O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-764-364

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable industrial injury to his left knee during the course and scope of his employment with Employer on March 20, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits.

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").

FINDINGS OF FACT

1. Employer is a company that installs commercial swimming pools and aquatic features. On February 27, 2008 Claimant began working for Employer as a construction laborer.
2. On March 20, 2008 Claimant was performing plumbing work in a collection tank. The collection tank was approximately 18 feet deep. Claimant descended into the tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee and fell several feet. Claimant landed on the concrete floor at the bottom of the tank. He experienced pain in his left knee and remained on the concrete floor for a short period of time. Claimant then completed his tasks in the collection tank, climbed up the rungs of the tank and finished his work shift.
3. Claimant's supervisor RP also testified about the March 20, 2008 incident. Mr. P explained that he witnessed Claimant fall several feet off the rungs of the collection tank onto the concrete floor at the bottom of the tank. Claimant remained on the floor for a short period of time but stood up without assistance. Mr. P then inquired about how Claimant was feeling and Claimant responded that he was sore. However, Claimant did not request medical treatment. Claimant then climbed up the rungs to the top of the collection tank and completed his work shift.
4. On March 21, 2008 Claimant completed his eight and one-half hour work shift for Employer. He spent most of the day crawling on his knees over rebar while searching for a leak. Mr. P explained that, although Claimant complained of knee pain, he did not relate the pain to the March 20, 2008 incident. Instead, Claimant attributed his knee pain to working on his knees over the course of many years.

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS
W.C. No. 4-334-784

ISSUES

The issues to be determined by this decision concern permanent total disability (PTD); medical maintenance benefits (*Grover* medicals); bodily disfigurement; offsets for receipt of Federal Social Security disability benefits (SSDI); and, Respondents' affirmative claim for interest, based on an overpayment of Colorado temporary total disability (TTD) benefits because the Social Security Administration (SSA) erroneously offset Colorado TTD benefits against Claimant's SSDI benefits from May 1, 2000, through April 2008 and, after the SSA reversed itself in April 2008, it made a retroactive payment of $22,291 to the Claimant. Respondents contend that they are equitably entitled to interest on this sum because they were deprived of the opportunity of taking contemporary offsets from May 1, 2000 through April 2008, if the SSA had been correctly applying the Colorado law permitting offsets of SSDI benefits against Colorado disability benefits.

At the commencement of the hearing, the parties stipulated to the following: (1) Claimant is entitled to all authorized and reasonably necessary *Grover* medicals; (2) Respondents have offered the Claimant vocational rehabilitation as an alternative to PTD, pursuant to the provisions of Section 8-42-111 (3), C.R.S. (2008); while the Claimant was living in North Carolina, the SSA off set her Colorado TTD benefits against her SSDI benefits under the law of North Carolina, in the aggregate amount of $22,291. The ALJ accepts these stipulations and finds them to be fact.

FINDINGS OF FACT

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

1. Claimant was awarded SSDI benefits as of May 1, 2000. The parties stipulated that the monthly amount awarded in May 2000 was $509.90, and the ALJ so finds.

2. When SSDI benefits were awarded to the Claimant, North Carolina's law was applied so that Claimant's Colorado workers compensation benefits were fully offset. Therefore, after the erroneous offset, Claimant received no payments of SSDI benefits from May 1, 2000 through April 2008.

3. In April 2008 the SSA agreed that Colorado's "reverse jurisdiction" law applies to Claimant's SSDI benefits. Accordingly, Claimant became entitled

to payment of full SSDI benefits, thereby entitling SCA Claims Management to the 50 % offset provided by Section8-42-103 (1) (c) (I), C.R.S. (2008).

4. At the time the SSA in North Carolina determined that Colorado law applied, Claimant had received cost-of-living increases raising her monthly SSDI benefit as of December 2007 to $704.00 per month.

5. The ALJ finds, however, that the amount of Claimant's initial award of SSDI benefits was $509.90. Based on this initial award, the offset for SSDI benefits calculates to $58.83 per week.

6. Claimant repaid $22,291.00 to SCA Claims Management for the overpayment of workers compensation resulting from her retroactive award of SSDI benefits. SCA Claims Management has been fully repaid through June 30, 2008.

7. To date, Respondents have not taken any offset for SSDI benefits. Claimant agreed to repay the overpayment of workers compensation benefits from July 1, 2008 through October 31, 2008, in one lump sum payment to SCA Claims Management. Thereafter, Respondents may take the 50 % offset against weekly benefits, pursuant to Section 8-42-103 (1) (c) (I), C.R.S. (2008).

8. Respondents concede that Claimant fully cooperated with Respondents in correcting the applicability of the North Carolina SSDI offset for workers' compensation benefits and the Claimant engaged in **no** wrongful acts, and the ALJ so finds.

9. The Claimant reached maximum medical improvement on **November 10, 2005.**

10. The parties stipulated, and the ALJ finds, maintenance medical benefits as recommended by her authorized treating care providers, including Dr. Jackson, Dr. Powers, Gastonia Pain Clinic and Dr. Kallenbach, are causally related to her compensable injury and reasonably necessary to cure and relieve the effects thereof.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Facts, the ALJ makes the following Conclusions of Law:

Social Security Disability Benefits

1. Section 8-42-103(1)(c)(I), C.R.S. (2008), provides that workers' compensation benefits shall be reduced by one-half of Social Security disability benefits. Respondents contend that because Colorado law concerning the offset was not properly applied to Claimant's SSDI benefits until 2008 they are entitled to the offset based on the SSDI

award amount established in December 2007, which encompassed annual cost-of-living adjustments (COLAs) since May 1, 2000. In *Engelbrecht v. HartF Accident and Indemnity Co.*, 680 P.2d 231 (Colo. 1984), the Colorado Supreme Court held that only the initial award of SSDI benefits is subject to the 50 % offset. COLAs can never be offset. Therefore, the 50 % offset against SSDI benefits is established as of May 1, 2000, at the monthly rate of $509.90. The offset for 50 % of Claimant's SSDI benefits, provided by Section 8-42-103 (1) (c) (I), C.R.S. (2008), is $58.83 per week.

Interest Payable by Claimant

2. Section 8-43-410(2), C.R.S. (2008), provides:

Every employer or insurance carrier of an employer shall pay interest at the rate of eight percent per annum on all sums not paid upon the date fixed by the award of the director or administrative law judge for the payment thereof or the date the employer or insurance carrier became aware of an injury, whichever date is later. . . .

Section 8-43-410(2), C.R.S. (2008), provides for interest payable only by the insurer, not the injured worker. Because of this, Respondents argue, the statute's failure to require an injured worker to pay interest is inequitable. The Workers' Compensation Act is silent on payment of interest by the injured worker. Consequently, Respondents argue that there should be a "default" to the Colorado Consumer Credit Code, Title 5. Respondents cite Section 5-12-102(1)(a), C.R.S. (2008), which provides that creditors shall receive interest:

a. [w]hen money or property has been wrongfully withheld, interest shall be an amount which fully recognizes the gain or benefit realized by the person withholding such money or property . . .

b. Section 5-12-102(2), C.R.S. (2008), provides that when there is no agreement as to the interest rates, creditors can receive interest at the rate of 8 percent per annum compounded annually. As found, Claimant fully cooperated with Respondents in correcting the applicability of the North Carolina SSDI offset for workers' compensation benefits and the Claimant engaged in **no** wrongful acts.

3. Respondents also cite Section 8-42-113.5(1)(a) C.R.S. (2008), arguing that Claimant had a duty to notify Respondents, in a timely fashion, of her *eligibility* for SSDI benefits:

Within twenty calendar days after learning of **such payment, award, or entitlement**, the claimant . . . shall give written notice of the payment, award, or entitlement to the employer or, if the employer is insured, to the employer's insurer. . .

[Emphasis supplied]

There is no provision in the Workers' Compensation Act requiring an injured worker to pay interest on any overpayment of workers' compensation bene-

fits. Colorado appellate courts have uniformly held that non-existent provisions cannot be read into the Workers' Compensation Act. See *Kraus v. Artcraft Sign Co.*, 710 P.2d 480 (Colo. 1985). Clearly, to find an obligation for an injured worker to pay interest on an overpayment of SSDI benefits is an issue properly for the General Assembly, not the ALJ. The same reasoning applies to Respondents' argument that Claimant had a duty to provide notice of her eligibility for SSDI.

4. Respondents argue that it is inequitable to have deprived them of the ability to take contemporaneous offsets against Claimant's entitlement to TTD benefits from May 1, 2000 through April 2008 (although Claimant received zero in SSDI benefits during this period of time because of the erroneous offset of Colorado TTD benefits against Claimant's SSDI benefits). The equitable jurisdiction of statutory judges (ALJs who decide workers' compensation cases) is limited to instances were it has either been conferred by statute or case law. *See Garrett v. Arrowhead Improvement Association,* 826 P.2d 850 (Colo. 1992). The specified instances of equitable jurisdiction include average weekly wage determinations when specific statutory methods would be inequitable conferred by statute, Section 8-42-102 (3), C.R.S. (2008); application of the equitable doctrine of "claim preclusion" [*See W v. Industrial Claim Appeals Office (ICAO),* 862 P.2d 1007 (Colo. App. 1993)]; application of the "law of the case" doctrine [*See Cooper v. ICAO,* 998 P.2d 5 (Colo. App. 1999)]; application of the doctrine of "estoppel" [*See Verzuh v. Rouse,* 660 P.2d 1301 (Colo. App. 1982)]; application of the doctrine of "laches" [*See Bacon v. ICAO,* 746 P.2d 74 (Colo. App. 1987)]; and, application of the doctrine of "waiver" [*See Johnson v. ICAO,* 761 P.2d 1140 (Colo. 1988). The ALJ concludes that equitable jurisdiction to award interest to Respondents and against the Claimant is lacking because there is no express statutory authority to do so, and there is no case law concerning an equitable award of "interest," which is a creature of statute. Also, to require the Claimant to pay Respondents interest on the retroactive payment of the $22,291 in SSDI benefits, which Claimant immediately repaid to SCA Claims Management on receipt thereof from the SSA, would effect an inequitable result against the Claimant who, as found, was not a fault for the SSA's erroneous application of North Carolina offset provisions. As found, there is no overpayment through June 30, 2008 because Claimant has fully repaid the insurer for the retroactive SSDI benefits. Since July 1, 2008 the fact that any overpayment may exist is because Respondents, despite being notified of the award, failed to begin taking the 50 %offset.

***Grover* Maintenance Medical Care**

5. An employee is entitled to continuing medical benefits after maximum medical improvement if reasonably necessary to relieve the employee from the effects of an industrial injury. *See Grover v. Industrial Commission 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-*

trial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. As found, Claimant reached MMI on **November 10, 2005,** and she is entitled to maintenance medical care, which is reasonable and necessary to address the injury. As found, Claimant is entitled to maintenance medical benefits as recommended by her authorized treating care providers, who include Dr. Jackson, Dr. Powers, Gastonia Pain Clinic and Dr. Kallenbach.

Permanent Total Disability

6. As found, Respondents have Claimant offered vocational rehabilitation, pursuant to Section 8-42-111 (3), C.R.S. (2008), as an alternative to a determination of PTD at the present time, and Claimant has accepted this offer. Accordingly, the issue of PTD is premature for determination.

7. Section 8-42-105(1), C.R.S. (2008), requires payment of TTD benefits when vocational rehabilitation is offered and accepted. *See also Larimer County v. Sinclair*, 939 P.2d 515 (Colo.App. 1997). Therefore, Claimant is entitled to temporary total disability benefits beginning **November 10, 2005**, the time when Claimant reached MMI and continuing during vocational rehabilitation.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall provide the Claimant with ongoing maintenance medical benefits that are reasonably necessary and causally related to her industrial injury as recommended by her authorized treating care providers, including Dr. Jackson, Dr. Powers, Gastonia Pain Clinic and Dr. Kallenbach.

B. Respondents shall pay the Claimant temporary total disability benefits of $359.33 per week from **November 10, 2005** and continuing during her vocational rehabilitation.

C. Respondents are entitled to a weekly offset of **$58.83** for Claimant's receipt of Federal Social Security Disability benefits, continuing pursuant to law.

D. Respondents' request for interest payable by Claimant to Respondents is hereby denied and dismissed.

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

F. Any and all issues not determined herein are reserved for future decision.

_____ day of November 2008. EDWIN L. FELTER, JR.

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-753-134

ISSUES

The issues to be determined by this decision concern compensability, medical benefits, temporary total disability (TTD) benefits and average weekly wage (AWW). The parties stipulated that the AWW was $380.00, thus, the TTD rate is $253.33 per week. Claimant bears the burden of proof, by a preponderance of the evidence, on all issues heard.

FINDINGS OF FACT

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

1. Claimant was employed in the Property Management Department of Employer. Claimant's job responsibilities included cleaning public access areas, performing snow and ice removal, and other similar duties.

2. Claimant resides in Silverthorne, Colorado. In order to reach her place of employment the Claimant must drive, carpool or ride the bus to Copper Mountain Ski Resort.

3. Employer provides parking for employees based on the expected level of visitors to the ski resort. Normally, Claimant must park in the Alpine Lot. However, when attendance is expected to be lower, Claimant may park in the Chapel Lot. An orange flag at the entrance to the resort signals employees as to when the Chapel Lot is available for employee parking.

4. Claimant drove to Copper Mountain Ski Resort on February 28, 2008. Upon arrival Claimant saw the orange flag and parked in the Chapel Lot.

5. Claimant sustained an injury on February 28, 2008, when she slipped on ice and fell outside the Village Square Hotel en route to her assignment meeting, located in the Mountain Plaza Hotel. This injury arose out of and was within the course and scope of her employment.

6. Claimant's supervisor found her on the ground and he had the Claimant transported by the Summit County Ambulance Service to the Copper Mountain Clinic of St. Anthony's hospital for medical treatment where she saw Timothy Keeling, D.O. Respondents made a first selection of St. Anthony's Hos-

pital and Dr. Keeling. The fall resulted in Claimant fracturing and dislocating her left elbow. At the hospital, Claimant's fracture was reduced and follow-up with an orthopedic physician was ordered. All of Claimant's medical care and treatment was within the chain of authorized referrals.

7. Claimant has been unable to follow-up with an orthopedic physician because she does not have insurance or the money to pay for physical therapy. She saw a doctor in Mexico at her own expense, but this was not within the chain of authorized referrals.

8. Claimant has not worked since her accident. Until she completes physical therapy the Claimant's use of her left arm is fully restricted. She has not earned any wages nor has she been released to return to full duty since the compensable accident. Also, she has not been declared to be at maximum medical improvement (MMI).

9. Claimant's testimony was credible, persuasive and it was not contradicted by any other testimony or evidence. Claimant convincingly exhibited inflexibility and weakness in her left arm, as well as pain in her left elbow, wrist and neck.

10. Claimant has proven, by a preponderance of the evidence that her left elbow, wrist and neck pain and limited use of her left arm is causally related to the injury of February 28, 2008; that medical care and treatment for this condition is reasonably necessary to cure and relieve the effects of Claimant's injury; and, that all medical care reflected in the evidence is authorized; and, that she has not been released to return to full duty, has been sustaining a 100% temporary wage loss since the date of the accident, and she has not been declared to be at MMI. Therefore, she has proven by preponderant evidence that she has been TTD since the date of the compensable accident.

CONCLUSIONS OF LAW

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

a. Generally, "harm or injury sustained by an employee while going to or from his work is not compensable." *Berry's Coffee Shop, Inc. v. Palomba*, 161 Colo. 369, 373, 423 P.2d 2, 5 (1967). However, several exceptions to this rule have been recognized. *Id.* Rather than resort to a list of exceptions, the proper approach to determine whether an exception to the "going to or coming from work" rule exists is to consider a number of variables. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 864 (Colo. 1999). "These variables include but are not limited to: (1) whether the travel occurred during working hours, (2) whether the travel occurred on or off the employer's premises, (3) whether the travel was contemplated by the employment contract, and (4) whether the obligations or

conditions of employment created a "zone of special danger" out of which the injury arose." *Id.*

b. Specifically, "[t]he fourth variable, the zone of special danger, refers to injuries that occur off an employer's premises but so close to the zone, environment, or hazards of such premises as to warrant recovery…" *Id.* at 865. For example, recovery has been allowed for accidents occurring on public streets, crossed from employer-provided parking to the place of employment. *Id.* The rule arising in that instance provides, "[w]here a parking lot constitutes a part of an employer's premises, or is provided by him, and an injury is sustained by an employee in a fall, or otherwise, while in such lot or while passing between it and his working place, or area, such injury has been held…to arise out of, or in the course of, the employment…" *State Compensation Ins. Fund v. Walter*, 143 Colo. 549, 555, 354 P.2d 591, 594 (1960) (citing and adopting the rule as stated in 99 C.J.S. Workmen's Compensation § 234, page 833). As found, Claimant's situation is similar to that described above. While walking from Chapel Lot, which was provided by the employer, to her place of work, Claimant sustained an injury in a fall. Thus, Claimant's injuries fall within the zone of special danger variable.

c. "Whether meeting one of the variables is sufficient, by itself, to create a special circumstance warranting recovery depends upon whether the evidence supporting that variable demonstrates a causal connection between the employment and the injury such that the travel to and from work arises out of and in the course of employment." *Madden*, at 865. As found, the evidence produced by Claimant at hearing demonstrated the necessary causal connection between her employment and the injury suffered.

d. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. Section 8-43-201, C.R.S. (2008). *See also, City of Boulder v. Streeb,* 706 P.2d 786, 789 (Colo. 1985). 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, 318, 592 P.2d 792, 800 (1979). *Also see, Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has sustained her burden of proof.

e. 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. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (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 (1936); CJI, Civil, 3:16 (2005). As found, Claimant's testimony was reasonable, not contradicted and credible.

f. Respondent is liable for medical treatment that is reasonably necessary to cure and relieve the effects of a work-related injury. Section 8-42-101(1)(a), C.R.S. (2008). 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 are sought. *See*, *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Whether a claimant sustained her burden of proof is generally a factual question for resolution by the ALJ. *See*, *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). As found, Claimant has established a causal relationship between her work-related injury and the condition for which benefits were sought.

g. To establish entitlement to temporary disability benefits, the Claimant must prove that the industrial injury has caused a "disability," and that she has suffered a wage loss that, "to some degree," is the result of the industrial disability. Section 8-42-103(1), C.R.S. (2008); *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). When a temporarily disabled employee loses her employment for other reasons which are not her responsibility, the causal relationship between the industrial injury and the wage loss necessarily continues. This is true because the employee's restrictions presumably impair her opportunity to obtain employment at pre-injury wage levels. *Kiernan v. Roadway Package System*, W.C. No. 4-443-973, [Industrial Claim Appeals Office (ICAO), December 18, 2000]. Claimant's termination in this case was because she was medically restricted from performing her full duties.

h. 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 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, Claimant has not been released to full duty, she has been sustaining a 100% temporary wage loss, she has not been offered modified employment, and she has not been declared to be at MMI. Therefore, as found, she has been TTD since the date of injury.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay for all medical benefits with regard to the Claimant's left elbow, wrist and neck pain, and the limited use of her left arm that are authorized, reasonably necessary, and causally related to the her injuries oc-

curring on February 28, 2008. The medical costs shall not exceed the amounts permitted by the Division of Workers' Compensation Medical Fee Schedule.

B. Respondents shall pay the Claimant temporary total disability benefits of $253.33 per week, or $36.19 per day, from February 29, 2008 through September 25, 2008, both dates inclusive, a total of 1771 days, in the aggregate amount of $6,188. 49,which is payable retroactively and forthwith. From September 26, 2008 until the conditions for cessation or modification of temporary disability benefits occur, Respondents shall continue paying the Claimant $**253.33** per week in temporary total disability benefits.

C. Respondents shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

D. Any and all issues not determined herein are reserved for future decision.

_____ November 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-392-766

ISSUE

The sole issue for determination in this order is permanent total disability (PTD) benefits.

FINDINGS OF FACT

1. Claimant sustained a compensable injury to her cervical spine on July 21, 1998. Claimant has reached maximum medical improvement (MMI).
2. Claimant was born in October 1968. At the time of the hearings she was 39 years old. Claimant has an eleventh grade education and no G.E.D. Claimant has attended some post-high school classes. Most of her employment history is in very physically demanding jobs. She was working in a very physically demanding job at the time of this injury.
3. After a surgery in July 2002, Claimant did light work at home for her husband's business. This work included working on a computer, payroll, running errands, and preparing bids. She also worked as a receptionist in a doctor's office and at a health club. She last worked in July 2004 when she left her part-time employment at the health club.
4. Claimant testified that she left her employment at the health club because her pain was so severe. She testified that she had excruciating neck pain and that she did not do anything to increase her neck symptoms. She testified that her condition has

gotten even worse since July 2004. She testified that she has pain and that this affects her concentration. She testified that she has good days and bad days. She testified that on bad days all she can do is go from the bed to the couch. She testified that she has headaches, neck aches, aches down into her arms and hands, pain in her shoulder blades, across her back, and down into her hips. She testified that her medications slow down her thinking. She testified that she can stand only one hour or walk thirty minutes, and that would be with pain. She testified that she can sit one-half to one hour. She testified that she cannot sit with her head in a flexed position. She testified that her sleep is affected. She testified that she did her best at an FCE.

5. Dr. Lawrence Lesnak testified that there were inconsistencies in Claimant's clinical presentations. In his August 30, 2007, report he stated that Claimant had multiple pain behaviors and non-physiologic findings. He stated that her complaints suggest a significant degree of somatization and functional overlay. He stated that when Claimant left work there were no intervening events that would have caused any decreased functional status and that Claimant's examination was extremely non-physiologic in nature. He stated that the November 2004 video tape suggests that Claimant's subjective reports and reports of her functional ability to her health care providers were not accurate. He stated that Claimant's subjective complaints were not reliable. He testified that activities shown in a November 2004 video were inconsistent with the medical records from that time. Dr. Lesnak testified that there were no objective changes before and after she left employment in July 2004. He testified that Clamant exhibited pain behavior, which is an unexpected result that has no anatomic or physiologic basis. He noted that there was no significant changes in her range of motion before 1998, in 1999, and in 2007, so there should be no changes in her restrictions between those dates. Dr. Lesnak testified that Claimant embellishes her symptoms and what she says about her pain levels is unreliable.

6. Dr. Michael Janssen examined Claimant once and met with her on four occasions between August and November 2004. In his November 18, 2004, report he stated that Claimant's subjective symptoms and generalized illness behavior far exceeded any obvious anatomical, radiographic, or clinical pathology. In his report of March 27, 2005, he stated that he had reviewed the November 2004 video, and that it clearly showed a discrepancy in the subjective complaints. He stated that there was no anatomical or objective pathology to support Claimant's ongoing subjective complaints. He testified that Claimant's subjective complaints do not match her clinical objective pathology. He testified that he reviewed the video, and her presentation on the November 2004 video was not consistent with her complaints in November 2004.

7. Dr. Woodcock is an authorized treating physician. He first treated Claimant in early 2004. He has continued to provide controlled substances for her pain, and has used a medication contract. He testified that Claimant's pain has been consistent over time and there is objective evidence and significant pathology, although there is non-physiologic pain behavior. He testified that Claimant's pain is so severe and impairing that she cannot be employed on a regular basis. He testified that he reviewed the video tapes and that they were not inconsistent with what Claimant told him she could do. He testified that Claimant exaggerated her symptoms, but was not malingering.

8. It is found that Claimant has significant functional overlay and exaggerates her symptoms. Claimant's testimony and her reports to her physicians as to the extent of her pain and impairment are not credible.

9. Dr. Woodcock took Claimant off work in July 2004. In his report he stated that Claimant had an acute exacerbation of neck pain with unknown etiology. He testified that her pain complaints were worse. He testified that objective tests showed no change, and that he did not know why she was worse. He testified that her cervical range of motion did not change between 1997 and 2006.

10. Dr. Lesnak testified that Claimant's symptoms were the same before and after she was taken off work in July 2004, and that tests afterward showed no objective changes. Dr. Reiss, in his November 2, 2005, report stated that Claimant was better than in 2004. Dr. Lockwood, in his April 6, 2006, report stated that Claimant has been stable since December 2002.

11. Claimant underwent an assessment of her functional capacity on August 22, 2006, at O. T. Resources. The assessment was performed by Marie Andrews, OTR. Doris Shriver, OTR, FOATA, QRC, reviewed the assessment and prepared a report. In the report, and in her testimony, Shriver stated that Claimant's one time maximum lift was 5 to 10 pounds, her maximum occasional lift was 2 to 5 pounds, and that Claimant could not do any frequent or continuous lifting. Shriver stated that Claimant's maximum sit, stand, and walk was 30 to 60 minutes, and that Claimant's maximum hand use was for two hours. Another significant finding of Shriver was that Claimant was at the less than one percentile for overall fine motor and gross motor coordination. Shriver did not do significant objective validity testing; rather, she based her opinions on her clinical observations and judgment. In her report, Shriver referred to studies that showed that clinical observation and judgment of the subject during testing was more accurate in assessing effort than the best statistical analysis.

12. Sherry Plumer, OTR, CFCE, evaluated Claimant and prepared a report on October 24, 2007. Plumer stated that Claimant was capable of lifting 10 to 15 pounds occasionally, push/pull with 25 pounds of force, frequently sit, and occasionally stand, walk, climb stairs, and kneel. She reported that Claimant could bend up to 20% of the time. She stated that Claimant could do constant light grasping and light pinching, frequent medium grasping and medium pinching. She stated that Claimant could do occasional poser grasping, power pinching, fingering or typing, and writing. Under "Interpretation of Findings," Plumer stated that Claimant demonstrated high effort, and that her subjective reports were consistently reliable, but that Claimant may, on occasion, have a tendency to overestimate her physical abilities. She stated that her interpretation was based on Claimant's subjective report of pain and physical abilities compared to objective clinical observation during both distracted and undistracted activities.

13. Dr. Lesnak criticized the report of O. T. Resources. He stated that the report and its conclusions were based on subjective opinions rather than objective evidence. Dr. Lesnak also stated that the FCE of Plumer had some validity checks, but that her conclusions appear not to be based on objective evidence but rather patient effort. Dr. Lesnak testified that one or two validity checks are not enough and that one should have four to six validity checks. This testimony of Dr. Lesnak is credible and persuasive.

14. The Claimant's physical restrictions provided by Shriver at O. T. Resources and Plumer are not persuasive. Dr. Woodcock's opinion in July 2004 that Claimant could no longer perform the work she was performing at that time is not persuasive.

15. Dr. Lockwood provided care for Claimant through 2002. In December 2002, he noted that Claimant was employable "in at least a sedentary work capacity." In April 2006, Dr. Lockwood, after an examination and record review, stated that Claimant's condition had been stable since December 2002.

16. Dr. Lesnak examined Claimant on August 30, 2007, and performed a medical records review. He stated that it was medically safe for Claimant to work in the sedentary to light work category.

17. Claimant testified that she is not capable of employment. Dr. Woodcock has stated in numerous reports that Claimant is not capable of competitive employment. Shriver has stated that Claimant cannot sustain work as a reliable worker, is unable to sustain work postures, is academically cognitively limited, and has limited hand skills. These opinions rely too much on Claimant's subjective complaints, which are not reliable. These opinions are not persuasive.

18. The opinions of Dr. Woodcock and Dr. Lesnak are credible and persuasive. Claimant is capable of performing work in the sedentary to light work category.

19. Shriver performed a vocational evaluation. She concluded that Claimant was not capable of employment. She based that conclusion on her opinion that Claimant was not capable of performing even sedentary work. The opinion of Shriver is not persuasive.

20. It is found that there has been no significant change in Claimant's ability to function after June 2004. Everything that Claimant was able to do from her surgery in 2002 to July 2004, she was able to do as of the date of the hearing. Claimant is capable of employment as a receptionist in a medical office and as a receptionist at a health club.

21. Kate Montoya performed a vocational evaluation, prepared a report, and testified at the hearing. Based on the restrictions of Dr. Lesnak, Montoya opined that Claimant was capable of employment in receptionist and clerical positions, counter attendant position, and some cashier positions. In a report dated December 18, 2007, Dr. Lockwood stated that Claimant could perform the duties of employment in the fields suggested by Montoya. The opinion of Montoya is credible and persuasive.

22. Employment is reasonably available to Claimant under her particular circumstances. Claimant is capable of earning wages in competitive employment.

CONCLUSIONS OF LAW

Section 8-40-201(16.5)(a), C.R.S., defines permanent total disability as the claimant's inability "to earn any wages in the same or other employment." The burden of proof to establish permanent total disability is on the claimant. In determining whether the claimant has sustained his burden of proof, the ALJ may consider those "human factors" that define the claimant as an individual. *Christie v. Coors Transportation Co.,* 933 P.2d 1330 (Colo. 1997). These factors may include the claimant's physical condition, mental ability, age, employment history, education and the "availability of work" the claimant can perform. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). The overall objective of this standard is to determine whether, in view of all of these factors, employ-

ment is "reasonably available to the claimant under his or her particular circumstances." *Weld County School District RE-12 v. Bymer*, 955 P.2d at 558.

Claimant has failed to establish by a preponderance of the evidence that employment is not available to her under her particular circumstances. Claimant is capable of earning wages. Claimant is not permanently and totally disabled.

ORDER

It is therefore ordered that Claimant's request for permanent total disability benefits are denied.

All matters not determined herein or by prior orders or admissions are reserved for future determination.

DATED*: November 26, 2008* Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-534-254

ISSUES

The issues determined herein are petition to reopen, temporary total disability ("TTD") benefits, and average weekly wage.

FINDINGS OF FACT

1. Claimant was employed by the employer as an industrial maintenance engineering technician. He was required to engage in lifting in the course of maintaining the equipment on the production floor, the hydraulics, the pneumatics, the robotics, and the HVAC system.

2. On June 17, 2001, claimant suffered an admitted work injury to his low back.

3. On December 18, 2001, Dr. Sceats performed a microdiscectomy surgery.

4. On February 7, 2002, claimant's authorized treating physician determined that he was at maximum medical improvement ("MMI").

5. In approximately March 2002, three months after the surgery, claimant began to suffer increased muscle spasms and some bladder incontinence.

6. On August 19, 2002, the insurer filed a final admission of liability terminating TTD benefits on February 7, 2002, admitting for permanent partial disability benefits through July 25, 2002, and admitting for post-MMI medical benefits.

7. Claimant continued to have low back and leg pain after MMI. On April 10, 2003, Dr. Sandell examined claimant and then began to provide post-MMI medical treatment.

8. On July 17, 2003, claimant reported to Dr. Sandell that he had suffered increased pain and some urinary incontinence since about three months after the surgery.

9. On March 26, 2004, Dr. Sandell documented the possibility of a worsening of condition on the part of claimant.

10. On May 6, 2004, Dr. Sandell noted that claimant had worsening low back pain and left leg pain. On May 28, 2004, Dr. Sandell noted a "new" symptom of loss of bladder control.

11. On August 17, 2004, claimant reported to Dr. Sandell that he had suffered increased low back pain and muscle spasm for about one month.

12. On November 9, 2004, Dr. Sandell concluded that claimant had significantly increased low back pain.

13. On August 5, 2005, Dr. Sandell noted that claimant was experiencing pain radiating into the left leg. Dr. Sandell noted that the last epidural steroid injection had not helped and that claimant might be worsening.

14. On June 26, 2006, claimant had an epidural steroid injection that was largely ineffective.

15. Dr. Sandell expressed concern that there may have been a change in the underlying anatomy.

16. On July 11, 2006, Dr. Sandell noted increased low back pain and radicular left leg pain. He referred claimant for a new magnetic resonance image ("MRI").

17. On August 9, 2006, Dr. Sandell noted that the new MRI showed worsening of the L5-S1 disc. He referred claimant back to Dr. Sceats to be surgically re-evaluated.

18. Dr. Sceats did not recommend any surgery.

19. On September 15, 2006, Dr. Sandell referred claimant for a second surgical opinion with Dr. Sung, but the insurer denied authorization for that examination.

20. On June 5, 2007, claimant filed a Petition to Reopen based upon a change of condition. Respondents filed an objection to the petition.

21. On August 22, 2007, Dr. Sung examined claimant and diagnosed severe collapse at L5-S1 with degeneration. Dr. Sung recommended a new MRI, which was completed on October 24, 2007. The new MRI showed significant degeneration at L5-S1 with some mild neural foraminal narrowing and disc bulging. Dr. Sung recommended a discogram, which was performed on February 25, 2008.

22. On April 3, 2008, Dr. Sung recommended fusion surgery at L5-S1.

23. On May 20, 2008, Dr. Sung performed an L5-S1 anterior lumbar interbody fusion.

24. On June 17, 2008, Dr. Sandell wrote that claimant was no longer at MMI as of April 3, 2008, when the surgical recommendation was made.

25. As of October 20, 2008, Dr. Sandell still had not released claimant to return to work.

26. Claimant filed a timely petition to reopen prior to six years from the date of his injury.

27. Claimant has proven by a preponderance of the evidence that he suffered a change of condition after MMI as a natural consequence of the work injury. The record evidence demonstrates that claimant started suffering a change of condition as early as three months after his first surgery. By August 2006, claimant clearly had suffered a significant worsening of his condition, as demonstrated on the MRI. Although the surgical recommendation did not occur until April 3, 2008, claimant's condition had worsened long before that recommendation. Dr. Sandell noted the worsening and wanted the second surgical evaluation by Dr. Sung. The insurer caused an eight-month delay in obtaining the evaluation by Dr. Sung.

28. Claimant has been unable to return to his usual job as of the date of injury due to his admitted work injury.

29. Since April 3, 2008, claimant has no longer been at MMI and he has been unable to perform any work. Claimant suffered increased disability due to his worsening of condition.

30. The preponderance of the evidence demonstrates that claimant's average weekly wage should not be modified effective April 3, 2008. He was unable to return to work due to his work injury. His average weekly wage for purposes of his renewed TTD is the admitted average weekly wage.

CONCLUSIONS OF LAW

1. Respondents first argue that claimant's petition to reopen is barred by the statute of limitations in section 8-43-303(1), C.R.S. That provision allows reopening within six years from the date of injury. Contrary to respondents' argument, claimant filed a timely petition to reopen prior to the expiration of six years from his injury. That petition was never withdrawn or dismissed. The fact that the hearing did not occur until 16 months later does not change the timely status of the petition. *Federal Express v. Industrial Claim Appeals Office of the State of Colorado,* 51 P.3d 1107 (Colo.App. 2002); *Mascitelli v. Giuliano & Sons Coal Company*, 157 Colo. 240, 402 P.2d 192 (1965); *Westerman v. Manitou and Pikes Peak Railway and/or High Bridge Saloon,* W.C. Nos. 3-903-645, 4-407-473 (Industrial Claim Appeals Office, November 17, 2000). Nothing in the statute prohibits from petitioning to reopen without a statement that he is no longer at MMI. Claimant merely has to prove that he has suffered a change since the previous closure of the claim and that he is entitled to additional benefits. Claimant has satisfied those requirements.

2. Section 8-43-303(1), C.R.S. provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Reopening is appropriate when the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. *Dorman v. B & W Construction Co.*, 765 P.2d 1033 (Colo. App. 1988). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). Claimant must prove that his change of condition is the natural and proximate consequence of the industrial injury, without any contribution from another separate causative factor. *Vega v. City of Colorado Springs,* W.C. No. 3-986-865 & 4-226-005 (ICAO, March 8, 2000). As found, claimant has proven by a preponderance of the evidence that he suffered a change of condition after MMI as a natural consequence of the work injury.

3. Claimant was unable to return to the usual job due to the effects of the work injury. Consequently, claimant is "disabled" within the meaning of section 8-42-105, C.R.S. and is entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits con-

tinue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Upon reopening, claimant must prove increased disability since the original MMI date. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997). As found, claimant has proven by a preponderance of the evidence that he suffered increased disability since MMI.

4. Respondents argue that claimant's average weekly wage effective April 3, 2008, should be zero because he was earning no wages on that date. Section 8-42-102(2), C.R.S., sets forth certain methods of calculating the average weekly wage at the time of the injury. Section 8-42-102(3), C.R.S., permits the ALJ discretion in the method of calculating the average weekly wage if the nature of the employment or the fact that the injured employee has not worked a sufficient length of time, has been ill or self-employed, or for any other reason, the specific methods do not fairly compute the average weekly wage. *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993) required recalculation of the average weekly wage in an occupational disease case involving a new period of TTD long after the initial onset of the disease when claimant had received significant average weekly wage increases in the meantime. *Pizza Hut v. Industrial Claim Appeals Office*, 18 P.3d 867 (Colo.App. 2001) upheld application of the *Campbell* holding to allow calculation of disability benefits based upon subsequent employment at a much higher wage than the claimant earned as a pizza delivery driver. As found, claimant's zero earnings on April 3, 2008, were caused by the work injury. Consequently, respondents have failed to demonstrate that the average weekly wage should be modified.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is granted.

2. Respondents' request to modify the average weekly wage is denied and dismissed.

3. The Insurer shall pay to claimant TTD benefits at the admitted rate of $557.56 per week commencing April 3, 2008, and continuing thereafter until modified or terminated according to law.

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

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

DATED: November 20, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-563-417

ISSUES

The following issues were raised for consideration at hearing:

1. Petition to Reopen;
2. Compensability;
3. Medical benefits; and
4. Temporary disability benefits.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. The hearing in this matter concerned two workers' compensation claims. One admitted claim (WC 4-461-532), concerned a left knee injury occurring on February 7, 2000. This claim was closed by operation of a September 20, 2001 Final Admission of Liability. The current issue in that claim involves Claimant's Petition to Reopen for worsening of condition dated December 1, 2005. Claimant is seeking medical benefits related to the alleged worsening of condition, as well as temporary total disability benefits (TTD) benefits starting November 14, 2005 and ongoing.

2. The second claim (WC 4-563-417), concerns an alleged bilateral knee injury occurring on April 26, 2002. Claimant is seeking workers' compensation benefits, including medical benefits and TTD benefits starting November 14, 2005 and ongoing, as a result of that claim.

3. At hearing, the Claimant provided no credible testimony that his left lower extremity injury had worsened solely related to the February 7, 2000 work related injury. Following his release at maximum medical improvement (MMI) in that claim, Claimant returned to full time work with the Employer. Claimant did not file an Objection to the Final Admission of Liability in that matter, and did not seek any additional treatment until after the alleged April 26, 2002 bilateral lower extremity injury. Further, Claimant provided no credible testimony at hearing as to how his left knee condition is worse at this time, or how in any way the symptoms differ from symptoms he had at the time of his release at MMI on June 8, 2001.

4. At hearing, the Claimant testified that on April 26, 2002, his left foot slipped on a piece of vinyl, causing his entire body to move to the right. Claimant testified that he felt pain in both knees as a result of this episode. However, this version of events bears little or no resemblance to the version of the incident as described in Claimant's Workers' Claim for Compensation or what was indicated

in the medical records provided for review by the parties. The Judge finds Claimant's testimony with respect to the April 26, 2002 episode to be inconsistent and not persuasive.

5. At hearing, the Claimant testified that following the April 26, 2002 alleged incident, he continued to work full time with the Employer, standing for the greater part of his eight hour work day. No evidence was provided that Claimant missed time from work following the April 26, 2002 alleged incident. In fact, the evidence indicates that the Claimant continued to work following April 26, 2002 until he suffered a new unrelated work injury to his hand on November 12, 2002. Claimant testified at hearing that he continued to work for the Employer following that date until February, 2003, when the restrictions from his hand injury could not be accommodated. Claimant testified at hearing that he most likely would have been able to continue working for the Employer had he not suffered the November 12, 2002 hand injury.

6. Following the alleged April 26, 2002 incident, Claimant treated conservatively with Dr. Hattem at Concentra. Concentra's May 1, 2002 report indicates that the Claimant had full range of motion of both knees, and no swelling of either knee. Subsequent reports of Dr. Hattem and Concentra supported these findings. Further in his May 30, 2002 report, Dr. Hattem noted that Claimant exhibited no distress on examination, and no instability of either knee. However, he did refer the Claimant for an MRI of both knees, which showed an old tear of the ACL in the right knee, and an intact ACL repair and degenerative changes in the left knee. At hearing, Dr. Hattem testified that the scarring noted in the right knee MRI ACL tear meant that the tear was old, most likely occurring before April 26, 2002. The Judge finds the reports and hearing testimony of Dr. Hattem to be credible and persuasive.

7. In his report dated July 22, 2002, Dr Hattem noted that the Claimant advised him he was not interested in any follow up consultation with Dr. Papilion. He also notes in that report that the Claimant declined additional treatment or referral, and indicated that he was working without issue and that his knee conditions were better. As such, Dr. Hattem released the Claimant at MMI, with no impairment, determining that the Claimant had returned to his pre-April 26, 2002 medical status, with no additional restrictions. Dr. Hattem confirmed these statements in his hearing testimony. At hearing, Claimant testified that he did not seek additional treatment as he was scared from prior surgical complications and did not know who would pay for the treatment. The Judge finds the reports and hearing testimony of Dr. Hattem to be credible and persuasive and the testimony of the Claimant on this issue to be inconsistent and unpersuasive.

8. Dr. Hattem testified at hearing that he treated Claimant following his November, 2002, unrelated hand injury, through mid-2003. He stated that during that time Claimant made no complaints of symptoms in his bilateral lower extremities. Further, no documentation was presented for the time period from July,

2002, through November, 2005 indicating that Claimant sought any treatment whatsoever for his alleged bilateral lower extremity injuries. It was not until November of 2005, that Claimant saw an unauthorized physician, Dr. Diaz for symptoms in his bilateral lower extremities. At hearing, Dr. Hattem asserted that the interval of time from July 22, 2002 and the November 14, 2005 evaluation with Dr. Diaz lead him to the conclusion that Claimant's current medical condition/ symptoms could not be related to the April 26, 2002 episode. Dr. Hattem opined that Claimant's current condition is more likely than not related to degenerative changes of Claimant's bilateral lower extremity, unrelated to the April 26, 2002 incident. The Judge finds this testimony of Dr. Hattem to be persuasive and credible.

9. At hearing, Claimant presented the deposition testimony of Dr. Stephen Lindenbaum. Dr. Lindenbaum testified that he first saw Claimant in June 2007. Based on his review of the medical records, Dr. Lindenbaum opined that Claimant was not at MMI following the April 26, 2002 episode. He further stated in his testimony that Claimant's current condition and need for treatment are related to the April 26, 2002 episode. Upon review of all of the evidence presented in this matter, including the deposition of Dr. Lindenbaum, the Judge finds Dr. Lindenbaum's opinions to be inconsistent with the other evidence presented, unpersuasive and not credible.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. Section 8-43-303(1), C.R.S. provides that an award may be reopened on the grounds of a change in condition. The question of whether the claimant has proved that the industrial injury was the cause of the worsened condition is one of fact for determination by the ALJ. *Hennerman v. Blue Mountain Energy*, W.C. No. 4-366-000 (November 8,2001), *citing Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo.App. 2000).

5. The Workers' Compensation Rules of Procedure, Rule X.B(2) requires on a petition to reopen based on worsening condition, a medical report describing the claimant's condition and how it has deteriorated or improved. The testimony of a claimant that his problems have increased is sufficient for an ALJ to order reopening of the case. *Savio House v. Dennis*, 665 P.2d 141 (Colo.App. 1983)(cert. Denied, 1983; *see also, Hennerman, supra; Brunette v. Denver Presbyterian Hospital,* W.C. No. 3-988-271 (I.C.A.O, August 4, 1994).

6. At hearing, Claimant provided no credible testimony that his left lower extremity injury had worsened solely related to the February 7, 2000 work related injury. Following his release at maximum medical improvement (MMI) in that claim, Claimant returned to full time work with the Employer. Claimant did not file an Objection to the Final Admission of Liability in that matter, and did not seek any additional treatment until after the alleged April 26, 2002 bilateral lower extremity injury. Further, Claimant provided no credible testimony at hearing as to how his left knee condition is worse at this time, or how in any way the symptoms differ from symptoms he had at the time of his release at MMI on June 8, 2001.

7. Since there was no credible or persuasive evidence that Claimant suffered a worsened condition, it concluded that the Petition to Reopen in W.C. # 4-461-532 is denied and dismissed.

8. Furthermore, Claimant failed to sustain his burden of proof that he suffered a bilateral lower extremity injury in W.C. # 4-563-417. Claimant's testimony was deemed less credible and persuasive than the testimony of Dr. Hattem. Dr. Hattem opined that Claimant's current condition is more likely than not related to degenerative changes of Claimant's bilateral lower extremity, unrelated to the April 26, 2002 incident.

9. Accordingly, it is concluded that Claimant's workers' compensation claim in W.C. # 4-563-417 is denied and dismissed.

ORDER

It is therefore ordered that:

1. The Petition to Reopen is denied and dismissed in W.C. # 4-461-532.

2. Claimant's claim for workers' compensation benefits in W.C. # 4-563-417 is denied and dismissed.

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

DATED: November 20, 2008 Margot W. Jones

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-568-735

ISSUES

The sole issue determined herein is claimant's petition to reopen based upon a change of condition.

FINDINGS OF FACT

1. Claimant has an implanted spinal cord stimulator to treat chronic pain complaints resulting from a February 2001 non-work-related motor vehicle accident. Claimant received treatment for the February 2001 injuries from Dr. John Nelson. The spinal cord stimulator was implanted in August 2002.

2. On October 13, 2002, claimant suffered an admitted work injury arising out of and in the course of her employment with the employer. Claimant was scanning an entertainment center with the assistance of two customers. The customers abruptly lowered one end of the entertainment center. As a result, claimant had to quickly catch the entertainment center with her right hand, causing injury to her low back.

3. Later on October 13, 2002, claimant reported to the Memorial Hospital Emergency Room with complaints of pain in her back and between her shoulder blades. The records of Memorial Hospital note a history of chronic low back pain and an implanted spinal cord stimulator. Claimant testified that this history is incorrect because she had chronic pain, but not chronic low back pain.

4. After being treated at the Memorial Hospital, claimant was referred to Dr. John Reasoner, the employer's designated provider for work-related injuries. Dr. Reasoner first treated the claimant on October 14, 2002. Dr. Reasoner diagnosed lumbar strain. Dr. Reasoner restricted claimant's work activities and prescribed medications and physical therapy. He also ordered x-rays of the claimant's lumbar spine. The x-rays of the lumbar spine taken October 23, 2002, showed no acute abnormalities, with no fracture or dislocation. The disc heights were well maintained. The sacroiliac ("SI") joints were normal.

5. Claimant failed to improve with the treatments prescribed by Dr. Reasoner and reported worsening symptoms.

6. Dr. Reasoner obtained copies of x-rays of claimant's thoracic spine ordered by Dr. Nelson. The x-rays, taken before the October 13, 2002 work injury, showed that the lead to the claimant's spinal cord stimulator had migrated.

