pain in the right foot and ankle following multiple surgeries." Dr. Bernton expressed concern for potential complex regional pain syndrome (CRPS) given the "appearance of the foot."

5. On May 12, 2014 Claimant underwent an Autonomic Testing Battery that demonstrated a "positive diagnostic assessment" for CRPS.

6. On August 25, 2014 Dr. Bernton noted Claimant had a positive diagnostic response to an initial sympathetic nerve block. Dr. Bernton stated that in conjunction with the results of the Autonomic Testing Battery Claimant met the Colorado Medical Treatment Guidelines (MTG) criteria for CRPS.

7. On September 22, 2014 Dr. Bernton stated Claimant had undergone a second sympathetic block. Dr. Bernton noted Claimant experienced transient improvement of her pain but experienced marked coldness of the entire leg with swelling and dramatic color change. Dr. Bernton stated that he did not want to move

forward with further blocks because Claimant "had a paradoxical response to blocks with some overall worsening of her condition, both subjectively and objectively."

8. On September 30, 2014 Dr. Bernton documented discoloration of Claimant's right leg from foot to mid thigh with evident swelling and "some hyperalgesia to light touch."

9. On December 23, 2014 Dr. Bernton noted that Claimant had CRPS of the right leg with evidence of ipsilateral spread to the right upper extremity. He stated Claimant had done poorly with blocks and suggested she return for a trial of topical analgesia. Dr. Bernton observed Claimant had "really shown the most benefit from this approach."

10. On January 8, 2015 Dr. Bernton documented "significant hypersensitivity and allodynia to the plantar aspect of the foot, more in the heel as well as the lateral aspect of the right foot and the medial aspect of the foot."

11. On January 12, 2015 Claimant reported to Dr. Bernton that she had not received the topical analgesic because the "the insurance company won't pay for it."

12. On January 12, 2015 Dr. Bernton wrote a letter to the Insurer stating that CRPS was "clearly a work-related condition" and that he prescribed topical analgesics in accordance with the MTG for CRPS page 79. Dr. Bernton stated that Claimant's condition was "likely to worsen, potentially irreversibly" as a result of the Insurer's failure to meet its obligation to provide care.

13. On January 29, 2015 Claimant reported to Dr. Bernton that she was in horrible pain with increased pain in the right foot and leg as well as in the right arm. She still had not received medications. Dr. Bernton noted Claimant's right foot and leg were discolored and swollen. Dr. Bernton recorded the presence of "mild hyperalgesia." He also observed mild swelling of the right hand. Dr. Bernton emphasized the importance of getting authorization for the medication and prescribed Gralise (long-acting gabapentin) and Vicodin.

14. On February 2, 2015 Dr. Bernton noted discoloration and in the distal right leg and into the foot. He also noted the dorsum of the right hand exhibited swelling and "some hyperalgesia." Similar findings were noted on February 10, 2015.

15. Claimant credibly testified as follows. In June or July, 2014 Dr. Bernton first prescribed a topical cream containing ketamine. She received the cream in the mail and applied it to painful areas of her right ankle and leg. The cream reduced her pain from 8 on a scale of 10 (8/10) to 4/10. She used the cream until the prescription ran out at the end of September or October 2014. The pharmacy then told her that further prescriptions for this compound had been denied by the Insurer. In January or February, 2015 she requested a prescription for Vicodin because she was in severe pain and had nothing to treat it. She did not need Vicodin when she was using the cream. She prefers the cream to Vicodin because the effects of Vicodin last only 3

hours and she wakes up in pain. Also, Vicodin causes Claimant to feel "groggy" and she fears becoming addicted to it.

16. WCRP 17, Exhibit 7, (G) (7) (j) (v.) (b) pp. 79-80, of the MTG for treatment of CRPS, provides that use of ketamine topical cream is a permissible non-operative treatment for CRPS under certain circumstances. This section of the MTG states that although there is good evidence that low dose ketamine cream (1%) does not relieve neuropathic pain, it is "physiologically possible" that higher doses of topical ketamine could have some effect on neuropathic pain. However, "use of … ketamine should be limited to patients with neuritic and/or sympathetically mediated pain with documented supporting objective findings such as allodynia and/or hyperalgesia." Further use of ketamine topical cream "beyond the initial prescription requires documentation of effectiveness, including functional improvement, and/or decreased use of other medications, particularly decreased use of opiates or other habituating medications."

17. Claimant proved it is more probably true than not that topical ketamine cream is a reasonable and necessary treatment for her CRPS.

18. Dr. Bernton credibly and persuasively opined that the use of ketamine based topical cream is a permissible treatment for CRPS under the MTG. Dr. Bernton credibly and persuasively opined that use of ketamine cream is appropriate under the MTG. In this regard Dr. Bernton has documented the presence of both allodynia and hyperalgesia. He has noted that application of topical medication has been the most effective treatment of Claimant's CRPS. Considering the totality of the evidence, the ALJ gives great weight to Dr. Bernton's testimony that use of ketamine cream is appropriate under the MTG.

19. Claimant credibly testified use of topical ketamine cream significantly reduced her pain before the Insurer stopped payment for the drug. She also credibly testified that after ketamine was stopped she had no effective relief from pain and was forced to request a prescription for Vicodin. The medical records corroborate Claimant's testimony. On December 23, 2014 Dr. Bernton noted Claimant had "shown the most benefit" from topical analgesia and suggested another trial. On January 29, 2015 Claimant reported "horrible" pain and Dr. Bernton prescribed Vicodin. The ALJ infers from this evidence that if Claimant is allowed to use topical ketamine cream there is a reasonable chance that she can reduce consumption of other medication, especially Vicodin.

20. The evidence produced by the Respondents, particularly the January 6, 2015 letter authored by Nicole Peck, R.N., is not persuasive insofar as it argues that ketamine topical cream is not a reasonable and appropriate treatment for Claimant's CRPS. First, this letter/report incorrectly states that the Colorado MTG do not address the "issue" of the use of ketamine cream for treatment of CRPS. As found above, and as mentioned by Dr. Bernton, the Colorado MTG for treatment of CRPS do in fact address this issue and indicate that use of ketamine topical cream may be appropriate under the specified conditions. Second, the January 6 report admits that use of

ketamine is “under study” and has shown “encouraging results” in “non-controlled studies for CRPS 1 and post-herpetic neuralgia.”

21. Evidence and inferences contrary to 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. 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.

REASONABLENESS AND NECESSITY OF KETAMINE TOPICAL CREAM

Claimant argues she proved by a preponderance of the evidence that the ketamine topical cream prescribed by Dr. Bernton constitutes reasonable and necessary post-MMI treatment designed to cure and relieve the effects of CRPS. The ALJ agrees with this argument.

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).

In cases where the respondents file a final admission of liability admitting for ongoing medical benefits after MMI they retain the right to challenge the compensability, reasonableness, and necessity of specific treatments. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003). When the respondents challenge a claimant's request for specific medical treatment the claimant bears the burden of proof to establish entitlement to the benefits. *Ford v. Regional Transportation District,* W.C. No. 4-309-217 (ICAO February 12, 2009). The question of whether a claimant proved that specific treatment is reasonable and necessary to maintain her condition after MMI or relieve ongoing symptoms is one of fact for the ALJ. *See Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

When determining the issue of whether proposed medical treatment is reasonable and necessary the ALJ may consider the provisions and treatment protocols of the MTG because they represent the accepted standards of practice in workers' compensation cases and were adopted pursuant to an express grant of statutory authority. However, evidence of compliance or non-compliance with the treatment criteria of the MTG is not dispositive of the question of whether medical treatment is reasonable and necessary. Rather the ALJ considering the totality of the evidence may determine the weight to be given evidence of compliance or non-compliance with the MTG. *See Adame v. SSC Berthoud Operating Co., LLC.*, WC 4-784-709 (ICAO January 25, 2012); *Thomas v. Four Corners Health Care*, WC 4-484-220 (ICAO April 27, 2009); *Stamey v. C2 Utility Contractors, Inc.*, WC 4-503-974 (ICAO August 21, 2008). *See also*, § 8-43-201(3), C.R.S.

As determined in Findings of Fact 17 through 20, Claimant proved it is more probably true than not that ketamine topical cream constitutes reasonable and necessary medical treatment to relieve the ongoing effects of injury-related CRPS. As found, Dr. Bernton credibly opined that ketamine topical cream has been the most effective treatment for relieving Claimant's CRPS symptoms. Dr. Bernton also credibly and persuasively opined that the MTG for treatment of CRPS authorize the use of topical ketamine cream under the conditions and circumstances present in this case. As determined in Finding of Fact 18, Claimant credibly testified that use of topical ketamine cream significantly reduced the symptoms of her CRPS. She also credibly testified that when ketamine cream was no longer available her symptoms increased and she was forced to request a prescription for Vicodin. As determined in Finding of Fact 18, the ALJ infers that if Claimant is permitted to use topical ketamine cream there is a reasonable prospect that she can reduce the consumption of other medication including Vicodin. Although respondents presented some evidence to the contrary, the ALJ finds this evidence is not credible and persuasive.

ORDER

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

1. Insurer shall provide ketamine topical cream as a form of reasonable and necessary post-MMI medical treatment. Insurer shall continue to provide this treatment as long as it remains reasonable and necessary and causally-related to the injury.

2. 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: July 17, 2015

DIGITAL SIGNATURE:

David P. Cain

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

W.C. No. 4-832-903-03 and 4-891-828

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

SELF-INSURED,

Self-Insured Respondent.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on June 10, 2015, in Denver, Colorado. The hearing was digitally recorded (reference: 6/10/15, Courtroom 1, beginning at 1:30 PM, and ending at 4:30 PM).

W.C. No. 4-832-902-03 concerns a closed case involving an admitted back/neck injury of August 2, 2010. The Claimant filed a Petition to re-Open this case. W.C. No. 4-891-828 concerns a fully contested alleged compensable back/shoulder injury of July 2, 2012.

Claimant's Exhibits 1 through 5 were admitted into evidence, without objection. Respondent's Exhibits A through S were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant. The proposed decision was filed, electronically, on June 16, 2015. On June 18, 2015, the Respondent filed objections which, to some extent advocated the Respondent's position by adding in more suggested findings into the proposed decision, consistent with the Respondent's overall theory of the case. This is helpful, however, an ALJ is not held to a crystalline

standard in articulating and dealing with each piece of evidence in his findings. *See Magnetic Engineering, Inc. v. Indus. Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). Although certain minute pieces of evidence may not be mentioned in a decision, there is a presumption that the minutae in the evidence was considered unless there is a showing that it was not considered. After a consideration of the proposed decision and the objections thereto, the ALJ has modified the proposal and hereby issues the following decision.

ISSUES

The issues to be determined herein concern the Claimant's Petition to Re-Open W.C. No. 4-32-902-03, based on an alleged worsening of condition. The issues in W.C. No. 4-891-828 concern compensability; if compensable, medical benefits, including change of physician and whether the Respondent received reasonable notice of this issue; and, temporary total disability (TTD) benefits from July 2, 2012 and continuing. The Respondent designated the issue of overpayment in W.C. No. 4-832-902-03. The Claimant's theory is there was either a worsening of the closed, admitted claim in W.C. No. 4-832-903-03; or, in the alternative, the Claimant sustained a new compensable injury on July 2, 2012. Claimant also requested a change of authorized physician to Kristin Mason, M.D., as an alternative to Dr. Mason being in the authorized chain of referrals after a refusal to treat for non-medical reasons by Dr. Fall, who was treating in the earlier case, W.C. No. 4-832-902-03, wherein the Petition to Re-Open is denied and dismissed.

The Claimant bears the burden of proof, by a preponderance of the evidence on all designated issues with the exception of overpayment, in which case the Respondent bears the burden, by preponderant evidence.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

Preliminary Findings

1. The Claimant worked for the Employer in the Public Library, specifically as a clerk and driver of the bookmobile. According to the Claimant, there are two bookmobiles, and they depart from the Public Library on a scheduled route each week. The Claimant had served as both a driver and a passenger, though on July 2, 2012, she was the passenger riding in the back seat because she had taken a pain pill that morning for her back pain and determined that she should not drive under the influence of a pain pill.

2. According to the Claimant, each vehicle had a driver and one other person that rode in the back of the bookmobile along the back wall, behind the rear wheels. The bookmobile was a unique vehicle to drive and ride in because of the stiffness of the ride. According to the Claimant, the bookmobile required very stiff springs because of the weight of the books, so the ride from stop to stop was very rough. If the bookmobile went over a bump or a dip in the road the person in the back would bounce up and down even if seat-belted.

3. The Claimant had an admitted injury to her lumbar spine in the course and scope of her employment on August 2, 2010 (W.C. No. 4-832-902-03). She was treated for this injury by Allison Fall, M.D., who placed the Claimant at maximum medical improvement (MMI) on December 10, 2010, with a zero percent impairment rating. The Claimant disagreed with Dr. Fall's rating and sought a Division Independent Medical Examination (DIME). Eramus Morfe, D.O., was selected to perform the DIME. Dr. Morfe agreed with Dr. Fall's date of MMI, however, he disagreed with her zero percent rating. Dr. Morfe rated the Claimant at 11% whole person for her lumbar spine. He did not rate her thoracic spine or cervical spine. Dr. Morfe indicated that maintenance treatment (lumbar steroid injections) was appropriate for the Claimant's lumbar spine.

4. Dr. Fall testified at the hearing that she has seen the Claimant for the maintenance treatment under W.C. No. 4-832-902-03, with the most recent visit in May of 2015. Dr. Fall provided the Claimant with medication and referred her to Osteopathic Dr. Krembs. Dr. Fall's current diagnosis is fibromyalgia, and Dr. Fall stated that she did not have any treatment to offer the Claimant at this time. The Claimant did not agree that Dr. Fall was appropriately treating her for her injury.

5. In addition to Dr. Fall, the Claimant had seen her personal physician at Kaiser several times after her date of MMI for the 2010 injury. The Claimant visited Kaiser-Permanente on December 28, 2011 and complained of headache and right-sided neck pain, thoracic spine pain, tenderness in the thoracic spine, constant right hip pain, stiffness, low back pain, bilateral leg weakness, dull ache in the lower back, and bilateral buttocks pain. According to the medical record, she complained that she felt tension with flexion of the neck, she had discomfort sitting, and that her "butt hurts all the time". Leslie Pearson, M.D., diagnosed cervical radiculopathy, thoracic spine pain, and low back pain, chronic. Dr. Pearson planned to refer the Claimant for physical therapy (PT) and ordered x-rays of the right hip, pelvis, and a lumbar MRI (magnetic resonance imaging) without contrast.

6. The Claimant returned to Kaiser Permanente on January 3, 2012 for a physical therapy evaluation. She repeated many of the complaints stated in the December 28, 2011 Kaiser report. The Claimant returned to Kaiser on June 27, 2012 and again saw Dr. Pearson. She complained of worsening back pain. Dr. Pearson's note stated that the lower back is worst and that there was bilateral buttocks and lower

back mid. Dr. Pearson found tenderness over the lumbar and lower thoracic spines, tender over the paraspinal muscles, right and left lumbar, and bilateral SI joints. Dr. Pearson's diagnosis was again chronic low back pain and again recommended a lumbar MRI without contrast. The Claimant stated on cross examination that she went to Kaiser on June 27, 2012 for the reasons described in Dr. Pearson's note. She also stated that she asked Dr. Pearson about long-term disability because she felt it was becoming difficult to do her job. According to the Claimant, in late June 2012, she was trying to make an appointment to see Dr. Fall because she felt her condition was getting worse.

7. The Claimant continued working, full time, during the course of her Kaiser visits and none of the Kaiser physicians took the Claimant off work during this time.

W.C. No. 4-891-828—The Incident of July 2, 2012

8. According to the Claimant, on July 2, 2012, while working for the Employer on the bookmobile, she significantly aggravated her underlying back condition and sustained new injuries. She stated that, on that day, she was working with Melanie Pierce who was the driver of the bookmobile. The Claimant was sitting in the back seat when the driver hit a pothole that shook the vehicle violently. According to the Claimant, the force of the impact caused her to be jolted up even though she was wearing a seat and lap belt. The books that were on the shelves flew off, and the bookshelf directly across from where she was sitting was cracked by the force of the impact. The Claimant had immediate pain in her cervical area, and her tailbone and lower back. According to the Claimant, this pain was much worse than it had been prior to this incident. The ALJ finds the Claimant's testimony regarding this incident credible and, essentially, undisputed. The Respondent presented **no** witnesses to dispute the veracity of the Claimant's description of the incident or concerning its occurrence.

9. The Claimant reported the incident and alleged injury to her supervisor, Jennifer Hoffman, after the vehicle arrived at its next stop. Jennifer came to get the Claimant in Jennifer's private vehicle so that the Claimant would not have to finish the day.

10. The Claimant was seen at the occupational clinic that is part of Denver Health Medical Center on July 3, 2012. She advised the clinic of her prior injury and reported that she had substantially increased back pain, and "different pain between her shoulder blades." She reported difficulty sitting, in addition to the pain in her upper and lower back. She was taken off work by the physician at the clinic, Lori Szczukowski M.D.

11. The Claimant was off work until she again saw Dr. Szczukowski at the clinic on July 10, 2012. The Claimant reported back and neck pain being the same, however, Dr. Szczukowski indicated in the notes that she told the Claimant that the

claim was not being accepted so she was unable to offer her treatment. Dr. Szczukowski stated that the Claimant could return to full-duty work. Dr. Szczukowski suggested that the Claimant return to see Dr. Fall (who she was scheduled to see for a maintenance visit under W.C. No. 4-832-902-03). There is no indication that the Claimant voluntarily chose Dr. Fall to be her authorized treating physician (ATP) for W.C. No. 4-891-828, rather the records make it clear that the Claimant was sent to Dr. Fall because the Respondent denied care for the alleged new injury and treated the referral to Dr. Fall as a maintenance-care-referral under W.C. No. 4-832-902-03.

12. Between July of 2012 and the time of the hearing in this matter, Dr. Fall continued to see the Claimant for maintenance treatment related to her 2010 injury. Dr. Fall continued to provide the Claimant with small doses of Vicodin and she made a referral to Jordanna Quinn D.O. On cross examination, Dr. Fall stated that she made no referrals for diagnostic testing, an MRI (magnetic resonance imaging), or referrals to any specialists for the Claimant's continued complaints of pain in her hips, back and "sit bones."

13. The Claimant saw Dr. Fall on July 31, 2012 complaining of bilateral pain in the neck between her shoulders, mid back pain, lower back, hip and buttock pain, stabbing pain in the buttocks on the left and painful to sit, with weakness in the legs. She rated her pain 8 out of 10. Previous records of visits with Dr. Fall provided by the Respondent indicated a consistent pain rating of 4 out of 10. (Resp. Ex I**) Dr. Fall recommended that she pursue treatment outside of workers compensation. She did not believe that there was a mechanism of injury to account for her (then) current symptomatology.** Based on this recommendation, the ALJ infers and finds that Dr. Fall declined to treat the Claimant for the 2012 injury, based on her non-medical determination that it was not a compensable injury. Dr. Fall did not provide treatment recommendations. Indeed, the ALJ infers and finds that Dr. Fall offered no meaningful treatment as of the last visit to alleviate the Claimant's condition. The ALJ infers and finds that this fact amounts to a *de facto* refusal to further treat the Claimant to improve her condition.

Independent Medical Examination (IME) by Gretchen Brunworth, M.D.

14. Dr. Brunworth performed an IME at the request of the Respondent. She outlined her review of the records provided to her in her report. It was her opinion that the Claimant remained at MMI for the 2010 injury, that she did not suffer a new injury in 2012, and that she was not in need of further treatment. She categorically agreed with the testimony of Dr. Fall that no further treatment was needed, though she did not dispute that the Claimant was "in pain." The ALJ finds that Dr. Brunworth's opinions are contrary to the weight of the evidence, contrary to the credible opinion of Kristin Mason, M.D. who had been treating the Claimant under the Claimant's health insurance and, therefore, has "no dog in the work-related fight."

Declining of Treatment by Dr. Fall for Non-Medical Reasons and Thereafter

15. When Dr. Fall advised the Claimant to seek treatment from her personal physician for the 2012 incident, the ALJ infers and finds that there was a refusal to treat for non-medical reasons. The Claimant thereupon sought treatment with her personal physician Amber Wobbekind, M.D. Dr. Wobbekind subsequently referred the Claimant to Dr. Kathyrn A Witzeman, M.D. Dr. Witzeman is a specialist in pelvic issues, working at the women's integrative pelvic health clinic. Dr. Witzeman's records indicate that she saw the Claimant on November 19, 2014 and on January 15, 2015. In her report dated January 15, 2015, Dr. Witzeman states that the Claimant has a 2 year history of worsening pelvic floor muscle pain after a coccygeal and sacral trauma that was work-related. She states "I do believe that her pelvic floor dysfunction and pain that has also extended to her lower back is directly related to this injury (the injury of 2012). This is a common coccyx injury. It is a common mechanism for pelvic floor dysfunction". The ALJ finds Dr. Witzeman's opinion on causality to be more persuasive than either Dr. Fall's or Dr. Brunworth's opinions because, among other things, Dr. Witzeman has more specific expertise in pelvic matters, and her opinion is consistent with the totality of the evidence. Indeed, Dr. Witzeman's opinion solidly supports a work-related aggravation and acceleration of a pre-existing pelvic problems, and this occurred on July 2, 2012.

16. Dr. Fall stated that she has no treatment to offer the Claimant. It would be ludicrous to maintain that the Claimant should return to Dr. Fall. The Respondent offered her no other option. The ALJ infers and finds that the Claimant has considerably more confidence in Dr. Witzeman's treatment than in Dr. Fall's treatment. The Claimant has more confidence in Dr. Witzeman's ability to adequately diagnose and treat her condition. Therefore, the ALJ finds that Dr. Witzeman and her referrals are authorized treating physicians for the purposes of this claim. (W.C. No.4-891-828-03).

Medical Benefits

17. All of the medical care and treatment for the Claimant's July 2, 2012 injuries was authorized, within the authorized chain of referrals, causally related and reasonably necessary to cure and relieve the effects of those injuries.

Reasonable Notice of Change of Physician/Authorization of Dr. Witzeman and Dr. Mason as ATPs

18. The Respondent alleges that it did not have sufficient notice of the "change of physician" issue. There is no space for the "change of physician" issue on

the Application for Hearing" form, however, there is a general space for "medical benefits." Based on the denial of the 2012 claim (W.C. No. 4-891-828) and ATP Dr. Fall's ultimate referral of the Claimant to her private physician in the context of the 2012 claim, the ALJ infers and finds that the Respondent had reasonable notice that authorization of Dr. Witzeman and her referrals; and, "change of physician" would be an issue under the general heading of "medical benefits."

19. Indeed, there is no rational reason supporting a return to Dr. Fall as an ATP. On the other hand, the ALJ infers and finds that the Respondent was aware that Kaiser Permanente, Dr. Prusmack, Dr. Witzeman and Dr. Mason were of the opinion that the Claimant's present condition was related to the 2012 injury, and Dr. Prusmack had treatment recommendations for a work-related condition. The ALJ, therefore, infers and finds that the Respondent had reasonable notice, prior to the hearing, that the Claimant was seeking a change of physician to Dr. Prusmack. When the "change of physician" prong of "medical benefits" was brought up at hearing, the Respondent offered no underlying reasons concerning any prejudicial effects of not being provided specific notice. No space for "change of physician" is provided in the "Application" form or the Case Information Sheet form. The ALJ, therefore, infers and finds that the Respondent had reasonable notice that "change of physician" to Kristin Mason, M.D., would be an issue subsumed under the heading of "medical benefits."

Petition to Re-Open

20. The Claimant filed a Petition to Re-Open 4-832-902 to cover all bases. The Petition should be denied because the Finding herein is that a new incident occurred on July 2, 2012, which has caused new injuries as well as substantially aggravating and accelerating any condition for which the Claimant was treating under the earlier claim.

21. The Claimant is currently not working and testified that she does not believe she has worked since approximately July 15, 2012, however, issues concerning the periods of temporary disability owed and offsets applicable should be deferred to a subsequent hearing, if needed, by agreement of the parties.

22. The Respondent seeks recovery of an overpayment in 4-832-902. The Petition to Re-Open that claim being denied, therefore, there are no benefits owed under that claim to offset. The Claimant, however, agrees to recovery of the overpayment as part of the benefits due in 4-891-828.

Ultimate Findings

23. The ALJ finds the Claimant's testimony credible and un-impeached. Further, the ALJ finds the opinions of Dr. Fall and Dr. Brunworth lacking in credibility,

and the opinions of Dr. Witzeman, Dr. Prusmack and Dr. Mason far more credible and persuasive because of her specific expertise.

24. The ALJ makes a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Mason, Dr. Prusmack and Dr. Witzeman and to reject any opinions to the contrary.

25. The Claimant has proven, by a preponderance of the evidence that she sustained an injury in course and scope of her employment on July 2, 2012 to her neck, upper and lower back, hips and pelvis and coccyx. To the extent that any of these areas were part of an earlier claim the Claimant has proven by a preponderance of the evidence that the incident of July 2, 2012 substantially aggravated and accelerated the underlying injuries to those parts of the body.

26. The Claimant has proven, by preponderant evidence that she should be allowed to proceed with the treatment recommended by Dr. Witzeman or her referrals. Dr. Fall will no longer be considered an authorized treating physician for the purposes of this claim (4-891-828). Indeed, the Respondent had reasonable notice that a change of physician was an issue subsumed under medical benefits. Further, in the earlier case, Dr. Fall refused to further treat the Claimant for non-medical reasons, the Respondent was aware that Kaiser Permanente, Dr. Prusmack, Dr. Witzeman and Dr. Mason (under the Claimant's health insurance) were providing meaningful treatment for the Claimant's July 2, 2012 injuries, and the Respondent offered no treatment alternative to these medical providers.

27. The Claimant is not at MMI for the injuries related to the incident of July 2, 2012.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558

(Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* S 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, the Claimant's testimony was credible and un-impeached. Further, the opinions of Dr. Fall and Dr. Brunworth were lacking in credibility, and the opinions of Dr. Prusmack, Dr. Witzeman and Dr. Mason were far more credible and persuasive because of her specific expertise.

Substantial Evidence

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, the ALJ made a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Mason, Dr. Witzeman and Dr. Prusmack and to reject any opinions to the contrary.

Compensability

c. A compensable injury is one that arises out of and in the course of employment. Section 8-41-301(1) (b), C.R.S. The "arising out of" test is one of causation. If an industrial injury aggravates or accelerates a preexisting condition, the resulting disability and need for treatment is a compensable consequence of the industrial injury. Thus, a claimant's personal susceptibility or predisposition to injury does not disqualify the claimant from receiving benefits. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). An injured worker has a compensable new injury **if the employment-related activities aggravate, accelerate, or combine with the pre-existing condition to cause a need for medical treatment or produce the disability for which benefits are sought.** § 8-41-301(1) (c), C.R.S. *See Merriman v. Indus. Comm'n,* 120 Colo. 400, 210 P.2d 448 (1949); *Anderson v. Brinkoff,* 859 P.2d 819 (Colo. 1993); *National Health Laboratories v. Indus. Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992); *Snyder v. Indus. Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). An injury resulting from the concurrence of a preexisting condition and a hazard of employment is compensable. *H & H Warehouse v. Vicory*, *supra*. *Duncan v. Indus. Claims App. Office*, 107 P.3d 999 (Colo. App. 2004). Even where the direct cause of an accident is the employee's preexisting disease or condition, the resulting disability is compensable where the conditions or circumstances of employment have contributed to the injuries sustained by the employee. *Ramsdell v. Horn*, 781 P.2d 150 (Colo.App. 1989). *Also see* § 8-41-301(1) (c), C.R.S; *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Indus. Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). As found, the Claimant sustained compensable injuries on July 2, 2012, when bounced in the Bookmobile.

Medical Benefits

d. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. *See Mason Jar Restaurant v. Indus. Claim Appeals Office,* 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). When an ATP refers an injured worker to his personal physician, under the mistaken belief that the claim was not compensable, the referral was nonetheless within the chain of authorized referrals and, thus, subsequent treatment was authorized. *See Cabela v. Indus. Claim Appeals Office,* 198 P.3d 1277 (Colo. App. 2008). As found, when Dr. Fall indicated that the new claim was outside the workers' compensation system, under the mistaken belief that it was not work-related, she gave the Claimant carte blanche to select a new treatment provider. The Claimant selected Dr. Prusmack who, ultimately, referred her to Dr. Witzeman. Dr. Mason had been treating the Claimant under the Claimant's health insurance. Consequently, as found, all referrals are in the authorized chain of referrals.

e. To be a compensable benefit, medical care and treatment must be

causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, the Claimant's medical treatment is causally related to the compensable injuries of July 2, 2012. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment, as reflected was and is reasonably necessary.

Reasonable Notice of Change of Physician/Authorization of Dr. Witzeman and Dr. Mason as ATPs

f. If the physician selected (Dr. Fall herein) refuses to treat for non-medical reasons, and the insurer fails to appoint a willing ATP after notice of the refusal to treat, the right of selection passes to the injured worker. *Weinmeister v. Cobe Cardiovascular, Inc.,* W.C. No. 4-657-812 [Industrial Claim Appeals Office (ICAO), July 10, 2006]. *Also see Lutz v. Industrial Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000); *Ruybal v. University Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988). As found, the respondent was aware that Dr. Fall had indicated that she had nothing more to offer the Claimant, and that the Claimant was treating with Dr. Mason (under health insurance), Dr. Prusmack and Dr. Witzeman, who had treatment to offer the Claimant, yet the Respondent offered no alternative treatment.

g. "The fundamental requisites of due process are notice and the opportunity to be heard." *Franz v. Indus. Claim Appeals Office,* 250 P.3d 755, 758 (Colo. App. 2010) [quoting *Hendricks v. Indus. Claim Appeals Office,* 809 P.2d 1076, 1077 (Colo. App. 1990)]. Workers' compensation benefits are a constitutionally protected property interest which cannot be taken without the due process guarantees of notice and an opportunity to be heard. *See Whiteside v. Smith,* 67 P.3d 1240, 1247 (Colo. 2003). Notice requirements apply to both parties. Reasonable notice requirements need not specify, in the application for hearing, the exact statute upon which a claimant relies in order to afford adequate notice of the legal basis of a claim. *See Carlee Carson v. Indus. Claim Appeals Office* [(No. 03CA0955, October 7, 2004) (not published), *cert. denied,* February 22, 2005]. A general request for the relief sought will suffice. *See Fang v. Showa Entetsu Co.,* 91 P.3d 419 (Colo. App. 2003). As found, the Respondent had reasonable notice that a change of physician was an issue subsumed under medical benefits. Further, in the earlier case, Dr. Fall refused to further treat the Claimant for non-medical reasons, the Respondent was aware that Kaiser Permanente, Dr. Prusmack, Dr. Witzeman, and Dr. Mason were providing meaningful treatment for the Claimant's July 2, 2012 injuries, and the Respondent offered no treatment alternative to these medical providers. At the hearing, the Claimant requested that Kristin Mason, M.D., be designated the authorized treating physician (ATP). The Respondent had reasonable notice that the "change of physician" issue was subsumed under "medical benefits."

Burden of Proof

h. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012). 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. C lark,* 197 Colo. 306, 592 P. 2d 792 (1979). *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained her burden on all issues.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Petition to Re-Open in W.C. No. 4-832-902-03 is hereby denied and dismissed.

B. The Claimant sustained compensable injuries in W.C. No. 4-891-828 and the Respondent is liable for workers' compensation benefits arising out of these injuries.

C. Medical care and treatment provided by Dr. Prusmack, Dr. Witzeman, Dr. Mason (prospectively in the case of Dr. Mason) and their referrals was and is authorized.

D. The Respondent shall pay all the costs of authorized medical treatment arising out of the July 2, 2012 injuries, subject to the Division of Workers Compensation medical Fee Schedule.

E. Any and all issues not determined herein, including overpayment offsets relating to W.C. No. 4-832-902-03 and temporary disability benefits, are reserved for future decision.

DATED this_____day of July 2015.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

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, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 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 form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order** on this_____day of July 2015, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.ord

ISSUES

- What was the Division Independent Medical Examination physician's "true opinion" concerning whether or not Claimant reached maximum medical improvement on August 17, 2011?
- Was the DIME physician's "true opinion" concerning the date of maximum medical improvement overcome by clear and convincing evidence?
- Are Respondents' liable to pay for a total knee replacement in order to assist the Claimant to reach maximum medical improvement?

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 though 19 were received into evidence. Respondents' Exhibits A through H were received into evidence. The depositions of Dr. Annu Ramaswamy and Dr. John Hughes were also received into evidence.

2. On March 25, 2010 Claimant sustained an admitted injury to his right knee.

3. Claimant initially treated with Concentra Medical Centers (Concentra). He was referred for an MRI of the right knee. The MRI was reportedly significant for an "indentation subchondral fracture of the anterior surface of the medial femoral condyle with radiating secondary subchondral microtabular fracture lines. Also noted were a horizontal tear of the posterior horn of the lateral meniscus and a mild ACL sprain. Claimant was referred to orthopedist Gary Hess, M.D., for consultation and treatment.

4. On June 3, 2010 Dr. Hess assessed right knee osteoarthritis and pain. He noted Claimant had failed "most conservative treatments" and recommended he undergo a right total knee replacement (TKR). Dr. Hess stated that he would "seek approval" for surgery "through Workers' Comp." He further noted Claimant would need vascular clearance before surgery.

5. In September 2010 Claimant changed authorized treating physicians (ATP) from Concentra to Rocky Mountain Medical Group (RMMG).

6. On September 24, 2010 Annu Ramaswamy, M.D., examined Claimant at RMMG. Dr. Ramaswamy is board certified in internal medicine and is Level II accredited. Dr. Ramaswamy diagnosed a "history of right knee contusion in the setting of lateral meniscus tear and arthritis." He noted that Dr. Hess had recommended a TKR. Dr. Ramaswamy wrote he needed to contact Dr. Hess regarding "the causality issues in regard" to the proposed TKR. Dr. Ramaswamy wrote that he explained to Claimant that his right knee exhibited "pre-existing arthritis and cartilage degeneration," and that the "lateral meniscus and bone contusions and hematomas" were likely related to the injury of March 25, 2010. Dr. Ramaswamy wrote the proposed TKR would treat all of the knee pathology, not just the "work-related pathology."

7. Dr. Hess examined Claimant in October, 2010. Dr. Hess opined Claimant's pre-existing osteoarthritis had been aggravated by the work-related injury of March 25, 2010. Dr. Hess also stated that because of Claimant's persistent "flexion contracture" that a "total knee replacement procedure" was the "only reasonable course" of treatment. Dr. Hess reiterated that a vascular evaluation was necessary before surgery to insure Claimant's wounds would heal without complication.

8. In an October 15, 2010 report Dr. Ramaswamy noted the opinion of Dr. Hess that the industrial injury aggravated Claimant's pre-existing arthritis and that he needed a TKR considering the nature of the injury and the presence of pre-existing arthritis. Dr. Ramaswamy recommended Claimant obtain a "second opinion."

9. On February 2, 2011, Hendrick Arnold, M.D., performed an independent medical examination (IME) of the Claimant. In his report Dr. Arnold opined that as a result of the March 25, 2010 fall Claimant sustained a subchondral compression fracture of the medial femoral condyle. He further opined that the fall caused "significant permanent aggravation" of the pre-existing degenerative arthritis. Dr. Arnold opined Claimant was not at maximum medical improvement (MMI) and needed to undergo a TKR "pending clearance by a vascular surgeon."

10. On July 11, 2011 Dr. Ramaswamy again examined Claimant. Claimant reported right hip and right knee pain and that the knee pain was worse. He rated the knee pain as 8 on a scale of 10 (8/10) and stated he could not kneel, squat, or climb because of the pain. However, Claimant could perform his job duties as a part-time vehicle driver. Claimant reported he was "not sure he wanted to undergo the total knee replacement" at that time. Dr. Ramaswamy wrote Claimant stated that he "knew quite a few individuals" that had "not done well" with a TKR and he was concerned about chronic pain. Claimant also reported that his "functional level [was] fairly reasonable" and he would "rather hold on such surgery." Dr. Ramaswamy noted that he discussed MMI "status" given that Claimant was "declining surgical intervention." Dr. Ramaswamy also wrote that he "most likely would keep the case open six months to a year after maximum medical improvement to see if the [Claimant's] knee pain worsens to a point where he would consider a total knee replacement."

11. On July 27, 2011 Dr. Ramaswamy examined Claimant. On this occasion Dr. Ramaswamy wrote that at the "last visit [Claimant] decided that he was not

interested in the total knee replacement at this point in time based on his tolerable pain." Dr. Ramaswamy further stated Claimant "might change his mind down the road, especially with the winter if his pain level increases.

12. On August 17, 2011 Dr. Ramaswamy placed Claimant at MMI for all of the injuries caused by the March 25, 2010 industrial injury. He assessed an overall impairment rating that included 18% impairment of the right lower extremity based on the right knee injury. Dr. Ramaswamy wrote that Claimant "felt like he would like to wait on the total knee replacement as he was concerned about complications given his age and vascular history." However Claimant wanted to keep the case "open for awhile to see if he would change his mind" about the TKR. Dr. Ramaswamy wrote that "in regard to medical maintenance, I am keeping the case open for one year to see how he does in terms of his right knee discomfort." Dr. Ramaswamy wrote that if Claimant's "right knee discomfort becomes disabling then he may wish to consider a total knee replacement."

13. On November 16, 2014 Claimant returned to Dr. Ramaswamy for treatment of his right knee. Dr. Ramaswamy took a history from Claimant that the right knee was "doing the same … 8/10 at times in the right knee." Claimant also reported that he received a "final admission of liability" to which he objected, that he had retained an attorney and that he was "possibly getting [a] DIME." Dr. Ramaswamy noted that so far Claimant "wants to hold on right TKR…he is working with an attorney re: length of maintenance care…"

14. On December 30, 2011, John Hughes, M.D., performed a Division-sponsored independent medical examination (DIME) of Claimant. Dr. Hughes took a history, reviewed pertinent medical records and performed a physical examination. Dr. Hughes noted that on August 17, 2011 Dr. Ramaswamy placed Claimant at MMI. Dr. Hughes stated that with respect to "injury-related follow-up Dr. Ramaswamy recommended keeping [Claimant's] case open for a while to see if he would change his mind about the knee replacement." Dr. Hughes agreed with Dr. Ramaswamy that Claimant had "post-traumatic right knee findings with severity in excess of the 'baseline' findings in the left knee." Dr. Hughes wrote that Claimant was considered to have reached MMI as of August 17, 2011. Dr. Hughes also wrote that, "I certainly do endorse total knee arthroplasty" and opined "the need for this surgery was substantially accelerated by the work-related injuries in question here today." Dr. Hughes completed a Division IME Examiner's Summary Sheet (WC 132) on which he wrote that Claimant reached MMI on "8/17/2011."

15. Claimant testified as follows. Prior to August 2011 he was "hesitant" to undergo a TKR because he was aware of several persons, including family members, who experienced severe complications from TKR surgery. These complications included death, amputation and infection. He expressed these concerns to his treating physicians.

16. At hearing Claimant was asked whether he knew he would be put at MMI in August 2011 if did not undergo TKR surgery. Claimant testified that based on his

conversations with Dr. Ramaswamy he believed that if he was put at MMI he would have 6 months to decide whether to undergo the TKR surgery. Claimant also testified that his condition was worsening in 2010 and by "late summer" 2011 he decided he wanted to undergo the TKR procedure.

17. Claimant testified he had a second injury in February 2012. He stated that he slipped on ice and injured his right shoulder and right knee. The knee injury resulted in a fractured patella. Claimant testified that he experienced an increase in right knee symptoms for a short period of time. Claimant further testified that he still desired to undergo the previously recommended TKR at the time of the February 2012 injury. Claimant could not recall whether at the time of the 2012 injury he was aware Insurer was denying his request for a TKR.

18. Dr. Hess examined Claimant on February 14, 2012. Dr. Hess stated x-rays of the right shoulder were negative and x-rays of the right knee demonstrated osteoarthritis and a nondisplaced facture of the right patella.

19. Dr. Ramaswamy examined Claimant on February 15, 2014. On February 15 Dr. Ramaswamy wrote that "by August" Claimant would "decide about tkr." Dr. Ramaswamy also stated the "recent patella fx will aggravate knee condition."

20. On May 16, 2012 Dr. Ramaswamy examined Claimant. On that date Dr. Ramaswamy noted Claimant "would like to undergo the TKR." On July 11, 2014 Dr. Ramaswamy placed Claimant at MMI for the February 2012 injury. Dr. Ramaswamy noted that Claimant's February 2012 right knee patella fracture was completely healed but he was still experiencing "right knee discomfort from preexisting injury."

21. Dr. Hughes testified by deposition on August 12, 2013. Dr. Hughes testified that when he wrote the DIME report on December 30, 2011 he "endorsed" the TKR procedure recommended for Claimant. However, he could not recall if he actually discussed the procedure with Claimant. Dr. Hughes opined the Claimant did not "require" a TKR in December 2011 because the surgery is a "fairly elective thing that is done for comfort and function more than preservation of life." At the time of the deposition Dr. Hughes continued to endorse the TKR procedure.

22. Dr. Hughes testified that when he completed the DIME report in December 2011 it was his opinion Claimant had reached MMI for the March 2010 injury. Dr. Hughes was asked whether Claimant's desire to undergo a TKR would "impact his MMI status." Dr. Hughes replied "yes" because Claimant's desire to undergo surgery "would create a situation where he no longer was at MMI, pending resolution after surgery."

23. Dr. Ramaswamy testified as follows in his post-hearing deposition. He placed Claimant at MMI on August 17, 2011 because a TKR was the only treatment that could "make a significant difference for him" and Claimant "was declining the treatment." If Claimant had expressed a desire to undergo the TKR in August 2011 Dr. Ramaswamy would have kept the case "open" and potentially proceeded to surgery. Because Claimant did not desire to undergo surgery Dr. Ramaswamy explained that he

offered Claimant "maintenance care" in case the knee condition should worsen and Claimant were to "change his mind" about undergoing the TKR. Dr. Ramaswamy saw Claimant on November 16, 2011 and at that time Claimant wanted to "hold" on undergoing a TKR. Dr. Ramaswamy was aware Claimant had objected to an FAL and doesn't recall Claimant's "reasoning" for filing the objection.

24. Dr. Ramaswamy remembered that at some point during "maintenance care" Claimant changed his mind about wanting the TKR. Dr. Ramaswamy pointed out that he saw Claimant on February 15, 2012 and the office note from that date states Claimant would "decide" by August about the TKR. However, on May 16, 2012 Dr. Ramaswamy recorded Claimant wanted to undergo the TKR. Dr. Ramaswamy explained that in May 2012 Claimant's right shoulder condition was "not doing well" and considering Claimant's complicated medical history he "wasn't quite the medical candidate" for a TKR. However, Dr. Ramaswamy noted that in May 2012 he "could have started a process to figure out if [Claimant] would have been a medical candidate" for the TKR.

25. Claimant's argument notwithstanding, the ALJ finds that it is Dr. Hughes's opinion as the DIME physician that Claimant reached MMI on August 17, 2011. At the time Dr. Hughes issued the DIME report on December 30, 2011 he had reviewed the records of Dr. Ramaswamy including the MMI report of August 17, 2011. Thus, Dr. Hughes was aware that Claimant had declined to undergo a recommended TKR and consequently Dr. Ramaswamy placed Claimant at MMI. Having this knowledge Dr. Hughes wrote in his DIME report and on the WC 132 that Claimant reached MMI on August 17, 2011. The ALJ infers Dr. Hughes essentially agreed with Dr. Ramaswamy that Claimant reached MMI on August 17, 2011 because he was refusing the only treatment that had a prospect for improving his condition. Indeed, Dr. Hughes "endorsed" a TKR as reasonable and necessary treatment.

26. Claimant's argument notwithstanding, Dr. Hughes's deposition testimony did not create an "ambiguity" or inconsistency with regards to whether he believed Claimant reached MMI on August 17, 2011. Rather, Dr. Hughes was asked in the deposition whether Claimant's desire to undergo a TKR would impact his MMI "status." Dr. Hughes replied that Claimant's desire to undergo surgery would "*create a situation* where he *no longer* was at MMI." (Emphasis added.) Dr. Hughes did not retract his opinion that Claimant reached MMI on August 17, 2011 when he declined to undergo TKR surgery. Dr. Hughes merely indicated that were the Claimant to change his mind about surgery his "MMI status" would change and he would "no longer" be at MMI. Thus, the ALJ finds that Dr. Hughes cannot be understood to have opined that Claimant's willingness to undergo surgery after August 17, 2011 meant that he did not reach MMI on August 17, 2011.

27. Claimant argues that the ALJ should infer from his testimony that he decided to undergo TKR surgery "soon after the MMI determination was made" by Dr. Ramaswamy. However, the ALJ does not draw that inference. Rather, Dr. Ramaswamy's credible office notes and testimony establish that Claimant did not express a desire to undergo TKR surgery until May 16, 2012. Prior to May 2012 Dr.

Ramaswamy's records, including those from November 16, 2011, and February 15, 2012, document that Claimant continued to decline TKR surgery.

28. Claimant further argues the ALJ should infer that he decided to undergo the TKR procedure soon after August 17, 2011 because he sought a DIME prior to suffering the second injury in February 2012. However, the ALJ does not draw that inference. Rather, the ALJ is persuaded by Dr. Ramaswamy's notes that Claimant did not express a desire to undergo the surgery until after February 15, 2012. Moreover, there is no indication in Dr. Hughes's DIME report that Claimant expressed a desire to undergo TKR surgery so as to negate Dr. Ramaswamy's MMI determination. Indeed Dr. Hughes could not recall that the issue of TKR surgery was even discussed during the DIME. Moreover, the mere act of requesting a DIME does not establish that Claimant had changed his mind about undergoing surgery. Claimant could have sought the DIME for the primary purpose of reviewing Dr. Ramaswamy's impairment rating.

29. Claimant asserts he did not understand the legal consequences of Dr. Ramaswamy's August 17, 2011 MMI determination. Specifically he asserts he would immediately have elected to undergo a TKR if he had understood the MMI finding meant he did not have an additional "6 months to decide" on surgery. The ALJ notes that this assertion is somewhat contrary to the contention that Claimant had recently changed his mind about undergoing TKR surgery and sought the DIME with a view towards displacing Dr. Ramaswamy's MMI determination. In any event, the ALJ concludes that even if Claimant misunderstood the consequences of the MMI determination with respect to surgery that misunderstanding is irrelevant. Claimant essentially alleges, based on his conversations with Dr. Ramaswamy, that he did not understand the *legal effect* of the MMI determination would be termination of his right to additional medical benefits including the right to take an additional 6 months to decide whether to undergo surgery. However, parties, even pro se parties, are presumed to know the law and must bear the consequences of their own legal errors. *Dyrkopp v. Industrial Claim Appeals Office,* 30 P.3d 821 (Colo. App. 2001); *Division of Workers' Compensation v. Sundance Equestrian Center*, (ICAO January 13, 2004).

30. Claimant failed to prove it highly probable and free from serious doubt that Dr. Hughes was mistaken when he placed Claimant at MMI on August 17, 2011. As determined in Finding of Fact 25, Dr. Hughes found Claimant reached MMI on August 17 because he was declining to undergo a TKR, the only medical treatment that offered a reasonable prospect for improving Claimant's condition. Dr. Hughes's opinion that Claimant reached MMI on August 17, 2011 is corroborated by Dr. Ramaswamy's report of August 17, 2011. It is further corroborated by Dr. Ramaswamy's credible testimony that in August 2011 claimant was declining a TKR but wanted to keep the claim "open" in case he changed his mind. Dr. Ramaswamy credibly explained that keeping the case "open" meant he was offering "maintenance care" in case the knee worsened and Claimant changed his mind about the only treatment that could "make a significant difference for him." Claimant cites no credible and persuasive medical opinion that he did not reach MMI on August 17, 2011 when he declined the TKR.

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. Except as noted below, 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.

DIME OPINION CONCERNING MMI

Claimant seeks a finding that he has not reached MMI for the March 25, 2010 industrial injury. He also seeks an order determining that a TKR is reasonable and necessary medical treatment the need for which is causally related to the March 2010 industrial injury. As a corollary to these contentions Claimant argues that the DIME physician's opinion (Dr. Hughes's opinion) concerning MMI was "conditioned on Claimant's desire to undergo" the TKR. Claimant reasons that since he was "pursuing the knee replacement" at the time of the DIME evaluation Dr. Hughes's true opinion is that he never reached MMI. Therefore, Claimant contends Respondents bear the burden to prove by clear and convincing evidence that he reached MMI. The ALJ disagrees with Claimant's argument that Respondents bear the burden of proof on the issue of MMI.

MMI exists at the point in time when "any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." Section 8-40-201(11.5), C.R.S. A DIME physician's finding that a party has or has not reached MMI is binding on the parties unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). If a DIME physician issues conflicting or ambiguous opinions concerning whether a claimant has reached MMI the ALJ must resolve the

conflict or ambiguity as a matter of fact. *MGM Supply Co. v. Industrial Claim Appeals Office,* 62 P.3d 1001 (Colo. App. 2002).

With respect to medical benefits, MMI serves as the line of demarcation between the availability of medical treatment designed to cure or improve the claimant's condition and post-MMI medical treatment designed to relieve the ongoing effects of an injury and prevent additional deterioration of the claimant's condition. See *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995); *Gonzales v. Industrial Claim Appeals Office,* 905 P.2d 17 (Colo. App. 1995). Indeed, the legal definition of MMI contained in § 8-40-201(11.5) recognizes that MMI is attained when no treatment is reasonably expected to "improve" a claimant's condition.

A claimant may be found at MMI "as a matter of law" if "he or she refuses to submit to the only treatment currently proposed to improve his or her condition." *MGM Supply Co. v. Industrial Claim Appeals Office,* 62 P.3d at 1001; *see also Neidens v. Firewall Forward Aircraft Engines, Inc.,* WC 4-553-056 (ICAO August 10, 2005).

Claimant's argument notwithstanding, the ALJ concludes there is no ambiguity or conflict between the DIME physician's (Dr. Hughes's) written report and his deposition testimony. Rather, as determined in Finding of Fact 25, Dr. Hughes found Claimant reached MMI on August 17, 2011 because Claimant was declining to undergo a TKR, the only medical treatment that offered a reasonable prospect for improving his condition. Put another way, Dr. Hughes found Claimant reached MMI on August 17 as "a matter of law." As determined in Finding of Fact 26 Dr. Hughes's deposition testimony did not establish any ambiguity or conflict with his written report. Rather, Dr. Hughes merely asserted that if, at some future date, Claimant changed his mind about undergoing TKR surgery his MMI "status" would change. Dr. Hughes's testimony did not retract or contradict his December 30, 2011 finding that Claimant was at MMI on August 17, 2011.

It follows that Dr. Hughes, as the DIME physician, found that Claimant reached MMI for his March 2010 industrial injury on August 17, 2011. In these circumstances Claimant bears the burden of proof to overcome Dr. Hughes's opinion by clear and convincing evidence. *Rainwater v. Sutphin*, WC 4-815-042-04 (ICAO September 9, 2014).

OVERCOMING DIME BY CLEAR AND CONVINCING EVIDENCE

Claimant does not advance any persuasive argument that he overcame by clear and convincing evidence Dr. Hughes's opinion that he reached MMI on August 17, 2011. Rather, the bulk of Claimant's argument in his position statement assumes that the Respondents bear the burden of proof to overcome the DIME opinion. Regardless, the ALJ concludes Claimant failed to overcome by clear and convincing evidence Dr. Hughes's opinion that he reached MMI on August 17, 2011.

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. 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. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The question of whether the party challenging the DIME physician's finding regarding MMI has overcome the finding by clear and convincing evidence is one of fact for the ALJ.

As determined in Finding of Fact 30, Claimant did not overcome by clear and convincing evidence Dr. Hughes's finding that he reached MMI on August 17, 2011. Rather, Dr. Hughes essentially found that as of August 11 Claimant reached MMI as a matter of law because he declined a TKR, the only treatment with a reasonable prospect for improving his condition. Dr. Hughes's finding of MMI is corroborated by the credible findings and opinions expressed by Dr. Ramaswamy.

Insofar as Claimant argues he "changed his mind" about undergoing the TKR before the DIME, and therefore he was not at MMI on August 17, 2011, the ALJ disagrees. As a matter of fact the ALJ has determined the Claimant did not "change his mind" until after February 15, 2012. The fact that Claimant changed his mind about surgery after February 15, 2012 does not negate the fact that he reached MMI on August 17, 2011, when he declined the TKR. It is of course possible that Claimant's change of mind, or a change in his condition after August 17, 2011 could support reopening the claim for additional medical treatment under § 8-43-303(1), C.R.S. However, Claimant has not framed the issues to include "reopening" and the ALJ does not consider that question.

For these reasons Claimant's request for an order requiring the Respondents to provide a TKR is denied. In light of this determination the ALJ need not address the other issues raised by the parties.

ORDER

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

1. The request for an order requiring Respondents to pay for a total knee replacement is denied.

2. 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: July 16, 2015

DIGITAL SIGNATURE:

David P. Cain

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

ISSUES

Whether the claimant has proven by a preponderance of the evidence that the proposed multi-level cervical fusion surgery recommended by Dr. Sung is reasonable, necessary and causally related to the admitted work injury.

FINDINGS OF FACT

1. The claimant sustained an admitted work related injury involving his cervical spine on January 17, 2012.

2. The claimant fell backwards down some stairs striking his back, neck and head.

3. The claimant was referred to Emergicare Medical Clinic for treatment related to the cervical spine injury. The authorized treating physician at Emergicare was Dr. Reasoner.

4. Dr. Reasoner referred the claimant for physical therapy and chiropractic therapy. Dr. Reasoner also provided medications and other conservative care in an effort to cure and relieve the effects of the claimant's cervical injury.

5. Despite conservative care, the claimant continued with chronic neck pain, pain and numbness in both upper extremities, with left upper extremity weakness and atrophy. Dr. Reasoner referred the claimant to Dr. Roger Sung, an orthopedic surgeon, for a surgical consultation.

6. Dr. Sung's initial assessment on February 14, 2013 included cervical degenerative disk disease, neck pain and cervical stenosis. Dr. Sung noted that the claimant presented with significant limited range of motion, secondary to pain with atrophy and weakness in the left triceps, and decreased sensation and weak grip strength in the left upper extremity.

7. The claimant returned to Dr. Sung on February 28, 2013. The claimant continued with left arm symptoms including pain and numbness and right upper extremity pain, weakness identified as first, second and third digit pain. In this report, Dr. Sung notes that the claimant "...is still very limited in both extremities."

8. In his medical report of February 28, 2013, Dr. Sung notes prior electro-diagnostic studies demonstrating acute left C7 radiculopathy and mild left ulnar neuropathy. MRI findings demonstrated degenerative changes from C3 to T1 with bulging at every level and severe left neuroforaminal stenosis at C6-7 on the left. At this time, Dr. Sung indicated that he was contemplating performing surgery at the C6-7 level.

9. Dr. Sung's medical report of March 20, 2013 indicates that Dr. Sung and the claimant discussed options of either a one level surgery or doing multiple levels. Dr. Sung indicated that the claimant's request for the multi-level fusion is reasonable.

10. The claimant testified that surgical authorization for a multi or five level cervical fusion was requested subsequent to Dr. Sung's March 20, 2013 evaluation. Surgical authorization was denied by the respondent-insurer.

11. The claimant underwent an independent medical evaluation with Dr. David Wong of Denver Spine Surgeons. The date of evaluation was April 26, 2013.

12. Dr. Wong's medical report notes that the claimant presented with aching and sometimes sharp pain in the neck with radiation to both upper extremities. Dr. Wong further notes the claimant has had treatment through analgesic anti-inflammatory medication, activity modification, physiotherapy and epidural steroids without resolution. Dr. Wong's medical report indicates that the claimant's overall symptom level has not improved and is slightly worse.

13. Dr. Wong assessed that the claimant's surgical options include the C3 to T1 procedure or a two level procedure at C6-7 and C7-T1. Dr. Wong's report states that the pros and cons of the options were reviewed with the claimant and the claimant was leaning towards the multi-level procedure discussed with Dr. Sung. Dr. Wong concludes that either surgical procedure is an option for the claimant's consideration.

14. The respondents referred the claimant to Dr. Klajnbart for an independent medical evaluation. Dr. Klajnbart evaluated the claimant on October 21, 2013. Dr. Klajnbart was deposed on April 15, 2014. Dr. Klajnbart notes that the claimant has failed non-operative treatment including injections, activity modification, manual medicine and medications. Dr. Klajnbart concludes that the proposed surgical fusion procedure involving C3 through T1 is a reasonable approach to address the claimant's neck pain and left upper extremity weakness. More specifically, Dr. Klajnbart states that the proposed procedure is medically reasonable.

15. Dr. Klajnbart acknowledged that performing a five level cervical fusion would be a medical reasonably procedure for the claimant, given his condition. Dr. Klajnbart acknowledged that he is familiar with Dr. Sung, stating that Dr. Sung is a very competent physician.

16. The claimant returned to Dr. Sung on January 29, 2015. At that time, an updated MRI of the cervical spine was available for Dr. Sung's review. Dr. Sung's medical report of that date notes ongoing bilateral arm pain and numbness, particularly pain, numbness and weakness in the left upper extremity. Despite having an ulnar nerve transposition surgery in October, 2014, the claimant continued with significant weakness.

17. Dr. Sung's medical report of January 29, 2015 indicates that x-rays were obtained on that date demonstrating C3-T1 severe degenerative disk disease and varying degrees of stenosis from C3 to T1, most significant at C4-5, C5-6 and C6-7. Dr. Sung's assessment at that time included C3-7 stenosis with degenerative disk disease and multiple herniated nucleus pulposus, left arm weakness and atrophy, and radiculopathy.

18. On January 29, 2015, Dr. Sung again noted significant atrophy and concluded that limiting the surgical fusion to only a few levels would not adequately address the entire problem and would set up the claimant for more complex revision surgery. Dr. Sung recommended addressing all levels, surgically, from C3 to T1.

19. In preparation for surgery, Dr. Sung advised that the claimant would require smoking cessation, further noting that the claimant did quit for the original surgery and is very comfortable that he could stop smoking immediately in preparation for surgery.

20. Dr. Jeffrey Sabin conducted an independent medical evaluation at the request of the respondents on April 22, 2015. As part of the evaluation, Dr. Sabin conducted a records review and also a physical examination of the claimant.

21. As part of the records review, Dr. Sabin references psychological notes from Dr. Evans dated April 1, 2013 in which Dr. Evans notes that there are no obvious psychological factors that would preclude the claimant's candidacy for the proposed surgery. At that time, the proposed surgery was for the multi or five level cervical fusion.

22. Dr. Sabin states that there is no history either through medical records or patient history to establish any preexisting cervical injury, pain or related symptoms to the upper extremities. Dr. Sabin concluded that any symptoms experienced by the claimant would be related to the work injury of January 17, 2012.

23. Dr. Sabin concludes that the claimant's work injury caused his symptomatology. More specifically, Dr. Sabin concludes that within "reasonable degree of medical probability it is the fall which caused an exacerbation of preexisting asymptomatic cervical spondylosis."

24. By deposition, Dr. Sabin testified that it is more likely than not that the claimant would need more surgery if he had just one level done because of the stresses that are going to be imparted to the adjacent levels. Dr. Sabin notes that Dr. Sung initially considered a one level fusion and later recommended a multi-level fusion because of the effect on adjacent levels if only a single level is fused. Dr. Sabin concluded that Dr. Sung's recommendation for the multi-level fusion surgery is reasonable.

25. Dr. Sabin testified that proceeding with a single or multi-level fusion is a very personal, very individualized decision. Dr. Sabin confirmed that the claimant had met with Dr. Sung on at least four or five occasions and there was considerable discussion between Dr. Sung and the claimant regarding the pros and cons of the multi-level fusion surgery. Dr. Sabin further acknowledges that there was nothing in Dr. Sung's medical records to support or suggest that the claimant's desire to go forward with the multi-level fusion surgery was not given due consideration.

26. Dr. Sabin acknowledged that the claimant was cooperative and gave full effort during the examination. Dr. Sabin confirmed that the claimant presented as credible and there was no evidence of any preexisting symptoms or treatment involving the cervical spine or upper extremities.

27. Dr. Sabin agreed that all evaluating physicians, including Dr. Sung, Dr. Wong and Dr. Klajnbart, concluded that the five level cervical fusion was medically reasonable. In this regard, Dr. Sabin acknowledged that the five level cervical fusion is medically reasonable.

28. In his deposition, Dr. Sabin concluded that any cervical symptoms experienced by the claimant would be related to the work injury of January 17, 2012.

29. Dr. Sabin further agreed that the injury sustained by the claimant on January 17, 2012 either aggravated or accelerated or combined with his asymptomatic condition to the cervical spine to cause his need for treatment, including surgery.

30. In regards to the issue of future surgery subsequent to either a single or multi-level surgery, Dr. Sabin admitted that, percent wise, the claimant is more likely to require more surgeries after a one or two level fusion because of the compromised nature of the unfused levels.

31. With regards to the issue of smoking cessation, Dr. Sabin acknowledged that this issue is best left up to Dr. Sung and the claimant and more specifically to the surgeon in regards to whether there has been compliance with smoking cessation.

32. The ALJ finds the opinions and analyses of Dr. Sung and Dr. Sabin to be credible and more persuasive than analyses and opinions to the contrary.

33. The ALJ finds that the claimant has established that it is more likely than not that the multi-level fusion recommended by Dr. Sung is reasonable, necessary and related to the claimant's industrial injury of January 17, 2012.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado in §8-40-101, et. seq. C.R.S. (2013) 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).

2. A worker's compensation case is decided upon its merits. See §8-43-102, C.R.S.

3. Facts in a workers' compensation case must be interpreted neutrally neither in favor of the rights of a claimant nor in favor of the rights of the respondents. See §8-43-201, C.R.S.

4. The Judges' factual findings concern only evidence that is dispositive of the issues involved: the Judge cannot address every piece of evidence that might lead to a conflicting result. See *Magnetic Engineering, Inc. v. ICAO*, 5. P.3d 285 (Colo. App. 2000).

5. When determining credibility the fact finder should consider among other things the consistency or any inconsistencies of the witnesses testimony or actions; the reasonableness or unreasonableness (probability or improbability) of the testimony or actions; the motive of the witness: and whether the testimony would have been contradicted and bias, prejudiced, or in any. See *Impure Prudential Insurance Co. v. Coin*, 57 P.2d 1205 (1936).

6. The 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 (Colo. 1994). 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 Parker,* W.C. No. 4-517-537 (ICAO, May 31, 2006); *In re Frazier,* W.C. No. 3-920-202 (ICAO, Nov. 13, 2000)

7. It is solely within the ALJ's discretionary province to weigh the evidence and determine the credibility of expert witnesses. *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964 (Colo. App. 2012).

8. **The respondents are required to furnish such medical and surgical treatment as may reasonably be needed at the time of injury and thereafter during the disability to cure and relieve the employee from the effects of the injury. (§8-42-101 (1)(a) C.R.S). Respondents assert that they are only liable for that portion of medical benefits that is attributable to the claimant's work related injury and not**

for any portion purportedly attributable to the claimant's preexisting spinal condition. This issue has been addressed on multiple occasions by Colorado Courts, including Resources One, LLC. v. Industrial Claim Appeals Office, 148 P.3d 287 (Colo. App. 2006); National Union and Fire v. Industrial Claims Appeals Office, WC 4-421-787; 4-829-364; Duncan v. Industrial Claims Appeals Office, 107 P.3d 999, (Colo. App. 2004); Geist v. Liberty Mutual Group, (Industrial Claims Appeals Office - WC No. 4-839-225).

9. The Colorado Court of Appeals noted that an employer is generally liable for the entire disability that results from a compensable accident. Resources One, LLC v. Industrial Claims Appeals Office, 149 P.3d 287 (Colo. App. 206) More specifically, where an 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. Geist v. Liberty Mutual Group, (Industrial Claims Appeals Office - WC No. 4-839-225), H&H Bicory, 805 P.2d 1167 (Colo. App. 1990). (Cited by Industrial Claims Appeals Office in National Union and Fire, WC 4-421-787, 4-829-364).

10. In this matter, the claimant has no preexisting history of neck pain, upper extremity weakness or pain, or any functional limitations related to his cervical spine. The respondents own independent medical evaluators conclude the claimant's work injury did cause the resulting symptomatology involving the cervical spine, upper extremities and eventual need for cervical fusion surgery. While there is some medical opinion that claimant's work injury caused an acute injury only to the C6-7 level, the respondents remain liable for the entire disability or need for treatment that results from the claimant's compensable injury. Resources One, LLC v. Industrial Claims Appeals Office, 149 P.3d 287 (Colo. App. 206), H&H Bicory, 805 P.2d 1167 (Colo. App. 1990). (Cited by Industrial Claims Appeals Office in National Union and Fire, WC 4-421-787, 4-829-364).

11. The ALJ concludes that the opinions and analyses of Dr. Sung and Dr. Sabin are credible and more persuasive than analyses and opinions to the contrary.

12. The ALJ concludes that the claimant has established by a preponderance of the evidence that the multi-level fusion recommended by Dr. Sung is reasonable, necessary and related to the claimant's industrial injury of January 17, 2012.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The respondent-insurer shall authorize and pay for the multi-level fusion surgery as recommended by Dr. Sung.

2. The respondent-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, 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: July 23, 2015

/s/ original signed by:
Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
12459 Lake Plaza Dr Ste 230
Colorado Springs, CO 80906

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-896-875-03

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Self-Insured Respondent.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on June 24, 2015, in Denver, Colorado. The hearing was digitally recorded (reference: 6/24/15, Courtroom 4, beginning at 8:30 AM, and ending at 11:35 AM).

Claimant's Exhibits 1 through 16 were admitted into evidence, without objection. Respondent's Exhibits A through I were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant. The proposed decision was filed, electronically, on June 26, 2015. On June 29, 2015, counsel for the respondent indicated no objection as to form. After a consideration of the proposed decision, the ALJ has modified the proposal and hereby issues the following decision.

ISSUES

The matter is set, primarily, on the Respondent's application to overcome the Division Independent Medical Examiner's (DIME's) [Franklin Shih, M.D.] determination that the Claimant sustained a14% whole person impairment to her cervical spine. Additional issues concern whether the Claimant is entitled to a permanent scheduled

rating for her left lower extremity (LLE); whether she is entitled to a permanent scheduled rating for her right upper extremity (RUE); and whether she is entitled to post maximum medical improvement (MMI) maintenance medical benefits (*Grover* medicals).

The Respondent bears the burden of proof, by clear and convincing evidence, to overcome Dr. Shih's DIME opinions on degree of whole person impairment and MMI. The Claimant bears the burden, by preponderant evidence, concerning scheduled ratings for the LLE and RUE, and for entitlement to post-MMI medical maintenance benefits (*Grover* medicals).

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

Preliminary Findings

1. The Claimant worked for the Employer as a paraprofessional. As part of her duties, she worked with special needs students, including those with profound disabilities.

2. On August 30, 2012, the Claimant was transporting students after a school program when she was involved in a motor vehicle accident (MVA) at the intersection of Santa Fe Drive (Colorado Highway 85) and Meadows Boulevard in Castle Rock. The Claimant was trapped in the vehicle and was then extricated by Castle Rock Fire and Rescue.

3. The Claimant waited with her students at the accident scene and then went to the Emergency Department (ER) at Castle Rock Adventist Health. She felt pain in her LLE and RUE. X-rays were taken at the hospital. The Claimant was diagnosed as suffering a left comminuted distal radius fracture, left lower leg crush injury, right lower leg laceration, right upper arm strain and right forearm strain.

Medical Treatment

4. The Claimant was referred to Sharon Walker, M.D., who was designated as the authorized treating physician (ATP) by the Respondent. Dr. Walker saw the Claimant the next day on August 31, 2012, noting that the Claimant's complaints involved the neck, left lower back, left wrist, left elbow, right knee, right lower leg, left jaw and right arm. Dr. Walker's records, which were admitted into evidence as Claimant's Exhibit 2 documented pain in those areas. Dr. Walker prescribed Ibuprofen, Cyclobenzaparine, Percocet and gave the Claimant a prescription for a wheelchair. Dr. Walker also referred the Claimant to In Sok Yi, M.D., a hand surgeon for an evaluation.

5. Dr. Yi's diagnosis was left distal radius fracture. The Claimant underwent surgical repair (open reduction and internal fixation) of her left wrist, which was performed by Dr. Yi on September 5, 2012. Dr. Yi's records were admitted into evidence as Claimant's Exhibit 3.

6. The Claimant next saw Dr. Walker on September 7, 2015, and Dr. Walker provided treatment for a left corneal abrasion and referred the Claimant for physical therapy (PT).

7. The Respondent filed its first General Admission of Liability (GAL) on September 12, 2012, admitting for wage indemnity and medical benefits under the Colorado Worker's Compensation Act (Claimant's Exhibit 4, page 17). This GAL admitted for an average weekly wage (AWW) of $369.04, which was subsequently changed to a higher AWW.

8. A MRI (magnetic resonance imaging) was taken of the Claimant's right knee on September 12, 2012. The indication on the MRI was right knee pain, swelling, instability and clicking two weeks after motor vehicle crash. The MRI documented a "significant subcutaneous hematoma formation just anterior to the patellar tendon insertion on the tibial tubercle". The MRI documented an auterolateral tibia impaction injury with bowing on the articular surface. The MRI was negative for gross linear meniscal tear and cruciate ligament disruption (Claimant's Exhibits 3 and 9).

9. Dr. Walker referred the Claimant to Peak Orthopedics. The Claimant was evaluated by Michael Hewitt M.D. on September 26, 2012. Dr. Hewitt diagnosed tibial plateau fracture and noted that the fracture was nondisplaced. He recommended conservative treatment and placed the Claimant into a knee brace (Claimant's Exhibit 7).

10. A Revised GAL was filed on September 26, 2012, admitting for a higher average weekly wage (AWW), $543.39 (Claimant's Exhibit 4, page 16). This AWW was admitted in the Final Admission of Liability (FAL).

11. The Claimant received treatment from chiropractor Dr. Jason Gridley, D.C., from November 14, 2012 through December 19, 2012. She was chiropractically diagnosed as suffering from a cervicothoracic strain with muscle spasm.

12. An Amended GAL was filed on November 7, 2012, reflecting Claimant's return to modified work on October 22, 2012, and variable temporary partial disability (TPD) benefits from October 22, 2012 to "unknown."

<u>Additional Medical Evaluations</u>

13. According to the Claimant, other physicians in Dr. Walker's office provided her with care in late 2012.

14. The Claimant was evaluated by Sander Orent, M.D. on December 3, 2012. Dr. Orent noted that the Claimant continued to have pain complaints in her knee, stiffness in her neck and left wrist. Dr. Orent released the Claimant to work eight hours per day.

15. The Claimant was evaluated on December 17, 2012, by John Raschbacher, M.D., whose assessment was: left radius fracture, right leg laceration and crush injury, left corneal abrasion, cervical strain, with numerous other injuries. Dr. Raschbacher ordered a recheck on January 3, 2013.