7. Dr. Reasoner evaluated the claimant on December 30, 2002. Claimant complained that her neck pain and back pain were very bad. Dr. Reasoner noted no significant changes and questioned whether the catheter insertion and subsequent movement contributed to claimant's ongoing pain complaints.

8. On January 15, 2003, Dr. Reasoner determined that claimant had reached maximum medical improvement ("MMI") on December 30, 2002, with zero percent permanent impairment. Dr. Reasoner suspected that claimant's continued low back pain was due to the spinal stimulator. He noted that most lumbar strains would have naturally resolved and she had no upper thoracic or cervical basis for ongoing lumbar pain.

9. At hearing, claimant testified that she disagreed with the MMI determination by Dr. Reasoner and believed that she needed additional diagnostic testing, including a magnetic resonance image ("MRI").

10. On February 6, 2003, the insurer filed a Final Admission of Liability denying permanent disability benefits and denying post-MMI medical benefits, consistent with the opinions of Dr. Reasoner.

11. On February 15, 2003, claimant returned to Dr. Reasoner, complaining that her pain had "tripled". She stated that her pain was not caused by the malfunctioning spinal cord stimulator. She complained of "severe" pain in her neck and upper back. In addition, she demonstrated minimal lumbar range of motion. Dr. Reasoner referred the claimant to Dr. Scott Ross for a second opinion.

12. On February 25, 2003, claimant again returned to Dr. Reasoner, reporting no change in her pain level and reporting that her back was in a lot of pain. Dr. Reasoner assessed chronic back pain.

13. On March 6, 2003, Dr. Ross examined claimant and opined that he had no evidence of thoracic or lumbar radiculopathy. He noted that claimant had diffuse tenderness to palpation that was much greater than expected with very superficial palpation. She also had multiple Waddell's signs, raising concerns about some non-organic pathology. Dr. Ross did not recommend any further intervention for claimant's superficial back pain.

14. On March 10, 2003, Dr. Reasoner discharged claimant from his care and released her to return to the restrictions set by Dr. John Nelson "due to chronic pain syndrome."

15. Claimant timely objected to the February 6, 2003 Final Admission of Liability and requested a Division Independent Medical Examination ("DIME").

16. On April 24, 2003, Dr. Hall performed an independent medical examination ("IME") for claimant. Dr. Hall diagnosed soft tissue injury to the cervicothoracic area, probable myogenic thoracic outlet syndrome on the left, possible left upper extremity radiculopathy, myofascial injury to the thoracolumbar area, and musculoskeletal headache. He recommended additional diagnostic testing and then treatment for the cervicothoracic and upper extremity symptoms. Dr. Hall also was of the opinion that the malfunctioning of the spinal stimulator was due to the admitted work injury. He recommended removing the stimulator, obtaining an MRI of the cervical spine, and then reimplanting the stimulator.

17. On June 2, 2003, Dr. Morgan performed the DIME. On physical exam, Dr. Morgan noted that the range of motion of claimant's cervical spine was diminished by at least 50 percent in all ranges due to pain complaints. Range of motion of the lumbar spine could not be tested due to pain complaints. Thoracic outlet provocation maneuvers could not really be tested due to complaints of pain. Four out of five Waddell's signs were consistently positive. Based on his review of the records and physical examination, Dr. Morgan agreed with the authorized treating physician's opinions on MMI and impairment. Dr. Morgan concluded that claimant demonstrated too many inconsistencies about her history and too many nonphysiologic findings on her serial physical exams to suggest that there was any true organic pathology as a result of the work injury. He concluded that the stimulator was unrelated to the work injury and that claimant suffered no neck or upper extremity injury in the industrial accident.

18. On July 17, 2003, the insurer filed a Final Admission of Liability denying permanent disability benefits and post-MMI medical benefits, consistent with the determinations of the DIME.

19. Claimant applied for a hearing, endorsing the issue of overcoming the DIME. Dr. Hall wrote a letter disagreeing with the conclusions of Dr. Morgan. Claimant later withdrew her application for hearing and the claim was closed.

20. Dr. Nelson continued treating claimant for chronic pain until he ceased his practice in approximately April 2007. On February 15, 2006, Dr. Nelson recommended revising the spinal stimulator to make it functional again. A January 24, 2007, computerized tomography ("CT") showed mild bulges at L3-4, L4-5, and L5-S1. Claimant requested a leave of absence from work to have the surgery to revise the stimulator, but she canceled the surgery due to the cost.

21. On August 1, 2007, Dr. Giancarlo Barolat evaluated claimant. Dr. Barolat diagnosed chronic regional pain syndrome ("CRPS") of the left foot, which was improving, as well as severe low back pain. He found the CT scan to be unremarkable for any pathology. Dr. Barolat recommended a MRI, but noted that the stimulator had to be removed before the MRI could proceed. Dr. Barolat was skeptical that any surgery would be reasonable to treat claimant.

22. On December 11, 2007, Dr. Barolat reexamined claimant and referred her to Dr. Goldman.

23. On July 10, 2008, Dr. Fall performed an IME for respondents. On range of motion testing, Dr. Fall noted that claimant flexed forward to five degrees and indicated an inability to flex any further due to pain. With extension, claimant achieved less than five degrees with complaints of worsening pain. Claimant complained of pain extending from L1 through the sacrum. On physical exam, Dr. Fall noted no paraspinal trigger points or spasming. There was no lateral shift. She concluded that the work injury had not caused the spinal electrode migration and that claimant suffered only a self-limiting strain of the thoracic-lumbar area. She agreed that the CT was unremarkable. She agreed that claimant was at MMI without any permanent impairment. Dr. Fall found no objective evidence of a lumbosacral condition or of any worsening of claimant's condition.

24. Dr. Barolat testified by deposition on July 22, 2008. Dr. Barolat testified he did not have complete copies of claimant's medical records. Dr. Barolat agreed that claimant had no objective findings consistent with her complaints of severe intractable back pain. Dr. Barolat was unaware of the claimant's psychiatric history. Dr. Barolat testified he could not state whether the claimant's condition now is any different or worse than it was when she was placed at MMI on December 30, 2002. Dr. Barolat testified that the recommended MRI was a diagnostic tool. Dr. Barolat has not recommended any treatment specifically designed to improve claimant's condition. He agreed that the CT scan was unremarkable, but disc degeneration would not show on a CT scan unless the disc was herniated. He recommended the MRI because claimant's pain had persisted for several years and the MRI would provide a "full evaluation."

25. Dr. Fall testified at hearing that claimant's condition had not worsened since she was placed at MMI on December 30, 2002. Dr. Fall noted that claimant's current range of motion is consistent with the measurements at the June 2, 2003 DIME. Dr. Fall further noted that the medical records do not document significant findings regarding claimant's lumbar spine. Dr. Fall agreed with the treating physician and DIME opinions

that claimant sustained a self-limited muscular strain of the thoracolumbar area without residuals and was appropriately placed at MMI with no impairment on December 30, 2002. Dr. Fall noted that the CT scan of the lumbar spine was unremarkable and additional diagnostic testing probably would not show any additional work-related findings. She would recommend the MRI for claimant only to rule out any spinal tumor or other pathology unrelated to the work injury.

26. Claimant has failed to prove by a preponderance of the evidence that she suffered a change of condition as a natural consequence of her admitted industrial injury. At MMI, she had high levels of pain complaints. She still has high levels of pain complaints. She is currently able to maintain full time employment. At MMI, claimant complained of pain so severe that it interfered with her sleep, affected her vocational activities, and affected her avocational activities. These complaints are consistent with claimant's current complaints. Claimant's testimony that her medical condition has worsened is not credible. Claimant's testimony is inconsistent with her prior statements and is not supported by the medical records or the testimony of either Dr. Barolat or Dr. Fall. The record evidence demonstrates that physicians recommend a MRI and that surgery to remove the implanted spinal stimulator is necessary before claimant can receive the MRI. The record evidence does not, however, demonstrate that claimant's condition has changed since MMI. Even Dr. Barolat admitted that he could not say that claimant is worse than at MMI.

CONCLUSIONS OF LAW

1. Claimant seeks to reopen the claim based upon a change of condition since MMI. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). Claimant must prove that her change of condition is the natural and proximate consequence of the industrial injury, without any contribution from another separate causative factor. *Vega v. City of Colorado Springs,* W.C. No. 3-986-865 & 4-226-005 (ICAO, March 8, 2000). As found, claimant has failed to prove by a preponderance of the evidence that she suffered a change of condition as a natural consequence of her admitted industrial injury.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is denied and dismissed.

DATED: November 7, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-574-504

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that she is entitled to the imposition of penalties against the respondent insurer for the filing of improper admissions of liability?

¬ Did the respondents prove by a preponderance of the evidence that the claims for penalties are barred by the statute of limitations found at § 8-43-304(5)?

¬ Did the final admissions of liability filed by the respondents serve to close some or all of the claims for benefits addressed in this order, including claims for penalties?

¬ Are the respondents entitled to an award of attorney fees because the claimant's counsel filed an application for hearing concerning issues that were not "ripe" for hearing?

FINDINGS OF FACT

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

1. The claimant suffered compensable workplace injuries on February 18, 2002, March 8, 2002, and April 10, 2002. The claims for these injuries were assigned W.C. No. 4-574-504, W.C. No. 4-546-112, and W.C. No. 4-539-048, respectively. The February 2002 injury resulted from a slip and fall, and the other two injuries resulted from motor vehicle accidents (MVA).

2. Dr. Bruce Lockwood, M.D., treated the claimant for these injuries. Dr. Lockwood first examined the claimant on May 24, 2002. The claimant gave Dr. Lockwood a history that the February injury affected her right shoulder. The claimant further stated that after the March 8, 2002, MVA, she experienced worsened right shoulder pain and the onset of neck pain. Following the April 10, 2002, MVA, the claimant reported that she had the onset of low back pain, lower thoracic pain, shoulder pain, and that all prior conditions became worse. Dr. Lockwood opined the claimant's examination was "most consistent with soft tissue injuries with psychologic overlay." Dr. Lockwood recommended medications and physical therapy.

3. The claimant returned to Dr. Lockwood on July 23, 2002. The claimant reported she had improved with physical therapy, but her symptoms recurred after she returned to work for the employer. The claimant advised Dr. Lockwood that she did not like going back to work and that she did not like the people there. The claimant advised Dr. Lockwood that she did not wish to undergo invasive therapies. Dr. Lockwood opined the claimant was likely at maximum medical improvement (MMI) and recommended a Functional Capacities Evaluation (FCE).

4. On August 30, 2002, Dr. Lockwood again examined the claimant. She reported all of her pain had resolved except for neck "achiness and stiffness" and right shoulder pain. Dr. Lockwood opined that based on the available information it "would appear as

though she has been appropriately placed at" MMI. Dr. Lockwood assigned 6 percent whole person impairment for the cervical spine and 2 percent whole person impairment for right shoulder range of motion deficits. Dr. Lockwood stated that with the "the information available to me it does not appear as though apportionment is appropriate." However, he stated that "if need be" he would "apportion 50% to each motor vehicle accident."

5. On September 10, 2002, the insurer filed a General Admission of Liability (GAL) with respect to the injury sustained on March 8, 2002 (W.C. No. 4-546-112). The GAL admitted for medical benefits only with no lost time.

6. On April 11, 2003, the insurer filed a Final Admission of Liability (FAL), with respect to the February 18, 2002, injury (W.C. No. 4-574-504). The FAL admitted for permanent partial disability (PPD) benefits in the amount of $5,530.03 based on a 4 percent whole person impairment rating. The FAL was accompanied by Dr. Lockwood's August 30, 2002, report.

7. On April 22, 2003, the insurer mailed to the claimant and the Division of Workers' Compensation an FAL with respect to the April 10, 2002, injury (W.C. No. 4-539-048). This FAL admitted for PPD benefits in the amount of $5,530.03 based on a 4 percent whole person impairment rating. The FAL further admitted liability for temporary total disability (TTD) benefits in the amount of $4297.48 for the time period April 11, 2002, through August 29, 2002. This FAL was accompanied by Dr. Lockwood's August 30, 2002, report.

8. The April 22, 2003, FAL contains a "Notice To Claimant" stating that the FAL is the "final admission" in the case, and advising the claimant that if she disagrees "with the amount or type of benefits which the carrier or self-insured has agreed to pay, WITHIN 30 DAYS OF THIS FINAL ADMISSION," she must object to the FAL in writing, file an application for hearing with respect to disputed issues, and request a Division Independent Medical Examination if disputing the date of MMI or the impairment rating. In the section of the FAL marked "Benefit History," the insurer specifically lists the amounts and periods of TTD and PPD benefits admitted. The Benefit History section also contains lines to insert the "amount of interest" and "amount of penalties" paid. On the April 22, 2003, FAL the interest and penalties lines are blank (not filled in with a dollar amount). However, in a line immediately beneath the interest and penalties lines, there is a line for "amount overpaid." In the "amount overpaid" line the insurer has inserted $839.69. In the remarks section of the FAL the insurer has inserted the words "TAKING CREDIT FOR OVERPAYMENT OF TTD AFTER DATED [sic] OF MMI" and "ALL BENEFITS NOT SPECIFICALLY ADMITTED SHOULD BE CONSIDERED TO BE DENIED." (Emphasis in original).

9. The parties stipulated concerning the claimant's expected testimony. The parties stipulated that the claimant would testify she was not represented by counsel at the time the insurer filed the GAL and the two final admissions. The parties further stipulated the claimant would testify that she is not educated or trained in the law, and that, apart from the contents of the admissions themselves, she had no knowledge of what to do, if anything, concerning the admissions.

10. The parties further stipulated that on December 17, 2003, Mr. Blundell entered his appearance as counsel for the claimant in all three claims.

11. On April 26, 2004, Mr. Blundell mailed an Application For Hearing, with respect to the February 18, 2002, injury (W.C. No. 4-574-504). The application listed the issue of penalties against the respondents for "filing and relying on invalid, improper and belatedly filed Final Admission per 8-43-203(2)(b)(II), and Rule IV of W.C.R.P." The application also lists "failing to admit" TTD benefits, average weekly wage and falsely stating the MMI date, and that the date of injury was "inconsistent with authorized medical reports." The record does not indicate that any hearing was ever held with respect to this application for hearing.

12. On April 26, 2004, Mr. Blundell mailed an Application For Hearing, with respect to the April 10, 2002, injury (W.C. No. 4-539-048). The application listed the issue of penalties against the respondents for: (1) Failing to file and rely on final admission based on MMI report and rating per 8-43-203(2)(b)(II), 8-42-107(8)(b)(c), 8-42-107.2, 8-421-105 [sic], 8-43-304, and Rule IV of W.C.R.P; (2) To report per 8-43-301 and Rule IV; (3) Failure to admit or deny per 8-43-203 and Rule IV.

13. On April 26, 2004, Mr. Blundell mailed an Application For Hearing, with respect to the March 8, 2002, injury (W.C. No. 4-546-112). The application listed the issue of penalties against the respondents for: (1) Failing to file and rely on final admission based on MMI report and rating per 8-43-203(2)(b)(II), 8-42-107(8)(b)(c), 8-42-107.2, 8-421-105 [sic], 8-43-304, and Rule IV of W.C.R.P.; (2) To report per 8-43-301 and Rule IV; (3) Failure to admit or deny per 8-43-203 and Rule IV; (4) Failure to admit an average weekly wage; (5) Medical benefits "falsely stated"; (6) MMI date "falsely stated"; (7) GAL filed late; (8) GAL falsely states it was mailed to claimant's attorney; (9) Failure to file an FAL and admit for PPD, average weekly wage and medical benefits.

14. For reasons that are not clear in the record, no hearings were held on these applications for hearing.

15. On September 16, 2004, Mr. Blundell again mailed applications for hearing seeking penalties in each of the three claims. The grounds for seeking penalties were essentially the same as the grounds cited in the April 2004 applications for hearing. However, in October 2004 the September 2004 applications for hearing were dismissed because claimant's counsel failed to consult with respondents' counsel prior to filing the applications.

16. On June 11, 2008, counsel for claimant, Mr. Sanders, again mailed applications for hearing in each of the three claims. These applications seek the imposition of penalties and are virtually identical to the applications for hearing filed on September 16, 2004.

17. The requests for penalties in all three claims were consolidated for hearing.

18. The respondents proved it is more probably true than not that requests for penalties with respect to the FAL filed on April 11, 2003, in W.C. No. 4-574-504 (February 18, 2002 date of injury), are barred by the statute of limitations contained in § 8-43-304(5), C.R.S. The vast majority of the requests for penalties involve assertions that the FAL was defective on its face because it was incomplete, inaccurate, and inconsistent with factual assertions contained in Dr. Lockwood's report of August 30, 2002. The FAL does in fact contain an alleged date of injury, an alleged date of MMI, and admits for PPD benefits. The ALJ finds that the alleged defects with respect to the date of injury, the date of MMI and the amount of benefits admitted could have been detected by a reasonable person had they immediately examined the FAL and Dr. Lockwood's ac-

companying report. Moreover, the facts giving rise to any inference that the insurer illegally delayed in filing the FAL should have been apparent to a reasonable person by examining the date Dr. Lockwood's report and the date the FAL was mailed. Specifically, the FAL and report were sent to the claimant on April 11, 2003, and there is no credible or persuasive evidence, that she did not receive the FAL and report in a timely fashion. However, no request for penalties with respect to this FAL was ever filed until April 26, 2004, more than one year after the claimant reasonably should have known of the facts giving rise to the alleged penalty claims.

19. The respondents failed to prove it is more probably true than not that requests for penalties with respect to the FAL filed on April 22, 2003, in W.C. No. 4-539-048 (April 10, 2002, date of injury) are barred by the statute of limitations contained in § 8-43-304(5). The evidence does not establish the date on which the claimant received the FAL that the respondents filed on April 22, 2003. Allowing three days for mailing and delivery of the FAL to the claimant, a period of time that the ALJ determines to be reasonable, the ALJ infers the claimant received the FAL no later than April 25, 2003. The ALJ takes administrative notice that April 25, 2003, was a Friday. Thus, by Friday, April 25, 2003, the claimant knew or reasonably should have known of the defects in the April 22, 2003, FAL, that give rise to the claims for penalties. The application for hearing requesting penalties was filed on April 26, 2004. The ALJ takes administrative notice that April 26, 2004, was a Monday. Thus, the ALJ finds the request for penalties was filed within one year of the date the claimant knew, or reasonably should have known of the alleged defects in the FAL mailed on April 22, 2003.

20. Nevertheless, the ALJ finds the issue of penalties was closed because the claimant failed to object to and request a hearing on that issue within 30 days of the April 22, 2003, FAL. The ALJ finds it is implicit in the April 22, 2003, FAL that the insurer denied liability for interest and penalties. If the insurer had intended to admit for any liability or penalties it would have completed the appropriate lines in the Benefit History section of the FAL. In that event, the claimed overpayment of $839.69 would have been reduced or eliminated. However, because the lines for penalties and interest were left blank, because the insurer did not reduce the claimed overpayment, and because the insurer expressly stated that benefits not admitted were denied, the insurer implicitly denied any liability for penalties. The claimant did not file a request for penalties until April 26, 2004, long after the 30 day limit to object to the FAL and request penalties had lapsed.

21. The respondents proved it is more probably true than not that requests for penalties with respect to the GAL filed on September 10, 2002, in W.C. No. 4-546-112 (March 8, 2002, date of injury) are barred by the statute of limitations contained in § 8-43-304(5). The vast majority of the requests for penalties involve assertions that the GAL was defective on its face because it was incomplete, inaccurate, and inconsistent with factual assertions contained in Dr. Lockwood's report of August 30, 2002. The claimant's position statement also notes an alleged violation of former WCRP IV (N)(2), which requires a "medical benefits only" GAL to "include remarks outlining the basis for denial of temporary and permanent disability benefits." Finally, the claimant alleges the insurer improperly failed to file an FAL admitting for benefits with respect to the injury of March 8, 2002.

22. The facts giving rise to any claim that the insurer acted illegally by improperly filing the GAL should have been known to a reasonable person no later than April 11,

2003. By April 11, 2003, the claimant had already received the September 2002 GAL, as well as the April 11, 2003, FAL. Thus, the fact that the GAL lacked any explanation concerning the failure to admit for temporary and permanent disability benefits should have been apparent in September 2002. The same is true with respect to any other facial errors in the GAL. Insofar as the GAL could be considered inconsistent with Dr. Lockwood's report of August 30, 2002, the facts surrounding such inconsistencies should have been apparent to the claimant by April 11, 2003, when she received Dr. Lockwood's report in connection with the FAL filed on that date. However, the claimant did not request any penalties with respect to the March 8, 2002, injury, until she filed the application for hearing April 26, 2004, more than a year after April 11, 2003, FAL was filed and two years after the GAL was filed.

23. Insofar as the claimant is asserting that the respondents should have filed an FAL with respect to the injury of March 8, 2002, the claimant, as a reasonable person, should have known the facts and circumstances surrounding this alleged legal duty by April 11, 2003. Dr. Lockwood's report, attached to the April 11, 2003, FAL, indicates that he was fully aware of all three injuries sustained by the claimant, and contains the opinion that the claimant was "appropriately placed at maximum medical improvement." Further, Dr. Lockwood assigns an 8 percent whole person impairment rating and suggests the possibility of apportionment between "each motor vehicle accident." Thus, by April 11, 2003, the claimant should have been aware that Dr. Lockwood had placed her at MMI fort the March 8 injury, and the possibility that he had assigned a permanent impairment rating for the March 8 injury. However, the claimant did not request any penalties for failure to file an FAL with respect to the March 8, 2002, injury, until she filed the application for hearing on April 26, 2004, more than a year after the April 11, 2003, FAL was filed.

24. Although the ALJ accepts as true the claimant's proffered testimony that she is not educated in the law, and that she did not know what to do about the admissions other than what was stated in them, the ALJ finds these facts do not alter the outcome of the case. The claimant is presumed to know the law, and to the extent she was ignorant of the law such ignorance does not alter her knowledge with respect *facts* relevant to application of the statute of limitations.

CONCLUSIONS OF LAW

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

STATUTE OF LIMITATIONS DEFENSE TO PENALTY CLAIMS

a. At hearing, the claimant raised numerous requests for penalties with respect to the admissions filed in each of the three claims. The claimant seeks the imposition of these penalties under § 8-43-304(1), C.R.S. The respondents contend that each claim for penalties is barred by the statute of limitations contained in § 8-43-304(5), C.R.S. The ALJ partially agrees with the respondents.

b. Whether statutory penalties may be imposed under § 8-43-304(1), C.R.S. involves a two-step analysis. The statute provides for the imposition of penalties of up to $500 per day where the insurer "violates any provision of article 40 to 47 of [title 8], or

does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or the panel, for which no penalty has been specifically provided, or fails, neglects or refuses to obey any lawful order made by the director or panel…" Thus, the ALJ must first determine whether the insurer's conduct constitutes a violation of the Act, a rule, or an order. Second, the ALJ must determine whether any action or inaction constituting the violation was objectively unreasonable. The reasonableness of the insurer's action depends on whether it was based on a rational argument based in law or fact. *Jiminez v. Industrial Claim Appeals Office,* 107 P.3d 965 (Colo. App. 2003); *Gustafson v. Ampex Corp.,* W.C. No. 4-187-261 (I.C.A.O. August 2, 2006), *but see, Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005) (standard is less rigorous standard of "unreasonableness"). However, there is no requirement that the insurer know that its actions were unreasonable. *Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996).

c. Section 8-43-304(5) provides that a "request for penalties shall be filed with the director or administrative law judge within one year after the date that the requesting party first knew or reasonably should have known the facts giving rise to a possible penalty." Section 8-43-305, C.R.S., provides that each day an insurer "fails to comply with any lawful order" of the director constitutes a "separate and distinct violation thereof." Section 8-43-305 further provides that in an action to enforce a penalty "such violation shall be considered cumulative and may be joined in such action."

d. In *Spracklin v. Industrial Claim Appeals Office*, 66 P.3d 176 (Colo. App. 2002), the claimant observed that § 8-43-305 provides that each day an insurer disobeys an order constitutes a "separate violation" of the order. Therefore the claimant reasoned that failure to file an application seeking a penalty within one year of first learning the facts giving rise to the penalty was not fatal to the entire penalty claim. Rather, the claimant reasoned that § 8-43-304(5) acts as a "cap" on the amount of recovery and bars only those penalty claims based on violations that occurred more than one year before the application for hearing was filed.

e. However the *Spracklin* court rejected the claimant's analysis of these statutes. The court reasoned that § 8-43-304(5) is a statue of limitations designed to "ensure prompt litigation of penalty claims once the underlying violation is first discovered." Thus, the statute plainly "requires a request for penalties to be filed within one year after the requesting party *first became aware of the circumstances* that constitute a violation and support the imposition of a penalty, even if that violation was ongoing." (Emphasis added).

f. Significantly, the statute of limitations in § 8-43-304(5) is triggered by knowledge or constructive knowledge of "facts" giving rise to a "possible" claim for penalties. Conversely, parties to workers' compensation cases are presumed to know the *law*, even if they are pro se. *See Dyrkopp v. Industrial Claim Appeals Office,* 30 P.3d 821 (Colo. App. 2001). Hence, it is no defense to application of the statute of limitations that a pro se claimant was ignorant of the applicable statutes and rules of procedure, or that they were pro se when the possible claim for penalties arose. *See Ray v. New World Van Lines,* W.C. No. 4-520-251 (ICAO, October 12, 2004), *reversed on other issues*, *Industrial Claim Appeals Office v. Ray,* 145 P.3d 661 (Colo. 2006).

g. The claimant seeks penalties with respect to the FAL filed on April 11, 2003, for the injury of February 18, 2002, (W.C. No. 4-574-504). The claimant alleges the FAL

violates the Act and/or applicable rules of procedure because it "utterly fails to address either the date of injury, any date of MMI, and permanent impairment." The claimant further alleges inconsistencies between Dr. Lockwood's August 30, 2002, MMI report and rating and the contents of the FAL. Finally, the claimant alleges the FAL was not properly completed as required by former WCRP XI (A), and was not timely filed.

h. The ALJ concludes that all requests for § 8-43-304(4) penalties with respect to the April 11, 2003, FAL, (W.C. No. 4-574-504, February 18, 2002 date of injury) are barred by the statute of limitations contained in 8-43-304(5). As determined in Finding of Fact 18, the FAL was mailed to the claimant on April 11, 2003, and there is no credible and persuasive evidence that she did not receive it in a timely fashion. Upon receipt of the final admission, a reasonable person would have recognized all of the facts necessary to request any of the penalties now alleged by the claimant. Nevertheless, the claimant did not file a request for penalties until April 26, 2004, more than one year after the deadline prescribed by § 8-43-304(5). Thus, the requests for penalties are barred by § 8-43-304(5).

i. The claimant seeks penalties with respect to the FAL filed on April 22, 2003, for the injury of April 10, 2002 (W.C. No. 4-539-048). The claimant alleges virtually all of the same defects as she did with respect to the FAL filed on April 11, 2003. The claimant further alleges that the April 22, 2003, FAL, did not include an objection form and a Notice and Proposal to select at DIME as required by former WCRP IV (N)(1), and that temporary benefits were improperly terminated in violation of former WCRP IX (C)(1)(a).

j. The ALJ concludes that all requests for § 8-43-304(1) penalties with respect to the April 22, 2003, FAL, (W.C. No. 4-539-048, April 10, 2002, date of injury) are not barred by the statute of limitations contained in § 8-43-304(5). In this regard, the ALJ notes that unless a statute specifies otherwise, "notice" is not generally considered to be effective until it is received. *See School District RE-11J v. Norwood,* 644 P.2d 13 (Colo. 1982). The reference to the word "year" in § 8-43-304(5), means a "calendar year." Section 2-4-107, C.R.S. When a statute requires the computation of a period of days, the first day is excluded and the last day is included. Section 2-4-108 (1), C.R.S. Further, if the "last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day which is not a Saturday, Sunday, or legal holiday." Section 2-4-108(2), C.R.S. Under former WCRP VIII (F), which was in effect when the April 2004 applications for hearing were filed, the date of filing a document with the Division of Administrative Hearings (currently OAC) is "the date the document is delivered, or the date of the certificate of mailing when the document is mailed." Compare OACRP 4(B).

k. As determined in Finding of Fact 18, the respondents' April 22, 2003, FAL was served by mail. As determined in Finding of Fact 19, the evidence does not establish the actual date that the claimant *received* the FAL, but the ALJ infers the claimant received it by Friday, April 25, 2003, three days after it was mailed. Therefore, the claimant knew, or reasonably should have known, of the alleged defects in the April 22, 2003, FAL by Friday, April 25, 2003. Because the application for hearing concerning penalties was, by rule, effectively filed on Monday, April 26, 2004, the request for penalties was made within in one year as required by § 8-43-304(5). This is true because April 25, 2003, did not count as the first day for purposes of the one-year statute of limitations, and because April 26, 2004, fell on Monday, the first business day after a Sunday. Sec-

tion 2-4-108(1) & (2). *See People v. Brunner,* 87 P.3d 267 (Colo. App. 2004); *Golden Aluminum Co. v. Weld County Board of County Commissioners,* 867 P.2d 190 (Colo. App. 1993).

l. The claimant seeks penalties with respect to the GAL filed on September 10, 2002, for the injury of March 8, 2002 (W.C. No. 4-546-112). The ALJ concludes it is more probably true than not that requests for penalties with respect to the GAL filed on September 10, 2002, in W.C. No. 4-546-112 (March 8, 2002, date of injury) are barred by the statute of limitations contained in 8-43-304(5). As determined in Finding of Fact 21, any facial errors in the GAL should have been apparent to the claimant, as a reasonable person, when she received the FAL in September 2002. Further, any alleged error resulting from inconsistency with Dr. Lockwood's report should have been apparent to the claimant as a reasonable person not later than April 11, 2003, when she received the FAL containing Dr. Lockwood's report. Similarly, as determined in Finding of Fact 23, any obligation on the part of the respondents to file an FAL with respect to the March 8, 2002, injury, should have been apparent to the claimant when she received Dr. Lockwood's report on or about April 11, 2003. Nevertheless, no request for penalties was filed until April 26, 2004.

m. Although the claimant asserts the statute of limitations defense was waived because it was not properly pled, the ALJ concludes this assertion is incorrect. The respondents' Response to Application for Hearing specifically raises the statute of limitations. The response states under the heading of other issues: "Bar to claim for penalties under § 8-43-304(5)."

n. The claimant's reliance on the cure provisions of § 8-43-304(4), C.R.S., is misplaced. The claimant's assertions notwithstanding, the cure provision is not inconsistent with and does not affect the application of the statute of limitations contained in § 8-43-304(5). Rather, the cure provision affects the burden of proof to be applied in cases where a party rectifies an alleged violation within twenty days after being notified of it by the filing of an application for hearing seeking penalties. *Ficco v. Owens Brothers Concrete Co.,* W.C. No. 4-546-848 (ICAO, May 30, 2007). In contrast, the statute of limitations concerns the amount of time a party has to "request" penalties after actually or constructively learning of the facts triggering the alleged violation.

2. CLOSURE OF PENALTY ISSUES BY APRIL 22, 2003 FAL

a. The ALJ has determined that the claims for penalties in W.C. No. 4-539-048 are not barred by the statute of limitations. Thus, the ALJ must next consider whether the claims for such penalties were closed because the claimant failed to object to the April 22, 2003, FAL, and request a hearing on penalties within 30 days of the filing of the FAL. The ALJ concludes claims for these penalties were are closed.

b. Section 8-43-203(2)(b)(II), C.R.S., provides that a claim will be automatically closed "as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the admission in writing and request a hearing on any disputed issues that are ripe for hearing." Section 8-43-203(2)(d), C.R.S., provides that once a case is closed under subsection (2) "the issues closed may only be reopened pursuant to section 8-43-303." These provisions are part of a "statutory scheme designed to promote, encourage, and ensure prompt payment of compensation to an injure worker without the necessity of a formal administrative determination in cases not presenting a legitimate controversy." *Feeley v. Industrial Claim*

Appeals Office, __P.3d__ (Colo. App. No. 07CA1389, September 4, 2008); *Dyrkopp v. Industrial Claim Appeals Office,* 30 P.3d 821, 822 (Colo. App. 2001). Thus, once an issue is closed by an FAL, it may not be the subject of further litigation unless the issue is reopened. *Feeley v. Industrial Claim Appeals Office, supra.*

c. If an FAL simply fails to address an issue that issue is not closed by the claimant's failure to object to the FAL and request a hearing on the issue. *Dalco Industries v. Garcia,* 867 P.2d 156 Colo. App. 1993). This is true because an FAL that fails to address some issue or benefit does not adequately apprise the claimant of the effect of the admission on her rights with respect to the admission. See *Leewaye v. Industrial Claim Appeals Office,* 178 P.3d 1254 (Colo. App. 2007) (one purpose of § 8-43-203(2)(b)(II) is to ensure timely and accurate notice to claimants concerning their rights and obligations with respect to contesting an FAL). However, the term "issues admitted" is not limited to "issues" concerning which the employer agrees to pay benefits. Rather, that language also refers to issues "on which the employer affirmatively takes a position, either by agreeing to pay benefits or by denying liability to pay benefits." Further, a "denial" of liability need not be explicit and may be implied from the particular contents of the admission. *Dyrkopp v. Industrial Claim Appeals Office, supra* (denial of permanent total disability benefits implied by admission for PPD benefits since both benefits cover permanent wage loss).

d. As determined in Finding of Fact 20, the ALJ concludes the issue of penalties was closed by the claimant's failure timely to object and to request a hearing with respect to the FAL filed on April 22, 2003. First, the April 22, 2003, FAL advised the claimant, in accordance with the requirements of § 8-43-203(2)(b)(II), that the FAL was the "final admission" in the case, and that if the claimant disagreed "with the amount or type of benefits which the carrier or self-insured has agreed to pay, WITHIN 30 DAYS OF THEIS FINAL ADMISSION, she was required to object to the FAL, file an application for hearing concerning disputed issues, and request Division Independent Medical Examination if desired. Further, in the "Benefit History" section of the FAL, there are specific lines for the "amount of interest" and "amount of penalties" paid. These spaces were left blank, and beneath them the insurer claimed an "amount overpaid" of $839.69. In the remarks section of the FAL the insurer explained that the overpayment was based on temporary total disability benefits paid after MMI, and emphasized that benefits not specifically admitted were denied. The ALJ concludes that it is implicit in the April 22, 2003, FAL that the insurer denied liability for interest and penalties. If the insurer had intended to admit for any liability or penalties it would have completed the appropriate lines in the Benefit History section of the FAL. In that event, the claimed overpayment of $839.69 would have been reduced or eliminated. However, because the lines for penalties and interest were left blank, because the insurer did not reduce or eliminate the claimed overpayment, and because the insurer expressly stated that benefits not admitted were denied, the insurer implicitly denied any liability for penalties. Because the claimant failed to object to the FAL and request a hearing on the issue of penalties, the April 22, 2003, FAL closed the issue.

e. In reaching this conclusion, the ALJ does not deny that for some purposes the Act creates distinctions between "benefits" and "penalties." However, since the FAL itself includes the issues of "penalties" and "benefits" within the rubric of "Benefit History," and because the FAL itself indicates that any alleged "overpayment" is to include a cal-

culation of amounts admitted for interest and penalties, the ALJ concludes that for purposes of the April 22, 2003, FAL penalties are the equivalent of benefits.

3. RESPONDENTS' REQUEST FOR ATTORNEY FEES

a. The respondents seek attorney fees on the ground that some of the requests for penalties were not "ripe." The ALJ concludes that attorney fees are not warranted.

b. Section 8-43-211(2)(d), C.R.S., provides that if any person "requests a hearing or files a notice to set a hearing on issues which are not ripe for adjudication at the time such request or filing is made, such person shall be assessed the reasonable attorney fees" incurred in preparing for such hearing or setting.

c. Generally, the term "ripeness" refers to whether an issue is real, immediate and fit for adjudication. Under the doctrine of ripeness, adjudication should be withheld for uncertain or contingent future matters that suppose a speculative injury that may never occur. Further, a court should consider whether there is any legal impediment to adjudication of the issue. *See Olivas-Soto v. Industrial Claim Appeals Office,* 143 P.3d 1178 (Colo. App. 2006).

d. The ALJ concludes that the claims for penalties asserted by the claimant were "ripe" within the meaning of § 8-43-211(2)(d). While the claimant delayed in filing the requests for penalties, and the ALJ has applied the statute of limitations to bar some of the claims, that does not mean the claims were not legally "ripe." The claims were indeed ripe in the sense that there was no legal impediment to their adjudication, nor was any right to penalties inchoate or contingent on uncertain events in the future. While the ALJ has determined the claimant's penalty claims are not meritorious, that does not mean they are not ripe.

e. The ALJ has considered the respondents' argument that some of the claims for penalties are not "ripe" because they are not "real" issues. For instance, the respondent asserts that the failure to admit an average weekly wage in the GAL is not a "real" issue because the GAL was for medical benefits only. The ALJ is not persuaded by the respondents' argument with respect to these penalty claims.

f. When speaking of a "real" issue in the context of ripeness, the issue must be one that it is of immediate consequence and its significance is not dependent on the occurrence of future circumstances. *See Olivas-Soto v. Industrial Claim Appeals Office, supra*. The respondents propose to use the term "real" to connote a penalty claim that is groundless or frivolous in the sense that it is not based on genuine facts or a rational interpretation of the law However, § 8-43-211(2)(d) does not permit the imposition of attorney fees based on the assertion of groundless and frivolous claims, and the ALJ declines to read the statute in that way. Indeed, the ALJ notes that, at one time, the General Assembly authorized the imposition of attorney fees if an ALJ determined that any claim was brought or defended "without substantial justification." However, the statute that authorized such awards was effectively repealed on March 1, 1996. 1991 Colo. Sess. Laws, ch. 219 at 1321; former § 8-43-216, C.R.S. Moreover, the General Assembly continues to permit the imposition of attorney fees against a party that files a frivolous petition to review or brief in support thereof. Section 8-43-301(14), C.R.S.

4. CLAIMANT'S REQUEST TO DETERMINE THE EFFECT OF FINAL ADMISSIONS

a. The claimant requests the ALJ to determine whether either of the final admissions filed by the respondents effectively closed the claims so as to prohibit the claimant from procuring additional benefits without filing a petition to reopen. With the exception

expressly noted above concerning the FAL filed on April 22, 2003, the ALJ declines to rule upon this issue and reserves it for future determination.

b. Section 8-43-207(1)(h) & (j), C.R.S., grants the ALJ authority to control the course of the proceedings and, "for good cause shown" adjourn any hearing to a later date for the taking of additional evidence.

c. Here, the claimant has not requested the ALJ to award any specific benefits except for the penalties discussed above. In these circumstances, the ALJ concludes it is premature to address the effectiveness of the final admissions with respect to closure of the claims or any particular benefits. Indeed, any order the ALJ might issue concerning whether or not the claims remain open would not be subject to review since it would neither award or deny any benefits or penalties. Section 8-43-301(2), C.R.S.; *Natkin & Co. v. Eubanks,* 775 P.2d 88 (Colo. App. 1989). Moreover, the determination of whether a claim for particular benefits was closed by either of the final admissions could conceivably depend on the particular benefit that was sought. See § 8-43-203(2)(d), C.R.S. ("issues" closed by FAL must be reopened); *Dalco Industries, Inc. v. Garcia*, *supra*.

d. For these reasons the claimant's arguments concerning whether or not the final admissions closed any of the claims are reserved for future determination and may be considered in connection with any future application for hearing requesting specific benefits under any of the claims.

ORDER

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

1. All of the claimant's requests for penalties are denied and dismissed.

2. The respondents' request for the imposition of attorney fees is denied and dismissed.

3. All issues not addressed by this order, including the effect of the final admissions with respect to closure of the claims, are reserved for future determination.

DATED: November 17, 2008

David P. Cain

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-628-850

ISSUES

The issues determined herein are authorized medical benefits and claimant's request for a change of physician.

FINDINGS OF FACT

1. On September 27, 2004, claimant suffered an admitted work injury to her low back.
2. Dr. Reasoner, at Emergicare, was the authorized treating physician ("ATP").
3. On April 25, 2005, Dr. Reasoner determined that claimant was at maximum medical improvement ("MMI"). Dr. Reasoner determined that claimant suffered 19% permanent impairment. He recommended post-MMI medical treatment with medications and physician re-checks for two years.
4. On May 31, 2005, the insurer filed a final admission of liability for permanent disability benefits and for post-MMI medical benefits.
5. Dr. Reasoner continued to treat claimant after MMI until he left the Emergicare office.
6. On April 1, 2008, claimant's attorney wrote to respondents' attorney to indicate that Dr. Reasoner was no longer in practice and no new ATP had been designated. Claimant stated that, unless a new ATP was immediately designated, she would have no alternative but to seek treatment with Dr. Timothy Hall.
7. On April 4, 2008, respondents' attorney responded to the April 1 letter by denying the request to change to Dr. Hall and authorizing claimant to choose any physician at Emergicare Clinic.
8. Claimant contacted Emergicare and obtained an appointment with Dr. Maisel for April 24, 2008.
9. On April 24, 2008, Dr. Maisel examined claimant and referred her for a magnetic resonance image ("MRI").
10. On April 29, 2008, claimant's attorney wrote to respondents' attorney to indicate that the physicians at Emergicare refused to see claimant or to offer any treatment. Claimant stated that she had selected Dr. Jeffrey Jenks as her new physician.
11. On May 3, 2008, claimant underwent the MRI referred by Dr. Maisel. The MRI showed marked improvement in the diskogenic disease at L4-5 with retraction of the protruding disk compared to the October 29, 2004, scan.
12. On May 27, 2008, Dr. Maisel examined claimant and discussed the MRI results. He informed claimant that she was "better."
13. Claimant became "uncomfortable" with Dr. Maisel after he told her that she was "better."
14. On July 11, the adjuster wrote to inform claimant that she had another appointment with Dr. Maisel on July 15, 2008.
15. Dr. Jenks did not become authorized due to respondents' failure to timely respond to the April 1 letter. Respondents immediately denied the requested change to Dr. Hall and authorized treatment by any Emergicare physician. Claimant was able to get in to an appointment with Dr. Maisel three weeks later.
16. Dr. Maisel did not refuse to treat claimant for a non-medical reason. He immediately obtained the MRI results, which, in fact, showed improvement in claimant's spine. Dr. Maisel remained authorized to provide treatment, as demonstrated by the July 11 letter.

17. Claimant has failed to make a proper showing for a change of ATP to Dr. Jenks. Dr. Maisel has examined claimant and obtained the MRI. The record evidence does not contain any report by Dr. Jenks. The record evidence does not demonstrate that Dr. Maisel did anything improper. Claimant's lack of comfort with what Dr. Maisel said does not suffice for a change of physician.

CONCLUSIONS OF LAW

1. 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). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afFed the right, in the first instance, to select a physician to treat the industrial injury. *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. Section 8-43-404(5), C.R.S. requires that the respondents designate a physician who is willing and able to provide treatment. *See Ruybal v. University Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988); *Tellez v. Teledyne Waterpik*, W.C. No. 3-990-062, (Industrial Claim Appeals Office, March 24, 1992). If the designated treating physician refuses to treat the claimant for non-medical reasons, the respondents' duty to select a replacement physician arises immediately upon knowledge that the designated physician has refused to treat. *Tellez v. Wal-Mart Stores Inc.,* W.C. No. 4-413-780 (ICAO July 20, 2000)*; Wesley v. King Soopers,* W.C. No. 3-883-959 (ICAO November 22, 1999); *Clemons v. Harrison School District #2*, W.C. No. 4-357-814 (ICAO, November 30, 2001). In order to change physicians, claimant has a statutory obligation to request that change in accordance with section 8-43-404(5)(a), C.R.S. (2007); *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). Pursuant to section 8-43-404(5)(a), C.R.S. (2007), the respondents had to respond within 20 days to a written request to change physician. As found, respondents timely responded to the request. Also, as found, Dr. Maisel did not refuse to treat claimant for a non-medical reason. Consequently, Dr. Jenks did not become authorized.

2. Pursuant to section 8-43-404(5)(a), C.R.S. (2007), a change of physician may be ordered prospectively "upon a proper showing." *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). A change of physician is not warranted by the mere fact that a claimant has more faith in a specific doctor or lacks confidence in the employer's doctor. 5 *Larson's Workers' Compensation Law* Section 94.02[3] (1999). As found, claimant has failed to make a proper showing for a change of ATP to Dr. Jenks.

ORDER

It is therefore ordered that:

1. Claimant's request for payment of the bills of Dr. Jenks after April 29, 2008, is denied and dismissed.

2. Claimant's request for a prospective change of physician to Dr. Jenks is denied and dismissed.

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

DATED: November 7, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-636-107

ISSUES

The issues presented for determination were Claimant's claim that she should be found to be permanently, totally disabled as defined in Section 8-40-201 (16.5) (a), C.R.S. and awarded benefits for permanent total disability under Section 8-42-111 C.R.S.

In the alternative, whether Claimant's permanent impairment should be compensated based upon the schedule found in Section 8-42-107 (2), C.R.S. or should be compensated as whole person impairment under Section 8-42-107 (8), C.R.S.

The parties stipulated that the issue of disfigurement would be reserved for future evaluation and determination.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to her right shoulder on December 8, 2004 in the course of her employment as a school bus driver for Employer. Claimant was referred by Employer to Dr. Robert Watson for treatment.

2. Claimant was seen in follow-up by Dr. Watson on January 3, 2005. At this visit, Dr. Watson assigned work restrictions of no lifting or carrying over 5 pounds with the right arm, no repetitive lifting over 5 pounds, and no reaching overhead. Claimant was also restricted from driving. Claimant was next seen by Dr. Watson on January 19, 2005 and the same physical restrictions were continued.

3. Claimant returned to work on/about January 21, 2005 to a light duty Teacher's Aide position at South Elementary School within the School Dis-

trict. Claimant's duties consisted of doing paperwork, helping in some of the classes and monitoring recess and street crossings (Report of Dr. Brunworth 2/28/05, Exhibit C).

4. Dr. Watson referred Claimant to Dr. Mark Failinger. Dr. Failinger initially evaluated Claimant on February 9, 2005. Dr. Failinger recommended a surgical decompression of the right shoulder. Dr. Failinger performed surgery on April 12, 2005 consisting of a debridement and decompression of the right shoulder.

5. Following the surgery in April 2005, Claimant again returned to work at light duty beginning May 19, 2005. Claimant performed work in the transportation office of the Employer consisting of light office work, human resources duties and answering the phone (Exhibit U). At the time Claimant returned to work in May 2005 her physical restrictions from Dr. Watson were lifting up to 5 pounds with no lifting above shoulder level, no carrying or repetitive lifting over 5 pounds and no reaching overhead based upon Dr. Watson's report of May 16, 2005.

6. Claimant was placed at maximum medical improvement by Dr. Watson as of November 2, 2005. Dr. Watson assigned physical restrictions of no lifting greater than 5-10 pounds with the right arm and no lifting above shoulder level at the time he placed Claimant at maximum medical improvement. These restrictions were the result of a functional capacity evaluation done on October 6, 2005 (Exhibit 10).

7. After being placed at MMI in November 2005 and given permanent work restrictions, Claimant was notified by letter from Employer dated November 22, 2005 (Exhibit 15) that the transportation department was unable to accommodate her restrictions. Claimant was encouraged to review available open positions within the School District (Employer).

8. Claimant then applied for the position of and was hired as a Teacher's Aide at Soaring Hawk Elementary School. Claimant's duties were to supervise the kids and classroom, supervise lunch and recess, some paper deliveries to classrooms and office, copy papers and grade papers (Exhibit U, O.T. Resources, Inc., Questionnaire dated 5/5/08). Claimant worked at this part-time position from March 2006 until the end of the school term in June 2006. Claimant performed this job under the same physical restrictions assigned to her by Dr. Watson at the time she was placed at MMI in November 2005. Dr. Watson again saw Claimant on May 15, 2006 at which time the physical restrictions remained permanent and unchanged. (Exhibit 10, report dated May 15, 2006).

9. Dr. Watson referred Claimant to psychologist, Dr. Kaplan, in May 2006. Dr. Watson's referral of Claimant to Dr. Kaplan followed the recommendations of the DIME physician, Dr. Shih, who considered Claimant not to be an

maximum medical improvement and recommended psychological intervention for pain management.

10. Dr. Kaplan initially evaluated Claimant on May 2, 2006. Dr. Kaplan noted in his report that Claimant had returned to work as a Teacher's Aide on March 22, 2006 working six hours per day, five days a week. Dr. Kaplan further stated that while Claimant had work restrictions, she was able to carry out her current work duties.

11. Dr. Kaplan again saw Claimant on May 22, 2006. Dr. Kaplan reported that Claimant was able to tolerate her job duties with work limitations and restrictions. Claimant reported no change in her pain levels to Dr. Kaplan.

12. Dr. Shih saw Claimant for a follow-up DIME appointment on August 31, 2006. Dr. Shih placed Claimant at maximum medical improvement as of July 19, 2006.

13. After being placed at MMI by Dr. Shih, Claimant sought further treatment for her right shoulder through her personal physician and was referred to Dr. Steven Topper, M.D. Dr. Topper examined Claimant on October 19, 2006 and recommended an MRI of the shoulder. At the time she was seen in October 2006 by Dr. Topper Claimant was complaining of occasional sharp or shooting pain that had become progressively worse and was aggravated by overhead activity. The severity of the pain was reported by Claimant to be moderate to severe.

14. At the request of the Insurer, Claimant was seen for an independent medical examination by Dr. William Shaw, M.D. on December 19, 2006 (Exhibit K). Claimant reported to Dr. Shaw that she had the physical capacity to perform the functions of office work and as a teacher's aide when she was performing those activities. Dr. Shaw opined, and it is found, that there were no medical contraindications to Claimant returning to work in the capacity of office work or as a teacher's aide.

15. Dr. Topper performed arthroscopic surgery on Claimant's right shoulder on January 9, 2007. This surgery consisted of extensive debridement of the glenohumeral joint including SLAP and rotator cuff tears and mini open distal clavicle excision.

16. Dr. Topper saw Claimant for surgical follow-up on April 23, 2007. Dr. Topper noted that Claimant's pre-operative symptoms had resolved.

17. Dr. Topper again saw Claimant on July 16, 2007. Claimant stated to the physician that she was 95% improved with the surgery and that her pain had resolved. Claimant told Dr. Topper that she wanted to return to work, but was worried about the workload. Claimant testified, and it is found, that the surgery by Dr. Topper in 2007 made a big difference in her pain symptoms, in-

creased the mobility in her arm and that she felt better both physically and mentally after the surgery.

18. Dr. Topper referred Claimant to Dr. Jack Rook, M.D. for evaluation of permanent impairment and work restrictions. Dr. Rook evaluated Claimant on September 14, 2007. Dr. Rook placed Claimant at maximum medical improvement, noting that her condition had improved as a result of the surgery done by Dr. Topper. Dr. Rook assigned a 24% impairment of the upper extremity that converted to 14% whole person impairment.

19. Dr. Rook placed work restrictions of no lifting/carrying over 5 pounds, occasional push/pull of up to 10 pounds, no reaching above shoulder with the right arm and occasional repetitive use of the upper extremity. These restrictions were considered to be permanent.

20. Claimant was capable of performing the duties of a Teacher's Aide within the physical restrictions of no lifting greater than 5-10 pounds and no overhead lifting as assigned by Dr. Watson. Claimant did not stop working in the Teacher's Aide position for reasons related to her physical restrictions or physical inability to perform the work related to the effects of her compensable injury. The ALJ finds that the opinion of Dr. Shaw expressed in his December 19, 2006 report that there are no medical contraindications to Claimant returning to work in light office work or as a Teacher's Aide to be credible, persuasive and is found as fact.

21. Claimant applied for various Educational Assistant positions with Employer during July 2006. In each of her applications, Claimant stated "I meet or exceed all job discription (sic) and Requirements for the for which I am Applying."

22. At the request of Insurer, Margo Burns performed a vocational evaluation of Claimant and issued a report dated June 18, 2008. Claimant stated to Ms. Burns that she walks 10,000 steps per day. Ms. Burns noted, and it is found, that Claimant's daily tasks included paperwork, paying bills, running errands, doing grocery shopping, watching television and reading.

23. At the time Claimant was evaluated by Margo Burns, Claimant had not applied for any jobs since 2006. Claimant reported to Ms. Burns that she would return to work as a Teacher's Aide with Employer if a job were available.

24. Ms. Burns noted that several of the positions as an Educational Assistant for which Claimant had applied would have exceeded her restrictions. However, Claimant is capable of performing lighter duty positions as an Educational Assistant I and had applied for those positions. As reflected in the report of Ms. Burns, Claimant either gave incorrect contact information or did not return calls for interviews for two of the positions for which she was qualified.

25. Ms. Burns conducted labor market research and found open positions with Employer for Instructional Assistants, Educational Assistant I, Child Care Program Leader or Program Aide, Receptionist and Volunteer Coordinator. Ms. Burns opined, and it is found, that these jobs would be physically appropriate for Claimant. Ms. Burns also identified open positions outside of the Employer as a ticket seller in a movie theatre or as a security gate guard.

26. In reaching her conclusions, Ms. Burns applied the restrictions assigned by Dr. Rook. The ALJ finds that Dr. Rook's restrictions are not representative of Claimant's physical capacity and understate her physical abilities. The jobs identified by Ms. Burns would comply with the physical restrictions and opinion of Dr. Shaw as found above. As opined by Ms. Burns, Claimant remains employable in entry-level light jobs such as teacher's aide, ticket seller, or security gate guard. Claimant is not permanently, totally disabled.

27. Subsequent to the evaluation by Dr. Rook, a second Division IME was performed by Dr. James Lindberg on January 28, 2008. Dr. Lindberg assigned the same impairment rating as Dr. Rook and concluded that Claimant was at maximum medical improvement.

28. Claimant experiences persistent pain from her right shoulder into her neck and from the shoulder down into the back in the area of the shoulder blade. Claimant has significant limitations in motion of the shoulder and cannot flex or raise her right arm above shoulder level. Dr. Shaw noted diffuse complaints of tenderness to palpation throughout the right paracervical, upper back and shoulder girdle. These complaints affect Claimant's cervical or neck rotation to the right as noted by Dr. Shaw. The tenderness and pain experienced in the paracervical and upper back areas affects the physical function of these areas.

CONCLUSIONS OF LAW

29. 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).

30. 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, 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 (2008) C.R.S.

31. Claimant is entitled to PTD benefits if she proves by a preponderance of the evidence that she is unable to earn wages in the same or other employment. C.R.S. § 8-40-201(16.5)(a); *Holly Nursing Care Center v. Industrial Claim_Appeals Office*, 992 P.2d 701 (Colo. App. 1999). In determining whether the claimant is unable to earn any wages, the ALJ may consider a number of "human factors." *Christie v. Coors Transportation Co.*, 933 P.2d 1330 (Colo. 1997). These factors include the claimant's physical condition, mental ability, age, employment history, education and the "availability of work" the claimant can perform. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). Another human factor is the claimant's ability to obtain and maintain employment within her physical abilities. *See Professional Fire Protection, Inc. v. Long*, 867 P.2d 175 (Colo. App. 1993). This is because the ability to earn wages inherently includes consideration of whether the claimant is capable of getting hired and sustaining employment. *See Christie v. Coors Transportation Co.*, *supra*; *Cotton v. Econ. Lube N Tune*, W.C. No. 4-220-395 (January 16, 1997), aff'd, *Econ. Lube N Tune v. Cotton* (Colo. App. No. 97CA0193, July 17, 1997). The determination of whether Claimant has met the burden of proof is one of fact for determination by the ALJ. *Weld County School District RE-12 v. Bymer*, *supra; Holly Nursing Care Center v. Industrial Claim Appeals Office, supra.*

32. In reaching the conclusion that Dr. Shaw's opinion regarding the Claimant's ability to work is persuasive, the ALJ has placed significant weight upon Claimant's own testimony that a further surgery by Dr. Topper in 2007 made a big difference in her pain symptoms, increased the mobility in her arm and that she felt better both physically and mentally after the surgery. The ALJ also finds support for this conclusion in the reports of Dr. Topper of April 23, 2007 stated that Claimant's pre-operative symptoms had resolved and Dr. Topper's report of July 16, 2007 at which time Claimant stated to the physician that she was 95% improved after the surgery and wanted to go back to work. In addition, as discussed above, Claimant represented to Dr. Kaplan that she was capable of performing work as a Teacher's Aide at a time when her symptoms were worse than they were after the surgery performed by Dr. Topper. Claimant's testimony at hearing that she does not feel she can return to work within the restrictions is not considered persuasive. Claimant's testimony that she cannot work within the restrictions is inconsistent with her representations concerning her condition after surgery to Dr. Topper. The ALJ resolves this conflict in favor of the statements contained in the reports of Dr. Topper. The subsequent work restrictions given by Dr. Rook are not persuasive in light of Claimant's own reports of the results of the surgery done by Dr. Topper that occurred after Dr. Shaw's evaluation. Dr. Rook's restrictions as not dissimilar from those given by Dr. Watson at the time he placed Claimant at MMI in November 2005. Claimant was able to work in office work and as a Teacher's Aide within the restrictions given by Dr. Watson. For Dr. Rook's restrictions to be accurate, Claimant's condition would have to

have essentially stayed the same after the surgery by Dr. Topper, not substantially improved as testified by Claimant and reported by Dr. Topper.

33. The ALJ concludes that Claimant has failed to sustain her burden of proof to show that she is permanently and totally disabled. In reaching this conclusion, the ALJ places greater weight upon the opinions of Respondent's expert, Margo Burns, than those of Claimant's expert, Doris Shriver. As reported by Ms. Burns, Claimant has sought other Teacher Aide positions and was contacted for interviews that did not occur because Claimant either gave incorrect contact information or did not return the calls. (Exhibit S, report page 10, Bates 000091). Ms. Shriver's testimony that there are no jobs available for Claimant within her restrictions is directly contradicted by the fact that Claimant applied for and obtained a light duty Teacher Aide position at Soaring Hawk Elementary and was capable of performing that work within her restrictions. The ALJ finds the labor market analysis and methodology used by Ms. Burns to be more credible and persuasive than that of Ms. Shriver. Ms. Shriver never personally evaluated Claimant. Ms. Shriver relied upon a general description of job duties from a national labor market database rather than specific contacts with local employers. That Claimant has not yet been hired for another position, either with the School District or another employer, is not considered persuasive to show that Claimant cannot obtain employment within her restrictions and be able to maintain such employment. As found, the opinions of Margo Burns are persuasive to show that Claimant remains employable within her physical capacity.

34. The ALJ initially issued a Summary Order dated October 23, 2008. Subsequent to that Summary Order, Claimant filed a Motion for Reconsideration in addition to a request for specific findings of fact. In her Motion, Claimant argues that the opinions of her expert, Doris Shriver, are unrebutted and that the work restrictions of Dr. Rook should be considered to be Claimant's permanent work restrictions by which her employability and claim for permanent total benefits should be assessed. In short, the Claimant argues that the ALJ was required to find that she was permanently totally disabled based upon the opinions of Dr. Rook and Doris Shriver. The ALJ disagrees. The ALJ is under no obligation to credit medical testimony even if such testimony is unrebutted. *Cary v. Chevron U.S.A., Inc.,* 867 P.2d 117 (Colo. App. 1993). The weight and credibility to be assigned expert testimony or opinions is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3fd 186 (Colo. App. 2002). The ALJ resolves conflicts in the evidence, makes credibility determinations, and draws plausible inferences from the evidence. *See Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192, 1197 (Colo. App. 2002). Thus, even in the absence of the opinions of Dr. Shaw and Ms. Burns, the ALJ would not be compelled to credit the opinions of Dr. Rook and Ms. Shriver. To the extent that Claimant's Motion requests the ALJ to re-weigh the evidence and reach a result in favor of Claimant, the ALJ declines to do so.

35. Section 8-42-107(1)(a), C.R.S. 2004, limits a claimant to a scheduled disability award if the claimant suffers an "injury or injuries" described in § 8-42-107(2), C.R.S. 2004. Strauch v. PSL Swedish Healthcare System, 917 P.2d

366 (Colo. App. 1996). The term "injury," as used in § 8-42-107(1)(a), refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss, and not necessarily the situs of the injury itself. Walker v. Jim Fuoco Motor Co., 942 P.2d 1390 (Colo. App. 1997). Whether a claimant has suffered an impairment that can be fully compensated under the schedule of disabilities is a factual question for the ALJ, whose determination must be upheld if it is supported by substantial evidence. Walker v. Jim Fuoco Motor Co.,supra. That determination is distinct from, and should not be confused with, the treating physician's rating of physical impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (rev. 3d ed.) (AMA Guides). Strauch v. PSL Swedish Healthcare System, supra; see also City Market, Inc. v. Indus. Claim Appeals Office, 68 P.3d 601, 603 (Colo. App. 2003)("The determination whether a claimant sustained a scheduled or nonscheduled injury is a question of fact or the ALJ, not the rating physician."). Kolar v. ICAO, 122 P.3d 1075 (Colo. App. 2005).

36. The ALJ concludes that Claimant has proven, by a preponderance of the evidence that the situs of functional impairment is above the level of the arm at the shoulder. Accordingly, Claimant's permanent impairment should be compensated as whole person impairment under Section 8-42-107(8), C.R.S. The pain and tenderness in the paracervical and upper back areas that impairs the function of these areas is sufficient to establish whole person impairment. *Salaz v. Phase II Co., W.C. No. 4-240-376 (November 19, 1997), aff'd., Phase II Co. v. Indus. Claim Appeals Office, (Colo. App. No. 97 CA 2099, September 3, 1998, NSOP), Webb v. Circuit City Stores, Inc., W.C. No. 4-467-005 (August 16, 2002).*

37. At hearing, Respondent's stated that they did not contest the ratings of Dr. Lindberg with respect to the whole person impairment. Therefore, as Claimant's impairment is to be converted to whole person impairment, the whole person impairment should be 14% as assessed by Dr. Lindberg.

ORDER

It is therefore ordered that:

1. Claimant's claim for permanent total disability is denied and dismissed.
2. Claimant is entitled to compensation for permanent partial benefits for 14% whole person impairment as provided in Section 8-42-107(8), C.R.S. Respondents are entitled to credit for all amounts of permanent partial benefits previously paid pursuant to the Final Admission of March 4, 2008.
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.

November 14, 2008 Ted A. Krumreich

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-664-944

ISSUE

The issue for determination is Richard Blundell's request for attorney fees.

FINDINGS OF FACT

1. Claimant alleged she sustained a compensable injury on December 29, 2006. Claimant also alleges injuries on other dates and Claimant has had prior compensable injuries.

2. Claimant retained Richard Blundell in January 2007 to represent her in connection with her workers' compensation claims. The Contingent Fee Agreement (fee agreement) signed by Claimant and Blundell contained the following pertinent paragraphs:

> We have discussed alternate agreements, including contingent, hourly, per diem, and fixed fees. I agree to pay said Attorney for services in this case a maximum fee of Twenty Percent (20%) of any and all payments recovered on any contested matters, *except as otherwise stated herein*. (Emphasis added).
>
> If the undersigned's services terminate prior to *any recovery* herein, the undersigned shall be entitled to receive in satisfaction of *all fees due* hereunder an amount equal to the greater of: (a) *his percentage fee stated above applied to any then outstanding settlement offer*; or (b) the proportion of the total fee ultimately charged the client in this matter from any subsequent recovery which fairly represents the reasonable value of the legal services rendered or the contribution of the undersigned's efforts to the amount recovered. (Emphasis added).

3. Claimant became frustrated and unhappy with the representation that Richard Blundell was providing to her. She was unhappy that her claims did not appear to be progressing, her medical bills were not paid, she did not receive a copy of Dr. Theil's restrictions, two settlement hearings had been postponed at the last minute, and she felt that she was unable to discuss her claims directly with Blundell as she wished. Claimant also was unhappy that Blundell had become angry and yelled at her or his office staff in her presence. Further, in November 2007, Claimant was to meet with Ira Sanders, who she was told would represent her at any hearing. When Claimant appeared for that meeting, she found that Sanders was not there. On December 24, 2007, Claimant had an appointment with Blundell and Blundell did not appear for that meeting.

4. In December 2007, Blundell obtained a settlement offer from Respondents for $35,000.00. Blundell, on behalf of Claimant, countered for a much higher figure.
5. In December 2007, Respondents also agreed to a one-time evaluation with Dr. Thiel.
6. Claimant terminated the services of Blundell on January 9, 2008. Blundell filed a motion to withdraw on January 31, 2008, and that motion was granted on February 14, 2008. Claimant proceeded without counsel.
7. Prior to the termination of his services, Blundell incurred expenses and costs to prosecute Claimant's claims in the amount of $245.42. Blundell has also requested $215.75 for copying after the termination of his services.
8. Dr. Thiel examined Claimant in March 2008.
9. In May 2008, Claimant settled eight claims with Respondents, including the claim with this W.C. number, for an amount in excess of the $35,000.00 offer obtained by Blundell.

CONCLUSIONS OF LAW

1. The ALJ has statutory authority to determine the "reasonableness of the fee charged by" Blundell. Section 8-43-403(1), C.R.S. Section 8-43-403(2), C.R.S., requires a written fee agreement setting forth the "specific fee arrangement" and "circumstances in which any modifications or adjustments to such fee will be made." The fee agreement represents a contract between Claimant and Blundell. The agreement should be enforced as written to the extent it is plain, clear, and no absurdity is involved. *See Cary v. Chevron U.S.A., Inc.,* 867 P.2d 117 (Colo. App. 1993); *Loar v. Want ads of Fort Collins,* W.C. No. 4-481-416 (ICAO, 2004).
2. Under the plain terms of the fee agreement, if Blundell was terminated before "any recovery" received by Claimant, Blundell's fee was to be determined by the greater of 20 percent of any outstanding settlement agreement or option "b." At the time Claimant terminated his services, there was an outstanding settlement offer for $35,000.00. Twenty percent of that amount, $7,000.00, is a reasonable fee for Blundell's services.
3. During the prosecution of Claimant's claims, Blundell incurred costs of $245.42. Claimant is liable for those costs. After the termination of his services, Blundell incurred copying costs. However, those costs were not to prosecute Claimant's claims, and therefore are not reasonably the costs of Claimant. Claimant is not liable for those costs incurred after she terminated Blundell's services.

ORDER

It is therefore ordered that Claimant shall pay Richard Blundell attorney fees and costs in the amount of $7,245.42.

DATED: *November 19, 2008*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-675-855

ISSUES

The sole issue determined herein is claimant's petition to reopen based upon a change of condition.

FINDINGS OF FACT

1. Claimant was born on May 12, 1956, and was 52 years of age at the time of the hearing. Claimant weighs approximately 275 pounds and has been diagnosed with rheumatoid arthritis in his hands and joints.

2. In March 2005, claimant began employment as a sales associate with the employer.

3. On May 7, 2005, claimant suffered an admitted work injury to his mid-back after moving pallets of dog food and pushing carts in the employer's parking lot.

4. Claimant was referred by the employer Concentra, where he was initially examined by Keith Kesten, D.O. Dr. Kesten diagnosed claimant with a thoracic strain and right rib pain. Claimant was treated with physical therapy, chiropractic treatment, and osteopathic treatment.

5. On July 29, 2005 claimant had a magnetic resonance image ("MRI") of his thoracic spine that demonstrated sizable predominately left-sided posterior and inferior extrusion of the T7-8 disc with mild cord compression; shallow protrusions of the T4-5, T5-6, T6-7, T8-9, T10-11, and T12-L1 discs associated with partial effacement of the subarachnoid, but no cord compression; and mild multilevel anterior degenerative spondylosis.

6. On August 10, 2005, Daniel Baer, D.O., examined claimant. Dr. Baer diagnosed claimant with a thoracic strain and degenerative disc disease at multiple levels of his thoracic spine. Dr. Baer performed epidural steroid injections.

7. On November 1, 2005, Dr. Hattem examined claimant, who complained of right pariscapular thoracic pain.

8. On December 15, 2005, claimant underwent a functional capacity evaluation ("FCE") that showed his ability to lift 45 pounds, carry 25 pounds, sit for 45 minutes, and stand for 90 minutes.

9. On December 27, 2005, Dr. Hattem determined that claimant reached maximum medical improvement ("MMI"). At MMI, claimant continued to complain of persistent mid-back pain. Claimant reported that he did not experience any improvement at all since the injury in May 2005. Dr. Hattem released claimant to return to his regular duty

work, but imposed permanent restrictions consistent with the FCE. Dr. Hattem determined that claimant suffered 10% whole person impairment due to the work injury. Dr. Hattem indicated that claimant did not need post-MMI medical care.

10. On February 2, 2006, the insurer filed a final admission of liability for permanent partial disability benefits and for post-MMI medical benefits.

11. On January 9, 2006, claimant returned to Dr. Hattem for a prescription refill. Concentra physicians prescribed medication refills on January 9, 2006, February 2, 2006, and March 7, 2006. On February 2, 2006, Dr. Hattem reexamined claimant, who continued to complain of mid-back pain.

12. Claimant returned to work for the employer in the Photo Lab on a full-time basis.

13. Claimant, on his own, sought unauthorized healthcare through his primary care physician, Douglas Clark, M.D. On April 12, 2006, Dr. Clark documented that claimant was obese, weighing 266lbs. On April 19, 2006, Dr. Clark recommended that claimant lose weight. Claimant did not lose weight, but continued to gain weight.

14. On April 28, 2006, Dr. Zyskowski diagnosed claimant with early rheumatoid arthritis.

15. Dr. Clark referred claimant to Dr. Sandell for treatment of mid-back pain. Dr. Sandell first saw claimant on October 24, 2006. Claimant reported mid-back pain with very little activity. Dr. Sandell noted that claimant's weight gain was likely now becoming a contributing factor to his pain problems. Dr. Sandell diagnosed radicular pain versus chronic muscular pain and recommended medications and pool therapy.

16. Claimant was re-examined by Dr. Sandell on January 15, 2007. Dr. Sandell noted that claimant continued to have the same symptoms and did not report any significant change.

17. On January 18, 2007, Dr. Hattem responded to correspondence from the adjuster and concluded that claimant's recurrent pain was not related to the work injury.

18. On February 5, 2007, Dr. Zyskowski reexamined claimant, who reported increased pain in his hands. Dr. Zyskowski diagnosed a flare up of the rheumatoid arthritis.

19. On March 6, 2007, claimant reported no change in his condition. Dr. Sandell recommended trigger point injections. Dr. Sandell noted that claimant was reluctant to proceed after finding out that he was responsible for co-payments on the medical appointments. Claimant elected to obtain the injections through his personal care physician under his health insurance.

20. On August 10, 2007, Dr. Sandell reexamined claimant, who reported increased symptoms, but denied any new injury. Dr. Sandell diagnosed chronic muscular pain. Dr. Sandell orally informed claimant that he should be limited to sedentary work.

21. Claimant informed the employer of his new restrictions to sedentary employment. The employer informed claimant that no such work was available for him. Claimant took a medical leave of absence from work and began receiving short-term disability benefits effective August 4, 2007.

22. After leaving work, claimant did not experience any decrease in his mid-back pain.

23. Claimant underwent a repeat thoracic MRI on October 8, 2007. The MRI showed T7-8 central disc herniation with mild thoracic cord flattening, relatively stable from the prior study; small disc herniations or protrusions at several levels, including T4-5, T6-7 and T8-T9 and T11-12, without evidence of thoracic cord compression; and multilevel degenerative disc disease and spondylosis.

24. The MRI findings on October 8, 2007 are unchanged from July 29, 2005, as noted by Dr. Sandell, Dr. Sung, and Dr. Hattem. The T7-8 disc herniation is of questionable relevance for claimant's symptoms because he primarily suffers chronic muscular pain.

25. Dr. Sandell referred claimant to Dr. Sung. On November 8, 2007, Dr. Sung evaluated claimant and diagnosed thoracic spine degenerative disc disease. Dr. Sung recommended a possible trial of a spinal stimulator.

26. On December 13, 2007, Dr. Zyskowski reexamined claimant, who reported developing morning stiffness, pain, and swelling, and pain in his back radiating to his hips. Dr. Zyskowski's impression was that claimant suffered progressing rheumatoid arthritis.

27. On December 31, 2007, claimant's health insurance coverage ended.

28. Dr. Sandell referred claimant to Dr. Mitchell. On January 29, 2008, Dr. Mitchell examined claimant and recommended a possible spinal stimulator or pain pump, but he noted that he first needed to review all of claimant's previous medical records.

29. On February 15, 2008, Dr. Corbett, a rheumatologist, examined claimant, who reported increased left hip pain because of a recent fall. Dr. Corbett recommended that claimant stop use of Piroxicam and continue Relafen.

30. On February 29, 2008, Dr. Sandell reexamined claimant, who reported that the rheumatologist told him to stop the Relafen. Claimant reported increased pain since stopping the Relafen, so Dr. Sandell prescribed Darvocet.

31. On May 21, 2008, Dr. Sandell, based only upon the February 29 examination, imposed restrictions against lifting over 10 pounds, standing more than two hours, and reaching more than occasionally. Dr. Sandell also indicated that claimant should alternate sitting and standing.

32. On an unknown date, claimant petitioned to reopen this claim based upon a change of condition.

33. On June 17, 2008, Dr. Hattem reexamined claimant, who reported that he was worse than one year earlier. Dr. Hattem indicated that he needed to review the previous medical records.

34. On August 12, 2008, Dr. Hattem reported that Dr. Sandell had agreed that claimant needed no further conservative treatment. Dr. Hattem concluded that claimant's rheumatoid arthritis was contributing to his pain and that a spinal stimulator was not appropriate. Dr. Hattem concluded that claimant was still at MMI and needed only medications as post-MMI maintenance treatment.

35. At hearing, claimant testified that suffered increasing symptoms in mid 2007 due to both work and activities of daily living.

36. At hearing, Dr. Sandell admitted that claimant's rheumatoid arthritis could be contributing to thoracic spine pain, although not to his muscular pain. Dr. Sandell also agreed that claimant's obesity could affect his back muscles. Dr. Sandell did not know if the degenerative changes were causing the symptoms.

37. At hearing, Dr. Hattem testified that active rheumatoid arthritis could affect the costovertebral joints in the mid-back. Dr. Hattem testified that the increasing symptoms in mid 2007 were possibly due to the rheumatoid arthritis. Dr. Hattem concluded that claimant's symptoms were multi-factorial: his rheumatoid arthritis, degenerative changes, and weight gain. He noted that claimant had no changes on MRI scans. Dr. Hattem concluded that the degenerative changes were not due to the work injury. He explained that claimant's thoracic strain did not cause a worsening of the spine condition.

38. Claimant failed to prove by a preponderance of the evidence that he suffered a change of his condition as a natural consequence of his admitted May 7, 2005, work injury. His MRI findings are unchanged. His T7-8 disc herniation is of questionable relevance for his symptoms. He had primarily chronic muscular pain due to the work injury. He has complicating factors from rheumatoid arthritis and obesity. He had persistent right-sided thoracic pain at MMI and thereafter. He reported increasing symptoms in mid-2007, due to both work and activities of daily living. After losing his health insurance benefits, he sought to reopen this workers' compensation claim. The opinions of Dr. Hattem, supported by the opinions of Dr. Sandell, are persuasive. Claimant might be worse than at MMI, but any such worsening is not as a natural consequence of the work injury.

CONCLUSIONS OF LAW

Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). Claimant must prove that his change of condition is the natural and proximate consequence of the industrial injury, without any contribution from another separate causative factor. *Vega v. City of Colorado Springs,* W.C. No. 3-986-865 & 4-226-005 (ICAO, March 8, 2000). As found, claimant failed to prove by a preponderance of the evidence that he suffered a change of his condition as a natural consequence of his admitted May 7, 2005, work injury.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is denied and dismissed.

DATED: November 6, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-685-629

ISSUES

Claimant sought to overcome the division independent medical examination (DIME) opinion with respect to permanent partial disability (PPD) and causation/relatedness with respect to the low back and right shoulder. Additionally, Claimant sought post-maximum medical improvement (MMI) *Grover*-type medical care.

FINDINGS OF FACT

1. Claimant suffered a work-related injury in February 2006. Claimant was initially treated for shoulder pain for his work-injury with Dr. Rosemary Greenslade and as indicated by Dr. Greenslade on April 28, 2006, Claimant's shoulder pain resolved after a subacromial injection on April 21, 2006. Subsequent medical records are inadequate to establish that Claimant's shoulder complaints at the time of his visit to Dr. Rook are related to the industrial injury. However, Claimant's cervical condition was determined to be related to the February 2006 work injury.

2. After Claimant's treating physician, Dr. Darrel Quick placed him at MMI on April 20, 2007, Dr. Jeffrey Wunder conducted a DIME of the Claimant on August 6, 2007. Dr. Wunder's "Impression" was: cervical strain; underlying cervical degenerative disc disease; right C7 radiculitis; and, nonspecific low back pain unrelated to work injury. Dr. Wunder found that Claimant was not at MMI for his work injury and recommended additional care addressing only the Claimant's cervical complaints.

3. After the additional care, including a C5 to C-7 anterior cervical discectomy, Claimant was again put at MMI and returned to Dr. Wunder for a follow-up DIME on May 8, 2008. Dr. Wunder determined the Claimant was at MMI for his industrial injuries and agreed with the treating physician's date of MMI of March 17, 2008. Dr. Wunder's "Impression" was: chronic neck pain; status post-C5 to C7 anterior cervical discectomy and fusion; and psychological factors. Dr. Wunder provided a whole person rating of 17%.

4. Claimant claims that he also has low back symptomology that he believes is related to his work injury. The medical documentation does not provide sufficient substantiation to conclude that any low back symptoms are related to the industrial injury, including Claimant's procured IME from Dr. Jack Rook. Dr. Wunder in his first DIME specifically found Claimant's low back condition to be non-work-related. Dr. Wunder's follow-up DIME does not find a causal connection and by implication again rejects Claimant's low back claim.

5. Claimant underwent an independent medical evaluation by Dr. Rook on August 19, 2008. Dr. Rook reviewed Claimant's medical records and performed an evaluation of Claimant. Additionally, Dr. Rook sent the Claimant for range of motion testing to a physical therapist. Dr. Rook opines that Claimant is not at MMI because he believes the Claimant's shoulder complaints at the time of his examination are related to the work-injury. He cites, *inter alia*, the results of the Claimant's MRI conducted on April 13, 2006, which indicated Claimant had a supraspinatus distal tendon undersurface low-grade partial thickness tear; subdeltoid/subacromial bursitis; superior labral fraying; and, AC joint early degenerative change. These are the same MRI results used by Dr. Greenslade prior to performing a subacromial injection.

6. Dr. Rook provided an impairment rating of 34% whole person if Claimant's low back condition is unrelated and 45% whole person if Claimant's low back condition is found to be related to his work injury.

7. The ALJ finds that the medical evidence submitted fails to establish by clear and convincing evidence that it is highly probable that Dr. Wunder's opinions are incorrect with respect to Claimant's PPD claim. The evidence establishes only a difference of opinion between Dr. Rook and Dr. Wunder.

8. By failing to specifically find that Claimant's low back symptomology was related to his industrial injury Dr. Wunder implicitly found that it was not part of Claimant's work injury. The ALJ finds that Dr. Wunder's opinion as to causation of Claimant's low back symptomology, based upon the Claimant's medical history available to him, is more persuasive than Dr. Rook's equivocal opinion. Claimant has failed to establish by clear and convincing evidence that it is highly probable that Dr. Wunder's opinion on causation of Claimant's low back symptomology is incorrect. The evidence establishes only a difference of opinion between Dr. Rook and Dr. Wunder.

9. By failing to specifically find that Claimant's shoulder symptomology was related to his industrial injury Dr. Wunder implicitly found that it was not part of Claimant's work

injury. The ALJ finds that Dr. Wunder's opinion as to causation of Claimant's shoulder symptomology, based upon the Claimant's medical history available to him, is more persuasive than Dr. Rook's contrary opinion. Claimant has failed to establish by clear and convincing evidence that it is highly probable that Dr. Wunder's opinion on causation of Claimant's low back symptomology is incorrect. The evidence establishes only a difference of opinion between Dr. Rook and Dr. Wunder.

10. Since the ALJ finds that Claimant's shoulder condition is not work related it follows that post-MMI *Grover* benefits for Claimant's shoulder are moot. To the extent that Claimant is requesting *Grover* benefits for his work-related injury, the ALJ finds Dr. Wunder's opinion that no maintenance treatment is necessary to be persuasive. Claimant has failed to establish by a preponderance of the evidence that he is entitled to any *Grover* medical benefits.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2007), 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. (2007). Generally, Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. (2007). 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. (2007).

2. Sections 8-42-107(8)(b)(III) and (c), C.R.S. (2007), provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

3. The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

4. After the Claimant reaches maximum medical improvement the Claimant may obtain future medical benefits only to maintain maximum medical improvement or to prevent a deterioration of his condition. *See Grover v. Industrial Commission,* 759 P.2d 705, 711 (Colo. 1988). The Claimant is therefore entitled to *Grover*-type medical benefits where there is substantial evidence in the record to support a determination that future medical treatment will be reasonable and necessary "to relieve a claimant from the effects of an [industrial] injury" or prevent further deterioration of the claimant's condition. *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995)*; Milco Construction v. Cowan*, 860 P.2d 539 (Colo. App. 1992).

5. In accordance with Section 8-43-215, C.R.S. (2007), 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. 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).

7. As found above, Claimant has failed to overcome the DIME physician's findings with respect to PPD or causation of Claimant's low back and shoulder symptomology.

8. Claimant has failed to produce substantial evidence to establish by a preponderance of the evidence that he is entitled to post-MMI *Grover* benefits.

ORDER

It is therefore ordered that:

1. Claimant's claim to overcome the DIME with respect PPD is denied and dismissed.
2. Claimant's claim for overcoming the DIME with respect to causation/relatedness of his low back and shoulder symptomology is denied and dismissed.
3. Claimant's claim for post-MMI treatment of his condition is denied and dismissed.
4. Any and all issues not determined herein are reserved for future decision.
5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATE: November 28, 2008

Donald E. Walsh

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-691-723

ISSUES

1. Whether Claimant has overcome by clear and convincing evidence the Division Independent Medical Examination (DIME) physician's determination that he reached Maximum Medical Improvement (MMI) on March 20, 2007.

2. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injury.

3. Whether Claimant has established by a preponderance of the evidence that he is entitled to receive Temporary Partial Disability (TPD) benefits and Temporary Total Disability (TTD) benefits from January 17, 2007 until terminated by statute.

4. Whether Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving TTD benefits because he was responsible for her 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 as a welder for Employer. On June 13, 2006 he sustained an industrial injury to his right wrist during the course and scope of his employment.
2. Claimant underwent two surgeries in order to repair his right wrist. On August 4, 2006 Insurer filed a General Admission of Liability acknowledging that Claimant was entitled to medical benefits, TTD benefits beginning on July 18, 2006, and an AWW of $613.68. An AWW of $613.68 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.
3. Termination from Employment
4. On October 31, 2006 Claimant was released to work with restrictions that included no use of his right arm. On December 15, 2006 Employer offered Claimant modified employment consistent with his work restrictions. Employer directed Claimant to report to work on December 26, 2006 at 8:00 a.m.
5. On the morning of December 26, 2006 Claimant underwent an evaluation with Mark Durbin, M.D. Dr. Durbin assigned Claimant work restrictions that prohibited Claimant from lifting, carrying, pushing and pulling more than two pounds and referred Claimant for physical therapy three times each week. Claimant then reported for modi-

fied employment. Over the ensuing days, Claimant performed modified duties but was ultimately terminated on January 17, 2007 for excessive absenteeism.

6. The decision of a Hearing Officer regarding Claimant's unemployment insurance benefits was included as an exhibit in the record. The decision reveals that Claimant attended physical therapy sessions on December 27-29, 2006. He left work early on December 29, 2006 with a number of other employees who were sent home early for the day. On January 2, 2007 Claimant contacted Employer and stated that he could not report to work because of wrist pain. On January 4, 2007 Claimant was late for work because he had a scheduled physical therapy appointment. On January 9, 2007 Claimant left work early because of wrist pain. On January 10, 2007 Claimant reported to work approximately 15 minutes late. On January 12, 2007 Claimant attended a morning doctor's appointment that was not related to his work injury and an afternoon physical therapy appointment that was related to his work-injury. On January 16, 2008 Claimant told Employer's shop foreman that he needed to leave work at 10:00 a.m. for personal reasons but refused to explain the details of his request. The appointment was with Claimant's mental health provider. Claimant explained that in additional to his medical appointments he took some time off from work because he was suffering from pain and needed to care for his children.

7. In contrast, a review of the physical therapy records reveals that Claimant did not have an appointment scheduled for January 4, 2007 and he did not attend his scheduled January 12, 2007 appointment. Moreover, Employer's shop foreman explained that Claimant failed to provide notes regarding attendance at physician's appointments or physical therapy. The shop foreman commented that he discussed tardiness and attendance problems with Claimant on two occasions.

8. Respondents have failed to demonstrate it is more probably true than not that Claimant committed a volitional act or exercised some control over his termination. Although Claimant missed parts of several scheduled work shifts between December 26, 2006 and January 16, 2007, many of the absences were caused by medical and physical therapy appointments related to his industrial injury. Small portions of Claimant's absences were related to non-work-related medical conditions or personal matters. Furthermore, because Claimant was generally terminated for excessive absenteeism, it is unclear whether the reasons for the termination included medical appointments that were related to his industrial injury. Finally, although Claimant's shop foreman specified that he discussed tardiness and attendance problems with Claimant on two occasions, there is no evidence that Claimant was apprised that any additional attendance problems would result in termination. Because the primary reasons for Claimant's absences involved his wrist injury, he did not exercise control over his termination under the totality of the circumstances.

9. MMI and DIME

10. After his termination, Claimant continued to receive medical care from his authorized treating physicians. On March 20, 2007 Dr. Durbin noted that Claimant was still doing poorly. He opined that Claimant should be placed at MMI because he did not feel that there was anything else that could be done for Claimant. Nevertheless, he stated that Claimant should be re-evaluated in six months to make sure that his condition was not worsening.

11. Claimant was referred to Gregory Reichhardt, M.D. for a report regarding MMI and impairment. Dr. Reichhardt agreed with Dr. Durbin that Claimant had reached MMI on March 20, 2007. He assigned Claimant a 13% upper extremity impairment rating based on right wrist range of motion deficits and a neurologic impairment to the ulnar nerve. Dr. Reichhardt recommended medical maintenance benefits.

12. On April 26, 2007 Insurer filed a Final Admission of Liability (FAL) consistent with Dr. Reichhardt's determination of MMI and impairment rating. Claimant objected to the FAL and sought a DIME. Joseph Fillmore, M.D. was selected to perform the DIME.

13. On September 17, 2007 Claimant underwent the DIME. Dr. Fillmore agreed with Dr. Reichhardt that Claimant had reached MMI on March 20, 2007. He assigned Claimant a 20% whole person impairment rating based on range of motion deficits and hypersensitivity in the ulnar distribution of the hand. Dr. Fillmore recommended medical maintenance care that included referral to a pain management specialist for medication management and follow-up with Dr. Durbin for maintenance treatment.

14. FAL and Objection

15. On November 2, 2007 Insurer filed a FAL consistent with Dr. Fillmore's DIME report. Claimant objected to the FAL and filed an Application for Hearing on November 30, 2007. Claimant endorsed the following issues for hearing: medical benefits; AWW; disfigurement; TTD benefits from 1/17/07 to 4/17/07; TPD benefits from various; permanent partial disability benefits; *Grover* medical care; treatment to maintain MMI; and that he was not at fault for his termination from employment.

16. On April 8, 2008 Claimant filed a second Application for Hearing. The second application contained identical issues to those listed in the November 2, 2007 application.

17. The applications for hearing also specified that other issued to be considered at the hearing included "*Grover* Medical Care, treatment to maintain MMI; Claimant objects to Final Admission dated 11/02/07. Claimant is not at fault for his termination from Respondent/Employer."

18. Claimant's applications for hearing did not expressly provide that he sought to challenge Dr. Fillmore's DIME determination. However, they specifically stated that he objected to the FAL. Insurer's FAL was based on Dr. Fillmore's DIME determination. Therefore, Claimant's specific objection to the FAL reflected that he disagreed with the DIME determination. Accordingly, Claimant's hearing applications encompassed a challenge Dr. Fillmore's MMI finding.

19. Medical Treatment and Opinions

20. During the period November 2007 through February 2008 Claimant visited James Derrisaw, M.D. for several evaluations. Dr. Derrisaw noted that Claimant continued to experience pain in his right wrist, his skin was mottled and his right hand was colder than his left hand. Additional testing revealed that Claimant was not suffering from thoracic outlet syndrome. He thus determined that Claimant was experiencing the onset of Chronic Regional Pain Syndrome (CRPS).

21. Claimant also returned to Dr. Reichhardt for medical treatment. Dr. Reichhardt recommended QSART testing to further explore the possible diagnosis of CRPS. Subsequent QSART testing revealed that Claimant had a low probability for CRPS.

22. At the request of Dr. Reichhardt, Claimant underwent a pain psychology evaluation with Ron Carbaugh, Psy.D. Dr. Carbaugh concluded that Claimant's personality

style and chronic pre-existing depression were likely to profoundly impact his pain perception and response to treatment. He noted that Claimant emphasized his psychological symptoms during the assessment. Dr. Carbaugh's diagnosis included the following: (1) Pain Disorder associated with both psychological factors and a general medical condition vs. Factitious Disorder with predominantly physical signs and symptoms; (2) Dysthymic disorder; (3) Probable personality disorder NOS-dependent and avoidant features.

23. Dr. Derrisaw, an expert in anesthesiology and pain medicine, testified through an evidentiary deposition in this matter. He explained that, during an initial assessment, Claimant was suffering from acute pain syndrome due to trauma and the potential onset of CRPS. During subsequent examinations, Claimant exhibited symptoms of CRPS that included right hand pain, coldness, weakness, mottling, edema and a glossy appearance to his skin. He commented that an alternative diagnosis for Claimant's symptoms could be mediated sympathetic pain, but that more diagnostic testing such as an alcohol block and neuromodulation would aid in a diagnosis. He also noted that Claimant could be suffering from vascular spastic disease that is typically caused by a person's genetic predisposition. Dr. Derrisaw concluded that, in addition to the diagnostic tests, there was little treatment that could be given to Claimant. Although he stated that Claimant had not reached MMI, he determined that Claimant was close to MMI.

24. DIME physician Dr. Fillmore, an expert in rehabilitation, physical medicine and pain management, testified through an evidentiary deposition in this matter. Dr. Fillmore stated that Claimant initially reached MMI on March 20, 2007. After receiving information that Claimant began experiencing symptoms of CRPS in approximately December 2007, Dr. Fillmore responded to a question about whether he had an opinion regarding Claimant's MMI status. He commented with the following: "No. That's a - - I don't. You've got to try and find out what works for the patient and what doesn't. If they were out of ideas for him, at some point it's medication management, he's at MMI." Later in the deposition Claimant responded that, based on the new information and without evaluating Claimant, he could not determine whether Claimant was currently at MMI.

25. Dr. Reichhardt, an expert in physical medicine and diagnostics, testified through an evidentiary deposition in this matter. He explained that it is unlikely Claimant suffers from CRPS but that a QSART test was one additional test that could be performed within the Medical Treatment Guidelines to ascertain whether Claimant suffers from CRPS. In fact, a QSART test performed after Dr. Reichhardt's deposition revealed a low probability for CRPS. Dr. Reichhardt opined that, although "some reasonable questions have been raised" about Claimant's condition, his condition since he reached MMI has not worsened. Therefore, Claimant remained at MMI and any additional treatment should be considered medical maintenance.

26. Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Fillmore's March 20, 2007 MMI determination was incorrect. At his deposition, Dr. Fillmore was presented with post-MMI medical evidence about Claimant's condition. When asked directly about whether Claimant remained at MMI, he simply could not offer an offer an opinion absent additional evaluation. He did not directly renounce his determination that Claimant had reached MMI on March 20, 2007. Furthermore, Dr. Fillmore's comments at the deposition reflect that, after treatment pro-

viders exhausted options, Claimant would be at MMI and any additional treatment would constitute medical maintenance.

27. The testimony of Dr. Reichhardt supports Dr. Fillmore's comments regarding MMI. Dr. Reichhardt testified that, although it is unlikely that Claimant suffers from CRPS, a QSART test constituted an additional test that could be performed within the Medical Treatment Guidelines in order to ascertain whether Claimant suffered from CRPS. The QSART test performed after Dr. Reichhardt's deposition revealed a low probability for CRPS. Based on the credible testimony of Dr. Reichhardt, Claimant has thus exhausted his options within the Medical Treatment Guidelines. Moreover, Dr. Reichhardt opined that, although "some reasonable questions have been raised" about Claimant's condition, he had not suffered a worsening of condition since he reached MMI. Therefore, Claimant remained at MMI and additional treatment should be considered medical maintenance. In contrast, Dr. Derrisaw's testimony regarding additional diagnostic testing such as an alcohol block and neuromodulation constitutes a difference of medical opinion regarding the extent of appropriate diagnostic testing. Dr. Derrisaw's comments do not constitute unmistakable evidence that Dr. Fillmore's DIME determination regarding MMI was incorrect.