16. On January 29, 2013, Dr. Walker saw the Claimant again and Dr. Walker assessed left comminuted distal radius fracture, right lower leg crush injury, right lower leg laceration, right upper arm strain, right forearm strain, left corneal abrasion, cervical strain, right tibial plateau fracture and right leg vascular insufficiency. The Claimant was also noted to have some anxiety related to the MVA and physical therapy was discontinued at that time. The Claimant was continued on modified duty at work.

17. The Claimant's next evaluation with Dr. Walker was on February 26, 2013, at which time the aforementioned diagnoses were identified. Dr. Walker anticipated maximum medical improvement (MMI) in two weeks.

Dr. Walker's Impairment Rating

18. Dr. Walker performed an impairment rating on March 13, 2013. Dr. Walker assigned an 8% scheduled RUE rating and a 0% LLE rating. Dr. Walker assigned no rating for Claimant's cervical spine, despite the fact that pain in the cervical spine was noted as one of the Claimant's chief complaints, and Dr. Walker's assessment included cervical strain. Dr. Walker assigned an MMI date of March 13, 2013. The ALJ infers and finds that Dr. Walker failed to rate the cervical spine due to an oversight.

19. Dr. Walker stated the opinion that for maintenance care, the Claimant should be allowed to continue her gym membership that was already put into place. Dr. Walker also stated that the Claimant's HGV stimulation unit should be purchased and supply should be provided for one year. Dr. Walker further was of the opinion that the Claimant should be allowed to maintenance visits as needed within one year with both Dr. Hewitt and Dr. Yi.

The Final Admission of Liability (FAL)

20. The Respondent filed a FAL on April 12, 2013, admitting for Dr. Walker's MMI date of March 13, 2013,, zero whole person permanent impairment, zero scheduled impairment of the LLE and 8% scheduled impairment of the RUE (Respondent's Exhibit B). The Claimant filed a timely objection and requested a Division independent Medical Examination (DIME).

The Division Independent Medical Examination (DIME)

21. Franklin Shih, M.D. was selected as the DIME and as a member of the DOWC IME panel, Dr. Shih was fully Level II accredited. Dr. Shih evaluated the Claimant on June 11, 2013. At that time, he noted that the Claimant was not at MMI. He recommended further diagnostic testing and treatment. He made a tentative assessment of the Claimant's permanent impairment, assigning an11% whole person impairment for her cervical spine, which included aTable 53 impairment and a loss of range of motion (ROM). Dr. Shih assigned a 2% scheduled impairment to the right knee and a 4% scheduled impairment to the left wrist (Claimant's Exhibit 10 and Respondent's Exhibit D). After his follow up DIME of February 17, 2015, Dr. Shih increased the tentative ratings, after determining that the Claimant had reached MMI on October 15, 2014.

22. The Respondent filed a new GAL on June 5, 2013 and additional treatment was provided to the Claimant (Respondent's Exhibit A).

23. A second MRI of the Claimant's knee was done on October 22, 2013 (Respondent's Exhibit H.) The MRI noted that there was sequelae of the prior anterolateral tibial plateau fracture. Chondral thinning along the far interior margins of the plateau was noted and there was a small area of chondral fissuring with minimal subcortical reactive marrow-type change/residual subcortical cystic change noted. Quadriceps and patellar tendons showed mild tendinosis/tendinopathy change. Mild pre-patellar soft tissue edema was noted (Respondent's Exhibit H).

Subsequent Medical Evaluations and Treatment

24. The Claimant was evaluated on November 5, 2013 by John Sacha, M.D., who diagnosed: (1) cervical facet syndrome; (2) headaches secondary to number 1; (3) left radial wrist fracture resolved; (4) right tibial plateau fracture; and (5) history of facial and extremity contusions and abrasions. Dr. Sacha recommended a right C2-5 intra-articular facet injection to be diagnostic, therapeutic and also for causality (Claimant's Exhibit 11).

25. Neil Pitzer, M.D., saw the Claimant on November 20, 2013 for persistent numbness in her hand and palm. An EMG was performed at that time, which documented no median neuropathy at this forearm (Claimant's Exhibit 12).

26. Dr. Sacha again evaluated the Claimant on April 28, 2014, and he recommended a right C2-5 medial branch block. This was performed on July 3, 2014. Dr. Sacha noted a therapeutic response to the treatment. He also recommended that the Claimant receive PT, which she received at Select Physical Therapy (Claimant's Exhibit 14).

27. Dr. Sacha again examined the Claimant on September 22, 2014, at which time the Claimant reported 70% improvement. MMI was anticipated in approximately three weeks.

28. Dr. Sacha responded to an inquiry sent by the TPA on September 30, 2014, noting that the Claimant had not reached MMI as of that date. The Claimant had just started her PT after the radial frequency protocol for her cervical spine, which was anticipated and completed within three weeks (Claimant's Exhibit 15).

29. Dr. Sacha concluded that the Claimant reached MMI when he examined her on November 3, 2014.

Dr. Shih's Follow Up DIME

30. The Claimant underwent a follow-up DIME, which was performed by Dr. Shih on February 27, 2015. Dr. Shih concluded that Claimant reached MMI as of October 15, 2014 and had a permanent medical impairment of the cervical spine, left upper extremity (LUE) and right lower extremity (RLE). He assigned a 14% whole person impairment of the spine, which included a Table 53 rating of 7% and an additional 8% impairment, based upon range of motion.

31. For the Claimant's LUE, he assigned a 3% scheduled rating.

32. Dr. Shih noted that his analysis for the right knee (RLE) remained the same and she would have no impairment for range of motion. Impairment was warranted given the plateau fracture, with depression noted on imaging. Dr. Shih stated: "I would utilize Table 40, Subsection 5 for arthritis, which I would place at 5% lower extremity . . ."

Independent Medical Examination (IME) by Carlos Cebrian, M.D.

33. The Respondent sent the Claimant for an IME with Dr. Cebrian, which took place on June 4, 2015. Dr. Cebrian was called as a witness by the Respondent at the hearing. He testified as an expert. H he is board certified in family practice and fully Level II Accredited.

34. In his report (Respondent's Exhibit H), Dr. Cebrian noted that the Claimant's current complaints were cervical spine, left wrist and right leg pain. He agreed with Dr. Shih's determination that Claimant reached MMI on October 15, 2014.

With regard to the Claimant's cervical spine, Dr. Cebrian was of the opinion that he would have anticipated the Claimant's impairment rating to be lower, since she received treatment after Dr. Shih's first DIME. Such an opinion is speculative and without foundation in objective medicine. Dr. Cebrian conceded that the ROM testing done by Dr. Shih in his evaluation on February 17, 2015 was valid, pursuant to the *AMA Guides to the Evaluation of Permanent Impairment*, 3rd Ed., Rev. (hereinafter referred to as the "AMA Guides").

35. Dr. Cebrian also disagreed with Dr. Sacha that there was facet pathology which required treatment. According to Dr. Cebrian, the medical records documented pain relief after the facet injection, which Dr. Cebrain acknowledged. Nonetheless, Dr. Cebrian's opinion in this regard is speculative and without foundation in objective medicine.

36. Dr. Cebrian disagreed with Dr. Shih's assessment of a 5% impairment to the Claimant's right knee. He agreed that the ROM did not require an impairment, but he stated the opinion that there was no evidence of post-traumatic arthritis with findings such as inflammation and swelling of the joint. The ALJ finds that Dr. Cebrian's opinion in this regard is partially speculative and without ample support in the totality of the Claimant's medical case. Consequently, Dr. Shih's opinion in this regard is considerably more credible than Dr. Cebrian's opinion.

37. Dr. Cebrian assessed a 2% scheduled impairment rating for the Claimant's left wrist. This represents a mere difference of opinion whereby Dr. Cebrian's opinion is insufficiently supported by the totality of the evidence. The Respondent made a judicial admission that Dr. Shih's 3% rating with regard to the left wrist was supported by a preponderance of the evidence.

38. According to the Claimant, she continues to experience swelling and clicking in the right knee. She estimated that the swelling occurs at least once a week and the clicking occurs when she uses her knee.

39. According to the Claimant, her injuries have limited her activities, including the playing and coaching softball. She has also not been able to participate in water sports, including waterskiing because of her physical limitations.

Ultimate Findings

40. The ALJ finds the Claimant's testimony credible and un-impeached. Further, the ALJ finds the opinions of DIME Dr. Shih more credible and persuasive than the opinions of IME Dr. Cebrian because Dr. Shih's opinions are more consistent with the totality of the medical evidence and the product of a more thorough treatment of the Claimant's medical case.

41. The ALJ makes a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Shih and to reject any and all opinions to the contrary.

42. The Respondent has failed to prove that it is highly probable, unmistakable and free from serious and substantial doubt that Dr. Shih's ultimate opinion, rating the Claimant's whole person impairment for the cervical spine at 14% whole person, with a final MMI date of October 15, 2014, was in error. Therefore, the Respondent failed to overcome Dr. Shih's DIME opinions, in this regard, by clear and convincing evidence. Dr. Cebrian maintains a mere difference of opinion with Dr. Shih, and even that difference of opinion is not that well supported by the aggregate medical record.

43. Dr. Shih, in the follow up DIME, rated the Claimant's LUE at 3% of the LUE, and the respondent made a judicial admission that this rating was appropriate.

44. The Claimant has proven, by preponderant evidence, that Dr. Shih's 5% scheduled rating for the RLE is adequately supported by the totality of the medical record, appropriate and, therefore, the Claimant is entitled to a 5% rating for the RLE.

45. The Claimant has proven, by a preponderance of the evidence, that post-MMI medical maintenance care is warranted in the discretion of the Claimant's ATPs.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or

inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* S 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, *See, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury,* 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. As found, the Claimant's testimony was credible and un-impeached. Further, as found, the opinions of DIME Dr. Shih were more credible and persuasive than the opinions of IME Dr. Cebrian because Dr. Shih's opinions were more consistent with the totality of the medical evidence and the product of a more thorough treatment of the Claimant's medical case.

Substantial Evidence

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, The ALJ made a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Shih and to reject any and all opinions to the contrary.

Overcoming the DIME on Degree of Whole Person Impairment

c. The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Indus.*

Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000). *Also see Leprino Foods Co. v. Indus. Claim Appeals Office,* 134 P.3d 475 (Colo. App. 2005). The DIME physician's determination of MMI is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); *See also Peregoy v. Indus. Claim Appeals Office,* 87 P.3d 261 (2004); and § 8-42-107(b)-(c), C.R.S. *Also see Whiteside v. Smith,* 67 P.3d 1240 (Colo. 2003). Where the threshold determination of compensability is not an issue, a DIME physician's conclusion that an injured worker's medical problems were components of the injured worker's overall impairment constitutes a part of the diagnostic assessment that comprises the DIME process and, as such the conclusion must be given presumptive effect and can only be overcome by clear and convincing evidence. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Leprino Foods Co. v. Indus. Claim Appeals Office,* 134 P.3d 475, 482 (Colo. App. 2005); *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 400 (Colo. App. 2009). "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. *Metro Moving & Storage Co. v. Gussert, supra; Leming v. Indus. Claim Appeals Office,* 62 P.3d 1015, 1019 (Colo. App. 2002). In other words, a DIME physician's finding may not be 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 [Indus. Claim Appeals Office (ICAO), Oct. 4, 2001]. 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); *see Shultz v. Anheuser Bush, Inc.,* W.C. No. 4-380-560 (ICAO, Nov. 17, 2000). As found, the Respondent failed to prove that it is highly probable, unmistakable and free from serious and substantial doubt that Dr. Shih's ultimate opinion, rating the Claimant's whole person impairment for the cervical spine at 14% whole person, with a final MMI date of October 15, 2014, was in error. Therefore, the Respondent failed to overcome Dr. Shih's DIME opinions, in this regard, by clear and convincing evidence. Dr. Cebrian maintains a mere difference of opinion with Dr. Shih, and even that difference of opinion is not that well supported by the aggregate medical record.

Judicial Admission of 3% LUE Rating

d. A judicial admission is defined as a "formal, deliberate declaration that a party or his or her counsel makes in a judicial proceeding for the purpose of dispensing with proof of formal matters or facts about which there is no real dispute." *Kempter v. Hurd,* 713 P.2d 1274 (Colo. App. 1986); *Gen. Steel Domestic Sales, LLC v. Hogan & Hartson, LLP,* 230 P.3d 1275, 1283 (Colo. App. 2010). Judicial admissions must be unequivocal but become binding once they are made. *Salazar v. American Sterilizer Co.,* 5 P.3d 357 (Colo. App. 2000). *Also see Valdez v. Texas Roadhouse,* W.C. No. 4-366-133 [Industrial Claim Appeals Office (ICAO), January 25, 2001]. Stipulations are a form of judicial admission and are binding on the party who makes them. *Maloney v, Brassfield,* 251 P.3d 1097, 1108 (Colo. App. 2010). As found, the Respondent made a

judicial admission that Dr. Shih's 3% rating for the LUE was appropriate. Therefore, the Claimant is entitled to a 3% rating for the LUE.

Scheduled and Whole Person ratings May not be Combined

e. Section 8-42-107 (7) (b) (II), C.R.S., provides that scheduled and whole person losses shall be compensated separately. As found, the Claimant sustained a 14% whole person rating, a 3% LUE rating, and a 5% RLE rating, all of which must be awarded separately, which must be awarded separately.

Post-MMI Maintenance Medical Benefits

f. An employee is entitled to continuing medical benefits after MMI if reasonably necessary to relieve the employee from the effects of an industrial injury. *See Grover v. Indus. Comm'n of Colorado*, 759 P.2d 705 (Colo. 1988). The record must contain substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve a claimant from the effects of an injury or to prevent further deterioration of his condition. *Stollmeyer v. Indus. Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Indus. Comm'n, supra*. Such evidence may take the form of a prescription or recommendation for a course of medical treatment necessary to relieve a claimant from the effects of the injury or to prevent further deterioration. *Stollmeyer v. Indus. Claim Appeals Office, supra*. An injured worker is ordinarily **entitled to a general award of future medical benefits**, subject to an employer's right to contest causal relatedness and reasonable necessity. *See Hanna v. Print Expediters,* 77 P.3d 863 (Colo. App. 2003). As found, the Claimant is entitled to maintenance medical care, as determined by her ATPs, which is reasonably necessary to address her injuries.

Burden of Proof

g. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits beyond those admitted. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P.2d 535 (Colo. App. 1992). 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,* 197 Colo. 306, 592 P. 2d 792 (1979). *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v.*

Principi, 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained her burden with respect to the 3% rating for the LUE; the 5% rating for the RLE; and, with respect to post-MMI maintenance medical benefits as dictated by the Claimant's ATPs.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Respondent shall pay the costs of all causally related and reasonably necessary post-maximum medical improvement maintenance medical benefits, as determined to be appropriate by her authorized treating physicians, subject to the Division of Workers Compensation medical Fee Schedule.

B. The Respondent shall pay the Claimant permanent whole person medical impairment benefits, based on 14% whole person, attributable to the cervical spine, from October 15, 2014, the date of maximum medical improvement, and continuing until paid in full.

C. The respondent shall pay the Claimant permanent scheduled impairment benefits, based on 3% of the left upper extremity and 5% of the right lower extremity, from October 15, 2014, and continuing until paid in full.

D. The Respondent is entitled to a credit for any permanent scheduled impairment benefits previously paid.

E. The Respondent shall pay the Claimant statutory interest at the rate of eight per cent (8%) per annum on all amounts due and not paid when due.

DATED this_____day of July 2015.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

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, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 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 form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order** on this_____day of February 2015, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

Division of Workers' Compensation
DIME Unit
Lori.Olmstead@state.co.us

_____
Court Clerk

Wc.ord

ISSUES

I. Whether Claimant has proven by a preponderance of the evidence that she is entitled to maintenance medical treatment in the form of a venous Doppler ultrasound, a triple phase bone scan and evaluation by a vascular (vein) specialist as maintenance care. The question to be answered is whether the recommended diagnostic testing and specialist evaluation are reasonable, necessary and related to claimant's November 24, 2012 industrial injury.

II. Whether Claimant is entitled to additional compensation for serious permanent disfigurement.

FINDINGS OF FACT

Based upon the evidence presented, including the deposition testimony of Drs. McFadden and Thurston, the ALJ enters the following findings of fact:

1. On November 24, 2012 Claimant sustained admitted injuries to her left knee after falling from a ladder at work.

2. A course of conservative care proved unsuccessful in ameliorating Claimant's condition. Consequently, she was referred for an orthopedic evaluation with Dr. Wily Jinkins. On April 18, 2013, Dr. Jinkins performed a diagnostic arthroscopy of the left knee during which the following procedures were performed: a patella chondroplasty, a lateral femoral condyle chondroplasty, microfracture subchondral plate, resection of synovial shelf and injection with primary portal closure.

3. On May 3, 2013 Claimant developed a sudden onset of cramping in her left calf which she was unable to relieve. She sought treatment in the emergency room of Memorial Hospital where a Venous Doppler study revealed a "clot in the left popliteal vein and gastrocutaneous veins." Subsequent pulmonary imaging demonstrated "small bilateral pulmonary emboli" characterized as mild, nonspecific patchy ground glass opacity bilaterally. Claimant was assessed with left lower extremity deep vein thrombosis (DVT) and pulmonary emboli (PE). Dr. William Kimble admitted Claimant to the hospital for additional treatment noting that the DVT and PE were "probably related to her recent left knee surgery."

4. On September 10, 2013, Dr. Jinkins opined that Claimant's DVT was related to her surgery of April 18, 2013. He also felt that Claimant was still in need of further treatment for the same. Claimant was placed on a prolonged course of anti-coagulant medication therapy.

5. A second venous duplex imaging of the left leg on January 10, 2014 revealed no evidence of persistent DVT.

6. At a return appointment dated February 7, 2014 Dr. Jinkins noted that although claimant did not have a great deal of calf pain; she had experienced an episode of chest pain while getting out of the bath. He also noted that he had recommended further imaging one week prior to the February 7, 2014 appointment due to the possibility that claimant was "redeveloping a DVT." Dr. Jinkins renewed his request for a venous Doppler ultrasound as "soon as possible at Penrad." Respondents initially denied the request; however, the study was ultimately approved and claimant underwent the recommended Doppler study on May 6, 2014. The study reflected a "continued absence of deep vein thrombosis."

7. Claimant was placed at MMI on June 17, 2014. Claimant subsequently requested a DIME, which was completed by Dr. Lee McFadden on November 6, 2014. In accordance with the DIME opinion, Respondents filed a Final Admission of Liability on December 5, 2014 admitting for 16% lower extremity impairment and post-MMI care.

8. Claimant has received maintenance medical care for her left knee from Dr. Jinkins. On December 16, 2014, Dr. Jinkins recommended a fourth venous Doppler ultrasound for continued pain and persistent swelling in her left lower leg. Respondents denied authorization for the recommended study requesting further that the recommendation be reviewed by Dr. Lloyd Thurston per W.C.R.P. 16-10.

9. In opining that the requested Doppler ultrasound was not reasonable necessary, or related maintenance care, Dr. Thurston opined that claimant's "only current risk factors for DVT are obesity and a prior episode of DVT and that "she had not suffered any recent trauma to her left lower extremity, had not experienced prolonged bed rest or immobilization, was not taking estrogens or any agents which would induce a hypercoaguable state, and had discontinued smoking in February 2014." Consequently, according to his report, the request for additional Doppler study was not reasonable, necessary or related to claimants admitted work injury.

10. Claimant returned to Dr. Jinkins on February 10, 2015 at which time she complained of burning in her left lower leg down to her foot, discomfort to the slightest pressure and significant calf pain and swelling. Dr. Jinkins noted:

> "I told Laura I would still recommend that a venous Doppler ultrasound be accomplished, however, to date, this has not been approved. I would recommend that she have a 3-phase bone scan. There are some physical findings, but also her history is consistent with a component of her present symptomology being sympathetically mediated."

11. Respondents requested that Dr. Jenkins' recommendation for a 3-phase bone scan be reviewed by Dr. Thurston per W.C.R.P. 16-10. In opining that the 3- phase bone scan was not reasonable, necessary, and related maintenance care, Dr. Thurston opined that Claimant's symptoms do not meet the clinical criteria for chronic regional

pain syndrome (CRPS). He further opined that vague descriptions of physical findings do not adequately document edema or "describe symptoms consistent with true allodynia."

12. Based upon careful review of Dr. Thurston's February 16, 2015 report, the ALJ finds, contrary to Dr. Thurston's assessment that Dr. Jinkins descriptions of claimant's ongoing symptoms are sufficiently specific to adequately document clinical findings consistent with a component of claimant's symptoms emanating from a sympathetically mediated cause. Crediting Dr. Jinkins report that claimant has 2+ edema in addition to "burning" and discomfort with the exertion of light pressure, the ALJ finds that claimant has proven, by a preponderance of the evidence, that a triple phase bone scan is reasonably necessary and related to claimant's work injury to further assess whether claimant's ongoing symptoms are sympathetically mediated as no other diagnosis better explains her current signs and symptoms.

13. Respondents requested the deposition of Dr. Lee McFadden, the DIME physician. This deposition occurred on March 31, 2015 and is marked as Respondents' Exhibit G. During his deposition, Dr. McFadden testified that continued calf and foot swelling constitutes a management of a perfusion problem in the leg, which was outside of his purview as an orthopedist. According to Dr. McFadden, claimant's continued swelling may be related to her prior vein issue but because vascular conditions were outside of his area of expertise management of the same would be addressed by "the vascular guys". Dr. McFadden was asked, "Would you recommend that she have an evaluation with a vein specialist?" He replied, "I don't think it's unreasonable" (Respondents' Exhibit G, page 24, lines 16-25 and page 25-26, lines 1-11).

14. Respondents also took the deposition of Dr. Lloyd Thurston, a Family Medicine Practitioner. During his deposition Dr. Thurston testified that he neither evaluates nor treats sympathetically mediated pain/CRPS, nor does he treat DVT or subsequent vein issues related to DVT. While Dr. Thurston indicated that the requested ultrasound would be reasonable, which opinion the ALJ finds constitutes a deviation from that expressed in his December 26, 2014 report, he testified that he did not feel the need for it was related to claimant's industrial injury. As noted by Dr. Thurston, claimant's risk factors for the development of a subsequent DVT are her obesity and her prior episode of DVT. Considering that claimant's obesity was pre-existing and there is, by Dr. Thurston's account an absence of other risk factors that cause hypercoaguable states, the ALJ finds that claimant's prior work related DVT is the most probable cause of any subsequent DVT and the need for additional diagnostic study, i.e. Doppler ultrasound. Consequently, the ALJ finds Dr. Thurston's opinion that the need for the additional ultrasound is unrelated to the "previous injury" unconvincing.

15. Claimant has residual arthroscopic scarring, described as two (2) red, 3/8 semi-circular scars, on either side of the left knee accompanied by mild swelling of the knee in general which alters the natural appearance of her skin and joint in this area.

16. Claimant's testimony regarding her ongoing symptoms and swelling is credible

and convincing. As noted above, the undersigned ALJ viewed the swelling described by claimant first hand during the disfigurement viewing phase of the hearing.

CONCLUSIONS OF LAW

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

General Legal Principals

A. 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. C.R.S. § 8-40-102(1). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of rights of respondents. §8-43-201, C.R.S. (2005). A preponderance of the evidence is that which leaves 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).

B. 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).

C. When determining credibility, the fact finder should consider, among other things the consistency or inconsistency of the witness' 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 (1936). A Workers' Compensation case is decided on its merits. Section 8-43-210, C.R.S. As found, Claimant is a credible witness and his testimony is both persuasive and consistent with the medical records in the case. Furthermore, the ALJ concludes that Dr. Fall's testimony to be contradicted by the more persuasive opinions of Drs. Larimore and Jones.

Medical Benefits

D. The claimant bears the burden of establishing entitlement to medical treatment. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). The claimant is only entitled to benefits as long as the industrial injury is the proximate cause of the claimant's need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). Ongoing benefits may be denied if the current and ongoing need for medical treatment or disability is not proximately caused by an injury arising out of and

in the course of the employment. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997). In other words, the mere occurrence of a compensable injury does not require an ALJ to find that all subsequent medical treatment and physical disability was caused by the industrial injury. To the contrary, the range of compensable consequences of an industrial injury is limited to those which flow proximately and naturally from the injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); § 8-41-301(1)(c), C.R.S. 1997. Based upon the totality of the evidence presented, the ALJ concludes that claimant has proven that the requested diagnostic testing and the need for a vascular evaluation are reasonable, necessary and related to her compensable left knee injury. Although Dr. Thurston opined the request for DVT ultrasound was not reasonable, necessary and related maintenance care, he admitted that Claimant has some risk factors for the development of DVT, including having had a prior DVT culminating in pulmonary emboli (PE) which were treated as work related conditions. Outside of her obesity and having had a prior DVT, Claimant's risk for development of additional DVT appears low based upon the testimony of Dr. Thurston. Yet, Claimant continues to experience symptoms associated with DVT or a sympathetically mediated pain complex. Consequently, the ALJ concludes it is reasonable and necessary, given the morbidity associated with DVT progressing to PE and Claimant's ongoing burning pain and swelling in the skin surrounding her left knee, to proceed with additional diagnostic testing and evaluation in an effort to determine the cause of Claimant's continued symptoms. While the risk for DVT may be low, it does not negate the fact, that the most probable cause of any new DVT is more probably than not related to her prior development of DVT over other causes. Consequently, the ALJ concludes that Claimant has established the requisite causal connection between her need for a Doppler study, a triple phase bone scan and an evaluation with a vascular specialist and her November 24, 2012 industrial injury.

E. The ALJ acknowledges that the Medical Treatment Guidelines (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). While it is appropriate for an ALJ to consider the Guidelines in deciding whether a certain medical treatment is reasonable and necessary for the claimant's condition, *Deets v. Multimedia Audio Visual,* W. C. No. 4-327-591 (March 18, 2005); *see Eldi v. Montgomery Ward* W. C. No. 3-757-021 (October 30, 1998)(medical treatment guidelines are a reasonable source for identifying the diagnostic criteria), the Respondents have not cited any authority, nor is the undersigned aware of any, which requires an ALJ to award or deny medical benefits based on the Guidelines. Indeed the Guidelines permit deviation as individual cases dictate. As noted here, claimant has continuing pain which is disproportionate to any inciting event; she has persistent edema and reports functional decline with the use of her left knee. Thus, while claimant may not meet all criteria as listed in the Guidelines, no other diagnosis, outside of a sympathetically mediated pain complex better explains her ongoing signs and symptoms. Consequently, the ALJ concludes that deviation from the Guidelines to allow for additional diagnostic testing in the form of a 3-phase bone scan is warranted in this case.

F. In *Arkin v. Industrial Commission*, 145 Colo. 463, 358 P.2d 879 (1961), the

Court held that the term “disfigurement” as used in the statute, contemplates that there be an “observable impairment of the natural person.” In this case, The ALJ concludes that Claimant’s swelling and scarring constitutes a disfigurement as provided for by Section 8-42-108 (1), C.R.S.

ORDER

It is therefore ordered that:

1. Respondent-Insurer shall pay for all medical expenses to cure and relieve claimant from the effects of her November 24, 2012 left knee injury, including but not limited to the venous Doppler ultrasound, a triple phase bone scan and an evaluation with a vascular specialist as requested by Dr. Wily Jenkins.

2. Respondent-Insurer shall pay Claimant $1,200.00 for her visible disfigurement; however, Respondent-Insurer shall be given credit for any amount of disfigurement previously paid in connection with 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.

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: July 22, 2015

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

I. Whether Claimant has proven by a preponderance of the evidence that she is entitled to maintenance medical treatment in the form of a venous Doppler ultrasound, a triple phase bone scan and evaluation by a vascular (vein) specialist as maintenance care. The question to be answered is whether the recommended diagnostic testing and specialist evaluation are reasonable, necessary and related to claimant's November 24, 2012 industrial injury.

II. Whether Claimant is entitled to additional compensation for serious permanent disfigurement.

FINDINGS OF FACT

Based upon the evidence presented, including the deposition testimony of Drs. McFadden and Thurston, the ALJ enters the following findings of fact:

1. On November 24, 2012 Claimant sustained admitted injuries to her left knee after falling from a ladder at work.

2. A course of conservative care proved unsuccessful in ameliorating Claimant's condition. Consequently, she was referred for an orthopedic evaluation with Dr. Wily Jinkins. On April 18, 2013, Dr. Jinkins performed a diagnostic arthroscopy of the left knee during which the following procedures were performed: a patella chondroplasty, a lateral femoral condyle chondroplasty, microfracture subchondral plate, resection of synovial shelf and injection with primary portal closure.

3. On May 3, 2013 Claimant developed a sudden onset of cramping in her left calf which she was unable to relieve. She sought treatment in the emergency room of Memorial Hospital where a Venous Doppler study revealed a "clot in the left popliteal vein and gastrocutaneous veins." Subsequent pulmonary imaging demonstrated "small bilateral pulmonary emboli" characterized as mild, nonspecific patchy ground glass opacity bilaterally. Claimant was assessed with left lower extremity deep vein thrombosis (DVT) and pulmonary emboli (PE). Dr. William Kimble admitted Claimant to the hospital for additional treatment noting that the DVT and PE were "probably related to her recent left knee surgery."

4. On September 10, 2013, Dr. Jinkins opined that Claimant's DVT was related to her surgery of April 18, 2013. He also felt that Claimant was still in need of further treatment for the same. Claimant was placed on a prolonged course of anti-coagulant medication therapy.

5. A second venous duplex imaging of the left leg on January 10, 2014 revealed no evidence of persistent DVT.

6. At a return appointment dated February 7, 2014 Dr. Jinkins noted that although claimant did not have a great deal of calf pain; she had experienced an episode of chest pain while getting out of the bath. He also noted that he had recommended further imaging one week prior to the February 7, 2014 appointment due to the possibility that claimant was "redeveloping a DVT." Dr. Jinkins renewed his request for a venous Doppler ultrasound as "soon as possible at Penrad." Respondents initially denied the request; however, the study was ultimately approved and claimant underwent the recommended Doppler study on May 6, 2014. The study reflected a "continued absence of deep vein thrombosis."

7. Claimant was placed at MMI on June 17, 2014. Claimant subsequently requested a DIME, which was completed by Dr. Lee McFadden on November 6, 2014. In accordance with the DIME opinion, Respondents filed a Final Admission of Liability on December 5, 2014 admitting for 16% lower extremity impairment and post-MMI care.

8. Claimant has received maintenance medical care for her left knee from Dr. Jinkins. On December 16, 2014, Dr. Jinkins recommended a fourth venous Doppler ultrasound for continued pain and persistent swelling in her left lower leg. Respondents denied authorization for the recommended study requesting further that the recommendation be reviewed by Dr. Lloyd Thurston per W.C.R.P. 16-10.

9. In opining that the requested Doppler ultrasound was not reasonable necessary, or related maintenance care, Dr. Thurston opined that claimant's "only current risk factors for DVT are obesity and a prior episode of DVT and that "she had not suffered any recent trauma to her left lower extremity, had not experienced prolonged bed rest or immobilization, was not taking estrogens or any agents which would induce a hypercoaguable state, and had discontinued smoking in February 2014." Consequently, according to his report, the request for additional Doppler study was not reasonable, necessary or related to claimants admitted work injury.

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11. Respondents requested that Dr. Jenkins' recommendation for a 3-phase bone scan be reviewed by Dr. Thurston per W.C.R.P. 16-10. In opining that the 3- phase bone scan was not reasonable, necessary, and related maintenance care, Dr. Thurston opined that Claimant's symptoms do not meet the clinical criteria for chronic regional

pain syndrome (CRPS). He further opined that vague descriptions of physical findings do not adequately document edema or "describe symptoms consistent with true allodynia."

12. Based upon careful review of Dr. Thurston's February 16, 2015 report, the ALJ finds, contrary to Dr. Thurston's assessment that Dr. Jinkins descriptions of claimant's ongoing symptoms are sufficiently specific to adequately document clinical findings consistent with a component of claimant's symptoms emanating from a sympathetically mediated cause. Crediting Dr. Jinkins report that claimant has 2+ edema in addition to "burning" and discomfort with the exertion of light pressure, the ALJ finds that claimant has proven, by a preponderance of the evidence, that a triple phase bone scan is reasonably necessary and related to claimant's work injury to further assess whether claimant's ongoing symptoms are sympathetically mediated as no other diagnosis better explains her current signs and symptoms.

13. Respondents requested the deposition of Dr. Lee McFadden, the DIME physician. This deposition occurred on March 31, 2015 and is marked as Respondents' Exhibit G. During his deposition, Dr. McFadden testified that continued calf and foot swelling constitutes a management of a perfusion problem in the leg, which was outside of his purview as an orthopedist. According to Dr. McFadden, claimant's continued swelling may be related to her prior vein issue but because vascular conditions were outside of his area of expertise management of the same would be addressed by "the vascular guys". Dr. McFadden was asked, "Would you recommend that she have an evaluation with a vein specialist?" He replied, "I don't think it's unreasonable" (Respondents' Exhibit G, page 24, lines 16-25 and page 25-26, lines 1-11).

14. Respondents also took the deposition of Dr. Lloyd Thurston, a Family Medicine Practitioner. During his deposition Dr. Thurston testified that he neither evaluates nor treats sympathetically mediated pain/CRPS, nor does he treat DVT or subsequent vein issues related to DVT. While Dr. Thurston indicated that the requested ultrasound would be reasonable, which opinion the ALJ finds constitutes a deviation from that expressed in his December 26, 2014 report, he testified that he did not feel the need for it was related to claimant's industrial injury. As noted by Dr. Thurston, claimant's risk factors for the development of a subsequent DVT are her obesity and her prior episode of DVT. Considering that claimant's obesity was pre-existing and there is, by Dr. Thurston's account an absence of other risk factors that cause hypercoaguable states, the ALJ finds that claimant's prior work related DVT is the most probable cause of any subsequent DVT and the need for additional diagnostic study, i.e. Doppler ultrasound. Consequently, the ALJ finds Dr. Thurston's opinion that the need for the additional ultrasound is unrelated to the "previous injury" unconvincing.

15. Claimant has residual arthroscopic scarring, described as two (2) red, 3/8 semi-circular scars, on either side of the left knee accompanied by mild swelling of the knee in general which alters the natural appearance of her skin and joint in this area.

16. Claimant's testimony regarding her ongoing symptoms and swelling is credible

and convincing. As noted above, the undersigned ALJ viewed the swelling described by claimant first hand during the disfigurement viewing phase of the hearing.

CONCLUSIONS OF LAW

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

General Legal Principals

A. 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. C.R.S. § 8-40-102(1). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of rights of respondents. §8-43-201, C.R.S. (2005). A preponderance of the evidence is that which leaves 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).

B. 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).

C. When determining credibility, the fact finder should consider, among other things the consistency or inconsistency of the witness' 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 (1936). A Workers' Compensation case is decided on its merits. Section 8-43-210, C.R.S. As found, Claimant is a credible witness and his testimony is both persuasive and consistent with the medical records in the case. Furthermore, the ALJ concludes that Dr. Fall's testimony to be contradicted by the more persuasive opinions of Drs. Larimore and Jones.

Medical Benefits

D. The claimant bears the burden of establishing entitlement to medical treatment. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). The claimant is only entitled to benefits as long as the industrial injury is the proximate cause of the claimant's need for medical treatment. *Merriman v. Indus. Comm'n*, 210 P.2d 448 (Colo. 1949). Ongoing benefits may be denied if the current and ongoing need for medical treatment or disability is not proximately caused by an injury arising out of and

in the course of the employment. *Snyder v. City of Aurora*, 942 P.2d 1337 (Colo. App. 1997). In other words, the mere occurrence of a compensable injury does not require an ALJ to find that all subsequent medical treatment and physical disability was caused by the industrial injury. To the contrary, the range of compensable consequences of an industrial injury is limited to those which flow proximately and naturally from the injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); § 8-41-301(1)(c), C.R.S. 1997. Based upon the totality of the evidence presented, the ALJ concludes that claimant has proven that the requested diagnostic testing and the need for a vascular evaluation are reasonable, necessary and related to her compensable left knee injury. Although Dr. Thurston opined the request for DVT ultrasound was not reasonable, necessary and related maintenance care, he admitted that Claimant has some risk factors for the development of DVT, including having had a prior DVT culminating in pulmonary emboli (PE) which were treated as work related conditions. Outside of her obesity and having had a prior DVT, Claimant's risk for development of additional DVT appears low based upon the testimony of Dr. Thurston. Yet, Claimant continues to experience symptoms associated with DVT or a sympathetically mediated pain complex. Consequently, the ALJ concludes it is reasonable and necessary, given the morbidity associated with DVT progressing to PE and Claimant's ongoing burning pain and swelling in the skin surrounding her left knee, to proceed with additional diagnostic testing and evaluation in an effort to determine the cause of Claimant's continued symptoms. While the risk for DVT may be low, it does not negate the fact, that the most probable cause of any new DVT is more probably than not related to her prior development of DVT over other causes. Consequently, the ALJ concludes that Claimant has established the requisite causal connection between her need for a Doppler study, a triple phase bone scan and an evaluation with a vascular specialist and her November 24, 2012 industrial injury.

E. The ALJ acknowledges that the Medical Treatment Guidelines (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). While it is appropriate for an ALJ to consider the Guidelines in deciding whether a certain medical treatment is reasonable and necessary for the claimant's condition, *Deets v. Multimedia Audio Visual,* W. C. No. 4-327-591 (March 18, 2005); *see Eldi v. Montgomery Ward* W. C. No. 3-757-021 (October 30, 1998)(medical treatment guidelines are a reasonable source for identifying the diagnostic criteria), the Respondents have not cited any authority, nor is the undersigned aware of any, which requires an ALJ to award or deny medical benefits based on the Guidelines. Indeed the Guidelines permit deviation as individual cases dictate. As noted here, claimant has continuing pain which is disproportionate to any inciting event; she has persistent edema and reports functional decline with the use of her left knee. Thus, while claimant may not meet all criteria as listed in the Guidelines, no other diagnosis, outside of a sympathetically mediated pain complex better explains her ongoing signs and symptoms. Consequently, the ALJ concludes that deviation from the Guidelines to allow for additional diagnostic testing in the form of a 3-phase bone scan is warranted in this case.

F. In *Arkin v. Industrial Commission*, 145 Colo. 463, 358 P.2d 879 (1961), the

Court held that the term “disfigurement” as used in the statute, contemplates that there be an “observable impairment of the natural person.” In this case, The ALJ concludes that Claimant’s swelling and scarring constitutes a disfigurement as provided for by Section 8-42-108 (1), C.R.S.

ORDER

It is therefore ordered that:

1. Respondent-Insurer shall pay for all medical expenses to cure and relieve claimant from the effects of her November 24, 2012 left knee injury, including but not limited to the venous Doppler ultrasound, a triple phase bone scan and an evaluation with a vascular specialist as requested by Dr. Wily Jenkins.

2. Respondent-Insurer shall pay Claimant $1,200.00 for her visible disfigurement; however, Respondent-Insurer shall be given credit for any amount of disfigurement previously paid in connection with 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.

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: July 22, 2015

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

The issues for determination are:

1. Post-maximum medical improvement (MMI) or "Grover" medical benefits without limitation.

2. Average weekly wage (AWW).

3. Whether the claimant overcame the division independent medical examination (DIME) opinions regarding MMI and permanent partial disability (PPD) by clear and convincing evidence.

4. In the event the claimant did not overcome the DIME opinions regarding MMI and PPD, whether the claimant proved his claim should be reopened based on a worsening of condition subsequent to MMI.

5. Temporary total disability (TTD) benefits from September 27, 2013, ongoing.

At hearing, the respondents' counsel stated the respondents now admit generally to Grover medical benefits, without the limitation on such medical benefits contained in the respondents' latest FAL, filed on June 12, 2014. Thus, the ALJ concludes this issue is moot. Also at hearing, and regarding AWW, the parties agreed the admitted AWW is $814.86, and that the claimant's weekly cost of continuing his healthcare coverage pursuant to COBRA is $131.97. The parties agreed that if the cost of continuing healthcare coverage is included, the claimant's AWW is $946.83.

FINDINGS OF FACT

1. The claimant sustained a work-related right inguinal hernia injury on December 27, 2012. He received primary treatment at Colorado Springs Health Partners (CSHP). Khurram Khan, M.D., performed hernia surgery on January 23, 2013.

2. On February 19, 2013, Dr. Khan noted the claimant complained he was "…still having a lot of pain, and tightness around surg area." Dr. Khan noted, "…c/o muscle spasm possibly from irritation from securing staples. Prescribed muscle relaxant and fill f/u in 2 weeks if symptoms do not resolve…"

3. The respondents admitted liability for the claimant's injury. The respondents paid temporary total disability (TTD) benefits from January 3, 2013 through March 3, 2013. The claimant returned to work with restrictions but at full wages on March 4, 2013.

4. On March 8, 2013, Dr. Rudderow at CSHP reported the claimant, "…Had surgery Jan 23, 2013. Mesh was implanted. Is in much pain today. R pelvic area…Pain was getting better until started working 3/4/13, then pain started to get worse again. Pt worried something is wrong. Has seen surgeon – told might be muscle strain or staple irritation. Good appetite. More comfortable standing than sitting, but then legs get numb and will give out because on feet for so long…" Work restrictions were continued.

5. On March 18, 2013, Dr. Rudderow reported, "…pain 4/10, goes up to 8-9/10 with bending down. Has appt w/surgeon 4/4/13. Can't lift anything on rt side [secondary to] pain. Pt walking slow. Pain a little better than last time seen. Rt handed. Had surgery on rt inguinal. Other night pt lifted something w/left hand and it causes pain. No known swelling. Still tender. Was taking ultram and naproxen – ran out – they did help with pain. No radiation of pain." Work restrictions were continued.

6. On April 4, 2013, Dr. Khan reported that he "Injected the area of tenderness with anesthetic with some relief. If patient symptoms improve over the next 24 hrs. will consider steroid injection in the area. F/u in 1 week." The claimant was restricted to lifting less than 20 pounds.

7. CT scan on April 16, 2013 revealed no inguinal hernia. An ultrasound on April 19, 2013 revealed no deep vein thrombosis.

8. On May 17, 2013, Dr. Rudderow reported, "…Not feeling well, pain now in rt testicle, had [ultrasound] to r/o clot 2 wks ago, was referred to Dr. Ford for pain mgmt by Dr. Kahn. Ford gave rx Lyrica, ins would not cover, Dr. Khan's office gave pt Gabapentin, makes pt dizzy at work, feels hazy. Told it may affect cog skills. Pt is working FT, doing bending, difficulty getting back up, etc…Pt has burning pain, feels like a bulge under area of surgery. Pain is min at rest and slouching in chair. Shooting pain worse with excessive walking and lifting…" Dr. Rudderow maintained work restrictions, and referred the claimant to "pain management."

9. Dr. Ballard at CSHP saw the claimant on June 12, 2013 and noted, "pt here for groin pain, and testicular pain, pt is also concerned on blood in stool and incontinence." Dr. Ballard reported, "…he has multiple issues and we will do the testing

for the back and the stomach and the melena and we will then address the prostate and the atrophy of the right testicle. At this time [it] is presumed that the right groin pain is a nerve entrapment of scar tissue but he also may have a nerve pain from the back from the scoliosis. The right groin pain is worse when he is sitting not standing."

10. Dr. Rudderow placed the claimant at maximum medical improvement (MMI) on June 20, 2013. The doctor issued permanent work restrictions and recommendations for post-MMI treatment, but opined the claimant sustained no permanent impairment.

11. The respondents filed a final admission of liability (FAL) consistent with Dr. Rudderow's findings on July 17, 2013.

12. On June 27, 2013, Dr. Rudderow reported, "…patient's surgical wounds healed well without complication, however patient has had persistent moderate to severe pain in the right inguinal area which has not significantly improved since surgery. Pt has been treated with pain medications including NSAIDS, narcotics, ultram and neurontin with minimal success….Due to patient's pain, he has not been able to return to full duty…Patient has healed from his surgical wounds, but continues to have chronic pain which is exacerbated by work. His chronic pain may or may not fade with the passage of time. He has no structural defect and improvement is possible but not definite…" Dr. Rudderow noted the claimant reported his pain "at rest" was 7/10.

13. The respondent-employer terminated the claimant's employment on September 26, 2013.

14. The claimant was issued a COBRA letter on October 4, 2013. It advised him that his cost to continue his medical, dental and vision healthcare benefits was $571.88 per month, effective October 1, 2013.

15. The claimant returned to Dr. Ballard on November 12, 2013 and the doctor reported, "…He is here for several reasons and he indicates he is depressed and he has a spot on his arm and he wants to see another surgeon to get the mesh removed…He has anhedonia and he has difficulty with focus and concentration. He is not exercising. He has no libedo {*sic*} and it is not ok with the wife. He has pain with the erection and the orgasm…" From a psychiatric perspective, Dr. Ballard reported, "sleep disturbances, depression, personality change and emotional problems, but not suicidal and no anxiety." Dr. Ballard reported, "…he has depressed affect and mood." Dr. Ballard indicated, "We will start him on fluoxetine [Prozac] since he has had success

with it before and we will refer him to urology for the frequency and noctuia and the pain from the results of the surgery and the testicular atrophy…"

16. Brian Beatty, M.D., performed a division independent medical examination (DIME) on April 29, 2014. Dr. Beatty reported, "…The patient notes that his symptoms have worsened since the injury. He has pain that radiates from his right lower abdomen into his testicle. His discomfort is constant." Dr. Beatty noted, "…The pain drawing reveals a burning pain in the right lower abdomen with a sharp stabbing pain in the inguinal region." He noted the claimant rated his pain "…as a 9 on a 0-10 scale…"

17. Dr. Beatty diagnosed "right inguinal hernia with repair, right ilioinguinal neuroitis." Dr. Beatty agreed the claimant had reached MMI as determined by Dr. Rudderow; however, he recommended that the claimant "…should have a second opinion with a general surgeon well-versed in hernia injuries with postop ilioinguinal nerve disorders. If it is felt the patient would benefit from injections to resolve his problem then I believe these could be done from a maintenance care standpoint. If it is determined that the patient would require a second surgery to remove the mesh or to perform an ilioinguinal neurotomy, then I do not believe he would remain at maximum medical improvement until he recovered from the surgery. Also, an evaluation with a physiatrist, knowledgeable in post surgical ilioinguinal nerve injuries would be appropriate."

18. Dr. Beatty issued a 4% whole-person permanent partial disability (PPD) rating. On June 12, 2014 the respondents admitted liability consistent with Dr. Beatty's findings.

19. The claimant's counsel wrote to Dr. Rudderow on June 3, 2014 regarding Dr. Beatty's recommendations. Dr. Rudderow responded on June 12, 2014, indicating she agreed it was reasonable to send the claimant to both a general surgeon and physiatrist per Dr. Beatty, and that, "…We will need to reopen this case to address your concerns and possibly review the MMI."

20. On July 7, 2014, Dr. Ballard responded to a written inquiry and confirmed that the claimant suffers from depression as a result of his ongoing chronic pain. Dr. Ballard confirmed he prescribed fluoxetine to treat that depression.

21. Dr. Ballard saw the claimant on September 16, 2014 and noted, "…He is now also divorced and is still having pain in the right inguinal area. He is not working and workmans {*sic*} comp is out and he is applying for social security disability…" Dr. Ballard reported, "…He feels that the titanium mesh is the cause of all his discomfort

and he wants it out and plastic product replacing it. He has had injections in the wound area with some benefit but it was only minimal and did not last." Dr. Ballard's diagnosis included chronic postoperative pain, depression, right groin pain and testicular atrophy.

22. Pursuant to Dr. Beatty's recommendations, the respondents arranged for the claimant to see physiatrist John Sacha, M.D., on September 23, 2014. Dr. Sacha reported, "…The patient has pain localized to the right groin that radiates into the right scrotum with burning, numbness, and tingling. He denies any back pain, leg pain, weakness, or pain in other areas." Dr. Sacha noted, "…There is some insomnia secondary to pain. He does have some slight increase in anxiety and depression…" Dr. Sacha opined that, "…the only consideration I would recommend for this patient is doing a one-time right ilioinguinal radiofrequency procedure…"

23. Pursuant to Dr. Beatty's recommendations, the respondents arranged for the claimant to see general surgeon Robert McDonald, M.D., on September 30, 2014. Dr. McDonald reported, "…He has consulted with a pain specialist in the area, and apparently he plans on undergoing a non-surgical procedure that involves nerve ablation. I told the patient I did not have any expertise in this area. I do, however, feel a pain specialist is the most appropriate person to be managing Daniel's pain…"

24. On October 10, 2014, Dr. Sacha performed "right ilioinguinal radiofrequency neurotomy." The claimant credibly testified this procedure was of no benefit whatsoever, and in fact made his pain worse.

25. Urologist Michael Crissey, M.D., saw the claimant on referral from Dr. Ballard on November 17, 2014. Dr. Crissey noted he was seeing the claimant, "…for an urological evaluation for pain involving the right testicle that started approximately 2 years ago following a mesh hernia repair. The pain is more in the inguinal area than in the testis. The patient denies an associated testicular mass or groin adenopathy. He does not have ED [erectile dysfunction], but says that a full erection will aggravate the pain, and an ejaculation even more so. Says he is therefore unable to have sex, and that his wife left him over the issue. There is not associated swelling. He has been treated with Neuronton and Tramadol. He has had an RFA procedure 1 month ago which he says made the pain worse. He has also developed pain in the arch of his right foot which he feels is a result of chronic limping…"

26. The claimant's examination revealed no evidence of hernia, but "…There is extreme tenderness in the right inguinal area, especially on digital exam of external ring." Dr. Crissey's recommendations included, "repeat surgical exploration with lysis

and possible mesh removal," "repeat RFA of inguinial nerve," and, "consider trial of Lyrica."

27. On December 4, 2014, Christa Coolidge, NP, at CSHP saw the claimant and reported, "…Evaluation of chronic right groin pain (hernia mesh repair). Pain right groin radiating to mid inner thigh. Feels like RLE is going to give out…Would like another referral for general surgery. Discussed Dr. Zimmerman." Ms. Coolidge also referred the claimant to Dr. Tyler for pain management.

28. Ms. Coolidge also prescribed a "cane for ambulation" on December 4, 2014. On January 21, 2015, Dr. Ballard confirmed the claimant's need for the cane to assist with ambulation is "directly related to his work injury."

29. Surgeon Peter Zimmer, M.D., saw the claimant on December 15, 2014 on referral from Dr. Ballard. Dr. Zimmer diagnosed "chronic inguinodynia following right inguinal hernia repair." He recommended against mesh removal surgery, but noted, "…I have discussed with him that neurectomy may be of benefit and have given him information about the Lichtenstein Amid Hernia Clinic at UCLA if wishes further evaluation there regarding neurectomy; I do not perform that procedure. MRI may be of possible benefit as well to evaluate for occult recurrence or other problem causing his pain; this can be ordered by Dr. Ballard as necessary…"

30. On January 12, 2015, Dr. Ballard reported, "…He has ongoing pain in the right leg and right lower abd and groin and he indicates he is not sleeping and he finally got ok to see Dr. Tyler and wants to get some relief so he can sleep. Patient rates their health as: poor."

31. The claimant began treating with Dr. Jeffrey Jenks, in lieu of Dr. Tyler, on February 24, 2015. On that date Dr. Jenks noted, "…He describes pain in his right groin region with radiation into the proximal aspect of his right leg. It is aggravated with Valsalva maneuvers. He also has increased pain with weightbearing on his right leg. He did have a right ilioinguinal nerve radiofrequency procedure done by Dr. Sacha on October 10, 2014. He states that following this his pain became much worse and his continued to be worse since then." Dr. Jenks noted, "...Additionally, he has developed significant depression due to the pain. He has seen Dr. Ballard for this. He has been on Prozac for at least 2 years for the depression. He is unsure if it is helping a lot at this point, however…"

32. On examination, Dr. Jenks found, "…There is significant tenderness in the right lower quadrant in the area of the ilioinguinal nerve. He has decreased sensation in

the distribution of the right ilioinguinal nerve…" Dr. Jenks diagnosed "status post right herniorraphy with subsequent right ilioinguinal neuropathy" and "secondary depression." Dr. Jenks started the claimant on Butrans patches; recommended he discontinue gabapentin and start Lyrica. He also changed from Prozac to Cymbalta, "…to continue with his antidepressant treatment, but also to hopefully help his neuropathic pain." Finally, Dr. Jenks referred the claimant to Bruce Ramshaw, M.D., at Advanced Hernia Solutions in Daytona Beach, Florida, noting that "Dr. Ramshaw is known nationally for revision surgery on failed herniorrhaphies with entrapment of the ilioinguinal nerve."

33. Dr. Jenks increased the dosage of the Butrans patches from 5 mcg to 10 mcg on March 24, 2015. On April 21, 2015 he noted the claimant was getting better pain relief with the increased dosage, and increased it again to 15 mcg. Dr. Jenks noted "The patient is ambulating with a cane."

34. Dr. Jenks testified by deposition on May 13, 2015 as an expert in the fields of physical medicine and rehabilitation, and pain medicine. Dr. Jenks explained the claimant has an ilioinguinal nerve problem due to the surgery he had. Dr. Jenks testified regarding the outcome of the claimant's hernia surgery indicating that although the surgery had not failed there were major complications.

35. Dr. Jenks testified that the claimant remains at MMI, but that if the claimant sees Dr. Ramshaw and Dr. Ramshaw recommends further surgery, then the claimant would no longer be at MMI.

36. Dr. Ballard testified by deposition on May 13, 2015 as an expert in the fields of family medicine and psychiatry. Dr. Ballard testified regarding the causes of the claimant's depression:

Q. What caused the pain -- excuse me – the depression?

A. What caused the depression. Chronic pain can cause depression. Not being able to have sexual relations without discomfort can cause depression. Not being able to work effectively can cause depression. Which exactly one of those was more than another, I did not determine.

Q. Was his depression a combination of the effects of all of those things you mentioned?

A. Yes.

37. Dr. Ballard testified regarding the cause of the claimant's sexual dysfunction:

Q. What about the problem with erection and orgasm?

A. That apparently was pain secondary to his inguinal area, compromise of the ilioinguinal nerve.

38. Dr. Ballard confirmed that he did not diagnose the claimant as having any problems with sexual dysfunction or depression prior to November 12, 2013.

39. Dr. Ballard testified that he made referrals to general surgery and for pain management in December, 2014 "because of ongoing difficulties with the right groin pain and continuing pain affecting his life."

40. Dr. Ballard testified regarding the worsening of the claimant's condition:

Q. Did [the claimant's] symptoms change after maximum medical improvement on June 20, 2013?

A. Not for any improvement. They may have worsened with the depression, with sleep deprivation and stuff. So I would say they worsened, yes.

Q. Specifically, what worsened after maximum medical improvement?

A. His depression worsened. He began to have back problems and continued to have pain.

41. Dr. Ballard explained the claimant developed back pain due to age, lack of activity, and weight gain. He explained that, "Well, I assume he limited his activities secondary to the effects of medication, depression and pain."

42. Dr. Ballard testified regarding the worsening of the claimant's leg pain:

Q. Why did you prescribe a cane for [the claimant] on December 4, 2014?

A. Because of his leg pain.

Q. Did his leg pain worsen subsequent to when you first saw him in June of 2013?

A. Yes. From the first to the last visit, it was worse, not better.

43. The ALJ finds the testimony of Drs. Jenks and Ballard to be credible, persuasive, and entitled to greater weight than opinions to the contrary.

44. The claimant testified that after being placed at MMI, his right groin pain began radiating to his genital area. He testified that subsequent to MMI, his pain has "really increased." He described his pain as "burning," and that "most of the time it's excruciating." The pain is in the claimant's right groin area, and radiates to his testicles and penis. The pain radiates to the right upper thigh area. The claimant takes prescribed medications, but very little relieves his pain.

45. The claimant testified he experiences problems with depression. The depression began several months after MMI. Dr. Ballard has prescribed Prozac for depression. Dr. Jenks prescribed Cymbalta, in part to treat depression. The claimant experiences depression as a result of the severe pain in his right groin.

46. The claimant testified he experiences problems with sexual dysfunction. The problems initially began after the hernia surgery. The claimant had some problems with sex due to pain while healing from the hernia surgery. The problems worsened after MMI, to point where the claimant is unable to have sexual relations due to the pain in his groin and genital area. The claimant's wife left him 13-14 months prior to hearing, because he was "unable to perform" sexually. The claimant experienced no problems with sexual dysfunction prior to the work injury.

47. The claimant testified he reviewed the surveillance video the respondents obtained in December 2014. He testified that on the video, he was walking with a limp and using a cane because of pain in his right groin area. He testified his right leg was "giving out more and more." This has caused the claimant to fall down. The claimant testified that prior to MMI, he had a limp, but did not walk in the manner shown in the surveillance video. He did not require the use of a cane. The claimant described his right leg as being the weakest it has ever been in his life. He attributes this to referred pain from his hernia injury.

48. The claimant testified he has not worked since being terminated by the respondent-employer. He testified he cannot work because his pain is too great and he has to use a cane, and "nobody will hire me." The claimant has looked for work and submitted job applications. The claimant survives by borrowing money from relatives.

49. The claimant testified his pain affects his ability to sleep, and he gets only 2-3 hours of sleep per night. The pain wakes him and he has difficulty falling asleep. He described the pain as "excruciating." Prior to MMI, the claimant was able to get 4-6 hours of sleep per night.

50. The claimant testified regarding the radiofrequency procedure performed by Dr. Sacha. The procedure did not help, and in fact made the claimant's pain worse. After the procedure, the claimant's leg gave out more frequently, and his groin pain was worse.

51. The claimant testified his pain is much worse now than even at the time of DIME examination on April 29, 2014. He described it as more of a "burning pain" that is consistent.

52. When Dr. Rudderow placed the claimant at MMI on June 20, 2013, she recommended continued use of Gabapentin and Ultram. The claimant now requires Butrans patches, Lyrica, and Cymbalta. The claimant's medication regimen has changed subsequent to MMI.

53. The ALJ finds the claimant's testimony to be credible and persuasive. The ALJ finds the claimant's condition has worsened since being placed at MMI on June 20, 2013, and that he no longer at MMI effective as of the date of hearing, May 20, 2015.

54. The ALJ finds that the claimant has failed to establish that Dr. Beatty's DIME opinion concerning MMI or PPD were clearly erroneous.

55. The ALJ finds that the claimant has established that it is more likely than not that he is entitled to TTD benefits beginning with the date of hearing, May 20, 2015, and continuing until terminated by operation of law.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. (2007), *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. Per C.R.S. §8-42-107(8)(b)(III), the findings of the Division independent medical examiner regarding MMI and PPD may be overcome only by clear and convincing evidence. This means evidence which proves that it is "highly probable" the DIME physician's opinion is incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). The question of whether the DIME physician's rating has been overcome by clear and convincing evidence is a matter of fact for determination by the ALJ. *Metro Moving & Storage*, supra.

5. The ALJ concludes the claimant has failed to prove by clear and convincing evidence that Dr. Beatty's DIME findings regarding MMI and PPD are incorrect. Accordingly, except as to admitted post-MMI treatment, the claimant's claim is closed, subject to reopening.

6. C.R.S. §8-43-303(1) provides in pertinent part that; "At any time within six years after the date of injury, the director or an administrative law judge may, after notice to all parties, review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition, except for those settlements entered into pursuant to section 8-43-204 in which the claimant waived all right to reopen an award…If an award is reopened on grounds of an error, a mistake, or a change in condition, compensation and medical benefits previously ordered may be ended, diminished, maintained, or increased. No such reopening shall affect the earlier award as to moneys already paid except in cases of fraud or overpayment. Any order entered under this subsection (1) shall be subject to review in the same manner as other orders."

7. The ALJ concludes the claimant has proved by a preponderance of the evidence that his condition has worsened since MMI, thus justifying the reopening of his claim. Factors supporting the determination that the claimant's condition has worsened

include the following; the claimant's ability to engage in sexual relations has been greatly curtailed, if not eliminated, due to increased groin pain subsequent to MMI. The claimant experiences depression as a result of the effects of his work injury. His depression was first diagnosed by Dr. Ballard on November 12, 2013, at which time Dr. Ballard prescribed Prozac. The claimant had not been diagnosed with work-related depression, nor was he prescribed medications to treat that condition, prior to November 12, 2013. In his deposition, Dr. Ballard confirmed the claimant's depression has worsened. Dr. Ballard testified the claimant's leg pain worsened subsequent to their first meeting on June 27, 2013. This worsening led Ms. Coolidge in Dr. Ballard's office to prescribe a cane for the claimant to use to assist with his ambulation. The claimant has been unable to find work due to the worsening effects of his work injury. The claimant's pain and dysfunction have increased subsequent to MMI.

8. To prove entitlement to TTD benefits, the claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that she left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, supra. Section 8-42-103(1)(a), 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*.

9. The ALJ concludes that the claimant is no longer at MMI effective May 20, 2015 and thus is entitled to TTD benefits beginning that date and continuing until terminated by operation of law.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The claimant's request to overcome the DIME with respect to MMI and PPD is denied and dismissed.

2. The claimant's request to reopen his claim is granted. The claimant's claim is reopened.

3. The respondent-insurer shall pay the claimant TTD benefits beginning May 20, 2015 and ongoing until terminated by operation of law.

4. The claimant's AWW effective October 1, 2013 is $946.83.

5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

6. 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: July 21, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Dr Ste 230
Colorado Springs, CO 80906

STIPULATIONS

1. The parties agreed that the claims adjuster would testify that, pursuant to the Final Admission of Liability filed on February 27, 2014 referencing the DIME report of Dr. Castrejon, Insurer paid permanent partial disability benefits based on an 11% scheduled impairment. The parties further agreed that the claims adjuster would testify that she did not notice the part of Dr. Castrejon's DIME report dealing with apportionment of 10% of the rating to a prior injury and inadvertently paid benefits on the full 11% without accounting for the difference due to apportionment. The parties do not stipulate that the above statements are fact, only that this would have been the testimony of the claims adjuster had she testified.

ISSUES

The following issues were raised for consideration at hearing:

1. Whether the Claimant proved, by a preponderance of the evidence, that the right shoulder surgery recommended by Dr. Hatzidakis is reasonably necessary to cure and relieve the Claimant from the effects of his January 12, 2013 work injury.

2. Whether the Claimant proved, by clear and convincing evidence, that DIME physician Miguel Castrejon, M.D. erred in finding that the Claimant reached MMI on June 4, 2013.

3. Whether the Respondents proved, by clear and convincing evidence, that DIME physician Miguel Castrejon, M.D. erred in finding that the Claimant's right shoulder condition, for which he provided an impairment rating, was causally related to the Claimant's January 12, 2013 work injury.

4. Whether apportionment of the Claimant's impairment rating is applicable pursuant to C.R.S. § 8-42-104(5)(a). If apportionment applies, the appropriate calculation for apportionment.

5. If apportionment is applicable pursuant to C.R.S. § 8-42-104(5)(a), whether Respondents proved that their final admission should be withdrawn, and modified, to permit Respondents to admit to Dr. Castrejon's post apportionment impairment rating of 1% upper

extremity, and claim an overpayment for permanent impairment benefits paid above that amount.

6. Whether Claimant proved by a preponderance of the evidence that he suffered a functional impairment contained off the schedule of injuries set forth at Section 8-42-107(2), C.R.S. and is entitled to permanent partial disability benefits based upon a whole person conversion of the upper extremity rating.

7. If the Claimant is at MMI, whether Claimant has proved, by a preponderance of the evidence, that future medical benefits are reasonably necessary to relieve the effects of his injury or prevent deterioration of his condition.

FINDINGS OF FACT

Based upon the evidence presented at hearing and through post-hearing deposition testimony, the ALJ finds as fact:

1. The Claimant is a 52 year old male who worked in construction industries for more than thirty years. The Claimant was hired by Employer on September 28, 2010 to work as a vacuum truck driver and operator. The Claimant's job was a very physical job requiring him to lift and move hoses weighing 75 lbs., if empty, and more if they were full. The Claimant's job required him to suction debris from pits and tanks using the vacuum hose attached to the vacuum truck. At times, the job required Claimant to use other tools, such as picks, shovels and water pressure to free debris off of the sides of tanks. The Claimant would typically work with another worker and his shifts were generally 12 to 16 hours long.

2. The Claimant has a history of right shoulder problems that pre-date the injury that is the subject of this claim and pre-date his employment with Employer.

3. In the 1980s, Claimant had a motorcycle accident, which resulted in a right shoulder injury, an AC joint separation, and a distal clavicle fracture (Hrg. Trans. p. 45, lines 16-24).

4. The Claimant also had a previous right rotator cuff repair and right open reduction of his ulna due to a work related fall. The Claimant testified that he was working on a pole barn and fell about 12 feet onto a concrete floor, shattering his elbow and pulling and tearing the tendons in his shoulder on the right side (Hrg. Trans. pp. 28-29). On March 16, 2002, the Claimant was seen at McKee Medical Center by Mark Durbin, M.D., a surgeon, who noted that Claimant had been working when he fell fourteen feet onto a concrete base. On physical examination for this injury, Dr. Durbin further noted the Claimant's right shoulder had an old injury with a large deformity of the AC joint. Dr. Durbin interpreted right shoulder x-rays as showing an old change from AC joint disruption with significant calcification (Respondents' Exhibit A, p. 1). On March 26,

2002, Dr. Durbin ordered a right shoulder MRI to rule out a rotator cuff tear (Respondents' Exhibit A, p. 5).

5. On April 9, 2002, a right shoulder MRI was read as showing a "large rotator cuff tear with complete detachment of the supraspinatus and infraspinatus tendons as well as a smaller focus of tear of the subscapularis tendon ...." There was also mild atrophy of the infraspinatus and scapularis muscles and mild to moderate atrophy of the supraspinatus muscle. Additionally, there was a medial dislocation of the biceps tendon extending through the full thickness tear of the subscapularis tendon, and a post-traumatic deformity of the acromioclavicular joint (Respondents' Exhibit B).

6. On May 1, 2002, Dr. Durbin operated on the Claimant's right shoulder, performing a diagnostic arthroscopy, arthroscopic acromioplasty, and open right rotator cuff repair (Respondents' Exhibit A, pp, 8-9; Respondents' Exhibit C).

7. The Claimant saw Dr. Durbin on May 9, 2002 and Dr. Durbin noted that the Claimant reported a noticeable significant difference in the pain in his shoulder. Dr. Durbin referred the Claimant for physical therapy (Claimant's Exhibit 7, p. 32; Respondents' Exhibit A, p. 12). On June 28, 2002, Dr. Durbin noted that the Claimant had some improvement in his range of motion, and his plan was to continue Claimant with aggressive range of motion and strengthening. Dr. Durbin anticipated seeing the Claimant in about four weeks for a final release (Claimant's Exhibit 7, p. 34; Respondents' Exhibit A, p. 12).

8. On May 10, 2007, the Claimant was evaluated by Dr. Kenneth Duncan at the Orthopaedic Center of the Rockies, who noted that three weeks earlier the Claimant was putting up sheet rock and had the gradual onset of right-sided neck pain and burning down his right arm. The Claimant reported that the symptoms were gradually getting worse and if he extends his neck it is worse and if he flexes, it is better. The Claimant reported seeing a chiropractor which did not help. The Claimant also reported taking Aleve and Advil which provides temporary improvement. Dr. Duncan opined that the symptoms were most likely related to an HNP involving C7 (Claimant's Exhibit 8; Respondents' Exhibit D).

9. The Claimant testified that on January 12, 2013, a Saturday, he was cleaning out a water jet system. He had run 75 feet of hose inside of a building to clean out a tank that was approximately 3 feet deep by 7-8 feet wide. The Claimant testified that once the corner was cleaned out with the hoses, he and his helper would then get inside the tank and, using shovels, picks and water, they would break up the material that was inside the tank in order to get it to go through the vacuum hoses and into the truck. During the course of this job, the Claimant was taking little swings with the pick to break up the material. Towards the end of this job, the Claimant testified that his shoulder was sore and he advised his coworker that he could hardly swing the pick anymore. The Claimant and his coworker finished the job and put the hoses back on the truck, but the Claimant testified that he could hardly get the hoses back up onto the truck. The Claimant testified that when he got into the truck as he prepared to drive it

back to the yard, he felt pain all down his whole right arm and his shoulder hurt so much, he couldn't lift his arm. The Claimant testified that he had not had this pain prior to January 12, 2013. After that day, the Claimant testified that his shoulder and arm never returned to the way it was before January 12, 2013 (Hrg. Trans., pp. 30-33).

10. The Claimant testified that he waited until Monday to report his injury to his boss, Mark McDonald, because it was his understanding that his boss only worked Monday – Friday. The Claimant testified that he also tried alternating ice and heat to see if he could make the shoulder feel better, but as of Monday morning, he still had to hold his shoulder due to the pain and couldn't even put his hand up to the steering wheel while driving to work (Hrg. Trans. pp. 33-34).

11. On January 14, 2013, Mark McDonald completed the First Report of Injury or Illness listing an injury/illness date of January 12, 2013 and noting that the Claimant, "overworked right shoulder" while cleaning water jets and using the vac, pick and shovel. A witness named Steve Meeks was listed (Claimant's Exhibit 1; Respondents' Exhibit E).

12. The Claimant was first seen by Dr. Michael McKenna at Care Plus Medical Center on January 14, 2013 (Hrg. Trans. p. 34). Dr. McKenna noted that the Claimant reported that,

> While working on Saturday and using a shovel and pick, he had sudden pain and indicates the anterior aspect of the right shoulder. He was really no longer able to use it anywhere near normally whatsoever. He has a significant past history 18 years ago that he did have surgery on the elbow, shoulder and I believe pelvis all on the right side. He has worked construction, etc, since then and states he has had no problems. He denies any other injuries from this incident on Saturday. Increasing pain over the weekend prompted his presentation this morning. He also complains of significant lack of range of motion in that shoulder.

Dr. McKenna diagnosed the Claimant with an acute injury, probable rotator cuff tear and possible supraspinatus issues. Dr. McKenna was not certain that an MRI could be performed due to the metal in the Claimant's shoulder and elbow from the prior injury, so he recommended that Claimant see Dr. Durbin and to check to see if an MRI could be performed. In the meantime, Dr. McKenna provided work restrictions and prescribed pain medication.

13. Dr. Durbin evaluated the Claimant on January 15, 2013. Dr. Durbin noted that the Claimant reported that "he was out doing some ax and pick work and was doing okay. He had a long day to finish and by the time he was done he had overworked it and was unable to raise his arm. He is having a moderate amount of pain in the arm and still cannot raise it up and is still pretty sore." Dr. Durbin stated his belief that the Claimant had "more of a rotator cuff strain than a tear" but was not certain. He recommended gentle range of motion exercises for the Claimant and if there was no

improvement, he would see the Claimant in 2-3 weeks and set up an MRI or consider a cortisone shot (Claimant's Exhibit 10, p. 52; Respondents' Exhibit G, p. 24).

14. From January 13, 2013 through January 22, 2013, the Claimant was off work and received temporary total disability benefits (Claimant's Exhibit 2, p. 3).

15. On January 24, 2013, Dr. McKenna noted that the Claimant reported that he thought his shoulder was less painful than the first visit with Dr. McKenna (Claimant's Exhibit 9, p. 39; Respondents' Exhibit F, p. 22). Dr. McKenna provided work restrictions that enabled the Claimant to return to modified duty with no use of the right upper extremity, and no commercial driving (Claimant's Exhibit 9, p. 38). The Claimant began receiving TPD benefits starting on January 23, 2013 (Claimant's Exhibit 2). He was provided modified duties working in the parts room.

16. On February 7, 2013, the Claimant returned to see Dr. Durbin in follow up from the shoulder injury. Dr. Durbin noted the Claimant was doing a little bit better, "slowly improving," and he was a little bit stronger in his rotator cuff muscles, but still had a little weakness on supraspinatus resistance testing. The Claimant reported that he would get sore with heavier overhead activities, but otherwise he felt he was "significantly improved." Dr. Durbin loosened the Claimant's restrictions to permit lifting up to 50 pounds, but he did not want the Claimant lifting heavy vacuums or performing overhead activities (Claimant's Exhibit 10, p. 56; Respondents' Exhibit G, p. 27).

17. On February 14, 2013, Dr. McKenna reviewed Dr. Durbin's report with the Claimant, and the Claimant concurred with Dr. Durbin's findings and recommendations. Dr. McKenna noted that the Claimant had "good range of motion, etc." on that date. His assessment was "Injury, right shoulder – improved". Dr. McKenna indicated the Claimant would be released to "essentially full duty", with a 50 pound lifting restriction, starting on February 18, 2013. The Claimant was scheduled for follow up with Drs. Durbin and McKenna (Claimant's Exhibit 9, p. 41; Respondents' Exhibit F, p. 23).

18. On February 18, 2013, due to his updated restrictions, the Claimant was placed in a new modified position with Employer driving tanker trucks and dumps. This position required the Claimant to drive a tanker truck to Colorado Springs twice a night. He would hook up a trailer to his truck at one location, drive, and then unhook the trailer at the second location. To hook up the trailer, the Claimant would turn a crank to raise and lower the hitch. He could do this with either arm. The crank was at waist level and when he turned the crank it would come up to eye level which was over his shoulder. The Claimant performed the cranking duty four to eight times per night. The Claimant testified that this activity increased his pain while he was doing it.

19. The Claimant testified that he did not want to keep doing the tanker driver work because it was painful to use the crank and because his pay was cut down to $10 per hour and he was only able to work 40 hours a week. So, overall, the Claimant was not happy with the work situation. He testified that he called his brother who informed the Claimant that he had all kinds of work and the Claimant would be paid $30 per hour.

The Claimant testified that he voluntarily resigned his job with Employer and has worked for his brother ever since February 28, 2013. The Claimant performs construction work including tenant finish, tile work and remodeling. The Claimant characterized this work as less physically demanding than the work he had been performing for Employer. The Claimant testified that he did not have any injuries or accidents to his right shoulder working for his brother (Hrg. Trans. pp. 39-41, also see Respondents' Exhibit H, p. 28).

20. On March 28, 2013, the Claimant failed to show up to his appointment with Dr. McKenna (Claimant's Exhibit 9, p. 41; Respondents' Exhibit I). On March 29, 2013, Insurer's representative called Care Plus, and scheduled a mandatory appointment for April 12, 2013 (Respondents' Exhibit J, p. 30).

21. On April 3, 2013, the Claimant was video recorded working construction with his brother. The video was reviewed in its entirety and in the video the Claimant can be seen performing the following activities, at the following times (as the times are noted on the video recording):

Time	*Activity*
7:56:32 a.m.	Claimant climbs into the back bed of a large truck and moves various pails, and other objects around in his truck bed using both arms, and then he climbs out the back of the truck bed with both arms on the hatch.
8:05:26	unloads objects from another large truck. closes the truck door with right arm.
8:07:13	coils hose, and is able to flex and abduct right arm without difficulty.
8:16:27	Claimant is seen reaching into the bed of the large pick-up truck with both arms over the back of the truck. Claimant pulls objects up and over the back hatch using his right arm, which is flexed greater than 100 degrees. Claimant pulls down the back hatch and pulls out more objects.
8:18	Claimant carries a metal and wood frame/equipment with his right arm (and not his left) while walking into a building.
8:23	Claimant on a second story balcony lifting and carrying work items in both hands.
8:24	Claimant throws a small object over the balcony, stretching his right arm out and down over the railing.
8:26-8:29	Claimant throws large rolls of materials off the balcony with both arms multiple times, using his right arm normally without hesitation; Claimant moves his arms while holding objects, up over his shoulders without apparent trouble. Claimant lifts objects from the floor without apparent trouble.
9:39	Claimant seen sweeping on balcony, moving right arm without apparent trouble.
9:40	Claimant abducts his right arm with broom to sweep debris into shovel.
9:41	Claimant moves a large machine with both arms, twists handles with right arm tightening object onto that machine.

9:47	Claimant moving a metal and wood object attempting to open the object; uses right arm without apparent difficulty.
9:48	Claimant moves large pails with both arm to another location.
9:50	Claimant lifts up tile saw machine with his right arm. Claimant moves object while abducting, flexing and pushing with the right arm to move the machine to the correct location.
9:51	Claimant lifts up a machine with right and left arms and places it in a different locations.
9:52	Claimant working with a tile saw machine, and he sets it up using both hands.
9:54	Claimant takes objects out of pails and sets them down on the ground. Lifts up another pail with water in it with right arm and holds it out.
9:55	Claimant holds another machine in his right arm and then hands it to another worker.
9:56	Claimant moves a saw and table with both arms into another location.
9:57	Claimant grabs two pails; one in each arm and walks into building.
10:04	Claimant comes out of building holding pails in each hand. Both pails are full and appear heavier but are being held in each hand.
10:04	Claimant lifts one of the full pails with his right arm and moves it to a different location.
10:05	Claimant lifts objects with right and left arms. Claimant moves them nearer to building.
10:06	Claimant lifts pail without apparent issue with right arm, and then he assembles a large hand held mixer and moves it to another location.
10:07	Claimant rolls out tarp and drags it into place with both hands.
10:08	Claimant moves pails with right arm without apparent issue and then he pours the contents of pail out.
10:10	Claimant holds the large mixer with both hands and mixes cement; mixer clearly causing vibration to upper arms.
10:11	Claimant uses large mixer again as other worker adds water to the cement mix.
10:16	Claimant comes out of building with pail filled with water in right hand, and he empties water from one pail into another.
10:21	Claimant checks watch and then lifts up mixer and mixes cement in pail again. Claimant then lifts mixer out of the pail using his right arm.
10:23	Claimant lifts up cap with right hand and places it back. Claimant's right arm comes up in >90 degrees of flexion.
10:29	Claimant picks up tile and places it on the tile saw, and then holds the tile in place with both hands.
10:30	Claimant flips a switch on his saw with his right hand and pushes tile through tile saw with both hands. Claimant pulls tile back from saw and takes piece off with right hand.
10:33	Claimant cuts another piece of tile by pushing it through the saw. Takes piece into building. Thereafter, Claimant repeats this numerous times.

10:37	Claimant exits the building with pail filed with water. Claimant picks up the large mixer and mixes cement in pail again. Claimant lifts pail up with cement in right hand and carries into building.
10:56	Claimant repeats tile cutting with saw, using both arms, and applying pressure while pushing tile through machine.
10:57	Claimant comes out of the building with empty pail, puts cement mix from sack into the pail. Claimant then puts water into pail, and then uses the mixer to mix.
10:58:41	Claimant empties more cement mix into pail. Claimant uses the large mixer again. Which he does again at 11:04; thereafter, Claimant uses his right arm to repeat this process, including pushing tile through tile saw process, reaching and stretching with his right arm.
11:21	Claimant reaches behind his back with right arm to put item in back pocket.
11:34	Claimant uses his right arm to reach in a bucket, and brush/scrape material off of tool using his right arm, while holding the tool in his left.
11:42	Claimant again using the large two hand mixer, causing vibrations to upper extremities.

22. During testimony at the hearing, the Claimant agreed that the video shows the Claimant using his left and right arm constantly below the waist, reaching over the trailer of a truck, taking carpet remnants over his shoulder and throwing them off a balcony, using his shoulder to mix grout with a vibrating mixer, and, one time during the video recording, using his arms overhead (Hrg. Trans., pp. 65-66).

23. On April 8, 2013, the Claimant called Dr. McKenna's office and requested that he be seen sooner than April 12, 2013. Care Plus obtained approval from Insurer, and the Claimant's appointment was moved to April 9, 2013 (Respondents' Exhibit J, p. 30). The Claimant could not recall at the hearing why he requested to move up his appointment with Dr. McKenna (Hrg. Trans. p. 67).

24. On April 9, 2013, Dr. McKenna noted that the Claimant had continued improvement. Dr. McKenna noted that the Claimant had last seen Dr. Durbin in February 2013 and Dr. Durbin had recommended a follow up visit with the Claimant in 6 weeks but was anticipating discharge. He was no longer working for Employer and he was not working with any particular restrictions, and while he noticed an occasional pop out of the shoulder, there hadn't been any real pain or discomfort. Dr. McKenna suggested that the Claimant follow-up with Dr. Durbin as scheduled and anticipated discharge with no rating (Respondents' Exhibit J, p. 31).

25. However, only 2 days later, on April 11, 2013, Dr. Durbin evaluated the Claimant and provided a significantly different opinion. In addition, Dr. Durbin noted that, contrary to the report provided to Dr. McKenna, the Claimant stated he had never regained full function to his shoulder, and that he always had pain limitations with abduction. Dr. Durbin recommended a right shoulder MRI "just to document integrity of

his rotator cuff" and scheduled a follow up appointment after the MRI (Claimant's Exhibit 10, p. 58; Respondents' Exhibit L, p. 42).

26. On April 16, 2013, a right shoulder MRI was interpreted as showing (1) a recurrent, complete tear of the supraspinatus and infraspinatus tendons with torn fibers retracted to the glenoid fossa, and subtle fatty atrophy of the infraspinatus muscle, (2) chronic, near full thickness tearing of the subscapularis tendon, and subtle fatty atrophy of the subscapularis muscle, (3) chronic, degenerative appearance of the superior labrum, (4) medial dislocation of the long head of the bicep tendon, and (5) post subacromial decompression and distal clavicular excision changes (Claimant's Exhibit 11, p. 61; Respondents' Exhibit M, p. 43).

27. On April 22, 2013, Dr. Durbin reviewed the MRI, noting that the Claimant had a "massive rotator cuff tear with significant atrophy, chronic-full thickness tearing of the supraspinatus, which has retracted significantly." Dr. Durbin further observed significant atrophy of the infraspinatus and supraspinatus muscles, and a medial dislocation of the long head of the biceps. Dr. Durbin opined the shoulder was "probably unfixable at this point." Dr. Durbin noted the Claimant was doing well functionally, except when he lifts in one certain direction. Dr. Durbin advised the Claimant that, ultimately, he would probably need a shoulder replacement. As the Claimant did not want to do that at the time, Dr. Durbin recommended conservative care, and opined that the Claimant could be placed at MMI (Claimant's Exhibit 10, p. 59; Respondents' Exhibit N, p. 44).

28. On April 26, 2013, the Claimant saw Dr. McKenna. Dr. McKenna reviewed the MRI findings and Dr. Durbin's report with the Claimant. The surgery discussed was a shoulder replacement, or a reverse arthroplasty for rotator cuff arthropathy. Dr. McKenna noted that Dr. Durbin instead recommended conservative therapy and he also noted that the Claimant was not excited about an extensive shoulder replacement surgery. Dr. McKenna concurred with Dr. Durbin that the Claimant was at MMI once a determination was made via Functional Capacity Exam (FCE) to determine the Claimant's range of motion and strength. Dr. McKenna further opined that he believed that the Claimant's restrictions would be made permanent, perhaps with some additional restrictions added per the results of the FCE (Claimant's Exhibit 9, p. 42; Respondents' Exhibit O, p. 45).

29. At the hearing, the Claimant testified that his thoughts, after having the MRI and discussing his condition with his doctors, were that the total shoulder replacement sounded like a lot of pain and he wasn't sure if it would be covered by workers' compensation. So, at that time, the Claimant opted to wait and see if it got better and if it didn't, then see what he needed to do to take care of the shoulder (Hrg. Trans., p. 43).

30. On May 6, 2013, the Claimant underwent an FCE with evaluator Heather Stokes at Physiotherapy Associates. The Claimant's shoulder range of motion and strength was tested and measured during a variety of physical tasks and Ms. Stokes

prepared a written report with the data entry points and a summary of the results (Claimant's Exhibit 12; Respondents' Exhibit P). The test was considered valid and the Claimant demonstrated consistent effort. The Claimant had no positive indicators of poor psychometrics or indicators of exaggerated symptoms. The level of pain was consistent with observed movement patterns. The test was limited by right shoulder pain (Claimant's Exhibit 12, p. 69 and 76; Respondents' Exhibit P, p. 52 and 59). The evaluation placed Claimant in the light work category and recommended maximum occasional and frequent lift of 35 lbs for floor to waist. The Claimant's ability to lift overhead with his right extremity was limited to 2lbs. Lifting with one hand to shoulder was limited to 7 lbs. on the right side (Claimant's Exhibit 12, pp. 69-70; Respondents' Exhibit P, pp. 52-53). The Claimant's right shoulder active range of motion was measured at 145 degrees flexion, 122 degrees abduction (133 degrees with pain), external rotation at 90 degrees with abduction at 75 degrees, and internal rotation at 90 degrees of abduction at 53 degrees. The Claimant's strength was normal, but painful (Claimant's Exhibit 12, p. 75; Respondents' Exhibit P, p. 58).

31. On May 28, 2013, the Claimant saw Dr. McKenna again and confirmed that he did not feel surgical intervention was appropriate at this time as he was not interested in the shoulder replacement. Dr. McKenna reviewed the FCE with the Claimant and discussed MMI and took range of motion shoulder measurements. Per Dr. McKenna's measurements the Claimant had a 19% impairment rating of the right upper extremity which, if converted, would be an 11% whole person impairment. Dr. McKenna indicated he would review the Claimant's full chart and if a rating were appropriate, he would do one. Dr. McKenna noted the restrictions were no use of the right arm above the shoulder level (Claimant's Exhibit 9, pp. 44-45; Respondents' Exhibit Q, pp, 61-62).

32. On June 4, 2013, Dr. McKenna placed the Claimant at MMI for this claim with a 19% right upper extremity rating. Dr. McKenna noted that apportionment may be appropriate if the Claimant had a previous rating secondary to his prior injuries. Dr. McKenna outlined restrictions of no use of the right upper extremity above the shoulder level, and no lifting, pushing, pulling greater than 50 pounds (Claimant's Exhibit 9, p. 48; Respondents' Exhibit Q, p. 63). Dr. McKenna noted that, "no formal maintenance care anticipated" (Claimant's Exhibit 9, p. 47; Respondents' Exhibit Q, p. 64).

33. On July 22, 2013, per Dr. McKenna's chart notes, the Claimant's wife called to see if the Claimant could proceed with the total shoulder replacement surgery. The notes indicate that the Claimant was authorized for a one time evaluation to discuss total shoulder replacement (Claimant's Exhibit 9, pg. 49).

34. On July 30, 2013, Dr. McKenna re-evaluated the Claimant, noting that the Claimant had reconsidered and was now interested in pursuing a surgical option for his shoulder and was requesting a second opinion. Dr. McKenna agreed that a second opinion was appropriate, but noted "I have cautioned him strongly that I am sure he can find a surgeon who is willing to operate but the question the question that he has to ask has to do more with how much improvement, particular in range of motion and strength, that he can possibly obtain versus the potential risk of any surgery." Dr. McKenna

nevertheless provided the referral. Dr. McKenna also noted that there were no changes to the rating or restrictions (Claimant's Exhibit 9, p. 50; Respondents' Exhibit R, p. 65).

35. On September 24, 2013, Insurer filed a final admission consistent with Dr. McKenna's opinions admitting for a 19% upper extremity impairment rating and MMI effective May 28, 2013. Liability for medical treatment and medications after MMI were specifically denied (Claimant's Exhibit 3; Respondents' Exhibit S).

36. On October 17, 2013, Dr. Armodios Hatzidakis performed a second opinion surgical evaluation. Dr. Hatzidakis examined the Claimant's shoulder, noting that on that date the Claimant had significantly limited range of motion, and significant tenderness over the long head of the biceps and over the lesser tuberosity. The Claimant had minimal tenderness over the AC joint. Dr. Hatzidakis reviewed prior medical records, including the right shoulder MRI, and he also reviewed nearly four hours of surveillance (Claimant's Exhibit 13, p. 99; Respondents' Exhibit T, p. 72). In reviewing the video surveillance from April 3, 2013, Dr. Hatzidakis noted that the Claimant worked a full day engaged in activities including, driving, lifting his arms to unload a truck, throwing objects off a balcony, using his right arm to assemble a tile table saw, mixing grout with a motorized mixer, lifting 30-50 lb. bags of cement and hoisting them to his right shoulder and working a sander. Dr. Hatzidakis notes that most of the activities were performed with the Claimant's arm below the shoulder, but while working with the tile cutter, the Claimant "lifts his arm seemingly quite easily multiple times above his shoulder to work the tile saw." Dr. Hatzidakis opined that the Claimant's current limited ability to actively elevate his arm is "in contradistinction to the reviewed video from April 3, 2013." Although, the doctor noted that it could simply be that the Claimant's shoulder has become worse over the last six months (Claimant's Exhibit 13, pp. 99-100; Respondents' Exhibit T, pp. 72-73). Dr. Hatzidakis interpreted the right shoulder MRI as showing grade 2 fatty infiltration. Dr. Hatzidakis also discussed further testing, therapy and surgical options (Claimant's Exhibit 13, pp. 102-103).

37. On November 5, 2013, the Claimant underwent a fluoro-guided right shoulder arthrogram with aspiration (Claimant's Exhibit 14; Respondents' Exhibit U, p. 81). The joint fluid was sent to the lab for analysis and cultures and no organisms were noted (Claimant's Exhibit 13, pp. 105-107). An EMG was conducted on November 14, 2013 and was found to be basically a normal study (Claimant's Exhibit 15, p. 111; Respondents' Exhibit V, p. 82).

38. On November 25, 2013, consistent with recommendations he made in his October 17, 2013 note, Dr. Hatzidakis' office wrote Insurer requesting authorization for a right shoulder arthroscopic rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavicle resection and open pectoralis major transfer (Claimant's Exhibit 13, p. 108; Respondents' Exhibit W, p. 84).

39. On December 2, 2013, Dr. Jon Erickson, an orthopedic surgeon, performed a physician advisor review in response to the surgical request from Dr. Hatzidakis. He noted that the Claimant's "medical records are extremely confusing." Dr.

Erickson opined that it was difficult to understand how all the damage seen on the MRI could occur from simple overuse. Dr. Erickson noted that there were "more questions concerning this case that one could reasonably list" and he stated that he had never before seen a case such as this "which begs an IME." Of particular concern to Dr. Erikson was that there were four hours of surveillance showing the Claimant using his shoulder aggressively, but Dr. Hatzidakis did not adequately explain how the Claimant's function had deteriorated so severely between April and October of 2013, other than to say it simply got worse over time. Dr. Erikson recommended denial of the procedure pending the results of an IME of the Claimant to "determine just how severely impaired he is" and "how this shoulder could become so severely involved when there was no clear work-related injury" (Respondents' Exhibit X).

40. On December 5, 2013, the Claimant's attorney was notified that the request for authorization for the surgery recommended by Dr. Hatzidakis was denied (Respondents' Exhibit Y).

41. On January 20, 2014, Dr. Miguel Castrejon performed a Division IME. He reviewed available records, but he did not review the surveillance. He took a history from the Claimant and noted that he found the Claimant to be a reliable historian (Claimant's Exhibit 16, p. 113; Respondents' Exhibit Z, p. 87). Although, the Claimant himself admitted that while he told Dr. Castrejon that working modified duties on the tanker truck aggravated his shoulder condition, he did not tell the doctor that he only worked four or five shifts on the tanker truck performing those duties (Hrg. Trans., p. 72). The Claimant also described to Dr. Castrejon his job duties when he worked the vacuum truck, stating that he worked 12-14 hour days and he used 75-pound vacuum hoses, picks and shovels to break up and remove materials inside tanks and pits (Claimant's Exhibit 16, p. 113; Respondents' Exhibit Z, p. 87). The Claimant advised Dr. Castrejon that, on January 12, 2013, he had been working with a coworker all day using a pick and shovel, but receiving little help from the coworker. The Claimant reported that he noticed discomfort involving the right shoulder but he continued to work as he needed to finish the job. The Claimant further reported to Dr. Castrejon that by the time he had to put the hoses back on the truck at the end of the job, he was having difficulty with this due to weakness and pain in his right shoulder. The Claimant advised Dr. Castrejon that he was concerned about this but could not contact his supervisor until Monday since he did not typically answer the phone on weekends. The Claimant advised that he did report the injury on Monday, January 14, 2013 and was referred for medical care with Dr. Durbin and he was placed on light duty. Dr. Castrejon also noted that the Claimant treated with Dr. McKenna. Through Dr. McKenna's records, Dr. Castrejon was advised of the Claimant's significant past history of right shoulder injury (Claimant's Exhibit 16, p. 114; Respondents' Exhibit Z, p. 88). The Claimant advised that subsequent to the date of injury until February 28, 2013, he worked the modified duty position with the tanker truck. As noted above, the Claimant did not tell Dr. Castrejon that he only worked four or five shifts in that modified position. Dr. Castrejon surmised that the modified work may have aggravated the Claimant's condition because the turning of the crank on the tanker truck "require a moderate amount of force" implicating his right upper limb as the Claimant is right handed (Claimant's Exhibit 16, p.

120; Respondents Exhibit Z, p. 94). Dr. Castrejon notes that the Claimant admitted that after leaving his employment with Employer, his pain symptoms improved.

42. Dr. Castrejon then addressed the surgical recommendation of Dr. Hatzidakis and noted that the Claimant wishes to proceed with this surgical intervention "with the goal of improving strength and motion to his limb" although the Claimant admitted that "his pain has improved and is present only with lifting in an above the shoulder manner" and "he is able to perform his current work activities as he limits any above shoulder activities" (Claimant's Exhibit 16, p. 121; Respondents' Exhibit Z, p. 95). With regard to right shoulder surgery, Dr. Castrejon opined as follows:

> On examination today there is an adequate and functional range of motion. There is no discomfort. There is one grade motor loss yet this does not functionally limit activities of daily living and current work activities. This examiner notes that when evaluated by Dr. Hatzidakis shoulder range of motion was significantly decreased when compared to today's findings. Dr. Hatzidakis documented flexion to 80 degrees, abduction to 80 degrees, and external rotation to 30 degrees. Today his flexion is 156 degrees, abduction is 122 degrees, internal rotation to 65 degrees and external rotation to 75 degrees. Based upon his examination today I question whether proceeding with surgery is appropriate. In this examiner's professional opinion it is unlikely that the Claimant's range of motion and strength will appreciably increase with surgery, given the MRI findings. And, if pain is not an issue, then this would not be considered an indication to proceed with surgery (Claimant's Exhibit 16, pp. 121-122; Respondents' Exhibit Z, pp. 95-96).

43. Dr. Castrejon opined that based upon his physical examination of the Claimant and review of the medical records he concluded that the Claimant was at MMI as of June 4, 2013 and he has remained stable since that date, he found no evidence to support a significant worsening of condition, and he noted that the Claimant's range of motion was very similar to that found during the May 6, 2013 FCE. Dr. Castrejon further noted that the Claimant continued to work in a new position, reporting minimal pain with the primary complaint of weakness and pain with elevation of weight, which he felt was not likely to improve with surgery (Claimant's Exhibit 16, p. 122; Respondents' Exhibit Z, p. 96).

44. Dr. Castrejon assigned a 7% impairment of the upper extremity for loss of range of motion and a 4% impairment for loss of function due to loss of strength (Claimant's Exhibit 16, p. 122; Respondents' Exhibit Z, p. 96). These combined for the upper extremity impairment rating of 11%, which, if converted per table 3, would result in a 7% whole person impairment rating, prior to apportionment.

45. Considering the issue of apportionment, Dr. Castrejon noted the Claimant sustained a prior work related injury to his right shoulder[1] which he opines, "would have been eligible for 10% impairment of upper extremity based upon distal clavical resection. After apportioning 10%, Dr. Castrejon opines a 1% upper extremity (and, if converted, a 1% whole person) impairment rating remains (Respondents' Exhibit Z, p. 97).

46. With respect to the issue of maintenance care, Dr. Castrejon noted that none was recommended by Dr. McKenna. Dr. Castrejon did not make any specific recommendation for maintenance care either, but he did state that, "based upon the Claimant's medical condition, it is reasonable for the claimant to retain access to surgical intervention should he experience a significant change in his condition that is found to be directly related to the industrial condition" (Respondents' Exhibit Z, p. 97).

47. On February 27, 2014, Insurer filed a Final Admission of Liability consistent with Dr. Castrejon's opinion regarding MMI (Claimant's Exhibit 4; Respondents' Exhibit AA). However, in error, the Insurer admitted to the original, unapportioned 11% upper extremity rating, failing to notice the apportionment section of Dr. Castrejon's report. At hearing, the parties stipulated that Insurer claims representative Felicia Hall would testify that Insurer mistakenly admitted to the 11% pre-apportionment upper extremity rating, and not the 1% upper extremity post-apportionment rating (Hrg. Trans. p. 15-16). The difference between the 11% scheduled rating and 1% rating is $5,553.18.

48. On March 12, 2014, Dr. Hatzidakis' office again requested authorization for surgery, including: right shoulder arthroscopic biopsies/cultures, rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavical resection and open pectoralis major transfer (Claimant's Exhibit 13, p. 109; Respondents' Exhibit BB, pp. 104).

49. On March 16, 2014, Dr. Erickson was again asked to review and address the surgical authorization requested and opine regarding the DIME report . Dr. Erickson noted Dr. Castrejon failed to address the very important issue of causality and whether the Claimant sustained a work related injury versus a cumulative trauma disorder. Dr. Erikson opined that if the Claimant's claim was a cumulative trauma disorder, then he had serious doubt that his work activities would justify the severe damaged noted on the MRI as a work related condition. Dr. Erickson stated that until the causation issue was properly addressed, he still saw no reason to approve the request for surgery (Respondents' Exhibit CC).

50. On March 17, 2014, Insurer issued a letter again denying Dr. Hatzidakis' surgery request (Claimant's Exhibit 6; Respondents' Exhibit DD).

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[1] In the section of his DIME report on apportionment on the 11th page of his report, Dr. Castrejon refers to a left shoulder work related injury on March 16, 2002. However, in his review of the medical records from 2002 on the 7th and 8th pages of his report, Dr. Castrejon correctly refers to a right shoulder injury.

51. On March 27, 2014, the Claimant applied for hearing on issues that included overcoming the DIME on MMI, medical benefits, namely authorization of the surgery recommended by Dr. Hatzidakis, disfigurement, and permanent partial disability benefits (related to conversion)(Respondents' Exhibit EE).

52. On April 25, 2014, Respondents filed their Response to March 27, 2014 Application for Hearing, indicating as additional issues causation/relatedness, apportionment of the impairment rating, intervening injury/aggravation at subsequent employment, offsets and overpayment, causation of disfigurement and failure to accept modified job offer (Respondents' Exhibit FF).

53. On July 23, 2014, Kathleen D'Angelo issued an IME report. Dr. D'Angelo obtained a detailed history from the Claimant regarding his prior shoulder issues, his work injury, his subsequent modified work for Employer, his subsequent work for his brother, and his ongoing shoulder issues. As part of her IME, Dr. D'Angelo also thoroughly reviewed available medical records, and examined the Claimant. Per the questionnaire completed by the Claimant, the Claimant provided the following mechanism of injury for the incident on January 12, 2013:

> I was using a pick and shovel all day to clean out a water jet tank. During this time I noticed some discomfort in my right shoulder but continued working as we needed to complete the job. At the end of the job I had [sic] difficult time putting the hoses back on the truck due to weakness and pain in right shoulder. When I go in the truck to go back to the yard I had to lift my right hand with my left hand to put it on the gear shift (Respondents' Exhibit GG, p. 114).

54. Dr. D'Angelo reviewed in detail the time period right after his reported injury with the Claimant as well as the period when he worked modified duty and when he left Employer to work for his brother. During the course of the interview, the Claimant indicated to Dr. D'Angelo that he believed working with the tanker truck and having to rotate the crank to raise and lower the trailers was damaging to his shoulder and he should not have been asked to do this. However, Dr. D'Angelo noted that this activity would have occurred prior to the Claimant's February 28, 2013 resignation from Employer. On April 9, 2013, Dr. McKenna noted the Claimant was not having pain and was much improved except for occasional popping. Dr. D'Angelo noted that it wasn't until 2 days after this when the Claimant saw Dr. Durbin that the Claimant complained of persistent, ongoing pain. Thus, she questioned whether the Claimant suffered a new injury between these 2 doctor appointments at a time when he no longer worked for Employer (Respondents' Exhibit GG, pp. 119-120). On physical examination, Dr. D'Angelo noted that range of motion "is full in all directions without apparent distress or pain. Range of motion of the right shoulder and left shoulder are equal" (Respondents' Exhibit GG, p. 125). Upon review of the impressions from the April 16, 2013 MRI, Dr. D'Angelo opined that the MRI revealed "changes which are not acute and do not date from his January 2013 work incident. The radiological study reveals chronic and subacute finding, which do not correspond to the time interval of 3 months." Dr. D'Angelo specifically notes that "fatty infiltration" and "atrophy" are indicative of chronic

tearing and also portend poor prognostic outcome for surgical repair and/or debridement of the tendons (Respondents' Exhibit GG, p. 128).

55. Ultimately, Dr. D'Angelo opined that the Claimant's right shoulder massive rotator cuff tears associated with retraction, atrophy and fatty infiltration were not causally related to his described work incident." She further opined that while she thought it was likely that the Claimant's work duties aggravated Claimant's his underlying degenerative shoulder condition, this was a temporary flare or aggravation, as evidenced by his improvement and reports on April 9, 2013. By that date, Claimant had been working for his brother in a physically demanding position for 6 weeks (Respondents' Exhibit GG, p. 131). Dr. D'Angelo concluded that "[Claimant's] present symptoms related to his right shoulder as well as his massive rotator cuff tears and the need for treatment are independent, and unrelated and incidental to work activities at [Employer]." Dr. D'Angelo opined that Dr. Castrejon erred in finding the Claimant's ongoing right shoulder issues were work related. She indicated Dr. Castrejon failed to take into account the MRI findings, and the interval amount of time it would take to develop those findings. She explained that the reason the Claimant was able to function at a high level with those issues was the length of time he had been compensating for his right shoulder cuff damage. She found that to the extent the Claimant requires any right shoulder surgery, whether for joint replacement or rotator cuff debridement, it is unrelated to a January 2013 work incident, but is rather, related to prior and chronic rotator cuff trauma and tears which predate the 2013 work incident (Respondents' Exhibit GG, p. 132).

56. At the hearing, Scott McDonald testified as the general manager for McDonald Farms. Mr. McDonald testified that he was familiar with the Claimant and had known him since they were both either ten or eleven years old (Hrg. Trans., p. 80). Mr. McDonald testified that he was working on the day that the Claimant stated he was injured and over the course of the weekend had been on the phone for a total of eight hours. He testified that his phone is with him 24/7 and he checks his voice messages regularly (Hrg. Trans., p. 82). Although Mr. McDonald conceded that the Claimant's pay was reduced when he worked in the parts room, the Claimant's pay went back up to his regular rate of pay as soon as he started driving the tanker truck (Hrg. Trans., pp. 83-84). Mr. McDonald testified that the Claimant worked modified duty on the tanker truck between February 18, 2013 and February 26, 2013 (Hrg. Trans., p. 87). During the time frame when the Claimant worked on the tanker truck, Mr. McDonald testified that the Claimant never called him to report that he was having shoulder problems (Hrg. Trans., p. 88). Mr. McDonald also testified that if you put the crank in the low gear, you can crank it with one arm (Hrg. Trans., pp. 89-90). He noted that if the cranking is done in a high gear it can be done very quickly, but it could take 10-15 minutes in the low gear. However, using the low gear requires much less strength (Hrg. Trans., pp. 92-93).

57. Dr. D'Angelo testified at the hearing as an expert in the areas of internal medicine, occupational medicine and as to Level II accreditation matters for workers' compensation. Consistent with her written IME report of July 23, 2014, Dr. D'Angelo testified that her opinion was that the Claimant sustained an aggravation of his

underlying right shoulder inflammatory process due to the mechanism of injury he described to her as occurring in January of 2013. Dr. D'Angelo agreed that there was a basis for a compensable claim due to the January 2013 work injury (Hrg. Trans., p. 117). Dr. D'Angelo testified that subsequently the Claimant was placed at MMI and he remains at MMI. She bases this opinion, in part, on the Claimant's reporting of improvement and on the range of motion measurements taken by her and Dr. Castrejon, which were similar (Hrg. Trans., p. 119). Dr. D'Angelo also testified that in her review of the MRI, in terms of causality, the findings were significant for the fatty infiltration of the torn rotator cuffs, the atrophy and the retraction. She opined that these three findings are seen in chronic rotator cuff tears as opposed to an acute injury (Hrg. Trans., p. 120 see also, pp. 132-133). She based this on medical literature that provides that although you will see fatty infiltration in patients over 68 years old within 2 ½ years following a massive tear. However, for patients under the age of 68, it takes, on average, three to four years before fatty infiltration and atrophy of the musculature develops. Since the Claimant's MRI was performed three ½ months after the injury in January, this would not support the time frame during which fatty infiltration or muscle atrophy is known to occur (Hrg. Trans., pp. 120-121). Dr. D'Angelo also testified that the mechanism of injury that the Claimant described to her was also an indication that the rotator cuff tear seen on the MRI could not be attributed to that activity for a couple of reasons: (1) his pain increased gradually throughout the day and there was no one moment where he could no longer work and, (2) the Claimant was working with a pick but was not doing overhead activity. Therefore, Dr. D'Angelo opined that the activities the Claimant was doing at work on January 12, 2013 would have increased inflammation in a person with the Claimant's long history of degenerative changes in his shoulder which would have caused pain and difficulty with range of motion. However, this is a temporary aggravation which resolves. She found that this conclusion fit the mechanism of injury, the duration of his issues per the medical records and the fact that he recouped his range of motion after a period of time (Hrg. Trans., p. 127-128). With respect to the surgery recommended by Dr. Hatzidakis, Dr. D'Angelo opined that she does not believe it is reasonable and necessary as patients with findings as severe as the Claimant's do not typically respond well to repair of severely damaged and atrophied rotator cuffs and the risk of re-injury is greater. Dr. D'Angelo acknowledged she is not a surgeon but opined that it is within her work and expertise as an internist to render opinions as to whether or not a surgery can benefit a patient (Hrg. Trans., pp. 128-132). Dr. D'Angelo also testified that she agreed with Dr. Castrejon that the Claimant was at MMI for his claim, although she disagrees that Dr. Castrejon's diagnosis is claim related since she finds the Claimant's shoulder condition wholly unrelated to the work incident (Hrg. Trans., p. 140). Thus, she would not have provided the Claimant with an impairment rating as Dr. Castrejon did. Nevertheless, to the extent that he provided an impairment rating, Dr. D'Angelo found no errors with his impairment rating process, including the apportionment (Hrg. Trans., pp. 141-142, see also pp. 145-146). Dr. D'Angelo further opined that Claimant's impairment, if any, should be compensated as a scheduled rating, as there was no indication Claimant had any functional disability outside of the right shoulder joint (Hrg Trans. p. 142).

58. Dr. D'Angelo's testimony was completed by deposition on October 17, 2014. On cross-examination, Dr. D'Angelo testified that at the time of her examination the Claimant had asymmetry of his upper periscapular muscle with atrophy of the right infraspinatus and supraspinatus on examination which are muscles of the rotator cuff located on his scapula which is proximal to the glenohumeral joint and located on his body (Kathy D'Angelo Depo. Trans., pp. 24-25). She also testified that the purpose of the rotator cuff is to assist in the use of the arm. The Claimant has testified that when he uses his arm over head or out to the side while weight bearing he has pain. Dr. D'Angelo also testified that the Claimant indicated he had pain on her examination which would go into his neck and that was when she noted significant atrophy on examination of the thoracic spine area (Kathy D'Angelo Depo. Trans., pp. 39-40). The Claimant's counsel also reviewed the issue of apportionment and argued that the total impairment of the Claimant's shoulder would be 10% for the distal clavical surgery plus the 11% for the range of motion and strength deficits for a 21% pre-apportionment rating and then the 10% would be apportioned from this amount (Kathy D'Angelo Depo. Trans., pp. 33-35). However, Dr. D'Angelo adamantly disagreed and testified that it was her opinion that it is not appropriate, per the AMA Guides, to have added in the 10% for the distal clavicle as it was not an issue in the Claimant's current condition (Kathy D'Angelo Depo. Trans., pp. 33-35). On redirect examination, Dr. D'Angelo again testified that it is her opinion that the rater does not include all prior surgeries in the pre-apportionment rating (Dr. Kathy D'Angelo Depo. Trans., p. 53).

59. Dr. Hatzidakis testified by deposition on January 29, 2015. Dr. Hatzidakis is a board certified orthopedic surgeon who specializes in shoulder surgery (Dr. Armodios Hatzidakis Depo. Trans., p. 3). Dr. Hatzidakis is also Level II accredited by the Division of Worker's Compensation (Dr. Armodios Hatzidakis Depo. Trans., p. 4). Dr. Hatzidakis saw the Claimant for a second opinion regarding medical treatment on October 17, 2013 (Dr. Armodios Hatzidakis Depo. Trans., p. 4). Based on his review of the MRI, Dr. Hatzidakis opined that the Claimant had Grade 2 fatty infiltration, which means that there were significant streaks of fat in the muscle. However, this was not to the level of a Grade 4 fatty infiltration where there is essential no muscle left. Since the fatty infiltration was still not too severe and the Claimant's humeral head wasn't excessively high-riding, Dr. Hatzidakis opined that this could still be consistent with an acute injury (Dr. Armodios Hatzidakis Depo. Trans., pp. 6-7). He did not agree with Dr. D'Angelo that the existence of fatty infiltration in an MRI taken 3 ½ months after the Claimant's work injury meant that the MRI findings could not be acute and related to the work injury (Dr. Armodios Hatzidakis Depo. Trans., p. 7). Dr. Hatzidakis testified that when he evaluated the Claimant he recommended an arthroscopic evaluation, debridement, removal of torn tissue, treatment of the biceps and possibly and open pectoralis major transfer to help the weak subscapularis (Dr. Armodios Hatzidakis Depo. Trans., p. 8). Dr. Hatzidakis testified that he disagrees with Dr. D'Angelo's opinion that the Claimant is not likely to do well with the repair. He further testified that in his practice, he has seen patients with tears like the Claimant who are treated successfully with surgery and have pain relief, improved function, improved range of motion and improved strength. Although he does agree that the prognosis for regaining full strength is less than if the tear were smaller. Yet, Dr. Hatzidakis maintains that the results can be

good and improve a patient's quality of life (Dr. Armodios Hatzidakis Depo. Trans., p. 9). He opined that, "[i]t's well-documented in the literature, repair of extensive rotator cuff tears has been well-documented to have good results. The treatment of biceps lesions with massive cuff tears, even in the state – in the setting of an irreparable rotator cuff, can help the patient's function and pain relief significantly. And even a simple debridement without any repair or treatment of an associated biceps lesion can result in pain relief" (Dr. Armodios Hatzidakis Depo. Trans., p. 11). Dr. Hatzidakis testified that since it had been a year and three months between the time he examined the Claimant and the date of his deposition, he would need to evaluate the Claimant again and he would recommend a repeat MRI to evaluate the progression of the tear and the fatty infiltration (Dr. Armodios Hatzidakis Depo. Trans., p. 14).

60. On cross-examination, Dr. Hatzidakis testified that he was only asked to provide a surgical opinion, and he did not assess causation (Dr. Armodios Hatzidakis Depo. Trans., pp. 19-20). As of the date of his deposition, Dr. Hatzidakis had not been provided with any additional documentation, he never reviewed the reports of Dr. Castrejon or Dr. D'Angelo, and he had not reviewed Dr. D'Angelo's testimony (Dr. Armodios Hatzidakis Depo. Trans., pp. 18-19). Dr. Hatzidakis admitted that his opinion regarding Claimant being a surgical candidate was based upon how Claimant presented to him on October 17, 2013 (Dr. Armodios Hatzidakis Depo. Trans., pp. 21-22). In discussing the video surveillance of the Claimant from April 3, 2013, Dr. Hatzidakis agreed that his function seemed better in the video that it did during the evaluation at Dr. Hatzidakis' office (Dr. Armodios Hatzidakis Depo. Trans., p. 22). Dr. Hatzidakis "absolutely" agreed that the question of whether a patient is a surgical candidate is a question two surgeons seeing the patient on the same date could disagree on. (Dr. Armodios Hatzidakis Depo. Trans., p. 28). Dr. Hatzidakis testified that the considerations that made him decide to recommend surgery on October 17, 2013 were his pain and his shoulder dysfunction (which included limited motion, weakness and pain with motion) (Dr. Armodios Hatzidakis Depo. Trans., pp. 29-29). On cross examination, Dr. Hatzidakis again testified that he didn't think he could currently make an assessment regarding whether the surgery he previously recommended could assist the Claimant with an increase in function since he hadn't seen the Claimant in over a year (Dr. Armodios Hatzidakis Depo. Trans., pp. 31-32).

Ultimate Findings of Fact

61. The Claimant's testimony regarding his mechanism of injury on January 12, 2013 is generally consistent with his reporting of the same to treating and evaluating physicians, is credible, and is found as fact. Specifically, it is found that the Claimant suffered an injury to his right shoulder while performing his job duties using vacuum hoses, a pick and a shovel to remove debris from a water jet tank.

62. The medical records of Drs. McKenna and Durbin and the May 6, 2013 FCE report, along with the video surveillance taken of the Claimant working for a subsequent employer on April 3, 2013, are persuasive in terms of establishing that the

Claimant's right shoulder condition improved significantly subsequent to January 12, 2013.

63. The surgery recommended by Dr. Hatzidakis for which he has submitted two requests for authorization is not reasonably necessary to cure and relieve the Claimant from an injury that he sustained on January 12, 2013. Per the medical records of Drs. McKenna and Durbin, it is more likely than not that the injury suffered by the Claimant on January 12, 2013 was a strain that resolved and the Claimant's function, range of motion and strength returned to his pre-injury baseline. That pre-injury baseline is not a healthy shoulder given that the Claimant sustained a prior work related injury and a non-work related injury to the right shoulder and the Claimant also has degenerative changes secondary to these prior injuries. The opinions of Drs. Castrejon, McKenna, Durbin, Erickson and D'Angelo are found to be more persuasive than that of Dr. Hatzidakis regarding whether the proposed surgery is reasonably necessary.

64. There was no testimony or evidence offered at the hearing or in subsequent deposition testimony of (a) an actual permanent impairment rating from the Claimant's prior work related injury; or (b) that the Claimant received an award or settlement under the Workers' Compensation Act of Colorado or similar act from another state.

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.

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).

Medical Benefits – Causally Related and Reasonably Necessary

Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. C.R.S. § 8-42-101, C.R.S. However, the right to workers' compensation benefits, including medical benefits, arises only when an injured employee establishes by a preponderance of the evidence that the need for medical treatment was proximately caused by an injury arising out of and in the course of the employment. C.R.S. § 8-41-301(1)(c); *Faulkner v. Indus. Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000). 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).

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). However, no compensability exists when a later accident or injury occurs as the direct result of an independent intervening cause. An unrelated medical problem may be considered an independent intervening cause even where an industrial injury impacts the treatment choices for the underlying medical condition. *Owens v. Industrial Claim Appeals Office*, 49 P.3d 1187 (Colo. App. 2002); *Post Printing & Publishing Co. v. Erickson,* 94 Colo. 382, 30 P.2d 327 (1934).

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,* 805 P.2d 1167 (Colo. App. 1990); *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).

Here, the Claimant's treating and examining physicians for the most part agree that, ultimately, the Claimant will require a shoulder replacement surgery. However, given his current level of function, range of motion and management of pain symptoms, none of the physicians recommend proceeding with this surgery at this time. Even Dr. Hatzidakis acknowledged that he had not evaluated the Claimant since October and November of 2013 and reevaluation would be required before he could opine if the Claimant were a candidate for surgery.

As for the surgical authorization request from Dr. Hatzidakis to perform right shoulder arthroscopic biopsies/cultures, rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavical resection and open pectoralis major transfer, Dr. Hatzidakis is alone among the physicians who have treated and evaluated the Claimant in recommending these procedures. All of the other physicians reject these proposed procedures due to questions regarding causation or the likelihood that the proposed procedures are not reasonably necessary to cure and relieve the Claimant of the effects of his work injury, or both. In fact, several physicians have opined that the procedures proposed by Dr. Hatzidakis are not likely to improve the Claimant's condition and may actually cause greater harm. Dr. Durbin, the orthopedic surgeon who performed a right rotator cuff repair in 2002, and was also an authorized treating physician over the course of this claim, opined that the Claimant's shoulder was probably unfixable at this point but that the Claimant was actually doing well functionally except when he lifted in one certain direction. Dr. Durbin recommended conservative care until such time as the Claimant ultimately required a shoulder replacement. The Claimant's other treating physician, Dr. McKenna, strongly cautioned that, given the Claimant's current range of motion and strength, the Claimant had to seriously consider how much he could gain from surgery versus the potential risks. The DIME physician Dr. Castrejon opined that, based upon his physical examination of the Claimant on January 20, 2014, he documented a significantly improved range of motion compared to the measurements documented by Dr. Hatzidakis earlier. He opined that the proposed surgery was not likely to appreciably increase the Claimant's range of motion and strength, so, if pain was not an issue, then he found surgery was not indicated. As for the issue of pain, the Claimant advised Dr. Castrejon, as well as other treating and evaluating physicians, that his pain had improved and was only present with lifting in an above the shoulder manner and the Claimant was able to perform his current work duties and he was not functionally limited in his activities of daily living. Dr. D'Angelo also took range of motion measurements and found the Claimant's range of motion to be full in all directions without apparent distress or pain and noted that range of motion of his right and left shoulders was equal. Based on reports in the medical records, Dr. D'Angelo also concluded that the Claimant's pain symptoms significantly improved between the January 12, 2013 incident and April 9, 2013. She opined that the Claimant's work duties temporarily aggravated his underlying condition and caused inflammation, but that these issues resolved.

Further, while the Claimant's testimony regarding the incidents of January 12, 2013 was credible, and it is found that the events that the Claimant consistently related to his Employer and medical providers did occur as he testified, this is not sufficient to

establish a causal relation to the need for the recommended surgery in light of the conflicting evidence. Per the credible and persuasive opinion of Dr. D'Angelo, as supported by the opinion of Dr. Erickson and the medical records of Drs. McKenna and Durbin, the mechanism of injury described by the Claimant would be more consistent with a strain but would not be consistent with the development of the condition of his shoulder as seen on the April 16, 2013 MRI which was interpreted as showing (1) a recurrent, complete tear of the supraspinatus and infraspinatus tendons with torn fibers retracted to the glenoid fossa, and subtle fatty atrophy of the infraspinatus muscle, (2) chronic, near full thickness tearing of the subscapularis tendon, and subtle fatty atrophy of the subscapularis muscle, (3) chronic, degenerative appearance of the superior labrum, (4) medial dislocation of the long head of the bicep tendon, and (5) post subacromial decompression and distal clavicular excision changes. Both Drs. D'Angelo and Erickson questioned how the mechanism of injury described by the Claimant could have caused, or even aggravated or accelerated, the structural condition of the Claimant's shoulder as shown on the April 16, 2013 MRI images. The fact that subsequent to the January 12, 2013 injury, but before the MRI, the Claimant was seen working at his new job duties for another employer in a manner demonstrating a relatively high level of function further supports the opinions of Drs. D'Angelo and Erickson. A number of actions the Claimant takes on the video using his right upper extremity, including, but not limited to the following, demonstrate the Claimant's improved level of function, range of motion, and apparent lack of pain with right shoulder and arm use:

8:16:27	Claimant is seen reaching into the bed of the large pick-up truck with both arms over the back of the truck. Claimant pulls objects up and over the back hatch using his right arm, which is flexed greater than 100 degrees. Claimant pulls down the back hatch and pulls out more objects.
8:26-8:29	Claimant throws large rolls of materials off the balcony with both arms multiple times, using his right arm normally without hesitation; Claimant moves his arms while holding objects, up over his shoulders without apparent trouble. Claimant lifts objects from the floor without apparent trouble.
9:50	Claimant lifts up tile saw machine with his right arm. Claimant moves object while abducting, flexing and pushing with the right arm to move the machine to the correct location.
9:51	Claimant lifts up a machine with right and left arms and places it in a different locations.
9:52	Claimant working with a tile saw machine, and he sets it up using both hands.
10:11	Claimant uses large mixer again as other worker adds water to the cement mix.

Dr. Castrejon ultimately opined that, as the Claimant continued to work in a new position, reporting minimal pain, with the primary complaint of weakness and pain with elevation of weight, he felt this was not likely to improve with surgery. The opinions of

Dr. Castrejon, Dr. D'Angelo, Dr. Erickson, Dr. Durbin and Dr. McKenna are more persuasive than that of Dr. Hatzidakis regarding the surgical recommendation to repair (rather than replace) the Claimant's right shoulder.

Moreover, the proposed medical treatment consisting of right shoulder arthroscopic biopsies/cultures, rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavical resection and open pectoralis major transfer, as recommended by Dr. Hatzidakis, is treatment for a pre-existing condition unrelated to the Claimant's January 12, 2013 industrial incident. The Claimant's January 12, 2013 work injury did not cause, combine with, or aggravate the Claimant's pre-existing right shoulder condition, nor did it accelerate the need for the surgical treatment proposed. As a result, the Claimant's request for medical benefits consisting of right shoulder arthroscopic biopsies/cultures, rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavical resection and open pectoralis major transfer is denied.

Burden of Proof to Overcome the MMI Opinion of a DIME Physician

The DIME physician's findings include his or her subsequent opinions, as well as his or her initial report. *Andrade v. Industrial Claim Appeals Office,* 121 P.3d 328, 330 (Colo. App. 2005). The party seeking to overcome that opinion concerning a claimant's MMI status bears the burden of proof by clear and convincing evidence. C.R.S. § 8-42-107(8)(b)(III); *Clark v. Hudick Excavating*, W.C. No. 4-524-162 (November 5, 2004); *MGM Supply Co. v. Industrial Claim Appeals Office*, 62 P.3d 1001 (Colo. App. 2002); *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Clear and convincing evidence is that which is "highly probable and free from serious or substantial doubt." Thus, the party challenging the DIME physician's finding must produce evidence contradicting the DIME which is unmistakable and free from serious or substantial doubt showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995); *Leming v. Industrial Claim Appeals Office,* 62 P.3d 1015 (Colo. App. 2002).

MMI exists at the point in time when "any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." C.R.S. §8-40-201(11.5), C.R.S. 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 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. *Mosley v. Industrial Claim Appeals Office,* 78 P.3d 1150 (Colo. App. 2003); *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). Therefore, a DIME physician's finding that a party has or has not reached MMI is binding unless overcome by clear and convincing evidence. Whether a party has overcome the Division IME's opinion as to MMI is a question of fact for the ALJ as the sole arbiter of conflicting

medical evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

A finding that the claimant needs additional medical treatment (including surgery) to improve his 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 1080 (Colo. App. 1990); *Sotelo v. National By-Products, Inc.,* W.C. No. 4-320-606 (I.C.A.O. March 2, 2000). Similarly, a finding that additional diagnostic procedures which offer a reasonable prospect for defining the claimant's condition or suggesting further treatment are warranted would be consistent with a finding that a Claimant was not at MMI. *Hatch v. John H. Harland Co.,* W.C. No. 4-368-712 (I.C.A.O. August 11, 2000). However, the requirement for future medical maintenance which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of MMI per C.R.S. § 8-40-201(11.5), nor does the need for recommended diagnostic testing solely to assist in the maintenance of a claimant's condition. *Brownson-Rausin v. Industrial Claim Appeals Office*, 131 P.3d 1172 (Colo. App. 2005).

On April 22, 2013, Dr. Durbin reviewed the Claimant's MRI, noting that the Claimant had a "massive rotator cuff tear with significant atrophy, chronic-full thickness tearing of the supraspinatus, which has retracted significantly." Dr. Durbin further observed significant atrophy of the infraspinatus and supraspinatus muscles, and a medial dislocation of the long head of the biceps. Dr. Durbin opined the shoulder was "probably unfixable at this point." Dr. Durbin noted the Claimant was doing well functionally, except when he lifts in one certain direction. Dr. Durbin advised the Claimant that, ultimately, he would probably need a shoulder replacement. As the Claimant did not want to do that at the time, Dr. Durbin recommended conservative care, and opined that the Claimant could be placed at MMI. On April 26, 2013, the Claimant saw Dr. McKenna. Dr. McKenna reviewed the MRI findings and Dr. Durbin's report with the Claimant. The surgery discussed was a shoulder replacement, or a reverse arthroplasty for rotator cuff arthropathy. Dr. McKenna noted that Dr. Durbin instead recommended conservative therapy and he also noted that the Claimant was not excited about an extensive shoulder replacement surgery. Dr. McKenna concurred with Dr. Durbin that the Claimant was at MMI once a determination was made via Functional Capacity Exam (FCE) to determine the Claimant's range of motion and strength.

On May 6, 2013, the Claimant underwent an FCE with evaluator Heather Stokes at Physiotherapy Associates. The test was considered valid and the Claimant demonstrated consistent effort. The evaluation placed Claimant in the light work category and recommended maximum occasional and frequent lift of 35 lbs for floor to waist. The Claimant's ability to lift overhead with his right extremity was limited to 2lbs. Lifting with one hand to shoulder was limited to 7 lbs. on the right side. The Claimant's right shoulder active range of motion was measured at 145 degrees flexion, 122 degrees abduction (133 degrees with pain), external rotation at 90 degrees with

abduction at 75 degrees, and internal rotation at 90 degrees of abduction at 53 degrees. The Claimant's strength was normal, but painful.

On May 28, 2013, the Claimant saw Dr. McKenna again and confirmed that he did not feel surgical intervention was appropriate at this time as he was not interested in the shoulder replacement. Dr. McKenna reviewed the FCE with the Claimant and discussed MMI and took range of motion shoulder measurements. On June 4, 2013, Dr. McKenna placed the Claimant at MMI for this claim.

On January 20, 2014, Dr. Miguel Castrejon performed a Division IME. He reviewed available records, but he did not review the surveillance. He took a history from the Claimant and noted that he found the Claimant to be a reliable historian. Through Dr. McKenna's records, Dr. Castrejon was advised of the Claimant's significant past history of right shoulder injury. The Claimant advised that subsequent to the date of injury until February 28, 2013, he worked the modified duty position with the tanker truck. Dr. Castrejon surmised that the modified work may have aggravated the Claimant's condition because the turning of the crank on the tanker truck "require a moderate amount of force" implicating his right upper limb as the Claimant is right handed. Dr. Castrejon noted that the Claimant admitted that after leaving his employment with Employer, his pain symptoms improved. Upon physical examination, Dr. Castrejon noted that the Claimant exhibited adequate and functional range of motion without discomfort. He noted one grade motor loss yet found this did not functionally limit the Claimant's activities of daily living and current work activities. Dr. Castrejon noted that when the Claimant was evaluated by Dr. Hatzidakis, his shoulder range of motion was significantly decreased when compared to Dr. Castrejon's findings. Dr. Hatzidakis documented flexion to 80 degrees, abduction to 80 degrees, and external rotation to 30 degrees. However, Dr. Castrejon measured the Claimant's flexion as 156 degrees, abduction at 122 degrees, internal rotation to 65 degrees and external rotation to 75 degrees. Dr. Castrejon opined that based upon his physical examination of the Claimant and review of the medical records he concluded that the Claimant was at MMI as of June 4, 2013 and he has remained stable since that date, he found no evidence to support a significant worsening of condition, and he noted that the Claimant's range of motion was very similar to that found during the May 6, 2013 FCE. Dr. Castrejon further noted that the Claimant continued to work in a new position, reporting minimal pain with the primary complaint of weakness and pain with elevation of weight. In addressing the surgery proposed by Dr. Hatzidakis, Dr. Castrejon found that surgery to be contraindicated.

Consistent with her written IME report of July 23, 2014, Dr. D'Angelo testified that her opinion was that the Claimant sustained an aggravation of his underlying right shoulder inflammatory process due to the mechanism of injury he described to her as occurring in January of 2013. Dr. D'Angelo agreed that there was a basis for a compensable claim due to the January 2013 work injury. Dr. D'Angelo testified that subsequently the Claimant was placed at MMI and he remains at MMI. She bases this opinion, in part, on the Claimant's reporting of improvement and on the range of motion measurements taken by her and Dr. Castrejon, which were similar.

Claimant's position that Dr. Castrejon is in error regarding whether the Claimant is at maximum medical improvement rests largely on the argument that the Claimant requires the surgery proposed by Dr. Hatzidakis. As set forth above, the recommended procedures were not found to be reasonably necessary to cure and relieve the Claimant from the effects of his work injury. Moreover, per Drs. Castrejon and D'Angelo, the Claimant's range of motion and strength are significantly improved and his condition has been stable since June 4, 2013, and arguably even prior to that date. Thus, the Claimant has failed to prove that Dr. Castrejon's opinion with regard to MMI is in error. Dr. Castrejon's opinion that the Claimant reached MMI as of June 4, 2013 will not be disturbed.

Overcoming the DIME on Impairment – Causation and Apportionment

The apportionment issues in this case involve apportionment of PPD benefits pursuant to C.R.S. § 8-42-104(5)(a). As the PPD benefits hinge on the impairment rating provided by the DIME physician in this case, there is also interplay with § 8-42-107(8)(c) because, since 1991, the medical impairment determination of the DIME is binding unless overcome by clear and convincing evidence. In this case, the DIME physician determined that there was an 11% upper extremity impairment, 7% for range of motions deficits and 4% for loss of function due to loss of strength. The DIME further determined that apportionment applied in this case and opined that because the Claimant had a distal clavical resection as part of his 2002 work-related injury, he would have been entitled to a 10% impairment rating for that procedure. Thus, per Dr. Castrejon, the post-apportionment residual scheduled impairment rating was 1%, which, if converted, would convert to a 1% whole person impairment.

A DIME physician must apply the AMA Guides when determining the claimant's medical impairment rating. C.R.S. § 8-42-101(3.7); C.R.S. §8-42-107(8)(c). The finding of a DIME physician concerning the claimant's medical impairment rating shall be overcome only by clear and convincing evidence. Clear and convincing evidence is that which is "highly probable and free from serious or substantial doubt." Thus, the party challenging the DIME physician's finding must produce evidence contradicting the DIME which is unmistakable and free from serious or substantial doubt showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995); *Leming v. Industrial Claim Appeals Office,* 62 P.3d 1015 (Colo. App. 2002).

As a matter of diagnosis, the assessment of permanent medical impairment inherently requires the DIME physician to identify and evaluate all losses that result from the injury, including 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); *Martinez v. Industrial Claim Appeals Office, 176 P.3d 826* (Colo. App. 2007). 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. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002); *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). The rating physician's determination concerning the cause or causes of impairment should include an assessment of data collected during a clinical evaluation and the mere existence of an impairment does not create a presumption of contribution by a factor with which the impairment is often associated. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000).

Ultimately, the questions of whether the DIME physician properly applied the AMA Guides, and whether the rating was overcome by clear and convincing evidence present questions of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office, supra*. Not every deviation from the rating protocols of the AMA Guides requires the ALJ to conclude that the DIME physician's rating has been overcome as a matter of law. Rather, deviation from the AMA Guides constitutes evidence that the ALJ may consider in determining whether the DIME physician's rating has been overcome. *Wilson v. Industrial Claim Appeals Office,* 81 P.3d 1117 (Colo. App. 2003); *Adams v. Manpower, supra*. Moreover, a mere difference of opinion between physicians does not necessarily rise to the level of clear and convincing evidence. *See Gonzales v. Browning Ferris Industries of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

Dr. Castrejon assigned a 7% impairment of the upper extremity for loss of range of motion and a 4% impairment for loss of function due to loss of strength. These combined for the upper extremity impairment rating of 11%, which, if converted per table 3, would result in a 7% whole person impairment rating, prior to apportionment. These calculations resulted in a lower impairment rating than the 19% upper extremity rating provided by Dr. McKenna bases on his range of motion shoulder measurements performed on May 28, 2013.

Respondents argued that Dr. Castrejon erred in finding the Claimant's ongoing right shoulder issues were work related and submitted that the impairment rating for the Claimant's right upper extremity was incorrect. This was based largely on the report and testimony of Dr. D'Angelo. She opined that Dr. Castrejon erred in providing an impairment rating at all. She indicated Dr. Castrejon failed to take into account the MRI findings, and the interval amount of time it would take to develop those findings. However, to the extent that he provided an impairment rating, Dr. D'Angelo testified that he calculated it correctly per the AMA Guides based on the range of motion shoulder measurements that he obtained. With respect to the causation issue, the Respondents offered the contrary opinion of Dr. D'Angelo, but did not establish that the opinion of Dr. Castrejon was in error. The Respondents failed to overcome Dr. Castrejon's finding of a causal relationship between the Claimant's January 12, 2013 injury and the impairment rating that he provided.

At the hearing and in the post-hearing briefs, the Claimant did not take issue with the substantive impairment rating provided by Castrejon of an 11% upper extremity rating (that would convert to a 7% whole person rating, if converted) prior to apportionment. Rather, the Claimant argued that apportionment was not appropriate in

this case. At issue was a 10% apportionment for a distal clavical resection that occurred as a result of the Claimant's 2002 work injury. This would implicate C.R.S. § 8-42-104(5)(a).

Apportionment of Medical Impairment for a Prior Work-Related Condition or Injury

In this case C.R.S. § 8-42-104(5) provides statutory authority for apportioning permanent medical impairment. As the parties arguments rest on interpretation and application of the statute, some history of the statutory scheme is helpful. After the 1991 amendment that implemented medical impairment determinations for PPD benefit awards, apportionment of those benefits was governed by C.R.S. § 8-42-104(2), which continued to refer to apportionment of "disability." Pursuant to *Askew v. Industrial Claim Appeals Office,* 927 P.2d 1333 (Colo. 1996), apportionment of medical impairment was governed by a two-step analysis. Respondents first had to show that a prior condition was disabling at the time of the instant work injury. If Respondents met that first step, the second step in the Askew test was whether the prior impairment "has been sufficiently identified, treated, or evaluated to be rated as a contributing factor in the subsequent disability" and whether there was evidence of a reduced capacity to meet the demands of life's activities. The Supreme Court noted that a dormant or asymptomatic condition cannot be adequately evaluated, and thus rejected any apportionment of such a condition as "arbitrary," quoting provisions from the AMA Guides instructing an evaluator not to attempt apportionment in the absence of information to measure prior impairment accurately.

For injuries from July 1, 1991 to July 1, 1999, "apportionment" had to be distinguished from the normal "causation" determinations that were part of the DIME ratings. *Public Service Co. of Colorado v. Industrial Claim Appeals Office,* 40 P.3d 68 (Colo. App. 2001); *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy Inc.,* W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). The distinction between "causation" and "apportionment" was drawn in *Johnson v. Christian Living Campus,* W.C. No. 4-354-266 (ICAO, October 5, 1999). Johnson explained that determination of whether an entire component of impairment is due to the industrial injury was a causation determination. Assessing the contribution of occupational factors to a particular aspect of the impairment was an apportionment determination.

Effective July 1, 1999, subsection (2) of C.R.S. § 8-42-104 was renumbered as (2)(a) and applied only to permanent total disability benefits. A new subsection (2)(b) provided, "When benefits are awarded pursuant to section 8-42-107, an award of benefits for an injury shall exclude any previous impairment to the same body part." This amendment rendered irrelevant the previous two-step apportionment analysis under Askew, supra. The existence of previous "disability" was irrelevant. The sole issue was whether claimant had "previous impairment to the same body part." This purely medical determination was part and parcel of the DIME determination of impairment for the work injury. *Martinez v. Industrial Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007).

Then, effective July 1, 2008, C.R.S. § 8-42-104, was extensively amended. Subsection (2) was repealed in its entirety. Subsection (5)(a) was added to provide for apportionment of previous awards or settlements of medical impairment ratings from a previous work injury. Subsection (5)(b) was added and provided for apportionment 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, is independently disabling. In this case, reference to the facts shows that the Claimant had previously suffered both a non-work related injury and a work-related injury. However, Dr. Castrejon only apportioned the impairment rating with respect to a procedure/specific injury he associated with the 2002 work injury.

Additionally, the Division of Workers' Compensation has adopted WCRP 12 to implement the statutory provisions for impairment rating determinations. WCRP 12-3(B) in pertinent part provides:

> For claims with a date of injury on or after July 1, 2008, the Physician may provide an opinion on apportionment for any preexisting work related or non work-related permanent impairment to the same body part using the AMA Guides, 3rd Edition, Revised, where medical records or other objective evidence substantiate a preexisting impairment. Any such apportionment shall be made by subtracting from the injured worker's impairment the preexisting impairment as it existed at the time of the subsequent injury or occupational disease. The Physician shall explain in their written report the basis of any apportionment. If there is insufficient information to measure the change accurately, the Physician shall not apportion. If the 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. Identified and treated in this context requires facts reflecting that a medical provider previously noted and provided some level of treatment for the non work-related impairment.
>
> > (1) The effect of the Physician's apportionment determination is limited to the provisions in section 8-42-104. When filing an admission an insurer shall provide documentation reflecting compliance with section 8-42-104.

The Claimant posits, as a matter of law**,** apportionment was not authorized under C.R.S. § 8-42-104(5)(a). The Claimant asserts that the plain language of C.R.S. § 8-42-104(5)(a) precludes apportionment in this case. Although WRCP 12-3(B) would allow for the opinion provided by Dr. Castrejon, the statute limits application of WRCP 12-3(B) by its very terms.

C.R.S. §8-42-104(5)(a) provides:

> In cases of permanent medical impairment, the employee's award or settlement shall be reduced:
>
> When an employee has suffered more than one permanent medical impairment to the same body part and has received an award or settlement under the 'Workers' Compensation Act of Colorado' or a similar act from another state. The permanent medical impairment rating applicable to the previous injury to the same body part, established by award or settlement, shall be deducted from the permanent medical impairment rating for the subsequent injury to the same body part.

It is the Claimant's position that, even if Respondents could provide medical support for apportionment of claimant's prior work-related injury, apportionment is not authorized because Respondents cannot meet the second part of the statutory test, which requires for apportionment of a prior medical impairment that the Claimant has received an award or settlement for the previous injury to the same body part.

When interpreting statutes a court should give words and phrases in a statue their plain and ordinary meanings. This is true because the object of statutory construction is to give effect to the legislative intent of the statute, and the best indicator of legislative intent is contained in the language of the act. Forced and subtle interpretations should be avoided. *Jones v. Industrial Claim Appeals Office,* 87 P.3d 259 (Colo. App. 2004); *Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176 (Colo. App. 2002). Further, statutes addressing the same subject matter should be construed together, and an interpretation that renders one clause meaningless should be avoided. *USF Distribution Services, Inc., v. Industrial Claim Appeals Office,* 111 P.3d 529 (Colo. App. 2005). When the legislature speaks with exactitude, we must construe the statute to mean that the inclusion or specification of a particular set of conditions necessarily excludes others. *Lunsford v. W. States Life Ins.,* 908 P.2d 79, 84 (Colo.1995). Finally, we note that when it chooses to legislate in a particular area, the General Assembly is presumed to be aware of existing case law precedent. *Pierson v. Black Canyon Aggregates, Inc.,* 48 P.3d 1215, 1219 (Colo.2002).

The statute in question is two sentences long. Both sentences make reference to "award or settlement." In the first sentence, the statute requires proof that a Claimant "*received an award or settlement* under the 'Workers' Compensation Act of Colorado' or a similar act from another state." The second sentence permits apportionment "applicable to the previous injury to the same body part, *established by award or settlement*…." It is abundantly clear from the plain language of the statute, repeated for further clarity, that apportionment is not authorized in the absence of proof of this element.

In considering the issue of apportionment, Dr. Castrejon noted the Claimant sustained a prior work related injury to the same body part which he opines, "would

have been eligible for 10% impairment of upper extremity based upon distal clavical resection. After apportioning 10%, Dr. Castrejon opined a 1% upper extremity (and, if converted, a 1% whole person) impairment rating remains.

The ALJ specifically found that no evidence was presented, in testimony at hearing, deposition testimony, or in the voluminous exhibits admitted into evidence, that the Claimant was compensated by award or settlement for previous injury to the same body part. Rather, Dr. Castrejon merely opined that the Claimant would have been entitled to a 10% scheduled impairment rating for that body part.

Under the plain language of C.R.S. § 8-42-104(5)(a), apportionment is not warranted in this case because Respondents failed to establish that the Claimant received an award or settlement for her prior work related injury. Because the Respondents failed to establish that the Claimant was compensated by award or settlement, the Claimant is entitled as a matter of law to permanent partial medical impairment benefits based on the 11% scheduled rating (which, if converted would equate to a 7% whole person impairment rating) as provided by the DIME physician for the January 12, 2013 work injury, without apportionment to reduce that rating.

Disability Compensation Based on Scheduled Injury vs. Whole Person Impairment

The claimant bears the burden of establishing functional impairment beyond the arm at the shoulder and the consequent right to permanent partial disability benefits under§ 8-42-107(8)(c), C.R.S., by a preponderance of the evidence. *Maestas v. American Furniture Warehouse,* W.C. No. 4- 662-3 69 (June 5, 2007); *Johnson-Wood v. City of Colorado Springs,* W. C. No. 4-536-198 (ICAO June 20, 2005).

The question of 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 site 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); *Warthen v. Industrial Claim Appeals Office,* 100 P.3d 581 (Colo. App. 2004).

There is no requirement that functional impairment take any particular form in order to be compensable under § 8-42-107(8)(c), C.R.S. Evidence of pain and discomfort which interferes with the claimant's ability to use a portion of the body may be considered impairment for this purpose. Aligaze *v. Colorado Cab Co. / Veolio Transportation*; W.C. No. 4-705-940 (ICAO April 29, 2009); *Chacon v. Nichols Aluminum Golden, Inc.,* W.C. No. 4-521-005 (ICAO November 29, 2004); *Guillotte v. Pinnacle Glass Company*, W.C. No. 4-443-878 (ICAO November 20, 2001), aff'd., *Pinnacle Glass Co. v. Industrial Claim Appeals Office*, (Colo. App. No. 01CA2386, August 22, 2002) (not selected for publication). The courts have held that damage to structures of the "shoulders" may or may not reflect a "functional impairment"

enumerated on the schedule of disabilities. *See Walker v. Jim Fouco Motor Company,* supra*; Strauch v. PSL Swedish Healthcare System,* supra, *Langton v. Rocky Mountain Health Care Corp.,* supra*; Price v. United Airlines,* W.C. No. 4-441-206 (ICAO January 28, 2002); *Johnson-Wood v. City of Colorado Springs,* supra. Pain that causes physical limitations, such as the ability to engage in actions requiring overhead movement has been determined to be a proper basis for a finding of functional impairment justifying a whole person rating. *Martinez v. Pueblo County Sheriff's Office,* W.C. No. 4-806-129 (ICAO December 7, 2011).