28. Although Claimant remains at MMI, the credible testimony of Dr. Fillmore and Dr. Reichhardt reflects that Claimant is entitled to medical maintenance benefits. Claimant has produced substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

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 worker's 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 worker's 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 worker's 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 (2005).

Overcoming the DIME and Medical Benefits

4. As found, Claimant's specific objection to the FAL reflected that he disagreed with the DIME determination. Accordingly, Claimant's hearing applications encompassed a challenge Dr. Fillmore's MMI finding. However, a DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, 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 (ICAP, Oct. 4, 2001). The 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 (ICAP, July 19, 2004); *see Shultz v. Anheuser Busch, Inc.*, W.C. No. 4-380-560 (ICAP, Nov. 17, 2000).

5. MMI exists when "any medically determinable physical or mental impairment as a result of injury has become stable and no further treatment is reasonably expected to improve the condition." §8-40-201(11.5), C.R.S. Furthermore, 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]." *In Re Brownson-Rausin,* W.C. No. 3-101-431 (ICAP, Oct. 21, 2004).

6. As found, Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Fillmore's March 20, 2007 MMI determination was incorrect. At his deposition, Dr. Fillmore was presented with post-MMI medical evidence about Claimant's condition. When asked directly about whether Claimant remained at MMI, he simply could not offer an offer an opinion absent additional evaluation. He did not directly renounce his determination that Claimant had reached MMI on March 20, 2007. Furthermore, Dr. Fillmore's comments at the deposition reflect that, after treatment providers exhausted options, Claimant would be at MMI and any additional treatment would constitute medical maintenance.

7. As found, the testimony of Dr. Reichhardt supports Dr. Fillmore's comments regarding MMI. Dr. Reichhardt testified that, although it is unlikely that Claimant suffers from CRPS, a QSART test constituted an additional test that could be performed within the Medical Treatment Guidelines in order to ascertain

whether Claimant suffered from CRPS. The QSART test performed after Dr. Reichhardt's deposition revealed a low probability for CRPS. Based on the credible testimony of Dr. Reichhardt, Claimant has thus exhausted his options within the Medical Treatment Guidelines. Moreover, Dr. Reichhardt opined that, although "some reasonable questions have been raised" about Claimant's condition, he had not suffered a worsening of condition since he reached MMI. Therefore, Claimant remained at MMI and additional treatment should be considered medical maintenance. In contrast, Dr. Derrisaw's testimony regarding additional diagnostic testing such as an alcohol block and neuromodulation constitutes a difference of medical opinion regarding the extent of appropriate diagnostic testing. Dr. Derrisaw's comments do not constitute unmistakable evidence that Dr. Fillmore's DIME determination regarding MMI was incorrect.

8. Although Claimant remains at MMI, the credible testimony of Dr. Fillmore and Dr. Reichhardt reflects that Claimant is entitled to medical maintenance benefits. To prove entitlement to medical maintenance benefits, a Claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of his condition. *Grover v. Industrial Comm'n.,* 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment "the claimant is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); *see Karathanasis v. Chilis Grill & Bar,* W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 919 P.2d 701, 704 (Colo. App. 1999). As found, Claimant has produced substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

Temporary Total Disability Benefits

9. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S. To demonstrate entitlement to TTD benefits a 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). 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). A claimant suffers from an impairment of earning capacity when he has a complete inability to work or there

are restrictions that impair his ability to effectively and properly perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

10. TTD benefits are terminated when a claimant reaches MMI. §8-42-105(3)(a), C.R.S. Therefore, because Claimant reached MMI on March 20, 2007 he is not entitled to any TTD benefits subsequent to that date. However, Claimant contends that he is entitled to receive TPD and TTD benefits beginning on January 17, 2007.

11. In contrast, Respondents assert that Claimant is precluded from receiving TTD benefits subsequent to January 17, 2007 because he was responsible for his termination from employment pursuant to §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. (collectively "termination statutes"). Under the termination statutes a claimant who is responsible for his termination from regular or modified employment is not entitled to TTD benefits absent a worsening of condition that reestablishes the causal connection between the industrial injury and the wage loss. *In re of George,* W.C. No. 4-690-400 (ICAP July 20, 2006); *see Anderson,* 102 P.3d at 330. The termination statutes provide that, in cases where an employee is responsible for his termination, the resulting wage loss is not attributable to the industrial injury. *In re of Davis*, W.C. No. 4-631-681 (ICAP Apr. 24, 2006). A claimant does not act "volitionally" or exercise control over the circumstances leading to his termination if the effects of the injury prevent him from performing his assigned duties and cause the termination. *In re of Eskridge,* W.C. No. 4-651-260 (ICAP Apr. 21, 2006). Therefore, to establish that Claimant was responsible for his termination, Respondents must demonstrate by a preponderance of the evidence that Claimant committed a volitional act, or exercised some control over his termination under the totality of the circumstances. *See Padilla v. Digital Equipment*, 902 P.2d 414, 416 (Colo. App. 1994).

12. As found, Respondents have failed to demonstrate by a preponderance of the evidence that Claimant committed a volitional act or exercised some control over his termination. Although Claimant missed parts of several scheduled work shifts between December 26, 2006 and January 16, 2007, many of the absences were caused by medical and physical therapy appointments related to his industrial injury. Small portions of Claimant's absences were related to non-work-related medical conditions or personal matters. Furthermore, because Claimant was generally terminated for excessive absenteeism, it is unclear whether the reasons for the termination included medical appointments that were related to his industrial injury. Finally, although Claimant's shop foreman specified that he discussed tardiness and attendance problems with Claimant on two occasions, there is no evidence that Claimant was apprised that any additional attendance problems would result in termination. Because the primary reasons for Claimant's absences involved his wrist injury, he did not exercise control over his termination under the totality of the circumstances.

Average Weekly Wage

13. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on his earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). As found, an AWW of $613.68 constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

ORDER

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

1. Claimant reached MMI on March 20, 2007.

2. Claimant shall receive medical maintenance benefits that are reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

3. Claimant shall receive TPD and TTD benefits for the period January 17, 2007 until March 20, 2007.

4. Claimant earned an AWW of $613.68.

5. All issues not resolved in this Order are reserved for future determination.

DATED: November 6, 2008.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-703-171

ISSUES

The issues include Claimant's seeking to overcome the DIME physician's findings as it relates to the impairment rating; Grover post-MMI medical benefits for the neck and shoulder; and, disfigurement benefits.

FINDINGS OF FACT

1. Claimant sustained an admitted work-related injury while working for the Respondent-Employer on October 27, 2006, when he slipped and fell and struck the top posterior portion of his scalp.
2. Claimant was treated through the Respondent-Employer's workers' compensation designated physician through CCOM. Dr. Mary Dickson treated claimant at CCOM.
3. On November 6, 2007 Dr. Dickson placed Claimant at maximum medical improvement (MMI). On November 8, 2007 Dr. Dickson provided a combined impairment rating of 26% whole person.
4. Claimant's final diagnoses from Dr. Dickson were a closed-head injury with persistent balance difficulties, with atypical benign positional vertigo of the horizontal canal on the left side; possible central dizziness from head injury; tinnitus and cervical strain. Dr. Dickson noted that Claimant had pre-existing advanced cervical spine degenerative disc disease with degenerative osteophytosis associated with intervertebral neuroforaminal stenosis greatest at the left at C6-C7, and on the right at C7-T1.
5. During the course of Claimant's treatment he was provided with a Neuromonics unit to address the ongoing tinnitus in his left ear. The Neuromonics unit was recommended through a referral by Dr. Shaw.
6. Claimant subsequently underwent a division independent medical examination (DIME) on April 2, 2008 with Dr. Carlos Cebrian. Dr. Cebrian produced his report on April 15, 2008.
7. Dr. Cebrian reviewed Claimant's medical records including diagnostic tests conducted during the course of Claimant's treatment. Dr. Cebrian also conducted a physical examination of the Claimant. Dr. Cebrian agreed with the MMI date of November 6, 2008 but provided an impairment rating of 15% whole person based upon Table I, page 109 of the American Medical Association Guides to the Evaluation of Permanent Impairment Third Edition. Dr. Cebrian opined that this rating encompassed the closed head injury with resultant balance issues concluding that this was the best representation of Claimant's impairment.
8. Dr. Cebrian determined that Claimant's post-MMI care should consist of follow-up visits every six months with Dr. Shaw for as long as he is using the Neuromonics unit.
9. Dr. Timothy Hall saw claimant for an independent medical examination on June 12, 2008. Based upon Dr. Hall's reports and his deposition testimony, Dr. Hall disagrees with the DIME physician's findings and impairment rating. The disagreement with Dr. Cebrian is a difference of medical opinion. The ALJ finds Dr. Cebrian's opinion to be credible and to carry the greater weight.
10. Claimant has a ½ inch to one-inch scar on a portion of the scalp covered with hair that is difficult to see without close inspection.

CONCLUSIONS OF LAW

1. Sections 8-42-107(8)(b)(III) and (c), C.R.S. (2007), provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

2. The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

3. The ALJ finds the DIME physician's opinion on the impairment rating to be credible and finds insufficient medical or other evidence to establish by clear and convincing evidence that the DIME physician's opinion was clearly wrong. Claimant has failed to overcome the DIME physician's finding on impairment.

4. Section 8-42-101(1), C.R.S. 2007, requires the employer or insurer to provide medical benefits which are reasonable and necessary to cure and relieve the industrial injury. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). However, after the claimant reaches maximum medical improvement the claimant may obtain future medical benefits only to maintain maximum medical improvement or to prevent a deterioration of her condition. *See Grover v. Industrial Commission,* 759 P.2d 705, 711 (Colo. 1988). The claimant is therefore entitled to *Grover*-type medical benefits where there is substantial evidence in the record to support a determination that future medical treatment will be reasonable and necessary "to relieve a claimant from the effects of an [industrial] injury" or prevent further deterioration of the claimant's condition. *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995)*; Milco Construction v. Cowan*, 860 P.2d 539 (Colo.App. 1992); *Jones v. Estes Express Lines*, W.C. No. 4-651-658 (April 25, 2008).

5. Claimant bears a burden of proving by a preponderance of the evidence that he is entitled to Grover post-MMI medical benefits. Claimant has failed to establish by a preponderance of the evidence that Claimant's current neck and shoulder issues are related to the industrial injury and require post-MMI Treatment. The ALJ finds the DIME physician's opinion to be credible and to carry the greater weight when compared to other medical evidence presented.

6. Based upon the definition found in section 8-42-108, C.R.S. (2006) indicating that disfigurement is serious, permanent disfigurement about the head, face or parts of the body normally exposed to public view, the ALJ finds that Claimant does not have a serious disfigurement of the head and additionally that Claimant's scar is not on a part of

the body normally exposed to public view. Therefore, benefits for disfigurement are denied.

ORDER

It is therefore ordered that:

1. Claimant's claim to overcome the DIME physician on the impairment rating is denied and dismissed.
2. Claimant's claim for Grover post-MMI medical benefits for the neck and shoulder is denied and dismissed.
3. Claimant's claim for disfigurement benefits is denied and dismissed.
4. All matters not determined herein are reserved for future determination.

DATE: November 3, 2008

Donald E. Walsh

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-704-417

ISSUES

The issue of apportionment of temporary disability benefits is added to the issues addressed in the Specific Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Findings of Fact made in the Specific Findings of Fact, Conclusions of Law, and Order are incorporated into this Supplemental Order.

CONCLUSIONS OF LAW

The Conclusions of Law made in the Specific Findings of Fact, Conclusions of Law, and Order are incorporated into this Supplemental Order, with the addition of this conclusion:

9. Apportionment of medical benefits and temporary disability benefits is appropriate where the record supports a finding that a claimant's employment with multiple employers caused the need for the present treatment and contributed to the disability. *University Park Care Center v. ICAO*, 43 P.3d 637 (Colo.App 2001). Respondents have shown by a preponderance of the evidence that 20% of the need for the treatment and 20% of the disability was caused by Employer. Insurer is liable for 20% of Claimant's temporary disability benefits in this claim.

SUPPLEMENTAL ORDER

It is therefore ordered that:

1. Insurer is liable for 20% of the costs of the February 5, 2007, surgery and related medical costs of recovery. Liability shall not exceed 20% of the amounts established by the Division of Workers' Compensation fee schedule. Section 8-42-101(3), C.R.S.
2. Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 11% of the leg at the hip. Section 8-42-107(2)(a), C.R.S. Insurer may credit any previous payments of permanent disability benefits.
3. Insurer shall pay 20% of the temporary disability benefits for the hours Claimant missed as identified in the parties' stipulation.
4. Insurer shall pay Claimant additional compensation for the identified disfigurement in the amount of $1,200.00.
5. Insurer may take an appropriate offset for short-term disability benefits as identified in the parties' stipulation and pursuant to Section 8-42-103(1)(d), C.R.S.
6. All relevant benefit calculations shall be based upon an average weekly wage of $431.43.
7. All matters not determined herein are reserved for future determination.

DATED: *November 5, 2009*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-711-469

ISSUES

The issues raised for consideration at hearing is whether Respondents have overcome the opinion of the Division independent medical examiner (DIME), Dr. Swarsen, and a disfigurement award.

FINDINGS OF FACT

Having considered the evidence and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant worked for the Employer as a route merchandiser at the time of her injury. She sustained an admitted injury to her elbow as a result of a slip and fall on January 5, 2007.

2. Claimant did not immediately seek medical attention because she believed the injury was simply bruising and soreness. When her symptoms did not resolve, Claimant sought medical treatment at Penrose St. Francis Emergency Room on January 7, 2007.

3. Claimant reported to the Emergency Room physicians that she had injured her right elbow and right hip. Claimant did not complain of any right shoulder symptoms. X-rays taken of Claimant's right elbow showed no evidence of a discrete fracture or dislocation. There did appear to be a small joint effusion.

4. Claimant subsequently received treatment from EmergiCare. On January 11, 2007, Dr. Schalin noted that Claimant denied any prior injuries to her right wrist or elbow. Dr. Schalin assessed Claimant with right elbow contusion and mild right hip contusion.

5. On February 9, 2007, Claimant was seen by Dr. Baptist at EmergiCare. Claimant told Dr. Baptist that her wrist was much better and she only had minimal pain in her wrist; however, Claimant said that she had ongoing pain in her elbow. Dr. Baptist noted full range of motion in Claimant's right wrist and referred her to see Dr. Ciccone for her right elbow. Dr. Ciccone is a board certified orthopedic surgeon.

6. Claimant was first seen by Dr. Ciccone on February 27, 2007. Dr. Ciccone noted that Claimant had full range of motion in her right shoulder. Dr. Ciccone recommended a MRI of Claimant's right elbow.

7. Claimant had a MRI taken of her right elbow on March 30, 2007. The MRI showed a probable partial tear of the deep insertion of the triceps tendon. It was noted that no complete rupture was seen and the tear was likely a subacute injury, consistent with the time of injury. The MRI also showed a strain injury of the common extensor tendon bundle with sprain of the lateral ulnar collateral ligament. The MRI also showed a small tear of the anconeus upper trocar area muscle with nerve edema and possible neuritis.

8. On April 3, 2007, Dr. Ciccone reviewed Claimant's MRI and diagnosed her with right elbow pain with triceps tear and possible cubital tunnel syndrome.

9. On May 9, 2007, Dr. Ciccone performed a right triceps tendon repair on Claimant. Pre-operation examination noted that Claimant had "no obvious muscular atrophy on full range of motion of the right shoulder."

10. Following surgery, Claimant underwent physical therapy for her elbow beginning June 1, 2007. Claimant continued to undergo physical therapy with no complaints of right shoulder pain or symptoms until October 30, 2007.

11. On September 18, 2007, Dr. Ciccone noted that Claimant was doing well but still had some pain and was somewhat restricted in her activities. Claimant did not complain to Dr. Ciccone of any right shoulder symptoms.

12. On October 12, 2007, Claimant was seen at Concentra by Dr. Darrel Quick, an authorized treating physician. Dr. Quick noted that Claimant said her right hip was

"okay." After examining Claimant, Dr. Quick noted localized tenderness over the distal right triceps tendon in the area of surgical repair with slight atrophy of the right triceps muscle and slight weakness of the right elbow extension, which may prohibit performance of essential job functions. Dr. Quick recommended continued physical therapy. Dr. Quick did not note any problems or symptoms with Claimant's shoulder.

13. Claimant was placed at maximum medical improvement and discharged from care by Dr. Ciccone on October 23, 2007. Dr. Ciccone recommended an in-home exercise program for future medical treatment. Dr. Ciccone, a orthopedic surgeon, did not note any problems or symptoms with Claimant's shoulder.

14. On October 30, 2007, physical therapy records note right shoulder symptoms for the first time.

15. Claimant testified that she told all providers about her shoulder symptoms. This testimony was not deemed persuasive or credible. The ALJ finds that the medical records do not support this contention by Claimant.

16. Mr. Quick placed Claimant at maximum medical improvement (MMI) on December 3, 2007. Dr. Quick assessed Claimant with 4% right upper extremity impairment for her right elbow. Dr. Quick did not assign any impairment for Claimant's shoulder. Dr. Quick did not recommend any future medical care. Respondents filed a final admission of liability consistent with Dr. Quick's opinion.

17. Claimant was evaluated by Dr. Swarsen for a DIME on May 8, 2008. Claimant told Dr. Swarsen that her right shoulder pain did not start until July or August 2007 and that prior to that time she was wearing a sling. However, the ALJ finds and concludes that the medical records to show that Claimant did not report shoulder pain until October 30, 2007 despite being in physical therapy beginning June 1, 2007. The ALJ further finds and concludes the records to reflect that Claimant's arm was only immobile and in a sling for a period of three weeks post-surgery.

18. Dr. Swarsen opined that Claimant injured her shoulder when she fell but that it was not producing any significant symptoms until after she was immobile post-surgery to her elbow. Dr. Swarsen further opined that Claimant may have some element of adhesive capsulitis.

19. Dr. Swarsen opined that Claimant was not yet at MMI. Dr. Swarsen assessed Claimant with 16% right upper extremity impairment consisting of 13% for her right shoulder and 4% for her right elbow.

20. Claimant was evaluated by Dr. Watson for an IME on August 7, 2008. Dr. Watson reviewed the medical records and noted that Claimant's shoulder symptoms did not appear until October 30, 2007, approximately 10 months post-injury and over 5 months post-surgery. After evaluating Claimant and reviewing Claimant's medical records, Dr. Watson opined that Claimant reached MMI as of December 3, 2007 as determined by

Dr. Quick. Dr. Watson's testified that Dr. Quick correctly determined Claimant's impairment rating and MMI date.

21. Dr. Watson also credibly opined that it was not medically plausible for Claimant's right shoulder impingement to be due to a loss of motion post-operatively. The medical records show that Claimant did not have any atrophy of her right shoulder when she was examined on February 27, 2007, May 9, 2007, and August 7, 2008. At the hearing, Dr. Watson testified that if Claimant's shoulder had been immobile for an extended period of time, she would have had some atrophy and the medical records are not consistent with Claimant's statements.

22. Dr. Watson also testified that Claimant's physical therapy records show that her arm was not immobile up until October 30, 2007 and that if Claimant had developed adhesive capsulitis it would have caused her problems when she began physical therapy on June 1, 2007.

23. Dr. Watson testified that he did not have a mere difference of opinion with Dr. Swarsen. Dr. Watson testified that Dr. Swarsen was wrong because his findings were not consistent with the medical records and Dr. Swarsen did not follow the *AMA Guides, 3rd Ed. Revised* (*AMA Guides*) when issuing his opinion. Dr. Watson opined that Dr. Swarsen did not follow the *AMA Guides* because he did not adequately resolve the disparities between his findings and that of Dr. Quick as required by the *AMA Guides*. Based on the totality of the evidence, the ALJ finds and concludes that Dr. Swarsen did not act consistent with the requirements of the *AMA Guides* in performing his evaluation. The ALJ concludes that the totality of the evidence supports the finding and Dr. Swarsen's opinion is incorrect and has been overcome.

24. Dr. Watson opined that the claimant's current shoulder symptoms are due to degeneration and not from her work injury. He also opined that Dr. Quick's opinions were correct. The ALJ has considered the totality of the evidence, and finds the opinions of Drs. Watson and Quick to be credible and persuasive. The ALJ has considered all evidence to the contrary to the opinions of Dr. Watson and Dr. Quick regarding MMI, causation and impairment, and finds these opinions and evidence to be unpersuasive.

25. As a result of a work-related injury, Claimant incurred disfigurement of a three-inch surgical scar to the right elbow. The disfigurement is serious, permanent and normally exposed to public view, and entitles Claimant to $300.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. In this case, Respondents seek to overcome the opinion of the DIME physician, Dr. Swarsen. Section 8-42-107(8)(b)(III) and (c), C.R.S. provides that the finding of a DIME physician with regard to the impairment rating and MMI determination (rating/IME) shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME (rating/MMI) must produce evidence showing it highly probable the DIME (rating/MMI) is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro, supra.*

5. Based on the totality of the evidence presented at hearing, Respondents established by clear and convincing evidence that the determination of the DIME physician with regard to MMI and impairment is most probably incorrect. Dr. Watson and Dr. Quick's' opinions on MMI and impairment rating were found to be more credible and persuasive than the opinion of Dr. Swarsen. Furthermore, Dr. Swarsen did not follow the *AMA Guides* because he did not adequately resolve the disparities between his findings and that of Dr. Quick as required by the *AMA Guides*.

6. It is concluded that Claimant reached MMI on December 3, 2007 and she has a 4% right upper extremity impairment rating.

7. As a result of a work-related injury, Claimant incurred disfigurement of a three-inch surgical scar to the right elbow. The disfigurement is serious, permanent and normally exposed to public view, and entitles Claimant to $300.

ORDER

It is therefore ordered that:

1. Respondents shall pay permanent partial disability benefits on the basis of a 4% right upper extremity impairment rating and a MMI date of December 3, 2007.
2. Respondents shall be liable for a disfigurement award in the amount of $300.
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.

DATED: November 24, 2008

Margot W. Jones

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-712-019

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUES

The issues to be determined by this decision concern: (1) Claimant's "Verified Motion to Recuse;" (2) whether or not Claimant was appropriately denied her request to take the deposition of a Division of Workers' Compensation (DOWC) official, Kathryn Mueller, M.D., the administrator of the DOWC Division Independent Medical Examination (DIME) Program; (3) whether the Claimant, by her actions and inactions, waived her right to a DIME; (4) whether or not the Claimant set issues for hearing that were not ripe, thus, entitling Respondent to reasonable attorney fees; and, if so, (5) what are Respondent's reasonable attorney fees?

FINDINGS OF FACT

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

Recusal

1. At the commencement of the hearing, Claimant filed a "Verified Motion to Recuse," alleging, *inter alia*: (1) "…such overt hatred of the undersigned [Claimant's attorney] was particularly evident at the telephonic pre-hearing conference [status conference] in this matter two days ago in which said ALJ perfunctorily, otherwise inexplicably, and improperly and unlawfully denied the Claimant the right to present evidence in support of the issues duly endorsed by her present Application for Hearing…by accordingly denying Claimant the right to depose either or both Katherine (*sic*) Mueller or the head of the [D] IME section…; (2) the ALJ has "consistently" ruled against Claimant's attorney regardless of the law and the facts in a criminal and political manner to "steal thousands of dollars in fraudulently claimed attorney's fees from said Mexicano's worker's compensation client and because the ALJ "detests, and has always detested the undersigned counsel [Claimant's counsel]; (3) and, several other conclusory allegations which are devoid of underlying factual allegations leading a reasonable person to form the conclusions formed by Affiant Claimant's counsel. The ALJ accepts the allegations of the "Verified Motion" as facially true for purposes of ruling on Claimant's recusal motion. As concluded below and ordered, the "Verified Motion to recuse" is denied at this juncture because all proceedings must halt until there has been a ruling on a recusal request.

2. In the "Verified Motion," Claimant alleges that the ALJ herein has improperly ruled against his clients on numerous previous occasions.). The "Verified Motion" does not allege that any of these prior rulings, against the clients of Claimant's attorney herein, have been reversed by a higher tribunal.

3. Claimant alleged that the ALJ is biased because during a status conference the ALJ denied Claimant's untimely request to subpoena Dr. Mueller or alternatively depose her. Claimant alleges that the ALJ stated "you're not going to get them. This is your hearing on that and I am denying it." Even if true, these allegations are insufficient to facially establish bias or lack of partiality.

4. Claimant's attorney herein has created negative allegations, *e.g.,* the judge "hates" him, and used these allegations as a basis for recusal.

Procedural Matters

5. In his position statement, Claimant requests the ALJ to take judicial notice of "computer entries and Office of Administrative Courts and Division Of Workers Compensation and its I.M.E. Unit's files in consideration of this matter pursuant to CRE 201." The ALJ declines Claimant's request. An evidentiary hearing was held in this matter on September 18, 2008 and Claimant declined to present any witnesses and produced only documents in her case in chief. Respondent presented its case in chief through documents and though the stipulated testimony of Polyakovics. At no time during the hearing did Claimant request the ALJ take judicial notice of any of these files. Further, Claimant failed to

present these files to the ALJ at the hearing and therefore Claimant has not complied with CRE 201(d). Claimant also has not complied with Workers' Compensation Rules of procedure (WCRP), Rule 9-4, because Claimant did not seek to have these records certified and did not seek to introduce them into evidence. This request of Claimant's is frivolous and groundless.

6. At a Status Conference on September 16, 2008, held after 1:00 PM, Claimant's attorney stated he intended to present the testimony of Kathryn Mueller, M.D., the Medical Director of the Division of Workers' Compensation (DOWC). Claimant's attorney admitted he had not subpoenaed Dr. Mueller and it was less than 48 hours to the hearing. See C.R.C.P. 45(c). [subpoenas must be served no later than 48 hours prior to trial]. Claimant has never produced a subpoena served on Dr. Mueller for the hearing nor does Claimant allege that one exists.

7. At the status conference, Claimant requested a deposition of Dr. Mueller. This request was denied. A status conference is not the appropriate place for a motion to depose a witness. From the date of his Application for Hearing in April 2008 until the Status Conference of September 16, 2008, the Claimant made no attempt to depose Dr. Mueller. In any event, WCRP 9-1(B)(2) states "Depositions of other witnesses may be taken upon written motion, order, and written notice to all parties." Claimant did not make a written motion to depose Dr. Mueller prior to or at the hearing.

8. Further, DOWC Rule 9-4, statesthat "absent extraordinary circumstances, no employee of the DOWC should be expected or required to testify at a hearing." Section 8-43-210 also states that a deposition may be submitted as evidence upon a showing of "good cause." Claimant has not presented the ALJ with any extraordinary circumstances. Claimant has not shown any good cause for deposition, and Claimant made no reasonable attempt to obtain Dr. Mueller's deposition prior to hearing.

9. Furthermore, Dr. Mueller's proposed testimony would only be relevant to the issue of the "propriety of the DIME," which Claimant is precluded from raising herein because ALJ Harr already decided the issue and concluded the Office of Administrative Courts did not have jurisdiction.

10. Claimant did not request a continuance of the hearing. Dr. Mueller was not under subpoena for the hearing. At the hearing itself, Claimant did not request a post hearing deposition of Dr. Mueller nor did Claimant make any showing of good cause for the deposition of Dr. Mueller and Claimant did not even raise the argument. To the extent that Claimant's position statement is a request for a post hearing deposition, it is denied for all the reasons outlined above.

The DIME

11. The Claimant sustained a work related injury on December 3, 2006. The Respondent referred Claimant to Dr. Johnson for medical care. On May 29, 2007, Dr. Johnson placed the Claimant at maximum medical improvement (MMI) with no impairment. Respondent filed a Final Admission of Liability on June 11, 2007, consistent with Dr. Johnson's report.

12. Claimant filed a Notice and Proposal for DIME on June 21, 2007. After negotiations for a physician failed, the Claimant filed an Application for a DIME on July 27, 2007.

13. The DOWC selected Brian Reiss, M.D., as the DIME physician on August 27, 2007.

14. Claimant did not schedule an examination with Dr. Reiss. From August 27, 2007 to the present, Claimant has undertaken no steps to schedule the DIME with Dr. Reiss. Claimant is presumed to know the Workers' Compensation rule concerning the scheduling of a DIME, and the ALJ infers and finds that despite this knowledge, Claimant did not timely schedule a DIME.

15. Claimant filed an Application for Hearing concerning the propriety of the DIME selection process. ALJ Mike Harr found Claimant's arguments concerning the DIME process frivolous. ALJ Harr stated "the judge finds the issue raised in her Application for Hearing to be frivolous and groundless." The Industrial Claim Appeals Office (ICAO) indirectly affirmed this finding in determining that although the issue was "frivolous," the award of attorney fees by ALJ Harr was reversed because the issue was "ripe," and ALJ Harr had jurisdiction to determine the issue. Claimant has not pursued any legal proceedings to challenge the DIME selection process or the DOWC's Selection of Dr. Reiss.

Waiver

16. After ALJ Harr found the Claimant's challenge to the DIME process "frivolous and groundless," the Claimant has failed to schedule the DIME examination. In addition, after ALJ Harr's order, Respondent reminded the Claimant of her obligation to schedule the DIME and she still has failed to schedule the DIME.

17. According to Suzanne Polyakovics, Claims Administrator for the Employer, the Claimant has never scheduled the DIME, and Polyakovics has never received notice of a DIME from the DOWC, the Claimant or from Dr. Reiss.

18. Claimant's inaction reflects her intent to relinquish her right to the DIME. Knowing that the Rule required her to schedule the DIME examination within five business days, the Claimant has failed to schedule the examination at all, up to and including the present time. She has intentionally failed to schedule the examination despite the fact that on March 6, 2008 ALJ Harr found her argu-

ments to be frivolous and groundless. She has failed to schedule the examination after being reminded to do so by the Respondent. She has failed to take any action to schedule the DIME for over a year. The totality of the evidence demonstrates Claimant's intent to abandon the DIME.

19. The Claimant had until September 4, 2007 to schedule the DIME. She failed to schedule the DIME for more than one year. Her conduct demonstrates that she knew of the selection of the DIME Examiner on August 27, 2007 and knew that she should have scheduled the examination within five business days or by September 4, 2007. Over the past year, she has failed to take any action to set the DIME with Dr. Reiss.

20. Setting the matter for hearing concerning the propriety of the DIME does not show Claimant's intent to pursue a DIME while challenging the specific process. This contention is inconsistent with the totality of the evidence because the designated issue in Claimant's Application for Hearing was previously determined to be frivolous and groundless and not a bona fide dispute over the DIME process. ALJ Harr previously concluded that Claimant's Application for Hearing was frivolous and groundless. ICAO affirmed this decision. Claimant failed to raise any legitimate challenge to the DIME, and her prior Hearing Application does not reflect an intention to maintain the DIME process.

Issue Preclusion

21. Claimant filed an Application for Hearing on August 13, 2007 concerning the "propriety of the Division IME." ALJ Harr conducted a hearing on that Application and issued a decision. His decision directly addressed Claimant's issue of the "propriety of the division IME." Respondent appealed that decision on March 14, 2008. While the decision was under appeal and before the ICAO issued a ruling, the Claimant filed the current Application for Hearing (on April 30, 2008), endorsing the exact same issues, *i.e.,* "propriety of the DIME process." The ALJ infers and finds that this issue was not ripe for determination on September 18, 2008 because the exact issue had previously been determined to be "frivolous and groundless."

Attorney Fees

22. Claimant filed a petition to review ALJ Harr's decision was on March 14, 2008. At the time the Claimant filed the Application for Hearing herein on April 30, 2008, the issues were subject to an appeal and the Application for Hearing was not "ripe" at the time it was filed.

23. Counsel for Respondent filed a sworn affidavit setting forth a breakdown of time, attorney fees and costs. Depending on the activity involved, Attorney Thomas billed the respondent either $75 an hour or $145 an hour, in the aggregate fee amount of $2,506, for over 100 hours of legal work to defend the

issues at the September 18 hearing. Considering the fact that Attorney Thomas has practiced law for 15 years, specializing in workers' compensation matters, the ALJ finds the hourly rates inherently fair and reasonable. Considering the complexity of the issue Respondent was required to defend, coupled with the fact that Respondent correctly argues that the exact issue had been defended, argued and decided before, the ALJ finds the 100 plus hours excessive and the ALJ infers and finds that 5o hours plus is more reasonable for aggregate attorney fees of $1,253 to defend the issues at the September 18 hearing. Respondent incurred costs of $83.85. The ALJ finds that Respondent incurred reasonably assessed attorney fees and costs of $1,338.85.

Ultimate Findings

24. Claimant has failed to prove, by a preponderance of the evidence that the DIME process was improper. Respondent has proven, by a preponderance of the evidence that the same issue Claimant designated for the September 18, 2008 hearing was adjudicated by ALJ Harr insofar as the claimed issue was determined to be "frivolous and groundless," and ICAO affirmed this adjudication, thus, the issue was not ripe for adjudication at the September 18, 2008 hearing.

CONCLUSIONS OF LAW

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

Recusal

1. Disqualification (recusal) is governed by Rule 97, C.R.C.P. The factual allegations upon which conclusions or inferences are based must be accepted as facially true in ruling on a motion to recuse. *See Wright v. District Court*, 731 P. 2d 661 (Colo. 1987). As found, the factual allegations in Claimant's "Verified Motion to Recuse" were accepted as facially true.

2. An affidavit alleging facts, not opinions or conclusions, supporting a reasonable inference of actual or apparent bias, is required for recusal. *Prefer v. PharmNetRx*, 18 P. 3d 844 (Colo. App. 2000), *cert. dismissed*, 2000. Mere conclusions or opinions, alleged in an affidavit in support of recusal, are insufficient to warrant recusal. *People v. Cook*, 22 P. 3d 947 (Colo. App. 2000). As found, Claimant's "Verified Motion" alleges conclusions and/or opinions, but no underlying evidentiary facts supporting a reasonable inference of actual or apparent bias. If there is a reasonable question concerning the judge's impartiality, recusal is required. *Wood Bros. Homes v. City of Fort Collins*, 670 P. 2d 9 (Colo. App. 1983). As found, Claimant's allegations do not raise a reasonable question concerning the ALJ's impartiality. An attorney cannot simply hurl out scandalous, conclusory accusations concerning a judge and then allege that the judge

would necessarily have to be biased and lack partiality because of those allegations inititated by the attorney seeking to disqualify the judge.

3. The most clearly articulated test for recusal is whether a reasonable person, knowing all the relevant facts, harbors doubts about a judge's impartiality. *Switzer v. Berry*, 198 F. 3d 1255 (10th Cir. 2000). As found, a review of the bedrock factual allegations in the Verified Motion to Recuse herein would not cause a reasonable person to harbor doubts about this ALJ's impartiality.

4. In the absence of a valid reason for disqualification relating to the subject matter of the litigation, the judge has a duty of presideing over the case. *Blades v. DaFoe,* 666 P.2d 1126 (Colo. App. 1983), *rev'd on other grounds* 704 P.2d 317 (Colo. 1985). As found and concluded, there is no valid reason for disqualiufication of the ALJ herein.

5. The fact that a movant for a jhudge's disqualification has appeared before a judge in other matters is insufficient for disqualification of the judge as a matter of law. *People v. Johnson,* 634 P.2d 407 (Colo. 1981). This principle holds true even when the judge has made numerous erroneous prior rulings. *Riva Ridge Apartments v. Robert G. Fisher Co., Inc.,* 745 P.2d 1034 (Colo. App. 1987). As found, the "Verified Motion" does not even allege that any of the prior rulings against the clients of Claimant's attorney herein have been reversed by a higher tribunal.

6. A judge's opinion formed against a party from evcidence before the court in a judicial proceeding, including an opinion on guilt or innocence, is generally not a basis for disqualification. *People ex rel. S.G.,* 91 p.3d 443 (Colo. App. 2004). The "Verified Motion" alleges "hatred" and implies that the ALJ has adverse opinions concerning Claimant's counsel, based on previous cases before the ALJ. The ALJ concludes that these allegations, accepted as facially true, do not form the basis of a recusal.

7. The Supreme Court determined that to allow a litigant to file a letter critical of a trial judge or to inform the judge of the filing of a complaint with the judicial qualifications commission and later assert the judge's knowledge of the complaint as a basis for disqualification would encourage impermissible judge shopping. *In re Mann,* 655 P.2d 814 (Colo. 1982). Quite simply, an attorney cannot create a negative factual composite of a judge and later use this as the basis for recusal. As found, Claimant's attorney herein has created negative allegations, *e.g.,* the judge "hates" him, and used these allegations as a basis for recusal.

<u>Waiver of the DIME</u>

8. The Doctrine of Waiver applies to workers' compensation proceedings. *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988). Waiver is the intentional relinquishment of a known right and may be implied when a party engages in conduct that manifests an intent to relinquish the right or acts inconsistently with its assertion. *Tripp v. Parga*, 847 P.2d 165, 167 (Colo. App. 1992). Waiver may be implied by conduct where the party acts inconsistently with a known right. *See Tripp* at 167. It is a factual

question for an ALJ to determine whether a claimant's conduct shows an intent to abandon her right to a DIME. As found, the Claimant's conduct and inaction established Claimant's intent to abandon the DIME.

9. In workers' compensation, courts have recognized that a claimant, through conduct, may waive the right to workers' compensation benefits. For example, in *Hanna v. Print Expediters, Inc.* 77 P.3d 863 (Colo. App. 2003), the Court of Appeals determined that a claimant, by failing to seek future medical care at a hearing on permanent partial disability waived her right to those future medical benefits. *See also Winters v. The Industrial Commission,* 736 P.2d 1256 (Colo. App. 1986) [claimant waived right to vocational rehabilitation by failing to cooperate with the vocational rehabilitation counselor); *Walton v. The Industrial Commission*, 738 P.2d. 66 (Colo. App. 1987) (claimant waived right to vocational rehabilitation and temporary disability benefits by failing to set the issue for hearing). As found, Claimant's inaction to pursue the DIME process for approximately one year amounted to a waiver of the DIME process through conduct (inaction).

10. The Industrial Claim Appeals Office (ICAO) has concluded that a party may waive its right to a DIME by an "unconscionable delay." *Gaither v. Resource Exchange,* W.C. No. 4-125-439 (ICAO, 1994) In *Gaither,* the ALJ found respondents waived their right to a DIME because they failed to take any action for sixty days to prosecute the DIME. The ALJ found a mere sixty days to be an "unconscionable delay" that manifested the respondents' intent to abandon the DIME process. As found, the delay in the present case was approximately one year. The ALJ concludes that this was a waiver of the right to a DIME.

11. Parties to a workers' compensation claim are presumed to know the applicable law. *Midget Consol. Gold Mining Co. v. Industrial Commission*, 64 Colo. 218, 193 P. 493 (Colo. 1920)*; Paul v. Industrial Commission*, 632 P.2d 638 (Colo. App. 1981). The presumption aids a party in meeting its burden of proof. *Union Ins. Co. v. RCA Corp.,* 724 P.2d 80 (Colo. App. 1986). Further, a party may not use ignorance of the law as a defense to its legal duties. *Grant v. Professional Contract Services*, W.C. NO .4-531-613 (ICAO, January 24, 2005). Under Workers' Compensation Rule 11-2(H), a claimant has five business days to "schedule the examination." As found, the Claimant had until September 4, 2007 to schedule the examination. Claimant waived her right to a DIME by failing to schedule the examination for more than one year. Claimant's conduct demonstrates that she knew of the selection of the DIME Examiner on August 27, 2007 and knew that she should have scheduled the examination within five business days or by September 4, 2007. Over the past year, the Claimant has failed to take any action to set the DIME with Dr. Reiss. By intentionally failing to set the DIME, the Claimant has waived her right to it. As found, setting the matter for hearing concerning the propriety of the DIME did not show Claimant's intent to pursue a DIME. The ALJ rejected this contention because Claimant's Application for Hearing was frivolous and groundless and not a bona fide dispute over the DIME process. ALJ Harr previously concluded that Claimant's Application for Hearing was frivolous and groundless. ICAO affirmed this ision. Because Claimant failed to raise any legitimate challenge to the DIME in her

present Application for Hearing, and in her prior Hearing Application, she had no intent to maintain the DIME process. Also, as found, because she failed to comply with the DOWC Rule for scheduling a DIME, and because she failed to take any action to schedule the DIME for more than one year, and because she failed to bring a bona fide challenge to the propriety of the DIME, her conduct demonstrates her intent to waive her right to the DIME process.

Issue Preclusion

12. Collateral estoppel, or issue preclusion, bars re-litigation of an issue that was actually litigated and decided in a prior proceeding. *Bebo Const. Co. v. Mattox & O'Brien, P.C.,* 990 P.2d 78, 84 (Colo.1999). Issue preclusion applies to workers compensation proceeding. *Sunny Acres Villa v. Cooper*, 25 P.3d 44 (Colo. 2001). Issue preclusion applies when: 1.) the issue precluded is identical to the issue actually determined in the prior proceeding; 2.) the party against whom estoppel is asserted has been a party to or in privity with a party in the prior proceeding; 3.) there is a final judgment on the merits in the prior proceeding; and 4.) the party against whom collateral estoppel is asserted has had a full and fair opportunity to litigate the issue in the prior proceeding. *Bebo* at 84-85. As found, Claimant presented the identical issue to ALJ Harr and it became final when affirmed on appeal by the ICAO. The Panel noted "the claimant filed an application for hearing regarding the propriety of the DIME panel selection and physician specialties." This is the same issue Claimant raised in the present Application for Hearing, the parties are the same, there is a final decision on the merits and Claimant had a full and fair opportunity to litigate the issue before ALJ Harr. Therefore, Claimant is barred from raising the issues at the present time.

Attorney Fees

13. Section 8-43-211(d), C.R.S. (2008), provides for attorney fees: "If any person requests a hearing or files a notice to set a hearing on issues which are not ripe for adjudication at the time such request or filing is made, such person sh*all* be assessed the reasonable attorney fees and costs of the opposing party in preparing for such hearing." This statute requires an ALJ to determine whether the issues were ripe "at the time the application for hearing" is filed. Later events have no impact on the analysis. Therefore, this ALJ must determine whether the issue of the "propriety of the Division IME" was ripe when claimant filed the application for hearing on April 30, 2008.

14. The ALJ concludes the issue of "propriety of DIME" was not ripe because it had been previously decided by another ALJ and was under appeal. Section 8-43-301(12) C.R.S. (2008) prohibits an ALJ from determining an issue that is under appeal. That statute states: "If a petition to review is filed, a hearing may be held and orders on any other issue during the pendency of the appeal." The ICAO has held that an issue is not "ripe" for adjudication" if a current appeal is pending. *See, Silence v. Carpet Clearance Warehouse*, W.C.4-172-786 (ICAO, March 10, 1995) [issues under appeal "were not ripe for adjudication" at subsequent hearing until appeal ended]. As found, a petition to review was filed March 14, 2008. At the time Claimant filed the Application for Hearing

on April 30, 2008, the issues were subject to an appeal and the Application for Hearing was not "ripe." Therefore, Respondent is entitled to attorney fees.

15. As found, Counsel for Respondent filed a sworn affidavit setting forth a breakdown of time, attorney fees and costs. Depending on the activity involved, Attorney Thomas billed the respondent either $75 an hour or $145 an hour, in the aggregate fee amount of $2,506, for over 100 hours of legal work to defend the issues at the September 18 hearing. Considering the fact that Attorney Thomas has practiced law for 15 years, specializing in workers' compensation matters, the ALJ finds the hourly rates inherently fair and reasonable. Considering the complexity of the issue Respondent was required to defend, coupled with the fact that Respondent correctly argues that the exact issue had been defended, argued and decided before, the ALJ finds the 100 plus hours excessive and the ALJ infers and finds that 5o hours plus is more reasonable for aggregate attorney fees of $1,253 to defend the issues at the September 18 hearing. Respondent incurred costs of $83.85. The ALJ finds that Respondent incurred reasonably assessed attorney fees and costs of $1,338.85.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's Verified Motion to Recuse is hereby denied and dismissed.

B. Claimant, through inaction, has waived her right to pursue a Division Independent Medical Examination.

C. The issue concerning the "propriety of the Division Independent Medical Examination" is precluded from being re-litigated by virtue of the doctrine of "issue preclusion."

D. The Claimant shall pay and reimburse the Respondent $1,338.85 for its attorney fees and costs, incurred in defending the "propriety of the Division Independent Medical Examination" a second time for the hearing of September 18, 2008.

E. Claimant is granted a stay of 20 days within which to pay the attorney fees and costs. In the event Claimant timely files a timely Petition to Review, payment for the attorney fees and costs shall be stayed while the appeal is pending.

F. Any and all issues not determined herein are reserved for future decision.

_____day of November 2008.

EDWIN L. FELTER, JR.

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-717-199

ISSUES

The issues for determination are disfigurement and permanent partial disability benefits.

FINDINGS OF FACT

1. Claimant injured her right shoulder in this claim on May 10, 2006. Claimant had a previous injury to her shoulders. In April 2000, she received a rating for her previous right shoulder condition of 20% of the right upper extremity or 12% of the whole person.
2. Claimant had a distal clavical resection on her right shoulder in November 2007. Claimant did well, and was released at MMI on March 25, 2008.
3. At MMI, Claimant's range of motion of the right shoulder was better than it had been when it was rated in 2000. Dr. Marc Steinmetz rated Claimant's impairment for this May 2006 injury. The rating was 10% of the right upper extremity for the resection of the distal clavical.
4. The clavical is part of the shoulder. It is not part of the arm.
5. Insurer filed a Final Admission of Liability admitted for an impairment of ten percent of the upper extremity.
6. Ten percent of the upper extremity converts to six percent of the whole person (Table 3, page 16, of the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment").
7. As a result of this injury, Claimant has four noticeable dark marks on her right shoulder.

CONCLUSIONS OF LAW

Claimant has established by a preponderance of the evidence that, as a result of this compensable injury, she sustained an impairment of 10% of the right upper extremity for the distal clavical resection that she underwent. The clavical is part of the shoulder, not the arm. The situs of her impairment is the shoulder. The impairment does not appear on the schedule of impairments. Section 8-42-107(2)(a), C.R.S. Claimant's impairment is 6% of the whole person. Insurer is liable for permanent partial disability based on an impairment of 6% of the whole person. Sections 8-42-107(8)(c) & (d), C.R.S.

Claimant has sustained disfigurement to her right shoulder, an area of her body normally exposed to public view. Section 8-42-108, C.R.S. Insurer is liable for additional compensation for that disfigurement in the amount of $1,200.00

ORDER

It is therefore ordered that:

1. Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 6% of the whole person. Insurer may credit any amounts previously paid for permanent partial disability. Insurer shall pay Claimant interest at the rate of eight percent per annum on any benefits not paid when due.
2. Insurer shall pay Claimant additional compensation for disfigurement in the amount of $1,200.00.