In this case, the Claimant's testimony, substantiated by the medical records and opinions of Drs. McKenna, Durbin, Castrejon and Hatzidakis, establishes that the Claimant is entitled to a whole person medical impairment compensable under § 8-42-107(8)(c), C.R.S., because he has suffered a functional impairment to a part of the body that is not contained on the schedule. The Claimant has proven by a preponderance of the evidence that the situs of his functional impairment extends beyond the arm at the shoulder. The Claimant testified credibly that as a result of this right shoulder injury he continues to suffer functional impairments that limit use of his arm overhead or extended out to the side, due to pain occurring in his shoulder. The Claimant was also provided permanent lifting restrictions by Dr. McKenna of: no use of the right upper extremity above the shoulder level, and no lifting, pushing, pulling greater than 50 pounds. The Claimant testified credibly that he can continue to perform his current work duties, but only if he limits overhead use of his right upper extremity.

Based on the testimony and the medical records, the situs of the Claimant's functional impairment is to his right shoulder, including credible and documented continuing complaints of pain and discomfort which were impact his functioning. As the Claimant's functional impairment is contained off the schedule of injuries, the 7% whole person rating (converted from the 11% scheduled upper extremity rating) is the correct impairment rating.

Medical Maintenance Treatment after MMI

Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. The need for medical treatment may extend beyond the point of maximum medical improvement where Claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). The evidence must establish a 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. Medical evidence is not required to establish causation and lay testimony alone, if credited, may constitute substantial evidence to support an ALJ's determination regarding causation. *Industrial Commission*

of Colorado v. Jones, 688 P.2d 1116 (Colo. 1984); *Apache Corp. v. Industrial Commission of Colorado, 717 P.2d 1000 (Colo. App. 1986).*

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). The claimant must prove entitlement to *Grover* medical benefits by a preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

The Claimant was placed at MMI on June 4, 2013, 2013 by Dr. McKenna made no recommendation for maintenance medical care. Dr. Castrejon also noted that no maintenance care was recommended by Dr. McKenna. Dr. Castrejon himself did not make any specific recommendation for maintenance care either, but he did state that, "based upon the Claimant's medical condition, it is reasonable for the claimant to retain access to surgical intervention should he experience a significant change in his condition that is found to be directly related to the industrial condition." At the time that the Claimant saw Dr. D'Angelo for evaluation on July 23, 2014, she noted that her measurements for range of motion were similar to those of Dr. Castrejon. Thus, the Claimant's condition was not deteriorating. Moreover, he continued to work at his job with his brother's company performing the same work that he did at the time of MMI.

The Claimant failed to prove entitlement to medical maintenance care by a preponderance of the evidence as the Claimant did not establish that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is therefore ordered that:

1. The Claimant's request for medical benefits consisting of right shoulder arthroscopic biopsies/cultures, rotator cuff repair, longhead biceps tenodesis, subacromial decompression with possible distal clavical resection and open pectoralis major transfer recommended by Dr. Hatzidakis is not reasonably necessary to cure and relieve the effects of his January 12, 2013 work injury and this claim for medical benefits is denied and dismissed.

2. The Respondents failed to prove, by clear and convincing evidence, that DIME physician Miguel Castrejon, M.D. erred in finding that the Claimant's right shoulder condition, for which he provided an impairment rating, was causally related to the Claimant's January 12, 2013 work injury.

3. The Claimant failed to prove, by clear and convincing evidence, that DIME physician Miguel Castrejon, M.D. erred in his MMI determination. The Claimant reached MMI on June 4, 2013.

4. The Claimant's impairment rating is not subject to apportionment pursuant to C.R.S. § 8-42-104(5)(a).

5. The Claimant proved, by a preponderance of the evidence, that he suffered a functional impairment contained off the schedule of injuries set forth at Section 8-42-107(2), C.R.S. and is entitled to permanent partial disability benefits based upon a whole person conversion of the upper extremity rating. The Claimant is entitled to a 7% whole person impairment rating.

6. Respondents shall file an amended Final Admission of Liability reflecting a whole person impairment rating of 7% in accordance with Dr. Castrejon's impairment rating report and shall pay permanent partial disability benefits based on the 7% whole person impairment rating.

7. The Claimant failed to prove, by a preponderance of the evidence, that future medical benefits are reasonably necessary to relieve the effects of his injury or prevent deterioration of his condition. The claim for medical benefits is denied and dismissed.

8. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

9. 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, 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 petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATED: July 23, 2015

Kimberly A. Allegretti
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

ISSUES

1. Whether the claimant's need for treatment to her low back is related to her admitted industrial injury of January 15, 2013; and,

2. If so, is the recommendation of an epidural steroid injection reasonable and necessary to treat that low back condition?

FINDINGS OF FACT

1. The claimant sustained an admitted work injury on January 15, 2013. On that date, the claimant worked as a paraprofessional for the respondent-employer. While walking at work, the claimant tripped and fell walking on an uneven sidewalk in icy conditions. The claimant has treated continuously since January 15, 2013.

2. Dr. Olson treated the claimant for multiple injuries as a result of this incident, including placing the claimant in a CAM boot to help resolve the issue the claimant was having with her ankle.

3. The claimant suffers from scoliosis that pre-exists her work related injury.

4. The claimant has treated for back pain on numerous occasions prior to January 15, 2013 injury, both with chiropractic care and osteopathic care.

5. The claimant began to have back pain as a result of her altered gait form the use of the CAM boot.

6. The claimant informed Dr. Olson of her pain and the claimant was sent to Dr. Sparr for further treatment. Specifically, Dr. Olson requested that the claimant receive trigger point injections and an epidural injection.

7. The claimant received the trigger point injections but did not receive the epidural injection.

8. The respondents denied the epidural injection requested by Dr. Olson.

9. Dr. Olson testified by deposition that he believes that the claimant should still undergo the epidural injection in an attempt to relieve the symptoms that she is having as a result of the use of the CAM boot. Dr. Olson testified that he believes that the claimant suffered an exacerbation of her low back condition as a result of the use of the CAM boot and that further treatment is necessary. Dr. Olson also agreed that the claimant's back pain, if it were from the altered gait should have resolved by now.

10. Dr. Olson conceded the claimant's low back problems "certainly could be" related to her preexisting low back complaint, since she has been out of the CAM walker for a long time yet continues to have low back complaints. He expected once she was out of the CAM walker, a normal gait would follow and problems would have resolved.

11. Mark Paz, M.D. preformed an independent medical examination of the claimant. Dr. Paz does not believe that the claimant's back condition is related to the use of the CAM boot. Dr. Paz believes that the claimant's condition would have gotten better after she discontinued the use of the CAM boot.

12. Dr. Paz opined that the claimant has an "established history of chronic low back pain . . . documented in the medical record prior to the January 15, 2013 date of injury." The Southern Colorado Family Medicine record from February 27, 2012, documents that treatment for the claimant's low back had been "ongoing for years." The claimant had a history of scoliosis with low back pain since she was a teenager, according to the records. The claimant provided a "direct history" during her evaluation with Dr. Paz that "she had no back or low back symptoms prior to the date of injury." The history she provided to Dr. Paz was not consistent with an aggravation of a preexisting condition.

13. Dr. Paz opined, based on a reasonable degree of medical probability, it is "not medically probable that the CAM walker aggravated or accelerated the preexisting back condition of scoliosis in the lumbar spine." The "natural history of a "flare" of chronic back discomfort . . . during use of the CAM walker is that the back condition would improve after the CAM boot is no longer used." In the claimant's case, she reported the symptoms further worsened after the CAM walker was used, which is inconsistent with a history where the CAM boot would have worsened the low back complaints.

14. The claimant has a degenerative disk disease according to Dr. Paz. It is not medically probable that the degenerative disease is related to the work injury. It is

not medically probable to Dr. Paz that the scoliosis or degenerative disk disease was aggravated or accelerated by the January 15, 2013 work injury according to Dr. Paz.

15. The ALJ finds Dr. Paz's opinions are credible and more persuasive than medical opinions to the contrary.

16. The ALJ finds that the claimant has failed to establish that it is more likely than not that her low back condition is causally related to her admitted industrial injury of January 15, 2013.

CONCLUSIONS OF LAW

1. The claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001).

2. The 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); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997.

3. The claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. 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).

4. Claimant has the burden to prove his entitlement to medical benefits by a preponderance of the evidence. §8-43-201, C.R.S. Respondents are only liable for the medical treatment that is reasonable and necessary to cure and relieve the work-related injury. §8-42-101(1)(a), C.R.S. Even after an admission of liability is filed, respondents retain the right to dispute the relatedness of the need for continuing treatment. This principle recognizes that the mere admission that an injury occurred cannot be construed as a concession that all subsequent conditions and treatments were caused by the admitted injury. *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250 (Colo. App. 1990); *Snyder v. ICAO*, 942 P.2d 1337 (Colo. App. 1997).

5. In accordance with § 8-43-215, C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

6. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16.

7. The preponderance of persuasive evidence demonstrates that the claimant failed to prove that her January 15, 2013 injury, including treatment for that injury, directly and proximately caused a low back condition for which medical benefits are sought.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The claimant's claim for medical benefits for her low back condition is denied and dismissed.

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: July 22, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Dr Ste 230
Colorado Springs, CO 80906

ISSUES

1. Whether the respondents proved by clear and convincing evidence that the Division independent medical examiner's determination regarding Maximum Medical Improvement (MMI) was incorrect and that the claimant was appropriately placed at MMI on June 12, 2014?

2. Whether the claimant proved by a preponderance of the evidence that she is entitled to further medical benefits including the treatment recommended by the DIME physician and Dr. Paul Stanton's recommendation for a lumbar fusion surgery?

FINDINGS OF FACT

1. The claimant was a general manager for the respondent-employer for 14 years at 4 different locations. She was employed at the respondent-employer for 16 years prior to being terminated on August 1, 2013.

2. The claimant injured her back on December 12, 2012 while working at the respondent-employer.

3. On December 12, 2012, the claimant lifted a keg of beer at the respondent-employer's and had immediate onset of low back pain. The claimant told another manager on duty, Pam Stebbenne, that she had injured her back. The claimant did not fill out an incident report because she thought that her back would feel better. The claimant was hoping that it wasn't anything serious.

4. The claimant's back initially felt better a couple weeks later. However, the claimant's pain gradually got more intense between the end of February and beginning of March 2013. On March 24, 2013, the claimant went to the emergency department at Penrose Hospital for the pain in her back.

5. The claimant was eventually evaluated by Dr. Paul Stanton on March 28, 2013. Dr. Stanton ordered an MRI which showed a disk herniation at L5-S1 on the right with mild compression of the S1 nerve root. The MRI also showed moderate degenerative disk disease at L4-L5.

6. Dr. Stanton recommended physical therapy. However, the claimant was unable to complete physical therapy because she was having difficulty walking.

7. Because the claimant was unable to participate in physical therapy and she continued to experience right sciatic and low back pain, Dr. Stanton recommended an L5-S1 discectomy.

8. On April 29, 2013, Dr. Stanton performed an L5-S1 discectomy on the claimant.

9. On May 6, 2013, the claimant returned to Dr. Stanton for a post-surgery follow-up. The claimant reported having new leg and foot pain since having the surgery. During that visit the claimant also told Dr. Stanton that she was uneasy about returning to work because she is a "hands on" manager. Dr. Stanton referred the claimant to physical therapy and wrote an off work note for May 6, 2013 through May 20, 2013.

10. On May 20, 2013, Dr. Stanton allowed the claimant to return to work with restrictions that included "no bending, lifting over 10-20 LBS, no twisting. Return 4 hours a day for the first two weeks then increase to 6 hours for two weeks then full time."

11. On June 11, 2013, Dr. Stanton released the claimant to a full days work with maximum lifting of 10-20 LBS, no prolonged sitting, no prolonged standing, and no repeated bending or twisting.

12. On July 9, 2013, the claimant returned to Dr. Stanton reporting that she is having trouble following her restrictions at work and an escalation in her pain. She also reported having some plantar fasciitis pain on the left side. Dr. Stanton noted that he believed the claimant "did not have an adequate chance to recover. She may have returned to work too early without having fully rehabbed her musculature. . . Ultimately, she may require significant strengthening before returning to work as she may have inflamed her current situation by returning to work at too high a level too soon."

13. On September 12, 2013, Dr. Stanton stated:

> At this point, it seems the patient has had a difficult course. She sustained an injury while at work lifting a heavy keg in December. She ultimately presented to my office with significant nerve pain. She was taken to surgery for discectomy and her symptoms were relieved. Her employer apparently had demanded she return to work. When she did, she was working extremely long hours with a significant amount of heavy lifting and twisting, despite her recent surgery. Eventually she was terminated for poor work performance. It seems clear that her injury was definitely sustained at work. I do not feel she had adequate time to

> recover before returning to work with such a heavy work load. Now I think she is sustaining dynamic foraminal stenosis where her L5-S1 disc is just not competent to maintain her foraminal dimensions and when she is in a standing position she has some recurrence of symptoms on the right side. . . I will see her back in 2 weeks for recheck. If at that time she is not markedly improved or still has recurrent symptoms, we discussed the possibility of reconstructing her L5-S1 segment for permanent resolution of her disc disease. This would also fare better for her obtaining meaningful employment in the future.

14. The respondent-insurer authorized the claimant to see Dr. Stanton for one visit on November 5, 2013. During that visit, Dr. Stanton noted:

> [T]he patient continues to have dynamic stenosis of her L5-S1 segment, which is causing persistent leg pain in the right lower extremity. The fact that her symptoms are relieved when she is supine suggests that this is dynamic in nature and the quality of her disc material is not competent enough to withstand her body weight when she is upright. . . At this point, I would recommend she undergo an L5-S1 epidural injections, as well as bilateral L5-S1 facet injections to see if we can quiet both her leg and back pain. . . I suspect that her symptoms would be short-term in nature as I feel that problem is mainly a structure one and not an inflammatory one. Ultimately, if she had some good results from her epidural and facet injections, she would be a candidate for reconstruction of her L5-S1 segment, which would stabilize her foraminal dimensions, alleviate her leg pain, as well as relieve her facet and ultimately muscular mediated back pain. Apparently, the patient was only approved for one visit today so I will need to see her back on a p.r.n. basis. Should she require further care, I will be glad to continue her treatment.

15. On November 12, 2013, the claimant filed an application for hearing to address medical benefits, reasonable and necessary, authorized provider, temporary total disability benefits, temporary partial disability benefits, and right of selection.

16. On January 20, 2014, the claimant saw Dr. Randall Jones. He recommended more physical therapy, referred the claimant back to Dr. Stanton, referred to pain management with Dr. Jenks for an EMG of right lower extremity, referral to Dr. David Hopkins, clinical psychologist, and if needed, Mr. Beaver for biofeedback, and a repeat MRI.

17. On January 2, 2014, Dr. Fall performed an Independent Medical Examination on the claimant. During that examination, the claimant noted that she currently experiences pain in her lower back. She noted that the pain in her right lower back is a constant aching and weakness, which goes down to her right gluteal area,

hamstring, and lateral hip. She also noted difficulty sleeping. Driving and sitting causes pain in her right calf. She noted that the pain does not go down to the hip as much as it did before the surgery. She also told Dr. Fall that she began experiencing bladder urgency and incontinence around November 2013. The claimant told Dr. Fall that sometimes her foot feels "lazy" and she does not always have control of her bowels.

18. A hearing was held on March 4, 2014. On April 3, 2014, 2014, ALJ Stuber Ordered the respondents to pay for the April 29, 2013 surgery by Dr. Stanton; and for the respondents to pay for reasonably necessary medical treatment by authorized providers, including Dr. Stanton, Dr. Jenks, and Dr. Hopkins.

19. On April 17, 2014, Dr. Albert Hattem examined the claimant. Dr. Hattem scheduled the claimant for a lumbar spine MRI with gadolinium to rule out recurrent disk. He noted that the claimant should return to clinic in one month for likely case closure if the MRI is unrevealing.

20. On April 24, 2014, the claimant underwent an MRI of her lumbar spine with and without contrast. The MRI revealed "Right hemilaminectomy L5-S1 with enhancing granulation tissue surrounding the thecal sac at the site of the surgery without recurrent herniation of stenosis. Mild buldge and endplate spur L4-L5 without significant stenosis."

21. On June 12, 2014, Dr. Hattem placed the claimant at maximum medical improvement ("MMI") and gave her a 19% whole person impairment rating. Dr. Hattem informed the claimant that the MRI looked good demonstrating only postsurgical changes without evidence of recurrent disk. He indicated that Dr. Stanton did not schedule a return appointment with the claimant and that the claimant was not a candidate for additional surgery.

22. However, the claimant testified she was not able to schedule a return appointment with Dr. Stanton because the respondent-insurer hadn't paid the claimant's medical bills from Dr. Stanton, which was ordered by ALJ Stuber.

23. On July 23, 2014, Dr. Edwin Healey performed an Independent Medical Evaluation of the claimant. Dr. Healey indicated that the claimant's current diagnosis related to her December 12, 2012, worker's compensation injury was "1. Acute L5-S1 subligamentous disc herniation with associated radiculitis, status post L5-S1 discectomy, with residual chronic low back and right leg pain. 2. Urinary frequency and urgency; rule out urinary sphincter dyssynergia."

24. Dr. Healey opined that the claimant is not at MMI. At the time of Dr. Healey's examination, he opined that the claimant needed to undergo another surgical opinion by a surgeon. However, subsequent to Dr. Healey's examination, the claimant was examined by Dr. Stanton and he recommended surgery.

25. Dr. Healey concurred the with 19% whole person impairment rating assessed by Dr. Hattem. Dr. Healey noted that there appeared to be some granulation tissue around the L5-S1 surgical site on the MRI report. Dr. Healey recommended that the claimant undergo a selective L5-S1 epidural steroid injection. Dr. Healey also recommended

> lumbar paraspinal muscle trigger point injection on one occasion with local anesthetic and cortisone. If this does not relieve the pain, then I would recommend L4-L5, L5-S1 facet blocks, if they relieve her pain medical branch blocks and if she gets 80% relief of medial branch blocks then the primary pain generator may be her L4-L5, L5-S1 facets because the lumbar MRI indicates there is arthrosis at these levels. If receives an 80 percent reduction of her pain with medial branch blocks she would be a candidate for radiofrequency neurotomies at the symptomatic levels. [The claimant] is receiving some relief of her pain with gabapentin and I would recommend that it be restarted.

26. On November 7, 2014, Dr. Kenneth Finn performed a Division Independent Medical Examination ("DIME"). Dr. Finn found that the claimant was not at MMI. Dr. Finn indicated that the epidural fibrosis noted on postoperative imaging could be the cause of her pain. Dr. Finn recommended that the claimant be under the care of a physician that can manage her pain and spasms. He recommended that she undergo spinal injections to address the potential nerve irritation based on the scar tissue. In addition, Dr. Finn recommended a spine strengthening and stabilization exercise program and an electrodiagnostic study.

27. On December 23, 2014, the claimant returned to Dr. Stanton for an examination. Dr. Stanton noted that:

> At this point, I think that [the claimant's] symptoms are mainly dynamic in nature. She had a significant disc herniation with loss of disc space material, and the remainder of her disc is not competent to hold up her body weight. This would explain the increase in symptoms when she is upright and improve her symptoms when she is lying supine. She said she has had a recent MRI and will drop it off at the office and I can review if after she had delivered it. . . She may eventually require reconstruction of the L5-S1 segment, but I would like to review her MRI in detail after it is delivered.

28. On February 5, 2015, Dr. Fall performed a follow up independent medical examination for the respondents. Dr. Fall indicated that the claimant:

> reported pain that radiated from the mid lower back through the hip and buttock down the right leg, lower back weakness with feeling of instability, sleep interruption and bladder urgency. [The claimant] reported loss of control of bladder beginning November of 2013. . . [The claimant] describes her back feels unstable, like a clunkiness.

29. Dr. Fall opined that "it is highly unlikely that there is any additional active medical treatment that would lead to any substantial change in [The claimant's] condition.

30. On February 17, 2015, the claimant returned to Dr. Stanton for examination and review of her April 2014 MRI. Dr. Stanton noted that

> At this point, I think [the claimant] will ultimately need a reconstruction of her L5-S1 segment. She has symptoms which are very positional in nature when she is standing upright. She has an increase symptoms when she lays down and she feels better. This indicates that her disc is not competent to hold her body weight when standing. This may be due to her L4-5 segment but I still think that her primary area of disease is L5-S1. Ultimately, if she is able to proceed with surgery I would want an updated MRI of her lumbar spine prior to surgery to reevaluate her L4-5 segment.

31. On February 17, 2015, Dr. Stanton reviewed the claimant's MRI films of her lumbar spine that were taken on April 24, 2014. The MRI demonstrated:

> disc disease at L5-S1 with loss of disc space height, a broad based annular bulge with small annular tear. There is evidence of right sided hemilaminotomy. There is moderate to severe foraminal stenosis, worse on the right side due to facet hypertrophy and loss of disc space height. At L4-5 there are end plate changes with loss of disc space height and a shallow broad based disc herniation causing mild to moderate foraminal stenosis. There is a small amount of foraminal extension of the disc into L4-5 disc space on the right.

32. On March 3, 2015, Dr. Stanton sent a referral for an MRI to the respondent-insurer.

33. On May 14, 2015, a post-hearing deposition of Dr. Paul Stanton was taken. Dr. Stanton was qualified as an expert in the field of spine surgery without objection.

34. Dr. Stanton testified that he performed a microscopic discectomy on the claimant on April 29, 2013.

35. Dr. Stanton opined that the claimant did not recover from the discectomy surgery in regards to strength. He opined that the claimant has dynamic foraminal stenosis where the L5-S1 disc is not competent to maintain her foraminal dimensions.

36. Dr. Stanton opined that:

> [T]he disc is like a shock absorber in between the vertebral bodies. When you stand upright, that shock absorber is exposed to more load. The shock absorber at the disc is responsible for holding open the nerve root window to allow safe passage for the nerve out of the spine. If the disc is incompetent, in other words, will not hold up body weight, when you stand upright and your full body weight is on the disc, it will squat down and lose height, closing the nerve window and pinching the nerve root.
>
> When you're lying down on your back, there's no gravity on that disc, so the stenosis or tightness is resolved and patients usually feel better.

37. Dr. Stanton testified that he recommended the claimant undergo epidural facet injections to see if those help her leg and back pain. Dr. Stanton testified the facet injections would be both therapeutic and diagnostic. He testified that he was hoping the injections would improve the claimant's back and leg pain in the short term. However, Dr. Stanton further explained that if her dynamic stenosis was severe enough, the epidural injection would not provide a full relief. He explained that if the injections provided relief, he would recommend a fusion stabilization surgery to restore the disc height and provide permanent opening for the nerve roots. He testified that to his knowledge, those injections were denied by the respondents.

38. Dr. Stanton testified that the next time he examined the claimant was in February 17, 2015. He testified that during this visit he reviewed the actual films from the claimant's MRI which was performed on April 24, 2014. Dr. Stanton testified that he recommended a reconstruction of the L5-S1 segment, but he wanted to see the L4-L5 segment on a new MRI. He explained that he wanted to see if the L4-L5 segment needed surgery.

39. Dr. Stanton testified that he did not make a referral for back surgery because he ordered the MRI and it was denied. He testified that the next step would be to obtain an updated MRI of the lumbar spine to assess the L4-L5 disc health. He

further testified that at a minimum, the claimant would need a reconstruction of the L5-S1 segment and he would base the treatment of the L4-L5 segment off the current MRI.

40. Dr. Stanton testified that the back surgery that he recommended is likely to improve the claimant's condition.

41. Dr. Stanton testified that it is his opinion, based on a reasonable degree of medical certainty, the back surgery that he recommended is reasonable and necessary to treat the claimant's symptoms for her industrial injury.

42. Dr. Stanton testified that the surgery that he recommended is directly related to the claimant's industrial injury.

43. Dr. Stanton testified that in his opinion, the claimant never reached maximum medical improvement.

44. The ALJ finds that the analyses and opinions of Dr. Healy, Dr. Finn and Dr. Stanton are credible and more persuasive than medical analyses and opinions to the contrary.

45. The ALJ finds that the respondents have failed to establish that Dr. Finn clearly erred in finding the claimant was not at MMI.

46. The ALJ finds that the claimant has established that it is more likely than not that the claimant requires further treatment to cure and relieve her from the effects of her industrial injury, as recommended by Dr. Finn and Dr. Stanton.

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 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. The respondents bear the burden of overcoming the DIME physician's opinions as to MMI by clear and convincing evidence.

5. Section 8-42-107(8)(c), C.R.S. 2006, provides that the DIME physician's findings of maximum medical improvement is binding unless overcome by clear and convincing evidence.

6. "Clear and convincing" evidence is stronger than a preponderance, is unmistakable and is free from serious or substantial doubt. *Martinez v. Triangle Sheet Metal, Inc.* (W.C. 4-595-741, ICAO October 8, 2008), citing *Dilco v. Koltnow*, 613 P 2.d 318 (1980). A mere difference of medical opinions is insufficient. *Medina-Weber v. Denver Public Schools* (W.C. 4-782-625, ICAO May 24, 2010).

7. In order to overcome the DIME report, there must be evidence which proves that it is highly probable that the DIME physician's opinions are incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P. 2d 411 (Colo. App. 1995).

8. The question whether a party has overcome the DIME by clear and convincing evidence is one of fact for the ALJ's determination. *Metro Moving and Storage Co. v. Gussert*, 914 P. 2d 411(Colo. App. 1995).

9. The decisions of a DIME physician are to be given presumptive effect when provided by the statute. *Cordova v. Industrial Claim Appeals Office*, 55 P. 3d 186 (Colo. App. 2002).

10. While the respondents provided evidence demonstrating a difference in opinion between the DIME physician, Dr. Stanton, Dr. Healey, and their retained independent medical examiner, Dr. Fall, regarding whether the claimant's back injury is

at maximum medical improvement, they did not present clear and convincing evidence that the DIME physician's opinion was incorrect when he demonstrated the claimant's back injury requires additional treatment.

11. The ALJ concludes that the analyses and opinions of Dr. Healy, Dr. Finn, and Dr. Stanton are credible and more persuasive than medical analyses and opinions to the contrary.

12. The ALJ concludes that the respondents have failed to prove by clear and convincing evidence that the DIME physician's findings that the claimant is not at MMI was incorrect and warrants reversal.

13. For a compensable injury, an employer and its insurance company must provide all medical benefits which are reasonably necessary to cure and relieve the injury. C.R.S. 8-42-101 (2010). The respondents are liable for reasonable and necessary medical treatment by a physician to whom a claimant has been referred by an authorized treating provider. *Rogers v. Industrial Commission*, 746 P.2d 565 (Colo. App. 1987). Whether such a referral was made in the "normal progression of authorized medical care" is a question of fact for the administrative law judge. *Cabela v. Industrial Claim Appeals Office*, 198 P.3d 1277 (Colo. App. 2008).

14. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the entitlement to benefits. C.R.S. § 8-43-201; See *City of Boulder v. Streeb*, 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office*, 24 P.3d 29 (Colo. App. 2000). 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*, 197 Colo. 306, 592 P.2d 792 (1979). *People v. M.A.*, 104 P. 3d 273 (Colo. App. 2004). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984).

15. The claimant has established by preponderance of the evidence that the MRI and back surgery recommended by Dr. Stanton is reasonable, necessary and related to treat the claimant's back injury.

ORDER

It is therefore ordered that:

1. The respondents' request to overcome the DIME opinion that the claimant is not at MMI is denied and dismissed.

2. The claimant is not at MMI.

3. The respondent-insurer shall pay for the claimant's medical care to cure and relieve the claimant from the effects of her industrial injury as recommended by Dr. Finn and Dr. Stanton, including authorization for spinal surgery as recommended by Dr. Stanton.

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.

DATE: July 6, 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 determined herein are as follows:

1. Whether the respondents may reopen the claim due to overpayments and are entitled to an order holding that the claimant must repay the overpayments;

2. Whether the claimant may reopen the claim on the issue of average weekly wage due to mistake or error;

3. If the claimant is allowed to reopen the claim on the issue of average weekly wage, then whether his admitted average weekly wage of $796.50 is correct;

4. Whether the permanent partial disability rating given by the authorized treating physician, Dr. Bradley, is correct; and,

5. Whether the permanent partial disability rating for the left thumb should be converted to a rating for the left hand or the left upper extremity?

FINDINGS OF FACT

1. On May 7, 2013, the claimant was working for the respondent-employer as a rigger. He was cutting a zip tie off of a cable when the knife slipped, lacerating his left thumb.

2. The respondent-insurer admitted to temporary total disability (TTD) benefits for May 8, 2013 through March 18, 2014. Benefits were admitted and paid at a weekly compensation rate of $531.03, which was based on an average weekly wage (AWW) of $796.50 as determined by the respondent-insurer.

3. The claimant reached MMI on March 18, 2014 however; he continued to receive TTD benefits until July 7, 2014.

4. On July 7, 2014, the respondents filed a Final Admission of Liability (FAL). The FAL terminated TTD benefits due to the placement of the claimant at maximum medical improvement (MMI) as of March 18, 2014 by his authorized treating physician

(ATP), Dr. Bradley. The respondent-insurer admitted to the 20% scheduled permanent partial disability (PPD) rating for the left thumb. This had a value of $1,868.86 [.20 x 35 weeks x $266.98]. The respondent-insurer claimed a $8,420.62 overpayment resulting from TTD benefits paid past the MMI date. After offsetting the PPD award against the overpayment, the resulting overpayment was $6,551.76.

5. The claimant filed an Application for Hearing (AFH) on August 7, 2014, endorsing the issues of disfigurement, PPD benefits, post-MMI medical benefits, and conversion of the PPD rating for the thumb to the equivalent rating for the upper extremity or the hand below the wrist.

6. A hearing was set to occur on November 20, 2014 at 1:30 p.m. in Pueblo.

7. On October 14, 2014, the respondents filed an amended FAL in response to a letter from the Division of Workers' Compensation.

8. The claimant filed an AFH on November 13, 2014, endorsing the issue of "Respondents did not have jurisdiction to file a FAL because it was filed beyond 30 days from the first FAL so penalties should begin August 6 2014 and ongoing." The claimant did not set a hearing date.

9. On November 19, 2014, the claimant cancelled the hearing that was set for his August 7, 2014 AFH.

10. The respondents filed an AFH on December 10, 2014 on the issue of overpayments.

11. On December 16, 2014, the claimant filed a Response to the AFH (RAH), endorsing the issues of AWW, petition to reopen the claim, disfigurement, "worsening of condition claimant no longer at MMI," conversion of the PPD rating, and overpayments.

12. At the outset of the hearing the claimant indicated that the issue of worsening of condition claimant no longer at MMI was no longer an issue for hearing.

13. The ALJ finds that the circumstances surrounding the claimant's employment do not fit squarely under the statutory formula for calculating an employee's AWW. Thus, the respondent-insurer was not obligated to follow the normal procedure in determining AWW. The ALJ finds that it is appropriate to calculate the claimant's AWW using an alternative manner that would fairly determine his AWW based on the facts presented.

14. Once the respondent-insurer admitted for a specific AWW in the final admission of liability dated October 14, 2014 the claimant was obligated to object within 30 days and file an application for hearing on the issue of AWW if he believed the admitted AWW was in error. Having failed to do so the ALJ is now without jurisdiction to address the issue of AWW as it is closed. The claimant's assertion that the respondent-insurer was mistaken in their calculations is not the kind of mistake for which the issue of AWW can be reopened.

15. On March 17, 2015, the claimant underwent an Independent Medical Examination (IME) with Douglas Scott, M.D. Dr. Scott examined the claimant's ability to use his left thumb IP joint.

16. Dr. Scott opined that the active IP joint range of motion measured at the FCE was not valid.

17. Dr. Bradley adopted the measurements from the FCE, which led him to assign a 20% scheduled PPD rating.

18. The ALJ finds that Dr. Bradley's assessment of the claimant's permanent partial disability rating is credible and persuasive. The ALJ finds that Dr. Bradley's 20% PPD rating for the thumb, which was based on the FCE measurements, was correct.

19. The value of the 20% rating is $1,868.86 [.20 x 35 weeks x $266.98].

20. The ALJ finds that the claimant was overpaid benefits in the amount of $8,420.62, prior to taking into account PPD benefits owed.

21. The amount of the overpayment ($8,420.62), after offsetting the value of the 20% PPD rating ($1,868.86), is $6,551.76. As found below the claimant is entitled to a payment of $2,000.00 for his disfigurement. Thus, reducing the overpayment to $4,551.76.

22. At the IME, Dr. Scott also evaluated the claimant's ability to use his left hand and left upper extremity to address his claim that the functional situs of his impairment was located at his left hand or left upper extremity.

23. The claimant told Dr. Scott that he had resumed his rock climbing hobby. Dr. Scott found this to be important because rock climbing requires a significant amount of bilateral hand, finger, and upper extremity strength and coordination. As a result, Dr. Scott doubted that the claimant could participate in rock climbing if he had any significant hand or upper extremity dysfunction or impairment.

24. The claimant testified at the hearing that he used his left hand in rock climbing because he thought it would be good therapy for his thumb. He described using his index through pinky fingers to grab some rock holds and using his entire hand to grab other holds.

25. Additionally, Dr. Scott reviewed surveillance footage, dated February 18th, 19th, and 20th, 2015, of a person whom he confirmed to be the same person that he examined on March 17, 2015. The claimant testified multiple times that he was the person depicted in the various scenes in the surveillance footage that were shown at the hearing.

26. Dr. Scott observed that the surveillance footage showed the claimant using his left hand without any signs of dysfunction. Among other activities, the claimant used his left hand to grasp a wrench, lift a propane tank, hold a propane torch, and use tools to work on coin mechanisms.

27. The claimant testified that he chooses to do some activities with his left hand, even though he could also do them with his right hand.

28. Dr. Scott opined that the video demonstrated the claimant using his left hand and left upper extremity without limitation or functional restriction. As a result, Dr. Scott persuasively opined that the functional situs of impairment is limited to the left thumb and that the left hand and left upper extremity are not impaired.

29. The ALJ finds that Dr. Scott's opinion on this issue is credible and persuasive. The ALJ finds that the functional situs of the claimant's impairment is limited to his left thumb and that his left hand and left upper extremity are not impaired. As a result, the ALJ finds that the scheduled PPD rating for the left thumb should not be converted to the equivalent PPD rating for either the left hand and or the left upper extremity.

30. The ALJ finds that as a result of his May 7, 2013 work injury, the claimant has a visible disfigurement to the body consisting of a surgical scar on the inside portion of the left thumb that is approximately two and one-half inches in length and one-eighth of an inch in width with a jagged appearance and being discolored when compared to the surrounding tissue. The left thumb's outer surface has an unusually smooth appearance with a slightly smaller appearance when compared to the opposite thumb. The left thumb also appears to have a permanent fixation when compared to the opposite thumb. The claimant has sustained a serious permanent disfigurement to areas of the body normally exposed to public view, which entitles the claimant to

additional compensation. Section 8-42-108 (1), C.R.S. The ALJ finds that the claimant is entitled to $2,000.00 for his disfigurement.

31. The ALJ finds that the respondents have established that it is more likely than not that the claim should be reopened to recover an overpayment.

32. The ALJ finds that the respondents have established that it is more likely than not that the claimant was overpaid in the amount of $4,551.76, after reducing the overpayment by PPD and disfigurement wards, and that they are entitled to recover that amount.

33. The ALJ finds that the respondents have failed to establish that it is more likely than not that the claimant's thumb should be rated at 5%.

34. The ALJ finds that the claimant has failed to establish that it is more likely than not the claim should be reopened on the issue of AWW.

35. The ALJ finds that the claimant has failed to establish that it is more likely than not the situs of the claimant's disability extends beyond the thumb.

CONCLUSIONS OF LAW

1. Pursuant to C.R.S. §8-43-203(2)(b)(II)(A), a claim is automatically closed as to the issues addressed in the FAL if the claimant does not timely object and request a hearing on any disputed issues that are ripe for hearing. These issues may not be litigated further unless they are reopened pursuant to C.R.S. §8-43-303. *Leewaye v. Indus. Claim Appeals Office*, 178 P.3d 1254, 1256-57 (Colo. App. 2007).

2. The ALJ finds that, by filing the December 10, 2014 AFH on the issue of overpayments, the respondents implicitly petitioned to reopen the claim; additionally, the issue of reopening was endorsed by the claimant and thus addressing reopening of the claim to address overpayments is appropriate.

3. In pertinent part, an overpayment is defined as "money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive." C.R.S. §8-40-201(15.5).

4. The respondents have the burden of proof on the issue of overpayments. *See* C.R.S. §8-43-303(4) (the party attempting to reopen an issue or claim has the burden of proof on the issue sought to be reopened).

5. Once the respondents have made a prima facie showing that a claimant received overpayments, it is mandatory that a claim be reopened only as to overpayments and that the claimant must repay the overpayment. C.R.S. §8-43-303(1), (2).

6. The ALJ finds that the respondents have made a prima facie showing that the claimant reached MMI on March 18, 2014 and that he continued to receive TTD benefits until July 7, 2014.

7. The ALJ finds that the payment of benefits after March 18, 2014 was an overpayment because TTD benefits should have terminated with the claimant's placement at MMI on that date. *See* C.R.S. §8-42-105(3)(a). The resulting overpayment amount is $8,420.62.

8. As found, the PPD award is worth $1,868.86. When offset against the $8,420.62 overpayment, the remaining amount of the overpayment is $6,551.76. When further reduced by the disfigurement award of $2,000.00 the resulting overpayment is $4,551.76.

9. As found, the correct amount of the overpayment is actually $4,551.76.

10. The ALJ finds that the respondents are entitled to seek repayment of the overpayment from the claimant and that the claimant is required to repay the overpayment.

11. The ALJ finds that the issue of AWW is closed because the claimant did not endorse it as a disputed issue in either his August 7, 2014 or November 13, 2014 AFH. Therefore, his petition to reopen this issue is appropriate.

12. The claimant indicated at the hearing that he was petitioning to reopen the claim on the issue of AWW because the respondents allegedly calculated it incorrectly.

13. At the hearing, the respondents objected to proceeding on reopening the issue of AWW, arguing that the claimant had waived his right to challenge it by not endorsing it as a disputed issue in either his August 7, 2014 or November 13, 2014 AFH.

14. The Industrial Claims Appeals Office (the "Panel") has held that a claimant's failure to apply for a hearing on the issue of AWW does not constitute a waiver of his right to challenge it. It also does not constitute a waiver of his right to

reopen the claim later on the basis of error or mistake. *See Casias v. Interstate Brands Corp. & ACE Am. Ins. Co.*, W.C. No. 4-740-818-02 (I.C.A.O. Mar. 25, 2013).

15. However, the instances in which a claimant has been allowed to reopen his claim on the issue of AWW based on an error or mistake are factually distinguishable from the instant case. For example, the *Casias* claim involved both a Social Security offset and the loss of the claimant's health insurance, both of which affected the calculation of her AWW. The ALJ found that the failure to include the cost of continuing her insurance constituted a mutual error or mistake, both of fact and of law. This was because neither party's counsel previously was aware that the claimant had insurance through the employer and subsequently lost it. The Panel upheld reopening the issue of AWW because the respondents were *statutorily required* to augment the claimant's AWW to include the cost of continuing her insurance.

16. In contrast, in the instant case, there is no error or mistake of fact. Neither party has recently discovered previously unknown information, like in *Casias*. Claimant's wage records were exchanged in 2013 and 2014.

17. Moreover, in the instant case, there is no error or mistake of law. The claimant has not presented any evidence that he had health insurance through the employer, and subsequently lost it, which would statutorily require his AWW to be augmented. Further, the respondents have not argued the applicability of any statutory offsets that would require the claimant's AWW to be adjusted. *See, e.g., Renz v. Larimer County Sch. Dist. Poudre R-1*, 924 P.2d 1177, 1181 (Colo. App. 1996).

18. The ALJ has not found any cases indicating that a disagreement between the parties on how a claimant's AWW should be calculated, when it does not involve an adjustment due to an offset or the loss of health insurance, qualifies as an error or mistake of either law or fact.

19. The ALJ finds that the method by which the respondents calculated the AWW was not a mistake of law or fact justifying reopening the issue of AWW.

20. The ALJ finds that the issue of PPD benefits remains open. This is because the claimant timely explicitly endorsed it as a disputed issue in his August 7, 2014 AFH.

21. This claim involves a PPD rating for a scheduled extremity injury. Therefore, neither party was required to apply for a Division Independent Medical Examination ("DIME") to challenge Dr. Bradley's 20% scheduled PPD rating for the thumb. As a result, the ALJ has jurisdiction to resolve disputes over the rating. *See*

McCormick v. Exempla Healthcare, W.C. No. 4-594-683 at 4 (I.C.A.O. Jan. 27, 2006); *Whiteside v. Smith*, 67 P.3d 1240, 1246 (Colo. 2003).

22. As found, Dr. Bradley's 20% PPD rating for the thumb, which was based on the FCE measurements, was correct. The appropriate scheduled PPD rating for the thumb is 20%.

23. When a claimant's injury is enumerated in the statutory schedule of injuries, the claimant is limited to PPD benefits as specified on the schedule. C.R.S. §8-42-107(1)(a), (2). In this context, the term "injury" refers to the situs of the functional impairment. *Walker v. Jim Fuoco Motor Co.*, 942 P.2d 1390, 1391 (Colo. App. 1997). The term "situs of the functional impairment" means the part of the body that sustained the ultimate loss of function and became disabled or impaired. This is not necessarily the location where the injury actually occurred.

24. As found, the functional situs of the claimant's impairment is limited to his left thumb, and his left hand and left upper extremity are not impaired. As a result, the ALJ finds that the scheduled PPD rating for the left thumb should not be converted to the equivalent PPD rating for either the left hand and or the left upper extremity.

25. The ALJ concludes that the claimant has sustained a serious permanent disfigurement to areas of the body normally exposed to public view, which entitles the claimant to additional compensation. Section 8-42-108 (1), C.R.S. The ALJ finds that the claimant is entitled to $2,000.00 for his disfigurement. The respondent-insurer shall be given credit for any amount previously paid for disfigurement in connection with this claim.

26. The ALJ concludes that the respondents have established by a preponderance of the evidence that the claim should be reopened to recover an overpayment.

27. The ALJ concludes that the respondents have established by a preponderance of the evidence that the claimant was overpaid in the amount of $4,551.76, after reducing the overpayment by PPD and disfigurement wards, and that they are entitled to recover that amount.

28. The ALJ concludes that the respondents have failed to establish by a preponderance of the evidence that the claimant's thumb should be rated at 5%.

29. The ALJ concludes that the claimant has failed to establish by a preponderance of the evidence that the claim should be reopened on the issue of AWW.

30. The ALJ concludes that the claimant has failed to establish by a preponderance of the evidence that the situs of the claimant's disability extends beyond the thumb.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The claim is reopened to address the issue of overpayments.

2. The respondents are entitled to payment from the claimant of an overpayment in the amount of $4,551.76.

3. The respondents request to change the admitted PPD rating is denied and dismissed.

4. The claimant's request to reopen the claim on the basis of mistake or error in the admitted AWW is denied and dismissed.

5. The claimant's request to change the scheduled impairment rating is denied and dismissed.

6. 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: July 31, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
2864 S. Circle, Suite 810
Colorado Springs, CO 80906

ISSUES

Although the Insurer has admitted liability for the claim, the parties framed the issue for hearing as "compensability of the Claimant's left hip injury." Thus, this decision determines whether Claimant's fall on August 26, 2013, while in the course and scope of her employment, caused an injury to Claimant's left hip, or aggravated a pre-existing condition. If the left hip injury is a compensable component of Claimant's claim, the remaining issue is whether Claimant is entitled to medical benefits to treat her left hip, including whether the total hip replacement performed by Dr. John Xenos was reasonable, necessary and related to the claim.

FINDINGS OF FACT

1. The Claimant is 58 years old and has worked for the Employer for 27 years as an account representative.

2. On August 26, 2013, Claimant was running late for a sales call at Parker Adventist Hospital. She was carrying a briefcase, a laptop, and an iPad along with several phone books.

3. While rushing to catch the elevator, Claimant reached for the elevator button, apparently tripped and fell onto her left side. After falling, she gathered her items and went to her appointment.

4. About an hour later, Claimant began noticing neck pain, so she called her manager, Tom Egan, to report the accident. She then returned to Parker Adventist Hospital to report the accident to the building manager. The building manager informed Claimant that she could go to the emergency room, but that she would have to pay for it herself. The Claimant decided against seeking treatment in the emergency room.

5. Following the accident, the Claimant had bruises on her left side from her knee to her hip.

6. Shortly after the accident, the Claimant took two weeks off from work and went on a previously scheduled vacation to visit her sister's family in Loveland. While in Loveland, Claimant testified that she engaged in little activity.

7. When the Claimant returned to work after her vacation, she performed administrative tasks in the office for two days. The Claimant began making sales calls again, and she noticed increased pain in her back and hip. She told Egan about her symptoms. He referred Claimant to HealthOne Occupational Medicine and Rehabilitation.

8. On September 11, 2013, Dr. Elizabeth Bisgard evaluated the Claimant at HealthOne. Claimant reported that on August 26, 2013, she fell and landed primarily on her knees and elbow with most of the impact on her left side. She initially noticed neck pain and limited range of motion in her neck. The Claimant reported that she had pain in her left hip since the fall and had gotten worse particularly when getting in and out of her car. The Claimant told Dr. Bisgard about the left hip labral tear she had surgically repaired in 2010. Claimant reported no residual symptoms in her left hip before the fall on August 26, 2013.

9. Dr. Bisgard diagnosed Claimant with a cervical strain and left hip contusion. Dr. Bisgard imposed work restrictions of no lifting, carrying, pushing or pulling over 5 pounds.

10. Claimant's x-rays revealed no fractures but did show degenerative changes in both of her hips.

11. The Claimant began missing work on September 16, 2013 and has not returned to work since that date. The Insurer filed a general admission on September 26, 2013 admitting for medical benefits and temporary total disability.

12. The Claimant had a labral tear in her left hip prior to the work injury. Dr. John Xenos performed a surgical repair of the tear in 2010. She recovered fully following the surgery and returned to her normal activities.

13. Claimant returned to Dr. Xenos on September 18, 2013 for treatment of her left hip. She was concerned about a re-tear of her labrum and told Dr. Xenos she did feel like the workers' compensation doctors were looking enough at her hip. Claimant did not have a referral to Dr. Xenos at that time.

14. Dr. Bisgard's physician's assistant, Thanh Chau, evaluated the Claimant on September 25, 2013. Mr. Chau documented Claimant's reports of a catching sensation in her left hip, as well as pain with walking and weight bearing.

15. On September 26, 2013, the Respondents filed a General Admission of Liability admitting for reasonable and necessary medical benefits for Claimant's back, neck and left hip, as well as temporary total disability benefits.

16. Claimant had a MRI on October 1, 2013, which showed a possible small labral tear and osteoarthritis in the left hip.

17. On October 4, 2013, Claimant saw Mr. Chau. Mr. Chau went over the MRI findings with the Claimant and referred her to Dr. Xenos for further evaluation of her hip.

18. Claimant returned to Dr. Xenos on October 8, 2013. He discussed non-surgical and surgical options with the Claimant regarding the MRI results. Claimant elected to undergo a total left hip arthroplasty and scheduled it for December 9, 2013.

19. On October 22, 2013, Claimant saw Dr. Bisgard. Dr. Bisgard noted that what she initially believed to be a soft tissue injury to the left hip is now more substantial. Dr. Bisgard stated that Claimant had been working full time and full duty until her fall at work after which she has rapidly deteriorated. Dr. Bisgard opined that the fall permanently aggravated Claimant's pre-existing degenerative joint disease in the left hip.

20. The Claimant testified that she had pain in her left hip from the day of the accident. Dr. Bisgard testified that the Claimant gave a consistent history of pain in the left hip from the day of the accident and ongoing.

21. Dr. Bisgard testified that she was familiar with Dr. Xenos and considered him an accomplished hip surgeon. She agreed with the referral to Dr. Xenos.

22. The Claimant had left hip surgery to repair a labral tear in 2010, but had returned to her regular physical activities without any hip symptoms. These activities included skiing, bowling, dancing, biking, power walking and golf. She engaged in these activities with no left hip symptoms up to the September 26, 2013 fall.

23. The Insurer denied the total hip arthroplasty as unrelated to this claim, but the Claimant proceeded with the surgery on December 9, 2013, under her personal medical insurance.

24. Following the surgery the Claimant's hip symptoms subsided and she and continued to recover from her injuries.

25. The Claimant had physical therapy for her hip beginning on January 7, 2014. A physical therapy record indicated that Claimant fell down some stairs and fractured her pelvis approximately two years earlier. The Claimant admitted that she fell down some stairs in September 2011, but she did not fracture her pelvis and her symptoms subsided within a short period of time. There are no other medical records suggesting Claimant sustained a fractured pelvis.

26. The Claimant continued to treat with Dr. Bisgard until Dr. Bisgard left the HealthOne practice in September 2014.

27. Dr. Barton Goldman took over Claimant's care. The history Claimant gave to Dr. Goldman was consistent with the history she provided to Dr. Bisgard. Dr. Goldman stated in his September 25, 2014 report that the Claimant had made a fairly good recovery from the hip replacement surgery. Dr. Goldman stated that the Claimant had pre-existing osteoarthritis in her left hip which was aggravated by the August 26, 2013 fall.

28. Dr. Bisgard testified that while the Claimant did have pre-existing osteoarthritis in her left hip, it was completely asymptomatic prior to the fall. It was clear to Dr. Bisgard that the Claimant fell on her left side because she still had bruising on her left side when Dr. Bisgard first saw her about 16 days after the accident. She stated that the cause of the bruising was the direct impact on her left side.

29. Dr. Bisgard based her causation opinion on several factors. The MRI showed that the hip was injured. There was a temporal relationship between the hip pain and the trauma in that the Claimant told her she had hip pain from the day of the accident and had no problems with her hip immediately before the accident. Dr. Bisgard could find no intervening factors which would have caused the hip injury or would have made it worse following the fall.

30. Dr. Bisgard stated that it is common for people to have arthritic conditions which have no symptoms until a trauma causes inflammation which causes the previously asymptomatic condition to become symptomatic and disabling.

31. Dr. Bisgard explained that a fall on the left hip can drive the femoral head into the hip socket and cause the pre-existing hip condition to become symptomatic. She testified that this is what happened with the Claimant and that there was no other reasonable explanation for the cause of the Claimant's left hip symptoms. Dr. Bisgard opined that symptoms can progress and may not be immediately apparent on the date of the injury.

32. Dr. Bisgard discounted a physical therapy report that stated the Claimant fell on her right side and rolled onto her left. She based this on the fact that there were no bruises on the right side and that there would have been no bruising on her left side if she had fallen on the right and then rolled to her left. She also testified that the surgery performed by Dr. Xenos appeared to be successful and she deferred to Dr. Xenos on the need for the surgery.

33. On February 19, 2014, Dr. Timothy O'Brien performed an independent medical examination (IME) at the Respondents' request. Dr. O'Brien opined that Claimant sustained only minor injuries on August 26, 2013 because she continued to work after her fall, and because she did not seek medical treatment right away.

34. Dr. O'Brien believes that Claimant suffered only a minor hip contusion when she fell on August 26, 2013. He stated that the minor contusion did not result in an aggravation or acceleration of underlying pre-existing osteoarthritis to the extent that the total hip arthroplasty is indicated. Dr. O'Brien indicated that Dr. Xenos' representation to the contrary is inaccurate.

35. Dr. O'Brien opined in his report that Claimant's candidacy for a left total hip arthroplasty was established based on radiographs which demonstrated joint space narrowing. These radiographic findings take years to become evident. According to Dr. O'Brien, Claimant was a candidate for a left total hip arthroplasty long before to Dr. Xenos' radiographs which were taken on September 18, 2013.

36. Ultimately, Dr. O'Brien opined that Claimant's need for a total left hip arthroplasty was not causally related to the August 26, 2013 work injury. Dr. O'Brien went on to opine that Claimant proceeded with a left hip total arthroplasty to treat her personal health issues and her long-standing pre-existing osteoarthritis in her left hip.

Dr. O'Brien opined that Claimant did not become more of a candidate for left or right total hip arthroplasty as a result of the work injury.

37. Dr. O'Brien completed a supplemental report dated April 16, 2014, after reviewing additional medical records. He stated that his medical opinion had not changed since the February 19, 2014 IME report.

38. Dr. O'Brien further opined that Claimant had a long-standing pre-existing chondromalacia of the acetabulum and left hip joint and this was due to congenital dysplasia of the left hip. Claimant's femoral head was "out of round" thus Claimant's left hip was biomechanically altered from the time of her birth. This pre-existing condition relentlessly progressed between the 2010 surgical intervention and the work injury that occurred on August 26, 2013. Dr. O'Brien indicated that joint space narrowing does not occur acutely as the result of a fall on the outside of the left hip that produced a bruise and a minor contusion, but rather these changes of cartilage thinning and joint space narrowing takes years to become evident. Dr. O'Brien stated that Claimant was a candidate for a total hip arthroplasty on August 25, 2013, one day before her alleged fall on August 26, 2013, and she did not become more of a candidate for a total hip arthroplasty because of her minor fall on August 26, 2013.

39. Dr. Mark Paz performed an IME at the request of Respondents on October 31, 2014. Dr. Paz examined the Claimant and reviewed medical records. In his report, Dr. Paz indicated that he agreed with Dr. O'Brien's opinion that Claimant's left hip surgery was not the result of the fall on August 26, 2013, and that her left hip condition is not work-related. Dr. Paz stated in his report that the mechanism of injury based on the history provided by Claimant was inconsistent with the mechanism of injury documented in Dr. Bisgard's initial evaluation on September 11, 2013.

40. Dr. Paz testified at hearing consistent with his report. Dr. Paz also testified that he listened to the audio recording of the Claimant's IME after the IME and prior to the hearing. Dr. Paz testified that Claimant indicated she developed pain in her hip approximately 2-3 days after the incident on August 26, 2013. Dr. Paz believed the 2-3 day delay in onset of pain was significant. Dr. Paz testified this would not be indicative of an acute traumatic injury to Claimant's left hip.

41. Dr. Paz testified that the initial diagnosis was a contusion and that a worsening of symptoms in the left hip region is inconsistent with a contusion. Dr. Paz stated that left groin pain and restricted motion of the left hip joint are expected clinical findings associated with symptomatic osteoarthritis of the hip. Dr. Paz opined that the findings reported by Dr. Bisgard in the absence of groin pain and restrictive movement of the left hip are clinically inconsistent with an acute traumatic event which caused bruising of the left hip and left lateral thigh.

42. The opinions of Dr. Paz fail to consider that Dr. Bisgard explained that she made a working diagnosis of "left hip contusion." Dr. Bisgard candidly explained that she did not believe she needed to perform left hip range of motion testing on the Claimant during the initial visit because she believed Claimant suffered only a

contusion. She testified that in hindsight she should have done a more thorough examination of Claimant's left hip. After Claimant's symptoms worsened, it became apparent to Dr. Bisgard that Claimant's injury to her left hip was more severe than initially thought.

43. Dr. Paz testified that Claimant's left hip MRI did not reveal a hematoma, which Dr. Paz indicated would be blood accumulating deep and around the hip joint. Dr. Paz testified that the bruising on Claimant's lateral hip was more superficial and progressed down Claimant's hip due to gravity. Dr. Paz testified the bruising Claimant had is more consistent with a soft tissue injury and not an acute traumatic injury to Claimant's left hip joint.

44. Dr. Paz testified that it was not medically probable that Claimant's fall aggravated her pre-existing condition to produce the need for treatment.

45. Dr. Paz's opinions seem to hinge on his credibility evaluation of the Claimant. As such, his opinions are not persuasive. The ALJ finds that Claimant consistently reported the mechanism of injury to various treatment providers. Further, the ALJ places little significance on any alleged delayed pain onset. Dr. Bisgard credibly testified that pain symptoms can evolve and progress with the passage of time especially as activities change.

46. Dr. Bisgard disagreed with the opinions of Dr. O'Brien on causation. She testified that visible bruising 16 days after the fall does not suggest a minor injury, and that Dr. O'Brien's apparent reliance on a "history of bilateral pelvic and hip pain" was misplaced, as the Claimant fully recovered from the prior hip injury and was without symptoms and was not getting treatment before she fell.

47. Dr. Bisgard also disagreed with Dr. Paz's opinions. Dr. Paz heavily relied on what he believed was inconsistent reporting by the Claimant concerning the injury and its effects. Dr. Bisgard said that the history from the Claimant that the pain began on the day of the accident was given to her just 16 days after the injury. Dr. Paz did not see the Claimant until 14 months after the accident. Dr. Bisgard believes, and the ALJ agrees, that the history given right after the accident is more reliable. She also said that the worst pain would not necessarily occur right after the injury and in the case of arthritis; it could get more painful over time as the condition was now made symptomatic, and worsened.

48. The ALJ finds the opinions of Dr. Bisgard and Dr. Goldman to be credible and persuasive. As treating physicians, they had a more extensive relationship with the Claimant and were better able to judge her credibility. Dr. Bisgard took Claimant's history sooner after the accident than did the Respondents' IME doctors. Their opinions regarding causation, particularly the opinion of Dr. Bisgard, are more persuasive than the IME opinions of Drs. O'Brien and Paz.

49. Claimant suffered an aggravation of the pre-existing left hip osteoarthritis when she fell on August 26, 2013, and that the hip replacement surgery was reasonable, necessary and related to her workers' compensation claim.

CONCLUSIONS OF LAW

Based on the evidence presented, the Judge makes the following conclusions of law:

General

1. 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. Except as specifically noted below, 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. Section 8-43-201, 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 Insurance Co. v. Cline*, 98 Colo. 275, 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).

Compensability - Causation

4. The Claimant must prove causation to a reasonable probability. Circumstantial evidence, including lay testimony alone, may be sufficient to prove causation. However, where expert testimony is presented on the issue of causation it is for the ALJ to determine the weight and credibility to be assigned such evidence. *Rockwell International v. Turnbull,* 802 P.2d 1182 (Colo. App. 1990). Ultimately, 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).

5. The Claimant has met her burden of proof. Claimant's pre-existing left hip condition was aggravated when she fell on August 23, 2013. The fall necessitated medical treatment including the left hip arthroplasty. Although Claimant had pre-existing osteoarthritis in her left hip, she had been symptom free for approximately three years. The ALJ is not persuaded by Dr. O'Brien's opinions that Claimant's hip required medical treatment prior to the fall on August 23, 2013. Dr. O'Brien based his opinions on imaging but he failed to consider her clinical presentation or lack thereof for the three-year period between her labral repair surgery and the work injury. Claimant did not have physical symptoms that would have required surgery until after she fell at work.

The ALJ is also not persuaded by Dr. Paz's opinions. Dr. Paz focused on Dr. Bisgard's initial diagnosis of "contusion" and ignored the fact that Dr. Bisgard admittedly erred in diagnosing only a contusion. Dr. Paz also focused on lack of restricted movement in Claimant's hip joint at her first evaluation with Dr. Bisgard; however, Dr. Bisgard admitted that she should have evaluated the Claimant's hip more thoroughly at that visit. Claimant went to Dr. Xenos and complained that HealthOne practitioners were not paying attention to her hip. Further, the ALJ disagrees with Dr. Paz's evaluation of Claimant's credibility. Claimant provided consistent reports of the mechanism of injury to her providers, and any deviation from her reports was minor.

Dr. Bisgard's opinions concerning the history of this claim and causal relatedness of Claimant's left hip condition to the work incident are more persuasive than those of Drs. O'Brien and Paz. Dr. Bisgard credibly explained that a fall on the left hip can drive the femoral head into the hip socket and cause the pre-existing hip condition to become symptomatic. She testified that this is what happened with the Claimant and that there was no other reasonable explanation for the cause of the onset of Claimant's left hip symptoms. Dr. Bisgard opined that symptoms can progress and may not be immediately apparent on the date of the injury.

Medical Benefits

6. Every employer must furnish to employees such 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 from the effects of the injury." Section 8-42-101(1)(a), C.R.S. *See also Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). It is Claimant's burden to prove a causal connection between the industrial injury and the need for specific medical treatment. *See City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997).

7. Claimant has proven that the total left hip arthroplasty was reasonable, necessary and related to her work injury. As found, Dr. O'Brien felt the need for a total hip arthroplasty was present in the Claimant regardless of the fall at work. In addition, Dr. Xenos felt the procedure was reasonable and necessary, and Dr. Bisgard deferred to the opinions of Dr. Xenos regarding the need for a left hip arthroplasty. No persuasive opinions were offered to the contrary. Because the Claimant has proven that her pre-existing left hip osteoarthritis was aggravated by the fall at work, the ALJ concludes that the surgery was related to the work injury.

ORDER

It is therefore ordered that:

1. Claimant sustained an aggravation of her pre-existing left hip condition when she fell at work on August 23, 2013. Respondents have already admitted liability for the injury, which shall now include the left hip.

2. Claimant is entitled to medical treatment for the left hip.

3. Respondents are liable for the total left hip arthroplasty Claimant underwent on December 9, 2013.

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: July 28, 2015

DIGITAL SIGNATURE:

L. Broniak

LAURA A. BRONIAK
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered compensable injuries during the course and scope of his employment with Employer on January 17, 2014.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to receive reasonable and necessary medical benefits to cure or relieve the effects of his industrial injuries.

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period January 17, 2014, excluding the period from September 30, 2014 through January 26, 2015, until terminated by statute.

4. Whether Respondents have established by a preponderance of the evidence that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment under §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. (collectively "termination statutes").

5. A determination of Claimant's Average Weekly Wage (AWW).

FINDINGS OF FACT

1. Claimant worked for Employer as an Electrician. He drove his personal vehicle to jobsites to perform electrical duties. Claimant testified that he transported necessary supplies and equipment in his truck. He noted that he sometimes used his truck during the course of the day to travel between jobsites and purchase materials from The Home Depot.

2. Dakota Carter worked for Employer as an Apprentice Electrician. During early to mid-January 2014 his car was not working so he received rides to jobsites from co-employee Harold Holland. On January 5, 2014 Mr. Holland was involved in an incident at the Precision job site located at 7076 South Alton Way in the Denver Metropolitan area. Because of the incident, Mr. Holland was prohibited from working at the Precision location and Mr. Carter did not have transportation to the site. Mr. Carter explained that he procured rides to the site from friends and family but missed 2-3 days of work during early to mid-January 2014 because of his inability to get to the job location.

3. On the evening of January 14, 2014 Mr. Carter contacted Claimant through text message to confirm a possible ride to the Precision jobsite. Claimant responded that he could give Mr. Carter a ride to the location but sent a text message to

owner of Employer Ron Burek stating "so I'm picking up Dakota in the morning. Am I supposed to take him with me." Mr. Burek responded to Claimant that "He [Dakota] just texted me. If you want he can go with you." Claimant then told Mr. Carter that he had just gotten off the phone with Mr. Burek and confirmed that he would be driving Mr. Carter to work. Claimant and Mr. Carter then exchanged text messages about the pickup location.

4. Claimant's commute from his home to the Precision jobsite required him to drive the following route: I-70 to I-25 Southbound, I-25 to Arapahoe Road, Arapahoe Road Westbound to Yosemite and South on Yosemite to the jobsite located on Alton Way. To pick up Mr. Carter Claimant deviated from his typical route by exiting I-25 on Santa Fe to pick up Mr. Carter at Broadway and Tufts. Claimant drove Mr. Carter to and from the Precision jobsite on January 15-16, 2014. He also drove with Mr. Carter to The Home Depot and at least one other jobsite on January 15-16, 2014.

5. On January 17, 2014 Claimant was traveling to pick up Mr. Carter but was involved in a motor vehicle accident at approximately 6:30 a.m. Claimant was rear-ended while heading Southbound on Santa Fe at the intersection of Santa Fe and Oxford. Claimant suffered numerous injuries including head trauma, fractured hips, a lumbar strain, PTSD and a cervical strain. He initially received medical treatment at a hospital but then obtained care through Concentra Medical Centers. Concentra physicians prohibited Claimant from working because of his injuries.

6. Mr. Carter testified that Employer was not involved in the driving arrangement he had made with Claimant. He explained that Mr. Burek did not care how he got himself to the jobsite. In fact, Mr. Carter remarked that Mr. Burek did not even care whether he made it to work because his job was simply as an apprentice assisting Claimant. If he did not make it to work Claimant was responsible for completing his job duties without help.

7. Mr. Carter commented that, after Mr. Holland was prohibited from working on the Precision jobsite, Claimant offered to give him a ride to and from work for $15.00 per day. He paid Claimant $15.00 for the first two days of transportation but never received a ride on the third day because Claimant was involved in a motor vehicle accident prior to picking him up for work..

8. Mr. Burek testified that Employer has a policy of not compensating employees for driving their personal vehicles to work in the morning and home in the evening. He noted that the policy has been consistently enforced for the previous 16 years. Mr. Burek explained that no employee has ever included "travel time" in his job description on a time sheet. He emphasized that he has never been involved in how employees get to and from work and has never reimbursed employees for gas, travel or associated expenses for getting to and from jobsites.

9. Mr. Burek explained that he sometimes communicated with employees via text messaging to confirm jobsite addresses. The text message he sent to Claimant on January 14, 2014 simply meant that Claimant could take Mr. Carter to work if he

wanted. He explained that Mr. Carter was working as an apprentice/assistant to Claimant at the time. Mr. Carter was learning the trade and otherwise helping at the jobsite. Mr. Burek remarked that he had enough employees on his jobsites and would not have incurred a detriment if Mr. Carter had not been able to make it to work during the week of January 14, 2014. He denied any involvement in the financial arrangement between Claimant and Mr. Carter regarding transportation to and from work.

10. Claimant maintained that in a telephone conversation Mr. Burek directed him to give Mr. Carter a ride to and from the Precision jobsite. He remarked that Mr. Burek reimbursed him for the deviation from his normal travel route to the jobsite when he picked up Mr. Carter. However, in a recorded statement to Insurer Claimant did not assert that Mr. Burek ordered him to transport Mr. Carter to and from the Precision jobsite. Claimant also acknowledged that he was not reimbursed by Employer to transport Mr. Carter to and from work.

11. Claimant has failed to demonstrate that it is more probably true than not that he suffered compensable industrial injuries during the course and scope of his employment with Employer on January 17, 2014. Applying the *Madden* factors, he has failed to establish an exception to the "traveling to or from work rule" because his travel was not considered the performance of services arising out of and in the course of employment. Initially, Claimant was injured in a motor vehicle accident while on his way to pick up Mr. Carter to transport him to the Precision jobsite. The travel thus did not occur during working hours and was not on Employer's premises. Although Claimant asserted that he was directed by Mr. Burek to transport Claimant to and from the Precision jobsite on January 17, 2014, the record reveals that the transportation agreement existed solely between Claimant and Mr. Carter. Mr. Carter noted that he paid Claimant $15.00 for the first two days of transportation to the Precision location but never received a ride on the third day because Claimant was involved in a motor vehicle accident. Mr. Burek credibly noted that he has never been involved in how employees get to and from work and has never reimbursed employees for gas, travel or associated expenses for getting to and from jobsites.

12. The critical inquiry is whether travel was contemplated by Claimant's employment contract and constituted a substantial part of his service to Employer. The record reveals that Claimant's travel was not contemplated by the employment contract. Specifically, Employer did not require Claimant to use his automobile in order to work. Claimant's vehicle was not used to perform job duties and thus did not confer a benefit to Employer beyond his mere arrival at work. Claimant's job was to perform electrician duties at a designated jobsite. Claimant explained that he sometimes used his truck during the course of the day to travel between jobsites and purchase materials from The Home Depot. However, Mr. Burek testified that Employer has a policy of not compensating employees for driving their personal vehicles to work in the morning and home in the evening. He noted that the policy has been consistently enforced for the previous 16 years. Mr. Burek explained that no employee has ever included "travel time" in his job description on a time sheet.

13. The credible evidence reveals that Claimant's contract of employment did not require him to transport his personal vehicle to Employer's job locations during the work day. Claimant merely had to get to the jobsite in order to work for the day. Although Claimant may have chosen to use his truck to travel to jobsites and make trips to The Home Depot, the record reveals that Employer did not receive a benefit beyond Claimant's mere arrival at work. Claimant's decision to give Mr. Carter a ride to work on January 17, 2014 was not at Employer's express or implied request and conferred no benefit to Employer. Because Claimant's injuries occurred prior to his arrival at the jobsite and picking up Mr. Carter was not contemplated by the employment contract, he has failed to establish that "special circumstances" exist justifying an exception to the "traveling to or from work" rule. A review of the *Madden* factors thus reveals that Claimant has failed to demonstrate a nexus between his injuries and his employment for Employer. Accordingly, Claimant's claim for Workers' Compensation benefits is 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. To establish a compensable injury an employee must prove by a preponderance of the evidence that his injury arose out of the course and scope of employment with his employer. §8-41-301(1)(b), C.R.S. (2006); *see City of Boulder v. Streeb*, 706 P.2d 786, 791 (Colo. 1985). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of

his employment and during an activity that had some connection with his work-related functions. *Triad Painting Co. v. Blair*, 812 P.2d 638, 641 (Colo. 1991). The "arise out of" requirement is narrower and requires a claimant to 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. *Id.* at 641-62.

5. Generally, injuries sustained by employees while they are traveling to or from work are not compensable because such travel is not considered the performance of services arising out of and in the course of employment. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). However, injuries incurred while traveling are compensable if "special circumstances" exist that demonstrate a nexus between the injuries and the employment. *Id.* at 864. In ascertaining whether "special circumstances" exist the following factors should be considered:

- Whether travel occurred during working hours;
- Whether travel occurred on or off the employer's premises;
- Whether travel was contemplated by the employment contract; and
- Whether obligations or conditions of employment created a "zone of special danger" out of which the injury arose.

Id. In considering whether travel is contemplated by the employment contract the critical inquiry is whether travel is a substantial part of service to the employer. *See id.* at 865.

6. "Special circumstances" may be found where the employment contract contemplates the employee's travel or the employer delineates the employee's travel for special treatment as an inducement. *See Staff Administrators Inc. v. Reynolds,* 977 P.2d 866, 868 (Colo. 1999). "Special circumstances" may also exist when the employee engages in travel with the express or implied consent of the employer and the employer receives a special benefit from the travel in addition to the employee's mere arrival at work. *See National Health Laboratories v. Industrial Claim Appeals Office,* 844 P.2d 1259, 1260 (Colo. App. 1992). The essence of the travel status exception is that when the employer requires the claimant to travel beyond a fixed location to perform his job duties the risks of the travel become the risks of the employment. *Breidenbach v. Black Diamond, Inc.,* W.C. No. 4-761-479 (ICAP, Dec. 30, 2009).