DATED: *November 6, 2008*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-719-618

ISSUES

Did Claimant establish by a preponderance of the evidence that she sustained an occupational disease involving her neck/cervical pathology while employed by the Respondent-Employer?

FINDINGS OF FACT

1. Claimant is currently a 61-year-old female food service worker hired by Respondent in 1989, to work in food service. She began as a lunchroom monitor, and then began working in the kitchen. She worked at two elementary schools, and later began working in the central kitchen at the High School. Claimant is not alleging any specific traumatic injury. Instead, Claimant is alleging an occupational disease with the last injurious exposure prior to neck surgery on December 11, 2006. Claimant could not pinpoint any one-day when her neck symptoms started.

2. While at the high school, most of Claimant's time was spent in the baking area. She made rolls, cakes, brownies and cornbread. Occasionally she would also help in the main kitchen.

3. Claimant transferred from the high school to a Middle School in August 2005. At the Middle School, Claimant made sandwiches and the food items specified on the day's menu. She also performed the duties listed in the job description for "snack bar server." She would also sit at a computer and serve as a cashier during the lunch hour. This job was usually slightly easier than the job in the central kitchen at the high school.

4. Claimant's job duties at the middle school included stocking the drink cooler. Claimant does not know how much a case of drinks weighs. She would use a cart to move the drinks from the cooler in the kitchen to a smaller cooler in the front. She

would also operate the dishwasher to wash cooking dishes and utensils. The students eat from disposable dishes, which were thrown away rather than washed.

5. Claimant's family physician has been Melissa Devalon, M.D. since 1994. Dr. Devalon's nurse practitioner is Karen Migliaccio.

6. There is no medically-documented complaint of neck pain before 2005. However, Dr. Devalon's records show that Claimant had been complaining of low back pain for several years. Dr. Devalon referred Claimant to Steven Waskow, M.D. in 2003, who ordered a low back MRI, which showed degenerative facet arthritis at L5-S1.

7. Claimant's first medically-documented complaint of neck pain occurred on October 20, 2005, when Claimant saw Ms. Migliaccio and gave the following history: "Approximately a week and a half ago she awoke in the morning feeling like she pinched her neck while she was sleeping. She has had some discomfort over the left neck and shoulder region and achiness in her arm."

8. Dr. Devalon referred Claimant for physical therapy and then for epidural steroid injections with Mark Meyer, M.D. Dr. Meyer then referred Claimant to Roger Sung, M.D. Claimant began treating with Dr. Sung on her own.

9. Claimant first saw Dr. Sung on May 25, 2006. She completed intake forms in which she stated that her primary complaint was neck pain and numbness of the left arm, with a 6-7 month duration of symptoms. She treated with Dr. Sung for approximately six months before Dr. Sung performed surgery.

10. On December 12, 2006, Dr. Sung performed surgery, consisting of a three-level cervical diskectomy and arthrodesis with hardware at C3-C6. His pre- and post-operative diagnoses were: C3 through C6 herniated nucleus pulposis with degenerative joint disease.

11. Dr. Sung has not given a causation opinion.

12. The surgery occurred before Claimant filed this workers compensation claim. Claimant did not seek preauthorization of the surgery through workers compensation or the Respondent-Employer.

13. Claimant returned to work for approximately three weeks in early 2007. When asked how her symptoms were at that time, Claimant testified, "The same as before; nothing had changed. Still painful; still taking too much Ibuprofen." She then stopped working.

14. On April 9, 2007, Claimant, through her attorney, completed a First Report of Injury alleging a date of injury of December 11, 2006. In the "Date Employer Notified" blank, Claimant indicated "04/09/2007."

15. Claimant did not tell anyone at the Respondent-Employer that she thought she was being hurt at work until April 2007.

16. The only medical evidence Claimant has supporting compensability is the opinion of Claimant's family physician, Melissa Devalon, M.D. Dr. Devalon issued her only report regarding causation on October 5, 2007. That opinion states "there is likely an association between her activity at work and the pain that she was having in her neck. There clearly was a relationship between her return to duty at work and an aggravation of her underlying pain."

17. Dr. Devalon's specialty is family medicine. She has never been Level II accredited by the Colorado Division of Workers Compensation. At one time, she was Level 1 accredited, but she "let it go" approximately four years ago. Her residency included two months of training in orthopedics. Since then, she has attended continuing education seminars, which may include some component of orthopedics. The last seminar she attended devoted exclusively to orthopedics was 15 years ago. She has no formal training in occupational medicine or physical medicine and rehabilitation; "just conferences and seminars."

18. Dr. Devalon has no information on Claimant's job duties other than what Claimant told her. She has never seen a written job description. She did not see the jobsite photos shown to Dr. Polanco.

19. Frank Polanco, M.D. performed an independent medical examination at the request of Respondent-Insurer. He reviewed medical records and diagnostic reports, as well as conducting an evaluation of the Claimant. He issued a report dated July 23, 2008, in which he opined, that Claimant's job activities did not cause Claimant's neck problems, he also opined within a reasonable degree of medical certainty that Claimant's work activities did not aggravate her neck pathology.

20. The ALJ finds Dr. Polanco's medical opinion to be more credible than that of Dr. Devalon and assigns Dr. Polanco's opinion great weight.

21. Based upon a totality of the circumstances, Claimant has failed to establish that she sustained an occupational disease involving her neck while employed by the Respondent-Employer.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2007), 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. (2007). Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. (2007). A preponderance of the evidence is that which leads the trier-of-fact, after con-

sidering 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. (2007).

2. In accordance with Section 8-43-215, C.R.S. (2007), 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).

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

4. Section 8-40-201(14), C.R.S. 2007, defines an occupational disease as one which results directly from the conditions under which work was performed, is a natural incident of the work, can fairly be traced to the employment as a proximate cause, and "does not come from a hazard to which the worker would have been equally exposed outside of the employment." The requirement that the hazard not be one to which the claimant was equally exposed outside of employment effects the "peculiar risk" test and serves to insure that the disease is occupational in origin. *Anderson v. Brinkhoff*, 899 P.2d 819, 822-823 (Colo. 1993).

5. The question whether a claimant has proven that a particular disease, or aggravation of a disease, was caused by a work-related hazard is one of fact for determination by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999).

6. It is not necessary that the ALJ determine what hazards or exposures outside of the Claimant's work caused or aggravated the Claimant's degenerative disc disease because the Claimant has the burden of proof to establish that the conditions of the employment were a direct and proximate cause of the alleged occupational disease. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, *supra*.

7. If the claimant succeeds in establishing that the hazards of employment caused, intensified or aggravated a pre-existing disease process, the burden shifts to the respondents to establish both the existence of non-industrial causes, and the extent to which they contribute to the disability and need for treatment. *See Cowin & Co. v. Medina,* 860 P.2d 535 (Colo. App. 1992); *Vigil v. Holnam Inc*. W. C., Nos. 4-435-795 & 4-530-490 (August 31, 2005).

8. Additionally, *ICAO* has previously stated: "Pain is a typical symptom caused by the aggravation of a pre-existing condition. However, an incident which merely elicits pain symptoms caused by a pre-existing condition does not compel a finding that the claimant sustained a compensable aggravation." *Witt v. James J. Keil*, Jr., W.C. No. 4-

225-334 (April 7, 1998); *Miranda v. Best Western Rio Grande Inn*, W.C. No. 4-663-169 (April 11, 2007).

9. Claimant has failed to establish that hazards of her employment caused, intensified or aggravated a pre-existing disease process. As found, the credible medical and other evidence fails to show that it is more probably true than not that Claimant's neck/ cervical pathology is an occupational disease arising out of and in the course of her employment with the Resopondent-Employer.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: November 5, 2008

Donald E. Walsh

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-425

ISSUE

The issues for determination are compensability, medical benefits, disfigurement, and average weekly wage.

FINDINGS OF FACT

1. Claimant testified that he injured his back on May 16, 2007, his first day of work for Employer. Claimant testified that he was working at the bottom of a steel 'C' channel and two co-workers on ladders were holding the 'C' channel. The piece that Claimant was working on is about teen feet tall. Claimant testified that he got something in his eye. Someone stated that it was time for lunch. Claimant testified that when he opened his eyes, the two co-workers were gone. Claimant testified that the 'C' channel began to tip over, and that he and the 'C' channel fell together. Claimant testified that he then felt pain in his low back.

2. TD, Claimant's wife, testified that she filled out a statement based on what her husband had told her about the accident. She was concerned about the requirement that injuries be reported in writing within four days. In the statement, she stated that the injury occurred on May 17, 2007, and she dated the statement on May 22, 2007, making it appear that the written statement was made five days after the accident. She also testified that the statement was made the same day that it was faxed, and that it was

faxed on May 23, 2007. The alleged accident was on May 16, 2007. The statement was faxed seven days after the accident.

3. TD did not witness the accident. She did testify as to statements and actions of Claimant that were generally consistent with Claimant's testimony of an injury on May 16, 2007. The testimony of TD is not persuasive.

4. Claimant had surgery to his low back at L4-5 on November 3, 2007. Claimant testified that he recovered, had no restrictions or symptoms, and returned to heavy work. However, the last medical report regarding this surgery was dated December 28, 2006. Dr. McMahon stated that Claimant had strained his back raking leaves. He noted that Claimant had severe pain in his low back. He recommended that Claimant not work.

5. Claimant testified that he told DD, the owner of Employer, that he had back surgery and that he did not want to do heavy lifting. Claimant testified that DD agreed that Claimant would not have to do any heavy lifting. DD testified that Claimant did not tell him that he had a back injury or surgery, or any lifting problem, and that he did not tell Claimant that he would not have to do heavy lifting. DD testified that the job involved heavy lifting, and he would not tell anyone he hired that they would not have to do heavy lifting.

6. EV, a co-worker, testified that at one time on May 16, 2007, it appeared that Claimant had something in his eye. EV testified that he asked Claimant if he was okay, and Claimant said he was fine. EV testified that Claimant did not appear to be in any pain or discomfort. EV testified that he never heard a 'C' channel fall.

7. Claimant testified that he told DD of the accident on May 16, 2007, and that DD told him to take the rest of the day off. Claimant testified that he did not have a ride home, so he continued to work. Claimant testified that he and DD waited at the end of the day for Claimant's wife to pick him up. DD testified that Claimant did not tell him that he had been injured and that he did not wait with Claimant at the end of the day for Claimant's wife to take him home.

8. Claimant testified that he went to work on May 17, 2007, the day after the alleged accident. Claimant testified that he first swept the floor and then went up to the second floor. He testified that on the second floor he lifted a truss and immediately put it back down realizing that he could not lift. Claimant testified that he then left work.

9. DD, the owner of Employer, testified that Claimant was not assigned to sweeping that morning and that other employees were assigned to that task. DD testified that Claimant left work on May 17, 2007, after telling him that he had a doctor's appointment. DD testified that Claimant did not tell him of the accident the day before, or that Claimant was seeking the medical care because of a work-related injury. Claimant did not have a doctor's appointment on May 17, 2007.

10. JN, a subcontractor who is not presently working for Employer, testified that he worked with Claimant on May 17, 2007. He testified that Claimant assisted in putting up tresses on May 17, 2007, and that Claimant was able to do this heavy work.

11. AC, a coworker who is not now working for Employer, testified that he worked near Claimant on May 16, 2007. He testified that he saw Claimant working on the 'C' channel, and that he did not see or hear a 'C' channel fall. AC testified that he worked with Claimant on May 17, 2007, and that Claimant was putting beams up into the roof. He testified that Claimant did not appear to be in discomfort. AC also testified that

Claimant on May 17, 2007, stated that he would like to be at home at the swimming pool drinking a beer.

12. Claimant testified that he discussed the accident and his back pain with DD on May 16, 2007, and May 17, 2007. DD testified that he was not aware of the claimed accident and injury until May 21, 2007. DD testified that on May 21, 2007, Claimant came to him and asked for his pay in cash. DD testified that he told Claimant he would receive his check on Friday and Claimant then stated that he would file a worker's compensation claim.

13. DD testified that Claimant called him four times on May 25, 2007, and that he kept notes on the calls. The notes (Resp. Exh. J 89) stated that at 9:00 a.m. Claimant called and stated that issues will be dealt with in court. At 11:00 a.m., someone called and left a message that he was calling on behalf of Claimant. DD's Caller ID identified that the call was made from Claimant's cell phone. At 11:19 a.m. Claimant called a left a message that he would contact the labor board, permitting, zoning, and state. At 12:48 p.m. Claimant called and left a message that was unclear.

14. Claimant first sought medical treatment for the alleged accident on May 21, 2007. This was after Claimant was notified that his employment had been terminated and after Claimant had stated that he would file a worker's compensation claim. The note from the Medical Center of Aurora states that Claimant complained of back pain with an gradual onset a week previous to that visit. The note states that the pain was dull and similar to prior episodes, and was moderate in degree. The note stated that "patient denies an injury." Another note from that visit stated that Claimant "had a fall, had to catch falling steel beam and after catching it, his back was worse again." On May 21, 2007, Claimant was examined by Michael J. Rauzzino, M.D. In a note prepared months later, Dr. Rauzzino stated that Claimant stated that on May 17, 2007, "the other workers let go the I-beam and when this happened, he tried to stop its fall, but it dropped on to the ground, and it landed him on his left side." The history Claimant gave, coming after his employment was terminated, is not persuasive.

15. The testimony of DD, AC, and JN is credible and persuasive. The testimony of Claimant is less persuasive or incredible.

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. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo.App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

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

4. The testimony of Claimant is not as persuasive as Respondents' witnesses, or is incredible. Claimant has not established by a preponderance of the evidence that he was injured in an accident at work on May 16, 2007. The claim is not compensable.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *November 5, 2008*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-988

ISSUES

The sole issue determined herein is claimant's petition to reopen.

FINDINGS OF FACT

1. Claimant suffered a previous injury to her left wrist on June 9, 1991, when she fell through a plate glass, suffering a severe laceration to her wrist and forearm. She had severe loss of sensation and strength as a result of that injury as well as chronic pain. She had permanent restrictions against lifting over 25 pounds. She did not notice any protrusions on her left wrist or forearm.
2. On August 31, 2006, claimant began work for the employer.
3. On September 23, 2006, claimant suffered an admitted industrial injury while lifting 60 pounds of product. She suffered pain in her left wrist and a knot soon developed.
4. Dr. Maisel treated claimant and referred claimant to Dr. Zickefoose. A January 23, 2007, magnetic resonance image ("MRI") showed abnormal signal over the volar aspect of the left forearm. A January 23, 2007, electromyography ("EMG") showed ax-

onal injury of the median nerve, affecting both sensory and motor branches with a conduction block across the wrist. The EMG also showed ulnar nerve injury at the distal forearm with primarily demyelination affecting both sensory and motor branches.

5. On March 9, 2007, Dr. Fall performed an independent medical examination ("IME") for respondents. She diagnosed left wrist sprain with a possible ganglion cyst, scar tissue, or vascular aneurysm. She agreed that claimant was not at maximum medical improvement ("MMI") and needed a MRI with gadolinium contrast.

6. The April 3, 2007, MRI with contrast showed probable distal radioulnar joint instability, extensor carpi ulnaris tendinosis, probable degenerative fraying of the triangular fibrocartilage with slight subcortical cyst formation, and probable partial tear of the volar navicular lunate intercarpal ligament.

7. On May 24, 2007, Dr. Marin performed endoscopic surgery for a left carpal tunnel release, debridement of a neuroma of the median nerve, debridement of a neuroma of the ulnar nerve, and tenolysis of the tendons.

8. On June 21, 2007, Dr. Marin reexamined claimant, who complained of shooting pain from the neuroma to the fingers. On July 5, 2007, Dr. DeRuiter examined claimant, who again reported that she still suffered shooting pains from the neuromas to the fingertips.

9. On August 29, 2007, Dr. Marin reexamined claimant, who reported still significant pain in her wrist and intermittent shooting pain down the hand to the fingers. Dr. Marin noted that, if claimant continued to suffer pain, he would recommend complete resection of the neuroma and a graft repair.

10. On September 13, 2007, claimant underwent a functional capacity evaluation, which was valid. On October 1, 2007, Dr. Zickefoose determined that claimant was at MMI.

11. On October 16, 2007, Dr. Zickefoose issued her report, noting that claimant still had numbness over the dorsal fourth and fifth metacarpi of the left hand as well as old numbness from the 1991 injury. Claimant reported problems gripping, including sweeping with a broom. Dr. Zickefoose recommended post-MMI maintenance treatment for one year, including Lexapro and Vicodin prescriptions. She imposed restrictions against lifting over 8 pounds frequently or 16 pounds occasionally with both hands. She noted that claimant's unilateral left hand grip strength was 6 pounds. Dr. Zickefoose also noted that claimant was limited to repetitive left hand use of 10 minutes at one time and 20 minutes per hour. Dr. Zickefoose determined 9% impairment of the upper extremity.

12. On November 6, 2007, the insurer filed a final admission of liability for the permanent impairment rating and for post-MMI medical benefits. Claimant timely objected.

13. On October 31, 2007, Dr. Marin reexamined claimant and concluded that the debridements had not helped claimant's hand numbness.

14. On January 2, 2008, Dr. Marin reexamined claimant, who still reported a lot of discomfort. Dr. Marin recommended allowing an additional period for healing after the May 2007 surgery.

15. On January 2, 2008, Dr. Kurz also reexamined claimant, who denied any changes in her signs or symptoms.

16. On March 28, 2008, hearing was held in this claim. On April 16, 2008, the judge issued an order awarding claimant disfigurement benefits, ordering the insurer to pay

medical benefits after March 28, 2008, and denying Lexapro and medical treatment before March 28, 2008. Neither party appealed.

17. On April 30, 2008, Dr. Marin reexamined claimant and noted that she did not get any relief from the May 2007 debridement. He recommended neuroma excision for the medial and ulnar nerves and placement of an interspaced neuro tube.

18. On May 15, 2008, Dr. Parks performed a medical records review for respondents. He concluded that the surgery recommended by Dr. Marin was to correct the 1991 injury. He noted that the neuromas formed during the healing of the severed nerves in 1991. He described a "neuroma" as a "tumor of nerves" with the cut nerve endings balled up in a lump, causing exquisite sensitivity and dysesthesias. Dr. Parks noted that the May 2007 surgery, freeing up large neuromas in continuity from a bed of scar tissue, could result in precipitation of severe pain. Dr. Parks noted that claimant likely disrupted scar adhesions with the industrial injury and her pain and hand function had worsened since the surgery. He related claimant's current pain to the industrial injury and subsequent surgery. He recommended that claimant be referred to a pain management specialist for neuropathic pain medications.

19. On June 18, 2008, Dr. Kurz reexamined claimant, who denied any worsening.

20. On June 25, 2008, claimant filed a petition to reopen her claim based upon a change of condition, and she attached the April 30, 2008, medical report by Dr. Marin.

21. On August 20, 2008, Dr. Fall performed a repeat IME for respondents. Claimant reported that, after her surgery, her "knot" went away and then came back, but she could not recall when it recurred. Claimant reported that everything was still the same since MMI. Claimant reported that her numbness and weakness remained the same after the May 2007 surgery, but her pain increased for a while and then got better. Claimant reported that she suffered constant pain in the left wrist, which increased with use. Dr. Fall diagnosed scar tissue irritation. Dr. Fall concluded that claimant's condition had not worsened since MMI. Dr. Fall agreed with Dr. Parks that the surgery recommended by Dr. Marin was to treat the 1991 injury rather than the 2006 industrial injury. She agreed with Dr. Parks regarding referral to a pain management specialist.

22. At hearing, Dr. Fall agreed that the work injury had aggravated tissue from the 1991 injury. She noted that claimant had reported that the "knot" returned before MMI. Dr. Fall noted that one cannot measure the size of a neuroma by any external appearances.

23. At hearing, claimant testified inconsistently. She admitted that she had severe left hand and wrist pain, weakness, and a bump at the time of MMI and that her pain and swelling are the same as at MMI. Claimant could not recall the approximate time when her "knot" returned after the surgery. She testified that it was after MMI, but then later testified that it returned about three to four months after the May surgery. She could not distinguish her symptoms now from those at MMI.

24. Claimant has failed to prove by a preponderance of the evidence that she suffered a change of condition since MMI. The medical records show consistency of symptoms after the May 2007 debridement surgery and before the October 1, 2007 MMI. Dr. Marin does not document that claimant is worse; he simply waited before recommending the surgery that he initially discussed on August 29, 2007. The notes by Dr. Kurz and Dr. Fall document no changes in claimant's condition. Claimant's own testimony was inconsistent and failed to demonstrate that she suffered a change of condition.

CONCLUSIONS OF LAW

1. Claimant sought to reopen this claim in order to obtain additional surgery. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Claimant has the burden of proving these requirements, *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). As found, claimant has failed to prove by a preponderance of the evidence that she suffered a change of condition since MMI.

2. Because claimant failed to prove that her claim should be reopened, the issue of authorization for the future surgery by Dr. Marin is moot.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is denied and dismissed.

DATED: November 5, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-730-423

ISSUE

The following issue was raised for consideration at hearing:

Whether Respondent's have overcome the opinion of the Division Independent Medical Examiner, Dr. Bart Goldman, regarding the question whether Claimant is at maximum medical improvement (MMI).

PARTIES' STIPULATIONS

The parties entered the following stipulations.

1. If Claimant is not at MMI, Claimant is owed temporary total disability benefits (TTD) from June 1, 2007 and continuing.

2. Claimant's average weekly wage is $815.00 per week.

3. Respondents are entitled to take an offset for short-term disability benefits paid to Claimant from July 11, 2007 to November 26, 2007.

4. Respondents are entitled to take an offset for unemployment compensation benefits paid to Claimant in the amount of $413.00 per week from March 1, 2008 to current.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. On June 10, 2006, while working for the Employer, Claimant was mopping the stairs, walking down backwards and twisted her left ankle and turned to the left, grabbed the stair rail stretching out over the stairs and she heard a popping sound in her back and had immediate pain in her lower back and hip area.

2. Claimant went to the control center and reported the injury to Sargent Terry Walker, her supervisor, who referred her to Sterling Regional Medical Center and completed an accident report.

3. On June 10, 2006, at Sterling Regional Medical Center, Claimant described the accident as, "mopping stairway, walking down stairs, stepped side ways on step edge, left leg twisted around and caught myself from falling, felt pop in hip."

4. On June 10, 2006, the nurse at Sterling Regional Medical Center noted "Left leg/hip pain 'toes a little numb' mopping stairs, stepped on edge of step of stairs, twisted, caught herself instead of falling "heard and felt pop," and noted pain in the hip/buttock and leg area and stated "when walking feels numbness with toes."

5. On June 10, 2006, Dr. David Powell at Sterling Regional Medical Center diagnosed "muscle strain' and noted "yes" the injury is work related and recommended pain medication, muscle relaxers and x-rays.

6. On June 20, 2006, Paulette Carpenter, nurse practitioner at Sterling Regional Medical Center, noted "approximately one week ago on 6/10/06, she was mopping the stairway, lost her footing and her left foot went out and ended up twisting and grabbing the rail to keep from falling… She does feel a sharp, shooting sensation from her left buttock area up to her neck." On exam, it is noted "There is tenderness to palpation to the lumbar region and in her left buttock area" and physical therapy, Ibuprofen and Flexeril was recommended.

7. On June 20, 2006, Nurse Carpenter noted under work related medical diagnosis, "Left lumbar strain" and claimant was limited to lifting, carrying, pushing, and pulling of no more than 10 pounds.

8. On June 20, 2006, Emergency Department Trauma Records, Nurse K. Contreras, noted "Left hip, neck, left shoulder, right and left side of back muscle spasms, twisted hip at work, workers comp." She recommended Ibuprofen, Flexeril, and circles placed on a form by the nurse reflects that Claimant had pain in back, left hip, left neck, and shoulder area. Under notes it states, "Left hip, neck, left shoulder and back pain/spasms. Patient reports having a workers compensation injury on June 10, 2006 and patient reports pain has gotten worse."

9. On June 20, 2006, at East Morgan County Hospital, Dr. Carpenter noted "Lumbar strain" and "Left hip strain, L5-S1 nerve root compression and myofascial tightness." and "6-10 patient works at prison, steps backward off step and hurt left hip" and "patient has had constant pain in left hip and neck since."

10. On June 23, 2006, the physical therapist at East Morgan County Hospital noted lumbar strain, left hip strain, L1-S1 nerve root impingement and increased myofascial tightness, and problems are in the left hip, low back, thoracic, and C-spine.

11. On June 28, 2006, Michael Speight, physical therapist, at Regional Medical Center noted that Claimant "was doing some mopping at work, stepped backwards down a step and missed a step, started to fall backwards, twisted to the left, and caught herself on a rail but did not fall all the way down. As she was going down and twisting, she felt a pop in the area of her left hip," and "pain started in the left hip and left low back area. Now it is going up her back into her mid back and even the left and central neck area. She states she feels stiff all the time. Primary pain is in the left low back and left hip area. States that initially the pain was just in the hip and low back, and then a couple of days later it went into the lower extremity and then more recently started going up her back." He assessed the following, "Need to rule out disk pain as a likely scenario. Today's subjective and objective testing would be consistent with this. Her symptoms are asymmetrical with radiating intermittently minor symptoms into the left lower extremity below the knee."

12. On July 10, 2006, Dr. Fillion stated "The patient presents to the clinic for follow up workman's comp. Back pain and left upper extremity injury, which occurred as a result of her back pain" and the doctor placed her at MMI with no permanent impairment.

13. On July 10, 2006, Claimant testified when she saw Dr. Fillion she was still having pain in her neck and back but had to stop taking the medications

because she was having problems staying awake on the medication during her graveyard shift.

14. On July 10, 2006 the physical therapist, Michael Speight, noted under objective findings "Elevate range tight and painful. Patient not able to do any extension strengthening due to pain" and, the therapist assessed, "Much better, but a long way from fully recovered. Needs to avoid flexion and do extensions frequently."

15. On July 10, 2006, Mr. Speight noted "2" was the current pain intensity on a 10 point scale; "5" was the current pain frequency on a 10 point scale; and current recovery is 65 out of 100. Mr. Speight further noted that "She still has limited range and pain in her low back. Flexion has not been recovered yet, as due to pain she is not ready for this. I did try to start lumbar strengthening exercises, but due to pain she was not able to start these exercises."

16. After July 2006, Claimant attempted to contact the adjuster and her work to go back to Dr. Fillion due to the pain in her back and neck. Claimant did not receive a response.

17. On June 1, 2007, Dr. Dilley noted that Claimant has tingling in the left side of her face, tingling down her right arm, tingling in her legs and feet, and… "complains of severe cervical pain and spasm." The doctor noted that Claimant's symptoms have been going on approximately a year and over the past four days it has gotten worse. The doctor recommended that Claimant take off work through June 4, 2007, prescribed Vicodin, and a MRI.

18. On June 11, 2007, Claimant went to Fort Collins Neurology because the stiffness in her back and neck and her headaches got worse.

19. On June 11, 1007, Dr. Curiel, the neurologist, noted that Claimant has "been experiencing intermittent neck pain and low back pain since she was injured at work a year ago. At that time she apparently slipped on stairs and did not actually fall to the ground but was able to grab onto the handrail and kept from falling down. She wrenched her back, however, and noticed low back pain. A couple of days later she started noticing neck pain as well. Since then the neck and low back pain have been occurring about once a month and could last anywhere from one to seven days." The doctor recommended a cervical MRI.

20. On June 13, 2007, Dr. Dilley noted that Claimant had cervical and upper thoracic back pain and on objective evaluation "spasm at C1-5" and "spasm at T2-6 bilaterally" and recommended "no lifting objects greater than ten pounds or pushing or pulling greater than 10 pounds."

21. On June 18, 2007, a cervical MRI reflected a disk protrusion at C5-6 and C6-7 on the left causing mild deformation of the cord on the left without abnormal cord signal as well as moderate left sided neural foraminal narrowing.

22. On June 18, 2007, Dr. Curiel noted the MRI showed mild bulging at several levels with some mild neural foraminal stenosis, which appeared to be worse at the left C6-7 level and the doctor recommended physical therapy.

23. On June 28, 2007, Dr. Curiel noted "neck pain intermittent over last year" and it began on "6/06". The doctor gave Claimant restrictions of no lifting more than 20 pounds, and only occasionally bending or stooping.

24. On July 5, 2007, Mr. Speight noted that there was neck pain present extending to the top of Claimant's head and it is "worsening" and "this patient has limited neck ROM due to myofascial restrictions in the left upper quarter."

25. On July 23, 2007, a workers compensation claim was filed, which stated that, on June 10, 2006 Claimant injured her neck, upper back, lower back, head, arms and legs when she was on the staircase and stepped back and fell downstairs.

26. On July 31, 2007, Respondent filed a Final Admission of Liability (FAL) placing Claimant at MMI on July 10, 2006 with no impairment. Claimant objected to the FAL and requested a Division independent medication examination (DIME).

27. On August 16, 2007, Dr. Curiel noted that "[Claimant's] neck pain is flaring up periodically," and his impression is her "neck pain is still bothering her and is aggravated by sometimes even minor movements" and the doctor recommended epidural steroid injections.

28. On August 21, 2007, Dr. Fillion diagnosed "neck and lumbar pain" and recommended spinal epidural injections and gave restrictions of no lifting, carrying, pushing or pulling more than 10 pounds.

29. On August 21, 2007, Dr. Fillion noted "She displays decreased range of motion with cervical flexion, extension, side-bending right and left" and the doctor recommended epidural steroid injections.

30. On November 2, 2007, Dr. Bart Goldman, the Division Independent Medical examiner (DIME) noted that Claimant was not at MMI and gave a provisional impairment rating of 35% whole person. He noted "her pain is still primarily throughout the left side of her body, although she notes specifically headache and neck pain, as well as left greater than right trapezius and arm pain and left greater than right low back and leg pain." On physical exam, he noted, "diminished bilateral sacroiliac motion in the back and cervical area." His impression

was chronic cervical and lumbosacral myofascial pain syndrome secondary to work related injury on June 10, 2006; mixed tension and regular headaches; depression and anxiety; L4-5 annular tear with chronic lumbosacral strain and sacroiliac joint dysfunction secondary to work related injury. He noted "the patient's low back and then neck complaints are well documented within approximately 2 weeks of the initial injury"… and "with respect to the neck, back and psychological area, the patient has had incomplete evaluation and treatment within the context of rule XVII guideline recommendations." He assessed the patient with fairly classical myofascial stigmata that certainly reproduced much of her symptomatology in the cervical and shoulder girdle region including her headaches, and he recommended trigger point injections, physical therapy, massage, trial of biofeedback, evaluation by a psychologist or psychiatrist, medications, and strengthening program.

31. On March 21, 2008, Dr. Hughes noted on physical exam of the cervical spine there was a "torticollic degree of muscular spasm present bilaterally over the posterior musculature of the cervical spine. While cervical spine extension is quite good at 65 degrees, flexion is consistently limited ranging from only 20-21 degrees as are right and left lateral flexion at 30 and 25 degrees respectively" and right and left rotation of the head was 55 and 41 degrees. Of the lumbar spine, he assessed "right-sided erector spinae muscular spasm. Lumbar ranges of motion are restricted primarily in sacral flexion at 40 degrees maximally and true lumbar flexion is 56 degrees. Significantly extension is limited basically to the degree noted by Dr. Goldman at only 10 degrees. Right and left lateral flexion are a bit more restricted than noted by Dr. Goldman, but follows the same pattern of right greater than left limitation at 17 and 22 degrees compared to Dr. Goldman's findings of 22 and 30 degrees." Dr. Hughes concluded that he "agrees completely with Dr. Goldman that she is not at maximum medical improvement" and did endorse interdisciplinary care as recommended by Dr. Goldman.

32. On April 9, 2008, Dr. Fillion noted "Patient does have an obvious antalgic gait, restricted hip flexion at 80 degrees, decreased side bending right and left" and his impression was "low back pain with radiulopathy to the left lower extremity consistent with sciatic neuralgia."

33. On April 14, 2008, Dr. Fillion noted "cervical/lumbosacral myofascial pain due to work related injury" and ordered "myofascial interventions including spray and stretch trigger point deactivation, massage, heat … and two additional physical therapy." He recommended a lumbar MRI for "radiculopathy unrelenting for 11 days."

34. On April 18, 2008, a MRI of the lumbar spine showed "left paracentral to postero lateral disk extrusion with mild cranial migration… This extrusion abuts and compresses the left SI nerve root," "mild to moderate lower lumbar spine facet joint arthropathy;" and "mild foraminal stenosis bilaterally at L3-4."

35. Claimant testified at the hearing she feels she needs the treatment recommended by Dr. Goldman because she has pain in her lower back, neck and hip and the pain has gotten worse in her left leg and making it numb on the bottom of her foot. She testified it radiates down her leg and her left leg now is numb on the left side from her buttocks all the way down to the bottom of her foot.

36. Dr. Fillion testified at his deposition that he did not feel Dr. Goldman was wrong in his report, he just did not see her at the time he had seen her on July 10, 2006.

37. It is found, based on the totality of the evidence, that Respondent did not overcome the opinion of the DIME physician regarding MMI by clear and convincing evidence. In this regard, the totality of Claimant's medical record, along with Dr. Goldman and Dr. Hughes's opinions, were found more credible and persuasive than the evidence presented by Respondent.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. In this case, Respondent seeks to overcome the opinion of the DIME physician, Dr. Goldman, regarding MMI. Section 8-42-107(8)(b)(III) and (c), C.R.S. provides that the finding of a DIME physician with regard to the impairment rating and MMI determination (rating/IME) shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME (rating/MMI) must produce evidence showing it highly probable the DIME (rating/MMI) is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro, supra.*

5. Based on the totality of the evidence presented at hearing, it is concluded that Respondent failed to establish by clear and convincing evidence that the determination of the DIME physician with regard to MMI is most probably incorrect. Dr. Goldman and Dr. Hughes's opinions concerning whether Claimant is at MMI is more credible and persuasive than the opinions of Respondent's witnesses. The medical records and Claimant's credible testimony further corroborates the determination of Dr. Goldman. Respondent failed to present clear or convincing evidence that Dr. Goldman's opinion was incorrect. Therefore, the determination of the DIME physician that Claimant is not at MMI is the law of the case.

ORDER

It is therefore ordered that:

1. Dr. Goldman's DIME opinion that Claimant is not at MMI was not overcome by Respondent by clear and convincing evidence.

2. 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.

DATED: November 25, 2008 Margot W. Jones

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-158

ISSUE ON REMAND

Did the Respondents prove by a preponderance of the evidence that Claimant is responsible for his termination and therefore not entitled to temporary total disability benefits?

FINDINGS OF FACT WITH RESPECT TO REMAND

1. On August 7, 2007 Claimant was an employee of Respondent-Employer. Claimant was hired as a finisher but also did some carpentry work.
2. On August 7, 2007 Claimant was assigned to a job at the United States Air Force Academy (USAFA). Claimant's job location was within a secured facility that required someone with a security badge in order to gain access into the facility. Claimant was not provided with a security badge and thus had to rely upon a co-worker in order to gain access if he were outside the facility.
3. On August 7, 2007 Claimant started his day at 6:15 a.m. Claimant was working on an elevator shaft within the secure facility. Claimant was engaged in using a hammer drill, to drill holes into the sides of the concrete elevator structure.
4. Later in the day Claimant informed K that he would need to be on light duty due to his injury.
5. While Claimant was working the USAFA job he left the secured facility repeatedly and would get locked out without any way to get back in until someone showed up with the security pass. Although Claimant would then try to help other co-workers who were working on the outside of the facility, the particular job he was supposed to be doing went undone until he could once again gain access to the facility.
6. Claimant was aware of the constraints in place with respect to access to the secure facility. On August 7, 2007 Claimant left the facility approximately seven times and was unable to gain immediate access back into the facility. As a result Claimant was unable to do his primary job for up to two hours. The ALJ finds that Claimant intentionally timed his cigarette breaks so that he would be locked out and unable to perform his primary job.
7. On August 8, 2007 Claimant reported to the office as instructed by AK the previous day. When Claimant arrived M informed him that he was being terminated. Claimant was terminated because he had been locked out of the facility too many times. Mr. M tried to place Claimant with two of his former foremen but they weren't willing to work with him.
8. With respect to the circumstances surrounding Claimant's termination from employment the ALJ finds Claimant was responsible for his termination. The ALJ finds that the credible evidence establishes by a preponderance of the evidence that the Claimant failed to take reasonable measures to ensure his ability to have continued access to the secured facility and purposefully timed his breaks to make reentry difficult.
9. The Respondent-Insurer is not responsible for temporary total disability benefits.

CONCLUSIONS OF LAW

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. 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, *supra*.

2. 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 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).

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

4. Claimant was purposefully taking breaks so as to inhibit his ability to return to the secure facility and resume his assigned work. Claimant was terminated as a result of this. The ALJ concludes that the Claimant was responsible for his termination within the meaning of § 8-42-103(1)(g) and 8-42-105(4), C.R.S. 2007.

ORDER

It is therefore ordered that:

1. Claimant's claim for temporary total disability benefits is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATE: November 14, 2008

Donald E. Walsh
OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-734-338

ISSUE

Whether Claimant has presented substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition pursuant to *Grover v. Industrial Comm'n.,* 759 P.2d 705 (Colo. 1988).

FINDINGS OF FACT

1. Claimant worked for Employer as a plumber. On August 22, 2007 he suffered an admitted industrial injury to his right hand and wrist during the course and scope of his employment.
2. On August 23, 2007 Claimant underwent surgery with John M. Pav, M.D. to repair nerves and tendons in his right wrist. He subsequently completed a course of physical therapy. Dr. Pav discharged Claimant from care in January 2008.
3. On May 21, 2008 Claimant reached Maximum Medical Improvement (MMI) for his industrial injury. Brian J. Beatty, D.O. assigned Claimant a 19% upper extremity impairment rating. Dr. Beatty's report was silent regarding the issue of maintenance medical benefits.
4. On August 25, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Beatty's impairment rating. The FAL denied medical maintenance benefits for Claimant.
5. Claimant initially objected to the FAL and requested a Division Independent Medical Examination (DIME). He subsequently withdrew the request for a DIME but has contended that he is entitled to receive medical maintenance benefits.
6. On October 6, 2008 Claimant visited Dr. Pav because he continued to experience pain and stiffness in his right hand and wrist. Dr. Pav directed Claimant to undergo additional physical therapy.
7. Claimant credibly testified that he has experienced pain, tightness, loss of sensation and cramping in his right hand and wrist since January 2008. He explained that while he was undergoing physical therapy he received nylon gloves to relieve the swelling in his right hand. Claimant noted that he subsequently purchased replacement gloves to alleviate his symptoms.
8. Claimant credibly commented that his pain became more pronounced when he began performing his duties as a plumber for a new employer. He noted that his right hand symptoms continue to limit his ability to perform his required tasks. Claimant explained that he thus desires additional medical treatment.
9. Claimant has produced substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition. Although medical providers have not prescribed medical maintenance benefits, Claimant credibly testified that he has continued to experience pain, tightness, loss of sensation and cramping in his right hand and wrist. Claimant obtained nylon gloves during physical therapy to relieve the swelling in his right hand. He has subsequently replaced the gloves because they alleviate his right wrist and hand symptoms. Claimant also credibly commented that his

right hand symptoms become more pronounced when he is performing his duties as a plumber for a new employer and that his right hand condition limits his ability to perform his required tasks. Finally, Claimant has visited Dr. Pav because of continued symptoms and was directed to undergo additional physical therapy. Based on Claimant's persuasive testimony, he is entitled to a general award of medical maintenance benefits.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a worker's 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 worker's 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 worker's 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 (2005).

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

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

5. As found, Claimant has produced substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition. Although medical providers have not prescribed medical maintenance benefits, Claimant credibly testified that he has continued to experience pain, tightness, loss of sensation and cramping in his right hand and wrist. Claimant obtained nylon gloves during physical therapy to relieve the swelling in his right hand. He has subsequently replaced the gloves because they alleviate his right wrist and hand symptoms. Claimant also credibly commented that his right hand symptoms become more pronounced when he is performing his duties as a plumber for a new employer and that his right hand condition limits his ability to perform his required tasks. Finally, Claimant has visited Dr. Pav because of continued symptoms and was directed to undergo additional physical therapy. Based on Claimant's persuasive testimony, he is entitled to a general award of medical maintenance benefits.

ORDER

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

1. Claimant shall receive medical maintenance benefits that are reasonably necessary to relieve the effects of his industrial injury or prevent further deterioration of his condition.

2. Any issues not resolved in this Order are reserved for future determination.

DATED: November 25, 2008. Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-737-293

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she sustained a compensable injury during the course and scope of her employment with Employer on October 2, 2007.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to receive reasonable and necessary medical benefits that are designed to cure and relieve the effects of an industrial injury.

3. Whether Claimant has proven by a preponderance of the evidence that she is entitled to receive Temporary Partial Disability (TPD) benefits and Temporary Total Disability (TTD) benefits as a result of her industrial injury.

STIPULATION

The parties entered into the following stipulation prior to the hearing in this matter: Claimant earned an Average Weekly Wage (AWW) of $953.09.

FINDINGS OF FACT

1. Employer is an organization that provides vocational rehabilitation and counseling to individuals. Claimant works for Employer as a site supervisor who is responsible for the mailroom. She oversees seven permanent employees and several temporary employees who are also clients of Employer. Claimant began working for Employer in 1992.

2. Claimant testified that on October 1, 2007 she left work early because she was experiencing menstrual cramps. She told Employer that she was leaving early because she was sick.

3. Claimant explained that on October 2, 2007 she was talking with her assistant T about an emergency housing need for a homeless client. Because the office was very busy, crowded, and noisy, Claimant and Ms. T went outside for a "smoke break" to continue their conversation about the client.

4. Claimant and Ms. T entered Employer's asphalt parking lot area. Claimant testified that Ms. T offered her a drink. Claimant recounted that when she stepped back, she tripped on a water hole cover that was one to two inches deep in the asphalt. She fell backwards, struck her head on the ground and lost consciousness. The fall occurred at approximately 10:00 a.m.

5. Claimant acknowledged that she was under stress at the time of the accident but denied that she was feeling dizzy or lightheaded. She testified that all documentation reflecting that she was dizzy, lightheaded or fainted was inaccurate. Claimant specifically remembered tripping over the water hole cover and falling.

6. Claimant explained that she missed work as a result of the injuries she sustained in the fall. She commented that she has experienced neck pain, lightheadedness and headaches since the accident. She has not returned to full duty employment and currently works 32 hours each week. Although Claimant has received full wages since the date of the accident, she has been paid for her missed work time by using accumulated sick leave.

7. Ms. T testified that she witnessed Claimant's fall. She explained that she had been outside with Claimant walking on asphalt for approximately 10 minutes prior to Claimant's fall. Ms. T stated that Claimant commented that she was feeling lightheaded. Ms. T then offered her a drink. While looking at Claimant's face, Ms. T noticed that something was clearly wrong. Ms. T noted that Claimant then collapsed, fell backward and struck her head on the asphalt. Because Ms. T was looking at Claimant's face, she did not know if anything caused

Claimant to trip and fall. Nevertheless, Ms. T commented that water hole covers existed in the asphalt surface where Claimant fell. Claimant lost consciousness after the fall and was immediately transported to the Veteran's Administration (VA) Hospital on Employer's site for medical treatment.

8. An emergency room note dated October 2, 2007 reflects that Claimant was outside smoking, complained of feeling dizzy and stretched out her hand to steady herself. However, Claimant was unable to hold herself, fell down and struck her head on the ground. Claimant's reported history from the previous day included abdominal soreness, diarrhea and vomiting. The report noted that Claimant's vomiting resolved, but she had experienced three loose stools since the morning. Emergency room treatment consisting of hydration with saline resolved Claimant's dizziness. The medical provider's impression was dizziness with near syncope. The dizziness was likely caused by dehydration secondary to diarrhea and vomiting.

9. Handwritten notes from the VA Hospital dated October 2, 2007 reflect that, based on the description of a witness, Claimant fell backwards while suffering syncope. Claimant was alert and responsive by 10:05 a.m. By 10:50 a.m. Claimant was aware that she had fallen but did not remember the circumstances. She recounted that she had experienced diarrhea on the previous day and that she felt better after receiving intravenous fluids. Claimant's treatment plan involved hydration and rest.

10. On October 2, 2007 Claimant signed a hand written document entitled Employee's Injury Report to Employer. Under "Employee's explanation of the injury," the document reveals that Claimant "got dizzy, fell back hit the back of my head on ground." Claimant testified that she signed the document but denied that she provided the description of the injury.

11. On October 2, 2007 an Accident Investigation Report was prepared. Under the section entitled "Description of Accident," the document states "[Claimant] was walking back inside from smoking a cigarette. Informed co-worker (Bea T) that she felt faint, immediately after her knees buckled, she fell backward, hit back of head on cement." Under Cause of Accident, the document provides, "possible illness; left work early day prior due to stomach illness."

12. On October 3, 2007 Ms. T prepared a statement about the October 2, 2007 incident. Ms. T recounted that she had left Employer's building with Claimant in order to discuss the housing needs of a homeless client. Ms. T's statement provides, in relevant part,

> During the discussion, [Claimant] was feeling stressed not knowing how to resolve the situation. When we were coming back in, [Claimant] stopped, and stated she felt a little lightheaded. [Claimant] was standing in front of two water hole covers (they looked like man holes – only smaller) when I noticed her knees starting to get

shaky and she stepped back and fell – hitting her head on the ground and was unconscious for at least 10-12 seconds.

13. On October 4, 2007 Claimant visited the VA Emergency Room for follow-up treatment. The report notes that Claimant "had syncopal episode while at work, felt to be volume issue related to vomiting and diarrhea."

14. On October 5, 2007 Claimant provided a recorded statement about the October 2, 2005 incident. She stated that she had been outside talking to Ms. T and became lightheaded. Claimant explained that she "felt really weird" and grabbed onto Ms. T's hand. Ms. T then offered her a drink and "just as she put her straw to my lips, that's when I don't remember anything else." Claimant next remembered "waking up off the floor." Claimant acknowledged that she completed the "Employer's First Report of Injury" based on the details she had disclosed to Ms. T on the day of the accident. More specifically, Ms. T had written Claimant's statement on a piece of paper on the day of the incident and Claimant subsequently copied the notes onto the First Report of Injury.

15. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable injury during the course and scope of her employment with Employer on October 2, 2007. Claimant testified that she tripped and fell on a water hole cover in Employer's parking area. She denied that she felt lightheaded or dizzy immediately prior to the fall. However, her testimony is inconsistent with the large body of evidence presented at the hearing in this matter. Medical records from the day of the incident reflect that Claimant fell to the ground because she was dizzy and lost her balance. The medical records suggest that Claimant required hydration because she had suffered vomiting and diarrhea on the previous day. Moreover, an Employee's Injury Report to Employer and an Accident Investigation Report reveal that Claimant felt faint and dizzy, fell backwards and struck her head on the ground. Claimant's recorded statement also specifies that she felt lightheaded immediately prior to striking her head on the ground. The preceding statements are more reliable than Claimant's statements at the hearing because they were prepared shortly after the October 2, 2007 accident. Finally, eyewitness Ms. T's account demonstrates that Claimant felt lightheaded and her knees became shaky immediately prior to the fall. The persuasive evidence thus demonstrates that Claimant suffered from lightheadedness and dizziness that caused an unexplained fall. Claimant has therefore failed to establish a direct causal relationship between the conditions of her employment and her injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim

has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

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

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

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of her employment. *Popovich v. Irlando,* 811 P.2d 379, 383 (Colo. App. 1991). The "time" limits of employment include a reasonable interval before and after working hours while the employee is on the employer's property. *In Re Eslinger v. Kit Carson Hospital,* W.C. No. 4-638-306 (ICAP, Jan. 10, 2006). The "place" limits of employment include parking lots controlled or operated by the employer that are considered part of employer's premises. *Id.*

5. The "arising out of" requirement is narrower and requires the claimant to demonstrate that the injury has its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Popovich,* 379 P.2d at 383. Nevertheless, the employee's activity need not constitute a strict duty of employment or confer a specific benefit on the employer if it is incidental to the conditions under which the employee typically performs the job. *Swanson,* W.C. No. 4-589-545. It is sufficient "if the injury arises out of a risk which is reasonably incidental to the conditions and circumstances of the particular employment." *Phillips Contracting, Inc. v. Hirst,* 905 P.2d 9, 12 (Colo. App. 1995).

6. The fact that an employee is injured on an employer's premises does not establish a compensable injury. *See Finn v. Industrial Comm'n.,* 165 Colo. 106, 437 P.2d 542 (1968). The burden remains on the claimant to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injury. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). When a claimant has fallen at work but fails to establish that her employment caused the fall she has sustained a "truly unexplained fall." *See In re Ismael,* W.C. No. 4-616-895 (ICAP, July 3, 2007). Therefore, a "truly unexplained fall" is not compensable simply because it occurred in the course of employment. *In re Blunt,* W.C. No. 4-725-754 (ICAP, Feb. 15, 2008). Whether there is a sufficient nexus or causal relationship between a claimant's employment and the injury is a question of fact for the ALJ. *In re Ismael,* W.C. No. 4-616-895 (ICAP, July 3, 2007).

7. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable injury during the course and scope of her employment with Employer on October 2, 2007. Claimant testified that she tripped and fell on a water hole cover in Employer's parking area. She denied that she felt lightheaded or dizzy immediately prior to the fall. However, her testimony is inconsistent with the large body of evidence presented at the hearing in this matter. Medical records from the day of the incident reflect that Claimant fell to the ground because she was dizzy and lost her balance. The medical records suggest that Claimant required hydration because she had suffered vomiting and diarrhea on the previous day. Moreover, an Employee's Injury Report to Employer and an Accident Investigation Report reveal that Claimant felt faint and dizzy, fell backwards and struck her head on the ground. Claimant's recorded statement also specifies that she felt lightheaded immediately prior to striking her head on the ground. The preceding statements are more reliable than Claimant's statements at the hearing because they were prepared shortly after the October 2, 2007 accident. Finally, eyewitness Ms. T's account demonstrates that Claimant felt lightheaded and her knees became shaky immediately prior to the fall. The persuasive evidence thus demonstrates that Claimant suffered from lightheadedness and dizziness that caused an unexplained fall. Claimant has therefore failed to establish a direct causal relationship between the conditions of her employment and her injury. *See In re Gray,* W.C. No. 4-721-655 (ICAP, Sept. 25, 2008) (where claimant passed out and could not explain what caused him to fall, his fall was unexplained and therefore not compensable).

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.

DATED: November 3, 2008.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-741-264

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he sustained a compensable injury on October 18, 2007 during the course and scope of his employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

1. Prior to the hearing in this matter, the Office of Administrative Courts mailed the Notice of Hearing to Respondent at his last known address. Respondent thus had proper notice of the hearing in this matter. Nevertheless, Respondent failed to appear.
2. Claimant worked for Employer performing various construction duties.
3. Claimant credibly testified that on October 18, 2007 he was performing construction duties for Employer on a private home. As he was walking in the dark on a wood floor, he tripped over a bucket and lost his balance. He fell to the ground and fractured his right ankle.
4. Employer drove Claimant to a hospital emergency room for treatment. After obtaining initial treatment, Claimant was directed to visit an orthopedic surgeon.
5. On October 24, 2007 Mark S. Fitzgerald, M.D. performed surgery on Claimant. The surgery involved the insertion of hardware into Claimant's right ankle.
6. Claimant suffered a deep vein thrombosis (DVT) in his right ankle as a result of his surgery. He was treated with the blood thinner Coumadin to prevent clotting. Claimant required Coumadin treatment until June 2008.
7. Claimant also suffered an abscess in his right ankle. On March 21, 2008 he underwent surgery to remove the hardware in his right ankle and relieve the abscess.
8. Claimant's medical expenses as a result of his October 18, 2007 right ankle injury totaled $16,325.90.
9. Claimant has established that it is more probably true than not that he suffered a right ankle injury during the course and scope of his employment with Employer on October 18, 2007. He credibly testified that he fractured his right ankle while performing construction duties for Employer.
10. Claimant has demonstrated that it is more probably true than not that he received reasonable and necessary medical treatment to cure and relieve the effects of his industrial injury. His need for medical treatment subsequent to October 18, 2007 was designed to alleviate the effects of his right ankle fracture. Claimant underwent two sur-

geries to repair his right ankle and required medication for the DVT that developed after his surgery. He incurred medical expenses totaling $16,325.90.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has established by a preponderance of the evidence that he suffered a right ankle injury during the course and scope of his

employment with Employer on October 18, 2007. He credibly testified that he fractured his right ankle while performing construction duties for Employer.

Medical Benefits

6. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. As found, Claimant has demonstrated by a preponderance of the evidence that he received reasonable and necessary medical treatment to cure and relieve the effects of his industrial injury. His need for medical treatment subsequent to October 18, 2007 was designed to alleviate the effects of his right ankle fracture. Claimant underwent two surgeries to repair his right ankle and required medication for the DVT that developed after his surgery. He incurred medical expenses totaling $16,325.90.

ORDER

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

1. Claimant suffered a compensable workers' compensation injury during the course and scope of his employment with Employer on October 18, 2007.

2. Respondent is financially responsible for Claimant's medical expenses totaling $16,325.90.

DATED: November 19, 2008. Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-745-895

ISSUES

The issues presented for consideration at hearing are compensability and medical benefits.

FINDINGS OF FACT

1. Claimant began working for the Employer in approximately March of 2007.

2. He was assigned to Coors, where he worked in the labeler production area.

3. On December 22, 2007, he carried two boxes to a conveyor, put them down and then bent over and went under the conveyor belt. When he stood up, he felt a pull in his back.

4. Claimant initially thought the pain would go away, but as he continued to work, it got worse.

5. When Claimant went to his first break, he told his supervisor, J S, of his work injury. Mr. S asked him if he could work the rest of the shift. Claimant said that he would try.

6. Claimant continued to work his shift, but his back pain increased. During the next work break, he informed Mr. S that his back was worse and Mr. S called security.

7. Security contacted Claimant and then called paramedics. The paramedics examined Claimant and transported him by ambulance to Lutheran Hospital.

8. Claimant was treated at Lutheran Hospital and referred to Concentra for further treatment. Claimant was given lifting restrictions and he returned to work for Coors.

9. Claimant testified that he was only allowed to work for the Employer at Coors for nine months and then he would have three months off. C R, the onsite supervisor for the Employer, testified that this was the arraignment Coors had made with the Employer.

10. Claimant and Ms. R both testified that Claimant was injured on the day before his last day on the Coors assignment.

11. Ms. R testified that the claim was denied because the alleged injury occurred the day before Claimant was to leave his assignment at Coors.

12. Claimant and Ms. both testified that the Clamant continued to work at Coors after the nine months had expired and that he was finally laid off when he was released to return to work without restrictions. Ms. R testified that it was company policy that temporary workers under restrictions continue to work after the assignment would have otherwise been terminated.

13. After the assignment terminated the Employer assigned Claimant to a job at the Pepsi Center.

14. Clamant was diagnosed by Dr. Thomas Gray and Dr. John Burris as having a lumbar strain. The treatment that Clamant received for his injuries consisted of therapy and sometimes painful injections.

15. It is found that Claimant was injured on December 22, 2007 while working at Coors for the Employer.

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 is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. In this case, Claimant's testimony about the mechanism of his injury was found credible and persuasive. The fact that Claimant was diagnosed with a back sprain and underwent painful treatment for the injury persuades the finder of fact that Claimant was injured while working for the Employer.

5. 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).

6. Since the evidence established that he suffered a work related injury, he is entitled to reasonably necessary and related medical benefits. Respondents shall be liable for these medical benefits.

ORDER

WHEREFORE, IT IS ORDERED:

1. That Respondents are liable to Clamant for medical benefits to cure and relieve the affects of his back injury.

2. That all other issues not decided by this order shall be reserved for future determination, if necessary.

DATED: November 19, 2008 Margot W. Jones

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-532

ISSUES

The issues for determination are compensability, medical benefits, reasonable and necessary treatment, and authorized provider.

FINDINGS OF FACT

1. In March 2007, Respondent-Employer hired Claimant. Claimant's job with Respondent-Employer involved the cleaning and waxing of stairwells and floors in commercial buildings.

2. On Thursday, January 10, 2008, at approximately 12:50 am, Claimant was waxing the floor in and about a stairwell when he slipped and fell on some wax landing on his buttocks and lower back.

3. Claimant did not report his injury at the time it occurred due to his inability to locate his immediate supervisor. Claimant finished his shift and went home.

4. Claimant reported the injury to his project supervisor, M, on Sunday, January 13, 2008. Claimant was not scheduled to work on Friday, January 11, 2008, or Saturday, January 12, 2008. At the time the injury was reported, Claimant was directed to Concentra Medical Center for care.

5. On January 15, 2008, Claimant presented himself to Concentra Medical Center where he was seen by the nurse practitioner. Claimant gave the nurse a history that he was cleaning stairs and waxing floors when he slipped and fell thus injuring his back.

6. The nurse practitioner examined Claimant and rendered a diagnosis of contusions to the buttocks and lumbar spine. Claimant was prescribed medication, physical therapy, and given work restrictions of no bending more than three times per hour, no squatting, no kneeling, no lifting over 10 pounds, and no pushing/pulling over 10 pounds.

7. Claimant initiated physical therapy at Concentra Medical Center on January 17, 2008. Claimant gave the physical therapist a history of slipping and falling in wax on January 10, 2008, while waxing floors. Claimant went to physical therapy on January 23, 2008. Claimant discontinued physical therapy due to non-authorization by Respondent-Insurer.

8. Claimant was seen at Concentra on January 23, 2008 and February 6, 2008. Claimant was given the same work restrictions as in his prior visit other than restricting Claimant to no lifting over 5 pounds.

9. Dr. Peterson at Concentra noted in his February 6, 2008 record that Claimant was continuing to have low back pain. Dr. Peterson noted that Clamant had gone to physical therapy two times but no further sessions had been approved due to the Respondent-Employer's failure to file a first report of injury. Dr. Peterson also noted that an MRI had not yet been authorized.

10. On February 8, 2008, Dr. Peterson discharged Claimant from further care at Concentra due to the claim being denied.

11. Claimant has continued to work his usual job with Respondent-Employer in spite of being injured. Claimant's job at Respondent-Employer entailed bending, stooping, squatting, and lifting over 10 pounds on a regular basis. Claimant continued to work as he needed money to support his family.

12. The bills for the care Claimant received at Concentra have not been paid. A letter from Concentra dated February 11, 2008, indicated that Respondent-Employer had not filed a first report of injury and that if Respondent-Employer did not file the first report of injury, the bills incurred for care rendered become Claimant's responsibility.

13. Because he was discharged from care at Concentra due to the denial of the claim, Claimant presented himself to Timothy Hall, M.D. for evaluation and treatment on June 25, 2008. Dr. Hall evaluated Claimant and opined that as a result of the January 10, 2008 slip and fall at work, Claimant has mechanical low back pain likely related to SI joint dysfunction, facet syndrome, possible discogenic pain, and probable pyriformis syndrome. Dr. Hall recommended an MRI and will prescribe treatment after the MRI results are known.

14. Claimant has continued to have problems with his low back up until the present.

15. The ALJ finds Claimant to be credible in the pertinent facts that establish compensability.

16. Claimant has proven by a preponderance of the evidence that he sustained a compensable injury to his low back within the course and scope of his employment with Respondent-Employer.

17. Claimant has proven by a preponderance of the evidence entitlement to medical benefits. The physicians at Concentra are authorized providers. As of June 25, 2008, Dr. Hall is the authorized treating physician.

CONCLUSIONS OF LAW

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

1. An 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. Sections 8-43-201 and 8-43-210 C.R.S. (2006). See *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *Lutz v. Industrial 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 than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1977).

2. Claimant credibly testified that he injured himself at work when he slipped and fell while cleaning and waxing floors thus landing on his lower back and buttocks. It is recognized that Claimant has given different histories of what transpired. However, while Claimant's memory was not crystal clear, his recall credibly establishes the compensability of this claim. As found, Claimant has proven by a preponderance of the evidence that he injured his low back within the course and scope of his employment with Respondent-Employer on January 10, 2008.

3. Respondents are liable for medical treatment reasonably necessary to cure and relieve the employee for the effects of the injury. Section 8-42-101, C.R.S. (2007); *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Respondents are only liable for authorized or emergency medical treatment. See Section 8-42-101(1), C.R.S. (2007); *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). The respondents have the right in the first instance to select a physician to treat the industrial injury. Section 8-43-404(5)(a), C.R.S. (2007). Once the respondents have exercised their right to select a physician, the Claimant may not change physicians without permission from the insurer or the ALJ. See *Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). If the physician selected by the respondents refuses to treat for non-medical reasons and the respondents fail to appoint a new treating physician, the right of selection passes to the Claimant and the physician selected by the

Claimant becomes authorized to treat the injury. See *Ruybal v. University Health Sciences Center*, 768 P.2d 1259 (Colo. App. 1988); *Tellez v. Teledyne Water Pic v. Industrial Claim Appeals Office*, W. C. No. 3-990-062 (March 24, 1992); *Buhrman v. University of Colorado Health Sciences Center*, W. C. No. 4-253-689 (November 4, 1996).

4. Claimant was referred by Respondent-Employer to Concentra. However, Respondent-Insurer denied the claim and did not pay for any of Claimant's care at Concentra. Therefore, Dr. Kiernan refused to treat Claimant. Claimant was free to select his own physician. The treatment provided at Concentra along with all of the referrals therefrom are authorized and reasonably necessary to cure or relieve the effects of the Claimant's industrial injury. In addition as found, as of June 25, 2008, the care provided by Dr. Timothy Hall is authorized and reasonably necessary to cure and relieve Claimant from the effects of his industrial injury.

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits is compensable.

2. Respondent-Insurer shall pay all reasonable and necessary costs of Claimant's work-related medical treatment at Concentra and any referrals therefrom.

3. As of June 25, 2008, Respondent-Insurer shall pay all reasonable and necessary costs of Claimant's work-related medical treatment with Dr. Timothy Hall.
4. The Respondent-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.
DATE: November 4, 2008

Donald E. Walsh
OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-753-189

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he sustained a compensable injury on March 5, 2008 during the course and scope of his employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

11. Claimant is a 56-year old individual who worked as an automotive technician for Employer. Claimant's job duties included the physical labor associated with performing automotive work on vehicles.

12. Claimant explained that on March 5, 2008 he was rebuilding the front-end differential on a Yukon SUV. After completing the differential assembly, Claimant contacted his coworker O and asked for assistance in installing the assembly. Claimant stated that he and Mr. O raised the assembly with a transmission jack. However, because the transmission jack did not adequately extend, they had to physically move the assembly into the differential case. Claimant used a pry bar to aid in positioning the assembly. Claimant testified that while using the pry bar he experienced a sudden pinch in his lower back that extended down his leg to his knee.

13. Claimant testified that, shortly after the incident, he took a morning break and ingested a powerful painkiller because of back pain. He explained that, although he completed his work shift, his back became increasingly painful during the course of the day.

14. Prior to March 5, 2008 Claimant suffered significant medical conditions. His feet were painful because of a condition called Morton's Neuroma. During 2005 he suffered from lower back problems without any identifiable injury. Moreover, Claimant had undergone two surgical interventions on his cervical spine. Although Claimant's conditions were painful, he worked full-duty and did not have any medical restrictions.

15. Mr. O testified that he assisted Claimant in installing the Yukon SUV differential during the morning of March 5, 2008. However, he did not notice that Claimant injured himself at the time of the installation. In fact, Mr. O stated that Claimant did not appear to be suffering any back symptoms until Claimant was leaving work for the day. Claimant told Mr. O that his back was hurting but did not disclose the cause of his pain.

16. Employer witnesses W and E testified that Claimant told them on Monday, March 3, 2008 that he had injured his back over the previous weekend while moving a fish tank. Claimant's supervisor H corroborated the accounts of Ms. W and Mr. E in a written statement.

17. Claimant stated that he had discussed moving the fish tank with Ms. W, but denied telling her or Mr. E that he had injured his back. Nevertheless, Claimant acknowledged that he was suffering from symptoms on March 3, 2008 that were severe enough to consider going to Urgent Care for treatment. He mentioned to Ms. W that he might need to visit Urgent Care. However, Claimant stated that he required treatment for his neck and not his back.

18. The record reflects that Claimant helped his daughter G move a fish tank to her basement on Sunday, March 2, 2008. Ms. G explained that Claimant helped her move a 30-gallon fish tank that had recently been drained. Ms. G commented that the tank still held one to two gallons of water, gravel and other items. She estimated that the tank weighed approximately 40-50 pounds. Ms. G and Claimant moved the fish tank down two flights of stairs. She noted that nothing unusual occurred while moving the tank.

19. Claimant's wife testified that Claimant returned home after moving the fish tank and did not appear to be suffering from any pain. He also did not mention that he sustained any injuries while moving the tank.

20. Claimant testified that after completing his job duties on March 5, 2008 he went home and put a heating pad on his lower back. He went to bed at 10:30 p.m.

21. On the morning of March 6, 2008 Claimant awoke in excruciating lower back pain. Claimant's wife went to work and scheduled an appointment for Claimant to visit Jerome C. Landblom, M.D. of the Longmont Clinic for an evaluation. Claimant's wife also contacted Ms. W at Employer's office to explain that Claimant would not be reporting for work. She did not disclose that Claimant had suffered a work-related injury.

22. At approximately 10:00 a.m. on March 6, 2008 Dr. Landblom examined Claimant. Dr. Landblom reported that Claimant was suffering "excruciating pain" in his right lower back, buttock and leg. Notably, Claimant told Dr. Landblom that the pain had begun earlier in the morning but did not mention the cause of the pain or relate the pain to any incident while performing his job duties. Claimant subsequently underwent x-rays of his lower back. Based on Dr. Landblom's examination, Claimant's history and the radiological results, Dr. Landblom arranged for Claimant's immediate admission into Longmont United Hospital.

23. Claimant was transferred to the Hospital for additional evaluation. He testified that at around 12:00 p.m. he attempted to contact Employer about his condition. Claimant sought to obtain information about Employer's workers' compensation carrier but was unsuccessful. He was directed to contact his supervisor Mr. H. Claimant left a message for Mr. H but did not hear back from him at anytime on March 6, 2008.

24. Later in the day on March 6, 2008 Claimant underwent an MRI of his lower back. The MRI revealed a herniated disk at the L4-5 level of Claimant's spine. Dr. Landblom determined that Claimant required an orthopedic consultation.

25. Claimant subsequently underwent an orthopedic evaluation with James A. Britton, M.D. Claimant reported to Dr. Britton that he "recently, over the weekend, did some significant lifting" without an identified injury, "though following that he had progressive elements of right sciatica, intermittently severe and lacinate hip-to-leg pain extending below the knee." Claimant did not tell Dr. Britton that he had injured his back the day before at his place of employment and made no mention of an injury while attempting to repair a front differential on a vehicle. Based on the evaluation, Claimant's history and the results of the MRI, Dr. Britton determined that Claimant required surgical intervention.

26. Prior to surgery on March 7, 2008 Claimant contacted Mr. H. Claimant testified that he told Mr. H that he had injured his back at work and requested the name of the designated treatment provider. Mr. H responded that he did not know Employer's medical provider.

27. Claimant was discharged from Longmont United Hospital on March 8, 2008. On March 10, 2008 Claimant conducted internet research to determine Employer's designated treatment provider. On Insurer's website Claimant discovered that the Workwell Clinic in Longmont, Colorado was Employer's designated treatment provider. Claimant visited the Workwell facility for an evaluation and was directed to continue medical treatment with Dr. Britton.

28. On March 10, 2008 Claimant also visited Employer's facility. He spoke with Mr. H and gave him a written statement noting that he had suffered a work injury and underwent surgery on March 7, 2008. Claimant submitted a claim for compensation to Insurer on March 11, 2008.

29. Claimant's post-surgical progress has been guarded. He has not returned to work and has not reached Maximum Medical Improvement (MMI).

30. Dr. Britton testified through an evidentiary deposition in this matter. He reiterated that during his initial evaluation Claimant reported that he had been doing some heavy lifting over the prior weekend but had not been injured. He also relayed that Claimant disclosed that he suffered "intermittently, progressively severe pain" following the weekend lifting incident. Claimant did not tell Dr. Britton that he injured his back while repairing a vehicle at work on March 5, 2008.

31. John S. Hughes, M.D. conducted an independent medical examination of Claimant, prepared a report and testified at the hearing in this matter. He explained that Claimant's condition on the morning of March 6, 2008 was probably caused by the fish tank-lifting episode the weekend before. Dr. Hughes noted that Claimant most likely had a genetic weakness of the connective tissues in his spine that predisposed him to either an idiopathic disc herniation or a disc herniation from a relatively minor injury. He opined that the aquarium incident probably accelerated Claimant's degenerative condition. Considering all of the evidence, Dr. Hughes concluded that Claimant suffered an annular tear while moving the fish tank and the tear suddenly opened in the early morning hours of March 6, 2008. He commented that no specific activity, trauma, or motion is necessary to cause the "dam to burst" allowing the intravertebral disc to protrude through the annulus. Dr. Hughes concluded that a gradual increase of symptoms as described by Claimant to Dr. Britton is common and a disc can herniate several days or weeks after the inciting event.

32. Claimant has failed to establish that it is more probably true than not that he suffered an industrial injury to his lower back during the course and scope of his employment with Employer on March 5, 2008. Claimant testified that he suffered an injury to his lower back during the installation of a differential assembly into a Yukon SUV on March 5, 2008. Claimant's daughter and wife testified consistently with his account that he did not appear to be suffering any pain as a result of moving the fish tank on March 2, 2008. However, Employer witnesses Ms. W and Mr. E contradicted Claimant's version of events. Ms. W and Mr. E stated that Claimant told them on Monday, March 3, 2008 that he had injured his back over the previous weekend while moving a fish tank. Furthermore, Claimant's supervisor Skip H corroborated the accounts of Ms. W and Mr. E in a written statement. Claimant also mentioned to Ms. W that he might need to visit Urgent Care on March 3, 2008. Finally, Mr. O testified that Claimant did not appear to have suffered an injury while installing the differential assembly, but Claimant was in pain later in the day from an undisclosed source. The weight of the testimony from lay witnesses thus suggests that Claimant has failed to satisfy his burden of proof.

33. The medical evidence reveals that Claimant has failed to demonstrate that an incident at work proximately caused his lower back injury or aggravated his condition. Initially, Claimant told Dr. Landblom that his lower back pain had begun earlier in the morning on March 6, 2005 but did not mention the cause of the pain or relate the pain to any incident while performing his job duties. More importantly, Claimant did not disclose any work-related injury to Dr. Britton, but instead stated that he had done some heavy lifting over the weekend without any injury but experienced "progressive elements of right sciatica, intermittently severe and lacinate hip-to-leg pain extending below the knee." Finally, Dr. Hughes persuasively testified that Claimant's condition on the morn-

ing of March 6, 2008 was probably caused by the fish tank-lifting episode during the prior weekend. Dr. Hughes noted that Claimant most likely had a genetic weakness of the connective tissues in the spine that predisposed him to either an idiopathic disc herniation or a disc herniation from a relatively minor injury. He opined that the aquarium incident probably accelerated Claimant's degenerative condition. Dr. Hughes thus concluded that Claimant suffered an annular tear from the aquarium-lifting incident and the tear suddenly opened in the early morning hours of March 6, 2008. He also commented that a gradual increase of symptoms as described by Claimant to Dr. Britton is common and a disc can herniate several days or weeks after the inciting event. The medical evidence is thus consistent with the lay testimony that Claimant suffered an injury to his lower back prior to March 5, 2008 and that the natural progression of the injury manifested itself in the form of excruciating pain on the morning of March 6, 2008. Claimant has therefore failed to establish that any of his work duties aggravated, accelerated, or combined with his lower back condition to produce a need for medical treatment.

CONCLUSIONS OF LAW

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

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

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

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006).

Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to establish by a preponderance of the evidence that he suffered an industrial injury to his lower back during the course and scope of his employment with Employer on March 5, 2008. Claimant testified that he suffered an injury to his lower back during the installation of a differential assembly into a Yukon SUV on March 5, 2008. Claimant's daughter and wife testified consistently with his account that he did not appear to be suffering any pain as a result of moving the fish tank on March 2, 2008. However, Employer witnesses Ms. W and Mr. E contradicted Claimant's version of events. Ms. W and Mr. E stated that Claimant told them on Monday, March 3, 2008 that he had injured his back over the previous weekend while moving a fish tank. Furthermore, Claimant's supervisor Skip H corroborated the accounts of Ms. W and Mr. E in a written statement. Claimant also mentioned to Ms. W that he might need to visit Urgent Care on March 3, 2008. Finally, Mr. O testified that Claimant did not appear to have suffered an injury while installing the differential assembly, but Claimant was in pain later in the day from an undisclosed source. The weight of the testimony from lay witnesses thus suggests that Claimant has failed to satisfy his burden of proof.

7. As found, the medical evidence reveals that Claimant has failed to demonstrate that an incident at work proximately caused his lower back injury or aggravated his condition. Initially, Claimant told Dr. Landblom that his lower back pain had begun earlier in the morning on March 6, 2005 but did not mention the cause of the pain or relate the pain to any incident while performing his job duties. More importantly, Claimant did not disclose any work-related injury to Dr. Britton, but instead stated that he had done some heavy lifting over the weekend without any injury but experienced "progressive elements of right sciatica, intermittently severe and lacinate hip-to-leg pain extending below the knee." Finally, Dr. Hughes persuasively testified that Claimant's condition on the morning of March 6, 2008 was probably caused by the fish tank-lifting episode during the prior weekend. Dr. Hughes noted that Claimant most likely had a genetic weak-

ness of the connective tissues in the spine that predisposed him to either an idiopathic disc herniation or a disc herniation from a relatively minor injury. He opined that the aquarium incident probably accelerated Claimant's degenerative condition. Dr. Hughes thus concluded that Claimant suffered an annular tear from the aquarium-lifting incident and the tear suddenly opened in the early morning hours of March 6, 2008. He also commented that a gradual increase of symptoms as described by Claimant to Dr. Britton is common and a disc can herniate several days or weeks after the inciting event. The medical evidence is thus consistent with the lay testimony that Claimant suffered an injury to his lower back prior to March 5, 2008 and that the natural progression of the injury manifested itself in the form of excruciating pain on the morning of March 6, 2008. Claimant has therefore failed to establish that any of his work duties aggravated, accelerated, or combined with his lower back condition to produce a need for medical treatment.

ORDER

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

Claimant's request for workers' compensation benefits is denied and dismissed.

DATED: November 14, 2008.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-754-858

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that on January 31, 2008, he sustained an injury arising out of and in the course of his employment?

¬ Did the claimant prove by a preponderance of the evidence that he is entitled to temporary total disability benefits commencing February 1, 2008?

¬ Did the claimant prove by a preponderance of the evidence that he is entitled to reasonable, necessary and authorized medical treatment as a result of the alleged injury?

¬ What is the claimant's average weekly wage?

¬ Did the respondents prove by a preponderance of the evidence that temporary total disability benefits should end because the claimant was responsible for his termination from employment?

¬ Should the claimant's benefits be reduced because he failed timely to report the injury in writing?

FINDINGS OF FACT

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

1. The claimant began his employment with the employer in October 2007. The claimant initially worked in production, but was later promoted to work in quality assurance (QA).
2. On January 31, 2008, the claimant was employed as a QA technician responsible for analyzing the fat content of meat. The claimant worked the second shift from approximately 3:00 p.m. until 11:00 p.m. or 12:00 a.m. This job required the claimant to lift tubs of meat, and involved twisting and turning the body.
3. The claimant testified that on January 31, 2008, he slipped while carrying a tub of meat. The claimant recalled that he twisted and grabbed onto a table to prevent him from falling all the way to the floor. The claimant stated that he then experienced the onset of low back and right hip pain. The claimant associates the back and hip pain with the twisting incident.
4. The claimant testified that on January 31, 2008, he reported to his lead person, R, that he slipped and that his back and hip were hurting. However, the claimant recalled that Ms. R did not refer him for medical treatment, but instead told the claimant the injury was his own fault because he didn't keep the floor clean.
5. Ms. R testified at the hearing. Ms. R denied that the claimant reported any injury to her on January 31, 2008. Ms. R stated that if the claimant had reported an injury to her she would have referred him to Health Services for treatment, or called out for assistance if Health Services was closed.
6. On January 31, 2008, the claimant returned to his home in Brush, Colorado, a substantial distance from the employer's premises. Late on the afternoon of January 31, 2008, the claimant sought medical treatment at the East Morgan County Hospital emergency room (ER). The ER records document that the claimant reported a history of low back pain beginning either one week or three days earlier. The claimant denied a history of recent injury and denied falling. The ER notes also state the claimant did a lot of lifting, twisting, and turning, and that he "maybe pulled his back slipping at home." The claimant was diagnosed with an acute thoracic strain and acute low back pain. The ER physician prescribed medications and released the claimant.
7. On February 6, 2008, Dr. Scott Johnson, M.D., examined the claimant in Brush. Dr. Johnson notes the claimant reported that he did a lot of lifting and carrying at work, but did not report any specific injury. Dr. Johnson prescribed medications and stated the claimant should "try to return to work tomorrow."
8. The claimant returned to the employer's plant on February 7, 2008. At that time he produced medical restrictions. The claimant was referred to Health Services where he was apparently provided with additional restrictions. The claimant took the restrictions to one of his supervisors, M. The claimant testified that Ms. M sent him home because she could not provide work within the restrictions. Ms. M testified that she sent

the claimant home but told him to return the next day because she would find him work within his restrictions.

9. The claimant did not return to work on February 8, 2008. Instead, he began calling in and reporting that he would not be able to work. On February 28, 2008, the employer terminated the claimant's employment because he was not reporting for work.

10. When the claimant returned to the employer's plant on February 7, 2008, he was referred to Dr. Hector Brignoni, M.D., for treatment of the alleged industrial injury of January 31, 2008.

11. Dr. Brignoni examined the claimant on February 11, 2008. Dr. Brignoni noted that the claimant moved tubs of meat, and that the claimant "started having low back pain" on January 31, 2008. Dr. Brignoni's notes do not reflect that the claimant reported any specific injury, such as slipping and twisting. Dr. Brignoni noted the presence of some paravertebral muscle spasm and diagnosed a "lumbar strain." Dr. Brignoni referred the claimant for lumbar spine x-rays, imposed restrictions of light duty, no lifting greater than 10 pounds, and to avoid bending.

12. On February 20, 2008, Dr. Brignoni noted that the lumbar spine x-rays showed "diffuse degenerative disease of the lumbar spine." Dr. Brignoni referred the claimant for physical therapy. On March 5, 2008, Dr. Brignoni referred the claimant for a lumbar MRI.

13. On March 14, 2008, Dr. Laura Caton, M.D., saw the claimant for a "one time evaluation" at the employer's request. The claimant gave Dr. Caton a history of developing back pain after "sliding on the wet floor" at work. The claimant also gave a history of "repetitive twisting and picking up" tubs of meat. Although the claimant appeared to be in pain, he had no muscular spasm in the thoracic or lower back regions, and no tenderness in the sacroiliac region. Tests for sciatic pain were negative. Dr. Caton diagnosed a possible lumbar strain, but noted she could not find any "objective physical findings."

14. By April 3, 2008, Dr. Caton was able to review the lumbar spine x-rays. Dr. Caton persuasively testified that these x-rays demonstrate "extensive degenerative changes, age related long-term changes that would not be related in an acute injury." On April 3, 2008, Dr. Caton wrote that if the claimant's "degenerative changes were exacerbated by work activity, now that he is not working, the pain should dissipate." At hearing, Dr. Caton testified that certain activities at work could have caused the claimant to experience pain because of the arthritis, but that work activities did not cause the claimant's spine to degenerate.

15. At hearing, the claimant testified that his back and right hip were still painful and that he was having difficulty sleeping at night. The claimant opined that he needs additional medical treatment.

16. The claimant failed to prove it is more probably true than not that on January 31, 2008, he sustained an injury to his low back and right hip proximately caused by the performance of his duties as a QA technician. First, the ALJ is persuaded by the credible testimony of Dr. Caton that for a substantial period of time prior to January 31, 2008, the claimant suffered from serious degenerative spinal disease, and that this disease was not caused by the claimant's employment. The ALJ finds the claimant's testimony that on January 31, 2008, he slipped and twisted his back while performing his duties as a QA technician, and experienced the corresponding onset of low back and right hip

pain, is not credible and persuasive. First, the claimant's testimony that he immediately reported the injury to his supervisor, Ms. R, is contradicted by the credible testimony of Ms. R that the claimant did not report any back injury on January 31, 2008. Moreover, the claimant's testimony is contradicted by the history he gave at the ER when he reported for treatment late on the afternoon of January 31, 2008. Specifically, the ER records establish that the claimant denied any history of recent injury, denied falling, and reported that the back symptoms had been present for three days or a week prior to January 31. Similarly, on February 6, 2008, the claimant advised Dr. Johnson that he did not sustain any specific injury. Finally, the ALJ is persuaded that it is more probably true than not that any symptoms the claimant experienced while working were the natural and proximate result of his non-industrial degenerative back condition, not any work-related injury. Dr. Caton credibly opined that if the claimant's symptoms were aggravated by work, they should subside when the claimant was not working. However, as demonstrated by the claimant's testimony, his symptoms had not subsided at the time of the hearing in October 2008. To the contrary, the claimant testified that he was having trouble sleeping and desired additional medical treatment.

17. Evidence and inferences inconsistent with these findings are not found to be credible and persuasive.

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, 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.

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. 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 OF ALLEGED INJURY

The claimant alleges the evidence supports a finding that he sustained an injury to his low back and right hip while performing services arising out of and in the course of his employment as a QA technician. Specifically, the claimant asserts that the evidence proves it is more probably true than not that he slipped and twisted his back while carrying a tub of meat on January 31, 2008. The ALJ concludes the claimant failed to meet his burden of proof to establish that his back and hip condition were proximately caused by an injury arising out of and in the course of employment.

The claimant was required to prove by a preponderance of the evidence that the conditions for which he seeks medical treatment and compensation were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The claimant must prove a causal nexus between the claimed 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. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

As determined in Finding of Fact 16, the claimant failed to prove it is more probably true than not that his back condition was proximately caused by an injury arising out of and in the course of the employment. The ALJ has discredited the claimant's testimony that he slipped and twisted his back at work on January 31, 2008. The ALJ finds this testimony to be contradicted by the credible testimony of Ms. R, as well as the ER records and Dr. Johnson's February 6, 2008, office note. The ALJ has also credited the opinion of Dr. Caton that the claimant suffered from serious pre-existing degenerative spinal disease. Dr. Caton credibly opined that if the claimant's condition were aggravated by his employment she would expect it to subside after he quit working. However, the claimant's symptoms persisted at the time of the hearing. Consequently, it is more probably true than not that the claimant's symptoms are causally related to his pre-existing spinal disease than to the alleged work related injury.

In light of the finding that the claimant failed to prove a compensable injury, 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 claim for workers' compensation benefits in W.C. No. 4-754-858 is DENIED and DISMISSED.

DATED: November 20, 2008 David P. Cain

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-759-706

ISSUES

¬ Did claimant prove by a preponderance of the evidence that he sustained an injury arising out of the course and scope of his employment?
¬ Did claimant prove by a preponderance of the evidence that he is entitled to temporary disability benefits from May 12, 2008, ongoing?

FINDINGS OF FACT

1. Claimant's date of birth is June 17, 1979; his age at the time of hearing was 29 years. Employer manufactures concrete pipe. Employer hired claimant to work as a concrete laborer on April 18, 2008. Claimant contends he injured his left knee from climbing and descending ladders on Tuesday, May 6, 2008.
2. On May 12, 2008, claimant sought treatment at the emergency room (ER) at Community Hospital, where Paul E. Numsen, D.O., examined his left knee. Claimant reported the following history of his symptoms:
3. [Claimant] for the last week has had progressive pain in his left knee. It seems to be hurting the most medially, he noticed 24 hours ago. It was swollen when he woke up. He denies any sort of injury.
4. Claimant did not report to Dr. Numsen any history of a work-related cause to his left knee condition. Upon physical examination, Dr. Numsen found moderate swelling. Dr. Numsen excused claimant from work for 2 days and referred him to Western Orthopedics for evaluation.
5. Upon referral from the ER, Orthopedic Surgeon Mitchell T. Copeland, D.O., evaluated claimant on May 14, 2008. Dr. Copeland noted that claimant's symptoms began insidiously over the prior week. Claimant did not report to Dr. Copeland any history of a work-related cause to his left knee condition. Dr. Copeland suspected an occult meniscal tear and recommended claimant undergo a magnetic resonance imaging (MRI) scan of his left knee. Dr. Copeland restricted claimant to sedentary work, with a 10-pound lifting restriction, no squatting, no climbing, and the ability to use crutches.

Restrictions imposed by Dr. Copeland prevent claimant from performing his regular job at employer.

6. Claimant testified that he experienced left knee swelling and pain at work on May 6, 2008. Claimant alike stated that he could not recall what work activity he was performing but that he had climbed up and down ladders that day. Claimant explained that he was climbing ladders on May 6th to place fiberglass cap rings on concrete pipe. Claimant said he had worked a 70-hour week by the end of the workweek on Friday May 9th. Claimant said he experienced slight pain and discomfort in his left knee that week.

7. Claimant testified that he telephoned employer on May 12, 2008, and told his supervisor, Gordon Horton, that he had left knee pain and could not come to work. While claimant testified he told Horton on May 12th that his knee condition might be work-related, this testimony lacks credibility because it is contrary to credible testimony from Horton and other coworkers. Claimant said that he is unable to afF the MRI and needs treatment.

8. Horton testified to the following: Horton supervised claimant's work and saw him on a daily basis while he was working. Claimant telephoned on the morning of May 12th and said his knee was swollen and painful. When Horton asked him if he hurt his knee on the job, claimant said he did not know how he had hurt it. Prior to May 12th, claimant neither reported knee pain to Horton nor said he could not work because of knee pain. Horton spoke with claimant on May 13th using a speakerphone, when claimant again told Horton he did not know how he hurt his knee. Claimant never reported to Horton that he hurt his knee while working for employer.

9. Claimant's coworker, David Hofferber, was present in the office on May 13th when Horton spoke with claimant on the speakerphone. Hofferber overheard Horton ask claimant how he hurt his knee and heard claimant respond that he was unsure how he hurt his knee. Hofferber's testimony supports Horton's testimony about the May 13th conversation with claimant.

10. Brian Muhr also was in the office on May 13th and overheard Horton's conversation with claimant on the speakerphone. Muhr overheard Horton ask claimant how he hurt his knee and heard claimant respond that he was unsure how he hurt his knee. Muhr's testimony supports that of Horton and Hofferber concerning claimant's May 13th admission that he was unaware how he hurt his knee.

11. Horton further testified: After he learned claimant reported an injury from climbing ladders on May 6th, Horton checked production sheets. The production sheets showed that May 6th production involved pulling pipe out of kilns. There was no pipe manufactured on May 6th, and claimant's duties did not involve climbing ladders to place pipe caps. Horton's testimony here was credible and persuasive.

12. Employer's Vice President of Finance, Royce Clement, testified to the following: On May 16th, claimant reported to Clement that he wanted to file a workers' compensation claim for his left knee. Claimant explained that he needed a MRI scan and could not afF to pay for it. Clement asked claimant three times how he hurt his knee at work. In the first two answers, claimant said he did not know how he hurt his knee at work. Clement pressed claimant by telling him he needed a reason why claimant thought his knee condition was work-related in order to file the Employer's First Report of Injury (E-1). In response, claimant said he must have hurt his knee climbing up and down lad-

ders. Clement filed an E-1 based upon what claimant reported. Clement's testimony is credible because it was consistent with that of Horton, Hofferber, and Muhr.

13. The Judge credits the testimony of Horton, Hofferber, and Muhr over that of claimant in finding no persuasive support for claimant's hunch that his left knee pain might be causally related to climbing up and down ladders on May 6th.

14. Clement referred claimant to employer's designated medical provider, Western Medical Associates, where Lynne Bigler, R.N., examined him on May 16th. Claimant reported to Nurse Bigler that he was unable to identify a specific injury but that his job involved a lot of climbing up and down ladders. On physical examination of claimant's knee, Nurse Bigler found swelling and decreased range of motion.

15. At respondents' request, Douglas C. Scott, M.D., performed an independent medical examination of claimant on September 24, 2008. Claimant told Dr. Scott he may have twisted his knee on May 6th while putting a cast iron cap ring atop a concrete pipe. Claimant told Dr. Scott he had no immediate pain from twisting his knee. The mechanism of injury claimant reported to Dr. Scott is markedly different from claimant's testimony at hearing. Claimant did not report to Dr. Scott any mechanism of injury from climbing up and down ladders. Crediting Horton's testimony, claimant's duties on May 6th did not involve climbing ladders to place cap rings. The history claimant gave Dr. Scott is unreliable and lacks credibility.

16. Dr. Scott assessed claimant with a possible meniscus tear and possible anterior cruciate ligament (ACL) insufficiency. Dr. Scott opined:

17. [T]his is usually related to a traumatic injury such as a forceful twisting of forceful valgus stress on the knee. If the meniscus is torn or if the ACL ligament is torn, the pain would have been immediate and he would have known that he injured his knee with some specific activity or work-related injurious exposure. [Claimant] gave no report of a specific traumatic event, incident, and/or injurious exposure at [employer]. As a result, there is no evidence supportive of a work-related injury to his left knee on or about May 6, 2008.

18. Based upon the history claimant gave of left knee pain and swelling when he awoke Saturday morning, Dr. Scott opined it likely claimant injured his knee Friday night (May 9th).

19. Dr. Scott testified as an Occupational Medicine Physician with expertise in determining causation of knee conditions. Dr. Scott listened to claimant's testimony at hearing. Based upon claimant's testimony, and based the history claimant gave the ER physician (Dr. Numsen), Dr. Scott opined it medically probable that claimant injured his knee within 24 hours of waking up on Sunday morning, May 11th. Dr. Scott explained that claimant reported to Dr. Numsen on May 12th that he experienced his first knee symptoms when he awoke Sunday morning with pain and swelling. This history was different from what claimant told Dr. Scott about waking with these symptoms on Saturday morning. Dr. Scott stated that claimant's presentation at the ER on May 12th was consistent with an acute left knee tear/injury within 24 hours of his waking with symptoms on Sunday morning. Dr. Scott opined that claimant more likely sustained an acute injury that resulted in immediate swelling and pain. Dr. Scott further stated that, had claimant acutely injured his knee either climbing ladders or placing the cast iron ring on pipes, he would have experience immediate symptoms and a functional inability to weight-bear, squat, or walk. Had claimant injured his knee on May 6th, he would not

have been able to work as he did on May 7th, 8th, and 9th. Dr. Scott's medical opinion was persuasive.

20. Claimant failed to show it more probably true than not: (a) That he injured his left knee while working for employer on May 6th; or (b) That his work activity at employer caused, aggravated, or reasonably accelerated his left knee injury. As found, claimant's testimony about how he injured his left knee lacks credibility. Crediting Dr. Scott's medical opinion, it is medically probable that claimant sustained an acute injury to his knee within 24 hours prior to presenting to the ER on May 12th. Claimant thus likely injured his knee on Sunday, May 11th. Crediting Dr. Scott's testimony, it is medically improbable that claimant's work caused, aggravated, or reasonably accelerated his left knee injury. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable knee injury while working for employer.

CONCLUSIONS OF LAW

1. Claimant argues he has proven by a preponderance of the evidence that he sustained a left knee injury arising out of the course and scope of his employment. The Judge disagrees.

2. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

4. The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undesigned occurrence. Section 8-40-201(1), *supra*. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which 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. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990).

5. Here, the Judge found claimant failed to show it more probably true than not either that he injured his left knee while working for employer on May 6th or that his work activity at employer caused, aggravated, or reasonably accelerated his left knee injury. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable knee injury while working for employer.

6. The Judge found claimant's testimony about how he injured his left knee lacked credibility when weighed against other credible or persuasive evidence. The Judge credited Dr. Scott's medical opinion in finding claimant likely injured his left knee on Sunday, May 11th, and in finding it improbable that claimant's work caused, aggravated, or reasonably accelerated his left knee injury.

7. The Judge concludes claimant's claim for workers' compensation benefits for his left knee should be denied and dismissed. In light of this finding, the Judge has not considered the remaining issues raised by claimant.

ORDER

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

1. Claimant's claim for workers' compensation benefits for his left knee is denied and dismissed.

DATED: _November 21, 2008_ Michael E. Harr,

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-317

ISSUES

¬ Did claimant prove by a preponderance of the evidence that his average weekly wage should be increased to more fairly approximate his wage loss?

¬ Did respondents prove by a preponderance of the evidence that claimant willfully failed to obey a reasonable safety rule adopted by employer and that his compensation should be reduced by 50%?