7. In considering whether travel was contemplated by the employment contract, case law reflects that the exception applies when a claimant is required by an employer to come to work in an automobile that is then used to perform job duties. The vehicle confers a benefit to the employer beyond the employee's mere arrival at work. *See Whale Communications v. Osborn,* 759 P.2d 848 (Colo. App. 1988). As explained in 1 A. Larson, *Workmen's Compensation Law*, §17.50 (1985), "[t]he rationale for this exception is that the travel becomes a part of the job since it is a service to the employer to convey to the premises a major piece of equipment devoted to the employer's purposes. Such a requirement causes the job duties to extend beyond the

workplace and makes the vehicle a mandatory part of the work environment." *See In Re Rieks,* W.C. No. 4-921-644 (ICAP, Aug. 12, 2014) (where employer required the claimant to come to work in an automobile to attend appointments and meet with customers, transport of car was contemplated by the employment contract and the claimant's motor vehicle accident on the way to work occurred in the course of and arose out of his employment); *Norman v. Law Offices of Frank Moya,* W.C. No. 4-919-557 ICAP, Apr. 23, 2014) (where attorney was required to use car to travel from work to courthouse and was injured in motor vehicle accident while she was driving to her first court appearance of the day, injuries were compensable because travel was contemplated by employment contract and conferred benefit to employer beyond mere arrival at work); *Lopez v. Labor Ready,* W.C. 4-538-791 (ICAP, Sept. 26, 2003) (where the claimant's job required her to spend large parts of her day in her personal vehicle and she was injured in a motor vehicle accident while driving home for lunch, claim was compensable because it conferred a benefit to the employer beyond the claimant's mere arrival at work). In contrast to the preceding case law, Claimant's use of his vehicle was not contemplated by the employment contract and did not confer a benefit to Employer. He was only required to travel to the jobsite to perform his duties as an Electrician.

8. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered compensable industrial injuries during the course and scope of his employment with Employer on January 17, 2014. Applying the *Madden* factors, he has failed to establish an exception to the "traveling to or from work rule" because his travel was not considered the performance of services arising out of and in the course of employment. Initially, Claimant was injured in a motor vehicle accident while on his way to pick up Mr. Carter to transport him to the Precision jobsite. The travel thus did not occur during working hours and was not on Employer's premises. Although Claimant asserted that he was directed by Mr. Burek to transport Claimant to and from the Precision jobsite on January 17, 2014, the record reveals that the transportation agreement existed solely between Claimant and Mr. Carter. Mr. Carter noted that he paid Claimant $15.00 for the first two days of transportation to the Precision location but never received a ride on the third day because Claimant was involved in a motor vehicle accident. Mr. Burek credibly noted that he has never been involved in how employees get to and from work and has never reimbursed employees for gas, travel or associated expenses for getting to and from jobsites.

9. As found, the critical inquiry is whether travel was contemplated by Claimant's employment contract and constituted a substantial part of his service to Employer. The record reveals that Claimant's travel was not contemplated by the employment contract. Specifically, Employer did not require Claimant to use his automobile in order to work. Claimant's vehicle was not used to perform job duties and thus did not confer a benefit to Employer beyond his mere arrival at work. Claimant's job was to perform electrician duties at a designated jobsite. Claimant explained that he sometimes used his truck during the course of the day to travel between jobsites and purchase materials from The Home Depot. However, Mr. Burek testified that Employer has a policy of not compensating employees for driving their personal vehicles to work in the morning and home in the evening. He noted that the policy has been consistently

enforced for the previous 16 years. Mr. Burek explained that no employee has ever included "travel time" in his job description on a time sheet.

10. As found, the credible evidence reveals that Claimant's contract of employment did not require him to transport his personal vehicle to Employer's job locations during the work day. Claimant merely had to get to the jobsite in order to work for the day. Although Claimant may have chosen to use his truck to travel to jobsites and make trips to The Home Depot, the record reveals that Employer did not receive a benefit beyond Claimant's mere arrival at work. Claimant's decision to give Mr. Carter a ride to work on January 17, 2014 was not at Employer's express or implied request and conferred no benefit to Employer. Because Claimant's injuries occurred prior to his arrival at the jobsite and picking up Mr. Carter was not contemplated by the employment contract, he has failed to establish that "special circumstances" exist justifying an exception to the "traveling to or from work" rule. A review of the *Madden* factors thus reveals that Claimant has failed to demonstrate a nexus between his injuries and his employment for Employer. Accordingly, Claimant's claim for Workers' Compensation benefits is denied and dismissed. *See In Re Hall,* W.C. No. 4-689-120 (ICAP, Nov. 7, 2007).(where the claimant had a motor vehicle accident while driving to transport inmates to work in exchange for payment from the inmates and the employer was not involved in the agreement, the claimant's activities were not contemplated by the employment contract).

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: July 24, 2015.

DIGITAL SIGNATURE:

Peter J. Cannici

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. WC 4-946-963-03

ISSUES

- Whether Insurer properly denied prior authorization of chiropractic treatment recommended by Dr. Miguel Castrejon as not being reasonable and necessary and related to the Claimant's March 26, 2015 admitted work related injury?

- Whether Insurer properly denied prior authorization for a SI joint injection as recommended by Dr. Miguel Castrejon as not being reasonable and necessary and related to the Claimant's March 26, 2015 admitted work related injury?

FINDINGS OF FACT

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

1. Claimant was employed as a carpenter by Employer for approximately six to seven months prior to his admitted work related injury of March 26, 2014. On March 26, 2014, Claimant had been lifting concrete forms throughout the day when he experienced pain involving his lower back and lower extremities.

2. Respondents filed a General Admission of Liability (GAL) on April 18, 2014 admitting for medical only. Respondents have not filed further GALs.

3. On August 27, 2014, Claimant applied for a hearing endorsing the following issues: Medical Benefits, Average Weekly Wage (AWW), Temporary Total Disability (TTD), and Penalties. This hearing application addressed the issue of TTD on an ongoing basis, and stated that "Respondents failed to object to 20 day letter dated June 4, 2104 for Claimant to see Dr. Timothy Hall for authorized treating provider (ATP). Respondents refused to pay for treatment with Dr. Timothy Hall." Also addressed was "Penalties for failure to pay benefits when due pursuant to C.R.S. 8-43-304." On October 10, 2104, an Order was entered approving the parties' September 30, 2014 Stipulation. In the Stipulation, the parties agreed that Dr. Miguel Castrejon would be Claimant's ATP; that Respondent would pay Dr. Hall $450.00; that Dr. Hall would have no further involvement with the case; and that Claimant would withdraw his penalty issue up to the date the Stipulation was approved. This Stipulation resolved the issues contained in Claimant's August 27, 2014 Application for Hearing except for AWW and TTD.

4. On January 7, 2014, a Judge approved the parties' December 22, 2014 Stipulation which addressed the remaining issues of AWW and TTD. The parties

stipulated that Claimant's AWW was $1,055.85. The parties also stipulated that the issue of TTD from March 27, 2014 to December 16, 2014 should be resolved by Respondents paying Claimant $25,000.

5. Respondents stated in the Stipulation that they agreed to file an amended GAL admitting to "the stipulated AWW and would admit therein to temporary total disability benefits." To date, although Claimant has continued to receive TTD, Respondents have yet to file the amended GAL based upon the Order of January 7, 2015.

6. On March 26, 2014 Claimant received medical care at Memorial Hospital Emergency Room. The Memorial Emergency Room records reflect that Claimant reported doing heavy lifting when he felt a pop in his low back and had pain in his legs to approximately his knees bilaterally. These records also state that Claimant was incontinent of stool on one occasion and that the Claimant underwent an MRI to rule out cauda equina syndrome.

7. On March 31, 2014, Claimant was seen again in the Memorial Hospital Emergency Room complaining of severe back pain for which medication was provided. The examining physician noted that the MRI revealed disc degeneration as well as some protrusion without nerve impingement.

8. On April 2, 2014 Claimant was seen again for back pain at Memorial Hospital. This report discussed the MRI which revealed a bulging disc but no cauda equina syndrome. The examining physician noted Claimant required outpatient follow-up and pain management.

9. On April 14, 2014, Claimant was evaluated by Dr. Timothy Sandell at Pikes Peak Physical Medicine. Claimant reported the same history he had provided to the emergency room doctors of lifting concrete forms and feeling pain in his low back and down his legs. Dr. Sandell stated Claimant exhibited extensive pain behaviors in the examination and that he was unable to note any neurological abnormalities. Dr. Sandell recommended another MRI and prescribed Claimant a Medrol Dosepak. On May 8, 2014, May 12, 2014, and May 22, 2014, Dr. Sandell's physician's assistant, Daniel Haecker saw Claimant. On June 10, 2014, Mr. Haecker indicated that Claimant had undergone a right L5-S1 epidural steroid injection with no benefit on May 27, 2105 Electrodiagnostic testing was recommended at that time.

10. On July 14, 2014, Dr. Sandell completed electrodiagnostic testing which indicated no evidence of lumbar nerve irritation or lumbar radiculopathy.

11. On July 30, 2014, Dr. Sandell's P.A evaluated Claimant, noting Claimant had undergone a right L5-S1 steroid injection and a right L4-S5 facet joint injection with no benefit. He noted that Claimant had undergone two physical therapy visits, and had been prescribed Gabapentin with no benefit. The P.A. stated, "I discussed this patient's case extensively with Dr. Sandell. At this point, we really have nothing further to offer this patient. No further office visits will be scheduled. Since he had increased pain with physical therapy, I advised him that it would be reasonable to hold

off on physical therapy for now. We recommend reevaluation by another pain medicine office, or else an independent medical evaluation."

12. On August 25, 2015, Dr. Timothy Hall evaluated Claimant. Dr. Hall noted in his report that a lumbar MRI revealed L4-5 facet arthropathy and narrowing of the spinal canal. Dr. Hall also noted at L5-S1 a small cluster of disc protrusion with posterior annular fissure and mild facet joint arthropathy. Dr. Hall recommended proceeding with a right SI joint injection at that time. But, this recommendation was made by Dr. Hall on August 25, 2014, just two days before Claimant filed his application for hearing, Claimant has not received the SI joint injection.

13. On October 10, 2014 ALJ Donald E. Walsh granted the parties' Stipulated Motion. In this Stipulation, as noted above, Respondents and Claimant agreed that Dr. Miguel Castrejon be designated as the Claimant's ATP.

14. On October 15, 2014, Claimant saw Dr. Castrejon for the first time. Dr. Castrejon noted that Claimant had not been under the care of any physician since last seeing Dr. Sandell's office on July 30, 2014 and that Claimant was not taking any medication at that time. Dr. Castrejon noted that the mechanism of injury consisted of lifting concrete forms, subsequent to which Claimant reported onset of back and right leg pain. Dr. Castrejon stated that these symptoms had remained consistent throughout the record and history review. Dr. Castrejon noted that Dr. Sandell had performed spinal injections, epidural and facet, but that they failed to benefit Claimant. He noted that these injections were medically reasonable based upon the MRI findings in conjunction with physical presentation. Dr. Castrejon recognized that Dr. Sandell performed electrodiagnostic testing after Claimant failed to improve, and that testing failed to reveal evidence of central or peripheral lesion.

15. Dr. Castrejon noted that Dr. Sandell did not consider sacroiliac or piriformis mediated pain as possible diagnoses, nor did he consider chemical radiculitis on the basis of the fissure that was seen on MRI. Dr. Castrejon noted that Claimant discussed these possibilities with Dr. Hall, who ultimately recommended proceeding with right SI joint injection. Dr. Castrejon noted many pain behaviors with some findings that were considered to be positive for Waddell's. Nevertheless, Dr. Sandell found that testing for Waddell's in the Latin population is not conclusive given cultural differences that exist between the Latin culture compared to other cultures. He testified that Claimant's behavior was normal within his population. Dr. Castrejon indicated positive examination findings that he found were reproducible involving the right SI joint piriformis. On October 15, 2014 Dr. Castrejon diagnosed Claimant as follows:

- Lumbar musculoligamentous strain/sprain with primarily right SI joint involvement.

- Right lower limb radiculities with no electrodiagnostic evidence of lumbar radiculopahty, consider related to piriformis syndrome vs discogneric.

- MRI evidence of posterior disc protrusion at L5-S1with posterior annular fissure and facet joint arthoropy.

- Right lower limb swelling likely secondary to disuse, with element of neuropathic pain not likely related to complex regional pain syndrome.

- Reactive depression and anxiety.

16. Dr. Castrejon initiated a trial of Cymbalta and Neurontin. He also prescribed a combination of chiropractic and physical therapy, with emphasis on treating the presumed sacroiliac and piriformis conditions. Dr. Castrejon discontinued Claimant's use of crutches and provided him with a cane for assisted ambulation. Dr. Castrejon found Claimant was not at maximum medical improvement (MMI) and considered Claimant temporary totally disabled at that time.

17. On March 26, 2014, and May 13, 2014, Claimant underwent MRI's of his lumbar spine. Dr. Castrejon noted the following regarding the May 13, 2014 MRI:

- it revealed a retrolisthesis at L5-S1, which would imply an inconsistent stacking of the two lower vertebrae, which could suggest instability;
- it identified a small mid-portion tear of the disc that creates instability to the disc, produces pain, andallows the internal contents of the disc to excrete onto the nerve root causing chemical radiculitis. Chemical radiculitis leads to lower limb pain. It can also lead to lower limb numbness and to findings described by the patient as burning pain or even sensation of weakness, if there is enough involvement of the nerve root.; and
- It showed facet joint changes at L4-5 and L5-S1.

18. Dr. Castrejon also noted the indication of a small protrusion in the May 13, 2014 MRI which was also apparent on the March 26, 2014 MRI. Dr. Castrejon noted that it was "medically reasonable based upon the MRI findings in conjunction with the physical presentation" for Dr. Sandell to have proceeded with the epidural and facet injections.

19. Dr. Castrejon testified the MRIs showed Claimant was neurologically intact and did not require other testing at that time. Dr. Castrejon felt that Claimant had received very limited conservative care, and planned to provide chiropractic/physical therapy directed to the SI joint in keeping with the *Guidelines*, and then move toward an SI joint injection, if needed.

20. On October 15, 2014, Dr. Castrejon made consistent, positive, reproducible findings of SI joint dysfunction when examining Claimant. These included pelvic obliquity which implies that there is an unlevel the pelvis; and reproducible joint pain with various maneuvers, including Gaenslen's maneuvers, a SI joint compression maneuver, and a Patrick's maneuver. Dr. Castrejon was aware of other doctors' notes notes indicating difficulty examining Claimant, but Dr. Castrejon had no such

difficulties and was able to rule out facet-loading pain which would be indicative of malingering. All of his findings were consistent with an SI-mediated problem.

21. Dr. Castrejon's November 17, 2014 report stated that Claimant was deriving benefit with chiropractic in terms of mild decrease in pain, and increase in strength, balance and overall function.

22. Dr. Castrejon stated Claimant's last chiropractic appointment was on December 1, 2014. He compared Claimant during treatment as moving better, he seemed in better spirits, and he was actually able to do more, of what I needed him to do, during the examination. After the chiropractic treatment was denied, "he looked like he had digressed, and was looking more the way he did the first time I saw him, where, he was keeping the weight off that leg, using the cane much more, having difficulty getting off -- on the examination table -- was not even sitting anymore. All he could do was stand."

23. On December 11, 2014, Dr. Castrejon formally made the request for the SI joint injection. Dr. Castrejon stated that he made this request "after the patient indicated that, as a result of that flare up, he needed some form of pain control." Dr. Castrejon explained the majority of Claimant's reproducible pain remained in the SI area and he needed to provide a diagnostic and therapeutic injection, and ensure that that actually was the etiology of his problem.

24. Claimant received Respondents denial for chiropractic care on December 12, 2014, and denial for SI joint injection on January 22, 2015. The Claimant was not seen for Respondents' independent medical examination (IME) with Dr. Raschbacher until February 23, 2015. Dr. Raschbacher saw Claimant one time for forty minutes according the audio recording of that date.

25. Dr. Raschbacher indicated in his February 23, 2015 report that he believed that Claimant reached MMI on April 14, 2014. His report states "Given that presentation, one could also reasonably make a case, medically, that 04/14/14 would be a reasonable MMI date given his presentation at that time with what were apparently florid pain behaviors."

26. Dr. Raschbacher stated that within three weeks of the date of the accident, Claimant should not have been entitled to any medical treatment whatsoever. "I think that 4/14/14 would be a reasonable MMI date because of his presentation, and I guess retrospectively you can say that that's been borne out by the imaging tests and his reported response to treatment."

27. Dr. Raschbacher does not believe that Claimant's MRIs s how anything significant: only age related degeneration which would not explain his presentation.

28. Dr. Raschbacher's findings are summarized as follows:

- Claimant was evaluated by physical medicine specialist, Dr. Sandell, who felt he had nothing further to offer. Multiple possible diagnoses were mentioned. More recently, Claimant has come under Dr. Castrejon's care, and he opines that an SI injection on the right side would be appropriate.

- Differential diagnoses include malingering or symptomatic right SI joint dysfunction. SI joint dysfunction or pain would certainly not explain the presentation, which is, with respect to subjective complaints, far out of proportion to the paucity of objective findings. Even if the SI joint were symptomatic, it would not be medically likely that he would present as he does.
- I think that with the presentation exhibited by Mr. Lucero, that there is reasonable likelihood that his primary diagnosis is malingering.

29. Dr. Raschbacher's February 23, 2015 report does not address Dr. Castrejon's recommendation of chiropractic care or Claimant's positive response to same.

30. Dr. Raschbacher makes mention of chiropractic care in his hearing testimony. He recommended against further chiropractic care because Claimant did not have a consistent presentation of SI joint findings from the outset. He further opined, "I think it unlikely that any type of care is going to change his subjective reports and change his presentation."

31. Dr. Raschbacher testified that he recommends SI joint injections "when there is clear evidence of an SI joint dysfunction that has been consistent, and -- basically if I feel that's the correct diagnosis and time [and] conservative care, occasionally chiropractic whatever you're treating it with hasn't resolved it, then it's a reasonable thing to consider for persistent SI joint dysfunction."

32. He testified that he would expect to see medical evidence from the outset that a claimant had consistent localizing tenderness at that joint. He would also expect other diagnoses to not appear to be likely. Facet joint, disc, et cetera. He would not expect florid pain behaviors.

33. Dr. Raschbacher testified that to a reasonable degree of medical certainty he does not believe that Claimant requires SI joint injections.

34. Dr. Castrejon and Dr. Raschbacher disagree on several issues. Dr. Castrejon disagrees with Dr. Raschbacher that Claimant reached MMI on April 14, 2014. Dr. Castrejon states, "at the time that he is indicating that Claimant would have been at MMI, there was still no diagnosis or etiology, etiology to explain his symptoms, nor his presentation, and the guidelines are clear, in stating that we need to determine -- do whatever is needed --to determine what the actual diagnosis is." Claimant had not been adequately diagnosed, he was still very functionally limited, and he had consistent, reproducible findings on examination.

35. Dr. Castrejon also disagrees with Dr. Raschbacher regarding the mechanism of injury. Dr. Raschbacher states "the lifting injury is not one that is particularly likely to cause SI joint injury or dysfunction." Dr. Castrejon concluded otherwise: "this gentleman was performing heavy lifting and at one point, when he had the pain, severe pain, he was actually unable to continue to do the lifting. In my opinion, the lifting and rotational movements, that he was performing, are consistent with the mechanism of injury for an SI condition." Dr. Castrejon's opinion was based in

part on an article written by Dr. Cohen from Johns Hopkins which identifies “all of the different mechanisms that can lead to an SI problem including myofascial pain, including lifting, including lifting and rotation . . . direct impacts onto the hip or the side.”

36. Dr. Castrejon addresses each reason Dr. Raschbacher states that a claimant would require an SI joint injection. Dr. Raschbacher states that “You’d expect that from the outset they would have had localizing tenderness at that joint. You would expect it to be consistent. Dr. Castrejon noted that in 20% of people the SI joint condition is not found until the patient has undergone an entire workup for other issues. Dr. Castrejon was critical of Dr. Raschbacher’s exanination of Claimant’s SI joint, his failure to perform a Gaenslen's maneuver, his failure to look for pelvic obliquity, his failure to do a Patrick's maneuver, and his failure to do SI joint-stressing or evaluate the gluteus medius or maximus.

37. Dr. Raschbacher testified that he did not perform a Gaenslen’s maneuver, a Patrick’s maneuver, or SI joint stressing and that he did not look for obliquity. Dr. Raschbacher said that his evaluation of the gluteus medius or maximus was just watching the Claimant’s gait but acknowledged he does not specifically mention this issue in his report.

38. Dr. Raschbacher opined, “You would also expect other diagnoses to not appear to be likely. Facet joint, disc, et cetera.” Dr. Castrejon disagrees, stating: “People, who have complicated spines, postsurgical spine and even non-surgical spines, will have two or three different diagnoses going on at the same time. And that's the purpose of sometimes doing these selective nerve root blocks or spinal injections, is to weed out which are -- which is actually the overwhelming factor.

39. Dr. Raschbacher states Claimant should not have the SI joint injection due to his “florid pain behaviors.” However, Dr. Castrejon explained that he did not observe such behavior. Rather, he observed consistent pain behaviors, “and they're not any more than I would expect in somebody of the Latin culture.”

40. Dr. Castrejon believes Claimant needs the SI joint injection that he recommended by testifying because he has multiple issues, multiple issues primarily because of the length of time that he has remained in pain, and really limited treatment. Dr. Castrejon noted that while Claimant has undergone some diagnostic testing, his care has been fragmented. He also explained that caused altered spinal and gait mechanics. Further Claimant has developed chronic pain. He recommended physical therapy and good psychological care.

41. Dr. Castrejon addressed that even though prior injections were not successful, he believes the SI joint injection would be different because it targets a different area and could provide diagnostic and therapeutic relief.

42. Dr. Raschbacher has commented why Claimant would not need chiropractic care. Dr. Raschbacher says that Claimant would not need chiropractic care because “Well, I think that going way back to the beginning now, he would have had consistent presentation with for example SI joint findings from the outset.” Dr. Castrejon disagreed, noting, “Chiropractic isn't just used for an SI problem. He has a

chronic lumbar-straining injury that is affecting the sacroiliac joint. So, chiropractic most likely was providing benefit not only to the SI but, also, to the other substantial structures of the spine."

43. Dr. Raschbacher stated another reason Claimant would not need chiropractic care was that Claimant "didn't appear to have localizing SI joint findings at the beginning, and certainly he wouldn't be likely medically to develop SI joint dysfunction later on." Dr. Castrejon disagreed, noting: "usually an SI problem, if it isn't immediate, it will be produced as time goes on, especially in the case of this gentleman, with the altered mechanics that he has in terms of his body movements and activity."

44. Dr. Raschbacher opined, "[Claimant] doesn't require further chiropractic care, and I think it is unlikely that any type of care is going to change his subjective reports and change his presentation." Dr. Castrejon disagreed, expressing frustration over what he perceived as Dr. Raschbacher's bias:

> Well, I disagree, because it appears to me, with all respect, that Dr. Raschbacher has already placed this gentleman into the malingering category, and no matter what question we ask of Dr. Raschbacher, he is going to use that as his support for denying, or not authorizing or not recommending, any ongoing care for [Claimant].

45. Dr. Castrejon opines to a reasonable degree of medical probability that he believes that Claimant requires continuing chiropractic care.

46. Dr. Raschbacher, and Respondents have indicated that Claimant's positive Waddell findings, which would have been 2 out of 5 or 3 out of 5 positive findings by Dr. Castrejon and 5 out of 5 by Dr. Raschbacher are indications that Claimant does not require further chiropractic care or the SI joint injections. Dr. Castrejon has addressed this issue. Dr. Castrejon's report of October 15, 2014, he states "On examination today, there are many pain behaviors with some findings that would be considered positive for Waddell's. Nevertheless, I have found that the testing for Waddell's in the Latin population is not entirely conclusive given the cultural differences that exist."

47. Dr. Castrejon also addresses the issue of Dr. Raschbacher's primary diagnosis of Claimant as malingering. Dr. Castrejon disagrees with this finding, noting consistency in Claimant's pain diagrams, he did not misuse medications, he underwent spinal injections without sedation, he followed every recommendation in his treatment plan, and his examinations have been consistent.

48. Respondents have stated throughout their cross examination of Dr. Castrejon on May 28, 2015 that "Dr. Sandell indicated that no further care was necessary." The ALJ finds that statement to be inaccurate. Dr. Sandell's office has provided a record of July 30, 2014 which states, "I [PA Hacker] discussed this patient's case extensively with Dr. Sandell. At this point, we really have nothing further to offer this patient. No further office visits will be scheduled. Since he had increased pain with physical therapy I advised him that it would be reasonable for him to hold off on

any further physical therapy for now. We recommend reevaluation by another pain medicine office or else an independent medical evaluation." The clear recommendation on July 30, 2014 is a "reevaluation by another pain medicine office."

49. It appears Dr Sandell's office left open the issue that another pain medicine office, not their own, could identify treatment that is being put on hold "for now." Based on this recommendation, Claimant saw Dr. Timothy Hall on August 25, 2014, before Respondents agreed that Dr. Miguel Castrejon would be the ATP in this case. Dr. Hall's August 25, 2014 report indicates objective, significant changes that were reproducible and supported that an industrial injury occurred. Dr. Hall recommended an SI joint injection, and planned a right SI joint injection for diagnostic purposes. Claimant followed up with Dr. Castrejon on October 15, 2014, with a noted SI joint dysfunction and a recommendation of an SI joint injection. Respondents' argument that Dr. Sandell recommended no further treatment is incorrect because he recommended treatment by "another pain management office." The follow up to another pain management office occurred when Claimant sought treatment from Dr. Hall. Dr. Hall's diagnosis supports the need for an SI joint injection and chiropractic treatment.

50. On April 4, 2014, Claimant testified at hearing that he received benefit from chiropractic care until Insurer cancelled the visits for chiropractic care. He noted that it helped his body, it allowed him to walk, and to move better. He testified that one month after he stopped chiropractic he hed more difficulty with range of motion.

51. Claimant testified that he wishes to have the SI joint injection because it was recommended by Dr. Castrejon and he trusts Dr. Castrejon and feels that the SI joint injection would be helpful.

52. Dr. Castrejon believes the Claimant should be entitled to additional chiropractic care and the SI joint injection that has been denied by the Respondents. In his opinion, Claimant has multiple issues primarily because of the length of time that he has remained in pain with only a limited amount of conservative care. This has caused him to develop chronic pain and chronic alterations of his biomechanics.

53. Dr. Castrejon is the agreed upon ATP in this case. He has seen Claimant numerous times since October 15, 2014. He also exhibited a credible and persuasive explanation of Claimant's presentation. The ALJI finds the opinions of Dr. Castrejon to be more persuasive and credible than those of Dr. Rashbacher.

54. Dr. Raschbacher saw the Claimant one time on February 23, 2015 for forty minutes. This was after Respondents' denied chiropractic care and the SI joint injection as not being reasonable and necessary. Dr. Raschbacher made a finding that the Claimant reached MMI on April 14, 2014 only three weeks after the date of his accident which the ALJ does not find to be credible. Dr. Raschbacher did not complete a full examination of Claimant in regard to identifying a SI dysfunction indicating that he was unable to do so. Dr. Raschbacher indicated that he did not do the sufficient testing to determine whether an SI joint injection was reasonable and necessary.

55. Dr. Raschbacher did not mention the chiropractic recommendation in his February 23, 2015 report, and addressed it in his testimony in a limited fashion. Dr.

Raschbacher's main diagnosis of the Claimant is malingering. However, he goes on to say "With respect to differential diagnosis, these include malingering or symptomatic right SI joint dysfunction." Dr. Raschbacher goes on to say, however, that "Even if the SI joint were actually symptomatic, it would not be medically likely that he would present as he does." Dr. Raschbacher states that he was unable to perform the testing necessary to determine an SI dysfunction although the ATP was able to do so. Dr. Raschbacher states that because his opinion is that the Claimant is a malingerer that he is not entitled to the denied medical treatment. The ALJ is not persuaded by Dr. Raschbacher's opinions.

56. Respondents' position is based on the report of Dr. Raschbacher, that the treatment is not reasonable and necessary. As stated, the ALJ is not persuaded by the opinions of Dr. Raschbacher. The ALJ is persuaded by the opinions of Dr. Castrejon, and by Claimant's testimony that he is not malingering and that he had not reached MMI as of April 14, 2014 as Dr. Raschbacher stated. Based on this, the ALJ finds that the opinions of Dr. Raschbacher are not persuasive. To the contrary, the ALJ finds the opinions of Dr. Castrejon to be credible and persuasive.

57. Further, the ALJ finds that Claimant, who the ALJ finds credible, has proven the reasonableness and necessity of continued chiropractic treatment and the SI joint injection. The ALJ further finds find that Respondents have not met their burden of proving otherwise.

58. Claimant's description of the injury and his physical complaints have been consistent throughout his medical records and his testimony is persuasive and credible.

59. Dr. Castrejon's opinions have been persuasive and credible in terms of the reasonableness and necessity of the Claimant's need for chiropractic care and the SI joint injection.

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 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. § 8-43-201, 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. § 8-43-201, C.R.S. A workers' compensation case is decided on its merits. § 8-43-201, C.R.S.

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*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2006).

In deciding whether a party to a workers' compensation dispute has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P3d 1192, 1197 (Colo. App. 2002).

Claimant has the burden of proving that requested medical treatment is reasonable, necessary and related to a work injury. Specifically, C.R.S. § 8-42-101(1)(a) provides the following directive on this issue: "Every employer shall furnish 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 from the effects of the injury."

Preponderance of the evidence means as follows: "Proof by a preponderance of the evidence requires the proponent to establish that the existence of a 'contested fact is more probable than its nonexistence." *Jimenez-Chavez v. Cargill Meat*, W.C. No. 4-704-536 (October 2008); *see Page v. Clark*, 592 P.2d 792 (Colo. 1979).

Pursuant to W.C.R.P 16-10, Respondents bear the burden of proof and must demonstrate by a preponderance of the evidence that a claimant's medical treatment is not reasonably necessary to cure or relieve the effects of the work injury. *Salisbury v. Prowers County School District*, W.C. No. 4-702-144 (June 5, 2012) (respondents have burden pursuant C.R.S § 8-43-201(1), to prove treatment is not reasonable, necessary or related).

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. C.R.S. Section 8-43-301(8) 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).

ATP Dr. Castrejon has been highly persuasive and credible in his opinions that the Claimant requires chiropractic care and the SI joint injection. The Claimant made

positive steps in regard to strength, range of motion and function with the limited chiropractic treatment that he had. His pain was better, he was able to walk and ambulate better and he was in better spirits while he was having the chiropractic treatment. After the chiropractic treatment was denied the Claimant regressed in all of these areas. Therefore, I am convinced that the chiropractic treatment is both reasonable and necessary. I am also persuaded that an SI joint dysfunction has been identified for the Claimant by Dr. Castrejon and was identified long ago. I am also persuaded that the SI joint injection is necessary for both diagnostic and therapeutic reasons as explained by Dr. Castrejon.

Claimant has proven by a preponderance of the evidence that he is entitled to receive both the recommended chiropractic treatment and the SI joint injection as reasonably necessary to cure or relieve the Claimant from the effects of the admitted work injury.

Respondents have failed to prove by a preponderance of the evidence that the recommended chiropractic treatment and SI joint injection are unreasonable and unnecessary in relation to the admitted work injury.

Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. C.R.S. 8-42-101(1)(a), *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994).

ORDER

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

1. Claimant's claim for further chiropractic care as recommended by Dr. Castrejon is GRANTED. Insurer shall provide such care.

2. Claimant's claim for SI joint injections as recommended by Dr. Castrejon is GRANTED. Insurer shall provide such care.

3. Issues not expressly decided herein are reserved to the parties for future determination.

4. 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: July 27, 2015

/s/ Kimberly Turnbow
Kimberly B. Turnbow
Administrative Law Judge
Office of Administrative Courts
1525 Sherman St., 4th Floor
Denver, CO 80203

STIPULATIONS

1. To the extent that Claimant's alleged back injuries are found to be related to the Claimant's April 22, 2014 work injury, the parties stipulate and agree that the Claimant's average weekly wage (AWW) is $736.71 with a corresponding TTD rate of $491.14.

ISSUES

The issues for determination are:

1. Whether the Claimant has proven, by a preponderance of the evidence, that he sustained an injury to his low back on April 22, 2014.

2. If the Claimant's low back claim is compensable, whether the Claimant has proven, by a preponderance of the evidence, that he is entitled to medical treatment to cure and relieve him from the effects of the April 22, 2014 injury.

3. If the Claimant's low back claim is compensable, whether Claimant proved, by a preponderance of the evidence, that he is entitled to temporary total disability benefits from May 7, 2014 through June 3, 2014.

FINDINGS OF FACT

1. The Claimant worked for Employer as a stocking clerk. In this position, his duties including loading and unloading product from skids to the freezer shelves and to frequently lift between 2 and 30 pounds, bend frequently, and twist frequently. Claimant further testified that this was the position he was working on April 22, 2014. The Claimant's testimony was credible and is found and is found as fact.

2. Claimant was working his shift on April 22, 2014 and was performing the duties of lifting items and placing them on the freezer shelves. Approximately an hour prior to the end of Claimant's shift, Claimant was had placed a package on the freezer shelve and was in the process of bending to pick up more product from the skid. As Claimant bent, he felt and immediate pain in his back that radiated into his legs. Claimant testified that his hands were empty at the time of the injury. The Claimant's testimony regarding his mechanism of injury was credible, not contested, generally consistent with the medical records, and is found as fact.

3. Claimant testified that he had a prior injury in his low back the year before on approximately August 10, 2013 for which he had filed a Workers' Compensation claim. Claimant testified that the previous injury had resolved with physical therapy after approximately 2 months of treatment. Claimant also testified following the previous injury, he did not have medical restrictions and was working at full duty prior to April 22, 2014. The Claimant's testimony regarding his prior low back injury and its resolution was credible and supported by the medical records at Claimant's Exhibits 19 – 23, and is found as fact.

4. Claimant immediately informed Grocery Manager, Austin Icke of what had happened and explained that he was in pain. Mr. Icke asked if Claimant wanted to report the injury as a work accident. Claimant testified that, at that time, he did not want to file a report because he believed that his symptoms would resolve shortly and Claimant returned to finish the remainder of his shift.

5. As Claimant continued his shift, his pain did not resolve and Claimant left his shift approximately 30 minutes early due to his pain. Following his shift, Claimant sought treatment at Kaiser Permanente. Claimant testified he was informed by providers at Kaiser Permanente that because the injury was work related, Claimant would not be able to continue to received medical treatment through that facility should his symptoms continue.

6. Claimant contacted Mr. Icke again and informed Mr. Icke that he wanted to report the injury as a Workers' Compensation Claim and seek medical treatment through a Workers' Compensation doctor.

7. The Claimant's testimony regarding the reporting of his injury to his supervisor is credible, not contested, and is found as fact.

8. Claimant was then sent to Union Medical, PC on April 23, 2014 where he was evaluated by Dr. Paz and Erin Lay, PA C/F. Claimant was given medical restrictions that limited him from lifting more than 10 lbs., carrying more than 10 lbs., and pushing/pulling more than 10 lbs. Based on this evaluation, Dr. Paz opined that his objective findings were consistent with a work related mechanism of injury. Claimant continued to treat with Union Medical, PC until May 7, 2014 and continued to remain on medical restrictions. The Claimant was provided modified light duty at work while he was in physical therapy recommended by Dr. Paz.

9. Respondents filed a Notice of Contest on May 6, 2014 and Claimant was no longer able to continue treating through the Workers' Compensation providers. Claimant attempted to return to work on May 7, 2014 but was sent home because he remained on restricted duty but his claim had been denied. Claimant was not allowed to return to work until he could provide a release to full duty from a medical provider.

10. Claimant continued to follow up with providers at Kaiser Permanente and remained on restrictions. Claimant testified that during that time, he experienced an

aggravation while completing yard work but that the aggravation ultimately improved. On June 2, 2014, Claimant was approved to return to full duty starting on June 3, 2014.

11. Between May 7, 2014 and June 3, 2014, Claimant was not paid wage loss benefits due to the claim being denied.

12. Claimant testified that he returned to full duty as of June 3, 2014 and has continued working since that time. Claimant continues to experience low back pain and symptoms but has not returned to a medical provider for treatment due to the financial expense of doing so.

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 benefits by a preponderance of the evidence. C.R.S. § 8-43-201. Respondent bears the burden of establishing any affirmative defenses. 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 fact 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 and a workers' compensation claim shall be decided on its merits. C.R.S. § 8-43-201 (2008).

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).

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*, 138 P.3d 684 (Colo. App. 2008; *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

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 than 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 mechanism of injury described by the Claimant during testimony at the hearing, which is consistent with his description to medical providers, is not contested and, per Dr. Paz, it is a mechanism of injury that is consistent with the physical findings on examination. The injury was significant enough to require work restrictions that caused the Employer to advise the Claimant he could not return to work until he was cleared by a doctor. The injury occurred during Claimant's work shift while he was performing activities that are a specific part of his job duties.

Based upon the Claimant's uncontroverted and supported testimony and the medical records confirming the Claimant's physical condition, it is found that the Claimant suffered a compensable injury.

Medical Benefits – Reasonable, Necessary and Causally Related

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. However, the right to workers' compensation benefits, including medical benefits, arises only when an injured employee establishes by a preponderance of the evidence that the need for medical treatment was proximately caused by an injury arising out of and in the course of employment. § 8-41-301(1)(c), C.R.S.; *Faulkner v, Industrial. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000). The evidence musty 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. Medical evidence is not required to establish causation and lay testimony alone, if credited, may constitute substantial evidence to support an ALJ's determination regarding causation. *Industrial Commission of Colorado*, 717 P.2d 1000 (Colo. App. 1986).

Here, Claimant testified credibly that he was working his regular duties on April 22, 2014 when experienced an injury to his low back. Though Claimant had previously been treated for symptoms related to his low back the year before, Claimant credibly testified, and the medical evidence supports, that Claimant had not been on medical restrictions prior to April 22, 2014 and that his previous symptoms resolved after approximately 2 months with physical therapy. Though Claimant was not holding anything in his hands at the time of the injury, his injury and the medical records are consistent with the mechanism of injury of bending and twisting. The Claimant has established that he is entitled to further evaluation of his lower back condition to determine if he requires additional medical treatment to cure and relieve the Claimant from the effects of the injury in accordance with the Act.

Temporary Disability Benefits

To prove entitlement to 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); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). § 8-42-103(1)(a), C.R.S., requires the 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). 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). If the period of disability lasts longer than two weeks from the day the injured employee leaves work as the result

of the injury, disability indemnity shall be recoverable from the day the injured employee leaves work. § 8-42-103(1)(b), C.R.S. TTD benefits ordinarily continue until one of the occurrences listed in § 8-42-105(3), C.R.S.; *City of Colorado Springs v. Industrial Claim Appeals Office, supra*, namely:

- The employee reaches maximum medical improvement;
- The employee returns to regular or modified employment;
- The attending physician gives the employee a written release to return to regular employment; or
- the attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.

The existence of disability presents a question of fact for the ALJ. There is no requirement that the claimant produce evidence of medical restrictions imposed by an ATP, or by any other physician. Rather, lay evidence alone may be sufficient to establish disability. *Lymburn v. Symbios Logic,* 952 P.2d 831 (Colo. App. 1997).

Here, the Claimant suffered a work injury on April 22, 2014. However, the Claimant did not miss work until May 7, 2014. Claimant credibility testified, and the employer records support, that Claimant was not allowed to return to work from May 7, 2014 through June 3, 2014 because of the medical restrictions imposed upon him by his providers. These restrictions resulted in Claimant being unable to perform his regular employment and the restrictions were a direct result of the injury that Claimant sustained while bending and twisting his shift on April 22, 2014.

The total work time missed lasted longer than two weeks and therefore the Claimant is entitled to temporary total disability benefits from the day he left work. The Claimant is entitled to TTD benefits from May 7, 2014 through June 2, 2014 when, by his own testimony, he was released by his physician to return to work and he did, in fact, return to work on June 3, 2014.

ORDER

It is therefore ordered that:

1. The Claimant's suffered a compensable injury on April 22, 2014.

2. The Claimant is entitled to medical benefits to treat his low back and associated symptoms which are causally related to the April 22, 2014 work injury and the Respondent is responsible for payment for such treatment in accordance with the Medical Fee Schedule and the Act.

3. The Claimant is entitled to temporary total disability benefits at the stipulated TTD rate of $491.14 per week, from the time period of May 7, 2014 through June 3, 2014.

4. All compensation not paid when due shall bear interest at the rate of 8% per annum.

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, 1523 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 the 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, 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: July 24, 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

W.C. No. 4-950-054-03

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

NON-INSURED and

Non-Insured and Insurer/Respondents.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on May 14, 2015, in Denver, Colorado. The hearing was digitally recorded (reference: 6/14/15, Courtroom 3, beginning at 8:30 AM, and ending at 12:00 PM).

Claimant's Exhibits 1 through 13 were admitted into evidence, without objection, Non-Insured Employer's Exhibits A through F were admitted into evidence, without objection. Respondent OSF/Pinnacol's Exhibits A through F were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ deferred ruling on the case for 15 working days to allow the parties to discuss and consider settlement. On June 5, 2015, the Claimant filed a "Status Report," indicating that the parties were continuing to engage in settlement negotiations. On June 12, 2015, the Claimant filed a subsequent "Status Report," indicating that a settlement had **not** been reached, and submitting Claimant's Exhibit 14, which reflects a Medicaid lien of $14, 832.28 by the Colorado Department of Health Care Policy and Financing against the Claimant's workers' compensation medical benefits, pursuant to § 25.5-4-301, C.R.S.

The matter was considered submitted for decision on June 12, 2015, however, due to the untimely final illness and passing of the ALJ's wife, the decision has been delayed until this time.

ISSUES

The issues to be determined by this decision concern whether or not the Employer was and "employer," as defined by the Workers' Compensation Act (hereinafter the "Act"); whether the Claimant was an "employee," as defined by the Act; whether OSF was the Claimant's statutory employer on the date of injury; whether the Employer failed to insure its liability for workers' compensation and is, therefore, subject to a 50% penalty on indemnity benefits; whether Respondent OSF/Pinnacol should be dismissed from the case; whether the Claimant suffered a compensable injury to his left hand on April 17, 2014. If compensable, the additional issues concern medical benefits, average weekly wage (AWW); temporary total disability (TTD) benefits from April 17, 2014 and continuing; and, daily penalties against the Employer for failure to timely admit or contest from May 12, 2014 (21 days after the Employer had notice of more than 3 days disability) through February 9, 2015, the date that the Respondent Employer filed a Response to Application for Hearing, which took a position on the claim, a total 274 days, both dates inclusive.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

Stipulations and Findings

1. At the commencement of the hearing, the parties stipulated, and the ALJ finds, that the Employer was a sole proprietor and was not insured for workers' compensation.

2. The parties further stipulated, and the ALJ finds, that the Employer was not under contract or performing any work for OSF, which was insured by Pinnacol Assurance, and that OSF and its insurance carrier, were not proper parties.

The Injury

3. On April 17, 2014, the Claimant was working as a helper (go-fer) for the Employer when he was cutting a piece of flooring and his left hand got caught in the table saw, thus, mangling the left hand. The Employer was contemporaneously aware of the injury, and the Claimant was immediately transported to Denver Health, where emergency surgery occurred by Kyros Ipaktchi, M.D., and his assistant Christopher Lyons, M.D., hand fellow.

4. Dr. Ipaktchi's pre-operative diagnosis was:

> (1) table saw injury to left hand with zone 2 distal to PIP joint segmental defect and new complete transaction to dorsal skin with bone and soft tissue loss; (2) transaction, near complete, from volar to dorsal skin with a dorsal cortical rim still standing on the long finger in a zone 2 middle phalanx level; and, (3) amputation of the ring finger to the DIP joint with avulsion of soft tissues into the distal pulp.

5. Dr. Ipaktchi's post-operative diagnosis was:

> (1) mangling hand injury to the left hand by a table saw, coming from volar through to the dorsal side with complete amputation of the ring finger through the DIP joint with avulsion of soft tissues into the distal pulp; (2) near complete transection of the middle phalanx level of the long finger with transaction of all flexor tendons as well as radial and ulnar-sided digital artery and nerve as well as segmental bone and skin and soft tissue as well as neurovascular and tendinous subtenon loss; and, (3) index finger oblique table saw injury into the distal phalanx with avulsion of the ulnar-sided neurovascular bundles from the distal phalangeal level at the bifurcation of the vessels.

6. The ALJ observation of the Claimant's left hand illustrated a severely mangled and disfigured left hand.

7. The Claimant was discharged from Denver Health on April 21, 2014. Subsequently, in a follow up at Denver Health on August 19, 2014, Dr. Ipatchi assessed: "near amputation of left index finger, long finger, ring finger with

revasularization of the long finger and completion amputation of the index finger and ring finger…." Dr. Ipaktchi, at Claimant's request, gave him a note allowing a return to "light duty" work, however, no light duty work has been offered by the Employer and the Claimant cannot return to full duty work.

Medical Benefits

8. The Employer did not designate any specific medical provider. Moreover, the Employer facilitated the Claimant's emergency transport to Denver Health and, thus, acquiesced in treatment by Denver Health. The evidence supports the fact, and the ALJ finds that all medical care and treatment for the Claimant's work-related left hand injury was authorized, within the chain of authorized referrals, causally related to the April 17, 2014 injury, and reasonably necessary to cure and relieve the effects of that injury.

Average Weekly Wage (AWW)

9. It was the Claimant's undisputed testimony that the contract of hire with the Employer contemplated full-time, 40-hour a week work at $18 an hour. This hourly rate is corroborated by the testimony of Justin Soderberg, a principal with the Respondent Employer. Therefore, the ALJ hereby finds that the Claimant's AWW is $720. 2/3rds of the AWW, penalized by 50% for failure to insure, equals a TTD benefit of $720 per week, or $102.86 per day, pursuant to Industrial Claim Appeals office approved method of calculating aggregate days of disability.

Temporary Total Disability Benefits

10. The Claimant has not been able to return to regular work since the date of injury nor has he been offered modified work, as permitted by Dr. Ipaktchi's light duty release in August 2014. As of the present time, the Claimant has not been released to return to work without restrictions; he has not actually worked and earned wages; and, he has not been declared to be at maximum medical improvement (MMI). He has been sustaining a 100% temporary wage loss since the date of injury. Consequently, the Claimant has been temporarily and totally disabled from April 18, 2014 through the present time and continuing the present time. The period from April 18, 2014 through the hearing date, May 14, 2015, both dates inclusive, equals a total of 396 days. Aggregate TTD benefits, for this period, penalized 50% for failure to insure, equal $40,732.56.

Daily Penalties for Employer's Failure to Timely Admit or Contest

11. Daily penalties against the Employer for failure to timely admit or contest are from May 12, 2014 (21 days after the Employer had notice of more than 3 days disability) through February 9, 2015, the date that the Respondent Employer filed a

Response to Application for Hearing which took a position on the claim, a total 274 days, both dates inclusive. In light of the stipulations and findings herein above that the Employer was a sole proprietor and was not insured for workers' compensation and that the Employer was not under contract or performing any work for OSF, which was insured by Pinnacol Assurance, and that OSF and its insurance carrier, were not proper parties, the ALJ finds no mitigation to excuse or mitigate the non-insured Employer's obligation to timely admit or contest liability. Therefore, the ALJ finds that an appropriate daily penalty equals the daily TTD rate of $102.86 per day. Therefore, aggregate daily penalties for failure to timely admit or contest for 274 days, equal $28, 183.64.

Ultimate Findings

12. The Claimant's testimony was, essentially, undisputed, straight-forward, and credible. There was no persuasive testimony to the contrary.

13. The ALJ makes a rational choice, between any conflicting testimony and evidence, to accept the Claimant's testimony and reject evidence to the contrary.

14. OSF/Pinnacol were not proper parties to this case because OSF (an insured entity) was not the statutory employer of the Employer herein.

15. The Claimant was an "employee" of the Employer herein on the date of injury, and the "Employer was an 'employer,' as defined by the Act.

16. On April 17, 2014, the Claimant sustained a serious mangling, compensable injury to his left hand, and the injury arose out of the course and scope of his employment for the non-insured Employer herein and was not intentionally self-inflicted.

17. The Employer was contemporaneously aware of the injury and arranged for the emergency transport of the Claimant to Denver Health. The Employer made no specific medical referrals. All referrals emanated from Denver Health and were, therefore, within the authorized chain of referrals, Therefore, all of the Claimant's medical care and treatment for the left hand injury was authorized, causally related to the April 17, 2014 compensable injury, and reasonably necessary to cure and relieve the effects thereof.

18. The Claimant's AWW is $720, thus yielding a 50% penalized TTD rate of $720 per week.

19. The Claimant has been temporarily and totally disabled since April 17, 2014 and continuing.

20. The Employer's failed to timely admit or contest from May 12, 2014 (21 days after the Employer had notice of more than 3 days disability) through February 9, 2015, the date that the Respondent Employer filed a Response to Application for Hearing which took a position on the claim, a total 274 days, both dates inclusive. In light of the stipulations and findings herein above that the Employer was a sole proprietor and was not insured for workers' compensation and that the Employer was not under contract or performing any work for OSF, which was insured by Pinnacol Assurance, and that OSF and its insurance carrier, were not proper parties, the ALJ finds no mitigation to excuse or mitigate the non-insured Employer's obligation to timely admit or contest liability. The Employer did not have any reasonably debatable defense to non-insured liability. Therefore, the ALJ finds that an appropriate daily penalty equals the daily TTD rate of $102.86 per day. Therefore, aggregate daily penalties for failure to timely admit or contest for 274 days, equal $28,183.64.

21. The Claimant has sustained his burden of proof, by preponderant evidence, on all issues.

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CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo.

275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* S 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). *Also see, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury,* 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. As found, the Claimant's testimony was, essentially, undisputed, straight-forward, and credible. There was no persuasive testimony to the contrary.

Substantial Evidence

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, the ALJ made a rational choice, between any conflicting testimony and evidence, to accept the Claimant's testimony and reject evidence to the contrary.

Non-Insurance and Employee Status

c. Section 8-43-408 (1), C.R.S., provides a 50% penalty of indemnity benefits for failure of an employer to insure its liability for workers compensation. As found, the Employer herein failed to insure its liability for workers' compensation and is, therefore, subject to a 50% increase in all indemnity benefits.

d. As found, the Claimant performed work for hire for the Employer herein and he was an "employee" within the definition of § 8-40-202, C.R.S., at the time of the compensable injury.

Compensability

e. In order for an injury to be compensable under the Workers' Compensation Act, it must "arise out of" and "occur within the course and scope" of the employment. *Price v. Indus. Claim Appeals Office,* 919 P.2d 207, 210, 210 (Colo. 1996). There is no presumption that an injury arises out of employment when an unexplained injury occurs during the course of employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 108-09, 4437 P.2d 542 (1968). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. § 8-41-301 (1) (c), C.R.S. *See Faulkner v. Indus. Claim Appeals Office,* 24 P.3d 844 (Colo. App. 2000)*; Eller v. Indus. Claim Appeals Office*, 224 P.3d 397, 399 (Colo. App. 2009); *Cabela v. Indus. Claim Appeals Office,* 198 P.3d 1277, 1279 (Colo. App. 2008). The question of causation is generally one of fact for the determination by the ALJ. *Faulkner* at 846; *Eller* at 399-400. As found, the Claimant sustained a compensable injury to his left hand on April 17, 2014, and this injury arose out of the course and scope of his employment.

Medical

f. Because this matter is compensable, the non-insured Respondent is liable for medical treatment which is reasonably necessary to cure or relieve the effects of an industrial injury. § 8-42-101(1) (a), C.R.S; *Snyder v. Indus. Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). Pursuant to § 8-43-404 (5) (a) (I) (A), C.R.S., the employer is required to furnish an injured worker a list of at least two physicians or two corporate medical providers, in the first instance. An employer's right of first selection of a medical provider is triggered when the employer has knowledge of the accompanying facts connecting the injury to the employment. *Jones v. Adolph Coors Co.,* 689 P. 2d 681 (Colo. App. 1984). An employer must tender medical treatment forthwith on notice of an injury or its right of first selection passes to the injured worker. *Rogers v. Indus. Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). As found, the Employer was contemporaneously aware of the injury and arranged for the emergency transport of the Claimant to Denver Health. The Employer made no specific medical referrals. Therefore, all of the Claimant's medical care and treatment for the left hand injury was authorized, causally related to the April 17, 2014 compensable injury, and reasonably necessary to cure and relieve the effects thereof.

g. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. *See Mason Jar Restaurant v. Indus. Claim Appeals Office,* 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). As found, all referrals emanated from Denver health, The Claimant's first selection of a medical provider, and were, therefore, within the authorized chain of referrals.

h. To be a compensable benefit, medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment is causally related to the left hand, mangling injury of April 17, 2014. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment was and is reasonably necessary to cure and relieve the effects of the April 17, 2014 compensable injury.

Average Weekly Wage (AWW)

i. An AWW calculation is designed to compensate for **total** temporary wage loss. *Pizza Hut v. Indus. Claim Appeals Office,* 18 P. 3d 867 (Colo. App. 2001). *See* § 8-42-102, C.R.S. As found, the Claimant's AWW is $720 which, ordinarily, would yield an insured TTD benefit of 2/3rds of $720, however, penalized by 50% for failure to insure the weekly TTD benefit is $720 per week, or $102.86 per day.

Penalized Temporary Disability Benefits

j. To establish entitlement to temporary disability benefits, the Claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. § 8-42-103(1), C.R.S; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Disability from employment is established when the injured employee is unable to perform the usual job effectively or properly. *Jefferson Co. Schools v. Headrick*, 734 P.2d 659 (Colo. App.1986). This is true because the employee's restrictions presumably impair his opportunity to obtain employment at pre-injury wage levels. *Kiernan v. Roadway Package System*, W.C. No. 4-443-973 (ICAO, December 18, 2000). . There is no statutory requirement that a claimant must present medical opinion evidence from of an attending physician to establish her physical disability. See *Lymburn v. Symbois Logic*, 952 P.2d 831 (Colo. App. 1997). Rather, the Claimant's testimony alone is sufficient to establish a temporary "disability." *Id*. Once the prerequisites for TTD are met (*e.g.,* no release to return to full duty, MMI has not been reached, a temporary wage loss is occurring, modified employment is not made available, and there is no actual return to work), TTD benefits are designed to compensate for a 100% temporary wage loss. *See Eastman Kodak Co. v. Industrial Commission,* 725 P. 2d 107 (Colo. App. 1986); *City of Aurora v. Dortch,* 799 P. 2d 461 (Colo. App. 1990). As found, the Claimant has not been able to return to regular work since the date of injury nor has he been offered modified work, as permitted by Dr. Ipaktchi's light duty release in August 2014. As of the present time, the Claimant has not been released to return to work without restrictions; he has not actually worked and earned wages; and, he has not been declared to be at maximum medical improvement (MMI). He has been sustaining a 100% temporary wage loss since the date of injury. Consequently, the Claimant has

been temporarily and totally disabled from April 18, 2014 through the present time and continuing the present time. The period from April 18, 2014 through the hearing date, May 14, 2015, both dates inclusive, equals a total of 396 days. Aggregate TTD benefits, for this period, penalized 50% for failure to insure, equal $40,732.56.

Daily Penalty for Failure to Timely Admit or Contest

k. Section 8-43-203 (2) (a), C.R.S., provides for a daily penalty of one day's compensation for each day's failure to timely admit or contest, up to 365 days, 50% payable to the Subsequent Injury Fund and 50% payable to the Claimant. As found, the Employer's failed to timely admit or contest from May 12, 2014 (21 days after the Employer had notice of more than 3 days disability) through February 9, 2015, the date that the Respondent Employer filed a Response to Application for Hearing which took a position on the claim, a total 274 days, both dates inclusive. In light of the stipulations and findings herein above that the Employer was a sole proprietor and was not insured for workers' compensation and that the Employer was not under contract or performing any work for OSF, which was insured by Pinnacol Assurance, and that OSF and its insurance carrier, were not proper parties, the ALJ finds no mitigation to excuse or mitigate the non-insured Employer's obligation to timely admit or contest liability. As found, the Employer lacked any reasonably debatable defense to non-insured employer liability. Therefore, the ALJ finds that an appropriate daily penalty equals the daily TTD rate of $102.86 per day. Therefore, aggregate daily penalties for failure to timely admit or contest for 274 days, equal $28,183.64.

Burden of Proof

l. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012). 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,* 197 Colo. 306, 592 P. 2d 792 (1979). *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its

nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained his burden, by preponderant evidence, on all issues.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents OSF Investments, LLC, and their insurance carrier, Pinnacol Assurance, are hereby dismissed as parties, with prejudice.

B. The Respondent Non-Insured Employer, sole proprietor, shall pay all of the costs of medical care and treatment for the Claimant's compensable left hand injury, subject to the Division of Workers' Compensation Medical Fee Schedule.

C. The Respondent Non-Insured Employer shall pay the Claimant temporary total disability benefits at the rate of $720.00 per week, or $102.86 per day, from April 18, 2014 through May 14, 2015, both dates inclusive (penalized 50% for failure to insure) in the aggregate subtotal amount of $40,732.56, which is payable retroactively and forthwith. From May 15, 2015 and continuing until cessation of temporary indemnity benefits is warranted by law, the Non-Insured Employer shall continue to pay the Claimant $720 per week in temporary total disability benefits.

D. For failing to timely admit or contest, Respondent Non-Insured Employer shall pay daily penalty benefits at the rate of $102.86 per day. For the penalty period from May 12, 2014 through February 9, 2015, both dates inclusive, a total of 274 days, the Non-Insured Respondent shall pay aggregate daily penalties the daily TTD rate of $102.86 per day, in the aggregate amount of $28,183.64., 50%, or $14,091.82, is payable to the Claimant and $14,091.82 is payable to the Subsequent Injury Fund, Division of Workers Compensation. The grand total of indemnity benefits due as of May 14, 2015, equal $68, 916.20. The exact amount of the cost of medical benefits is as of the present time not ascertainable other the Medicaid lien of $14, 82.28, placed on medical benefits by the Colorado Department of Health Care Policy and Financing. Consequently, the grand total of presently ascertainable indemnity and medical benefits equals $83,748.48.

E. The Non-Insured Respondent Employer shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts of indemnity benefits due and not paid when due.

F. Any and all issues not determined herein are reserved for future decision.

G. In lieu of payment of the above compensation and benefits to the Claimant, the Respondent property Owner shall:

a. Deposit the sum of $ 83,748.48 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik/Trustee; or

b. File a bond in the sum of $ 100,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:
   (1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or
   (2) Issued by a surety company authorized to do business in Colorado.
   The bond shall guarantee payment of the compensation and benefits awarded.

IT IS FURTHER ORDERED: That the on-insured Respondent Employer shall notify the Division of Workers' Compensation of payments made pursuant to this order.

IT IS FURTHER ORDERED: That the filing of any appeal, including a petition to review, shall not relieve the Non-Insured Respondent Employer of the obligation to pay the designated sum to the trustee or to file the bond. §8-43-408(2), C.R.S.

DATED this_____day of July 2015.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

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, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 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 form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order** on this_____day of July 2015, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

Division of Workers' Compensation
Sue.Sobolik@state.co.us

_____
Court Clerk

Wc.ord

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-951-860-03

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Insurer / Respondents.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on June 17, 2015, in Denver, Colorado. The hearing was digitally recorded (reference: 6/17/15, Courtroom 3, beginning at 8:30 AM, and ending at 12:00 PM). Fayha Suleman served as the official Arabic/English Interpreter.

Claimant's Exhibits 1 through 42 were admitted into evidence, without objection. Claimant's Exhibit 43 was withdrawn. Respondents' Exhibits A through M were admitted into evidence, without objection.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to counsel for the Claimant. The proposed decision was filed, electronically, on June 24, 2015. On the same date, the Respondents filed objections requesting more findings including the dates of chiropractic treatment from king Chiropractic and Sean Lloyd, M.D. (an FMLA physician); and, more detailed findings concerning the basis why Kristin Mason, M.D., was designated as the designated medical provider, as detailed in the bench ruling but not included in the proposed decision. After a consideration of the proposed decision and the objections thereto, the ALJ has modified the proposal and hereby issues the following decision.

ISSUES

The issues to be determined by the decision concern compensability; if compensable, whether the right to select an authorized treating physician (ATP) passed to the Claimant when Carlos Cebrian, M.D., denied medical treatment for a non-medical reasons, thus, making the Claimant's selection of Kristin D. Mason, M.D. as the new ATP WHEN THE Respondents knew of Dr. Cebrian's opinion and offered no further medical treatment to the Claimant; also, whether the medical treatment rendered by Dr. Mason is reasonably necessary and causally related to the Claimant's injury of September 11, 2013; average weekly wage (AWW); and temporary total disability (TTD) benefits from September 11, 2013 and continuing. The Claimant withdrew the issue of temporary partial disability (TPD) benefits from September 11, 2013 and continuing. The Respondents raised the affirmative defense of "responsibility for termination."

The Claimant bears the burden of proof, by a preponderance of the evidence, on the issues of compensability, ATP, reasonably necessary, AWW, and TTD benefits. The Respondents bear the burden of proof, by a preponderance of the evidence, for the affirmative defense of "responsibility for termination."

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

Preliminary Findings

1. According to the Claimant, he worked for the Employer since March 14, 2011, and he speaks Arabic as his primary language.

2. The parties stipulated, and the ALJ finds, that if the claim is found compensable, the Claimant's AWW is $662.92.

3. The Respondents made a judicial admission that there was a compensable injury on September 11, 2013.

The Injury

4. On September 11, 2013, the Claimant was working at the Employer's plant as a Loin Tail Boner.

5. On September 10, 2013, the Claimant was feeling well with no previous problems or injuries in the low back, buttocks, or legs prior to the incident of September 11, 2013.

6. According to the Claimant, the following events occurred on September 11, 2013. He started work at 5:30 AM and he suffered an injury to his low back when his supervisor asked him to lift a box of meat weighing approximately forty (40) pounds. The Claimant lifted the box of meat, as directed by his supervisor, and as he twisted he felt a pain in his low back. He reported the injury immediately to his supervisor who escorted the Claimant to the Employer's clinic for treatment.

7. At hearing, the Respondents stipulated to the fact that the Claimant suffered a work-related injury on September 11, 2013, and the ALJ so finds.

Medical Treatment at the Employer's Clinic

8. The Claimant received treatment from the Employer's clinic from September 11, 2013 through May 13, 2014.

9. Dr. Cebrian testified at hearing that he holds the position of Onsite Medical Director for the Occupational Health Department, at the Employer's medical clinic, where the Claimant was treated for his low back injury until May 13, 2014.

10. Dr. Cebrian stated that the only treatment provided to the Claimant from September 11, 2013 to May 13, 2014, was ice, stretches, and home exercise education.

11. Kristin Mason, M.D., credibly testified at hearing that the care that the Claimant received at the Employer's clinic from September 11, 2013 to May 13, 2014, was a "passive kind of palliative type care."

12. On October 22, 2013, Dr. Cebrian ordered x-rays of the Claimant's low back.

13. On December 17, 2013, Dr. Cebrian placed the Claimant at maximum medical improvement (MMI).

The Claimant

14. According to the Claimant, from December 17, 2013 to February 26, 2014, his symptoms were getting worse, consisting of pain every day in the low back, buttock, and legs, which he related to the September 11, 2013 incident.

15. On February 26, 2014, the Claimant returned to the Employer's clinic for additional treatment for his low back pain.

16. On February 26, 2014, the Claimant filled out a new Employee Statement of Injury form, with a date of injury of February 20, 2014. According to the Claimant, February 20, 2014, is the date that his low back pain **worsened to a point where he determined the need to return to the Employer's medical clinic** for treatment. He testified, unequivocally, that February 20, 2014, was not a new injury date.

17. On March 17, 2014, **Dr. Cebrian released the Claimant from care, stating the opinion that there was no work related incident that occurred.**

18. On March 17, 2014, the Claimant still had back pain and it was getting worse.

19. According to the Claimant, from March 17, 2014 to May 7, 2014, his low back, buttock and leg symptoms were in the same painful condition, consisting of pain every day in the low back, buttock, and legs, which he related to the September 11, 2013 incident.

20. On May 7, 2014, because his pain in the low back, buttock, and legs was getting worse, the Claimant returned to Dr. Cebrian for treatment.

21. On May 7, 2014, the Claimant was asked to fill out another Employee Statement of Injury form. On the May 7, 2014 form, however, the Claimant testified that he did not fill in the date of entry or time of injury fields, despite the form listing a date of injury of May 7, 2014.

22. **On May 13, 2014, Dr. Cebrian released the Claimant from care for the third time and referred the Claimant to a chiropractor outside the Worker's Compensation system (as a non-work related proposition).**

<u>King Chiropractic</u>

23. According to Respondents' Exhibit F (bates 163-172), the Claimant was seen at King Chiropractic on April 4, 2014 for intake; May 9, 2014, for an adjustment and x-ray; and, May 21, 2014 for an adjustment.

24. The Claimant provided undisputed testimony that on May 19, 2014, he asked his supervisor multiple times for a break so that he could seek medical treatment for his low back pain at the Employer's medical clinic, however, the Claimant was not allowed to leave his post. After lunch, he asked again for a break to see the nurse at the Employer's medical clinic. He then proceeded to the Employer's medical clinic and requested medical treatment for his low back pain. His supervisor told the Employer's clinic not to treat the Claimant because the Employer had a note from a doctor (Dr. Cebrian) stating that the Claimant's injury is not work related. The Claimant then sought

out a union representative, who advised him to document the May 19, 2014 incident. The Claimant then documented the incident.

25. On May 19, 2014, the Claimant's Employer denied him treatment for his low back pain.

26. The fact that from September 11, 2013 to May 13, 2014, the only treatment the Claimant received consisted of ice packs, heat pads, and massage that he performed on himself is reiterated.

27. The Claimant's testimony and the medical records from the Employer's medical clinic support, that from September 11, 2013 to May 13, 2014, the Claimant worked full-duty without any medically-imposed restrictions by his ATP, Dr. Cebrian.

28. According to the Claimant, the Employee Statement of Injury forms, completed on September 11, 2013, February 26, 2014, and May 7, 2014, all relate to the injury that occurred on September 11, 2013.

Family Medical Leave Act (FMLA) Referral to Sean Lloyd, M.D.

29. The Claimant's first visit with Dr. Lloyd was on May 30, 2014, on a FMLA referral (Respondents' Exhibit J, bates 179-206). He saw Dr. Lloyd again on June 3, 2014 for an office visit and an FMLA Report (Respondents' Exhibit J, bates 201-204). He next saw Dr. Lloyd on November 21, 2014 for an FMLA office visit (Respondents' Exhibit J, bates 179-200).

Dr. Cebrian's Final Release and Referral to Physician Outside Workers Compensation System.

30. Dr. Cebrian's December 8, 2014 medical report states, "[h]e is released from care. **He was told to follow-up with his primary care physician outside of the workers' compensation system[,]"** with a MMI date of December 10, 2013.

31. In addition, the Claimant testified that the descriptions of what he was doing at the time the injury occurred, listed on the Employee Statement of Injury forms, *i.e*. "I am carrying back of meat" and "I am carrying box of meat," references the September 11, 2013 incident.

32. The Claimant stated that he communicated to the Employer's medical clinic in English each time he was evaluated.

Selection of Kristin Mason, M.D. as the ATP

33. Dr. Cebrian refused to treat the Claimant's medical condition as a work-related condition as of May 13, 2014, and ultimately referred the Claimant to a private chiropractor, thus, severing his role as the workers' compensation ATP.

34. After Dr. Cebrian's refusal to treat for non-medical reasons, Dr. Mason was the first qualified physician selected to be the Claimant's ATP. She is fully Level 2 accredited. King Chiropractic, and Dr. Lloyd, from Aurora South Medical Center do not qualify as validly selected referrals to be ATPs. King Chiropractic is only an ancillary provider, much like physical therapy, and cannot be considered an ATP for workers' compensation purposes.

35. Additionally, the Claimant was referred to Dr Lloyd of Aurora South Medical Center in regard to his FMLA claim, and not his work-related injury, and Dr. Lloyd is therefore not an appropriate ATP for workers' compensation purposes. Therefore, as of June 5, 2014, Dr. Mason became the Claimant's validly selected ATP for workers' compensation purposes.

Dr. Mason's Treatment and Opinions

36. The Claimant was evaluated and treated by Kristin Mason, M.D., from June 5, 2014 and thereafter, under his private health insurance.

37. According to Dr. Mason, on June 5, 2014, the Claimant complained of low back pain and pain down his right leg, which is consistent with the symptoms the Claimant reported and are documented in the Employer's medical clinic Daily Visit Log.

38. When Dr. Mason treated the Claimant, he reported that his low back and right leg pain complaints were attributed to his September 11, 2014 work-related injury. Dr. Mason also stated that the Claimant never reported any other injury or injury date.

39. On July 3, 2014, Dr. Mason ordered an MRI (magnetic resonance imaging) and x-rays including flexion/extension views of the Claimant's low back to determine if there was a structural reason for his pain.

40. Dr. Mason was of the opinion that "the MRI showed central disc bulges at L4-5 and L5-S1 impinging on the bilateral L5 and S1 nerve roots."

41. Dr. Mason initially treated the Claimant with physical therapy (PT). When the PT failed to resolve the Claimant's symptoms, she ordered imaging. After the imaging, Dr. Mason ordered right-sided epidural steroid injections.

42. Dr. Mason attributed the MRI findings to the Claimant's September 11, 2013 work-related injury. The basis for her opinion is that the Claimant reported no previous history of injuries or back pain prior to lifting something heavy at work.

According to Dr. Mason, a lifting injury is a common mechanism for a disc injury, the Claimant reported persistent similar symptoms since the time of onset of his pain, and the disc bulges were identified as the pain generator when he got over 50% benefit from the epidural injections. Therefore, it made sense that the abnormality on the MRI was caused or exacerbated by the lifting injury. Based on the thoroughness of Dr. Mason's exam and treatment of the Claimant, the ALJ finds her opinions far more persuasive, credible and compelling than any opinions to the contrary.

43. On August 13, 2014, the Claimant received right L4-5 and L5-S1 transforaminal epidural steroid injections by Nicholas Olsen, D.O., on referral from Dr. Mason, which resulted in a greater than 50% decrease in pain in his low back and right leg pain.

44. Dr. Mason's diagnosis of the Claimant is discogenic back pain with some right-sided L5-S1 radicular pain.

45. Dr. Mason's opinion, within a reasonable degree of medical probability, is that the Claimant's condition of discogenic back and right-sided L5-S1 radicular pain was aggravated and accelerated by the work related incident on September 11, 2013, and the ALJ so finds.

46. In Dr. Mason's opinion, the Claimant's condition is causally related to the September 11, 2013 work-related incident for the following reasons: (1) the Claimant provided a straightforward report that he lifted something heavy at work; (2) the Claimant had pain since that time; (3) the Employer medical clinic records demonstrate a continuous and chronic period of time the Claimant continued to have similar complaints following the lifting injury that were voiced to the Employer. Dr. Cebrian refused to continue to treat the Claimant's medical condition as a work-related condition as of May 13, 2014, and referred the Claimant to a private chiropractor. In denying to further treat the Claimant for his condition on the grounds that it is not work-related, Dr. Cebrian severed his role as the ATP; and, (4) the Claimant's complaints were similar to the complaints he presented to Dr. Mason. For those reasons, Dr. Mason concluded the Claimant's complaints were all due to the same injury. The ALJ finds her opinion, in this regard highly persuasive and credible.

47. According to Dr. Mason, the Claimant was not at MMI prior to June 5, 2014, because he continued to be symptomatic and he was not actively treated prior to that date.

48. According to Dr. Mason, all of the medical treatment that the Claimant received from September 11, 2013 through October 23, 2014 was reasonable, necessary and causally related to the September 11, 2013 work-related injury.

49. Dr. Mason is of the opinion that the Claimant reached MMI on October 23, 2014.

Temporary Disability Claim

50. The Claimant continued to work for the Employer at full wages and until November 18, 2014, when he was terminated.

Ultimate Findings

51. The ALJ finds the Claimant's testimony credible and un-impeached. Further, the ALJ finds the opinions of Dr. Cebrian lacking in credibility, and the opinions of Dr. Mason far more credible and persuasive because of her specific expertise, thorough treatment of the Claimant's medical case, and because she was treating the Claimant under his health insurance before being designated as the ATP at the conclusion on the June 17, 2015 hearing, thus, she did not have "a dog in the fight," which makes her opinion more objective and disinterested.

52. The ALJ makes a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Mason, and to reject the opinions of Dr. Cebrian and any other opinions to the contrary.

53. Dr. Cebrian made a referral to a chiropractor under the mistaken belief that the Claimant's condition was not work-related. At that point, the right of the Claimant to select a qualified ATP came into being. Because a chiropractor provides ancillary services, the chiropractor cannot serve as an ATP on any continuing basis. Also, as found herein above, evaluations and treatments by Dr. Llloyd at Aurora South Medical Center were for FMLA purposes and did not constitute a valid selection of a workers' compensation ATP. Therefore, the Claimant's first selection of a workers' compensation ATP was Dr. Mason. All of the referrals from Dr. Mason, including the steroid injections by Dr. Olsen, were authorized and within the authorized chain of referrals.

54. All of the medical care and treatment for the Claimant's aggravated and accelerated back injuries of September 11, 2013 was and is causally related thereto and reasonably necessary to cure and relieve the effects thereof.

55. The Claimant has proven, by a preponderance of the evidence that he sustained compensable injuries as herein above described in course and scope of his employment on September 11, 2013.

56. As found herein above, the Claimant continued to work for the Employer at full wages and until November 18, 2014, when he was terminated, which was beyond Dr. Mason's MMI date. Therefore, there is no proof of temporary disability.

57. The Claimant has proven, by preponderant evidence that Dr. Cebrian, under the mistaken belief that the Claimant's condition was not work-related, refused to treat the Claimant's condition as work-related after May 13, 2014 for non-medical reasons, the Respondents were aware of this, and the Claimant made a valid first selection of a qualified ATP by selecting Dr. Mason as of June 5, 2014. All of Dr. Mason's referrals were authorized and within the authorized chain of referrals.

58. All of the medical care and treatment for the Claimant's injuries of September 11, 2013 is causally related thereto and reasonably necessary to cure and relieve the effects thereof.

59. The Claimant continued to work for the Employer at full wages until November 18, 2014, when he was terminated. Dr. Mason, the ATP, declared him to be at MMI, effective October 23, 2014. Therefore, the Claimant failed to prove entitlement to temporary disability benefits.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Bodensleck v. Indus. Claim Appeals Office,* 183 P.3d 684 (Colo. App. 2008);*Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Rockwell International v. Turnbull,* 802 P.2d 1182, 1183 (Colo. App. 1990); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. A*renas v. Indus. Claim Appeals Office*, 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *Youngs v. Indus. Claim Appeals Office,* 297 P.3d 964, **2012 COA 85.** The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913); *also see Heinicke v. Indus. Claim Appeals Office,* 197 P.3d 220 (Colo. App. 2008). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions

(this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). The ALJ has broad discretion to determine the admissibility and/or weight of evidence based on an expert's knowledge, skill, experience, training and education. *See* S 8-43-210, C.R.S; *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995). As found, the Claimant's testimony was credible and un-impeached. Further, as found, the opinions of Dr. Cebrian were lacking in credibility, and the opinions of Dr. Mason were far more credible and persuasive because of her specific expertise, thorough treatment of the Claimant's medical case, and because she was treating the Claimant under his health insurance before being designated as the ATP at the conclusion on the June 17, 2015 hearing, thus, she did not have "a dog in the fight", which makes her opinion more objective and disinterested.

Substantial Evidence

b. An ALJ's factual findings must be supported by substantial evidence in the record. *Paint Connection Plus v. Indus. Claim Appeals Office,* 240 P.3d 429 (Colo. App. 2010); *Leewaye v. Indus. Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007); *Brownson-Rausin v. Indus. Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). *Also see Martinez v. Indus. Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co.v. Gussert,* 914 P.2d 411 (Colo. App. 1995). Reasonable probability exists if a proposition is supported by **substantial evidence** which would warrant a reasonable belief in the existence of facts supporting a particular finding. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985). It is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence. See *Pacesetter Corp. v. Collett,* 33 P. 3d 1230 (Colo. App. 2001). An ALJ's resolution on questions of fact must be upheld if supported by substantial evidence and plausible inferences drawn from the record. *Eller v. Indus. Claim Appeals Office,* 224 P.3d 397, 399-400 (Colo. App. 2009). As found, the ALJ made a rational choice, between conflicting medical opinions, to accept the opinions of Dr. Mason, and to reject the opinions of Dr. Cebrian and any other opinions to the contrary.

Refusal of Dr. Cebrian to Treat for Non-Medical Reasons/Selection of Dr. Mason as ATP

c. If the physician selected refuses to treat for non-medical reasons, and the insurer fails to appoint a willing ATP after notice of the refusal to treat, the right of *selection passes to the injured worker. Weinmeister v. Cobe Cardiovascular, Inc., W.C.*

No. 4-657-812 [Industrial Claim Appeals Office (ICAO), July 10, 2006]. Also see Lutz v. Industrial Claim Appeals Office, 24 P.3d 29 (Colo. App. 2000); Ruybal v. University Health Sciences Center, 768 P.2d 1259 (Colo. App. 1988). As found, Dr. Cebrian, under the mistaken belief that the Claimant's condition was not work-related, refused to treat the Claimant's condition as work-related after May 13, 2014 for non-medical reasons, the Respondents were aware of this, and the Claimant made a valid first selection of a qualified ATP by selecting Dr. Mason as of June 5, 2014.

d. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. *See Mason Jar Restaurant v. Indus. Claim Appeals Office,* 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Indus. Claim Appeals Office,* 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). When an ATP refers an injured worker to his personal physician, under the mistaken belief that the claim was not compensable, the referral was nonetheless within the chain of authorized referrals and, thus, subsequent treatment was authorized. *See Cabela v. Indus. Claim Appeals Office,* 198 P.3d 1277 (Colo. App. 2008). As found, Dr. Cebrian, under the mistaken belief that the Claimant's condition was not work-related, refused to treat the Claimant's condition as work-related after May 13, 2014 for non-medical reasons and referred him to a chiropractor. As further found, the Claimant made a valid first selection of a qualified ATP by selecting Dr. Mason on June 5, 2014. All referrals by Dr. Mason have been within the authorized chain of referrals.

Medical Treatment

e. To be a compensable benefit, medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's medical treatment is causally related to the aggravation of his back condition on September 11, 2013. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Indus. Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, the Claimant's medical care and treatment was and is reasonably necessary to cure and relieve the effects of his injury.

Temporary Disability

f. To establish entitlement to temporary disability benefits, a claimant must prove that the industrial injury has caused a "disability," and that he has suffered a wage loss that, "to some degree," is the result of the industrial disability. § 8-42-103(1), C.R.S; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). As found, the Claimant continued to work for the Employer at full wages until November 18, 2014, when he was terminated. Dr. Mason, the ATP, declared him to be at MMI, effective

October 23, 2014. Therefore, the Claimant failed to prove entitlement to temporary disability benefits. Therefore, the Respondents' "responsibility for termination" defense is moot.

Burden of Proof

g. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000). *Kieckhafer v. Indus. Claim Appeals.Office*, 284 P.3d 202, 205 (Colo. App. 2012). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P.2d 535 (Colo. App. 1992). 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,* 197 Colo. 306, 592 P. 2d 792 (1979). *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). "Preponderance" means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant has sustained his burden of proof with respect to all issues with the exception of "temporary disability benefits through the date of MMI. Consequently, the Respondents issue of "responsibility for termination" is moot.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. On September 11, 2013, the Claimant sustained compensable low back injuries.

B. Dr. Cebrian is no longer the Claimant's authorized treating physician.

Kristin Mason, M.D., became the Claimant's authorized treating physician on June 5, 2014, and the Respondents are liable for the costs of her work-related treatment, subject to the Division of Workers' Compensation Medical Fee Schedule. The Claimant reached MMI on October 23, 2014.

C. The Respondents shall pay costs of all medical care and treatment, including post maximum medical improvement maintenance care provided or ordered by Dr. Mason and her referrals from June 5, 2014, 2014 and continuing, subject to the Division of Workers' Compensation Medical Fee Schedule

D. Any and all claims for temporary disability are hereby denied and dismissed.

E. Any and all issues not determined herein, including permanent disability, are reserved for future decision.

DATED this_____day of July 2015.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

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, CO 80203.** You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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* § 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 form for a petition to review at** *http://www.colorado.gov/dpa/oac/forms-WC.htm*.

CERTIFICATE OF SERVICE

I hereby certify that I have sent true and correct copies of the foregoing **Full Findings of Fact, Conclusions of Law and Order** on this_____day of July 2015, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.ord

ISSUES

- Whether claimant has proven by a preponderance of the evidence that she sustained a compensable 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 medical treatment she received was reasonable and necessary to cure and relieve claimant from the effects of the work injury?

- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that she is entitled to an award of temporary total disability ("TTD") benefits?

- The parties stipulated prior to the hearing that if the claim is compensable, claimant's average weekly wage ("AWW") is $1,454.79.

- Whether respondents have proven by a preponderance of the evidence that claimant's benefits should be reduced pursuant to an injurious practice?

- Whether respondents have proven by a preponderance of the evidence that claimant's benefits should be terminated based on an intervening accident?

FINDINGS OF FACT

1. Claimant was employed with employer as a package car driver. Claimant testified at hearing that on May 14, 2014 she was lifting a box when she developed pain in her leg. Claimant was initially seen following her injury by Mr. Fox, a physician's assistant with Cottonwood Holistic Family Health on May 27, 2014. Claimant reported to Mr. Fox that she had pulled her hamstring in 2013 and felt she had injured her leg again using an inversion table. Claimant reported pain in her left inferior gluteal region for about 4-5 weeks. Claimant reported a gradual onset of pain and denied any acute trauma. Claimant also reported pain in her left low back region.

2. Claimant returned to Mr. Fox on May 29, 2014 and reported a lot of pain and tightness in her left calf after working. Mr. Fox noted that claimant's symptoms

were more consistent with left sided sciatic and recommended diagnostic studies of the lumbar spine.

3. Claimant underwent a magnetic resonance image ("MRI") of the lumbar spine on May 31, 2014. The MRI showed moderate sized posterior and left lateral disc extrusions at L4-L5 and L5-S1 with significant foraminal compromise at both levels on the left.

4. Claimant was evaluated by Dr. Weber on June 5, 2014. Claimant reported that she was lifting several 100 boxes on May 5, 2014 when she got hemorrhoids and self treated. Claimant reported she also developed left leg pain about 3 weeks ago and had an MRI that showed disc extrusions at the L4-5 and L5-S1 levels. Dr. Weber referred claimant for physical therapy. Claimant testified she went to Dr. Weber because when she reported her injury she was informed by Mr. Masse that she should go to the physician who performed her Department of Transportation ("DOT") physical.

5. Claimant was subsequently referred by employer to Dr. Jernigan for treatment. Claimant was examined by Dr. Jernigan on June 6, 2014. Dr. Jernigan noted claimant reported developing leg pain on May 14 while working heavily moving 70 pound packages. Claimant reported her symptoms got worse over the ensuing days. Dr. Jernigan recommended work restrictions that limited claimant to no more than 20 pounds. Dr. Jernigan noted that claimant's work was very heavy and noted she reported problems with hemorrhoids after heavy lifting on May 2, 2014 and following that incident she continued to lift upwards of 70 pounds. Dr. Jernigan referred claimant to Spine Colorado for additional treatment and recommended prednisone and physical therapy.

6. Claimant returned to Dr. Jernigan on June 16, 2014 and reported her pain level was unchanged with the prednisone. Dr. Jernigan again recommended a referral to Spine Colorado. Claimant continued to treat conservatively with Dr. Jernigan. Dr. Jernigan opined in his medical records that claimant's condition was related to her work activities with employer.

7. Claimant was examined by Dr. McLaughlin with Animas Spine on July 2, 2014. Dr. McLaughlin noted claimant's accident history that she developed left gluteal and calf pain at work on May 14, 2014 that progressively got worse. Dr. McLaughlin further noted claimant's work history of having to left up to seventy pounds. On physical examination, Dr. McLaughlin noted that claimant had four out of five EHL weakness on the left compared to the right. Dr. McLaughlin diagnosed claimant with left lower extremity radiculopathy secondary to disc extrusion at L4-5 and L5-S1 and

recommended claimant repeat her course of oral steroids. Dr. McLauglin also recommended transforaminal injections.

8. Dr. McLaughlin noted that while claimant did not recall a deciding mechanism of injury for her pain, he still felt her condition was a work related injury given the work that she performed.

9. Claimant returned to Dr. Jernigan on July 15, 2014 with continued complaints of significant pain. Dr. Jernigan noted that claimant was unable to lay down due to severe pain and reported claimant was very depressed due to the constant pain.

10. Claimant testified she took a vacation that had been previously planned in mid-July 2014. Claimant's vacation included driving to Virginia and North Carolina. Claimant continued to complain of significant pain on her vacation and was seen at the emergency room ("ER") at Howard County General Hospital in Columbia, Maryland on July 31, 2014 with complaints of left sided sciatica pain that increased a couple of hours ago. Claimant was given medications and released. Claimant returned to the ER at Mary Washington Hospital in Fredricksburg, Virginia on August 1, 2014 with additional complaints of back pain. Claimant was again given medications and released. Claimant testified at hearing that during the vacation her husband was driving and she was in the back seat. Claimant testified she had a sudden increase in back pain after she shifted her body weight which resulted in her treatment at the ER on August 1, 2014.

11. Claimant was again treated at Beach Medical Care on August 6, 2014 with complaints of low back pain. Claimant noted she was under care of a work injury that developed on May 14, 2014 and had received treatment on July 31 and August 1 during the course of her trip. Claimant was again evaluated and released.

12. Claimant returned to Dr. Jernigan on August 12, 2014. Dr. Jernigan noted that Dr. McLaughlin was recommending an injection, which he agreed with. Dr. Jernigan took claimant off of work completely.

13. Claimant was examined by Mr. Baumchen, the physician's assistant for Dr. Youssef with Spine Colorado on August 19, 2014. Mr. Baumchen examined claimant and recommended she undergo a surgical evaluation.

14. Claimant eventually underwent the transforaminal epidural steroid injection recommended by Dr. McLaughlin on August 21, 2014.

15. Claimant was next evaluated by Dr. Youssef on August 27, 2014. Claimant reported to Dr. Youssef that she had a gradual onset of symptoms that got

particularly worse every time she went to work. Dr. Youssef noted that claimant was not able to walk on her heels because of obvious foot drop and weakness in her EHL and ankle dorsiflexion. Dr. Youssef further noted decreased sensation in the L5 and S1 distribution on the left compared to the right. Dr. Youssef diagnosed claimant with contiguous L4-5 and L5-S1 left sided herniated nucleus pulposus with left sided radiculopathy and neurologic deficit which was failing nonoperative treatment. Dr. Youssef recommended surgery including an L4-5 and L5-S1 microdiscectomy on the left with medial facetectomy and foraminotomy at L4-5 and L5-S1 on the left.

16. Claimant returned to Dr. Jernigan on September 2, 2014. Claimant reported continued complaints of pain radiating into her left lower extremity. Claimant reported relief following the epidural steroid injection including a decrease in her pain from 8 to 2 making her much more comfortable in general. Dr. Jernigan kept claimant off of work and noted that he agreed with Dr. Youssef's surgery recommendation.

17. Claimant returned to Dr. McLaughlin on September 5, 2014. Dr. McLaughlin noted that claimant reported a near 100 percent relief of her calf pain following the injection, but continued to complain of pain in her left gluteal and hip area with weakness in her left toe. Dr. McLaughlin noted that claimant's symptoms were returning and noted that he could provide her with a repeat injection for pain relief until her scheduled September 18, 2014 surgery.

18. Claimant eventually underwent the left sided L4-L5 microdiscectomy with medial facetectomy and foraminotomy at L4-L5 on the left along with left sided L5-S1 microdisectomy with medial facetectomy on the left at L5-S1 under the auspices of Dr. Youssef on September 18, 2014.

19. Claimant followed up with Mr. Hamlin, a physician's assistant, on October 3, 2014. Mr. Hamlin noted that claimant was two weeks post-op and was doing well. Mr. Hamlin noted that claimant's pain was manageable and claimant had been weaning off the medications. Claimant was instructed to begin physical therapy.

20. Claimant continued to treat with Dr. Jernigan following her surgery. Dr. Jernigan kept claimant off of work and noted claimant was undergoing physical therapy.

21. Claimant underwent an independent medical examination ("IME") with Dr. Rauzzino on December 6, 2014. Dr. Rauzzino reviewed claimant's medical records, obtained a history from claimant and performed a physical examination in connection with his IME. Dr. Rauzzino noted the initial accident history claimant presented to Dr. Fox involving a pulled hamstring and the use of an inversion table. Dr. Rauzzino noted that he reviewed a phone conversation from Mr. Evans and a representative of insurer in which Mr. Evans indicated he had lent the inversion table to claimant's husband and

he believed claimant had used the inversion table on one occasion and it had apparently made her symptoms worse. Dr. Rauzzino noted that claimant had reported that she had recently begun jogging before her symptoms developed and she initially thought her symptoms may have been related to running. Claimant reported that she ran 2-3 times per week and had increased her mileage up to about 6 miles. Dr. Rauzzino also noted claimant's need for emergency medical treatment during her trip to the East Coast.

22. Dr. Rauzzino opined in his report that claimant's condition was not related to her work with employer. Dr. Rauzzino indicated in his report that his opinion was based specifically on the report by Mr. Fox of May 27, 2014 where claimant described a history of pain in her left inferior gluteal region for four to five weeks, which would have put the injury outside the reported accident date of May 14, 2014. Dr. Rauzzino also noted that claimant failed to describe any specific trauma and developed as a gradual onset of symptoms. Dr. Rauzzino also noted that the report made no mention of an onset of symptoms related to her work with employer. Dr. Rauzzino noted that the first mention that claimant's injury was work related occurred after her MRI revealed two herniated disks in her lumbar spine. Dr. Rauzzino further opined that the road trip in July 2014 significantly aggravated her low back condition. Dr. Rauzzino opined that the surgery claimant underwent was reasonable, but was not related to any injury at work on May 14, 2014.

23. Dr. Rauzzino testified in this case consistent with his medical report. Dr. Rauzzino noted in his testimony that claimant's running would be an activity that would specifically lead to compression of her disk. Dr. Rauzzino further testified that the inversion table aggravated claimant's pain, based on her report of injury. Dr. Rauzzino testified that claimant's physical examination after her cross country road trip was significantly worse than it was prior to her road trip, with diminished sensation in her leg and foot.

24. Dr. McLaughlin testified at hearing in this matter. Dr. McLaughlin testified he treated claimant with respect to her back injury. Dr. McLaughlin testified when he examined claimant on July 2, 2014 claimant presented with pain radiating into her left hamstring and calf. Dr. McLaughlin testified he diagnosed claimant with 2 herniated discs. Dr. McLaughlin testified it was his opinion that the cause of claimant's 2 lumbar herniated discs was due to her repetitive bending, lifting, twisting and turning related to her work with employer. Dr. McLaughlin testified that it was his opinion that the use of the inversion table would not be a cause of the herniated discs in claimant's back. Dr. McLaughlin noted that prior to claimant's trip to the East Coast, he had documented weakness in claimant's left foot during the July 2, 2014 evaluation. The ALJ finds the testimony of Dr. McLaughlin to be credible and persuasive.

25. Dr. Jernigan testified at hearing in this matter. Dr. Jernigan noted in the course of his testimony the medical care he provided for claimant in relation to her lumbar spine issues. Dr. Jernigan testified he took claimant off of work completely as of July 15, 2014. Dr. Jernigan opined at hearing that claimant's back condition was related to the lifting she performed for employer. Dr. Jernigan further testified that he was aware of claimant's trip to the East Coast and the trip did not violate the work restrictions he had provided to claimant in relation to her back condition.

26. Mr. Van Iderstine testified at hearing in this matter. Mr. Van Iderstine testified that he performed a job analysis of claimant's position with employer. Mr. Van Iderstine testified claimant worked in a heavy to very heavy job. Mr. Van Iderstine's testimony is not credited with determining whether claimant's condition was related to her work with employer and was of limited assistance in reaching the conclusions regarding whether claimant's injury was compensable.

27. Claimant testified at hearing in this case regarding her work with employer. Claimant testified she would drive a truck and perform approximately 100 stops per day. Claimant testified the average package she delivers weighs approximately 45 pounds. Claimant testified her lifting of the packages requires her to squat and reach and twist the package to maneuver it to her "power zone" to lift. Claimant testified that the heavier packages she will slide to the back of the truck, and then use a dolly to deliver the package.

28. Claimant testified that she began to experience symptoms on May 14, 2014 (a Wednesday) and her symptoms gradually got work from there. Claimant denied having any sudden sharp pain with lifting and denied any specific incident. Claimant testified that pain began as a pain in her left hamstring and lower buttocks area and the pain got worse over the next week. Claimant testified she did not originally correlate her symptoms to a back injury and though she had a pulled hamstring. Claimant testified her symptoms increased and she was in significant pain as of July 14, 2014 and could not get to work. Claimant testified that during this time she was not sleeping beyond 2 hours per night. Claimant testified Dr. Jernigan increased her work restrictions and she has not returned to work in any capacity since July 15, 2014. Claimant testified that the weakness in her toe began in late June 2014 and continued to progress until four days prior to her transforaminal epidural steroid injection. The ALJ finds the testimony of claimant to be credible and persuasive in this regard.

29. Mr. Blaine, claimant's supervisor, testified at hearing in this matter. Mr. Blaine testified that claimant accurately testified about safe lifting methods required by employer. Mr. Blaine testified that the purpose of the safe lifting methods is to reduce injuries. Mr. Blaine testified he was familiar with claimant's route which consists of approximately 100 stops and roughly 200 to 300 packages. Mr. Blaine testified

claimant's average weight per package would be approximately 25 pounds. Mr. Blaine testified the work environment claimant is employed in is fast paced. The ALJ finds the testimony of Mr. Blaine to be credible.

30. The ALJ ultimately credits the opinions expressed by Dr. Jernigan and Dr. McLaughlin regarding the cause of claimant's condition over the contrary opinions expressed by Dr. Rauzzino. The ALJ further credits claimant's testimony regarding the onset of her symptoms in this regard. The ALJ notes that claimant's symptoms originally manifested themselves in her hamstring and gluteal area. The ALJ finds the opinions expressed by Dr. Jernigan and Dr. McLaughlin appear to coincide with one another and are supported by the medical records entered into evidence.

31. The ALJ, in crediting the testimony of claimant and the opinions expressed by Dr. Jernigan and Dr. McLaughlin, finds that claimant has proven that it is more likely than not that she sustained a compensable injury arising out of and in the course of her employment with employer.

32. The ALJ credits the testimony and opinions of Dr. Jernigan and Dr. McLaughlin, along with the corresponding medical records, and finds that claimant has proven that it is more likely than not that her medical treatment, including the surgery performed by Dr. Youssef, was reasonable and necessary to cure and relieve the claimant from the effects of her work injury.

33. The ALJ credits claimant's testimony that she has not worked in any capacity since July 15, 2014 and credits the medical records from Dr. Jernigan that took her off of work completely and determines that claimant has shown that it is more likely than not that she is entitled to an award of TTD benefits commencing July 15, 2014 and continuing until terminated by law. Respondents reserve the right to take any allowed statutory offsets against the award for TTD benefits.

34. The ALJ finds respondents have failed to establish that claimant suffered an intervening injury or engaged in an injurious practice by taking the road trip to the East Coast. The ALJ credits Dr. Jernigan's testimony that the road trip would not have exceeded the work restrictions he had established in reaching this conclusion. The ALJ further credits the testimony of Dr. McLaughlin who noted claimant was experiencing weakness in the lower extremity prior to her trip to the East Coast.

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 she suffered a compensable work injury on May 14, 2014 resulting in the need for medical treatment. As found, the testimony of claimant regarding the onset of her symptoms along with the testimony and opinions expressed by Dr. McLaughlin and Dr. Jernigan are found to be credible and persuasive on this issue.

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. As found, the ALJ credits the medical opinions of Dr. Jernigan and finds that claimant has proven by a preponderance of the evidence that the medical treatment she received from the medical providers was reasonable and 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 work restrictions set forth by Dr. Jernigan that limited claimant's ability to earn wages. As found, claimant has established that he is entitled to TTD benefits as a result of her work injury beginning July 15, 2014 and continuing until terminated by law.

9. Section 8-43-404(3), C.R.S. provides in pertinent part that if "any employee persists in any unsanitary or injurious practice which tends to imperil or retard recovery or refuses to submit to such medical or surgical treatment or vocational evaluation as is reasonably essential to promote recovery, the director shall have the discretion to reduce or suspend the compensation of any such injured employee."

10. As found, the ALJ credits the testimony of Dr. McLaughlin and claimant's testimony at hearing, and finds that respondents have failed to establish that claimant taking a vacation in July after her work injury that involved an injurious practice under Section 8-43-404(3), C.R.S.

11. The doctrine of intervening injury concerns the effect of a separate injury, which occurs while the claimant is receiving medical and disability benefits for a compensable injury effectively holds that respondents are not liable for injuries which occur subsequent to a compensable injury, and are not a "natural result" of the compensable injury. *Post Printing and Publishing Co. v. Erickson,* 94 Colo. 382, 30 P.2d 327 (1934). Respondents are only liable for subsequent injuries which "flow proximately and naturally" from the compensable injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970).

12. As found, respondents have failed to prove by a preponderance of the evidence that claimant suffered an intervening injury that would sever their liability for claimant's medical treatment by taking the vacation in mid-July 2014. As found, the testimony of Dr. McLaughlin that claimant had weakness in her left lower extremity as documented by his examination of claimant prior to the trip is found to be credible and persuasive on this point. As found, claimant was complaining of increased pain prior to the trip and the trip did not result in an intervening injury that would sever their liability in this case.

ORDER

It is therefore ordered that:

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: July 21, 2015

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. Whether KM has demonstrated by a preponderance of the evidence that she was the common law spouse of Decedent and is thus entitled to receive death benefits as the dependent widow of Decedent pursuant to §8-41-501(1)(a), C.R.S.

2. Whether AP is entitled to receive death benefits as a wholly dependent minor child of Decedent pursuant to §8-41-501(1)(b)-(c), C.R.S.

3. Whether Claimants are financially responsible for Decedent's Oregon child support lien.

STIPULATIONS

The parties agreed to the following:

1. Decedent earned an Average Weekly Wage (AWW) of $500.00;

2. AP is the wholly dependent minor child of Decedent;

3. AP's date of birth is July 7, 1997;

4. Decedent's date of death was July 18, 2014.

FINDINGS OF FACT

1. On July 15, 2014 Decedent began working for Employer as an Installation Technician. On July 17, 2014 Decedent fell from a ladder during the course and scope of his employment. He suffered multiple traumatic head and internal organ injuries. Decedent underwent emergency surgery upon his arrival at Denver Health Medical Center. However, on July 18, 2014 he died as a result of his industrial injuries.

2. At the time of Decedent's death, a child-support lien from the State of Oregon shows he was responsible for a monthly payment of $158.00 or $35.05 per week for AP. The lien also reflects an arrears amount of $1,835.32. The lien utilizes Decedent's Social Security number as to the person responsible for payment. The Oregon administrative order specifies that it applies only to Decedent.

3. KM testified that she had known Decedent for over 20 years. They worked together and were friends. KM was married to another individual at the time but the marriage ended in approximately 2001.

4. In approximately 2010 KM and Decedent reconnected through social media. Approximately one year later they began to communicate through text messaging. Decedent explained to KM that he had left his wife and was moving from Oregon to Colorado to begin a new life. KM remarked that Decedent filed divorce papers in approximately February 2012 but did not know when the divorce became final.

5. Decedent moved into a trailer in his parents' driveway when he arrived in Colorado. KM remained in Oregon but spoke frequently with Decedent on the telephone. KM flew to Colorado in November 2011 to visit Decedent. In January 2012 she moved to Colorado and resided with Decedent in his trailer.

6. KM testified that she and Decedent did not care about the "piece of paper" or marriage license. Nevertheless, Decedent wanted to buy KM an engagement ring. The couple planned to marry in Ireland and take a vacation around the event. KM summarized that the couple intended to purchase an engagement ring, apply for a marriage license and have a formal marriage ceremony in Ireland.

7. KM and Decedent lived together from January 2012 until Decedent's death in July 2014. They purchased furniture and a television using Decedent's credit card. At times each of them was unemployed but supported by the other. For approximately 10 months prior to Decedent's death he was unemployed and KM paid the bills because she was working. Nevertheless, KM acknowledged that the couple never filed joint federal or state tax returns and Decedent listed himself on his 2012 return as "single."

8. KM and Decedent pooled their income into a single bank account owned by Decedent. KM's name was not on the account and she did not have access to the account. KM had a credit card on Decedent's credit card account and could charge to the account. She explained that she was unable to obtain an account at Decedent's credit union because she had a poor credit history from a previous bankruptcy.

9. In July 2012 Decedent bought a home. KM explained that Decedent had used money from the sale of a home in his prior divorce proceedings as a down payment. KM was not listed on the mortgage for the house nor as an owner on the deed. Similarly, Decedent bought a car used by KM. Only Decedent was named on the car loan and the car was only registered in his name. When Decedent died KM had to leave the home and the car was repossessed.

10. Decedent identified KM as his emergency contact for Employer. He listed KM as his "fiancée" and noted that he was "single." On his application for health insurance through Employer Decedent noted that he was "single" although "common law" was an option on the form.

11. KM testified that she considered herself married to Decedent when she moved into the Colorado trailer with him in January 2012. However, Decedent was still married to another woman and thus could not legally marry KM. KM explained that

Decedent and his ex-wife did not file divorce documents until February 2012 and she did not know when the divorce became final.

12. Because KM was listed as an emergency contact she was notified and went to Denver Health Medical Center after Decedent's July 17, 2014 industrial injury. Decedent's parents, brother, sister, aunt, uncle and nephew were also at the hospital. KM explained that the entire family made the decision to remove Decedent from life support. Decedent's mother Linda Poland confirmed that the family collectively made the decision to remove Decedent from life support. Ms. Poland commented that KM was considered part of the family but was not considered "married" to Decedent. Ms. Poland remarked that KM signed the do not resuscitate order because the family knew that she was planning to marry Decedent.

13. Ms. Poland testified that Decedent and KM did everything together and she knew them as boyfriend and girlfriend. Decedent told Ms. Poland that he planned to marry KM at some time in the future when they were more financially stable. Decedent did not tell her that he considered himself married to KM. Decedent referred to KM as his fiancée and planned to purchase an engagement ring when he was financially able. Ms. Poland did not refer to KM as her daughter-in-law.

14. Jean Barringer was Decedent's aunt. Ms. Barringer testified that she was close to Decedent and KM. She described them as a close couple who "acted married." Decedent told her that he planned to buy KM a ring but he did not want to do anything until he purchased the ring. Ms. Barringer was aware of their plans to apply for a marriage license and marry in Ireland.

15. Carl Dyess testified on behalf of AP. Mr. Dyess is Decedent's former father-in-law and AP's maternal grandfather. He initiated the proceedings to act as a conservator for AP concerning Decedent's estate. As conservator Mr. Dyess' duties involved maximizing the return of the estate for AP. The estate was liquidated through a Colorado attorney.

16. After Decedent's death Mr. Dyess was introduced to KM. KM identified herself as Decedent's girlfriend or fiancée. Mr. Dyess knew KM and Decedent were living together at the time of Decedent's death but did not know them to be husband and wife. He was not aware of their intentions to marry in the future but KM mentioned that Decedent had planned to buy her an engagement ring. Mr. Dyess confirmed that KM had not made any claim on Decedent's estate.

17. KM has failed to demonstrate that it is more probably true than not that she was the common law spouse of Decedent and is thus not entitled to receive death benefits as the dependent widow of Decedent pursuant to §8-41-501(1)(a), C.R.S. Although KM and Decedent lived together from January 2012 until Decedent's death in July 2014, the record reveals that there was no general understanding or reputation among persons in the community that KM and Decedent held themselves out as husband and wife. Instead, Decedent intended to purchase an engagement ring for KM. The couple then planned to apply for a marriage license and have a formal

marriage ceremony in Ireland. Although the record reveals a future intent to marry, the indicia of a common law marriage were not present at the time of Decedent's death on July 18, 2014.

18. Decedent and KM never filed joint federal or state tax returns and Decedent listed himself as "single" on his 2012 return. In July 2012 Decedent bought a home. KM explained that Decedent had used money from the sale of a home in his prior divorce proceedings as a down payment. KM was not listed on the mortgage for the house nor as an owner on the deed. Similarly, Decedent bought a car used by KM. Only Decedent was named on the car loan and the vehicle was registered solely in his name. Decedent identified KM as his emergency contact for Employer but listed her as his "fiancée" and noted that he was "single." Moreover, on his application for health insurance through Employer Decedent noted that he was "single" although "common law" was an option on the form.

19. Decedent told his mother Ms. Poland that he planned to marry KM at some time in the future when they were more financially stable. Decedent did not tell her that he considered himself married to KM. Decedent referred to KM as his fiancée and planned to purchase an engagement ring when he was financially able. Ms. Poland did not refer to KM as her daughter-in-law. Although Ms. Barringer described Decedent and KM as a close couple who "acted married," Decedent told her that he planned to buy KM a ring in the future. Finally, KM identified herself to Mr. Dyess as Decedent's girlfriend or fiancée. He was not aware of their intentions to marry in the future but KM mentioned that Decedent had planned to buy her an engagement ring. Accordingly, the bulk of the persuasive evidence reflects Decedent and KM had a future plan to marry but did not generally hold themselves out to the community as husband and wife.

20. At the time of Decedent's death, a child-support lien from the State of Oregon shows he was responsible for a monthly payment of $158.00 or $35.05 per week for AP. The lien also reflects an arrears amount of $1,835.32. The lien utilizes Decedent's Social Security number as to the person responsible for payment. The Oregon administrative order specifies that it applies only to Decedent. Accordingly, the Oregon child support lien is discharged as to benefits payable to AP.

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).

Dependents

4. Pursuant to §8-42-114, C.R.S. death benefits are payable to dependents of a decedent in the amount of two-thirds of the AWW subject to the applicable minimum amount of $218.86. If there are wholly dependent persons at the time of the employee's death, they are entitled to weekly compensation equal to two-thirds of the decedent's AWW. §8-42-115(1)(b), C.R.S.

5. Section 8-41-501(1), C.R.S. designates classes of persons who are presumed to be wholly dependent on a decedent. Section 8-41-501(1)(a) provides that a widow or widower is wholly dependent "unless it is shown that she or he was voluntarily separated and living apart from the spouse at the time of the injury or death or was not dependent in whole or in part on the deceased for support." The statutory presumption of spousal dependency can thus only be rebutted by demonstrating that the surviving spouse was voluntarily separated and living apart from the decedent or was not dependent upon the decedent for any support. *See Exeter Drilling v. Industrial Claim Appeals Office,* 801 P.2d 20, 21 (Colo. App. 1990); *Michalski v. Industrial Claim Appeals Office,* 781 P.2d 183, 184-85 (Colo. App. 1989).

6. Section 8-41-501, C.R.S. presumes that a decedent's minor children under the age of 18 years are wholly dependent on the decedent. Pursuant to §8-41-501(1)(c), C.R.S. minor children of a decedent who are over 18 years of age and under 21 years of age who are engaged in courses of study as full-time students at accredited schools are also wholly dependent on the decedent. Section 8-42-121, C.R.S. grants discretion to the Director to apportion death benefits among the beneficiaries in the manner the Director deems just and equitable. Because the undersigned ALJ acts on behalf of the Director in determining appropriate apportionment after a hearing, the ALJ is afforded the same power to apportion the benefits.

Common Law Marriage

7. Proof of a common law marriage requires a party to establish mutual agreement of the parties to be husband and wife followed by a mutual and open assumption of the marriage relationship. *People v. Lucero,* 747 P.2d 660, 663 (Colo.

1987); *In Re Marquez*, W.C. No. 4-425-155 (ICAP, Apr. 5, 2001). The agreement must be manifested by conduct that provides evidence of the parties' mutual understanding. *Lucero,* 660 P.2d at 663. The court in *Lucero* noted that the "two factors that most clearly show an intention to be married are cohabitation and a general understanding or reputation among persons in the community in which the couple lives that the parties hold themselves out as husband and wife." *Id.* at 665. The court also listed a number of other "behaviors" that may be considered including the maintenance of joint bank accounts, joint ownership of property, use of the man's surname by the woman and the filing of joint tax returns. *Id.* Disclosures to relatives regarding marital status may also be relevant because it may be reasonably inferred that marriage would be disclosed to certain family members. *In re Emenyonu,* W.C. 4-391-071 (ICAP, Mar. 12, 2001); *see Whitenhill v. Kaiser Permanente,* 940 P.2d 1129 (Colo. App. 1997). Furthermore, a promise to marry in the future is not consistent with a current marital relationship. *In re Emenyonu,* W.C. 4-391-071 (ICAP, Mar. 12, 2001). Ultimately, "there is no single form that any such evidence must take" and the ultimate determination "turns on issues of facts and credibility, which are properly within the trial court's discretion." *Lucero,* 660 P.2d at 665; *see In re Custody of Nugent,* 955 P.2d 584 (Colo. App. 1997).

8. As found, KM has failed to demonstrate by a preponderance of the evidence that she was the common law spouse of Decedent and is thus not entitled to receive death benefits as the dependent widow of Decedent pursuant to §8-41-501(1)(a), C.R.S. Although KM and Decedent lived together from January 2012 until Decedent's death in July 2014, the record reveals that there was no general understanding or reputation among persons in the community that KM and Decedent held themselves out as husband and wife. Instead, Decedent intended to purchase an engagement ring for KM. The couple then planned to apply for a marriage license and have a formal marriage ceremony in Ireland. Although the record reveals a future intent to marry, the indicia of a common law marriage were not present at the time of Decedent's death on July 18, 2014.

9. As found, Decedent and KM never filed joint federal or state tax returns and Decedent listed himself as "single" on his 2012 return. In July 2012 Decedent bought a home. KM explained that Decedent had used money from the sale of a home in his prior divorce proceedings as a down payment. KM was not listed on the mortgage for the house nor as an owner on the deed. Similarly, Decedent bought a car used by KM. Only Decedent was named on the car loan and the vehicle was registered solely in his name. Decedent identified KM as his emergency contact for Employer but listed her as his "fiancée" and noted that he was "single." Moreover, on his application for health insurance through Employer Decedent noted that he was "single" although "common law" was an option on the form.

10. As found, Decedent told his mother Ms. Poland that he planned to marry KM at some time in the future when they were more financially stable. Decedent did not tell her that he considered himself married to KM. Decedent referred to KM as his fiancée and planned to purchase an engagement ring when he was financially able. Ms. Poland did not refer to KM as her daughter-in-law. Although Ms. Barringer described Decedent and KM as a close couple who "acted married," Decedent told her

that he planned to buy KM a ring in the future. Finally, KM identified herself to Mr. Dyess as Decedent's girlfriend or fiancée. He was not aware of their intentions to marry in the future but KM mentioned that Decedent had planned to buy her an engagement ring. Accordingly, the bulk of the persuasive evidence reflects Decedent and KM had a future plan to marry but did not generally hold themselves out to the community as husband and wife.

Oregon Child Support Lien

11. Death benefits are entirely separate and independent from compensation benefits paid to the injured employee. *Hoffman v. Hoffman*, 872 P.2d 1367 (Colo.App. 1994); *Richards v. Richards & Richards*, 664 P.2d 254 (Colo.App. 1983). The legal distinction of death benefits as separate from an injured worker's compensation benefits is called the "rule of independence." *City of Loveland Police Department v. Industrial Claim Appeals Office*, 141 P.3d 943 (Colo. 2006); *Metro Glass & Glazing, Inc. v. Orona*, 868 P.2d 1178 (Colo.App. 1994). A child support lien applies only to benefits payable to the specific injured worker. *See* §8-43-204 (4), C.R.S.

12. As found, at the time of Decedent's death, a child-support lien from the State of Oregon shows he was responsible for a monthly payment of $158.00 or $35.05 per week for AP. The lien also reflects an arrears amount of $1,835.32. The lien utilizes Decedent's Social Security number as to the person responsible for payment. The Oregon administrative order specifies that it applies only to Decedent. Accordingly, the Oregon child support lien is discharged as to benefits payable to AP.

ORDER

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

1. KM's request for death benefits as the dependent widow of Decedent is denied and dismissed.

2. AP is the wholly dependent minor child of Decedent and is thus entitled to receive death benefits pursuant to statute.

3. The Oregon child support lien is discharged as to benefits payable to AP.

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: July 23, 2015.

DIGITAL SIGNATURE:

Peter J. Cannici

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

ISSUES

Whether the claimant has established by a preponderance of the evidence that on or about July 23, 2014 she sustained a compensable industrial injury arising out of and in the course of her employment with the respondent-employer.

FINDINGS OF FACT

1. The claimant is a 44-year-old woman with a July 15, 1970 date of birth. The claimant was hired by the respondent-employer on April 27, 2011 to work as a customer service manager.

2. The claimant's medical history is significant for chronic right knee problems with a patellar dislocation injury approximately ten years ago and second injury to the right knee approximately five years prior to the incident in question. On the date of the incident, the claimant was utilizing an open patella right knee brace, as was her practice when "her knee was bothering her".

3. On July 23, 2014, the claimant slipped on some water near the self-scan registers and fell. The claimant has given varying descriptions of the July 23, 2014 accident. On July 28, 2014, the claimant described the incident to Physician Assistant Steven Quackenbush as occurring when she stepped into water with her left foot, her right knee twisted inwards and she heard a "pop" with instant pain and swelling. The claimant reported she did not fall down. She denied any hip or back pain associated with the incident.

4. At hearing, and in her discovery responses, the claimant described the incident as occurring when she slipped in water and fell hard hitting the left knee on the ground. The claimant testified she immediately experienced "excruciating pain." According to the claimant, she remained on the ground for up to a minute after the fall and required the assistance of another associate to stand up. The claimant testified she was then helped to the service desk, in extreme pain.

5. The incident was witnessed and captured on in-store security video. Review of the video shows that on July 23, 2014, at approximately 5:55 p.m., the

claimant entered the self-check-out area wearing a brace on her right knee. At 5:55:52 p.m., the claimant turns from the cashier and slips. The claimant catches herself with the left upper extremity. From the video evidence, it does appear that the claimant's left knee made contact with the floor. Immediately after slipping, at 5:55:53 p.m., the claimant very quickly returns to full upright position, with no evidence of injury. The claimant then bends at the waist to exam the floor. At 5:55:58 p.m., the cashier hands the claimant a roll of paper towels. At 5:56 p.m., the claimant begins wiping up the spill with paper towels, using first her left and then her right lower extremities to mop the spill. At 5:56:39 p.m., the claimant is seen to leave the area, unassisted, with no evidence of a limp and no pain behaviors.

6. The claimant completed her work shift on July 23, 2014. The claimant reported the incident on July 23, 2014. Although she described being in excruciating pain immediately following the slip, the claimant did not request medical treatment.

7. On July 26, 2014, the claimant reported an accident and requested medical treatment. The claimant testified that on July 26, 2014, she was in extreme pain and her right knee had swollen to the same size as her thigh.

8. The claimant selected CCOM as the provider designated to treat her injuries. That facility was closed on July 26, 2014. The claimant proceeded to Canyon City Urgent Care where she gave a history of falling on her left knee and her right knee giving out and twisting out. The claimant also reported a history of "right knee pain". On physical exam, the knees were symmetrical and without obvious joint angulation. The right knee was reportedly "slightly swollen". X-rays were taken and read as normal. The treating physician assessed a "strain of the right knee" and referred the claimant to the workers' compensation provider.

9. On July 28, 2014, P.A. Steven Quackenbush evaluated the claimant. On that date, the claimant indicated her average pain related to the incident was at a level 2/10. On physical exam, the claimant did not have any pain with palpation of the spine, right hip, upper leg, foot, or ankle. P.A. Quackenbush described a "mild effusion" without discoloration, increased warmth or redness of the right knee.

10. The claimant returned to CCOM on July 31, 2014, complaining of "severe" and "constant" pain in her right knee. On physical exam, P.A. Quackenbush noted the claimant did not appear to have a contusion, with no discoloration or increased warmth of the right knee. The claimant had full active extension and flexion of the right knee without popping, locking or crepitus. P.A. Quackenbush released the

claimant to return to work, with restrictions. Due to the claimant's subjective pain complaints, P.A. Quackenbush referred the claimant for an MRI of the right knee.

11. The respondent-employer offered the claimant a modified position within the physician-imposed restrictions. The claimant accepted the modified position.

12. MRI of the right knee was performed on August 7, 2014. The right knee MRI was read as normal.

13. Physician Assistant Thomas Shepard evaluated the claimant on August 8, 2014. The claimant was reporting pain at a level 9.9/10. P.A. Shepard noted the normal MRI findings and opined the claimant's pain seemed disproportionate. Despite the normal MRI and the "disproportionate findings", P.A. Shepard ordered physical therapy.

14. The claimant returned to CCOM on August 28, 2014, reporting no improvement from any treatment. On physical exam, the claimant was ambulating without an obvious antalgic gait. There was no obvious swelling, increased warmth, or increased redness of the right knee. The claimant had full active extension and flexion without popping, locking or crepitus. Due to "persistent severe pain in the right knee", "not responding to therapy", P.A. Quackenbush referred the claimant to Dr. Keith Minihane for a surgical consult.

15. Dr. Minihane evaluated the claimant on September 8, 2014. The claimant was again complaining of pain at a level 10/10. Dr. Minihane opined the MRI was consistent with a "soft tissue contusion", although the claimant does not report falling on to the right knee. Dr. Minihane performed a right knee intra-articular injection, which the claimant testified increased her 10/10 pain sevenfold.

16. By September 12, 2014, the claimant was reporting aching, pins and needles, burning, stabbing and "other" pain at a level 11+/10 in her entire right leg. The claimant described the pain as "excruciating". On physical exam, the claimant had "very good" flexion of the right knee to about 135 degrees and full extension. The movements were without pain. The right knee joint did not show "the slightest swelling and there was no tenderness". Dr. Nanes opined the MRI was "quite unremarkable" and the claimant's knee exam was "very benign." He opined the claimant's complaints were "inconsistent with her physical exam".

17. The claimant continued to complain of pain at a level 10+/10, without objective evidence of injury. The claimant demonstrated excessive pain complaints, including grimacing and crying with pain. Dr. Nanes questioned whether there was

"self-limiting going on." Nonetheless, on November 4, 2014, Dr. Nanes restricted the claimant from all work activity "because of her severe pain". Dr. Nanes credibly testified there was no objective evidence to support restricting the claimant's work activities on November 4, 2014.

18. On November 20, 2014, the claimant presented to Dr. Nanes, accompanied by her husband. On that date, the claimant was again complaining of knee pain at a level 10+/10, grimacing and crying with pain. On physical exam, there was no joint redness and no swelling.

19. On November 25, 2014, Dr. Wallace Larson performed an IME at the respondent-insurer's request. The claimant presented to Dr. Larson complaining of pain exceeding level 10/10. On physical exam, the claimant reported decreased sensibility and tingling over the entire right leg and a glove stocking distribution as far proximal as the upper thigh. The claimant reported an inability to sense sharp dull sensation in the same area through her entire leg. On motor testing, she demonstrated very minimal strength of the quadriceps, hamstring, tibialis anterior, extensor halluces longus, extensor digitorum, or gastrocsoleous muscle groups. Dr. Larson credibly testified the claimant's motor testing and strength on physical exam was inconsistent with even the ability to ambulate. The claimant reported extreme tenderness to palpation of the right knee, even to very light touch in an area from 10 cm above the knee to 10 cm below the knee in a relatively global distribution.

20. Dr. Larson noted the claimant demonstrated "a very large amount of pain behavior." There were no skin or trophic changes. The claimant demonstrated cogwheel type of giving way on muscle testing of the upper and lower leg. She demonstrated minimal motor ability, but had no atrophy to either visualization or to direct measurements of the thighs. Dr. Larson opined the claimant had much greater right knee motion on casual exam than she did on direct exam. There was no joint effusion. Dr. Larson was unable to test ligamentous integrity of the right knee because the claimant reported extreme pain to even light touch and would not allow her knee to straighten on direct exam.

21. Dr. Larson opined the claimant has a very large amount of nonphysiologic findings. Her reported symptoms are not supported by any objective findings. There was a very high degree index of symptom magnification or malingering. He advised against knee arthroscopy "in the strongest possible terms." He further opined, the claimant's symptoms cannot be explained by the presence of a medial synovial plica. A medial synovial plica would not result in the symptoms the claimant describes.

22. Dr. Larson credibly opined it is medically probable the claimant's reported symptoms are unrelated to structural injury. Dr. Larson credibly opined the claimant does not have a work-related diagnosis of any specific injury to the right knee. Dr. Larson credibly opined the claimant has not had any objective evidence of injury. Dr. Larson credibly opined the claimant had no objective findings to support an injury. Dr. Larson credibly testified that based on his review of the records and his examination of the claimant, the claimant's most medically probable diagnosis is malingering.

23. Dr. Nanes reviewed Dr. Larson's IME report. Dr. Nanes credibly testified that based on his review of the report, he "completely agrees" with Dr. Larson's opinions and assessment. Dr. Nanes credibly testified that the claimant has given "an inconsistent history as well as an inconsistent physical exam".

24. On February 5, 2015, the claimant presented to Dr. Jennifer Fitzpatrick, as a self-referral. The claimant reported right knee pain with dysesthesia throughout the entire right leg in a stocking glove distribution. The claimant also reported changes in skin color of the right leg. She also reported hip and back pain. On physical exam, there was no knee effusion, no erythema and no ecchymosis. In contrast to Dr. Larson's findings six weeks prior, knee extension and flexion were full and symmetric to 110 degrees. Dr. Fitzpatrick opined the claimant's symptoms were "difficult to interpret" and may be representative of a reflex sympathetic dystrophy type syndrome. Given the claimant's report of hip and back pain, she recommended x-ray and MRI of the lumbar spine. There was no recommendation for treatment of the claimant's right knee symptoms. Dr. Fitzpatrick opined, "At this point, it is difficult for me to link her fall reported in July to her current symptoms."

25. The claimant's care was transferred to Dr. Jorge Klajnbart based on Dr. Nanes' refusal to treat for nonmedical reasons. Dr. Klajnbart evaluated the claimant on February 15, 2015. On that date, the claimant was reporting right knee pain, but no hip or back pain. The claimant did report numbness of the right foot. She denied any kind of mechanical symptoms to include locking, catching and giving way or buckling. Dr. Klajnbart noted the claimant was wearing an orthotic which was "quite tight." He opined, "It is somewhat incongruent to my physical exam as she has acute response to include grimacing and closing her eyes to light touch when she is able to wear her brace quite tightly around her knee." On physical exam, the claimant had full range of knee motion. There were no skin or hair changes indicative of complex regional pain syndrome. Dr. Klajnbart opined that neither the MRI nor the physical examination demonstrated any acute pathology from the alleged injury. He opined the claimant was not a surgical candidate and should be immediately returned to work.

26. Six days later, on February 19, 2015, the claimant returned to Dr. Fitzpatrick with ongoing complaints of hip and back pain, but no complaints of knee pain. Dr. Fitzpatrick did not recommend any treatment for the claimant's right knee. Instead she recommended evaluation by a spine doctor for possible injection of L5-S1 nerve impingement versus other intervention. Dr. Larson credibly testified that the claimant's right hip and low back complaints are not related to the July 23, 2014 slip and treatment for those complaints should be outside the workers' compensation system.

27. The ALJ credits the testimony of authorized provider, Dr. Richard Nanes, and independent examiner, Dr. Wallace Larson, that the claimant's reported symptoms are not supported by any objective findings.

28. The ALJ finds insufficient evidence to establish that it is more likely than not that the claimant suffered an injury arising out of and in the course of her employment with the respondent-employer on July 23, 2014.

CONCLUSIONS OF LAW

1. According to C.R.S. § 8-43-201, "a claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence; the facts in a workers' compensation case shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer, and a workers' compensation case shall be decided on its merits." *Also see Qual-Med, Inc. v. Indus. Claim Appeals Off.,* 961 P.2d 590, 592 (Colo. App. 1998) ("The Claimant has the burden of proving an entitlement to benefits by a preponderance of the evidence."); *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915, 918 (Colo. App. 1993) ("The burden is on the claimant to prove his entitlement to benefits by a preponderance of the evidence.").

2. 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).

3. For an injury to be compensable under the Workers' Compensation Act, it must "arise out of" and "occur within the course and scope" of the employment. *Price v. Indus. Claim Appeals Off.,* 919 P.2d 207, 210, 210 (Colo. 1996); *Schepker v. Daewoo North*, W.C. No. 4-528-434 (ICAO April 22, 2003). An injury "arises out of" employment when the origins of the injury are sufficiently related to the conditions and circumstances under which the employee usually performs his or her job functions as part of the

employee's services to the employer. *See Schepker, supra.* "In the course of" employment refers to the time, place, and circumstances of the injury. *Id.* There is no presumption that an injury arises out of employment when an unexplained injury occurs during the course of employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 108-09, 4437 P.2d 542 (1968).

4. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. § 8-41-301 (1)(c) C.R.S.*; Faulkner v. Indus. Claim Appeals Off.,* 12 P.3d 844, 846 (Colo. App. 2000). The question of causation is generally one of fact for the determination by the ALJ. *Faulkner,* 12 P.3d at 846.

5. In deciding whether claimant has met his burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Indus. Claim Appeals Off.*, 53 P.3d 1192, 1197 (Colo. App. 2002).

6. When considering 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).

7. 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).

8. Colorado's Workers' Compensation Act creates a distinction between the terms "accident" and "injury". The term "accident" refers to an "unexpected, unusual, or undesigned occurrence." *See* §8-40-201(1), C.R.S. In contrast, an "injury" refers to the physical trauma caused by the accident. In other words, an "accident" is the cause and an "injury" is the result. *City of Boulder v. Payne,* 426 P.2 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable "injury."

9. A compensable injury is one which requires medical treatment or causes a disability. It is well established that it is the claimant's initial burden to prove a compensable injury. *City of Boulder v. Payne, supra; Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). The determination of whether the claimant proved an injury which required medical treatment or resulted in disability is one of fact for the ALJ. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). Moreover, the ALJ's findings may be based on reasonable inferences from circumstantial evidence. *Ackerman v. Hilton's Mechanical Men, Inc.*, 914 P.2d 524 (Colo. App. 1996).

10. It is the claimant's burden to prove a causal connection between her employment and the resulting condition for which medical treatment and indemnity benefits are sought. Section 8-43-201, C.R.S.; *Ramsdell v, Horn*, 781 P.2d 150 (Colo. App. 1989); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). The determination of whether the claimant sustained that burden of proof is factual in nature. The claimant bears the burden of proof, by a preponderance of the evidence, to establish that an injury arising out of and in the course of the employment was the cause of the disability and need for treatment. The question of whether the claimant has met the burden is one of fact for the ALJ. *Faulkner v. Industrial Claim Appeals Office*, *supra.*

11. It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between her employment and her injuries. An ALJ might reasonably conclude the evidence is so conflicting and unreliable that the claimant has failed to meet the burden of proof with respect to causation. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 191 (Colo. App. 2002) (weight to be accorded evidence on question of causation is issue of fact for ALJ). *See also, In the Matter of the Claim of Tammy Manzanares, Claimant*, W. C. Nos. 4-517-883 and 4-614-430, 2005 WL 1031384 (Colo. Ind. Cl. App. Off. Apr. 25, 2005).

12. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. 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).

13. In the instant claim, there was clearly a slip accident on July 23, 2014, as documented by in-store security video. Despite extensive medical treatment, including diagnostics and surgical referral, no medical provider has identified any objective evidence of an injury requiring medical treatment or resulting in disability.

14. The ALJ concludes that the opinions and analysis of Dr. Larson and Dr. Nanes is credible and persuasive and the ALJ concludes that the claimant has failed to establish by a preponderance of the evidence that she sustained a compensable injury arising out of and in the course of her employment with the respondent-employer on July 23, 2014.

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: July 17, 2015

/s/ original signed by:
Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Dr Ste 230
Colorado Springs, CO 80906

ISSUES

The issues for determination at the hearing were:

1. Whether the Claimant proved, by a preponderance of the evidence, that he suffered a compensable injury in the course and scope of his employment on December 18, 2013.

2. If the Claimant's claim is compensable, whether the Claimant proved that medical treatment he received was authorized, causally related and reasonably necessary to cure and relieve the effects of the December 18, 2013 industrial injury.

3. If the Claimant's claim is compensable, whether the Claimant proved, by a preponderance of the evidence, that he is entitled to temporary total disability indemnity benefits from March 17, 2014 ongoing.

4. If the Claimant is entitled to temporary total disability indemnity benefits, whether the Respondents proved that there are applicable offsets.

5. If the Claimant's claim is compensable, determination of the Claimant's average weekly wage ("AWW").

6. If the Claimant's claim is compensable, whether the Respondents proved, by a preponderance of the evidence, that the Claimant is subject to penalty for failure to timely report his injury.

FINDINGS OF FACT

1. The Claimant testified at the hearing that he had back pain in the past but he had no prior diagnosis of a hernia. He testified that he attributes his current back condition to his work during a heavy work load due to the holiday season. The Claimant testified that, during mid-December of 2013, he was lifting lots of kegs and that is when he started to notice pain. There are no medical records in evidence showing that the Claimant sought treatment in December of 2013. The Claimant placed the date of injury on December 18, 2013 but indicated that he returned to work on December 19, 2013 (Respondents' Exhibit D, p. 11). The Claimant testified that he continued to work for the Employer at the same job duties with no modifications.

2. The Claimant calculated his average weekly wage, including overtime and a health insurance benefit as $1,246.40 (Respondents' Exhibit D, p. 11). Respondents attached wage records from March 15, 2013 through March 14, 2014, the year period

before the Claimant ceased working on March 26, 2014. The Claimant's gross earnings were $61,931.64. $61,931.64 divided by 52 weeks equals $1,190.99 per week. It is not known if this gross earnings amount includes the health insurance benefit, but it is presumed to include the overtime. The health insurance benefit amount was not separately listed by the Claimant in his Worker's Claim for Compensation.

3. The Claimant testified that at some time in December, 2013, he had trouble getting out of bed so he saw Dr. Theiss and complained of back pain but did not state when it happened or that it was work-related because at that time the Claimant wasn't certain that it happened at work the week he was lifting the kegs before Christmas. On cross-examination, the Claimant later testified that he told Dr. Theiss that it was work-related in January of 2014. There is no medical record in evidence to support the Claimant's testimony that he saw Dr. Theiss in December of 2013 complaining of back pain, nor is this medical record discussed in the IME report of Dr. McCranie.

4. The earliest medical record in evidence is from January 23, 2014.[1] The Claimant saw Dr. Thomas D. Mino at Firestone Family and Occupational Medicine complaining of "left calf pain for 6 days." The Claimant reported that he left calf pain was constant since the onset 6 days ago when he woke up. The Claimant reported that could not recall any injury whatsoever. The Claimant described the pain "like a cramp that just won't go away." The pain was described as starting near the posterior knee and radiating towards the Achilles. Dr. Mino noted the Claimant walked without a limp and had full range of motion on the left knee and ankle. The calf was described as "supple" but the Claimant reported tenderness to palpation, medial more than lateral (Respondents' Exhibit M, pp. 78-83). Dr. Mino ordered an ultrasound as the Claimant is diabetic, "to exclude DVT" and noted that if the ultrasound were negative, the Claimant would be treated with heat and compression and over the counter analgesics (Respondents' Exhibit M, p. 78). The ultrasound was normal with no findings of deep vein thrombosis or superficial thromophlebitis (Respondents' Exhibit M, p. 76).

5. The Claimant returned to Firestone Family and Occupational Medicine and saw Dr. Ruth Vanderkooi on January 28, 2014 with continued left leg complaints. The Claimant reported that it hurts behind the knee/calf down to the lateral ankle area and the pain could be 10/10 at times, worse if he is standing and putting weight on it and better if he is lying down. The Claimant was now walking with an antalgic gait. Dr. Vanderkooi noted that the Claimant's pain was unusual with an unclear etiology. She opined that it is possible that it is a referred pain from a lumbar process, but the Claimant declined an MRI due to cost (Respondents' Exhibit M, pp. 71-73).

6. On March 3, 2014 the Claimant saw Dr. Megan Eliassen at the Firestone Family and Occupational Medicine Clinic. She noted that the Claimant reported that he was having more leg pain. He had thought it was going away, but then about 10 days before the appointment the pain came back. The pain is described "like a leg cramp that

[1] There are references to some earlier medical records of the Claimant in the IME report of Dr. McCranie dated April 28, 2015, but no earlier medical records were offered or admitted into evidence in this claim.

won't go away in back of L calf, radiates down to ankle and up to hip." Ice and heat do not help and nothing the chiropractor did changed the pain. The Claimant stated that he is not sure what made the pain better a few weeks ago and not sure what made it worse the previous Saturday. The Claimant offered that maybe the pain was worse because he has to lift heavy things and go up and down stairs at work. The Claimant reported that there was "no trauma /injury that he knows of." The Claimant continued to decline an MRI due to cost (Respondents' Exhibit M, pp. 65-70).

7. On March 17, 2014, the Claimant saw Dr. Nicholee Theiss for a follow up appointment for his diabetes condition. Dr. Theiss notes that the Claimant has chronic diabetes mellitus that is poorly controlled. On this visit, the Claimant also reported low back pain with left-sided radiculopathy. The Claimant reported to Dr. Theiss that he has had the low back pain with leg pain since Christmas and that he had been seen at the Exempla primary care clinic in Firestone. Dr. Theiss noted that the Claimant reported he took Soma and Percocet for the pain and it helped initially, but in the last week the pain has been severe again. Dr. Theiss noted the Claimant had limited range of motion. Dr. Theiss noted that a Medrol Dosepak was provided for the short-term for relieve from acute symptoms. Dr. Theiss indicated that the records from the Exempla clinic would be ordered for review (Respondents' Exhibit G, pp. 32-34).

8. In March 2014, the Claimant testified that he slipped and fell in the restaurant bringing in kegs and he stated that he reported to Greg Miller that he fell down the stairs bringing up kegs. The Claimant testified that he saw Dr. Theiss and reported that he fell on the stairs with kegs. The Claimant testified that he filled out a report with Greg Miller in March 2014 about the fall on the stairs. The Claimant testified that Mr. Miller asked the Claimant if he wanted to see one of their doctors and the Claimant testified that he said, "No, I'm fine" because he was already injured by then. The Claimant testified that he did not fill out a Worker's Claim for Compensation for the March 2014 incident. He testified that there was no reason, he just didn't do it.

9. On March 21, 2014, the Claimant underwent an MRI of the lumbar spine without contrast. The MRI findings included (1) mild disc bulge with moderate sized, broad, left foraminal disc protrusion at L5-S1 which abuts and displaces the left L5 nerve root in the neural foramen and results in moderate left neural foraminal narrowing; (2) mild bilateral neural foraminal narrowing at L4-5, left greater than right; (3) minimal disc bulges in the other intervertebral disc levels in the lumbar spine; and (4) mild facet arthropathy throughout the lumbar spine with no marrow edema or spondylolisthesis (Respondents' Exhibit L, pp. 62-63).

10. The Claimant testified that he stopped working as of March 26, 2014.

11. On March 26, 2014, the Claimant presented to the emergency department at Good Samaritan Medical Center with left lower extremity pain. The Claimant stated that "the pain started in his left leg about 3 months ago" and the pain has gotten worse and now includes low back pain. The Claimant brought a copy of the MRI he had done the previous Friday on DVD. The Claimant denied any new trauma or fall. The pain

medication he was given previously was no longer controlling his pain (Respondents' Exhibit K, p. 52). PA-C Christine Andrea Zakar noted that the Claimant reported "his symptoms initially began in January and have been intermittent up until recently, and now they are persistent." The Claimant's pain was localized to the left posterior let to the lateral aspect of his ankle with no right lower extremity symptoms. The Claimant rated his pain at 10/10 for the leg pain and 4 to 5 / 10 for the back pain (Respondents' Exhibit K, pp. 55-56). The Claimant was also seen by Dr. Kara Beasley who assessed the Claimant with a left L5-S1 disk protrusion and she recommended conservative treatment with physical therapy. The Claimant received an epidural steroid injection, which reduced the Claimant's pain by 50%, and oral pain medication. On discharge, the Claimant was provided a 10 lb. lifting restriction, was referred for physical therapy, and was to follow up with Dr. Beasley in 2-3 weeks. The Claimant was discharged on March 28, 2013 (Respondents' Exhibit K, p. 60).

12. On March 31, 2014, the Claimant saw Dr. Theiss for the purpose of completion of disability paperwork. Dr. Theiss noted that since the last visit on March 17th, the Claimant noted a very slight improvement with the steroid burst, but then his pain became so severe he had to go to the Emergency room. Dr. Theiss assessed a herniated L5-S1 disc which is impinging on the left L5 nerve root with lumbar disc degeneration of L4-5, as well as osteoarthritis throughout his lumbar spine with persistent radiculopathy symptoms into the leg. Dr. Theiss noted that the Claimant would start physical therapy and follow up with Dr. Beasley. Dr. Theiss also completed the disability claim form (Respondent's Exhibit G, pp. 29-31). On the disability claim form, Dr. Theiss noted that he first treated the Claimant on March 17, 2014. He noted that the Claimant "cannot bend, twist, pull, push, or crawl" until cleared by his neurosurgeon. The treatment planned included, "epidural injections, PT, MRI, neurosurgical evaluation, muscle relaxers, anti-inflammatories and narcotic pain relievers (Respondents' Exhibit J, p. 45).

13. On April 14, 2014, the Claimant saw Dr. Kara Beasley for follow up. She noted that the Claimant reported that the ESI on March 27, 2014 "significantly helped his leg pain and the back pain resolved completely." The Claimant also reported that the twice-weekly PT was helping. Dr. Beasley discussed the Claimant's MRI with him and treatment options. At that visit, the Claimant opted to try another injection and continue with PT in an attempt to avoid surgical intervention (Respondents' Exhibit E, p. 18).

14. On May 20, 2014, the Claimant underwent a left L5 transforaminal epidural steroid injection performed by Dr. Greg Arends (Respondents' Exhibit I, p. 39).

15. On June 5, 2014, the Claimant saw Dr. Theiss for follow up regarding his back pain. Dr. Theiss noted the Claimant has undergone three epidural injections on referral from Dr. Kara Beasley. Dr. Theiss noted that the Claimant reported some relief but that the Claimant has not been able to return to work yet. The Claimant was provided with refills for the Oxycodone prescription for pain (Respondents' Exhibit G, pp. 27-28).

16. On June 27, 2013, the Claimant was seen in Dr. Beasley's office by PA-C Christine Zakar. She noted that the Claimant has had 3 epidural steroid injections, the last one on 5/20/2014. The Claimant reported that his leg pain was improved compared to the previous month. Continued conservative care was recommended with a possible referral for another ESI if the pain intensifies, with the understanding that the number of injections be limited to 3-4 per year (Respondents' Exhibit E, p. 12).

17. The Claimant's attorney completed a Worker's Claim for Compensation for the alleged December 18, 2013 injury dated August 4, 2014 stating that the Claimant injured his lower back while "lifting kegs and boxes of wine & spirits upstairs downstairs" (Respondent's Exhibit D, p. 11). On the form, the Claimant does not state that he reported this injury to anyone, but just wrote "NA" in that box. On the form, the Claimant also reports that he had no initial treatment.

18. Respondents filed a Notice of Contest on September 9, 2014 (Respondents' Exhibit B).

19. Dr. Kathy McCranie saw the Claimant for an independent medical examination (IME) and prepared a report dated April 28, 2015. The Claimant reported a five-year history of low back pain to Dr. McCranie. He reported that on December 18, 2013, he was performing his regular job duties of lifting case of wine and kegs up and down stairs and ramps and he noted more pain than usual in his back over the course of that week. The Claimant told Dr. McCranie that he thinks he mentioned this to his employers but he did not file a work injury claim or seek medical care at that time. The Claimant told Dr. McCranie that on December 25 or December 26, he noted a muscle cramp in his left leg. He did not seek medical treatment for this until approximately January 13, 2014 when he was seen at Firestone Exempla Clinic (Respondent's Exhibit A, p. 1). The Claimant reported that he then saw several doctors, including Dr. Theiss, Dr. Beasley and Dr. Arends and he received epidural steroid injections, underwent physical therapy twice a week for three months and was referred to a chiropractor, Dr. Johnson, who he saw twice a month for about 12 sessions of adjustments and electrical stimulation. The Claimant told Dr. McCranie that he did not report a work injury until March of 2014 when he had a separate injury where he slipped and fell and landed on his back. The Claimant stated that he did not seek any medical treatment with respect to this new injury (Respondents' Exhibit A, p. 2). Dr. McCranie provided a thorough review of the Claimant's medical records both prior to his alleged December 2013 injury and since then (Respondents' Exhibit A, pp. 2-5). Dr. McCranie assessed the Claimant with (1) left-sided low back and lower extremity pain; and (2) left-sided lumbar disk protrusion, L5-S1. After taking the Claimant's history and reviewing the medical records, Dr. McCranie opined that she "do[es] not think it is medically probable that the patient had any type of industrial accident." She went on to opine that the Claimant's report of injury is inconsistent with the medical records, having been seen by a doctor on December 22, 2013 and reporting no back pain. Further, Dr. McCranie notes that the reports of calf pain start on January 23, 2014 and, at that time, the Claimant stated that the onset was 6 days prior to the doctor visit. Dr. McCranie notes that, in the medical records, the Claimant cannot recall any injury or trauma and that it is not until March of

2014 that the Claimant mentioned to one of his doctors that he lifted heavy items at work. Ultimately, Dr. McCranie opined that she did not find "any medically probable causal relationship between the onset of the patient's lumbar disc herniation and his work activities of December 18, 2013" (Respondents' Exhibit A, p. 7).