FINDINGS OF FACT

1. Employer operates a grocery warehouse business. Claimant works for employer as an order selector. Claimant's supervisor is T. F. R. V is employer's Risk Manager. Claimant's job duties include operating a pallet jack inside the warehouse building while wearing a headset. Claimant sustained an admitted injury to his right-knee on March 29, 2008, when the pallet jack he was driving collided with a pallet jack driven by J. B. Co-employee, J. D, witnessed the accident.

2. On June 9, 2008, insurer filed a General Admission of Liability, admitting for an average weekly wage (AWW) of $705.53. Insurer calculated the AWW by averaging claimant's earnings over 13 weeks prior to the week ending on March 15, 2008. Insurer reduced claimant's compensation benefits by 50%, asserting claimant willfully violated a safety rule.

3. During calendar year 2007, claimant earned gross wages of $51,374.71, which reflects average weekly earnings of $987.98. F explained that claimant volunteered to work a lot of overtime during calendar year 2007 that is no longer available because employer hired more employees to reduce overtime hours. Claimant cannot reasonably expect to work as much overtime during calendar year 2008 as he worked in 2007. Thus, an average weekly wage based upon claimant's earnings during calendar year 2007 would not fairly approximate his wage loss from the injury in 2008.

4. Claimant earned $10,713.12 over the 14 weeks prior to the week ending March 29, 2008. During several of those weeks, claimant earned over $1,000.00 because of overtime he worked. Employer periodically requests that senior employees work fewer hours when business slows. Claimant answered employer's request to work fewer hours during the week ending February 22, 2008, when he earned $357.79. The wages claimant earned during the week ending February 22nd thus fail to approximate his wage loss from the injury. Subtracting claimant's earnings during the week ending February 22nd leaves gross earnings of $10,355.33 over 13 weeks ($10,713.12 - $357.79 = $10,355.33). The Judge thus finds it more probably true that an AWW of $796.56 more fairly approximates claimant's wage loss from the injury ($10,355.33 divided by 13 weeks equals $796.56).

5. On April 29, 2008, claimant reported to F that his knee was bothering him. F investigated the accident. According to F, claimant and D initially placed blame on B, saying that B ran into claimant's pallet jack. Claimant suggested that F watch the film from one of the surveillance cameras. F later concluded from his investigation that claimant was at fault for the accident.

6. F watched the film of the accident, which is no longer available. F believes the film showed that claimant negligently ran into B's pallet jack. According to F, the film showed the following: Claimant was standing on the warehouse floor and facing D while talking. Claimant then jumped onto his pallet jack and drove forward without looking where he was driving. The film has no sound track, so B could not tell from watching the film whether claimant honked the horn of his pallet jack when he started driving.

7. At F's behest, V also watched the film of the accident. V's testimony about what he saw on the film supports F's account. According to V, claimant negligently ran into B's pallet jack in the heaviest trafficked shipping corridor in the warehouse. V stated that, had claimant looked up when he started driving his pallet jack, he could have avoided the collision. V believes claimant violated safety rule numbers 23 and 33, which provide:

8. Failure to keep eyes on path when performing job, especially when driving, walking through wet or slippery floor hazards.

9. Negligence or carelessness in the use of any type of equipment or performing of work.

10. V stated that claimant would not admit that the collision was his fault.

11. It is more probably true that claimant was reasonably aware of employer's safety rules. Employer posts safety rules at the entrance to the warehouse, in the break room, and in the cafeteria. Supervisors hold bimonthly safety meetings to discuss safety issues with their team members. Claimant attended several safety meetings where the team discussed the following safety issue:
Travel & Traffic, Gotta Look first > Use Horns > move cautiously at aisle ends, doorways, blind spots!

12. The Judge adopts claimant's stipulation in finding that he was aware of the safety rules.
13. D provided F a written statement and also watched the film of the accident. The collision occurred where the end of Aisle 45 intersects the north/south traffic corridor. Crediting D's testimony, the Judge finds the following: Sitting in the north/south traffic corridor at the end of Aisle 45 were two pallets stacked with product. The two pallets were located in the northbound lane just north of the end of aisle 45. The two pallets obstructed the view of northbound operators. Northbound operators had to pull into the southbound lane to navigate around the two pallets. Around 5:00 p.m., claimant was northbound in the north/south traffic corridor headed to the north end of the warehouse to clock out. Claimant stopped to talk to D, who had parked his pallet jack within the end of Aisle 45. Claimant parked his pallet jack in the northbound lane of the north/south traffic corridor at the intersection of Aisle 45.
14. D testified that he observed the following at the time of the collision: Claimant stepped back onto his pallet jack and honked his horn as he started to pull into the southbound lane of the north/south traffic corridor. Because the two pallets obstructed their view, neither D nor claimant could see B driving his pallet jack southward in the southbound lane. Claimant collided with a pallet of product B was carrying on the rear forks of his pallet jack.
15. Claimant's testimony was consistent with that of D: Claimant stopped to tell D he would see him the following week. Claimant stepped onto his pallet jack and looked northward but the two pallets blocked his view. Claimant honked his horn and merged into the southbound lane. B's pallet jack struck claimant. Both B and D asked claimant if he was all right. Claimant answered, "No" as he grabbed his knee in pain. Claimant reported his injury to F at the beginning of the following workweek. F told claimant to take it easy on his knee. On April 29th, claimant requested that F to send him for medical care.
16. Claimant also saw the film, which he believes alike supports his and D's testimony. Claimant believes he exercised reasonable care under the circumstances. Claimant believes B was negligent because claimant had pulled his pallet jack completely into the southbound lane before B collided with his pallet jack.
17. The Judge credits the testimony of claimant and D as direct eyewitnesses to the collision. Both claimant and D described how the two pallets blocked their view looking north into the north/south traffic lane. Neither F nor V refuted that testimony or otherwise discussed how the pallets affected the safety of the northbound operators attempting to navigate around them. Although F and V describe a slightly different version of events based upon the film, D and claimant believe what the film depicts instead supports their version of the facts based upon what they witnessed. Because the film

lacked a sound track, the testimony of claimant and D stating that claimant honked his horn is unrefuted and credible.

18. Respondents failed to show it more probably true than not that claimant willfully violated the above quoted safety rules. It is more probably true that the collision occurred because someone other than claimant or D had blocked the northbound lane of the north/south traffic corridor with loaded pallets, creating an unsafe condition. The pallets obstructed claimant's view of the north/south traffic corridor. Claimant acted in a reasonably safe manner by honking his horn as he pulled into the southbound lane to navigate around the pallets. Crediting his testimony, claimant looked forward before pulling into the southbound lane and could not see B. B reasonably should have anticipated northbound drivers like claimant needing to pull into the southbound lane to navigate around the pallets. The collision could easily have been the result of B's negligence instead of claimant's. Crediting claimant's testimony, it is more probably true that, under the totality of the circumstances, claimant operated his pallet jack in a reasonably safe manner at the time B collided with him. There was no persuasive evidence otherwise showing claimant operated his pallet jack in a willfully negligent or willfully careless manner. Respondents thus failed to prove by a preponderance of the evidence that claimant willfully violated a safety rule.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

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

as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

A. Average Weekly Wage:

Claimant argues he has proven by a preponderance of the evidence that his AWW should be increased to more fairly approximate his wage loss. The Judge agrees.

The Judge must determine an employee's average weekly wage (AWW) by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of injury, which must include any advantage or fringe benefit provided to the employee in lieu of wages. *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995). Section 8-42-102(2), *supra*, requires the JUDGE to base claimant's AWW on his earnings at the time of injury. Under some circumstances, the Judge may determine a claimant's TTD rate based upon his AWW on a date other than the date of injury. *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Section 8-42-102(3), *supra*, grants the Judge discretionary authority to alter that formula if for any reason it will not fairly determine claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective of calculating AWW is to arrive at a fair approximation of claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997).

Here, the Judge found it more probably true that an AWW of $796.56 more fairly approximates claimant's wage loss from the injury. Claimant thus proved by a preponderance of the evidence that his AWW should be increased to $796.56.

As found, claimant cannot reasonably expect to work as much overtime during calendar year 2008 as he worked in 2007. Thus, an average weekly wage based upon claimant's earnings during calendar year 2007 would not fairly approximate his wage loss from the injury in 2008.

As found, claimant earned $10,713.12 over the 14 weeks prior to the week ending March 29, 2008. During several of those weeks, claimant earned over $1,000.00 because of overtime he worked. The Judge however found that the $357.79 in wages claimant earned during the week ending February 22nd failed to fairly approximate his wage loss from the injury. The Judge calculated claimant's AWW based upon earnings of $10,355.33 divided by 13 weeks.

The Judge concludes that insurer should pay claimant compensation benefits based upon an AWW of $796.56.

B. Safety Rule:

Respondents argue they have proven by a preponderance of the evidence that claimant willfully failed to obey a reasonable safety rule adopted by employer and that his compensation should be reduced by 50%. The Judge disagrees.

Sections 8-42-112(1)(a) and (b), *supra*, provide a 50% reduction in compensation where respondents prove either that claimant's injury was caused by the willful failure to use safety devices provided by the employer or that the injury resulted from the employee's willful failure to obey any reasonable rule adopted by the employer for the safety of the employee. The safety rule penalty is only applicable if the violation is willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). Violation of a rule is not willful unless the claimant did the forbidden act with deliberate intention. *Bennett Properties Co. v. Industrial Commission*, 437 P.2d 548 (Colo. 1968); *Stockdale v. Industrial Commission*, 232 P. 669 (Colo. 1925); *Brown v. Great Peaks, Inc.*, W.C. No. 4-368-112 (Industrial Claim Appeals Office, July 29, 1999). Respondents satisfy the burden by showing that the employee knew of the rule yet intentionally performed the forbidden act; respondents need not show that the employee, having the rule in mind, determined to break it. *Stockdale v. Industrial Commission*, 76 Colo. 494, 232 P. 669 (1925).

A violation which is the product of mere negligence, forgetfulness or inadvertence is not willful. *Johnson v. Denver Tramway Corp.*, 171 P.2d 410 (Colo. 1946). Conduct which might otherwise constitute a safety rule violation is not willful misconduct if the employee's actions were intended to facilitate accomplishment of a task or of the employer's business. *Grose v. Riviera Electric*, W.C. No. 4-418-465 (ICAO August 25, 2000). A violation of a safety rule will not be considered willful if the employee can provide some plausible purpose for the conduct. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990).

The Judge found that respondents failed to show it more probably true than not that claimant willfully violated the above quoted safety rules. Respondents thus failed to prove by a preponderance of the evidence that claimant willfully violated a safety rule.

The Judge instead found it more probably true that the collision occurred because of an unsafe condition where someone other than claimant or D had blocked the northbound lane of the north/south traffic corridor with loaded pallets. The pallets obstructed claimant’s view of the north/south traffic corridor.

The Judge credited claimant’s testimony in finding: Claimant acted in a reasonably safe manner by honking his horn as he pulled into the southbound lane to navigate around the pallets. Claimant looked forward before pulling into the southbound lane and could not see B. B reasonably should have anticipated northbound drivers like claimant needing to pull into the southbound lane to navigate around the pallets. The collision could easily have been the result of B’s negligence instead of claimant’s.

The Judge found that, under the totality of the circumstances, claimant operated his pallet jack in a reasonably safe manner at the time B collided with him. There was no persuasive evidence otherwise showing claimant operated his pallet jack in a willfully negligent or willfully careless manner. Respondents thus failed to prove by a preponderance of the evidence that claimant willfully violated a safety rule.

The Judge concludes that respondents request for a 50% reduction of claimant's compensation benefits for allegedly violating a safety rule should be denied and dismissed.

ORDER

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

1. Insurer shall pay claimant compensation benefits based upon an AWW of $796.56.

2. Respondents request for a 50% reduction of claimant's compensation benefits for allegedly violating a safety rule is denied and dismissed.

3. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

4. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _November 18, 2008 Michael E. Harr,

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-477

ISSUES

The issues to be determined are:

1. Compensability.
2. Temporary Disability Benefits from May 19, 2008 and ongoing.
3. Medical benefits, specifically, treatment for Claimant's right shoulder including but not limited to an MRI and physical therapy.
4. Stipulation to an average weekly wage of $385.00.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ finds the following findings of facts:

1. Claimant began working with Respondent-Employer on July 15, 2007. She was employed as a security guard. Part of her duties as a security guard were to make sure the premises of Penrose Hospital were secure and also to perform watches for people requiring special attention. The purpose of a watch was to aid a person who might be intoxicated and who might need protection from himself or herself or protection for the medical staff.

2. Claimant began working her shift May 18, 2008 at midnight and was on duty until 8:00 a.m. on May 18, 2008. During that time, she made rounds of various areas of the hospital. Claimant was in room 19 in the emergency room (ER) beginning shortly after midnight and then continuing until around 5:15 a.m. for a watch. At 5:15 a.m. the person in room 19 was transported to detox and the watch ended.

3. At that time, the Claimant began to patrol various areas of the hospital. Around 6:00 a.m., she was patrolling the ER when she heard loud yelling and screaming coming from the down hall. She walked down the hall to room 19. She saw what appeared to her to be a female patient, in her mid to late teens, lying in the bed. When the patient made eye contact with Claimant, the patient rolled off the bed. Claimant rushed into the room to help lift this patient back onto the bed. Claimant believed the patient's sister was also in the room and the sister helped lift the patient back onto the bed. Claimant used her right arm to help lift the patient.

4. As Claimant was lifting the patient back onto the bed, she felt a tearing and burning sensation in her right shoulder. Not wanting to drop the patient, she switched to the left arm in which she was able to lift the patient into bed. Claimant had shouted out for help when she entered the patient's room. When Claimant was leaving the room Penrose employee Michelle McHugh was coming into the room. Claimant put up the rails to the patient's bed but the patient was sliding down the bed. After Ms. McHugh entered the room she slid the patient up into the bed.

5. Claimant then told the patient's nurse what had happened. And then feeling pain to her shoulder, she spoke to Security Officer James Forrest who was manning the ER entrance. Claimant told Mr. Forrest of her injury and he volunteered to help her fill out any paper work that she might have. Claimant also tried to call her supervisor John Burdan, who told her to "stand by" which means "don't talk to him right now."

6. Around 6:30 a.m., Claimant went to the General Security Office and informed Mr. Burdan of her injury and then she filled out a Worker's Compensation Claim Form. Another supervisor of Claimant, Terri Soto, came on duty at 7:30 a.m. and sent Claimant directly to the ER, against her wishes, and after going to the emergency room for treat-

ment and being released from the ER with her arm in the sling, Claimant met with Ms. Soto to help with any additional paperwork.

7. Claimant was then sent to the workers' compensation doctor at Concentra the next day. The assessment at that time was a rotator cuff strain and rotator cuff tear. The Claimant was told she needed an MRI of her right shoulder and she was to be placed on modified activity with no use of the right arm.

8. After the appointment with Concentra, the Claimant returned to her employer asking for work, and she was told there was no job for her if she could not use her arm. Claimant has not worked since the date that she was injured. It was her understanding that she was on administrative leave and, therefore, she was unable to return to work. Respondent-Employer has not offered claimant employment since the day she was injured.

9. Claimant had an appointment with Dr. Susan Malis at Concentra on July 28, 2008, in which the assessment was a "rotator cuff strain" and she recommended reopening the case due to continuous aspects of impingement and referred Claimant to physical therapy at that time, and if there was no relief, an orthopedic consult. Claimant also went for another follow-up appointment on August 11, 2008, in which there was a similar assessment and a request for an MRI. Claimant was told by the doctor at Concentra that they would not be able to do anything unless an MRI was ordered so they could figure out what was going on inside her shoulder.

10. Claimant sustained a rotator cuff strain or tear to her right shoulder. The objective findings are consistent with the mechanism of injury. Claimant needs physical therapy, an MRI and, possibly an orthopedic evaluation to look at the shoulder.

11. Claimant is still an employee of Respondent-Employer and on administrative leave.

12. Claimant injured her right shoulder in the course and scope of her employment. Claimant's statement that she injured herself while lifting the patient has been consistent throughout the case.

13. The ALJ finds that Claimant is credible and that she was injured in the course and scope of her employment on May 18, 2008. The authorized treating physician gave Claimant restrictions and the Respondent-Employer has failed to offer her modified duty to fit within those restrictions. The ALJ further finds that Claimant needs medical benefits to treat her right shoulder.

CONCLUSIONS OF LAW

10. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2007), 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. (2007). Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. (2007). 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. (2007).

11. In accordance with Section 8-43-215, C.R.S. (2007), 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).

12. 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).

13. Claimant in this matter has the burden of proof of showing by a preponderance of the evidence that she was injured in the course and scope of her employment on May 18, 2008, which led to the injuries of which she now complains. The ALJ finds the Claimant has met her burden of proof showing the injury to her right shoulder is work related. The ALJ concludes that the Claimant is credible. Claimant's reports regarding how she was injured were consistent from the time she first reported her injury and throughout.

14. C.R.S. Section 8-42-101, C.R.S. (2007) provides that employers shall provide those medical benefits as may be reasonably necessary to cure and relieve the employee from the effects of an industrial injury. Claimant sustained a rotator cuff strain or tear to her right shoulder. The objective findings are consistent with the mechanism of injury. Claimant needs physical therapy, an MRI and possibly an orthopedic evaluation to look at the shoulder. Thus, the ALJ finds that the Respondents are responsible for the payment of these medical benefits.

15. Claimant seeks temporary total disability benefits for the period of time that she was unable to work, from the time she was injured on May 18, 2008 and ongoing until terminated by law. Claimant went back to work on May 19, 2008, and was told they could not provide a position for her if she was unable to use her right arm. Claimant is still an employee of Respondent-Employer and on administrative leave. Claimant has not received any income and was unable to work or receive unemployment benefits

since the time that she was injured. Respondents are responsible for the temporary total disability benefits from the first day of work that she was out because of her injury, May 19, 2008 and ongoing until terminated by law.

16. Respondents are responsible for payment of temporary total disability payments to Claimant from May 19, 2008 and ongoing until terminated by law.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado is compensable.
2. Respondent-Insurer shall pay for Claimant's reasonable and necessary medical care to cure or relieve her from the effects of the injury to her right shoulder area, including but not limited to, the treatment recommended as found above.
3. Respondent-Insurer shall pay Claimant temporary total disability benefits from May 19, 2008 and ongoing until terminated by law.
4. Respondent-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.

DATE: November 14, 2008

Donald E. Walsh

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-761-110

ISSUES

The issues litigated before the ALJ include compensability, medical benefits, and temporary total disability benefits. Based upon the finding herein that the claim is not compensable the ALJ does not address the additional issues.

FINDINGS OF FACT

1. Claimant sustained a fall while at work for the Respondent-Employer while she was walking to the restroom from her workstation. Claimant unequivocally states that she did not see what, if anything, made her fall. Claimant stated to her supervisor that she slipped off her shoe causing the fall. Claimant at hearing indicated that she was just guessing as to what may have caused her fall.
2. Subsequent investigation revealed there were no defects in the carpet in the area where the Claimant fell. Additionally, no objects or spilled liquids or materials were found in the vicinity of the fall.

3. Claimant bears the burden of proof to establish she sustained a compensable injury. Claimant's evidence consistently establishes that she does not know what caused her to fall. Her testimony that she was guessing at what may have caused her fall is speculative and not sufficient to establish compensability. Claimant's fall is unexplained.

CONCLUSIONS OF LAW

1. Burden of proof. Claimant has the burden of proving a compensable injury and entitlement to benefits. Sections 8-41-301 and 8-43-201, C.R.S. The WCA has no "presumption of compensability"; instead, WCA cases are to be decided on their merits. Section 8-43-201, C.R.S.; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The question of whether a claimant has met the burden of proof is one of fact for determination by the ALJ. *Faulkner v. Industrial Claim Appeals Office, supra*, (threshold issue of compensability is question of fact for ALJ).

Generally, WCA claims and affirmative defenses must be established by a preponderance of evidence. A "preponderance of evidence" is that which leads the prior-of-fact after considering all evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo.306, 592 P2d 792 (1979).

2. Specific Findings and Conclusions. This decision does not specifically address every item contained in the record. In accordance with Section 8-43-215, C.R.S., this decision contains 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). When the testimony of a witness contains internal inconsistencies or conflicts, an ALJ must resolve them, and may do so by crediting part or none of the witness's testimony. *See In re Gorsuch*, W.C. No. 4-588-229 (ICAO, 7/18/2005) and *In re Lang*, W.C. No. 4-450-747 (ICAO, 5/16/2005), both citing *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968). The ALJ has not addressed and is not required to address every piece of evidence or possible inference in rendering a decision. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Offic*e, 5 P.3d 385 (Colo.App. 2000). Thus, to the extent that there conflicts arising from the testimony of the various witnesses, the findings of fact have resolved those conflicts by making appropriate credibility determinations.

3. In this case, the preponderance of the evidence shows that Claimant was injured when she fell while walking to the restroom at work. Claimant has the burden of proof to establish compensability; however, she was unable to pinpoint any mechanism, object, or condition of the premises as causing her to fall. Additionally, subsequent investigation by the Respondent-Employer revealed no mechanism, object, or condition of the premises. Claimant's evidence consistently establishes that she does not know what caused her to fall. Her testimony that she was guessing at what may have caused her fall is speculative and not sufficient to establish compensability. No special hazards

of employment were implicated in Claimant's injury and none are found by the ALJ. Claimant's fall is unexplained. *Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968); *Rice v. Dayton Hudson Corporation*, W.C. No. 4-386-678 (July 29, 1999).

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: November 26, 2008

Donald E. Walsh
OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-761-823

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable industrial injury to his left shoulder during the course and scope of his employment with Employer on June 1, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

STIPULATIONS

1. The parties agreed that the following entities were authorized medical care providers: (1) Centura Health/Porter Adventist Hospital; (2) HealthOne Occupational Medicine; (3) John W. Dunkle, M.D.; (4) Robert S. Campbell, PA-C; (5) Steve Horan, M.D. and (6) Orthopaedic Physicians of Colorado, P.C.

2. The parties agreed that June 1, 2008 was the last day that Claimant worked for Employer.

FINDINGS OF FACT

1. Claimant is a 54 year-old male who worked for Employer as a deli chef. He began working for Employer in June of 1989. Claimant's job duties included mixing meatloaf, chopping vegetables, cooking pasta, slicing meat, washing dishes and lifting pots and pans.

2. On July 2, 2008 the parties in the present matter proceeded to hearing in Workers' Compensation case number 4-740-420 before the undersigned ALJ. Claimant asserted that he suffered an occupational disease to his right shoulder during the course and scope of his employment with Employer. On August 11, 2008 the undersigned ALJ

entered Findings of Fact, Conclusions of Law and Order. The ALJ concluded that Claimant failed to establish by a preponderance of the evidence that he sustained an occupational disease to his right shoulder during the course and scope of his employment with Employer. Claimant's right shoulder condition was not caused, accelerated, intensified or aggravated by his duties for Employer. The undersigned ALJ thus denied and dismissed Claimant's request for Workers' Compensation benefits.

3. In the present matter, Claimant credibly testified that at approximately 2:00 p.m. on June 1, 2008 he was performing his job duties in a walk-in refrigerator. He reached overhead with his arms to remove a box of vegetables from a shelf that was approximately six to seven feet high off the refrigerator floor. As Claimant pulled out the box of vegetables, another box fell off the shelf towards him. The falling box weighed approximately five pounds. Claimant immediately reacted by fully extending his left arm upwards approximately four to six inches in order to deflect the falling box. Although Claimant successfully deflected the box, he experienced immediate severe pain in his left shoulder.

4. Claimant explained that his supervisor, deli-assistant store manager Amanda Becker, was standing near him in the walk-in refrigerator when the incident occurred. He told her that he had injured his shoulder.

5. After the incident, Claimant left the walk-in refrigerator and filled out paperwork for about 20 minutes. He continued to experience pain in his left shoulder and could not raise his left arm without pain.

6. While completing paperwork Claimant heard an announcement on Employer's public address system that directed him to report to the store office. Claimant arrived at the office between 2:20 and 2:30 p.m. The assistant store managers were present and Claimant reported his left shoulder injury. Because the incident occurred on a Sunday, the assistant store managers instructed Claimant to report to the Emergency Room at Centura Health/Porter Adventist Hospital for medical treatment.

7. Claimant subsequently visited the emergency room at Porter Adventist Hospital. Andrew L. Knaut, M.D. diagnosed Claimant with a probable left shoulder ligamentous injury.

8. On June 2, 2008 Claimant obtained authorized medical treatment from HealthOne Occupational Medicine and Rehabilitation. Robert S. Campbell, PA-C examined Claimant and determined that he had suffered a work-related left rotator cuff tear. He stated that Claimant could return to work with restrictions that included no use of his left arm and wearing a splint "except for gentle range of motion and stretching." PA-C Campbell expected Claimant to reach Maximum Medical Improvement (MMI) within six months if surgery was required.

9. On June 6, 2008 Claimant underwent an MRI of his left shoulder. The MRI revealed that Claimant suffered primarily from a bursal surface tear, but

also had a partial full thickness tear, of his left shoulder. The tear was "possibly acute."

10. Claimant was subsequently referred to Steven E. Horan, M.D. at Orthopaedic Physicians of Colorado. Based on the rotator cuff tear, Dr. Horan recommended surgical intervention.

11. Henry J. Roth, M.D. testified at the hearing in this matter. He explained that Claimant's left shoulder MRI was similar to the MRI findings in Claimant's right shoulder. Dr. Roth stated that both shoulders had downsloping acromioms, AC joint arthrosis, spurring and other degenerative findings. He commented that, because of Claimant's downsloping acromiom, spurring and AC joint arthrosis, he expected Claimant to have a left rotator cuff tear. Dr. Roth thus concluded that a natural degenerative condition caused Claimant's left rotator cuff tear.

12. Nevertheless, Dr. Roth further testified that Claimant's degenerative condition did not necessarily cause his rotator cuff tear. He also acknowledged that an individual with similar degenerative findings might never develop a rotator cuff tear. Moreover, Dr. Roth testified that he could not exclude the possibility that Claimant's left shoulder rotator cuff injury was caused by a sudden, acute event as described by Claimant.

13. Claimant has established that it is more probably true than not that he suffered an industrial injury to his left shoulder during the course and scope of his employment with Employer on June 1, 2008. Claimant credibly explained that, as he pulled a box of vegetables from a shelf in a walk-in freezer, another box fell off the shelf towards him. Claimant reacted by fully extending his left arm upwards approximately four to six inches in order to deflect the falling box. He immediately experienced pain in his left shoulder and suffered a rotator cuff tear. Although Dr. Roth explained that Claimant's rotator cuff tear was caused by a natural degenerative condition, he acknowledged that an individual with Claimant's MRI findings might never develop a rotator cuff tear and could not exclude the possibility that Claimant's injury was caused by a sudden, acute event. Claimant has thus demonstrated that the June 1, 2008 incident aggravated, accelerated, or combined with his pre-existing, degenerative left shoulder condition to produce a need for medical treatment.

14. Claimant has demonstrated that it is more probably true than not that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left shoulder rotator cuff tear. Claimant's need for medical treatment subsequent to June 1, 2008 was designed to alleviate the effects of his left rotator cuff tear.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.*, 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner, 12 P.3d at 846.*

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has established by a preponderance of the evidence that he suffered an industrial injury to his left shoulder during the course and scope of his employment with Employer on June 1, 2008. Claimant credibly explained that, as he pulled a box of vegetables from a shelf in a walk-in freezer, another box fell off the shelf towards him. Claimant reacted by fully extending his left arm upwards approximately four to six inches in order to deflect the falling box. He immediately experienced pain in his left shoulder and suffered a rotator cuff tear. Although Dr. Roth explained that Claimant's rotator cuff tear was caused by a natural degenerative condition, he acknowledged that an individual with Claimant's MRI findings might never develop a rotator cuff tear and could not exclude the possibility that Claimant's injury was caused by a sudden, acute event. Claimant has thus demonstrated that the June 1, 2008 incident aggravated, accelerated, or combined with his pre-existing, degenerative left shoulder condition to produce a need for medical treatment.

Medical Benefits

7. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

8. As found, Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left shoulder rotator cuff tear. Claimant's need for medical treatment subsequent to June 1, 2008 was designed to alleviate the effects of his left rotator cuff tear.

ORDER

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

1. Claimant suffered a compensable left shoulder rotator cuff tear on June 1, 2008.

2. Respondent shall pay all of Claimant's reasonable and necessary medical expenses from his authorized providers as stipulated by the parties. Respondent shall also provide Claimant additional authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his work-related injury.

3. Any issues not resolved by this Order are reserved for future determination.

DATED: November 20, 2008.

_____
Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-762-496

ISSUES

The sole issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was employed as a guide setter. He was responsible for set up to guide pieces of production steel to the next station on the production line. He had to straighten pieces with a sledgehammer. Claimant worked the night shift from 7:00 p.m. to 7:00 a.m.

2. Claimant has been a weight lifter for many years.

3. In January 2006, claimant sought care from his personal physician, Dr. King, due to left shoulder pain that he had experienced for years.

4. On August 15, 2006, Dr. King reexamined claimant, who reported two weeks of left shoulder pain after lifting a cherry picker with his son.

5. On October 15, 2007, Dr. Rowland examined claimant, who reported a history of one and one-half years of left shoulder pain.

6. On May 20, 2008, claimant informed Mr. M, the Production Supervisor, that he had a "kink" in his neck from using a pry bar to try to free up a stuck wedge.

7. On May 20, 2008, Dr. King reexamined claimant, who reported a history of ten days of right shoulder and neck pain. Claimant reported that the previous left shoulder pain from 2006 and 2007 had resolved. Dr. King prescribed Norflex and instructed claimant to continue to use naproxen.

8. Claimant alleges that he suffered a work injury on May 27, 2008 at approximately 4:00 a.m., while hitting a rail with a 12-pound sledgehammer. Claimant had to work in a confined space and had to swing the sledge right-handed only from shoulder height to

approximately knee height. Claimant alleges that after about six swings, he suffered right shoulder pain.

9. Claimant did not report a work injury, but continued to work his normal job duties for the rest of his shift.

10. Claimant went home to rest. At about 1:00 p.m., he sought treatment at the emergency room. Claimant reported that he thought that his “rotator cuff is shot.” Claimant reported a history of right hand numbness and increased pain over three weeks. Claimant reported that he had been receiving cortisone shots from Dr. King.

11. After being released from the emergency room, claimant called Mr. O, his foreman, and told him that he would be unable to return to work. Mr. O told claimant to call Mr. M. Claimant called Mr. M and reported that he had neck problems, but he did not report any work injury.

12. On May 28, 2008, Dr. Nakamura examined claimant, who reported two years of right shoulder pain and receiving three injections. Claimant did not report suffering any work injury the previous day. Dr. Nakamura referred claimant for a magnetic resonance image (“MRI”).

13. On May 29, 2008, claimant took the documentation to Mr. M, but he still did not report that he had been injured using the sledge.

14. The June 3, 2008, MRI showed a probable right shoulder rotator cuff tear.

15. On June 16, 2008, the employer completed the first report of injury, stating that claimant had reported a May 27 injury to his neck using the pry bar and then reported shoulder pain on May 29.

16. On June 20, 2008, Dr. Nakamura reexamined claimant, who reported a history of many months of right shoulder pain.

17. On June 28, 2008, claimant returned to the emergency room and reported shoulder pain for two years, with worsening for three weeks and radiating to the left shoulder.

18. On July 22, 2008, Dr. Ramos performed surgery to repair the right rotator cuff tear.

19. On September 5, 2008, Dr. Hall performed an independent medical examination (“IME”) for claimant. Claimant reported a history of no prior right shoulder problems, although he did report seeing Dr. King one week before the alleged work injury. Dr. Hall noted that he did not have the May 20 notes from Dr. King, but those would be important. Dr. Hall concluded that the reported mechanism of injury was consistent with a work injury to the rotator cuff.

20. On September 30, 2008, Dr. Ridings performed an IME for respondents. Claimant denied any prior right shoulder treatment, although he did mention the May 20 treatment by Dr. King. Dr. Ridings concluded that the injury was not a work-related injury on May 27, 2008. Dr. Ridings noted that the records of Dr. King showed right shoulder symptoms on May 20 and that the reported mechanism of injury was not consistent with a rotator cuff tear.

21. At hearing, Dr. Ridings explained that rotator cuff tears typically occur when the shoulder is forced back down after being abducted and externally rotated or they occur from lifting over 90 degrees. Claimant's reported mechanism of using the sledge did not involve either likely cause for a cuff tear. Dr. Ridings noted that claimant tore his rotator cuff prior to the May 20 appointment with Dr. King. Dr. Ridings noted that, once claimant tore the cuff, any use of the shoulder would cause pain, but it would not cause injury.

22. Claimant has failed to prove by a preponderance of the evidence that he suffered an accidental injury to his right shoulder on May 27, 2008, arising out of and in the course of his employment. The opinion evidence from Dr. Ridings is credible and persuasive. The reported mechanism on May 27 would not be expected to cause a rotator cuff tear, although it would cause pain from the preexisting tear. Claimant already had torn his cuff as of May 20, causing him to seek treatment from Dr. King on that date. He failed to report any work injury on the day in question. He also failed to report any work injury to the medical providers on May 27 and May 28, 2008. Claimant's testimony that his only symptoms on May 20 were neck pain and headaches is not credible.

CONCLUSIONS OF LAW

Claimant must prove that he 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). 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). 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. 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). As found, claimant has failed to prove by a preponderance of the evidence that he suffered an accidental injury

to his right shoulder on May 27, 2008, arising out of and in the course of his employment.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits is denied and dismissed.

DATED: November 10, 2008 Martin D. Stuber

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-299

ISSUES

The issue to be determined by this decision is the following:

1. Compensability

PROCEDURAL MATTERS

Claimant's Exhibits 1-3 were admitted into evidence. Respondents' Exhibits A-H were admitted into evidence.

The parties reached the following stipulations:

1. If the claim is found compensable, Respondents will pay Claimant TTD from June 26, 2008 through July 17, 2008.

2. Claimant's average weekly wage is $421.69.

3. Respondents referred Claimant to Dr. Denzel at Greeley Quick Care. Respondents will pay the expenses at Greeley Quick Care and Dr. Denzel.

4. If the claim is found compensable, Respondents will pay the expenses at Sunrise Community Health Center.

5. Claimant will choose an authorized treating physician through negotiation with Respondents.

These stipulations were approved and accepted by the ALJ.

FINDINGS OF FACT

1. Claimant was employed as a yardman with Employer on May 29, 2008. His job duties included loading, unloading and assembling products. Claimant was required to lift 5 lbs. to 200 lbs. The job was physically demanding and claimant was typically sore at the end of a workday.

2. Claimant testified that on May 29, 2008 he unloaded 154 bales of alfalfa with two other workers. Following the unloading of the alfalfa, Claimant testified that he then unloaded and stacked straw. Claimant alleges he sustained a right shoulder injury performing this work.

3. Claimant initially testified that he did not report the shoulder injury until one month later, on approximately June 25, 2008 because he did not realize he was injured. Claimant thought he had the normal aches and pains from a hard day at work. When the symptoms did not improve he allegedly reported the injury. However, on cross-examination Claimant testified that he answered interrogatories stating that he reported the shoulder injury to his supervisor on May 29, 2008.

4. Claimant testified at hearing that he began taking Advil following May 29, 2008. When his pain was not relieved he requested that he be seen by a workers' compensation doctor. He was sent to Dr. Denzel by his employer. Claimant testified that he reported the injury in writing on June 25, 2008. However, the only written report of injury is dated June 27, 2008 on which date claimant authored a noted stating that he injured his right shoulder on May 29, 2008 during work at which time he advised his supervisor M. *Respondents' Exhibit H.*

5. Claimant agreed there was a tornado in the Greeley-Windsor area in late May 2008. Following the tornado, his roof needed to be re-shingled. Claimant denied doing the work himself. Claimant alleges the heavy work was done by his son-in-law and that Claimant did not do the work. Claimant denies telling anyone he was injured while shingling his roof.

6. Mr. B was not present on the day of Claimant's alleged injury. Mr. B returned to work on or about June 3, 2008. He did notice that Claimant was favoring his shoulder. When he inquired what was wrong, Claimant told him he had been working on his own roof that weekend and his shoulder was sore. Claimant did not mention a shoulder injury again until June 25, 2008. Mr. B testified that Claimant was able to complete his normal work duties and did not appear to have any problems using his shoulder.

7. Mr. W testified that between May 29, 2008 and June 25, 2008 Claimant did not complain of shoulder pain. Mr. W was working with Claimant on the date of the alleged injury. Claimant did not report shoulder pain and did not mention a shoulder injury while unloading bales of alfalfa and stacking straw. Claimant did not appear to have any prob-

lems while working. Claimant continued to work his regular job duties that required heavy lifting on a daily basis.

8. Mr. W testified that they did not unload the bales of alfalfa and straw on the same day. They were unloaded on different days. Mr. W testified further that Claimant was working with heavy tarps weighing 50-60 lbs. on or around June 13, 2008. Claimant did not complain of shoulder pain or exhibit any noticeable difficulties.

9. Mr. M testified that Claimant did not work on June 24, 2008. When Claimant reported to work on June 25, 2008 he informed Mr. M that he had injured his shoulder unloading alfalfa in May 2008 and wanted to see a doctor. Mr. M testified further that the unloading and stacking of alfalfa and hay did not occur on the same day as alleged by Claimant.

10. The testimony of M, W and B is found persuasive and credible. Claimant did not sustain an injury while in the course and scope of employment with Employer.

11. The testimony of Claimant is not credible or persuasive. Claimant has failed to prove by a preponderance of the evidence that he sustained an injury in the course and scope of employment with Employer.

CONCLUSIONS OF LAW

1. A claimant is required to prove that an injury arose out of and in the course of the claimant's employment. *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844 (Colo. Ct. App. 2000). To prove compensability, a claimant must show both an "accident" and resulting "injury." Accident refers to an "unexpected, unusual or undersigned occurrence." Colo. Rev. Stat. § 8-40-201(1) (2007). In contrast, "injury" refers to the physical trauma caused by the accident. *City of Boulder v. Payne*, 426 P.2d 194 (Colo. 1967). No benefits flow to the victim of an industrial accident unless an "accident" results in a compensable "injury." Compensable injuries involve an "injury" which requires medical treatment or causes disability. *H&H Warehouse v. Victory*, 805 P.2d 1167, 1169 (Colo. Ct. App. 1990). All other "accidents" are not compensable injuries. *Ramirez v. Safeway Steel Prods. Inc.*, W.C. No. 4-538-161 (I.C.A.O. Sept. 16, 2003).

2. Arising out of employment requires the claimant to prove "a causal connection between the employment and injuries such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract." *Madden v. Mountain W. Fabricators*, 977 P.2d 861, 863 (Colo. 1999). Course of employment refers to the time, place and circumstances of the claimant's injury. *Wild West Radio, Inc. v. Indus. Claim Appeals Office*, 905 P.2d 6 (Colo. Ct. App. 1995).

3. It is claimant's burden to prove by a preponderance of the evidence that he was injured in the course and scope of employment. 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). The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. § 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 failed to prove by a preponderance of the evidence that he was injured in the course and scope of employment. Cory W credibly testified that in June 2008 claimant told him he had been working on his roof. It was after this activity that Claimant began complaining of shoulder pain. Claimant worked from May 29, 2008 through June 25, 2008 and did not mention a shoulder injury while unloading bales of alfalfa and straw. Claimant continued to work his regular job that required daily heavy lifting. Claimant did not appear to have any problem with his right shoulder during this time.

5. Troy B credibly testified that Claimant told he had been working on his roof over the weekend and injured his shoulder.

6. Claimant testified that he unloaded many bales of alfalfa and straw back to back on May 29, 2008. However Cory W and Robert M testified credibly that the alfalfa and straw were unloaded on different days. Claimant initially testified that he reported the injury on May 29, 2008. On cross-examination claimant admitted that he stated in his answers to interrogatories he did not report the injury until June 25, 2008. Claimant's testimony is not credible or persuasive. He has failed to sustain his burden of proof to show by a preponderance of the evidence that he was injured in the course and scope of his employment.

ORDER

IT IS, THEREFORE, ORDERED THAT Claimant's claim for workers' compensation benefits is hereby denied and dismissed.

DATED: November 25, 2008 Barbara S. Henk

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-892

ISSUES

The sole issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was employed as a slot attendant for the employer.
2. On September 12, 2006, claimant sought treatment from his personal physician, Dr. Jensen-Fox, due to hearing loss and tinnitus. On November 6, 2006, Dr. Jensen-Fox reexamined claimant, who complained of hearing loss, tinnitus, and two days of nausea, dizziness, and diarrhea.
3. On November 8, 2006, claimant was found sitting on the bench in the employee locker room. He had complained previously of an upset stomach.
4. On November 15, 2006, Dr. Jensen-Fox diagnosed vertigo and noted that claimant's brain magnetic resonance image ("MRI") was normal.
5. On June 19, 2008, claimant was working the 8:00 a.m. to 4:00 p.m. shift for the employer. Claimant felt ill and told Mr. B that his stomach was upset. Claimant went to the public restroom in the employer's premises. Claimant believed the time was approximately 10:00 a.m. As a matter of fact, the time was much later. Claimant alleges that his right foot slipped out from under him and he fell straight onto his back and head.
6. Mr. B, the lead security person on June 19, 2008, answered a radio call about claimant being found on the floor. He found claimant lying on his back with his arms and legs perfectly straight. Claimant was mumbling incoherently. Mr. B found no moisture on the floor around claimant. Mr. B remained with claimant until the emergency medical technicians ("EMTs") arrived. At that time, claimant moaned in pain when he was loaded on a backboard.
7. Mr. S, a key manager, went to the restroom and found claimant lying on his back with his arms rigid, unresponsive, and mumbling. Mr. S found no substance on the floor around claimant.
8. Mr. M, another key manager, went to the restroom and found claimant lying on his back "at attention." Mr. M found no substance on the floor around claimant.
9. The EMTs arrived at 1:30 p.m. and transported claimant to the emergency room. At the hospital, clamant reported a history of slipping in the restroom and suffering pain to his back and to the back of his head. Claimant underwent computerized tomography ("CT") scans of his head and neck and x-rays of his low back. The physician diagnosed back contusion, muscle spasm, and mild concussion.
10. Claimant reported his injury as a work-related injury. The employer referred him to Dr. Wever. On June 23, 2008, Dr. Wever examined claimant, who reported the history of the slip and fall in the restroom. Dr. Wever diagnosed whiplash and minor concussion. He excused claimant from work for one week and referred him to physical therapy. Claimant attended one therapy session and then stopped going.
11. Claimant canceled his June 30, 2008, reexamination by Dr. Wever. He failed to set another appointment. Eventually, the respondents set a new appointment date of July 18, 2008.
12. In the meantime, the employer terminated claimant's employment on July 11, 2008.
13. On July 18, 2008, Dr. Wever reexamined claimant and noted that he suspected secondary gain. Dr. Wever requested that the physical therapist resume treatment of claimant. Dr. Wever excused claimant from work through July 25.

14. On July 25, 2005, Dr. Wever reexamined claimant and concluded that he thought that claimant was legitimately hurt in the described incident. He noted that the x-rays showed chronic changes in the back. He referred claimant to Dr. Oliveira, a neurologist.

15. On August 4, 2008, Dr. Rook performed an independent medical examination ("IME") for claimant. Claimant reported the history of the slip and fall. Dr. Rook diagnosed posttraumatic headache, cervical strain, left sacroiliac joint strain, cognitive complaints, and sleep disturbance.

16. On August 5, 2008, Dr. Oliveira examined claimant, who provided the history of the slip and fall. Dr. Oliveira diagnosed typical posttraumatic headaches and low back pain with probable left S1 radiculopathy.

17. An August 12 brain MRI showed mild deep white matter ischemic changes. A lumbar MRI showed disc bulges at all levels with no neurological impingement.

18. On September 3, 2008, Dr. Hammerberg performed an IME for respondents. He diagnosed posttraumatic headache, cervical strain, and lumbar strain. He recommended ear, nose, and throat ("ENT") evaluation with vestibular testing.

19. On September 17, 2008, Dr. Lipkin, an otolaryngologist, examined claimant, who reported a two-year history of hearing loss and tinnitus with no vestibular symptoms. Dr. Lipkin concluded that the alleged work injury did not cause any change in ENT status.

20. Claimant has failed to prove by a preponderance of the evidence that he suffered an accidental injury on June 19, 2008, arising out of and in the course of his employment. Claimant's testimony is not credible. Claimant's case has three principal problems: he had a preexisting history of similar nausea and dizziness, the restroom floor had no water or other substance causing a slip hazard, and claimant was found lying straight on his back with his arms and legs straight. It is unlikely that claimant would fall into such a position either from a slip or from dizziness. The trier-of-fact cannot say with any probability that claimant slipped on the floor and fell, causing injury. It is a possibility, but not a probability.

CONCLUSIONS OF LAW

1. Claimant must prove that he 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). 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). 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. 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). 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, claimant has failed to prove by a preponderance of the evidence that he suffered an injury arising out of and in the course of his employment.

ORDER

It is therefore ordered that Claimant's claim for compensation and benefits is denied and dismissed.

DATED: November 26, 2008 Martin D. Stuber

5. After the March 20, 2008 incident Claimant completed his job duties for Employer over the next two and one-half months. However, Claimant explained that his work activities aggravated his knee pain and caused swelling on a daily basis.

6. On June 17, 2008 Employer terminated Claimant from employment. Employer's owner RR testified that he had expected Claimant to learn the trade and become a foreman for Employer but Claimant failed to demonstrate any initiative. He specifically noted that he worked with Claimant on a project during May of 2008. Claimant worked slowly, inefficiently and required more time than other employees to complete his job tasks. Mr. R terminated Claimant on June 17, 2008 because Claimant was the wrong person for the job, worked slowly and did not desire to learn the technical aspects of the business.

7. On June 25, 2008 Claimant visited Edward H. Parks, M.D. to obtain medical treatment for left elbow pain and left knee pain. Claimant reported that, while working on March 20, 2008, he was climbing down a ladder into a cistern. He missed the last three steps of the ladder and fell approximately six feet. Claimant explained that he did not immediately seek medical treatment but continued to experience swelling and discomfort in his left knee.

8. X-rays of Claimant's left knee did not reveal any fractures or lesions. Dr. Parks thus diagnosed a "possible meniscus tear" and "lateral epicondylitis." He then administered cortisone injections into Claimant's left elbow and left knee.

9. On July 3, 2008 Claimant filed a Worker's Claim for Compensation. He reported that he was climbing down a ladder in a concrete vA on March 20, 2008 while performing his job duties for Employer. He fell off the ladder, twisted and landed on his left knee at the bottom of the vA. Claimant noted that, because his left knee condition continued to worsen, he visited Dr. Parks on June 25, 2008.

10. On August 6, 2008 Claimant engaged in a telephone discussion with Dr. Parks. Dr. Parks recommended an MRI of Claimant's left knee.