20. When questioned on cross-examination why the Claimant waited until August to fill out a claim, the Claimant testified that at first the pain subsided, but then it got worse again. The Claimant also testified that between March and August, he was on short-term disability and he received about $2,300.00 per month, but that ended at the beginning of August. The Claimant testified that now he is on long-term disability but that is only $1,500.00 per month.

21. The Claimant testified that he was aware of posters around the workplace about reporting injuries but he had never read them or paid attention to them since he hadn't needed to report anything. He testified that he did keep telling Greg Miller that his back was hurting more and more.

22. Greg Miller testified at the hearing that he is the Transportation Manager for the Employer. He managed 78 drivers and is also responsible for the initial filings for all Workers' Compensation claims. He testified that at orientation, all employees are advised about reporting work injuries and there are big posters at the workplace that provide information on work injuries and advise to report injuries to Greg Miller. Mr. Miller testified that when an employee reports an injury to him, they are provided and are to complete the Sedgwick forms. The employee then picks a medical provider as different ones are available all over town. Then, Mr. Miller sends in the Sedgwick forms.

23. Mr. Miller testified credibly that the Claimant never reported an injury in December 2013 to him. Mr. Miller testified that he did not know the Claimant had a work injury and if he had known, he would have had the Claimant fill out the Workers' Compensation paperwork. Mr. Miller likewise testified that he was never advised that the Claimant had a fall in March of 2014. Mr. Miller testified that he was only made aware that the Claimant was off work on short term disability after the fact.

24. On the issue of reporting alleged injuries occurring on either December 18, 2013 or in March of 2014, the testimony of Mr. Miller is found to be more credible and persuasive than that of the Claimant. The Claimant's testimony about reporting back and leg pain due to work injuries is not credible and the medical records do not support acute injuries during these time frames. Moreover, no paperwork was completed and there is no written record of the Claimant having reported work injuries to Mr. Miller.

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. Respondent bears the burden of establishing any affirmative defenses. 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 (2008).

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).

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).

Compensability

A claimant's right to compensation initially hinges upon a determination that the claimant suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. C.R.S. §8-41-301. 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. 2009). It is the burden of the claimant to establish causation by a preponderance of the evidence. *Faulkner v. Indus. Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000). There is no presumption than 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. Medical evidence is not required to establish causation and lay testimony alone, if credited, may constitute substantial evidence to support an ALJ's determination regarding causation. *Industrial Commission of Colorado v. Jones*, 688 P.2d 1116 (Colo. 1984); *Apache Corp. v. Industrial Commission of Colorado, 717 P.2d 1000 (Colo. App. 1986).* The weight and credibility to be assigned expert testimony on the issue of causation is a matter within the

discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002).

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,* 805 P.2d 1167 (Colo. App. 1990); *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).

Ultimately, the evidence does not support Claimant's allegation that he sustained a work injury on December 18, 2013. The Claimant continued to work through March of 2014. He testified that he stopped working as of March 26, 2014. Prior to this, he worked at his regular job with no modifications. He even testified that he had a fall down stairs at work in March of 2014 prior to the date he stopped working. He missed no days from work until the day he presented to the emergency room on March 26, 2014. The Claimant's supervisor testified credibly and persuasively that the Claimant never reported a December 2013 work injury or a March 2014 fall at work to him. There is no paperwork filed with the Employer to initiate a Workers' Compensation claim and receive medical treatment until the Claimant filed his Worker's Claim for Compensation on August 4, 2014. The Claimant's supervisor also testified that he was not even aware that the Claimant was off work on disability leave until after the fact.

Dr. Kathy McCranie saw the Claimant for an independent medical examination (IME) and prepared a report dated April 28, 2015. The Claimant reported a five-year history of low back pain to Dr. McCranie. He reported that on December 18, 2013, he was performing his regular job duties of lifting case of wine and kegs up and down stairs and ramps and he noted more pain than usual in his back over the course of that week. The Claimant told Dr. McCranie that he thinks he mentioned this to his employers but he did not file a work injury claim or seek medical care at that time. The Claimant told Dr. McCranie that on December 25 or December 26, he noted a muscle cramp in his left leg. He did not seek medical treatment for this until approximately January 13, 2014 when he was seen at Firestone Exempla Clinic. The Claimant also told Dr. McCranie that he did not report a work injury until March of 2014 when he had a separate injury where he slipped and fell and landed on his back. The Claimant stated that he did not seek any medical treatment with respect to this new injury. After a thorough review of the medical records and a physical examination, Dr. McCranie assessed the Claimant with (1) left-sided low back and lower extremity pain; and (2) left-sided lumbar disk

protrusion, L5-S1. However, after taking the Claimant's history and reviewing the medical records, Dr. McCranie opined that she "do[es] not think it is medically probable that the patient had any type of industrial accident." She went on to opine that the Claimant's report of injury is inconsistent with the medical records, having been seen by a doctor on December 22, 2013 and reporting no back pain. Further, Dr. McCranie notes that the reports of calf pain start on January 23, 2014 and, at that time, the Claimant stated that the onset was 6 days prior to the doctor visit. Dr. McCranie notes that, in the medical records, the Claimant cannot recall any injury or trauma and that it is not until March of 2014 that the Claimant mentioned to one of his doctors that he lifted heavy items at work. Ultimately, Dr. McCranie opined that she did not find "any medically probable causal relationship between the onset of the patient's lumbar disc herniation and his work activities of December 18, 2013."

The credible and persuasive evidence does not support an injury occurring at work. The Claimant's testimony regarding the mechanism of injury and the facts surrounding an incident occurring at work on December 18, 2013 is at odds with the testimony of Mr. Miller, his supervisor, the documentary evidence and the medical records. The Claimant had a preexisting low back condition. However, the Claimant testified that this pain was different. Yet, with respect to the medical records, there were multiple confusing reports by the Claimant to his various doctors regarding the onset of his symptoms. Moreover, the Claimant continued to perform his physically demanding job for approximately three months following his alleged date of injury. Overall, there is considerable doubt whether the Claimant was actually injured in the manner he has described.

This doubt is not resolved by the Claimant's testimony at the hearing that he also suffered a slip and fall work injury on stairs in March of 2014 while carrying kegs and cases of wine and spirits. While the Claimant testified that he did report this injury, there is no record of this and the testimony of his supervisor is more credible that the Claimant did not report a March 2014 injury. Then, with respect to this March 2014 injury, the Claimant never filed a Worker's Claim for Compensation.

By March 26, 2014, the Claimant has leg pain that is so severe, he goes to the emergency department and he never returns to work. Instead, he files paperwork for short-term disability. However, even at this point, he does not file any paperwork to initiate a Workers' Compensation claim.

The credible and persuasive evidence demonstrates that it is more likely than not that the Claimant was treating a non-work related low back problem. The credible and persuasive evidence shows that it is more likely than not he was missing work for a non-work related low back problem. From that point forward, the Claimant remained in treatment and on restrictions for his low back. Given the circumstances, including the inconsistent statements made by the Claimant regarding the onset of pain, the contrasting and more persuasive testimony of Mr. Miller on the lack of any report of work injury, and the opinion of Dr. Kathy McCranie, the ALJ determines that the Claimant has failed to meet his burden of proof to establish that he sustained a work

injury and his need for treatment is related to his employment or any work-related injury. As such, the Claimant's claim for compensation is denied and dismissed.

Remaining Issues

The Claimant failed to prove that his December 18, 2013 claim is compensable. Therefore, the remaining issues regarding medical benefits and temporary disability benefits are moot.

ORDER

It is, therefore, ordered that:

1. The Claimant has failed to sustain his burden of proving by a preponderance of the evidence that he suffered a compensable injury resulting from work activities on December 18, 2013.

2. 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 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: July 27, 2015

Kimberly A. Allegretti
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, Colorado, 80203

ISSUES

Issues raised for consideration were compensability of an August 16, 2014 right shoulder injury and if compensable entitlement to medical benefits including authorized provider and reasonably necessary care. Specifically, Claimant sought an Order requiring respondents to provide physical and massage therapy.

STIPULTION

The parties' stipulated that in the event of a finding of compensability, the authorized treating facility was Centura Centers for Occupational Medicine (CCOM). The parties stipulation regarding identity of the authorized provided is approved.

FINDINGS OF FACT

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

1. Claimant is employed as a registered nurse (RN) for Employer at their Belmont Lodge Health Care facility.

2. On August 16, 2014 Claimant was "called in" to work due to staff shortages. Upon her arrival at work, she assumed her normal duties of taking care of elderly patients residing in the facility. Claimant asserts that at around 7:00 PM, two hours after arriving, she was walking down a hallway in the facility when the plastic covering of an overhead light fixture fell and struck her on her right shoulder.

3. Claimant testified that she cried out "ouch" and felt immediate pain in her right shoulder area.

4. An unidentified patient, a co-worker (Barbara Miller), and the interim Director of Nursing for Employer (Janet Green) responded to the area of the incident. Ms. Green testified she was approximately fifteen to twenty feet away in another patient's room when she heard a "clang" in the hallway, like something had fallen.

5. Ms. Green testified that she did not see the actual incident. Instead, Ms. Green testified that as she backed out of the patient's room she was in to look into the hallway, she observed the broken light cover on the floor. According to Ms. Green, there were several 3-4 inch pieces of broken plastic on the floor and multiple smaller pieces in the vicinity. Ms. Green also testified that Claimant did not exclaim "ouch", i.e. Claimant did

not cry out from the hallway. Ms. Miller did not testify.

6. Claimant testified that Ms. Green instructed her to retrieve a broom and dustpan from the maintenance closet and clean the broken plastic from the floor. Claimant testified that she complied despite being in pain. Per Claimant's testimony, she used her left arm as it caused her pain to use her right arm.

7. Ms. Green challenges Claimant's recollection, testifying that she did not require Claimant to clean the mess up. Rather, Ms. Green testified that she observed a resident of the facility approach the area and begin to bend over to pick the broken plastic up from the floor. For safety reasons, Ms Green stopped the resident from attempting to clean up the broken cover after which she noticed that Claimant had already retrieved a broom and dust pan and was cleaning up the area using both arms without apparent pain.

8. Ms. Green testified that Claimant did not report that the light cover had struck her on the shoulder at the time and Claimant testified that she did not show Ms. Green any injury.

9. Claimant testified that she attempted to continue her duties over the next twenty minutes, but was unable secondary to pain. She reportedly returned to the nursing station and requested to Ms. Green that she be able to seek immediate medical treatment for her injured shoulder.

10. Ms. Green agreed that Claimant reported that the cover hit her on the shoulder approximately twenty minutes after the incident occurred. At that time, Ms Green testified that she took Claimant's report as a claim for an on the job injury and repeatedly told her to stop working. Specifically, Ms. Green testified that she told the Claimant to stop using her arms if she was claiming an injury to her shoulder. According to Ms. Green, Claimant refused to stop working during which time she observed Claimant reach out and over her head with both arms to retrieve files for charting without limitation or obvious pain.

11. Claimant testified that after she reported her injury, Ms. Green was exasperated and threw the on the job injury incident paperwork at her. According to Claimant, Ms. Green demanded that she complete it immediately or sign a refusal. Ms. Green disputes this, testifying instead that Claimant refused to stop working when instructed to do so. According to Ms. Green, she heard a visitor to the facility ask claimant if she was hit by the light cover and if so that she would be a witness for claimant. Ms. Green claimed to be out of eye-sight, but within earshot of the visitor's comment. Ms. Green testified that within seconds of this alleged interaction between the visitor and Claimant, Claimant came to her asking to make a report of injury and to seek medical treatment. According to Ms. Green's testimony the interaction between Claimant and this visitor put her "on alert" to a likely workers compensation situation.

12. After some confusion on where to report for treatment initially, Claimant reported

to the emergency room (ER) at St. Mary Corwin Medical Center where she was eventually evaluated by Dr. Sara Kruger-Johnson at 12:03 AM on August. Prior to her seeing Dr. Kruger-Johnson, Claimant was triaged by Kathleen Bujanda, RN who documented the following history of injury at 10:24 (2224) PM: "pt states she was ambulating down hallway at work and the covering of the overhead light fell striking her on the r. shoulder . . ."

13. At midnight (0000) Tabatha Wills, RN completed an initial emergency department (ED) Assessment which the undersigned ALJ finds included a visual inspection of the right shoulder after which RN Wills documented "redness noted to shoulder."

14. During her encounter with Claimant, Dr. Kruger-Johnson took a verbal history regarding the mechanism of injury which is documented in her report as: "was walking through a hallway at work when a light fixture fell from the ceiling striking her in the right shoulder." Dr. Kruger-Johnson also completed a physical examination (P.E.) of the extremities the results of which yielded the following documentation from Dr. Kruger-Johnson: "Patient has tenderness about the posterior joint line of the right shoulder. There is some mild erythema and tenderness to palpation over the a.c. joint. Patient has full range of motion with abduction and adduction with some discomfort with full arm extension and internal rotation."

15. On August 19, 2014, Claimant went to CCOM where she was evaluated by PA-C Steven Byrne at which time she complained of having a sore, aching shoulder which was made worse by lifting. PA Byrne assessed "contusion" of the right shoulder noting that the "objective findings are consistent with the history of a work-related etiology." PA Byrne prescribed Bio Freeze and Ibuprofen and imposed restrictions on Claimant's activities tightening a fifteen pound lifting limitation to ten pounds.

16. Claimant returned to CCOM on August 25, 2014 where she saw Dr. Paul Merchant. During this encounter, Claimant reported continued pain of 8/10 associated with decreased right arm range of motion (ROM). Physical examination revealed tenderness to palpation over the AC joint, along the infraspinatus and deltoid as well as limited right shoulder ROM. Dr. Merchant referred Claimant for four weeks of physical and massage therapy. He also modified Claimant's restrictions reducing her lifting capacity to five pounds. Working diagnosis remained contusion of the right shoulder.

17. Claimant was unable to immediately begin her physical or massage therapy due to scheduling issues, but she had scheduled an initial evaluation for September 3, 2015. On September 2, 2014, she again returned to CCOM with no change in diagnosis or treatment plan by Dr. Merchant. He recommended she remain in a sling.

18. On September 3, 2014, Claimant went for her initial evaluation at the Institute for Total Rehab in Pueblo, CO. The physical therapist noted she displayed signs and symptoms of a shoulder contusion. She was given a treatment schedule of two times per week for a minimum four weeks.

19. Claimant was unable to begin continue physical therapy and initiate massage therapy treatment or return to CCOM due to Respondents' decision to contest the claim.

20. At respondents' request, claimant was seen by Dr. Eric Ridings on November 17, 2014 for an Independent Medical Examination (IME). Respondents submitted Dr. Ridings report as evidence at hearing. Dr. Ridings did not testify. The ALJ has reviewed the report of Dr. Ridings submitted by Respondents at hearing and finds it incomplete. Although Respondents contend that the report provides that Dr. Ridings was of the opinion, assuming claimant was struck by the plastic light cover, she suffered a contusion injury which requires no additional treatment; the ALJ finds no such opinions are contained in the report submitted by Respondents given its incomplete nature. For purposes of this Order the ALJ accepts Respondents assertion that Dr. Ridings opined that Claimant's right shoulder contusion requires no additional treatment, including PT and massage therapy because "her marked (and likely self-limited) loss of range of motion at the right shoulder is inconsistent with being struck by a plastic light cover in the anterior shoulder, which [he] would not expect to have any effect on the movement of her arm given her essentially normal x-rays. The ALJ is not convinced, finding the contrary opinions and recommendations of Dr. Merchant more persuasive than those of Dr. Ridings.

21. Based upon the content of RN Bujanda, RN Wills and Dr. Kruger-Johnson's records, the ALJ finds that Claimant has consistently reported that the cover of the light fixture fell from the ceiling striking her on the right shoulder. Moreover, the ALJ finds the visual inspection of RN Wills and the physical examination of Dr. Kruger-Johnson to contain objective findings (redness and warmth) consistent with being struck on the shoulder by a falling object. The ALJ finds it more probable than not that Claimant's described mechanism of injury is the cause of her shoulder pain and limited ROM and that the care required for her shoulder condition is reasonably necessary to cure or relieve Claimant from the ongoing effects/symptoms caused by this injury. Consequently, the ALJ finds that Claimant has proven, by a preponderance of the evidence, that she suffered a compensable right shoulder injury entitling her to medical benefits, including physical and massage therapy as recommended by Dr. Merchant.

22. Claimant's testimony is credible and persuasive.

CONCLUSIONS OF LAW

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

General Legal Principals

A. 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.

B. In accordance with § 8-43-215, C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office*, *84 P.3d 1023 (Colo. 2004).* This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).*

C. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16. Here, there are some inconsistencies in the testimony of Claimant and Ms. Green. Nonetheless, the ALJ finds many of those inconsistencies immaterial to the threshold issue concerning compensability and resolves the remaining inconsistencies in favor of Claimant to find that her account of the injury and the events thereafter are credible and supported by the record evidence. Consequently, the ALJ concludes that Claimant's testimony concerning the cause of his alleged injury is reliable and persuasive.

Compensability

D. Under the Workers' Compensation Act, an employee is entitled to compensation where the injury is proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment. *Section 8-41-301(1), C.R.S.; Horodyskyj v. Karanian* 32 P.3d 470 (Colo. 2001). The phrases "arising out of "and "in the course of" are not synonymous and a claimant must meet <u>both</u> requirements. *Younger v. City and* County of Denver, 810 P.2d 647, 649 (Colo. 1991); *In re Question Submitted by U.S. Court of Appeals,* 759 P.2d 17, 20 (Colo. 1988). The latter requirement refers to the time, place, and circumstances under which a work-related injury occurs. *Popovich v. Irlando,* 811 P.2d 379, 381 (Colo. 1991). Thus, an injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected with the employee's job-related functions. *In re Question Submitted by U.S. Court of Appeals,*

supra; Deterts v. Times Publ'g Co., 38 Colo.App. 48, 51, 552 P.2d 1033, 1036 (1976). Here there is little question that Claimant produced sufficient evidence to support a conclusion that her symptoms occurred in the scope of employment. Rather, based Ms. Green's testimony and Respondents' assertion regarding the content of Dr. Ridings' report, the ALJ concludes that the question for determination is whether Claimant's injuries and consequently, her need for treatment arise out of her employment.

E. The term "arises out of" refers to the origin or cause of an injury. *Deterts v.Times Publ'g Co. supra.* There must be a causal connection between the injury and the work conditions for the injury to arise out of the employment. *Younger v. City and County of Denver, supra.* An injury "arises out of" employment when it has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered part of the employee's employment contract. *Popovich v. Irlando supra.* As noted above, it is the Claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between employment and the alleged injuries. Section 8-43-201, C.R.S. 2013.

F. The determination of whether there is a sufficient "nexus" or causal relationship between Claimant's employment and the injury is one of fact which the ALJ must determine based on the totality of the circumstances. *In Re Question Submitted by the United States Court of Appeals,* 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle,* 934 P.2d 861 (Colo. App. 1996). While it is true, under *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Parra v. Ideal Concrete,* W.C. No. 3-963-659 and 4-179-455 (April 8, 1988)*; Barba v. RE1J School District,* W.C. No. 3-038-941 (June 28, 1991); *Hoffman v. Climax Molybdenum Company,* W.C. No. 3-850-024 (December 14, 1989), that an incident which merely elicits pain symptoms without a causal connection to industrial activities does not compel a finding that the claim is compensable, the totality of the persuasive evidence presented establishes that a light cover fell from its mooring onto Claimant's right shoulder while she was engaged in her routine duties as a nurse for Employer. As a consequence Claimant reported that she sustained an injury to her shoulder. As found, the persuasive evidence, including the visual inspection of RN Wills and the physical examination of Dr. Kruger-Johnson, hours after the asserted injury, supports Claimant's assertion. Consequently, the ALJ concludes that a logical causal connection between the Claimant's complaints and her work-related duties exists in this case. The claim is compensable.

Medical Benefits

G. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondent's are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. *Section 8-42-101, C.R.S.*; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo.App. 1990). The question of whether the need for treatment is causally related to an industrial injury is one of fact. *Walmart Stores, Inc. v. Industrial Claims Office,* 989 P.2d 521 (Colo. App.

1999). Where the relatedness, reasonableness, or necessity of medical treatment is disputed, Claimant has the burden to prove that the disputed treatment is causally related to the injury, and reasonably necessary to cure or relieve the effects of the injury. *Ciesiolka v. Allright Colorado, Inc.*, W.C. No. 4-117-758 (ICAO April 7, 2003).

H. Based upon the medical records submitted, including the visual observations of RN Wills and the objective findings of Dr. Kruger-Johnson on physical examination, the ALJ credits the opinions/recommendations of Dr. Merchant to conclude that additional treatment in the form of physical and massage therapy is reasonable and necessary to cure and relieve Claimant of the ongoing effects of her compensable right shoulder injury.

ORDER

It is therefore ordered that:

1. Claimant's August 16, 2014 shoulder injury is deemed compensable and Respondents shall pay for all medical expenses to cure and relieve claimant from the effects the effects of this injury, including but not limited to, additional physical therapy and massage therapy as requested by Dr. Merchant.

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: July 28, 2015

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

- Whether claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope 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 industrial injury?

- The parties stipulated prior to the hearing that Western Medical Associates and Work Partners are designated providers for claimant's work injury.

- The issue of whether claimant failed to timely report his injury in writing to employer was held in abeyance by the parties at the hearing.

FINDINGS OF FACT

1. Claimant was employed with employer as a manager. Claimant testified that on May 22, 2014 he was working on getting the swamp coolers for employer functioning and took an extension ladder and set it up along the building to access the swamp coolers. While working on the ground next to a large overhead door, the wind blew the extension ladder over and the extension ladder struck claimant on the back.

2. Claimant presented the testimony of Mr. Halmark at the hearing. Mr. Halmark was a customer of employer and witnessed the ladder get blown over and strike claimant. Mr. Halmark testified he went over to claimant after he was struck by the ladder and lifted his shirt where he saw substantial red marks and abrasions on claimant's back.

3. Claimant testified he experienced muscle soreness but didn't think he would need medical care initially. Claimant testified he didn't seek medical treatment until June 27, 2014 when he sought treatment with Western Medical Associates and was treated by Ms. Saunders, a nurse practitioner. Claimant reported to Ms. Saunders that he had pain between his shoulder blades and spine on his left side for the previous

2 weeks. Ms. Saunders recommended trigger point injections into the medial side of the scapulis along the 5th to 6th rib.

4. Claimant testified at hearing that he told Ms. Saunders that he was hit by a ladder at work but told her he didn't want to file a workers' compensation claim.

5. Claimant was seen by Dr. Moore on July 6, 2014 on referral from Ms. Saunders. Dr. Moore noted claimant reported he had no obvious injury. Dr. Moore performed manipulations.

6. Claimant was evaluated by Ms. Twardowski, a nurse on July 15, 2014 with complaints of left shoulder pain that he reported felt like a sapasm with severe pains. Claimant reported to Ms. Twardowski that he had left shoulder pain for the last month. Claimant reported that he had a ladder fall on him 1 ½ months ago, but there was no pain at that time. Claimant reported he felt like hi shoulder is cramped and at time he has sharp and stabbing pain. Examination revealed cervical and thoracic motion was restricted. Claimant was provided a prescription for Celebrex.

7. Claimant was examined by Dr. Twardowksi (not to be confused with nurse Twardowski) on August 5, 2014. Dr. Twardowski reported that claimant had left shoulder pain down the back of his arm to his 5th finger, but noted his neck and back pain felt much better. Dr. Twardowski also noted claimant had tenderness at the left first rib and left 4th rib laterally with motion restricted in his cervical and upper thoracic spine. Claimant was diagnosed with neck pain with some radiculopathy and cervicalgia.

8. Claimant was referred for physical therapy and was evaluated by Mr. Olsson with Olsson Physical Therapy on August 13, 2014. Claimant reported to Mr. Olsson that he had been having problems since the beginning of June and didn't know how it started, but did have a ladder fall on his back. Claimant reported intiiatlly he didn't have any problems after the ladder fell on him, but some time after that he started having pain in his left shoulder blade and rib cage area. Claimant reported that the pain was consistent but fluctuated in intensity. Claimant was diagnosed with a left intercostal and rhomboid strain.

9. Claimant eventually reported his injury to employer in writing as a workers' compensation claim on or about August 14, 2014 by filling out a workers' claim for compensation. Claimant testified he spoke to the controller for employer approximately one week before he filled out the form and reported the injury verbally. Claimant was referred to Dr. Winnefeld with Western Medical Associates for treatment.

10. Claimant was evaluated by Dr. Winnefeld on August 14, 2014. Claimant reported to Dr. Winnefeld that he had pain in his shoulder that began after a ladder at

work hit him on the back. Dr. Winnefeld provided claimant with work restrictions of no lifting over 20 pounds. Claimant returned to Mr. Olsson on August 18, 2014. Claimant reported to Mr. Olsson that he had been on prednisone and it had made a big change with less pain than he had experienced in the previous 2 months.

11. Claimant testified he was referred by Dr. Winnefeld to the emergency room ("ER") at some point due to complaints of severe chest pain. Claimant testified he underwent tests in the ER and had asked that insurer pay for the ER visit related to his severe chest pain. The records from this ER visit were not entered into evidence and the ALJ determines that respondents are not responsible for the cost of the ER visit.

12. Claimant was eventually referred for a magnetic resonance image ("MRI") of the left shoulder by Dr. Winnefeld on August 25, 2014. The MRI was essentially normal with only some minor spurring inferiorly from the tip of the acromion being noted. Claimant had a falling out with Dr. Winnefeld after the MRI and his care was transferred to Dr. Heil.

13. Claimant was examined by Dr. Heil on September 5, 2014 as a referral from Dr. Winnefeld. Claimant reported to Dr. Heil the incident of being struck by the ladder and the development of pain. Dr. Heil noted that he believed claimant likely injured his neck when he was hit in the back by the ladder. Dr. Heil noted that claimant had reported pain down the back of his arm, which could be related to a problem with the C8 nerve root. Dr. Heil performed x-rays of the cervical spine and recommended claimant undergo an MRI of the cervical spine.

14. Claimant continued to treat with various providers and was evaluated by Dr. Gustafson with Work Partners on September 25, 2014. Dr. Gustafson noted claimant's accident history of being struck by a ladder in May 2014 and had undergone a course of care since that time that included chiropractic care, acupuncture, massage, x-rays, EKG, MRI of the left shoulder without finding a cause of his pain. Dr. Gustafson noted tenderness present with palpation over rhomboids on the left side along border of scapula. Claimant reported pain with side bending of his neck to the left. Dr. Gustafson noted that no specific cause was known for claimant's pain. Dr. Gustafson also noted that there were signs of radiculopathy of the left upper extremity and recommended an electromyelogram ("EMG").

15. Claimant testified his symptoms were resolving in October 2014, but never fully abated. Claimant testified in January 2015 he contacted insurer regarding getting additional treatment. Claimant also testified he woke up in January 2015 and his hand was numb.

16. Claimant was evaluated by Dr. Richard Price on February 2, 2015. Claimant continued to complain of pain in his shoulder blade region that radiates down the ulnar aspect of the arm with numbness into the 4th and 5th digits with weakness. Dr. Price noted claimant had a significant prior injury to the left wrist and elbow with a partial left wrist fusion. Dr. Price diagnosed claimant with cervical radiculopathy and neck pain of unknown etiology. Dr. Price noted claimant's symptoms seemed to be associated with the C8 nerve root. Dr. Price recommended a cervical MRI and an EMG.

17. Claimant eventually underwent the cervical MRI on February 20, 2015. The cervical MRI revealed multilevel central canal narrowing, greatest at C3-4 and C4-5 along with degenerative retrolisthesis of C6-7 and anterolisthesis of C7-T1 with broad based disc bulges noted at multiple levels.

18. Claimant also underwent an EMG with Dr. Frazho. Dr. Frazho noted on March 5, 2015 that the EMG was abnormal with left likely C8 and possibly some component of C7 radiculopathy. Dr. Frazho recommended a referral to Dr. Clifford or Dr. Gebhard to discuss possible surgical options.

19. Respondents arranged for claimant to undergo an independent medical examination ("IME") with Dr. Lindberg on April 7, 2015. Dr. Lindberg obtained a medical history from claimant, reviewed claimant's medical records and performed a physical examination in connection with his IME. Dr. Lindberg issued a report dated April 7, 2015 that noted claimant's lack of medical treatment between his date of injury (May 22, 2014) and his first medical treatment with a chiropractor in mid June. Dr. Lindberg noted that claimant reported he never had neck pain following the incident and does not have neck pain now. Dr. Lindberg opined in his report that claimant has severe cervical diseases and had a posterior chest wall contusion form the falling ladder. Dr. Lindberg noted that claimant's medical records were silent on the issue of the falling ladder when he first started seeking medical treatment. Dr. Lindberg noted claimant was not complaining of neck pain, and therefore, he disagreed with Dr. Heil's hypothesis that claimant maybe injured his neck when he got hit by the ladder. Dr. Lindberg noted that claimant's pain in his chest wall went away in September 2014, only to return in October 2014 that started another workup. Dr. Lindberg opined that the posterior chest wall contusion (that was mislabeled as a shoulder contusion) had no effect on claimant's cervical spine and resolved. Dr. Lindberg opined that the severe degenerative changes in claimant's cervical spine had no relationship to the alleged ladder contusion. Dr. Lindberg opined that any further care to claimant's left arm, neck or shoulder would be unrelated to the May 22, 2014 work injury.

20. Dr. Lindberg testified at hearing consistent with his report. Dr. Lindberg noted that he did not question claimant having an injury when the ladder fell on him, as the accident was witnessed, but opined that the degenerative changes shown on the

MRI were not related to the incident in which the ladder fell on claimant. Dr. Lindberg testified that if the incident with the ladder had caused an injury to the cervical spine, he would expect claimant to have complained of neck pain following the incident.

21. The ALJ notes that respondents at hearing conceded that with the witness testimony provided at hearing and the testimony of Dr. Lindberg, they were not contesting necessarily that there was a compensable injury when claimant was struck by the ladder, but instead whether the current need for medical treatment, including the cervical MRI and surgical consultation referral to Dr. Clifford or Dr. Gebhard was related to the work injury.

22. The ALJ notes that Dr. Heil was indicating that claimant's injury could involve the C8 nerve root and recommending an MRI of the cervical spine in September 2014, fairly early on in claimant's treatment from his May 22, 2014 injury. The ALJ further notes that Dr. Lindberg opined that claimant's injury was originally mislabeled as a shoulder injury, which may have helped develop the confusion involving his initial treatment for this injury (along with claimant's admitted misstep in not wanting to report his injury as a workers' compensation claim, and providing an inaccurate accident history to his initial providers by telling them he didn't want this injury to be treated as a workers' compensation claim).

23. The credits the reports from Dr. Heil as more credible and persuasive than the contrary opinions expressed by Dr. Lindberg in his report and testimony and finds that claimant has demonstrated that it is more probable than not that the cervical MRI and referral for surgical consultation are reasonable medical treatment necessary to cure and relieve claimant from the effects of the May 22, 2014 injury. The ALJ notes that claimant's diagnosis of having his injury involve a radicular component related to the C8 nerve root was addressed early on in claimant's treatment with Dr. Heil. This evidence is persuasive to the ALJ that the incident with the ladder falling on claimant on May 22, 2014 aggravated, accelerated or combined with claimant's pre-existing condition to cause the need for medical treatment recommended by Dr. Heil in September 2014 and confirmed by Dr. Price and Dr. Frazho in February 2015.

24. Based on the foregoing, the ALJ determines that claimant has demonstrated that it is more likely than not that the recommended medical treatment is related to his compensable May 22, 2014 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. 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 when he was struck by the ladder.

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 claimant has proven by a preponderance of the evidence that the MRI performed in February 20, 2015 and the referral from Dr. Frazho to Dr.

Gebhard or Dr. Clifford for surgical consultation represent reasonable medical treatment that is necessary to cure and relieve the claimant from the effects of the 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 the industrial injury, including but not limited to the treatment provided by the physicians authorized to treat claimant for his work injury, and the cervical MRI performed on February 20, 2015.

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: July 30, 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

W.C.No. 4-961-975-02

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIM OF:

Claimant,

v.

Employer,

and

Insurer/Respondent(s)

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ) on June 18, 2015, in Denver, Colorado. The hearing was digitally recorded (reference: Courtroom 1, beginning at 8:30 AM, and ending at 10:30 AM).

Claimant's Exhibits 1-14 were admitted into evidence without objection. Respondents' Exhibits A – C where admitted into evidence without objection.

At the conclusion of the hearing, the ALJ established a post-hearing briefing schedule: The Claimant's opening brief was filed, electronically, on June 23, 2015. The Respondent's answer brief was filed on June 25, 2015. The Claimant's reply brief was filed on June 27, 2015, at which time the matter was deemed submitted for decision. The ALJ hereby issues the following decision.

ISSUES

The issues to be determined by this decision are whether Claimant sustained compensable injuries, arising out of and in the course of his employment with the Employer, on September 6, 2014; and, if so, medical and disfigurement benefits and temporary total disability benefits from September 6, 2014 and continuing.

FINDINGS OF FACT

Based upon the evidence presented at hearing and by depositions, the ALJ makes the following Findings of Fact:

Preliminary Findings

1. At the commencement of the hearing, the parties stipulated, and the ALJ finds as fact, that the Claimant's average weekly wage (AWW) was $320 per week.

2. The Claimant worked for the Employer, a temporary staffing agency, on the date of his alleged injuries.

3. At all times relevant to this case, the Claimant was assigned by his Employer to work as a materials handler for Communications Test Design, Inc., (hereinafter "CTDI"). CTDI processes and packages cable infrastructure at a warehouse facility in the Denver area.

4. While assigned to CTDI, the Claimant worked full-time (40-hours per week), Monday through Friday, with his shift usually beginning at 6:00 AM and ending at 2:30 PM. Upon CTDI's request, the Claimant worked on Saturday. The Claimant worked a Saturday shift on two separate occasions while assigned to CTDI, with the second of those two Saturdays being the date of Claimant's automobile accident and alleged injury.

The On-Premises Lunchroom

5. CTDI permitted workers, including the Claimant, to take a thirty minute lunch break during each shift. While on lunch break, the Claimant was not responsible for clocking in and out when going to and returning from lunch. Rather, thirty minutes of pay was deducted from the Claimant's wages for each shift to reflect the unpaid nature of the lunch break.

6. CTDI provides a lunchroom or break area on the premises for employees. The lunchroom is located inside of CTDI's warehouse, and it is separated from the warehouse floor by a set of doors that open and close. The lunchroom consists of tables and chairs, two refrigerators, two microwaves, and an assortment of vending machines. Employees may store their lunches in the refrigerators provided in CTDI's lunchroom. While on shorter breaks or lunch break, employees can retrieve, warm/prepare, and enjoy their meals in the lunchroom. In addition to bringing their own lunches, employees

may purchase small foodstuffs from the vending machines provided inside of CTDI's lunchroom. The vending machines contain items such as sandwiches and beverages for purchase. CTDI's lunchroom is open and accessible to employees on workdays, which are generally Monday through Friday, but includes Saturday if employees work those days. The lunchroom is for the mutual benefit of the Employer and employees.

7. According to the Employer's witnesses, CTDI's lunchroom is never locked. It is always accessible to employees while working, even on Saturdays. As testified to by all of Respondent's witnesses (Paul Kelly, Salvador Lopez Cuevas, Anthony Folks, and Maurice Edgerton), the lunchroom's doors have no locking mechanisms and are incapable of being locked.

8. In addition to offering a lunchroom, CTDI also permits a food truck to park on company property. This food truck provides hot meals for purchase to employees during lunch breaks. The food truck parks on the premises from Monday through Friday, and is not present on the Saturdays when employees work.

9. The Claimant usually purchased lunch items from the CTDI's lunchroom vending machines or from the food truck, usually eating in the lunchroom.

The Alleged Work-Related Incident

10. According to the Claimant and Christopher Rangel, a co-worker, on September 6, 2014, a Saturday, the Claimant and Rangel, took a 15-minute break. While on break, the pair went to CTDI's lunchroom because Rangel wanted to purchase an energy drink from a vending machine inside and the Claimant wanted to use the restroom located nearby. According to the Claimant and Rangel, Rangel attempted unsuccessfully to open the doors to the lunchroom. Believing that the doors to CTDI's lunchroom were locked, the Claimant and Rangel exited the warehouse to take a smoke break outside. While outdoors and smoking the duo discovered that the food truck was not on the premises that day either.

The Injury Incident

11. The Claimant allegedly believing that CTDI's lunchroom was inaccessible, and observing that the food truck was absent, chose to leave the jobsite to purchase lunch. The Claimant and several co-workers (Roberto Castillo, Paul Littlejohn, and Christopher Rangel) drove to a nearby Wendy's restaurant. The Claimant rode in the front passenger seat. During the drive to Wendy's, the Claimant and his co-workers were involved in a motor vehicle collision (MVA). Roberto Castillo, the driver, ran a red light and his vehicle was T-boned in an intersection by another automobile. The vehicle rolled several times, and ejected the Claimant onto the pavement. He was transported by ambulance to Denver Health Medical Center, where he was admitted to the Intensive Care Unit.

12. The Respondents' witnesses presented and testified more credibly than the Claimant and Rangel. The Respondents' witnesses had less interest in the outcome than the Claimant and Rangel. Indeed, to accept the Claimant's version of events, the ALJ would be required to find an unusual anomaly, without supporting evidence, that the lunchroom was mysteriously inaccessible on the day in question when there were no locking mechanisms according to all of the Respondents' witnesses. The Claimant's and Rangel's version of events makes no sense unless one would accept a "grand conspiracy theory" to lie on the part of all of the Respondents' witnesses. To do so, without any evidentiary basis, would be arbitrary and capricious on the part of the ALJ. Between conflicting sets of evidence, the ALJ makes a rational choice to accept the credible testimony of the Respondents witnesses, and to reject the ultimate testimony of the Claimant that the lunchroom was inaccessible on the Saturday in question. Indeed, the preponderance of evidence supports the proposition that the lunchroom was incapable of being locked and inaccessible on the Saturday in question. The testimony of Respondents' witnesses was more persuasive and credible than the testimony of the Claimant and Rangel because the Respondents' witnesses, among other things, were more familiar with CTDI's warehouse facility, its lunchroom, and the company's procedures relating to work scheduling as well as the availability of resources. Indeed, the temporary job service was the Claimant's employer and not CTDI, which had no monetary interest in the outcome of the Claimant's workers' compensation claim.

Medical

13. As a result of the collision, the Claimant suffered serious and significant injuries to his head, back, right elbow, arms, and hands. Specifically, his injuries included: "(1) right orbital fracture; (2) right frontal hemorrhagic contusion; (3) right subdural hematoma; (4) occipital degloving; (5) right eyebrow/forehead lacerations; (6) right optic neuropathy; and (7) right open elbow fracture." (Claimant's Exhibit 2, Pages 2-6).

14. The Claimant remained unconscious in the Intensive Care Unit at Denver Health Medical Center from September 6 - 10, 2014. During that span, on September 7, 2014, the Claimant underwent emergency surgery to repair his various injuries.

15. On September 11, 2014, the Claimant was discharged from Denver Health Medical Center. Since that time until the present, the Claimant has visited several doctors and other medical specialists who are assisting him in recuperating from his injuries. Claimant is diligently working towards his recuperative goals.

16. The Claimant suffers lingering impairments as a result of the September 6, 2014 collision. As assess by Susan E. Ladley-O'Brien, M.D., on December 11, 2014, the Claimant endured "a traumatic brain injury with residual cognitive difficulties, headache, fatigue, irritability, loss of vision in the right eye due to optic nerve trauma,

right shoulder bicipital tendinitis, and healing right elbow arthrotomy" (Claimant's Exhibit 9, p. 73).

Ultimate Findings

17. The Respondents' witnesses presented and testified more credibly than the Claimant and Rangel for the reasons specified in paragraph 12 herein above. The Respondents' witnesses had less interest in the outcome than the Claimant and Rangel. Their testimony was more consistent with reason and common sense. The Claimant and Rangel's version that the lunchroom was inaccessible on the Saturday in question is without any visible means of support. Between conflicting sets of evidence, the ALJ makes a rational choice to accept the credible testimony of the Respondents witnesses, and to reject the ultimate testimony of the Claimant that the lunchroom was inaccessible on the Saturday in question.

18. The Claimant has failed to prove, by a preponderance of the evidence, that he sustained an industrial accident resulting in multiple injuries to his body including, but not limited to, his head, back, right elbow, arms, and hands. His medical injuries are therefore not compensable in contemplation of law because he was outside the course and scope of employment, on his way to or from and off-premises lunch break, when the on-premises lunchroom was accessible. Consequently, the Claimant was not in the course and scope of his employment and the resultant injuries and disfigurement suffered as a result of the September 6, 2014 car collision are not work-related.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." See *Kroupa v. Indus. Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The ALJ determines the credibility of the witnesses. *Arenas v. Indus. Claim Appeals Office*. 8 P.3d 558 (Colo. App. 2000). The weight and credibility to be assigned

evidence is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*. 55 P.3d 186 (Colo. App. 2002). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. See *Prudential Ins. Co. V. Cline*, 98 Colo. 275, 57 P.2d 1205 (1930); CJI, Civil, 3:16 (2005). As found, the Respondents witnesses were more credible than the Claimant and Rangel for the reasons specified in paragraph 12 herein above. As further found the testimony of Respondent's witnesses were more persuasive and credible than the testimony of Claimant's witness because, among other things, the Respondents' witnesses were more familiar with CTDI's warehouse facility, its lunchroom, and the company's procedures relating to work scheduling as well as the availability of resources, critical facts concerning the accessibility of the lunchroom on the Saturday in question.

Substantial Evidence

b. As found, between conflicting sets of evidence, the ALJ made a rational choice to accept the credible testimony of the Respondents' witnesses and to reject the testimony of the Claimant and Rangel. Beyond the testimony, Claimant tendered no substantial evidence to substantiate his assertion that CTDI's lunchroom was locked. If the Claimant offered any persuasive evidence that doors were capable of being locked, his assertion that the doors were locked on a particular day could become more probable and plausible. Lacking such evidence, the ALJ is left to decide the case based on Claimant's and Respondents' conflicting in court testimony, which weighs in favor of the doors being incapable of being locked, thus, making the lunchroom on CDTI's premises accessible on the Saturday in question.

Course and Scope of Employment

c. Off-remises lunchtime travel generally falls within the "to and from work" rule and is not compensable because the claimant was free to do what he wanted at lunchtime. *Perry v. Crawford & Co.,* 677 P.2d 416 (Colo. App. 1983). In *Perry,* the claimant went to lunch at a nearby restaurant and was struck by a car on the trip back to the employer's premises. The court determined that the absence of lunch facilities at work was not a sufficient nexus to the employment to make the claimant's injury compensable. As found, the Claimant's injuries resulting from the auto accident occurred during the drive to Wendy's when the Claimant and his co-workers were involved in a motor vehicle collision (MVA). Roberto Castillo, the driver, ran a red light and his vehicle was T-boned in an intersection by another automobile. The vehicle rolled several times, and ejected the Claimant onto the pavement. As found, the accident occurred "to and from work" to get lunch at Wendy's.

d. A narrow exception to the "to and from" rule was articulated In *City & County of Denver School Dist. No. 1 v. Indus. Comm'n*, 196 Colo. 131, 131, 581 P.2d 1162, 1162 (1978), the Supreme Court of Colorado held that an automobile accident in which school board employees were injured occurred within the scope of the employees' employment, and that the injuries were therefore subject to workers' compensation. In that case, the accident happened when the employees were driving to lunch on a day on which they were later required to be at school for a teachers' meeting. Normally, the teachers had the option of going off the school premises for lunch or eating at the school cafeteria. On the day of the accident, the school cafeteria was closed. The claimants and some of their co-employees decided to drive to a restaurant for lunch. During the trip to the restaurant, the claimants were injured. *Id*. at 132. Applying the totality of the circumstances test, the Court held that there was sufficient evidence in the record to support the finding of the Industrial Commission that claimants were acting within the scope of their employment when injured. *Id*. at 133. As found, the Claimant's testimony that the lunchroom was inaccessible on the Saturday in question was not credible and it made no sense in the context of the totality of the evidence. Indeed, the preponderance of evidence supports the proposition that the lunchroom was incapable of being locked and inaccessible on the Saturday in question. The testimony of Respondents' witnesses was more persuasive and credible than the testimony of the Claimant and Rangel because the Respondents' witnesses, among other things, were more familiar with CTDI's warehouse facility, its lunchroom, and the company's procedures relating to work scheduling as well as the availability of resources. Consequently, the lunch room at CDTI was accessible and available on the day in question, and the Claimant and his co-workers chose to go off the premises to have lunch, thus, the auto accident does **not** fall under the narrow exception enunciated in *City & County of Denver School Dist. No. 1 v. Indus. Comm'n, supra.* The Claimant's injuries resulting from the auto accident, as found, occurred when the Claimant was outside the course and scope of his employment because he was "coming from" work to have lunch at Wendy's.

Burden of Proof

e. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits §§ 8-43-201 and 8-43-210, C.R.S. See *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 884 (Colo. App. 2000)*; Lutz v. Indus. Claim Appeals Office*, 24 P.3d 29 (Colo. App. 2000). *Kieckhafter v. Indus. Claim Appeals Office*, 284 P.3d 202, 205 (Colo. App. 2012). 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*, 197 Colo. 306, 592 P.2d 792 (1979). *People v. M.S.*, 104 P. 3d 273 (Colo. App. 200); *Hoster v. Weld County Bi-Products, Inc*. W.C. No.: 4-483-341 [Indus. Claim Appeals Office (ICAO), March 20, 2002]. Also

see *Ortiz v. Principi*, 274 F.3d 1361 (D.C. Cir. 2001). Preponderance: means "the existence of a contested fact is more probable than its nonexistence." *Indus. Claim Appeals Office v. Jones*, 688 P.2d 1116 (Colo. 1984). As found, the Claimant failed to sustain his burden on the designated issues.

ORDER

IT IS, THEREFORE, ORDERED THAT:

Any and all claims for workers' compensation benefits are hereby denied and dismissed.

DATED this _____ day of July 2015.

EDWIN L. FELTER, JR.
Administrative Law Judge

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 CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the 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 § 8-43-301(2) C.R.S. (As amended, SB 09-070). 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.coloado.gov/dpa/oac/forms-WC.htm.

CERTIFICATE OF MAILING

I hereby certify that on I have sent true and correct copies of the foregoing Full Findings of Fact, Conclusions of Law and Order on this _____ day of _____ 2015, electronically in PDF format, addressed to:

Division of Workers' Compensation
cdle_wcoac_orders@state.co.us

_____
Court Clerk

Wc.ord

ISSUES

The following issues were raised for consideration at hearing:

1. Did Claimant prove that he sustained a compensable injury within the course and scope of his employment with Employer?

2. If claimant sustained a compensable injury, did he prove by a preponderance of evidence that the ongoing medical treatment and, specifically, the request for a total hip replacement, is reasonable, necessary and causally related to the work injury?

FINDINGS OF FACT

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

1. Claimant works for Employer as a store manager and had done so for three and a half years.

2. Claimant's duties include all aspects of operating the store. He is required to do paperwork, unloading of inventory, stocking, and inside and outside sales. The inventory that the store receives arrives in large plastic totes. They are supposed to weigh no more than 60 lbs but frequently the totes exceed this weight.

3. On April 8, 2014, Claimant was lifting an overweight tote and he felt a pop in the front of his right hip. Claimant dropped the tote and felt pain in his hip which was constant.

4. Claimant reported the injury to his supervisor, Martin Royer. Mr. Royer instructed Claimant to fill out an accident report, and to report the injury to the risk management and human resources departments. Claimant was directed to go to one of two clinics.

5. Claimant chose HealthOne from the list and went to that clinic where he was treated by Dr. Jeffrey Hawke.

6. Dr. Hawke diagnosed Claimant as having a strain of the right hip and ordered an x-ray. In his April 9, 2014, report, Dr. Hawke stated that the hip injury was work related. Claimant received physical therapy from HealthOne but this did not lessen the pain. After that, Dr. Hawke recommended an MRI of the hip.

7. Claimant had two MRIs. One MRI was without contrast and it did not show any injury to the hip. Dr. Hawke then ordered a MRI with contrast and it showed a labral tear. Dr. Hawke then sent Claimant to Cornerstone Orthopedic where he was seen by Dr. Thomas Mann and Dr. Thomas Eichmann. X-rays were taken which showed mild osteoarthritis in both hips and a labral tear in the right hip. A total hip replacement was recommended.

8. Insurer denied liability for the injury and denied authorization for the hip replacement. Claimant went forward with the surgery and it was paid for by his medical insurance carrier. The surgery occurred on December 15, 2014. Claimant missed five weeks from work as the result of the surgery.

9. Claimant did not have problems with either hip prior to lifting the tote at work. His hobbies have included golfing and hiking and he was able to do all of his activities at work and outside of work without hip problem prior to April 8, 2014.

10. Claimant testified that his symptoms were much better following the surgery and that he continues to improve.

11. Dr. Mann is quoted in Dr. Samuel Chan's November 6, 2014, report as saying that there were degenerative changes in the hip that were exacerbated by the work injury and that the patient may need to have a total hip arthroplasty.

12. Dr. Brooks Conforti provided treatment for Claimant. She stated in her June 18, 2014, report that the patient sustained a strain affecting the muscles of the hip and also the lumbopelvic juncture. She reiterates that Claimant suffered an on-the-job injury to his hip in her June 25, 2014, report. She treated Claimant with osteopathic manipulation and trigger point injections. While seeing Dr. Conforti, Claimant reported slipping on a ladder at work and having pain in his back as a result.

13. Dr. Mann stated in his October 21, 2014, report that Claimant had a labral tear and underlying hip arthritis. He stated that the injury "progressed the labral tear," but that the benefits of an arthroscopy would be short-lived due to the underlying arthritis. Regarding causation, he said it is "multifactorial with the aggravating work injury contributing and possibly progressing the underlying arthritis."

14. Dr. Bisgard performed an independent medical examination at the request of Claimant. She is board certified in occupational medicine and Level II accredited. Part of her education in occupational medicine included training in determining causation of an injury. She has also taught classes on causality analysis. Dr. Bisgard stated that she obtained a history from Claimant which was consistent with the history given to his medical providers.

15. Dr. Bisgard testified that the original MRI of Claimant's hip did not show a labral tear because it was not done with contrast. However, the tear was identified on a

repeat MRI which was done with contrast. She also stated that the x-ray showed that Claimant had arthritis in both of his hips. The fact that there was arthritis in both hips was significant to Dr. Bisgard because only the hip that was injured at work was symptomatic. The left hip remained asymptomatic. She stated that the injury to the right hip likely caused the labral tear and caused a cascade of pain from the labral tear that caused the arthritis to become symptomatic. Dr. Bisgard testified that when the labrum tears there is a reaction causing inflammatory cells to come in which starts a pain pathway. This is enough to cause arthritis to flare and precipitate more pain and inflammation. She said that many people have arthritis from which they suffer no symptoms until there is a trauma.

16. Dr. Bisgard credibly opined that, in Claimant's case, it was the lifting of the heavy tote, combined with lifting and twisting that caused the injury to Claimant's hip and caused the arthritis to become symptomatic. Dr. Bisgard stated that there was no record of Claimant having any right hip symptoms prior to the injury at work.

17. In determining causation, Dr. Bisgard stated that she diagnosed degenerative joint disease and a labral tear. She then looked at the onset of symptoms as it correlated with the diagnosis and to see if the described mechanism could have caused the injury. She credibly opined that it was more than 50% likely that the symptoms were related to the work injury. She stated that it was unlikely that Claimant's preexisting arthritis happened to become symptomatic independent of the injury but at the exact same time as the injury. She cited the *Medical Treatment Guidelines* (Exhibit 20.) which state that "The provider must establish a change in the patient's baseline condition and a relationship to work activities including but not limited to repetitive heavy lifting or specific injury to the hip." Dr. Bisgard opined that Claimant's injury fits within these guidelines as Claimant had a baseline condition of no pain or symptoms and then, as a result of a specific injury, his preexisting osteoarthritis became symptomatic.

18. With regard to the labral tear, Dr. Bisgard credibly opined that if the symptoms were only from the labral tear, the treatment would be to simply repair the tear, but with the underlying arthritis, now symptomatic from the injury, the best course would be to replace the hip. It was her opinion that without the incident of April 8, 2014, Claimant would probably not have needed the hip replacement. She also stated that Claimant had a very good outcome from the surgery and was back to work soon thereafter.

19. On cross examination, Dr. Bisgard confirmed that the radiologist said the labral tear was chronic, but the doctor opined that it was unclear what he meant by chronic since the MRI was taken six months after the injury. According to the doctor, it was uncertain if the radiologist meant that it was of 6 months duration or longer than that. She stated that there was no other explanation why Claimant would suddenly develop pain in his hip that never went away immediately following the episode at work, other than her conclusion that the incident caused the preexisting condition to become symptomatic and require treatment.

20. Dr. Bisgard was questioned about Dr. Conforti statement in her July 28, 2014, report that Claimant reached baseline from his slip at work. Dr. Bisgard said that Dr. Conforti was talking about Claimant's back which was injured when he slipped coming down a ladder at work. This occurred after the August 8, 2014, lifting incident. Dr. Bisgard concluded that the baseline that Dr. Conforti was referring to was Claimant's condition before the slip and not before the lifting incident, as there was no slip during the lifting incident.

21. Dr. Bisgard was directed to a sentence in the *AMA* guides that refers to other causative factors to consider in order to determine if a previous trauma was the cause of the arthritis. Dr. Bisgard credibly opined that the section is clearly speaking of arthritis being caused by trauma and not preexisting arthritis becoming symptomatic due to trauma.

22. The fact that the left hip also shows an arthritic condition was significant to Dr. Bisgard because she could do a side-by-side comparison and observe that both hips have the same condition but there were no symptoms in the left hip and there was pain in the right hip. She stated that the variable was the injury to the right hip while working for the Employer.

23. Dr. Bisgard opined credibly that she frequently sees pre-existing asymptomatic arthritis become symptomatic with trauma and that this is what occurred in Claimant's case.

24. Dr. Wallace Larson testified as an expert witness on behalf of the Respondents. He is board certified as an orthopedic surgeon. He performed an independent medical examination at the request of the Respondents.

25. Dr. Larson testified that according to the radiologist report, the labral tear was complex involving multiple tears. He opined that this meant the labral tears were degenerative in nature and caused by a deformity in the femoral head which tore at the labrum over time. He stated that complex tears are chronic in nature. He opined the mechanism of injury would not cause trauma to the hip joint and the arthritis was not caused by the lifting. He opined the total hip replacement was not work related.

26. Dr. Larson opined that Claimant's work-related injury was a muscle strain, and that he would have certainly recovered from a muscle strain. However, he was unable to explain why the pain had not gone away until after the surgery.

27. The ALJ credits Dr. Bisgard testimony as being more persuasive on the issue of the cause of Claimant's preexisting and previously asymptomatic right hip osteoarthritis becoming symptomatic. It is found that, while Claimant has arthritic conditions in both hips, the cause of the right hip becoming painful and requiring surgery was the injury which occurred at work on August 8, 2014. It is also found that the total hip replacement surgery was performed by an authorized treating

physician and that it was reasonable and necessary to cure and relieve the effects of Claimant's work-related injuries.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

1. 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. 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.

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 Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *Bodensieck v. Industrial Claim Appeals O*ffice, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

3. 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. Proof by a preponderance of the evidence requires the proponent to establish the existence of a "contested fact is more probable than its nonexistence." *Page v. Clark*, 592 P.2d 792, 800 (Colo. 1979). Whether the claimant sustained his burden of proof is a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997).

4. 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). However, the right to workers' compensation benefits, including medical benefits, arises only when an injured employee establishes by a preponderance of the evidence that the need for 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.; *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo.App.2000). 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. Medical evidence is not required to establish causation and lay testimony alone, if credited, may constitute substantial evidence to support an ALJ's determination regarding causation. *Industrial Commission of Colorado v. Jones*, 688 P.2d 1116 (Colo. 1984); *Apache Corp. v. Industrial Commission of Colorado*, 717 P.2d 1000 (Colo. App. 1986).

5. If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicor*y, 805 P.2d 1167 (Colo.App. 1990). In this case, the totality of the evidence supports a conclusion that claimant suffered from a latent pre-existing osteoarthritis in the right hip which manifested after the Claimant lifted an overweight tote at work and felt a pop in his hip. Such injuries are compensable. *Subsequent Injury Fund v. Devore*, 780 P.2d 39 (Colo. App. 1989); *Seifried v. Industrial Commissi*on, 736 P.2d 1262 (Colo.App. 1986). As found, Claimant has proven by a preponderance of the evidence that he suffered a compensable aggravation of a pre-existing condition when he lifted the tote at work. This aggravation made the hip replacement necessary. All of the credible and persuasive evidence supports that the arthritis in the Claimant's hip was asymptomatic up until the lifting episode and then became symptomatic immediately thereafter.

ORDER

It is therefore ordered that:

1. Claimant's April 8, 2014, hip injury, including the aggravation of his preexisting right hip arthritis, is compensable.

2. Respondents are liable for reasonably necessary and related medical treatment of the hip injury, including the total hip replacement.

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: ___July 23, 2015_____

DIGITAL SIGNATURE:

Margot W. Jones

_____

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

ISSUES

I. The issues addressed in this decision involve Claimant's entitlement to disfigurement benefits and maintenance medical treatment.

FINDINGS OF FACT

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

1. On May 29, 2014, Claimant sustained an admitted injury to his left elbow while employed as a recruit for the Colorado Springs Police Department. During combat training the weight of Claimant's training partner came down on his outstretched arm dislocating his left elbow.

2. Claimant was taken to the emergency room at Memorial Hospital where his elbow was reduced and splinted. Claimant subsequently sought and received medical treatment through the designated treating provider, the City Occupational Health Clinic under the direction of Dr. Miguel Castrejon and Nurse Practioner (NP) Paulette Miksch. As noted, Claimant's elbow was splinted. He was also provided Meloxicam and Norco for pain. Through the authorized chain of referrals, Claimant also received medical treatment from orthopedic specialist Dr. Christopher Jones.

3. Dr. Jones first evaluated claimant on June 6, 2014 and determined at that time that he would treat Claimant non-operatively. Dr. Jones placed Claimant into a hinged elbow brace which blocked his elbow extension at approximately 30 degrees. Claimant was scheduled for follow-up in two weeks at which time Dr. Jones anticipated increasing claimant's extension to a negative 15 degrees. Overall, Dr. Jones anticipated six weeks of splinting.

4. Claimant returned to Dr. Jones on June 23, 2014. Dr. Jones noted that Claimant was doing well with improvement in his pain, although he continued to have a "little neurapraxic pain . . . relative to the superficial radial nerve." Claimant's splinting was adjusted to a negative twenty degree extension block and he was instructed to return to the clinic in two weeks.

5. While receiving treatment from Dr. Jones, Claimant concurrently continued treatment with Dr. Castrejon and NP Miksch.

6. On June 27, 2014, NP Miksch documented that Claimant "may stop Meloxicam and start Ibuprofen 800 mg tid with food" and continue "Norco if needed." Ambien was added to Claimant's medications as he was having difficulty sleeping.

7. By July 28, 2014, due to good progress, Dr. Jones directed Claimant to return to activities as tolerated and permitted Claimant to discontinue use of the hinged brace when he was not participating in physical activity. Dr. Jones intended to "protect" Claimant in this fashion for an additional six weeks after which he would re-evaluate for potential full-release from care.

8. On August 20, 2014, Paulette Miksch documented that Claimant was permitted to judge his own physical restrictions, noting that he experienced a pain level of 1 on a scale of 10 while at rest and upwards of 6/10 with activities. Left elbow range of motion (ROM) was measured at 0-120 degrees and right elbow ROM was measured at 0-140 degrees. Left pronation and supination was painful and mildly limited. Although an MRI, which demonstrated a rupture of the lateral ulnar collateral ligament (LUCL) had been obtained by the date of this visit, Dr. Jones continued to recommend PT and strengthening as surgery was not indicated and "often" resulted in negative outcomes for injuries such as Claimant's.

9. During his August 20, 2014 appointment with NP Miksch, Claimant completed a PATIENT FOLLOW-UP VISIT questionnaire in which Claimant documented that he was currently taking Ibuprofen among other medications. Consequently, while NP Miksch ceases references regarding the need for Ibuprofen and Norco in her notes after July 11, the ALJ finds that Claimant probably continued to take Ibuprofen through his August 20 appointment with NP Miksch as documented in his Patient Follow-Up Visit questionnaire.

10. On September 8, 2014, Claimant was re-evaluated by NP Miksch who added Dermatran Cream with Tramadol for continued pain and trigger points in the elbow and biceps.

11. On September 17, 2014, Claimant returned to NP Miksch who documented continued improvement in Claimant's pain levels and ROM. During this encounter, Claimant reported a "dull ache" in the elbow, but no pain. As noted above, Dermatran with Tramadol had been added to Claimant's treatment regime on September 8, 2014, which Claimant was instructed to continue to use as directed.

12. Claimant returned to Dr. Jones on September 22, 2014. Dr. Jones' medical examination of Claimant that date showed Claimant to have full extension, full pronation and supination, and improved stability of the elbow. He documented that Claimant had "really turned the corner and is starting to feel better. [Claimant] started doing some weights. As soon as he started to do that, the pain started to subside and his strengthen [sic] is starting to improve."

13. Dr. Jones released Claimant to full duty on September 22, 2014. Although Dr. Jones did not recommend specific maintenance care he noted that "[Claimant] will return to see me only as needed."

14. On September 26, 2014, Claimant reported to NP that the Dermatran was helpful for his discomfort. Consequently, NP Miksch documented that Claimant was to "continue Dermatran Cream #6 with Tramadol to elbow and biceps" as directed.

15. On October, 21, 2014, Claimant was instructed to discontinue the Dermatran Cream with Tramadol secondary to development of a rash in the area of the left elbow, biceps and forearm. Additional medications were added to cure his rash.

16. On November 20, 2014, Dr. Castrejon placed claimant at maximum medical improvement, documenting that Claimant had full pronation and supination, no discomfort with pronation and supination, and only a very mild dull ache that did not interfere with Claimant's full duty work activities

17. Dr. Castrejon specifically stated when placing Claimant at MMI that "[m]aintenance care is not indicated." Indeed, Dr. Castrejon did not even recommend that claimant required an ongoing home exercise program. Rather, Dr. Castrejon returned Claimant to full duty without work restrictions. Nevertheless, the PATIENT FOLLOW-UP VISIT questionnaire indicates Claimant's response as "same" to question 3: What are the names of the MEDICATIONS that you are taking? As noted above, the prior Patient Follow-up Visit questionnaire completed August 20, 2014 indicated that Claimant was taking Ibuprofen. Consequently, the ALJ infers and finds from these questionnaires that Claimant, more probably than not, continued his use of Ibuprofen between August 20, 2014 and November 20, 2014 when he was placed at MMI.

18. Respondent filed a final admission of liability (FAL) on December 3, 2014 consistent with Dr. Castrejon's report of MMI in which it denied liability for any maintenance medical care per Dr. Castrejon's specific statement that maintenance care is not indicated.

19. Claimant filed an objection to the FAL and an application for hearing endorsing the issues of medical benefits, reasonably necessary, Grover meds should remain open, and disfigurement.

20. At hearing, claimant testified that he continues to experience left elbow pain for which he takes Ibuprofen from 1 to 3 times per day. He does not know if he should push continued exercise or back off due to persistent pain. Consequently, Claimant testified that he would like to return to Dr. Jones for further evaluation. Claimant testified that the pain he currently experiences "is the same as when [he] last saw Dr. Castrejon." Claimant last saw Dr. Castrejon on November 20, 2014 when he was placed at MMI during which time the ALJ finds that Claimant was using Ibuprofen for pain control. Based upon complete and careful review of the medical records, the ALJ finds support for Claimant's testimony concerning his ongoing symptoms and his

continued need to take Ibuprofen for pain/discomfort related to his admitted work injury. The medical records reveal that over the course of his treatment Claimant has been prescribed various medications, including Ibuprofen and Norco to address the pain problems attendant with his injuries. A self reported listing of Claimant's medications at the time of MMI simply indicates "same" which previously included Ibuprofen. Consequently, the ALJ finds Claimant's testimony regarding the necessity for the use of Ibuprofen to cure and relieve him of ongoing pain associated with his industrial injury credible and convincing. Without ongoing medication, the ALJ finds that Claimant's condition will likely deteriorate.

21. Claimant testified that he understood per Dr. Jones and NP Miksch that he was to return to Dr. Jones after physical therapy if he felt he had not improved. Respondents contend that neither the last record of Dr. Jones dated September 22, 2014 nor any of the reports issued by NP Miksch leading up to Claimant's placement at MMI or the MMI report of Dr. Castrejon reference any recommendation for Claimant to Dr. Jones for reevaluation. The undersigned ALJ is not persuaded. Based upon the totality of the evidence presented, the ALJ finds Respondent's interpretation of Dr. Jones' September 22, 2014 exceedingly narrow. While Dr. Jones' September 22, 2014 report does not use the terms "recommend" or "re-evaluation", it does indicate that Claimant will return to his attention only on an as needed basis. The ALJ infers and finds that Dr. Jones' use of the term "only" was not intended to preclude Claimant from returning for further assessment. Rather, the ALJ finds that the term "only" and the phase in its entirety, more probably meant that Claimant was not going to be scheduled for additional routine appointments and that he "will" return as needed. Accordingly, the ALJ credits Claimant's testimony to find that Dr. Jones, more probably than not, advised Claimant to return for further assessment if symptoms persisted. Because Claimant's symptoms have persisted despite the use of analgesics, a "re-evaluation" with Dr. Jones is warranted, i.e., it is reasonably necessary to maintain and otherwise prevent further deterioration of Claimant's condition.

22. The ALJ credits the medical records and Claimant's testimony to find that he is in need of maintenance medical treatment; including Ibuprofen and a return visit to Dr. Jones for further evaluation regarding the etiology of his ongoing pain and discomfort in order to prevent further deterioration of his condition.

23. Claimant has a visible disfigurement to the body consisting of mild swelling to the lateral portion of the left elbow when compared to the right as a consequence of his left elbow dislocation injury.

CONCLUSIONS OF LAW

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

General Legal Principals

A. The purpose of the Workers' Compensation Act of Colorado is to assure 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).* Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. 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).

B. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16.

C. A workers' compensation case is decided on its merits. *Section 8-43-201*. In accordance with Section 8-43-215, C.R.S., this decision contains Specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. See *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Maintenance Medical Benefits

D. Claimant is entitled to ongoing medical benefits after MMI if he presents substantial evidence that future medical treatment will be reasonably necessary to relieve the claimant of the effects of the injury or prevent deterioration of the claimant's condition. *Grover v. Industrial Commission,* 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995).

E. 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, 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 then enter a "general order similar to that described in Grover." Thus, while Claimant does not have to prove the need for a specific medical benefit, he must prove the probable need for some treatment after MMI due to the work injury. *Milco Construction v. Cowan*, *supra*. The question of whether the claimant met the burden of proof to

establish an entitlement to ongoing medical benefits is one of fact for determination by the ALJ. *Holly Nursing Care Center v. Industrial* Claim Appeals Office, 992 P.2d 701 (Colo. App. 1999); *Renzelman v. Falcon School District,* W. C. No. 4-508-925 (August 4, 2003).

F. Here, the ALJ concludes that Claimant has met his burden to establish his entitlement to maintenance medical treatment. Substantial persuasive evidence demonstrates that there is a need to treat Claimant's ongoing chronic pain caused by the injuries sustained in this admitted claim. The Claimant was injured in excess of one year ago and has completed a course of physical therapy. Yet, he continues to have persistent pain which he credibly testified is relieved by the use of medications previously provided. Without ongoing treatment and medications, Claimant's present condition will likely deteriorate further. Moreover, the ALJ is not persuaded by Respondent's suggestion that the return to Dr. Jones on an as needed basis constitutes a speculative statement/recommendation supporting a conclusion that Claimant is not entitled to maintenance care because there was "no way to determine whether claimant would actually require a return to Dr. Jones at the time Dr. Jones issued the September 22, 2014 medical treatment record." To the contrary, the ALJ concludes that Claimant proved such "need" to return to Dr. Jones at hearing. Claimant has proven, by a preponderance of the evidence that there is a probable need for treatment post MMI, to maintain MMI and otherwise prevent deterioration of his current condition entitling him to an order for ongoing medical benefits.

G. Claimant is entitled to ongoing medications and follow-up with his authorized treating physicians subject to Respondent's right to challenge any specifically requested future care or form of treatment based on established case law. *See for example, Hanna v. Print Expediters, Inc.* 77 P.3d 863 (Colo. App. 2003). *See Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003) (a general award of future medical benefits is subject to the employer's right to contest compensability, reasonableness, or necessity).

H. In *Arkin v. Industrial Commission*, 145 Colo. 463, 358 P.2d 879 (1961), the Court held that the term "disfigurement" as used in the statute, contemplates that there be an "observable impairment of the natural person." As found in this case, Claimant has mild swelling of the lateral portion of his left elbow which the undersigned ALJ concludes constitutes a disfigurement as provided for by Section 8-42-108 (1), C.R.S.

ORDER

It is therefore ordered that:

1. Claimant is entitled to ongoing medical treatment reasonably necessary and related to his May 29, 2014 industrial injury to maintain MMI. Respondents shall pay for the attendant cost associated with Claimant's use of Ibuprofen as well as the attendant cost of reasonably necessary and related follow-up visit(s) with Dr. Jones.

2. Respondent-Employer retains the right to dispute any treatment recommended on the basis that the need for treatment is not causally related to Claimant's May 29, 2014 work injury and/or that the recommended treatment is not reasonable or necessary.

3. Claimant has sustained a serious permanent disfigurement to areas of the body normally exposed to public view, which entitles Claimant to additional compensation. Respondent-Employer shall pay Claimant $500.00 for that disfigurement. Insurer shall be given credit for any amount previously paid for disfigurement in connection with this claim.

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: July 23, 2015

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

1. Whether Claimant has established that she suffered a compensable injury to her left upper extremity/shoulder arising out of and in the course of her employment with Employer on September 9, 2014.

2. If the claim is compensable, whether Claimant has established that an MRI of the left shoulder as recommended by Dr. Kawasaki is reasonable, necessary, and related to Claimant's September 9, 2014 work injury.

PROCEDURAL

Claimant endorsed the issue of a neck injury in addition to the left upper extremity/shoulder injury. At the outset of hearing, Claimant withdrew the issue of a neck injury and proceeded solely on the left upper extremity/shoulder issue.

FINDINGS OF FACT

1. Claimant has worked for Employer as an Engineer Technician evaluating well permits for approximately 22 years. Her job duties involve primarily sitting at a computer desk, mousing, keyboarding, and talking on the phone. Claimant has been at her current desk/work station for approximately 18 years without significant changes.

2. Claimant testified that she has had pre-existing problems with her neck for three to four years or possibly longer. Claimant testified that she woke up one morning with some left shoulder pain and didn't really know exactly what it was from. Claimant reported that she noticed at work when she was on the job that she was in an awkward position while keying on the keyboard.

3. Claimant testified that while keying on the keyboard her left arm is above chest level, bent at the elbow, and sticking out to the left in an awkward position. Claimant testified that this is due to a wide keyboard tray and working centered on her mouse. Claimant testified that around early September of 2014 she had a lot of discomfort/pain, and limited mobility in her left arm to the point of being unable to lift it.

4. Claimant testified that other than the awkward keying at work she had not previously injured her left shoulder anytime in 2014 or before. Claimant reported she had not been treated or evaluated for any left shoulder problems or left shoulder pain since she had a tumor removed in the late 1990's.

5. Claimant reported her left shoulder pain to Employer and filled out an Employee Statement of Injury/Exposure form on September 23, 2014. For place of

accident/exposure Claimant reported, "not real sure if work related – just feeling discomfort while doing my job." For how the injury/exposure occurred Claimant reported, "not sure – have had neck pain and back pain for the past couple of years now having pain from neck to left shoulder to arm." For the date of injury/exposure Claimant reported, "no specific date, neck issues for past couple years now shoulder and arm since beginning of September, 2014." *See* Exhibit H.

Prior medical treatment

6. Claimant has had neck pain for more than a couple of years. Claimant has had documented neck pain for approximately 12 years and going back to at least 2003. In 2003 Claimant also reported that she had experienced neck stiffness in the past.

7. Claimant also has had left shoulder and arm pain prior to September of 2014. Claimant has had documented left shoulder/arm pain for approximately 11 years and going back to at least 2004.

8. Two months prior to Claimant's alleged injury, and on July 14, 2014 Samuel Clinch, M.D. evaluated Claimant. Claimant was diagnosed with bipolar disorder, borderline personality disorder, back and neck pain, poor appetite, and economic and other psychosocial and environmental problems. Claimant reported struggling with anxiety and sleep problems. Claimant reported ongoing economic concerns and bad reviews at work. Claimant also reported neck and back pain. *See* Exhibit G.

9. Approximately one year prior to her claim, and on September 9, 2013 Claimant underwent chiropractic treatment. Claimant reported neck pain and tightness that had been going on for years and that she was not sure what initially caused the pain. Claimant reported pain in her left lower neck and left upper trapezius. *See* Exhibit G.

10. A little over one year prior to her claim, and on July 2, 2013 Claimant was evaluated by Dianne Glenn, M.D. Claimant reported neck pain, *shoulder pain*, and upper back pain that was now *into her left arm*. Claimant reported that *lifting her left arm hurt and that she had numbness and tingling in her left arm* that comes and goes. *See* Exhibit G

11. On April 3, 2009 psychologist Laura Richardson evaluated Claimant. Claimant reported feeling stupid at work, missing major steps, making mistakes, and feeling that her Employer was trying to push her out. Claimant reported struggling to get her work done and getting it wrong. Claimant reported thinking of applying for long term disability because she felt she couldn't do her job, was afraid of another bad performance review, and because she was unable to transfer jobs. Claimant also reported *numbness/tingling in her thumb and first two fingers of her left hand*. *See* Exhibit G.

12. On March 30, 2004 physician assistant (PA) Michael Borkowski evaluated Claimant. Claimant reported pain between her shoulder blades, in her neck area, and *in her upper arms*. PA Borkowski noted she had recurrent episodes of upper back pain and *paresthesias in the back of her arms*. PA Borkowski noted objectively that Claimant had severe cervical and thoracic paraspinal spasm. *See* Exhibit G.

13. On August 8, 2003 Frances Macdonald, M.D. evaluated Claimant. Claimant reported neck pain and stiffness and *numbness and tingling in the lateral aspect of her left hand to the left wrist and reported her entire left arm felt sore.* Claimant reported to Dr. MacDonald that she had stiffness in her neck in the past. Dr. MacDonald noted objectively that Claimant had full range of motion in her neck with some discomfort on rotation to the left and some discomfort on full flexion. *See* Exhibit G.

14. On June 5, 1998 Claimant underwent surgery on her left shoulder to excise a mature adipose tissue which was removed and found to be consistent with a lipoma. *See* Exhibit G.

Current claim treatment

15. On September 9, 2014 Dr. Glenn evaluated Claimant. Claimant reported pain in the left neck and arm with no history of injury but that the pain was in her arm and worse when Claimant got up. Claimant reported her arm was achy and hurt more when she moved it. Dr. Glenn noted Claimants long history of neck pain. Dr. Glenn questioned whether the pain was work related (? If related to work) and noted that Claimant worked on a computer and was having an ergonomic evaluation. *See* Exhibit G.

16. On September 24, 2014 Julie Parsons, M.D. evaluated Claimant. Claimant reported discomfort in her left arm and left side of her neck for about a month. Claimant reported her work setup was not correct and that her company was working on a new setup. Claimant reported left shoulder, upper arm, and forearm pain that was getting worse. Claimant reported pain in the left lateral neck that radiates to the left shoulder, left upper arm, and left forearm. Dr. Parsons did not place Claimant on any work restrictions and returned Claimant to full work/activity. *See* Exhibit B.

17. On October 20, 2014 Timothy Mazzola, M.D. evaluated Claimant. Claimant reported left sided shoulder and neck pain down into the left arm and into the ulnar side of the forearm with no specific injury to her shoulder. Dr. Mazzola ordered X-rays of her shoulder and C-spine. The shoulder x-rays showed normal left shoulder without joint degenerative changes and a normal acromion. The C-spine X-rays showed degenerative disc disease, mild at C4-5 and more severe at C5-6 and C6-7 before normalizing at C7-T1. *See* Exhibit C.

18. On October 27, 2014 Claimant underwent an MRI of her C-spine that was interpreted by Robert Liebold, M.D. Dr. Liebold found no acute fracture or neoplastic marrow replacement process. His impression was mild to moderate C5-C6 central stenosis with moderate to severe left foraminal stenosis, and mild to moderate C6-7 central stenosis with moderate to severe left and moderate right foraminal stenosis. *See* Exhibit F.

19. On October 29, 2014 Dr. Mazzola evaluated Claimant. Claimant reported cervical spine pain, with less arm pain but that her neck really bothering her. Dr. Mazzola reviewed the C-spine MRI with Claimant and noted it showed central stenosis with moderately severe left sided neuroforaminal stenosis at both C5-6 and C6-7. He found that Claimant indeed had significant left sided neuroforaminal stenosis at C5-6 and C6-7 levels that affected the C6 and C7 nerve roots. *See* Exhibit C.

20. On November 3, 2014 Robert Kawasaki, M.D. performed a physical medical consultation. Claimant reported no specific injury to Dr. Kawasaki and indicated that she had had problems in her neck for a few years. Claimant reported developing pain in her neck, pain in her left shoulder, and pain in her left arm and believed that her work activities caused the problems to develop. Claimant reported while working her left shoulder and arm began having increasing pain. *See* Exhibit A.

21. Dr. Kawasaki indicated Claimant's cervical pain complaints were minimal, that she had weakness in her left shoulder that appeared to be pain generated from lack of shoulder motion, and left shoulder impingement with a firm mechanical block in shoulder abduction. Dr. Kawasaki recommended further investigation of Claimant's prior shoulder tumor resection, an MRI of the left shoulder with arthrogram, and further workup of the shoulder before performing cervical epidural steroid injections. *See* Exhibit A.

22. Dr. Kawasaki opined that Claimant's main pain generator may be the left shoulder. Dr. Kawasaki opined that if Claimant's cervical pathology was causing her symptoms it would be difficult to relate it to her job. Dr. Kawasaki opined that if her shoulder pathology was causing her complaints, then a job description and ergonomic evaluation would be helpful to determine her job activities and risk factors for a cumulative trauma type of injury. *See* Exhibit A.

23. On November 7, 2014 Dr. Parsons evaluated Claimant. Claimant reported intermittent left shoulder pain and that her symptoms had improved. Dr. Parsons assessed left shoulder strain. Dr. Parsons reviewed the ergonomic evaluation that had been performed. After review, Dr. Parsons opined to a reasonable degree of medical probability that Claimant's job duties did not meet criteria for any form of cumulative trauma disorder. *See* Exhibit B.

24. On January 8, 2015 Jack Sylman performed neurodiagnostic studies. Dr. Sylman noted Claimant's history of several months of left neck pain radiating down her left arm occasionally causing tingling of digits 2 and 3. Dr. Sylman provided the

diagnosis of cervical radiculopathy and opined that Claimant had left C5 chronic radiculopathy. *See* Exhibit G.

25. Claimant has not undergone the left shoulder MRI recommended by Dr. Kawasaki as the authorization was denied by Insurer.

Ergonomic evaluations

26. On September 9, 2014 Claimant completed an Ergopoint Self-Assessment. Claimant reported moderate concern with her workstation and identified the areas she had concern with. After identifying the areas of concern Claimant was provided recommendations for reducing ergonomic risk and improving the workstation.

27. On October 2, 2014 Jess Baysinger from the State of Colorado Office of Risk Management performed an ergonomic evaluation. Ms Baysinger recommended that: Claimant get a new ergonomic chair, Claimant not turn her neck to speak with other people entering her cubicle but turn her whole body; Claimant get a different keyboard tray that doesn't have a separation between the mouse and keyboard; Claimant get a different mouse that fits her hand better; Claimant get a headset for telephone use to ease neck and shoulder tension; and that Claimant take stretching breaks twice per day. *See* Exhibit D.

28. On October 28, 2014 Marianne Pullman, R.N. performed a job site evaluation. Ms. Pullman interviewed Claimant regarding her complaints, observed Claimant performing her job, and took photographs. Ms. Pullman identified that Claimant spends 8-9 hours per day on the computer, with the majority of the time spent on mapping activities requiring heavy use of the mouse with her right hand. *See* Exhibit E.

29. Claimant reported to Ms. Pullman having had neck pain for years but noticing left shoulder and left arm pain in early September. Claimant reported feeling the pain continuously even when not working. Ms. Pullman noted Claimant tended to center herself in front of her mouse on the right of her keyboard tray due to the heavy mousing work. Ms. Pullman noted that while seated to the right, Claimant often reaches her left arm across the length of the keyboard try to meet the alpha keys. Ms. Pullman noted that led to an awkward reach to the left which Claimant reported brings immediate pain to her left arm and shoulder. Claimant's left arm, in this position, is winged out from her flank. Ms. Pullman noted Claimant exhibited awkward posture of hands and arms while working on the keyboard. Ms. Pullman made several recommendations similar to those of Ms. Baysinger. *See* Exhibit E.

Credibility

30. Claimant's testimony lacks credibility. Claimant did not report prior pain and symptoms in her left arm/shoulder that pre-date her claim and denied having any pain or symptoms following her lipoma removal surgery in 1998. The medical records

document otherwise, and document several symptoms and reports of pain in the past that are similar to those she testified began in September 2014. Claimant also testified and demonstrated that she has to reach above chest level with her elbow bent to reach her keyboard. This is not credible nor is it reasonable based on Claimant's workstation and the position of her keyboard and mouse. The position in which Claimant demonstrated typing is an extremely unreasonable way to simply reach across to a keyboard. The ergonomic evaluation does not support that the extreme awkward angle that Claimant demonstrated was necessary for her to reach her keyboard or perform her job duties.

31. Dr. Kawasaki's testimony is found credible and persuasive. Dr. Kawasaki was unable to opine that Claimant's left shoulder complaints were work related. Dr. Kawasaki reviewed the job site evaluation and opined that the only activity that implicated the left shoulder was reaching to the side for the keyboard. Dr. Kawasaki opined that would not be an injurious activity and that there was a low probability that just reaching out to the side, even frequently, would cause a shoulder injury.

32. Dr. Kawasaki reviewed medical records and noted Claimant's long history of neck pain going back to 2003. Dr. Kawasaki opined that Claimant's presentation when he saw her included very similar symptoms as far as her neck pain and pain radiating up the left upper extremity that she has had in the past.

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*, 197 Colo. 306, 592 P.2d 792 (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. *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). 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,* 165 Colo. 504, 441 P.2d 21 (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

The Claimant is required to prove by a preponderance of the evidence that the conditions for which he seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. *See* § 8-41-301(1)(c), C.R.S. The 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). However, the mere occurrence of symptoms at work 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 may represent the result of or natural progression of a pre-existing condition that is unrelated to the employment. *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). 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).

Claimant has failed to meet her burden to prove by a preponderance of the evidence that she suffered a left upper extremity/shoulder injury proximately caused by her employment. As found above, there was no specific injury or trauma to Claimant's left upper extremity/shoulder. Claimant woke up one morning with pain and was unsure what caused it. Although Claimant reported pain while working and believed her work to be the cause of her pain, she has presented insufficient evidence to support this argument. There is insufficient evidence of an acute injury to the left shoulder/upper extremity. There is also insufficient evidence to support a claim of occupational disease to the left shoulder/upper extremity due to Claimant's job duties. As found above, Claimant had multiple pain complaints prior to the claim related to her left shoulder, arm, fingers on her left hand, and left trapezius area that are similar to the complaints she has following this claim. Claimant's arguments are not found

persuasive. She was not performing job duties at the time of a left shoulder injury. Rather, she woke up with increased pain and the medical records show she has had on and off pain in this same area for many years.

Claimant's testimony is not credible. Claimant reported no left shoulder/left upper extremity problems or symptoms following a lipoma removal surgery in 1998. Yet, the medical records show that on the following occasions she made the following complaints:

September 9, 2013 --	pain in left lower neck and left upper trapezius
July 2, 2013 -	shoulder pain, upper back pain that went into her left arm, pain lifting left arm, numbness/tingling in left arm
April 3, 2009 -	numbness/tingling in her thumb and first two fingers of her left hand
March 30, 2004 -	pain in upper arms with parasthesias in the back of her arms
August 8, 2003 -	numbness and tingling in the lateral aspect of her left hand to the left wrist and entire left arm sore

These symptoms are similar to those Claimant complains of in this claim including her more current complaints of achiness of left arm, tingling of digits 2 and 3 on her left hand, and neck pain that radiates into her left arm. These symptoms all existed prior to this claim despite Claimant's testimony otherwise. Further, Claimant's assertion that she was required to hold her left arm above chest level at an awkward angle to use her keyboard is not credible or persuasive. Although ergonomic recommendations were made, the ergonomic evaluations in this case do not support a conclusion that she was required to wing out her arm in the extremely awkward position she demonstrated in order to reach her keyboard. Claimant's testimony is not reasonable. The pictures support that her keyboard was located close to her, and her chair had wheels to move. There would be no reason to wing out her arm in such an extreme fashion just to get to the keyboard.

The medical providers in this case have not opined that her left shoulder/upper extremity pain is work related. Dr. Kawasaki opined that there was a low probability that just reaching out to the side to reach a keyboard, even frequently, would cause a shoulder injury. Dr. Parsons, after reviewing the ergonomic evaluation opined that Claimant's left shoulder/upper extremity symptoms were not work related. Dr. Parsons did not believe that Claimant's job duties would meet criteria for any kind of cumulative trauma disorder to her left shoulder/upper extremity. Dr. Syllman and Dr. Mazzola point to Claimant's C5-6 and C6-7 problems as the cause. Dr. Glenn initially at the first visit noted it was questionable whether the symptoms were work related. With several medical providers unable to make a causal connection to Claimant's job duties and employment and with Claimant's testimony of onset of symptoms not credible or persuasive, Claimant has failed to meet her burden to show that her employment

proximately caused any injury, aggravation, or acceleration to any symptoms in her left shoulder/upper extremity.

Medical Benefits

The respondent is liable for medical treatment which is reasonably necessary to cure and relieve the effects of the industrial injury. § 8-42-101 (1)(a), C.R.S.; *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Country Squire Kennels v. Tarshis*, 899 P.2d 362 (Colo. App. 1995). The 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); *Snyder v. Industrial Claim Appeals Office*, *supra.* Where a Claimant's entitlement to benefits is disputed, the Claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Id.* Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. *Faulkner v. Indus. Claim Appeals Office*, *supra; See* § 8-41-301(1)(c), C.R.S. Whether the claimant sustained his burden of proof is generally a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo.App. 1997).

Claimant seeks an MRI of her left shoulder as recommended by Dr. Kawasaki. Although an MRI of her left shoulder might be a reasonable step to determine if her current pain symptoms are coming from left shoulder pathology or are coming from her C5-6 and C6-7 neck pathology, Claimant has not established proof of causation or that an MRI of her left shoulder would be related to any work injury. Rather, as found above, Claimant is unable to show that any left shoulder/upper extremity symptoms are a result of an occupational injury. Claimant woke up one morning with pain per her reports, although medical records show ongoing problems throughout the years. Claimant's job duties also do not support a causal connection between her work and her symptoms of pain. Dr. Parsons opined that her symptoms were not work related and Dr. Kawasaki opined that there was a low probability that her work and reaching to her keyboard would cause shoulder problems.

Claimant argues that the Division recommends under Rule 17 that initial diagnostic procedures be considered the responsibility of the workers' compensation carrier to ensure that accurate diagnosis and treatment can be established. The Division recommendation is noted, but is a recommendation and is not mandatory nor does it require that an MRI be covered by Respondents in this case. Rather, the case law requires and places the burden on Claimant to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. Claimant is seeking an MRI of her left shoulder, but has failed to meet her burden to show a causal relationship or that her left shoulder complaints were caused by any work related duties. Therefore, her request for MRI is denied.

ORDER

It is therefore ordered that:

1. Claimant has failed to establish that she suffered a compensable injury to her left shoulder/upper extremity arising out of and in the course of her employment. Her claim is denied and dismissed.

2. Claimant has failed to establish that an MRI of the left shoulder as recommended by Dr. Kawasaki is reasonable, necessary, and related to a work injury. Her request for left shoulder MRI is denied.

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: July 27, 2015

/s/ Michelle E. Jones

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

ISSUES

Whether the surgery recommended by Dr. Jinkins is causally related to his September 3, 2014 work injury and medically reasonable and necessary.

FINDINGS OF FACT

1. The claimant is a 44 year old employee of the respondent-employer who injured his right knee on September 3, 2014 while coming down a flight of stairs.

2. The claimant sustained a prior work injury to his right knee on November 29, 2012 while working for the respondent-employer while working as an installer. The respondent-insurer admitted liability for this injury. The claimant received treatment for his 2012 right knee injury from Dr. Daniel Peterson and Dr. Wiley Jinkins

3. The claimant was off of work for this injury from November 30, 2012 through January 13, 2013 and then returned to work as an installer. There is conflict between the medical records of Dr. Peterson and Dr. Jinkins whether he was released to full duty or modified duty but it is apparent that the claimant was in fact working full duty after returning to work after his 2012 injury.

4. The medical records indicate that the claimant did not report much improvement in his condition with time and by April of 2013 Dr. Jinkins began a series of hyaluronic injections (Supartz). The claimant did not report any long term relief from the Supartz injections and in June of 2013 reported pain at a level of 6-7 out of 10. On June 18, 2013, Dr. Jinkins recommended one final injection and if that failed to provide him with relief then surgery, specifically an arthroscopic debridement, would need to be considered.

5. The claimant was eventually placed at maximum medical improvement on August 29, 2013 and was released to full duty to his new position. The claimant returned to work for the respondent-employer for the next year.

6. After injuring his right knee on September 3, 2014, the claimant returned to see Dr. Jinkins on September 23, 2014. At that appointment, the claimant advised Dr. Jinkins that prior to the new incident his knee was doing "so-so" and that he had not

experienced significant relief of his symptoms from the Supartz injections. He stated that he had persistent problems with his right knee from the previous injury and rated his pain level as a 5-6/10 prior to the September 3, 2014 incident. As of the date of the September 23rd exam the pain had escalated to an 8/10. Dr. Jinkins ordered an MRI of the knee and recommended a corticosteroid injection. The claimant inquired about the previously discussed arthroscopic debridement from June of 2013 but Dr. Jinkins advised that this procedure had low predictability and in some cases could actually aggravate the symptoms.

7. On September 29, 2014, Dr. Jinkins stated that there had been no great deal of change in the claimant's knee symptoms. The claimant reported pain at a level of 7/10 and Dr. Jinkins requested authorization for a specialized series of x-rays. On October 15, 2014, Dr. Jinkins requested authorization for a Fulkerson type procedure. At that time, the claimant was still reporting pain at a level of 7/10.

8. At the request of Dr. Jinkins, the claimant was examined by Dr. Derek Purcell on October 30, 2014 for a second opinion to discuss options for his knee. Dr. Purcell reviewed the claimant's records including treatment from the 2012 and 2014 injuries. Dr. Purcell discussed with the claimant various options including continued conservative care, as well as different surgical options. Dr. Purcell ultimately concluded that the Fulkerson osteotomy recommended by Dr. Jinkins would address the claimant's patellofemoral issues but would not provide the claimant long term or short term relief because of the other issues present in the claimant's knee. Dr. Purcell opined that the only surgical intervention that would be appropriate for the claimant would be a total knee arthroplasty.

9. In response to Dr. Jinkins initial request for surgery, the respondent-insurer obtained a Rule 16, records review from Dr. Mark Failinger. On October 22, 2014, Dr. Failinger concluded that a Fulkerson procedure would not solve much or even most of the claimant's pain complaints and recommended additional conservative measures and an IME. Upon receipt of Dr. Purcell's report recommending a total knee arthroplasty, Dr. Failinger completed a follow up records review on November 17, 2014. Dr. Failinger opined that assuming the claimant had completed the appropriate conservative care, then he agreed with Dr. Purcell that the total knee replacement was the more appropriate procedure given the amount of degenerative joint disease (DJD) in the claimant's tibiofemoral compartment. However, he stated it was his strong opinion that the need for the knee replacement was due to the pre-existing DJD rather than the September 3, 2014 incident.

10. Dr. Failinger subsequently completed an independent medical examination of the claimant on March 16, 2015. Dr. Failinger took a history from the claimant, conducted an examination and reviewed additional records. Dr. Failinger requested the actual x-ray or MRI films, but then opined that if the claimant's films confirmed what the written reports documented that the claimant had significant medial and lateral compartment arthritis, then it would not be reasonable to perform the patella realignment procedure being proposed by Dr. Jinkins. In his opinion, such a procedure was only reasonable where the arthritis was strictly limited to the patellafemoral joint. It was also Dr. Failinger's opinion that the recommended procedure was targeting a condition for which the claimant had been treating for 1 ½ years prior to the September 3, 2014 incident and not related to the incident.

11. On April 29, 2015, Dr. Failinger reviewed the actual MRI films of the claimant's right knee which confirmed the presence of both lateral and medial compartment arthritis. The MRI film also showed high grade loss on the central patellar region. Based upon all of these findings, Dr. Failinger re-affirmed his earlier conclusions that a patellofemoral osteotomy would not result in a good outcome for the claimant.

12. The claimant testified on his own behalf and testified that he had no difficulties working full duties after his 2012 work injury and that he could have tolerated continuing to work as an installer. The claimant testified that he approached his employer about the change in positions but that the change was not specifically related to his work-related right knee injury. The claimant further testified that he only experienced symptoms off and on after being placed at MMI for the 2012 injury and that his condition significantly worsened as a result of the September 2014 incident.

13. Dr. Jinkins testified via deposition on behalf of the claimant. Dr. Jinkins opined that the claimant had exhausted all conservative measures and that surgery was the next reasonable treatment option. However, Dr. Jinkins admitted that most of the conservative treatment to which he was referring had been performed in conjunction with the 2012 injury and that the claimant had reported a lack of improvement as a result of that treatment, he did not repeat most of what had been tried after the September 3, 2014 work injury.

14. Dr. Jinkins opined that the claimant's need for surgery was related to his industrial injury of September 3, 2014.

15. Additionally, Dr. Failinger conceded that "…If there was not significant degenerative joint disease in the tibiofemoral joint, then, a Fulkerson-type procedure is

a reasonable option." Dr. Jinkins testified that the claimant's standing view x-rays "…did not show any significant arthritis of the tibiofemoral joint." Thus, under Dr. Failinger's reasoning, the surgery recommended by Dr. Jinkins is "a reasonable option."

16. The ALJ finds Dr. Jinkins' opinions as the authorized treating orthopedic surgeon credible, persuasive, and entitled to greater weight than the contrary opinions of either Dr. Purcell or Dr. Failinger.

17. The ALJ finds that the claimant has established that it is more likely than not that the surgery proposed by Dr. Jinkins is related to the claimant's industrial injury of September 3, 2104 and that the surgery is reasonable and necessary.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. (2007), *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. The claimant has the burden of proof to establish the right to specific medical benefits by a preponderance of the evidence. Section 8-43-201, C.R.S.; see *Valley Tree Service v. Jimenez*, 787 P. 2d 658 (Colo. App. 1990). 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).

5. The ALJ concludes that the claimant has established by a preponderance of the evidence that he requires the right knee surgery as recommended by Dr. Jinkins. The needed surgery is directly related to the claimant's industrial injury of September 3, 2014. The surgery is reasonably needed to cure and relieve the claimant of the effects of this September 3, 2014 injury. The respondent-insurer is liable for payment of that surgery, as well as all related follow-up treatment necessary to cure and relieve the claimant of the effects of the injury.

[The Order continues on the following page.]

ORDER

It is therefore ordered that:

1. The respondent-insurer shall authorize and pay for the surgery as recommended by Dr. Jinkins.

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, 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: July 15, 2015

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Dr Ste 230
Colorado Springs, CO 80906

ISSUES

The threshold issue determined by this order is compensability of an alleged December 1, 2014 hernia. The ALJ also heard testimony concerning several associated issues, including Claimant's entitlement to medical and temporary total disability (TTD) benefits, as well as a request for determination of Claimant's Average Weekly Wage (AWW).

FINDINGS OF FACT

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

1. Claimant was employed by Employer as a seasonal employee. He was hired on November 10, 2014 as an order picker. Claimant was to work 40 hours per week at on the "1st Shift." He reported to work between the hours of 7:30 a.m. and 4:30 p.m., Monday through Friday with a possible Saturday shift. Claimant was paid $9.25 per hour.

2. Claimant made a total of $877.00 between his date of hire and his last date of work, December 1, 2014. The ALJ finds that there are 20 days between November 11, 2014 and December 1, 2014 for a daily rate of pay equal to $43.85 based upon Claimant's total earnings of $877.00. Consequently the ALJ finds Claimant's average weekly wage (AWW) to equal $306.95. ($877.00 total wages ÷ 20 days employment = $43.85/ day × 7 days/week = $306.95).

3. As a picker, Claimant's duties included, but were not limited to, picking orders from bins at assigned shelf locations, performing cleanup activities in the work area to ensure cleanliness, organizing bins, and pulling product inventories from the rear to the front of bins for easy access. Claimant's position required the ability to lift and carry 50 lbs.

4. On December 1, 2014, at approximately 10:30 a.m., Claimant was retrieving an order from a bin on a bottom row shelf. The inventory was located on a pallet toward the back of the shelf. Consequently, Claimant bent down and moved underneath the shelf in an effort to reach the stock and bring it forward. From a semi forward flexed position with one knee on the pallet and one knee on the floor, Claimant reached forward and attempted to pull what he thought was a stack of 20-30 light bread pans forward. The stack of pans did not move. Claimant vigorously tried to pull the pans forward. Despite Claimant's efforts, the stack still did not move. Thus, Claimant lifted the top two pans to discover that they were made of heavy cast-iron. Claimant proceeded to move the inventory forward as required. As he was bent over moving the

pans, Claimant testified that he began to feel pain in his abdomen.

5. After moving the entire stack of cast-iron pans forward in piecemeal fashion, Claimant backed out from under the shelf and grabbed the metal support beam on an upper shelf to assist in pulling himself upright. As Claimant stood up, he experienced an immediate "shooting" pain in his lower abdomen and groin area. The pain improved but did not completely subside after a minute or two leading Claimant to believe he pulled a muscle in his leg.

6. Claimant testified that the pain was the worst he had ever felt. Consequently, he modified his work activities, slowing his pace of work and being cautious about the weight he lifted, for the remainder of his shift.

7. Claimant finished his shift and returned home. He was hopeful the pain would just "go away" so did not report the incident before leaving work for the evening. When he was hired, Claimant completed paperwork acknowledging that all work related injuries were to be reported immediately to his direct supervisor.

8. Upon retiring for the night, Claimant was unable to sleep because of intense shooting pains in his groin. By the morning of December 2, 2014, Claimant was in severe pain. He noticed swelling in the groin, testifying that he was "blowing up down there". Consequently, Claimant testified that he called into work before his scheduled shift and informed the shift leader that he would not be coming to work because he was "probably going to the emergency room". However, during cross examination, Claimant conceded that he did not report that he had injured himself, had a hernia, or any other condition. He stated only that he was "sick".

9. Claimant went to the Emergency Room at Memorial Hospital where he was evaluated by Dr. Tietz at 8:38 a.m. During his emergency room (ER) visit, Claimant complained of "pain in the right groin". He also reported that he "[did] a lot of heavy lifting, bending, straining". Examination revealed a freely reducible "indirect right inguinal hernia" which was documented simply as "coming on for a while." There is no indication in the ER report of the mechanism of injury described by Claimant at hearing. Claimant was instructed to follow-up with general surgery and discharged from the ER with a note for resumption of light duty work for 4 days.

10. Claimant testified that he informed his shift leader, Elaine Martinez of his restrictions that same morning, December 2, 2014. Claimant testified that he was told not to return to work by Ms. Martinez as there were no light duty positions available. Consequently, Claimant testified that Ms. Martinez informed him that she would push his "termination paperwork through."

11. Elaine Martinez, disputes the aforementioned assertions of Claimant. Ms. Martinez testified that Claimant never spoke with her on the date of his alleged injury, and did not speak to her by phone at any time on December 2, 2014. Rather, she testified that Claimant only left a voicemail indicating simply that he was "sick".

12. Claimant contacted Employer's HR Department on December 3, 2014 regarding his hernia where after he was referred to Employer's designated medical provider, Concentra Urgent Care.

13. Claimant was seen at Concentra on December 5, 2014 where he was evaluated by Physicians Assistant (PA), Kenneth Ginsburg. The history of present injury completed by PA Ginsburg provides the following account of the injury: ". . . states that he knelt down, pulled some boxes off the bottom of a pallet then stood up again without lifting anything and had a sudden onset sharp pain." PA Ginsburg noted that "there was no excessive force exerted to the inguinal canal compared to activities of daily living." PA Ginsburg noted that while it was "possible" that Claimant's work activities caused his symptoms, it was not "necessarily probable". Regarding causation, PA Ginsburg opined that Claimant's "work activities probably irritated his pre-existing inguinal canal defect." The ALJ infers from this report that Claimant likely had a pre-existing inguinal canal defect making him susceptible to the development of a full hernia in the face of strenuous pulling.

14. According to the WC M164 form signed by Dr. Randell Jones, Claimant provided the following description of the accident/injury: "I stood up and pain shot through my pelvis. Pain subsided after 1 min or two". Dr. Jones also checked the "Yes" box to question #3. "Are your objective findings consistent with history and/or work related mechanism of injury/illness".

15. Following his December 5, 2014 evaluation at Concentra, Claimant was placed on restrictions of 20 lbs. for lifting and push/pull limits of 20 lbs. Concentra listed Claimant's activity status as, "Return to modified work/activity today." Respondent did not offer Claimant modified duty. Claimant did not find alternative employment until March. Claimant is seeking Temporary Total Disability benefits from December 2, 2014, through February 4, 2015.

16. On January 9, 2015, Claimant returned to Memorial Hospital for surgery. The surgery was performed by Dr. Larry Butler, who reduced Claimant's right inguinal hernia and repaired it with mesh. Dr. Butler's post-operative instructions directed Claimant to wait until after a follow-up appointment, scheduled 7-10 days out, before returning to work. Regarding the history of injury, Dr. Butler noted as follows: "This man who was doing seasonal work noted sudden onset of groin pain last week after he was pulling from a semi-bent over position". Based upon evidence presented, the ALJ finds Dr. Butler's treatment related to Claimant's industrial injury and reasonably necessary to cure and relieve Claimant of the effects of the same.

17. Claimant was seen for an independent medical examination (IME) with Dr.

Lawrence Lesnak on April 21, 2015. Dr. Lesnak performed a causation analysis opining that there was no evidence from an anatomical perspective that the mechanism of injury (MOI) described by Claimant could cause his hernia or the treatment necessary to repair it. While congenital defects can cause hernias, Dr. Lesnak testified that the primary cause of inguinal hernias is the increased pressure on the contents of the abdominal cavity associated with forceful Valsalva maneuvers. According to Dr. Lesnak, Claimant would not have experienced a Valsalva sufficient to cause a hernia merely by pulling himself up from a squatting position and/or while pulling inventory forward from a kneeling position. Consequently, there is an absence of the movement and other necessary physiological conditions associated with Claimant's work duties to cause a hernia in this case, in Dr. Lesnak's opinion. The ALJ is not convinced for the reasons set forth in paragraph 19 below.

18. Dr. Lesnak also testified that it is important to consider the first reported history of injury provided by the patient to the first medical provider when formulating a causation opinion. In this case, Dr. Lesnak attributed the statement that right inguinal hernia had been "coming on for a while" to Claimant, testifying that this account was inconsistent with Claimant's report to him that the pain came on acutely while returning to an upright position. Consequently, Respondents suggest that Claimant has been inconsistent in his reporting of the injury. Again, the ALJ is not convinced. Based upon review of the medical record in question, the ALJ attributes the statement that the hernia had been "coming on for a while" to the author of the ER report rather than Claimant. More probably than not, the statement reflects what the provider understood was the duration of Claimant's symptoms before he sought treatment. Rather than define that time carefully, the provider in artfully documented that the hernia had been "coming on for some time" leaving interpretation of how long to the reader. As a consequence, Respondents suggest that Claimant's hernia was caused by factors other than his work duties on December 1, 2014. After careful review of the entire record, the ALJ finds that Claimant has consistently reported that his symptoms came on abruptly after pulling and lifting a stack of heavy cast iron pans and returning to an upright position rather than any indication that the hernia had been "coming on for a while". Moreover, Claimant's action in seeking treatment within hours of worsening symptoms militates against the suggestion that the hernia and accompanying symptoms had been coming on over time.

19. The ALJ has considered the totality of the evidence and finds that Dr. Lesnak's opinion that Claimant's condition was not caused, aggravated or accelerated by his work for Employer unpersuasive. While Dr. Lesnak gave no weight to Claimant's indication that the injury was from straining to move a heavy stack of pans while in a semi-bent over or kneeling position reaching to the back of the bottom bin, the ALJ finds PA Ginsburg's causation opinion that Claimant's work activities probably irritated a pre-existing inguinal canal defect more credible than Respondent's suggestion that Claimant's hernia was caused by factors other than his employment. The ALJ finds that,

more probably than not, the strenuous pulling in combination with lifting from an awkward position involved sufficient force to aggravate a small, pre-existing defect (hernia) in the inguinal canal causing it to become symptomatic which in turn prompted Claimant to seek treatment. The ALJ has considered, and hereby rejects all other evidence which is contrary to the above findings.

20. Although there are inconsistencies in the record, the ALJ resolves those inconsistencies in favor of Claimant to find that the totality of the persuasive evidence supports that he sustained a compensable hernia on December 1, 2014 as he has alleged.

CONCLUSIONS OF LAW

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

General Legal Principals

A. 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.

B. In accordance with § 8-43-215, C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office*, *84 P.3d 1023 (Colo. 2004).* This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).*

C. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony

and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16. As found, there are some inconsistencies in the record concerning Claimant's testimony. Nonetheless, the ALJ resolves those inconsistencies in favor of Claimant to find that his account of the injury and the events thereafter are generally credible and supported by the record evidence. Consequently, the ALJ concludes that Claimant's testimony concerning the cause of his alleged injury is reliable and persuasive.

Compensability

D. Claimant has proven, by a preponderance of the evidence that he suffered a compensable hernia on December 1, 2014. Under the Workers' Compensation Act, an employee is entitled to compensation where the injury is proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment. *Section 8-41-301(1), C.R.S.; Horodyskyj v. Karanian* 32 P.3d 470 (Colo. 2001). The phrases "arising out of "and "in the course of" are not synonymous and a claimant must meet both requirements. *Younger v. City and* County of Denver, 810 P.2d 647, 649 (Colo. 1991); *In re Question Submitted by U.S. Court of Appeals,* 759 P.2d 17, 20 (Colo. 1988). The latter requirement refers to the time, place, and circumstances under which a work-related injury occurs. *Popovich v. Irlando,* 811 P.2d 379, 381 (Colo. 1991). Thus, an injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected with the employee's job-related functions. *In re Question Submitted by U.S. Court of Appeals, supra; Deterts v. Times Publ'g Co.,* 38 Colo.App. 48, 51, 552 P.2d 1033, 1036 (1976). Here there is little question that Claimant produced sufficient evidence to support a conclusion that his symptoms occurred in the scope of employment. Rather, the question for determination here is whether Claimant's injuries arise out of his employment.

E. The term "arises out of" refers to the origin or cause of an injury. *Deterts v.Times Publ'g Co. supra.* There must be a causal connection between the injury and the work conditions for the injury to arise out of the employment. *Younger v. City and County of Denver, supra.* An injury "arises out of" employment when it has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered part of the employee's employment contract. *Popovich v. Irlando supra.* As noted above, it is the Claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between employment and the alleged injuries. Section 8-43-201, C.R.S. 2013.

F. The determination of whether there is a sufficient "nexus" or causal relationship between Claimant's employment and the injury is one of fact which the ALJ must determine based on the totality of the circumstances. *In Re Question Submitted by the United States Court of Appeals,* 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle,* 934 P.2d 861 (Colo. App. 1996). While it is true, under *F.R. Orr*

Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985); *Parra v. Ideal Concrete,* W.C. No. 3-963-659 and 4-179-455 (April 8, 1988)*; Barba v. RE1J School District,* W.C. No. 3-038-941 (June 28, 1991); *Hoffman v. Climax Molybdenum Company,* W.C. No. 3-850-024 (December 14, 1989), that an incident which merely elicits pain symptoms without a causal connection to industrial activities does not compel a finding that the claim is compensable, the persuasive evidence presented here establishes that Claimant engaged in physically demanding work activity which, more probably than not, aggravated a pre-existing defect (hernia) in Claimant's inguinal canal causing his symptoms and need for treatment. If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo.App. 1990). But for Claimant's obligations to his employer combined with the conditions of his employment, specifically the requirement to face product from the back of low lying shelves, necessitating his need to pull and lift from an awkward position, Claimant likely would not have aggravated his pre-existing inguinal canal defect. *See Conlon v. Dillon Companies, Inc. d/b/a King Soopers*, W.C. No. 4-835-313 (November 14, 2011); *City of Brighton v. Rodriquez*, 318 P.3d 496 (Colo. 2014). Consequently, the ALJ concludes that Claimant has established a sufficient causal connection between his injury and his work duties to support a finding that his hernia arises out of his employment. Accordingly, the injury is compensable.

Medical Benefits

G. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondent's are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. *Section 8-42-101, C.R.S.*; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo.App. 1990). The question of whether the need for treatment is causally related to an industrial injury is one of fact. *Walmart Stores, Inc. v. Industrial Claims Office,* 989 P.2d 521 (Colo. App. 1999). Where the relatedness, reasonableness, or necessity of medical treatment is disputed, Claimant has the burden to prove that the disputed treatment is causally related to the injury, and reasonably necessary to cure or relieve the effects of the injury. *Ciesiolka v. Allright Colorado, Inc.*, W.C. No. 4-117-758 (ICAO April 7, 2003).

H. Based upon the medical record, including the credible opinions of PA Ginsburg, the ALJ concludes that the treatment, including Claimant's emergency room treatment and the subsequent surgery performed by Dr. Butler was related to Claimant's December 1, 2014 industrial injury. Moreover, the ALJ concludes that this treatment was reasonably necessary to cure and relieve him from the effects of the same.

Average Weekly Wage

I. The overall purpose of the average weekly wage (AWW) statute is to arrive at a fair

approximation of Claimant's wage loss and diminished earning capacity resulting from the industrial injury. *See Campbell v. IBM Corp., 867 P.2d 77 (Colo. App. 1993); National Fruit Prod. v. Crespin, 952 P.2d 1207 (Colo. App. 1997).*

Sections 8-42-102 (3) and (5) (b), C.R.S. (2013), give the ALJ discretion to determine an AWW that will fairly reflect loss of earning capacity. An AWW calculation is designed to compensate for total temporary wage loss. *Pizza Hut v. Indus. Claim Appeals Office,* 18 P. 3d 867 (Colo. App. 2001). *See* § 8-42-102, C.R.S. The best evidence of Claimant's actual wage loss and therefore a fair approximation of his diminished earning capacity comes from the wage records submitted into evidence. The ALJ adopts Respondents calculation of Claimant's AWW to find that his AWW is $306.95 as that figure represents the average weekly earnings over the entire period of Claimant's employment. The ALJ finds that this figure most closely approximates Claimant's wage loss and diminished earning capacity at the time of his December 1, 2014 compensable work related injury.

Temporary Total Disability

J. To receive temporary disability benefits, a Claimant must prove the injury caused a disability, that he/she leaves work as a consequence of the injury, and the disability is total and lasts more than three regular working days. *C.R.S. § 8-42-103(1); PDM Molding, Inc. v. Stanberg,* 898 P.2d 542 (Colo. 1995). As stated in *PDM Molding*, the term "disability" refers to the claimant's physical inability to perform regular employment. *See also McKinley v. Bronco Billy's,* 903 P.2d 1239 (Colo. App. 1995). Once the claimant has established a "disability" and a resulting wage loss, the entitlement to temporary disability benefits continues until terminated in accordance with C.R.S. § 8-42-105(3)(a)-(d).

K. C.R.S. § 8-42-105(3) provides in pertinent part: Temporary total disability benefits shall continue until the first occurrence of any one of the following:

> (a) The employee reaches maximum medical improvement;
>
> (b) The employee returns to regular or modified employment;
>
> (c) The attending physician gives the employee a written release to return to regular employment; or
>
> (d)(I) The attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.

L. From the evidence presented, the ALJ concludes that Claimant was provided with physical restrictions and released to return to work in a modified capacity following his December 2, 2014 ER visit. Moreover, the ALJ is persuaded that Respondents did not accommodate Claimant's restrictions and that Claimant returned to work for a

different employer after February 4, 2015. Thus, the ALJ concludes that Claimant experienced a wage loss lasting more than three regular work days due to his inability to perform regular work duty and Respondents unwillingness to accommodate his work restrictions. Consequently, Claimant was "disabled" within the meaning of the statute and entitled is entitled to receive temporary total disability benefits from December 2, 2014 through February 4, 2015.

ORDER

It is therefore ordered that:

1. Claimant's December 1, 2014 claim for a work related injury is compensable.

2. Respondents shall pay for all reasonable, necessary and related medical expenses to cure and relieve Claimant from the effects of his industrial injury, including but not limited to the Memorial Hospital ER visit as well as the surgery and care associated therewith as obtained through Dr. Butler.

3. Respondent shall pay the Claimant TTD benefits from December 2, 2014 through February 4, 2015, at the appropriate TTD rate associated with Claimant's average weekly wage of $306.95.

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: July 16, 2015

/s/ Richard M. Lamphere

Richard M. Lamphere
Administrative Law Judge
Office of Administrative Courts
1259 Lake Plaza Drive, Suite 230
Colorado Springs, CO 80906

ISSUES

- Whether claimant has proven by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment on November 7, 2014 (W.C. No. 4-970-682-01)?

- Whether claimant has proven by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment on April 6, 2015 (W.C. No. 4-979-719-01)?

- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that the surgery he underwent with Dr. Griggs on April 22, 2015 was reasonable medical treatment necessary to cure and relieve the claimant from the effects of the industrial injury?

- The parties stipulated at the hearing to an average weekly wage ("AWW") of $1,027.70 if the claim is compensable.

FINDINGS OF FACT

1. Claimant was employed as a Waste Water Plant Operator for employer. Claimant testified that on November 7, 2014, he was assembling a twelve inch pipe and was crossing the T section of the pipe when he slipped off the pipe and his knee got wedged between the pipe and the side of the ditch. Claimant was working with a co-worker (Mr. Early) who inquired after the incident if claimant was OK.

2. Claimant went home on November 7, 2014 (a Friday) and iced his knee. Claimant eventually sought medical treatment the next day at the emergency room ("ER") in Gunnison, Colorado.

3. Claimant reported to the ER doctor that he had injured his right knee the previous day when he fell at work. Claimant underwent x-rays of the right knee that showed tricompartmental degenerative joint disease of the right knee, most severe in the lateral compartment and associated with a moderate sized knee joint effusion. Claimant was provided medications and discharged.

4. Claimant had a prior history of treatment to his right knee, including treatment to his knee in December 2013 when he was complaining of right knee pain. Claimant initially injured his knee on August 16, 1988 when he fell 40 feet landing on his

feet. Claimant underwent surgery under the auspices of Dr. Winkler on July 3, 1989 involving an arthroscopy with removal of a medial plica and debridement of chondromalacia and synovitis. Claimant underwent a second surgical procedure on October 3, 1989 which consisted of arthroscopic removal of referormed plica in the medial compartment of his right knee and removal of 25% of the lateral meniscus. Claimant underwent a third surgical procedure, again with Dr. Winkler, on August 14, 1990 that involved additional removal of plica across the suprapatellar pouch and a partial right lateral menisectomy.

5. Claimant testified at hearing that he did not recall receiving medical treatment for his right knee between 1990 and November 2014. Claimant acknowledged that the medical records contained an x-ray of his knee from December 2007, but did not recall the circumstances that led to his getting the x-ray. Claimant testified that his right knee was not 100% but was in good shape and testified that in the autumn of 2014 he had been able to go hunting and had previously participated in activities such as coaching his children.

6. Following claimant's treatment with the ER on November 8, 2014, claimant was evaluated by Dr. Griggs, an orthopedist, on November 10, 2014. Claimant reported a history to Dr. Griggs of falling at work and feeling a pop in his knee. Claimant noted he had four prior knee surgery and had steroid injections into his knee in the past which only lasted a short time. Dr. Griggs diagnosed claimant with suspected degenerative joint disease and a lateral collateral ligament sprain of the right knee. Claimant was referred for a magnetic resonance image ("MRI") of his right knee.

7. Claimant underwent the MRI of the right knee on November 17, 2014. The MRI showed a large joint effusion with synovial osteochondromata in a posterior recess behind the knee laterally. The medial meniscus was noted to be frayed with a horizontal tear in the posterior horn. Bone bruising involving the medial proximal tibia with some osteophytic lipping was also noted. The lateral meniscus showed a tear with no meniscus interposed at the posterior joint space. The anterior cruciate ligament was noted to be torn, perhaps chronically. The radiologist noted that there was a complete tear with loss of the meniscus lateral joint space with degenerative changes in the lateral joint space and at least a grade II injury of the lateral collateral ligament. The radiologist also noted that the findings appeared to be chronic in nature except for the lateral collateral ligament.

8. Claimant returned to Dr. Griggs on November 20, 2014. Dr. Griggs agreed with the radiologist that the findings on MRI appeared to be chronic with the exception of the lateral collateral ligament. Dr. Griggs recommended physical therapy.

9. Claimant was examined by Dr. Thorson on November 20, 2014. Dr. Thorson noted claimant reported he was walking on a pipe and slipped resulting in his right knee being caught between the ditch and the pipe. Claimant reported his knee

was unstable. Dr. Thorson noted claimant would undergo physical therapy and, if he did not improve, he would likely be a surgical candidate.

10. Claimant underwent a course of physical therapy but noted in a visit with Dr. Ward on December 19, 2014 that while he thought he had been getting better, he felt like he tweaked his knee at therapy and noted his knee gives out at times with some locking and catching at other times.

11. Dr. Thorson noted on January 8, 2015 that claimant was being evaluated for surgery. Dr. Thorson noted claimant had an increased risk for cardiac complications due to coronary artery disease, but cleared claimant for surgery. The request for authorization for the surgery to be performed by Dr. Griggs was ultimately denied, however, by Insurer.

12. Claimant continued to treat with Dr. Thorson who noted claimant continued to complain for grinding and popping in the knee when she evaluated him on February 20, 2015.

13. Claimant underwent an independent medical examination ("IME") with Dr. O'Brien on March 18, 2015. Dr. O'Brien reviewed claimant's medical records, obtained a history and performed a physical examination in connection with his IME. Dr. O'Brien issued a report dated April 3, 2015 associated with his IME. Dr. O'Brien noted in his report that claimant's symptoms included weakness, locking, swelling, stabling, giving out, clicking, sharpness, throbbing and catching. Dr. O'Brien opined in the IME report that claimant's November 7, 2014 work injury resulted in a right knee strain/sprain which temporarily aggravated his pre-existing and long-standing tricompartmental degenerative joint disease of his right knee. Dr. O'Brien opined that in accordance with the natural history of healing of minor injuries such as the one claimant sustained, he had an "end of healing" regarding his right knee strain/sprain that was reached on or before the IME on March 18, 2015.

14. Dr. O'Brien testified consistent with his medical report at hearing. Dr. O'Brien agreed on cross-examination that claimant did sustain an injury on November 7, 2014 that required medical care.

15. Claimant continued to work for employer with work restrictions. Claimant testified that on April 6, 2015 he was helping co-workers hook a trailer to a truck when he stepped off the trailer tongue with his right foot, and his heel got hooked in the trailer safety chain. Claimant testified he again felt his knee pop. Claimant testified his employer had him fill out a new workers' compensation claim for the April 6, 2015 injury.

16. Claimant was evaluated by Dr. Griggs the day after the April 6, 2015 incident. Dr. Griggs noted claimant had immediate pain following the incident where he

caught his right leg on the safety chain, even though he was wearing his brace at the time of the incident.

17. Claimant subsequently underwent surgery under the auspices of Dr. Griggs on April 22, 2015. The surgery included a right arthroscopic ACL reconstruction, right arthroscopic partial lateral and medial menisectomy, and right arthroscopic lateral femoral condyle chondroplasty. The surgical report noted that claimant's medial meniscus had a small medial tear, the ACL was completely torn, the medial compartment was grade 1-2 and the patellofemoral joint was grade 1-2 as well. The lateral compartement was noted to be grade 4 mostly, but had a large lateral meniscus tear with small cartilage flaps.

18. Dr. O'Brien testified at hearing that he reviewed the MRI studies and opined that all the findings in the MRI were chronic. Dr. O'Brien testified there were no acute findings on MRI. Dr. O'Brien testified that it was his opinion that the surgery that was performed on April 22, 2015 was not related to claimant's November 7, 2014 injury nor to his April 6, 2015 injury.

19. Claimant testified at hearing that he was not in need of medical treatment for his right knee condition until the injury of November 7, 2014. The ALJ finds this testimony to be credible and persuasive. The ALJ further credits the opinions of Dr. Griggs and the radiologist that noted acute findings of a lateral collateral ligament tear and finds that claimant has demonstrated that he sustained a compensable injury arising out of his employment on November 7, 2014.

20. The ALJ credits the opinions expressed by Dr. Griggs in the medical records over the contrary opinions expressed by Dr. O'Brien in his report and testimony and finds that the surgery recommended by Dr. Griggs and performed on April 22, 2015 was reasonable and necessary to cure and relieve claimant from the effects of the November 7, 2014 work injury.

21. The ALJ notes that claimant was not under active medical care at the time of the work injury and the record is devoid of any credible evidence that claimant was in need of surgery for his pre-existing knee condition until the November 7, 2014 work injury. The ALJ therefore finds that claimant has demonstrated that it is more likely than not that the injury of November 7, 2014 resulted in acute tears to the lateral collateral ligament, aggravating his pre-existing condition and accelerating claimant's need for treatment at the ER following his injury and ultimately surgical intervention. The ALJ credits the reports from Dr. Griggs on this issue that claimant would need the surgery after his course of physical therapy failed to offer claimant relief from his symptoms as credible and persuasive.

22. The ALJ further finds that the April 6, 2015 incident at work was not a compensable injury, as no changes to claimant's underlying condition occurred during

the incident and the incident did not result in the need for additional medical treatment. Instead, the ALJ finds claimant has proven that it is more likely than not that the medical treatment, including the surgery performed on April 22, 2015 was related to claimant's November 7, 2014 work injury with employer.

23. Claimant's claim for benefits related to the April 6, 2015 work injury (W.C. No. 4-979-719-01) is therefore denied and dismissed.

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 when he slipped and fell off the pipe on November 7, 2014. As found, the testimony of claimant regarding his symptoms before and after he fell off the pipe and the opinions expressed by Dr. Griggs in his medical records are more credible and persuasive than the contrary opinions expressed by Dr. O'Brien in his report and testimony.

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. As found, the medical treatment claimant received from the ER, Dr. Griggs and his referrals, including the surgery performed on April 22, 2015, are found to be reasonable medical treatment necessary to cure and relieve claimant from the effects of his work related injury.

7. As found, claimant has failed to show by a preponderance of the evidence that the incident at work on April 6, 2015 resulted in any new injury to his knee. Therefore, claimant's claim under W.C. No. 4-979-719-01 is denied and dismissed.

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 work injury, including but not limited to the treatment from the ER on November 8, 2014, Dr. Griggs treatment and referral for physical therapy and the surgery performed on April 22, 2015.

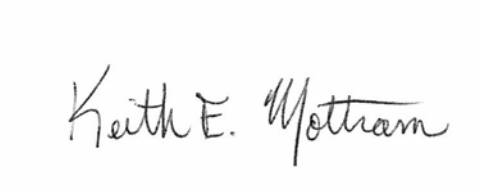
2. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

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: July 22, 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 claimant from the effects of the industrial injury and provided by a physician authorized to treat claimant?

- 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 December 29, 2014 until February 23, 2015 when claimant returned to work for a different employer?

- If claimant has proven a compensable injury, whether claimant has proven by a preponderance of the evidence that he is entitled to temporary partial disability ("TPD") benefits beginning February 24, 2015 and continuing?

- If claimant has proven a compensable injury, whether respondents have proven by a preponderance of the evidence that claimant committed a volitional act that led to his termination of employer?

- The parties stipulated at the hearing to an average weekly wage ("AWW") of $1,601.47 that is calculated by combining claimant's earnings of $1,354.31 with Claimant's COBRA increase of $247.16.

FINDINGS OF FACT

1. Claimant was employed with employer as a Systems Operator I on December 27, 2014. Claimant testified his job duties included operating a fork lift and a front end loader. Claimant testified that through his work with employer, he would work shifts from 5:30 p.m. to 6:00 a.m.

2. Claimant testified that he was working on a drilling site in Wyoming on December 27, 2014 when at approximately 9:00 p.m., he slipped and fell on an icy ramp and landed on his right shoulder. Claimant testified he called his supervisor, Mr. Hansen and informed him that he fell. Claimant testified Mr. Hansen told him he would

tell Mr. Chambers, the direct supervisor for the area, of claimant's fall. Claimant testified he continued working and took it easy and was going to see how he felt in the morning.

3. Claimant testified that following his fall, he continued to work, but would use his left arm to lift. Claimant testified he finished his shift with employer and his shoulder was numb and throbbing.

4. Claimant testified that following his shift, he was scheduled to return to work on December 28, 2014 at 5:30 p.m., but was woken up at approximately 2:00 p.m. by Mr. Hansen and was told to pack up because he was going to another job site where he would catch a ride back to his home in Colorado. Claimant testified Mr. Hansen helped him load his belongings, including his tools and a cooler.

5. Claimant testified that while he was in the car with Mr. Hansen, he again mentioned that he hurt his shoulder. Claimant testified Mr. Hansen told him to sleep on it and that he had reported the injury to Mr. Chambers and someone would be getting back to him. Claimant testified he went to the new job site and operated a loader with his left hand. Claimant testified he was at the new job site for approximately 12-13 hours, before leaving the job site on December 29, 2014 at approximately 6:00 a.m.

6. Claimant testified he got a ride back to Colorado with Mr. Rotta and arrived at his home late in the afternoon on December 29, 2014. Claimant testified he did not receive a referral from employer to a physician between December 29, 2014 and January 2, 2015. Claimant testified that during this time, his pain began getting worse.

7. Claimant testified he was advised that he was terminated by employer on January 2, 2015. Claimant testified he then made a medical appointment with his personal physician, Dr. Smith with Roaring Fork Family Physicians.

8. Claimant was examined by Dr. Smith on January 2, 2015. Dr. Smith noted claimant reported he fell and landed on his right shoulder on December 27, 2014. Dr. Smith noted claimant had pain since his fall and documented "a little bruising down into the proximal upper arm". Claimant reported pain with overhead activity. Dr. Smith diagnosed claimant with a likely injury to the rotator cuff and provided claimant with restrictions of no lifting over 10 pounds. Claimant testified at hearing that he had not had an injury to his right shoulder before December 27, 2014.

9. Claimant testified that after his appointment with Dr. Smith, he called Axiom, a medical service provided by employer that allows the employees to call with medical questions involving work related injuries and speak to a nurse. Claimant testified he knew to call Axiom from a co-worker. Claimant testified he spoke with "Jan" at Axiom and asked her if a report had been filed. Claimant testified he was not referred to a physician by Axiom or employer after reporting the injury.

10. Claimant returned to Dr. Smith on January 14, 2015. Claimant noted continued pain in his right shoulder and Dr. Smith recommended claimant obtain a magnetic resonance image ("MRI") of his right shoulder. Claimant was referred by Dr. Smith to Dr. Adams.

11. Dr. Adams evaluated claimant on January 21, 2015 and noted claimant's accident history of slipping at work, landing on the right shoulder. Dr. Adams referred claimant for an MRI of the right shoulder.

12. Claimant returned to Dr. Smith on February 11, 2015. Dr. Smith noted that it was evident that claimant had a torn rotator cuff, but that insurer had denied the request for the MRI. By March 30, 2015, Dr. Smith was noting that claimant had a known rotator cuff tear and would likely need surgery.

13. Mr. Norwood, claimant's co-worker, testified at hearing that he was working with claimant on December 27, 2014 and witnessed claimant fall when he slipped on iron. Mr. Norwood testified claimant was talking on the phone and walking away from him when he stepped on iron, slipped and fell, landing on his right side. Mr. Norwood testified he walked over to claimant and asked him if he was OK, to which claimant replied that he was OK. Mr. Norwood testified he asked claimant several times through the day if he was OK, to which claimant responded that he was OK. Mr. Norwood testified he did not notice any difference in how claimant performed his work.

14. Mr. Norwood testified that he did not work with claimant anymore after the shift in which claimant fell (the shift ending December 28, 2014). Mr. Norwood testified he later saw claimant and his supervisor loading claimant's belongings. Mr. Norwood testified he did not hear claimant complain of right arm pain following his fall.

15. Mr. Hansen testified at hearing in this matter that he had spoken with claimant in December 2014 regarding a tire claimant had blown on the loader. Mr. Hansen confirmed that claimant had told him that he had fallen. Mr. Hansen testified he asked claimant if he was OK, and claimant replied that he was OK. Mr. Hansen testified he did not interpret this as claimant reporting a work related injury.

16. Mr. Hansen testified that the next day he removed claimant from the rig he was working on because of complaints employer had received from the rig owner about claimant. Mr. Hansen testified he moved claimant to a different rig and helped claimant move some of his belongings. Mr. Hansen testified that in the drive to the new rig, claimant did not complain of shoulder pain. Mr. Hansen testified he did not tell Mr. Chambers of claimant having fallen at work.

17. The ALJ credits the testimony of claimant and Mr. Norwood and finds that claimant has established that on December 27, 2014 he slipped and fell on ice at work and landed on his right side. The ALJ credits the medical records from Dr. Smith that

document claimant had bruising on his right shoulder on examination on January 2, 2014 and diagnosed claimant with a possible torn rotator cuff and finds that claimant has proven that it is more likely than not that claimant sustained an injury at work when he slipped and fell on December 27, 2014.

18. The ALJ notes that respondents take issue with the fact that claimant indicated he was OK to co-workers after the fall and did not seek medical treatment immediately after the injury. However, the evidence establishes by a preponderance of the evidence that claimant did sustain an injury when he fell on December 27, 2014 that resulted in the need for medical treatment.

19. Claimant was placed on restrictions by Dr. Smith on January 2, 2015. The ALJ finds that the claimant has demonstrated that it is more likely true than not that the medical restrictions are a result of his December 27, 2014 slip and fall when he landed on his right side and resulted in claimant's subsequent wage loss. The ALJ finds that the wage loss continued until February 24, 2015 when claimant returned to work for a new employer.

20. The ALJ notes that claimant sought TTD benefits beginning December 29, 2014. However, the evidence at hearing establishes that claimant was off of work beginning December 29, 2014 due to his normal scheduled time off. Claimant has failed to establish that it is more likely true than not that his failure to work between December 29, 2014 through January 2, 2015 was related to his work injury.

21. Claimant also argues that he is entitled to TPD benefits beginning February 24, 2015. However, claimant has failed to establish that it is more likely true than not that his earnings after he returned to work for the new employer were related to claimant's work injury. Insufficient evidence was presented at hearing of a wage loss after February 24, 2015 related to claimant's work injury and, therefore, claimant's claim for TPD benefits is denied.

22. Respondents presented the testimony of Mr. Merritt, the Senior Human Resources Operations Partner for employer. Mr. Merritt testified that claimant was fired on January 2, 2015 for failing to attend safety meetings and because the owner of the drilling rig had requested claimant be removed from the job site. Mr. Merritt testified if claimant had attended the safety meetings, he would not have been fired.

23. Claimant testified on rebuttal that he missed some safety meetings because the tool pusher in charge of the safety meetings allowed other workers to smoke during the meetings and he did not like being around the smoke.

24. Mr. Cook testified at hearing in this matter. Mr. Cook is the Principal HSE Official for employer. Mr. Cook testified he first became aware of claimant's injury when he was contacted by Axiom, a service that provides 24 hour care through an 800

number, and advised that an employee had called seeking medical care, on January 3, 2015 between 8:00 to 9:00 a.m. Mr. Cook testified he eventually spoke to Mr. Padgett and found out that claimant was a former employee. Mr. Cook testified he called Axiom back and filled out the first report of injury. Mr. Cook testified he did not call claimant when he found out that claimant was claiming an injury.

25. Significant testimony was presented regarding other issues with claimant's employment, including an incident in which claimant was written up for locking a seatbelt behind him in the truck to circumvent a rule that seatbelts be worn at all times when operating a vehicle. Because the ALJ finds that claimant's termination was not related to this incident (as evidenced by the lack of any write ups for claimant for the incident being entered into evidence at hearing), the ALJ finds these incidents immaterial to the ultimate decision of whether claimant committed a volitional act that resulted in his termination of employment.

26. The ALJ finds based on the testimony that was presented at hearing that claimant was terminated for failing to attend the safety meetings. However, insufficient evidence was presented that demonstrated claimant was aware that his failure to attend the safety meetings would result in his termination of employment. Claimant testified that he was not allowed to stand next to an open door to attend the safety meetings, but would have to be in the room exposed to the second hand smoke to attend the safety meetings.

27. The ALJ finds respondents have failed to demonstrate that claimant was terminated for committing a volitional act that he reasonably knew would lead to his termination of employment. The ALJ notes that despite testimony at hearing that indicated employer used a progressive discipline process, claimant was never warned that his failure to fully attend the safety meetings would lead to his termination of employment. Therefore, the ALJ determines that respondents have failed to prove that claimant reasonably should have known that his actions would lead to his termination of employment.

28. The ALJ further finds that claimant's testimony that he objected to being exposed to second hand smoke in the safety meetings was a reasonable excuse on his part to abstain from the safety meetings absent some kind of written warning from employer or the tool pusher that his failure to attend the meetings would lead to his termination of employment.

29. Furthermore, evidence presented at the hearing indicates Mr. Cook issued an e-mail shortly after claimant reported his injury that indicated claimant was terminated December 31, 2014 for "unsatisfactory job performance" and made no mention of claimant's failure to attend the safety meetings or other insubordination that led to his termination of employment. Therefore, the ALJ concludes that respondents have failed to meet their burden of proof in this regard.

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 when he slipped and fell on his right side injuring his shoulder. The ALJ notes that claimant's co-worker witnessed the fall and Dr. Smith documented claimant having bruising on his right shoulder when he examined claimant on January 2, 2015. The ALJ finds that claimant has proven by a preponderance of the evidence that the fall caused the injury to his right rotator cuff that necessitated the need for medical 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). 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. As found, the treatment provided by Dr. Smith and Dr. Adams, including the recommendation for the MRI of the shoulder is reasonable medical treatment necessary to cure and relieve claimant from the effects of the medical treatment.

7. "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." "[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).

8. As found, the treatment provided by Dr. Smith on January 2, 2015 was not authorized. As found, claimant initially reported the incident to employer, but didn't express a desire to seek medical treatment. As found, employer was not put on notice of the claimant's desire to seek medical treatment until claimant called Axiom and Axiom informed Mr. Cook of claimant's request for medical treatment.

9. However, after Mr. Cook became aware of the claimant's request for medical treatment, he did not refer claimant to a physician designated to treat claimant for his work injury. Therefore, claimant's treatment with Dr. Smith beginning January 14, 2015 is authorized, as the choice of physician had by then transferred to claimant pursuant to Section 8-43-404(5)(a), C.R.S. As found, Dr. Smith's referral to Dr. Adams is likely deemed authorized as within the chain of referrals.

10. 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).

11. As found, claimant has demonstrated that the injury resulted in work restrictions from Dr. Smith as of January 2, 2015. As found, the work restrictions resulted in a wage loss to claimant. As found, claimant is entitled to TTD benefits commencing January 2, 2015 when the restrictions came into place. The ALJ notes that claimant was off of work prior to January 2, 2015 due to his normal scheduled time off. Therefore, claimant's wage loss did not develop until January 2, 2015 and any wage loss prior to January 2, 2015 is not related to the work injury.

12. The mere fact that Dr. Smith was not an authorized provider at the time that he placed claimant on restrictions does not negate the fact that claimant has proven by a preponderance of the evidence that he sustained an injury that resulted in disability and led to an impairment of wage earning capacity. The TTD benefits continue until February 23, 2015 when claimant returned to work for a different employer.

13. 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).

14. As found, claimant has failed to provide sufficient evidence that he is entitled to an award of TPD benefits. As found, insufficient evidence was presented at hearing that there was a wage loss that occurred when claimant returned to work for the subsequent employer and that the wage loss was attributable to the work injury.

15. 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).

16. As found, respondents have failed to demonstrate that claimant committed a volitional act that led to his termination of employment. As found, claimant was terminated for failing to attend the safety meetings, but was not advised by employer that his actions would result in his termination of employment. Moreover, when claimant was terminated, he was simply advised that it was for poor work performance, and not specifically for failing to attend the safety meetings. As such, respondents have failed to prove by a preponderance of the evidence that claimant exercised a degree of control over the circumstances surrounding his termination of employment.

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 pursuant to the Colorado Medical Fee Schedule after January 14, 2015 from Dr. Smith and Dr. Adams, including but not limited to the recommended MRI scan of the right shoulder.

2. Claimant's claim for payment of the January 2, 2015 medical bill from Dr. Smith is denied as Dr. Smith was not yet authorized to treat claimant for his work related injuries.

3. Respondents shall pay claimant TTD benefits for the period of January 2, 2015 through February 24, 2015 based on the stipulated AWW.

4. Claimant's claim for TPD benefits is denied.

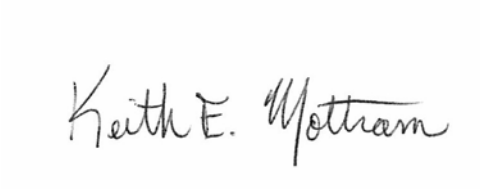
5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

6. 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: July 31, 2015



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

ISSUE

Claimant's Average Weekly Wage (AWW).

FINDINGS OF FACT

1. Claimant works for Employer as a cleaner. Claimant performs her cleaning work primarily at Kinder Morgan Day Porter, Cresthill Middle School, and Cougar Run Elementary School.

2. Claimant alleges that she suffered an industrial injury on November 10, 2014.

3. On November 10, 2014 Claimant was earning $9 per hour.

4. On December 5, 2014 Claimant began earning $9.50 per hour for her work as lead cleaner. Claimant continued to earn $9.50 per hour for the months of December, 2014, January, 2015, February, 2015, and March, 2015.

5. Prior to and leading up to her alleged industrial injury, Claimant typically earned $9 per hour with the exception of the month of August, 2014 where she earned $10 per hour on most days and $9 per hour on a few days.

6. Claimant's work involved varied hours per week and on occasion she earned overtime pay.

7. From May 6, 2014 through November 10, 2014 Claimant worked approximately 906.02 hours over 26 and 6/7 weeks, for an average of 33.73 hours per week. During this period of time Claimant earned total gross wages of $8,372.57 for the 906.02 hours, for an average hourly wage of $9.24. Claimant's average hourly wage of $9.24 multiplied by the average number of hours she worked per week of 33.73 comes out to $311.67.

CONCLUSIONS OF LAW

Generally

The purpose of the Workers' Compensation Act of Colorado, 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. § 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. § 8-43-201, C.R.S. Respondent bears the burden of establishing any affirmative defenses. 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 shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer and a worker's compensation case shall be decided on its merits. § 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).

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).

Average Weekly Wage

Section 8-42-102(2), C.R.S., requires the ALJ to base the claimant's AWW on his earnings at the time of injury. However, under certain circumstances the ALJ may determine the claimant's AWW from earnings received on a date other than the date of injury. *Avalanche Industries, Inc. v. Clark,* 198 P.3d 589 (Colo. 2008); *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Specifically, § 8-42-102(3), C.R.S., grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine the claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp., supra.* Where the claimant's earnings increase periodically after the date of injury the ALJ may elect to apply § 8-42-102(3) and determine that fairness requires the AWW to be calculated based upon the claimant's earnings during a given period of disability, not the earnings on the date of the injury. *Avalanche Industries, Inc. v. Clark, supra*; *Campbell v. IBM Corp.*, *supra*.

The ALJ concludes that the best way to reach a fair approximation of Claimant's wage loss in this matter is to use the total wages Claimant earned in the six months leading up to her alleged industrial injury. For the 27 and 6/7 weeks prior to her injury Claimant earned approximately $9.24 per hour when her wages varied between $9 and $10 per hour. Claimant worked on average 33.73 hours per week during this time period. $9.24 x 33.73 hours equals an average weekly wage of $311.67. As Claimant's hours varied, the number of overtime hours varied, and her hourly wage varied during this time, the ALJ concludes that taking this average for the 6 months prior to and leading up to her alleged industrial injury is the best way to come to a fair approximation of her diminished earning capacity.

Although the ALJ notes that in the month of December Claimant received a raise to $9.50 per hour, it is unclear if Claimant's wages at that rate were expected to continue, or if they were expected to return back to $9 per hour as they did previously when Claimant received a raise from $9 to $10 per hour and then went back to $9 per hour. The evidence is insufficient to support that calculating wages based on $9.50 per hour would be the best way to fairly approximate her diminished earning capacity. Rather, the ALJ finds it most appropriate to use the calculation outlined above and the average weekly wage based on the 6 months prior to the alleged industrial injury. Claimant's average weekly wage is $311.67.

ORDER

It is therefore ordered that:

1. Claimant's Average Weekly Wages is $311.67.

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.

/s/ Michelle E. Jones

DATED: July 27, 2015

Michelle E. Jones
Administrative Law Judge
Office of Administrative Courts
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Denver, Colorado, 80203