11. Claimant has proven that it is more probably true than not that he sustained a left knee injury on March 20, 2008 during the course and scope of his employment with Employer. Claimant credibly testified that he descended into a collection tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee, and fell several feet to the bottom of the tank. Claimant immediately experienced left knee pain but completed his work shift. Claimant's supervisor Mr. P corroborated Claimant's account of the incident in the collection tank. Furthermore, the medical records of Dr. Parks regarding the March 20, 2008 incident are consistent with Claimant's account. The March 20, 2008 incident thus aggravated, accelerated, or combined with Claimant's pre-existing left knee condition to produce a need for medical treatment.

12. Claimant has demonstrated that it is more probably true than not that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left knee injury. Claimant credibly explained that, although he performed his job duties for approximately two and one-half months after the incident, he continued to experience swelling and discomfort in his left knee. Because x-rays of Claimant's left knee did not reveal any fractures or lesions, Dr. Parks diagnosed a "possible meniscus tear" and "lateral epicondylitis." Dr. Parks subsequently recommended an MRI of Claimant's left

knee. Claimant's medical treatment with Dr. Parks and an MRI of his left knee are designed to evaluate his left knee condition and relieve the effects of the March 20, 2008 incident.

13. Claimant has failed to establish that it is more probably true that not that he is entitled to TTD benefits. He has not proven that his March 20, 2008 industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. Claimant continued to perform his job duties for approximately two and one-half months after he injured his left knee. Although he experienced pain and swelling in his left knee as a result of his job activities, he did not suffer a wage loss. Claimant did not cease working for Employer until June 17, 2008 when he was terminated from employment based on an unsatisfactory job performance.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-

301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp*., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner, 12 P.3d at 846.*

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has proven by a preponderance of the evidence that he sustained a left knee injury on March 20, 2008 during the course and scope of his employment with Employer. Claimant credibly testified that he descended into a collection tank on rungs that were attached to a concrete wall. He lost his balance, missed the last rung, twisted his left knee, and fell several feet to the bottom of the tank. Claimant immediately experienced left knee pain but completed his work shift. Claimant's supervisor Mr. P corroborated Claimant's account of the incident in the collection tank. Furthermore, the medical records of Dr. Parks regarding the March 20, 2008 incident are consistent with Claimant's account. The March 20, 2008 incident thus aggravated, accelerated, or combined with Claimant's pre-existing left knee condition to produce a need for medical treatment.

Medical Benefits

7. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

8. As found, Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his left knee injury. Claimant credibly explained that, although he performed his job duties for approximately two and one-half months after the incident, he continued to experience swelling and discomfort in his left knee. Because x-rays of Claimant's left knee did not

reveal any fractures or lesions, Dr. Parks diagnosed a "possible meniscus tear" and "lateral epicondylitis." Dr. Parks subsequently recommended an MRI of Claimant's left knee. Claimant's medical treatment with Dr. Parks and an MRI of his left knee are designed to evaluate his left knee condition and relieve the effects of the March 20, 2008 incident.

Temporary Total Disability Benefits

9. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S. To demonstrate entitlement to TTD benefits a 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). 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 a claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). A claimant suffers from an impairment of earning capacity when he has a complete inability to work or there are restrictions that impair his ability to effectively and properly perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

10. As found, Claimant has failed to establish by a preponderance of the evidence that he is entitled to TTD benefits. He has not proven that his March 20, 2008 industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. Claimant continued to perform his job duties for approximately two and one-half months after he injured his left knee. Although he experienced pain and swelling in his left knee as a result of his job activities, he did not suffer a wage loss. Claimant did not cease working for Employer until June 17, 2008 when he was terminated from employment based on an unsatisfactory job performance.

ORDER

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

1. Claimant suffered a compensable left knee injury on March 20, 2008.

2. Respondents shall pay for all of Claimant's authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his work-related left knee injury.

3. Claimant's request for TTD benefits is denied and dismissed. It is therefore unnecessary to address Respondents' contention that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment under the termination statutes.

4. Any issues not resolved by this Order are reserved for future determination.

DATED: Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-710-481

ISSUES

¬ Did respondents overcome by clear and convincing evidence the determination of Dr. Machanic that claimant's injury includes a cervical spine component and that claimant has not reached maximum medical improvement?
¬ Did respondents overcome by clear and convincing evidence the determination of Dr. Machanic that claimant's cognitive impairment warrants a rating of 20% of the whole person?

FINDINGS OF FACT

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

1. Claimant's date of birth is August 6, 1950; his age at the time of hearing was 58 years. Employer operates a propane gas distribution business. Claimant works for employer as a yard supervisor. Claimant sustained an admitted injury from a slip and fall on ice while working in employer's yard on November 30, 2006. Claimant completed an Injury and Illness Report form, indicating he injured his head, neck, and back.
2. Claimant lost no time and continued working his regular job, until January, when he developed a 4-day history of headaches. Claimant sought medical treatment from Ann Trawick, D.O., on January 4, 2007. Claimant mentioned to Dr. Trawick that he fell while working, hit his head, and may have lost consciousness. Upon examination of claimant, Dr. Trawick found his cervical region supple and non-tender. Dr. Trawick noted that claimant had normal mental status, normal neurosensory, and normal cerebellar function examinations. Dr. Trawick suspected some intracranial process and referred claimant for a CT scan of his head and brain.
3. Claimant underwent the CT scan on January 4th, which revealed a moderate, acute, right-sided subdural hematoma. Dr. Trawick referred claimant to Neurosurgeon Thomas C. Ribovich, M.D.

4. Dr. Ribovich evaluated claimant on January 5, 2007, when claimant neither complained of any neck symptoms nor complained of any memory loss or cognitive problems. On physical examination, Dr. Ribovich noted claimant's neck was supple. Dr. Ribovich noted that Claimant exhibited full upper and lower extremity strength and normal fine motor movements of both hands. Dr. Ribovich read the CT scan as revealing new fluid mixed with preexisting fluid in the subdural space. Dr. Ribovich recommended surgical evacuation of the fluid from the subdural space the following Monday.

5. Also on January 5th, Dr. Trawick's colleague Lisa Gieseke, D.O., performed a pre-op physical examination of claimant. Claimant did not complain to Dr. Gieseke of any neck symptoms. Dr. Gieseke noted that claimant's neck was supple, non-tender and that he had full range of motion. Dr. Gieseke also noted that claimant was alert cooperative and oriented, revealing a normal mental status examination.

6. Dr. Ribovich performed a right-frontal craniotomy with evacuation of the subdural hematoma on January 8, 2007. Dr. Ribovich noted that, following evacuation of the fluid, claimant's brain re-expanded into the subdural space. A post-operative CT scan revealed a successful outcome from surgery. Dr. Ribovich discharged claimant from the hospital on January 11, 2007.

7. On January 18, 2007, Dr. Ribovich noted claimant doing quite well, other than some complaints of headaches and lightheadedness, secondary to Dilantin -- his anti-seizure medication. On February 22, 2007, Dr. Ribovich noted that claimant continued to complain of lightheadedness and slight imbalance, again secondary to the Dilantin. Another CT scan continued to reveal satisfactory evacuation of the subdural space. On March 22, 2007, Dr. Ribovich released claimant to return to work with some restrictions. Dr. Ribovich planned to keep claimant on Dilantin for another month.

8. On May 1, 2007, Dr. Ribovich discharged claimant and released him to return to full-time work. Dr. Ribovich noted that claimant had discontinued his use of Dilantin. Dr. Ribovich advised claimant to return on an "as needed" basis. Claimant did not complain to Dr. Ribovich of any neck pain or cognitive problems.

9. Claimant returned to Dr. Trawick for an evaluation on July 12, 2007, when his daughter accompanied him. Claimant complained of persistent headaches. Dr. Trawick recorded the following history of neck complaints:

> [Claimant] also notices neck pain every day and sometimes has popping, certain positions … makes (sic) him have sharp shooting pain down his arm and will get momentary tingling in his hands.

****

> **No history of recent or remote neck problems, car accidents, work injuries**.

Claimant thus did not relate his onset of neck complaints in July of 2007 to his slip and fall injury at employer the preceding November. Claimant's daughter reported that claimant's memory was not as good. Because of radicular symptoms, Dr. Trawick suspected claimant's headaches might be the result of a cervical disk problem. Dr. Trawick recommended magnetic resonance imaging (MRI) scans of claimant's cervical spine and head. Dr.

> Trawick later noted that claimant's private health insurance refused to authorize the MRIs, asserting they were for work-related conditions. The Judge infers that Dr. Trawick believed that claimant's cervical condition, by history, was unrelated to his slip and fall at employer some 7 months earlier on November 30, 2006.

10. Insurer referred claimant to Lawrence A. Lesnak, D.O., for an assessment of his permanent medical impairment from the subdural hematoma injury. Dr. Lesnak spent some 70 – 80 minutes with claimant and his daughter when examining him on August 1, 2007. Dr. Lesnak noted that claimant had returned to full-duty work at employer as a yard supervisor/forklift operator. Dr. Lesnak noted:

> [Claimant] was pleasant and cooperative throughout today's interview and evaluation. He was awake, alert, and oriented x 3 during today's evaluation. He had fluent speech patterns and showed no specific signs of semantic or phonemic language errors.
>
> ****
>
> He was able to perform abstract thinking without difficulty. Simple calculations seemed to be intact.
>
> The only cognitive complaints claimant reported to Dr. Lesnak involved intermittent memory difficulties.

11. Dr. Lesnak also recorded a history from claimant that he developed neck and upper back pain and headache immediately following his slip and fall injury on November 30, 2006. Dr. Lesnak later testified that this history of immediate neck symptoms is inconsistent with the history established by claimant's medical records. Upon physical examination, Dr. Lesnak noted limitations in claimant's cervical range of motion due to complaints of pain. At the time of his initial report, Dr. Lesnak had an incomplete set of Dr. Ribovich's records and lacked a complete set of Dr. Trawick's reports. Dr. Lesnak thought it possible claimant had sustained a neck strain, but he lacked documentation he felt he needed to give an evidence-based, medically probable medical opinion on causation of claimant's cervical condition.

12. Dr. Lesnak placed claimant at maximum medical improvement (MMI) as of May 1, 2007, and assessed his brain impairment from subdural hematoma injury according to the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides). Dr. Lesnak rated claimant's impairment at 5% of the whole person based upon his head injury and cognitive deficits.

13. On August 15, 2007, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability (PPD) benefits based upon Dr. Lesnak's impairment rating. Claimant timely objected to the FAL and requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Neurologist Bennett I. Machanic, M.D., the DIME physician. Claimant also filed an application for hearing dated September 18, 2007, specifically endorsing compensability of the neck. The hearing set on claimant's application was continued pend-

ing the results of Dr. Mechanic's DIME. All issues were reserved pursuant to order dated January 2, 2008.

14. At the request of claimant's counsel, John S. Hughes, M.D., performed an independent medical examination on September 13, 2007. Dr. Hughes also testified as an expert on Occupational Medicine. Dr. Hughes noted that claimant had returned to work and was working full duty. Claimant reported to Dr. Hughes that his main complaint was neck pain, possibly causing his headaches. Regarding his brain functioning, claimant and his daughter reported there are times when he forgets things, like where he parks his car. Based upon his evaluation, Dr. Hughes assessed persistent disturbance of complex integrated cerebral function, secondary to his closed-head injury. Dr. Hughes wrote:

> I agree completely with Dr. Lesnak that [claimant] manifests a disturbance of his complex integrated cerebral function. However, **findings that I note on examination today seem measurably worse than those that were noted six weeks ago by Dr. Lesnak**.

(Emphasis added). While Dr. Hughes recommended a neuropsychological evaluation to assess the magnitude of claimant's post subdural hematoma brain injury, Dr. Hughes estimated claimant's permanent impairment at 15% of the whole person according to the AMA Guides. Dr. Hughes based this estimate upon what claimant and his daughter reported to him on September 13, 2007.

15. Dr. Hughes opined that claimant had not reached MMI because he needed treatment for the cervical spine component of his injury. Dr. Hughes recommended a MRI scan of claimant's cervical spine to assess for impingement of the neural foramina. Dr. Hughes provisionally assessed impairment of claimant's cervical spine at 9% of the whole person.

16. Dr. Machanic evaluated claimant on December 20, 2007, when he obtained the following history from claimant and from his daughter.

> [Claimant] has a good deal of difficulty with cognitive function. His daughter feels she must care for him almost constantly. She says that he is forgetful. He has poor focus and concentration. He loses items. He has a poor sense of humor. He is moody and irritable. He is restless. He often forgets one task, and when he attempts to multitask, he becomes very confused, indeed. [Claimant's] daughter tells me that not only does he have difficulty with his memory and intellectual function but also with his behavior. She says he is "not the same as he was before this injury".
>
> The **daughter further freely expresses her disappointment** regarding the sequence of events.

> (Emphasis added). The above-quoted history given by claimant's daughter is markedly inconsistent with what she and claimant gave to Dr. Lesnak and to Dr. Hughes. Dr. Hughes remarked some 6 weeks after Dr. Lesnak's evaluation that claimant and his daughter had given him a history of cognitive problems markedly worse than what they gave Dr. Lesnak. The above-quoted history is markedly worse than what they gave Dr. Hughes.

17. While Dr. Machanic agreed that claimant had reached MMI for his head injury as of May 1, 2007, he opined that claimant should undergo neuropsychological testing. Dr. Machanic's recommendation for neuropsychological testing mirrors the recommendation of Dr. Hughes. The Judge interprets this recommendation as a request for neuropsychological testing to more accurately determine the extent of claimant's cognitive impairment. Dr. Machanic nonetheless rated claimant's cognitive impairment at 20% of the whole person, based upon the history he received from claimant and his daughter.

18. Dr. Machanic determined that claimant's cervical spine condition is causally related to his slip and fall at employer on November 30, 2006. Dr. Machanic opined that claimant had not reached MMI for the cervical spine component of his injury. Dr. Machanic recommended that claimant undergo a MRI scan of his neck. Dr. Machanic provisionally rated the impairment to the cervical region of claimant's spine at 13% of the whole person. Dr. Machanic's determination that claimant's cervical spine condition is causally related to his work injury, that he sustained cognitive impairment rated at 20% of the whole person, that he sustained impairment to the cervical region of his spine rated at 13% of the whole person, and that the 13% and 20% values combine into an overall rating of 30% under the AMA Guides is presumptively correct unless overcome by clear and convincing evidence.

19. Clinical Neuropsychologist Gregory A. Thwaites, Ph.D., performed an independent neuropsychological evaluation of claimant on April 11, 2008. Claimant told Dr. Thwaites he believes his cognitive problems began with the surgical evacuation of the subdural hematoma. Dr. Thwaites however noted from the medical records that claimant's subdural hematoma evacuation was performed without anesthetic or surgical complications; that hospital records fail to suggest any cognitive complaints or signs of cognitive problems; and that follow-up visits with Dr. Ribovich and Dr. Trawick fail to reflect any neurocognitive complaints or observations. Dr. Thwaites noted that claimant's complaints of cognitive problems were mild to Dr. Lesnak but increasingly severe with each subsequent evaluator. Dr. Thwaites noted that claimant displayed a significant level of impairment during his evaluation that is incongruent with his reported level of vocational functioning – claimant reported to Dr. Thwaites that he continues to drive and works full-time. Dr. Thwaites thus noted that claimant exhibited response bias and that his reported level of functioning was inconsistent with his continued ability to perform his supervisory position for the employer. Dr. Thwaites testified that claimant did not appear to have any cognitive problems and again cautioned that he would only assess the claimant with a very mild cognitive impairment if he even had any cognitive impairment at all.

20. At respondents' request, Neurologist Peter S. Quintero, M.D., examined claimant for a neurological consultation on May 16, 2008. Dr. Quintero also testified as an expert

in General Neurology. Claimant reported to Dr. Quintero that he feels forgetful and tends to misplace things. Claimant told Dr. Quintero he might plan something and then forget what he planned. Dr. Quintero reported:

> In spite of the problems [claimant] described with memory, headache, neck and back pain, he has continued to function on a fairly normal level. [Claimant] awakens in the morning with an alarm …. He gets up before his wife. He takes a shower. He does not eat breakfast nor does he prepare coffee. He did relate that he did eat breakfast prior to the accident. **[Claimant] then drives to work. He drives a van**.
>
> [Claimant] has continued to work full-time. He still works in the capacity of a supervisor and forklift operator. He stated that he is not aware of any problems doing his work. His work does require that he do paperwork which he has been able to do without difficulty. [Claimant] has not received any criticisms or bad reviews for his work.

(Emphasis added). This history of continuing to drive is consistent with what claimant reported to Dr. Thwaites, but contrary to what claimant's daughter told Dr. Hughes when she reported they did not allow claimant to drive anymore.

21. Dr. Quintero documented other discrepancies between what claimant reported to him and what the medical records supported. For instance, claimant reported to Dr. Quintero that his headaches were constant and gradually worsening since the slip and fall accident. The medical records however showed claimant initially reporting in January of 2007 that his headache following the accident dissipated until 4 days prior to January 4th. And claimant told Dr. Machanic that his headache was intermittent, lasting 45 to 60 minutes, rather than a constant headache. Dr. Quintero cited other discrepancies in his report. Dr. Quintero opined:

> Taking into account what is documented in the medical records in comparison to what [claimant] now describes, I strongly suspect an **underlying problem with symptom magnification**.
>
> ****
>
> A complete battery of neuropsychological testing would help to clarify the etiology of [claimant's] cognitive symptoms and would help to rule out symptom magnification as a contributing factor.

(Emphasis added). Like Dr. Machanic and Dr. Hughes, Dr. Quintero recommends neuropsychological testing to answer the inconsistencies between cognitive problems claimant was reporting to evaluators of permanent impairment and the absence of cognitive problems he reported to his treating physicians. At the time he prepared his report, Dr. Quintero did not have Dr. Thwaites's report. Dr.

Quintero found no basis for functional impairment based upon the medical records and his nuerological evaluation.

22. Dr. Quintero noted that Claimant reported that he was able to complete his supervisory job duties, including paperwork and reports, without any problems. Claimant further reported to Dr. Quintero that he was able to do his job effectively and had not received any complaints about his work. Dr. Quintero opined that Claimant's delay in developing headaches after the accident was understandable; however, there was no explanation for the delay in developing neck symptoms or cognitive problems. Dr. Quintero suspected an underlying problem with symptom magnification.

23. On May 23, 2008, claimant underwent a MRI scan of his cervical spine. Crediting Dr. Quintero's medical opinion, the MRI scan revealed spondylosis – a chronic, progressive degenerative disease of the cervical spine. Crediting Dr. Hughes's medical opinion, the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with the idea that claimant's neck problems are related to an aging process instead of an injury process.

24. Dr. Thwaites testified to the following as an expert in Clinical Neuropsychology: Dr. Thwaites had no problem communicating with claimant. Dr. Thwaites administered a battery of tests to claimant to determine how he measured against his peer group of the same gender and age. Dr. Thwaites weighed inhibiting factors such as the amount of sleep claimant got the night before and other factors that affect his performance on the testing. Claimant performed quite poorly on testing to assess the effort he was giving; he scored lower than he should have on a very easy test. The course of claimant's symptoms immediately following his concussion was typical because symptoms resolved on November 30th. Claimant reported to Dr. Thwaites no cognitive problems until after the surgical procedure to evacuate the subdural hematoma. What claimant told Dr. Thwaites however was inconsistent with the medical records, which show no evidence of cognitive difficulty.

25. According to Dr. Thwaites, claimant's reported pattern of recovery is inconsistent with the typical pattern for patients with brain injuries. The typical brain-injured patient has worse symptoms after the injury, which improve with the passage of time. Claimant's report of more severe symptoms with the passage of time fails to make neurologic sense. Dr. Quintero's testimony that claimant's report of symptoms is contrary to the normal progression of patients with subdural hematomas supports the testimony of Dr. Thwaites. Dr. Quintero agrees that claimant's cognitive symptoms typically would be present while the hematoma is pressing upon the brain – just prior to surgery.

26. Dr. Thwaites further stated: Claimant's poor scoring on motivation and other cognitive tasks is inconsistent with his performance vocationally at work. Claimant's work also involves driving heavy equipment. Claimant's level of performance was further inconsistent with the fact that claimant drove himself to the evaluation. Dr. Thwaites thus opined that claimant presented worse on testing than he functions in everyday life. Dr. Thwaites thus disagrees with Dr. Machanic's assessment of claimant's cognitive impairment. Dr. Thwaites believes claimant sustained a moderate brain injury, with possible mild cognitive impairment.

27. According to Dr. Hughes, brain-injured patients often need help from family members to provide a complete history of cognitive functioning. Dr. Hughes however

cautioned that such help from family members can also be problematic, depending what they are advocating for. In response to Dr. Quintero's opinion concerning what claimant's ability to return to his regular job demonstrates about his cognitive functioning, Dr. Hughes testified:

> [Claimant's] job is a very automatic type of job and that much of his behavior during that job is in a very well rehearsed, repetitive pattern, wherein he deals with people that he deals with all the time in ways that occur over and over again in the same fashion.
>
> And so that particular type of repetitive job is well retained by people with measurable deficits in complex integrated cerebral functioning.

28. Dr. Hughes testified that he and Dr. Quintero have a mere difference of opinion concerning claimant's rating for cognitive losses under the AMA Guides. Dr. Hughes stated:

> [Dr. Quintero and I] have both agreed that a rating is appropriate. We both agree that a rating is within this particular severity classification, outlined by the AMA Guides. We just disagree with where on this sliding scale of 5 to 15 percent the assignment should be.

Dr. Hughes explained that Dr. Machanic used the range of 20 to 45% as outlined on Page 105 of the AMA Guides based upon his opinion that claimant requires some level of supervision in some activities of daily living.

29. Dr. Hughes testified that Dr. Ribovich's description of claimant's neck as supple and non-tender involved screening for pathology other than for a neck injury. By contrast, Dr. Lesnak testified what Dr. Ribovich likely meant when he described claimant's neck as supple and non-tender:

> [I]f Dr. Ribovich says that his neck is supple, nontender, it's from a neurosurgical standpoint, looking at the posterior portion of the neck, looking for musculoskeletal or neurological deficits.
>
> ****
>
> [I]n neurosurgical training when you talk about the neck being supple, you're trained to look at range of motion and look at function of the neck.

Here, the Judge credits Dr. Lesnak's opinion over that of Dr. Hughes.

30. Dr. Quintero testified that claimant did not complain of any neck symptoms for some 7 months after his injury. When asked if Exhibit 9, showing claimant reported to employer on November 30, 2006, that he injured his neck, changed his opinion, Dr. Quintero stated:

> No. It does not alter my conclusions with this case. The reason being for the time delay between the date of the accident, when he

> may have had those initial complaints, and the time when he began to complain of them, evidently on a more regular basis, in July of 2007.
>
> ****
>
> [W]hat happened initially was a strain injury, … which he recovered from, both in the neck and the back and the subsequent later development is a reflection of the chronic degenerative process that's going on.
>
> ****
>
> [T]he degenerative disk disease became the precipitator of the pain, at least documented in the July 12th, 2007, record of Dr. Trawick. I don't know exactly when the pain in the neck stopped after the accident, but there's no mention of any neck pain in the January 4, 2007, record of Dr. Trawick ….
>
> ****
>
> And also, in Dr. Ribovich's records there's no documentation of the neck being a problem.

Dr. Quintero thus opined that, at most, claimant sustained a neck strain that resolved shortly after his injury on November 30, 2006.

31. At his deposition, Dr. Lesnak reviewed the reports of Dr. Trawick and Ribovich, which he had not previously had at the time he issued his original report. Dr. Lesnak opined that the absence of reports of neck symptoms by claimant in the records supported the conclusion that the claimant's neck problems were not part of the original injury. Dr. Lesnak also reviewed Dr. Hughes deposition and agreed with Dr. Hughes that the absence of any neck complaints or neck problems until six months post-injury makes it highly unlikely that claimant's neck symptoms are causally related to his industrial injury on November 30, 2006.

32. Respondents showed it highly probable that Dr. Machanic incorrectly determined that claimant has not reached MMI. As found, Dr. Machanic based his MMI determination upon his finding that claimant's cervical complaints are causally related to his slip and fall injury. Dr. Machanic lacked the May 23, 2008, MRI scan of claimant's cervical spine, which showed evidence of spondylosis – a chronic, progressive degenerative disease of the cervical spine. The Judge credited Dr. Hughes's medical opinion in finding the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with chronic neck problems naturally due to an aging process instead of an acute injury process. The Judge found that Dr. Trawick believed claimant's cervical condition, by history, was unrelated to his slip and fall at employer some 7 months earlier on November 30, 2006. Although Dr. Lesnak initially thought it possible claimant had sustained a neck strain, he stated he needed medical records to review before to

he felt comfortable giving an evidence-based, medically probable medical opinion on causation of claimant's cervical condition. Once he had medical records, Dr. Lesnak opined that claimant's cervical condition is not causally related to his injury at employer. The Judge credited Dr. Lesnak's opinion that Dr. Ribovich's physical examination findings ruled out neck symptoms during the months he examined claimant. The Judge credits Dr. Quintero's opinion in finding that claimant's neck symptoms began in July of 2007 and are a result of the progressive degenerative disease in his cervical spine. The Judge further credits Dr. Quintero's opinion in finding that claimant, at most, sustained a neck strain from the slip and fall that resolved shortly after his injury on November 30, 2006.

33. Respondents showed it highly probable that Dr. Machanic incorrectly determined the impairment rating for claimant's brain injury. Dr. Machanic, Dr. Hughes, and Dr. Quintero all agreed that claimant should undergo a neuropsychological evaluation to assess his cognitive functioning. The Judge thus credits Dr. Thwaites's neuropsychological opinion and testimony as evidence-based and persuasive. The Judge credits the medical opinion of Dr. Quintero as consistent with Dr. Thwaites's opinion and as consistent with record-evidence showing claimant failed to complain of symptoms of cognitive problems to Dr. Trawick or to Dr. Ribovich during his treatment for his subdural hematoma. The Judge credits the opinions of Dr. Quintero and Dr. Thwaites in finding that claimant's report of cognitive symptoms is contrary to the normal progression of such symptoms in the typical patient with a subdural hematoma. The Judge credits the testimony of Dr. Quintero in finding that Dr. Machanic failed to weigh in his report the inconsistencies between the record-evidence and the history of cognitive problems claimant's daughter reported to him. Dr. Machanic failed to verify claimant's report of his symptoms with the medical records. And the Judge credits Dr. Quintero's testimony in finding Dr. Machanic's rating alike unsupported by Dr. Thwaites's neuropsychological testing and by the fact that claimant is largely independent with his work and with his activities of daily living. The history claimant's daughter gave Dr. Machanic that claimant needs supervision is inconsistent with credible evidence showing claimant able to drive, work, and supervise others.

34. The Judge finds it more probably true than not that the 5% whole person rating given by Dr. Lesnak and by Dr. Quintero appropriately assesses claimant's impairment from his subdural hematoma injury according to the AMA Guides. The Judge notes that Dr. Hughes reported that his 15% rating was an estimate based upon the history given by claimant and his daughter. Dr. Hughes recommended a neuropsychological evaluation to more truly assess claimant's impairment from his brain injury. Dr. Thwaites provided a neuropsychological evaluation and persuasively explained inconsistencies in claimant's presentation on testing and evidence of his actual cognitive functioning in activities of daily living. Dr. Thwaites's opinion shows that the history claimant and his daughter provided Dr. Hughes is unreliable. Dr. Thwaites's opinion thus fails to support Dr. Hughes's estimated rating of 15%. Dr. Quintero relied upon Dr. Thwaites's opinion and other evidence in assessing claimant's impairment at 5% of the whole person. Dr. Quintero's rating is consistent with Dr. Lesnak's opinion, wherein he rated claimant's impairment at 5%.

CONCLUSIONS OF LAW

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

A. Maximum Medical Improvement:

Respondents argue they overcame Dr. Machanic's determination of MMI by clear and convincing evidence. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The judge's factual findings concern only evidence that is dispositive of the issues involved; the judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Bing Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and

evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

Here, the Judge found respondents showed it highly probable that Dr. Machanic incorrectly determined that claimant has not reached MMI. Respondents thus overcame Dr. Machanic's determination of MMI by clear and convincing evidence.

As found, Dr. Machanic based his MMI determination upon his opinion that claimant's cervical complaints are causally related to his slip and fall injury. Dr. Machanic lacked the May 23, 2008, MRI scan of claimant's cervical spine, which showed evidence of a chronic, progressive degenerative disease of the cervical spine.

The Judge credited medical opinions of Dr. Hughes, Dr. Lesnak, and Dr. Quintero in finding the cervical pathology and degenerative changes revealed on the MRI scan are more consistent with chronic neck problems naturally due to an aging process instead of an injury process. The Judge also credited Dr. Quintero's opinion in finding that claimant's neck symptoms began in July of 2007 and are more probably a result of the progressive degenerative disease process in his cervical spine. And the Judge credited Dr. Quintero's opinion in finding that claimant, at most, sustained a neck strain from his slip and fall at employer that resolved shortly after November 30, 2006.

The Judge concludes that claimant reached MMI as of May 1, 2007. The Judge further concludes that claimant's request for workers' compensation benefits related to his cervical spine should be denied and dismissed.

B. Permanent Partial Disability Benefits:

Respondents argue they overcame Dr. Machanic's determination of claimant's permanent impairment by clear and convincing evidence. The Judge agrees.

The DIME physician's finding under §8-42-107(8)(c), *supra*, is generally the impairment rating. *DeLeon v. Whole Foods Market, Inc.*, W.C. No. 4-600-477 (ICAO November 16, 2006). Once a party sustains the initial burden of overcoming the DIME physician's impairment rating by clear and convincing evidence, the judge's determination of the correct rating is then a matter of fact based upon the lesser burden of a preponderance of the evidence. *DeLeon v. Whole Foods Market, Inc.*, *supra*. The judge is not required to dissect the overall impairment rating into its component parts and determine whether each part has been overcome by clear and convincing evidence. *DeLeon v. Whole Foods Market, Inc.*, *supra*.

Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. 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).

Here, the Judge further found respondents showed it highly probable that Dr. Machanic's impairment rating for claimant's brain injury is incorrect. Respondents thus overcame Dr. Machanic's determination of MMI and whole person impairment rating by clear and convincing evidence.

As found, Dr. Machanic, Dr. Hughes, and Dr. Quintero all agreed that claimant should undergo a neuropsychological evaluation to assess his cognitive functioning. The Judge credited the opinions of Dr. Thwaites and Dr. Quintero in finding: (1) Claimant failed to report any cognitive problems to Dr. Trawick or to Dr. Ribovich during his treatment for his subdural hematoma; and (2) claimant's report of cognitive symptoms is contrary to the normal progression of such symptoms in the typical patient with a subdural hematoma.

The Judge found that Dr. Machanic failed to weigh in his opinion the inconsistencies between record-evidence of no symptoms and the history of cognitive problems claimant's daughter reported to him. Dr. Machanic failed to verify claimant's report of his symptoms with the medical records. The Judge found that the history claimant's daughter gave Dr. Machanic of claimant requiring supervision was inconsistent with credible evidence showing claimant able to drive, work, and supervise others. The Judge found Dr. Machanic's rating alike unsupported by Dr. Thwaites's neuropsychological testing and by the fact that claimant is largely independent with his work and with his activities of daily living.

Because respondents overcame Dr. Machanic's rating by clear and convincing evidence, the burden shifts to claimant to establish his permanent impairment by a preponderance of the evidence.

The Judge found it more probably true than not that the 5% whole person rating given by Dr. Lesnak and by Dr. Quintero appropriately assesses claimant's impairment from his subdural hematoma injury according to the AMA Guides. Respondents thus proved by a preponderance of the evidence that claimant's permanent partial disability benefits should be based upon medical impairment of 5% of the whole person.

The Judge found that Dr. Hughes estimated claimant's brain injury impairment at 15% based upon an unreliable history given by claimant and his daughter. The Judge instead credited Dr. Thwaites's opinion as persuasively explaining inconsistencies between claimant's presentation on testing and evidence of his actual cognitive functioning in activities of daily living. Dr. Thwaites's opinion failed to support Dr. Hughes's estimated rating of 15%. Dr. Quintero however relied upon Dr. Thwaites's opinion and other evidence in assessing claimant's

impairment at 5% of the whole person. Dr. Quintero's rating was consistent with Dr. Lesnak's rating at 5%.

The Judge concludes that claimant sustained permanent medical impairment of 5% of the whole person for his brain injury. Because respondents admitted liability for permanent partial disability (PPD) benefits based upon impairment of 5% of the whole person, the Judge concludes claimant's claim for additional PPD benefits should be denied and dismissed.

ORDER

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

1. Claimant reached MMI as of May 1, 2007.

2. Claimant's request for workers' compensation benefits related to his cervical spine condition is denied and dismissed.

3. Claimant's claim for additional PPD benefits is denied and dismissed.

4. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: Michael E. Harr

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-764-577

ISSUE

The issue for determination is permanent partial disability benefits. Claimant seeks an award based on the whole person.

FINDINGS OF FACT

1. Claimant sustained an injury on January 17, 2008, after slipping on ice and falling on his right side. Claimant reached maximum medical improvement (MMI) on May 16, 2008.
2. Claimant underwent an MRI of the right shoulder on February 6, 2008. The MRI showed rotator cuff tears involving the distal anterior aspect of the rotator cuff, primarily affecting the supraspinatus tendon.

3. R. Baptist, M.D., an authorized treating physician, assessed Claimant with a rotator cuff tear and sprain to the right shoulder. At MMI, he measured a loss of range of motion of Claimant's shoulder. He rated Claimant's impairment at 16% of the upper extremity or 10% of the whole person.

4. Kathy McCranie, M.D., examined Claimant on October 28, 2008, prepared a report, and testified by deposition. It is her opinion that Claimant sustained an injury to his right shoulder.

5. Claimant testified that he continues to have pain in his shoulder. At times, the pain runs from his elbow to the base of his neck. He stated that he has felt a sharp pain in his chest when raising his arm over his head.

6. The testimony of Claimant and the opinions of Dr. Baptist and Dr. McCranie referred to above are credible and persuasive.

7. The situs of Claimant's functions impairment is his shoulder. Claimant's impairment is not limited to the arm.

CONCLUSIONS OF LAW

1. The question of whether the claimant sustained a "loss of an arm at the shoulder" within the meaning of Section 8-42-107(2)(a), C.R.S., or a whole person medical impairment compensable under Section 8-42-107(8)(c), C.R.S., is one of fact for determination by the ALJ. In resolving this question, the ALJ must determine the situs of the claimant's "functional impairment," and the 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). Although a physician's impairment rating is not dispositive, it may be considered in determining the situs of the functional impairment. *Strauch v. PSL Swedish Healthcare System, supra*. That issue is separate and distinct from the claimant's medical impairment rating. In fact, upper extremity impairment ratings contained in the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition, Revised (AMA Guides) are inconsistent with the scheduled injury ratings contained in Section 8-42-107(2), C.R.S. *See Mountain City Meat Co. v. Oqueda,* 919 P.2d 246 (Colo. 1996).

2. Claimant has established by a preponderance of the evidence that the situs of his impairment is not limited to the arm at the shoulder. Claimant's impairment is not on the schedule. Claimant shall receive permanent partial disability benefits based on an impairment of 10% of the whole person. Sections 8-42-101(8)(c) and (d), C.R.S.

ORDER

It is therefore ordered that Insurer shall pay Claimant permanent partial disability benefits based on an impairment of 10% of the whole person. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATED: Bruce C. Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-397

ISSUES

The following issues were raised for consideration in claim numbered, W.C. #4-723-172:

1. Temporary total disability benefits (TTD);
2. Medical benefits; and
3. Penalties.

The following issues were raised for consideration in claim numbered, W.C. #4-751-397:

1. Compensability;
2. Medical benefits;
3. Average weekly wage;
4. TTD; and
5. Penalties.

Respondents assert that, on September 10, 2008, a General Admission of Liability (GAL) was filed in W.C. # 4-751-397 admitting liability for medical benefits only. Respondents contend that the filing of the GAL renders moot the issues raised in this claim. Respondents' assertion regarding the admission of liability was made in a cover email attached to the Respondents' September 29, 2008 post hearing position statement. No evidence was received that a GAL was filed by Respondents. Claimant filed a position statement on September 29, 2008 addressing all issues raised by the two claims. Claimant did not acknowledge Respondents' assertion that the claim in W.C. # 4-751-397 is rendered moot by Respondents' post hearing filing of the GAL.

On October 29, 2008, the ALJ entered a Summary Order finding that Claimant suffered a compensable injury in W.C. # 4-751-397. With regard to this claim, it was further found that Respondents are liable for reasonably necessary and related medical benefits and Claimant was responsible for her wage loss and, therefore, was not entitled to indemnity benefits. With regard to claim numbered W.C. # 4-723-172, an admitted claim, it was determined that Claimant was entitled to reasonably necessary and related medical benefits and Respondents were not liable for a penalty for directing medical treatment.

On November 6, 2008, Claimant moved for reconsideration of the Summary Order. Claimant seeks reconsideration of the determination that Claimant was responsible for her wage loss and the she is not entitled to a penalty. Claimant's motion for reconsideration is granted and these findings follow.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant injured her right ankle on May 9, 2007, when she stepped in a hole in the floor at work, in claim numbered W.C. 4-723-172. She treated with Dr. Andrew Plotkin and Dr. Barat Desai. She was treated by Dr. Plotkin on May 11, 2007. Dr. Plotkin advised work restrictions of walking or standing only 30 minutes per hour. On June 21, 2007, Dr. Plotkin returned Claimant to regular duty. Claimant was also released to regular duty by Dr. Plotkin on July 6 and July 31, 2007. Claimant was then referred to Dr. Desai. She saw Dr. Desai on August 10, 2007, September 24, 2007, February 25, 2008, and March 13, 2008. He diagnosed arthrosis of the ankle joint. Dr. Desai did not recommend restrictions in his reports of these dates.

2. On November 14, 2006, January 6, 2007, and February 21, 2007, the Employer issued to Claimant warnings concerning her attendance. In each warning, management listed numerous instances of tardiness and absenteeism. On May 18, 2007, Claimant was given a termination notice citing her inability to correct her attendance issues. This last notice recounted 9 tardies and 2 unexcused absences. It also referred to a situation occurring on May 11, 2007, wherein Claimant was noted to have failed to call in to advise the Employer she was going to see the doctor about her ankle. Claimant's testimony concerning the May 11, 2007 incident was not credited. Nor were Claimant's testimony and the testimony of her witness JS credited with regard to the five minute grace period and N J's alleged effort to set Claimant up for termination.

3. The evidence of three warnings concerning Claimant's attendance supports the conclusion that she was responsible for her termination from employment on May 18, 2007 and is not entitled to TTD in W.C.# 4-723-172.

4. On October 1, 2007, Dr. Desai's office sent to the Insurer a fax stating "see following office note, with surgery request. surgery rt foot calcaneocuboid debridement, sural nerve release and exostectomy. please call with any questions. Thanks, lori". The attached report stated, in regard to the right ankle:

> "Right foot MRI: … Lesser spurring of the distal abductor digiti minimi musculotendinous junction. Nonspecific subcutaneous soft tissue edema associated with his surrounding the 5th metatarsophanlangel joint, particularly laterally. Mild peroneus longus tendinosis."

5. Under "Plan" in the report, it provided, "Treatment plan is to proceed with the consented surgery, consisting partially of a joint arthrotomy,

synovectomy, and possible osteophyte removal." The diagnosis was "Villonodular synovitis ankle and foot … uncontrolled; Location: right". This was the totality of the information in the report regarding the right ankle.

6. On February 21, 2008, a second fax was sent to the Insurer with precisely the same request for surgery. However, this request was not accompanied by any medical documents, except the surgical consent form signed by Claimant. The Insurer did not respond with an authorization.

7. Dr. Desai's office then sent to the carrier on March 13, 2008, a report stating the doctor was recommending a compression stocking to address the swelling and observing that, if successful, this would obviate the need for any surgery. The report concludes:

> "Impression: unchanged; no immediate surgical indication at this time".

8. On May 7, 2008, Dr. Desai's office sent a fax message to the Insurer stating, "see following office note from dr. desai with surgery request". This time the report diagnosed "loose body in joint Phalanges, foot". Dr. Desai's impression was:

> "Pt still has pain despite conservative measures. Pt has had intermittent locking in her calcaneocubooid joint which has not improved despite conservative TX and her Peronea lpalp is the same. I feel she may be subluxing at the peroneal tendon causing her symptoms and would explore and repair if necessary. These are related to her work injury".

9. On May 15, 2008, the claims adjuster for the carrier faxed a written authorization to Dr. Desai's office, stating: "Lori, Please accept this authorization for the recommended surgery: joint arthrotomy, synvectomy and possible osteophyte removal". The authorized surgery was completed on July 8, 2008.

10. Claimant alleges entitlement to a penalty on the grounds that Respondents attempted to direct medical treatment with regard to the procedure, which was performed on July 8 2008. Based on the foregoing findings, it cannot be concluded that Respondents directed medical care.

11. The claim reflected in W.C. No. 4-751-397 regards claimant's alleged carpal tunnel syndrome. Claimant alleges that her repetitive work over time for the employer caused her carpal tunnel syndrome. Claimant filed a workers' compensation claim reflecting an injury date of May 18, 2007, Claimant's last

day of employment. Medical records show that she initially saw Dr. Eppler for problems with her upper extremities on October 5, 2005.

12. Dr. Stephen Eppler diagnosed claimant with carpal tunnel syndrome. Dr. Eppler related the carpal tunnel syndrome to claimant's work for employer. Dr. Eppler stated that the employer would not comply with the restrictions. Dr. Eppler testified, as follows:

> Q. Doctor, did you ever advise her to get another job?
>
> A. No, but I'm not certain I see the relevance because she was employed at an employer who – and had sustained an injury during the course of her employment that had failed to be resolved and I was trying to continue to work with her employer in good faith and she also tried to work with her employer in good faith, but there was no evidence at any point that [the Employer] did anything other than hinder her ability to seek medical attention and, furthermore, that they purposefully did not acknowledge medical restrictions and conducted themselves in a fashion to either force her to quit or to create a situation where they could fire her.

13. Dr. Eppler's testimony concerning the Employer's failure to comply with work restrictions was deemed credible and persuasive, particularly, in light of Ms. NJ's corroborating testimony. (Findings concerning NJ's corroborating testimony are found below.) Dr. Eppler testimony concerning the Employer alleged effort to cause Claimant to quit or to fire her was not credited in light of Claimant's history of tardiness and absenteeism.

14. Dr. Tracy Wolf confirmed the diagnosis of bilateral carpal tunnel syndrome.

15. Dr. David Orgel noted that "if [Claimant's] story is confirmed, then some of her symptoms probably are related to her extensive use of her hands and arms."

16. Dr. Eppler further testified that Claimant's condition was aggravated by her continued work for the employer. He testified, as follows:

> Q. So is it your opinion within a reasonable degree of medical probability that her upper extremity symptoms are related to her work at [the Employer]?

> A. Yes. Furthermore, their negligence in terms of their management of this case has caused her ongoing disability and significantly affected her ability to recover from this and it remains to be seen whether she ever will recover. There may be permanent disability on the basis of this to both upper extremities.
>
> Q. And would her work have continued to aggravate those symptoms until she left there on May 18th 2007?
>
> A. Yes, absolutely.

17. NJ, the Employer's general manager and Claimant's supervisor, testified at hearing. Ms. J admitted that she received the doctor's notes regarding the work restrictions for Claimant. Ms. J testified that after Claimant returned to the store after being off work pursuant to the Family Medical Leave Act, Ms. J did not schedule Claimant within her work restrictions. Ms. J testified that Claimant's work for the Employer exceeded the work restrictions provided by Claimant's physician.

18. Dr. Eppler testified that the Employer worked claimant beyond the restrictions he provided.

> NJ was still her general manager and that she'd immediately been scheduled for six days and – in a row and that if she was full-time that they will not file any work restriction and indicated that they wouldn't schedule any eight-hour days, but that she worked four days in a row this week and that she was feeling worn out. She indicated that she had increased pain in her right hand and wrist associated with this change in her schedule, and that when she had scheduled her for so many days that she was unable to work and actually had called in the previous day and that she was off for two days and then called in the next; and that she was told that her employer stated that it wasn't a doctor who decided the duration of her work schedule or any restrictions, but it was the employer.

19. Claimant credibly testified that she was constantly scheduled to work outside of her work restrictions. Further, Claimant credibly testified that she repeatedly gave her work restrictions to her employer. Claimant testified that the work continued to aggravate her pain until she was terminated.

20. Dr. David Orgel placed Claimant on restrictions of no repetitive motion and no lifting over two pounds. Dr. Eppler provided similar restrictions, which changed over time. On August 10, 2006, Dr. Eppler provided a four-hour daily work limit, 16 hours a week work limit, no working for more than two consecutive days, no repetitive tasking and no lifting over five pounds. These restrictions continue to be in force.

21. Medical records reflect that Claimant started seeing a physician for her carpal tunnel syndrome on October 5, 2005. As of that date, Claimant's earnings decreased. Claimant's average weekly wage is fairly calculated prior to October 5, 2005. Taking the compensation Claimant earned from June 10, 2005, to the compensation she received through October 8, 2005, reveals that Claimant earned $5,246.78 over a period of 134 days. Dividing $5,246.78 by 134 days reveals a daily wage rate of $39.16, which translates to an average weekly wage of $274.12.

22. Claimant filed a workers' claim for compensation in W.C. # 4-751-397 for carpel tunnel syndrome on February 22, 2008. Neither an admission nor a notice of contest was ever filed by Respondents. Claimant is entitled to a penalty under Section 8-43-203, C.R.S. from March 13, 2008 and continuing as a result of the Respondents' failure to admit or deny the claim.

CONCLUSIONS OF LAW

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

1. The purpose of the Workers' Compensation Act of Colorado is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. The credibility of witness testimony and the weight to be given their testimony is within the ALJ's authority to determine. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. The respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve her of the effects of the industrial injuries in WC nos. 4-751-397 & 4-723-172, including the surgery performed on Claimant's foot on July 8, 2008.

5. Claimant is seeking an award of TTD benefits in W.C. 4-723-172. Respondents contend that Claimant is responsible for her wage loss and, therefore, is not entitled to an award of TTD under Section 8-42-105(4), C.R.S. Respondents further contend that Claimant was released from medical care by her physicians without restrictions and therefore she is not entitled to TTD.

6. To obtain TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, she left work as a result of the disability, and the disability resulted in an actual wage loss. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 639 (Colo. App. 1997). A claimant must establish a causal connection between a work-related injury and a subsequent wage loss. Section 8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546, 546 (Colo. 1995). The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earnings capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.,* 964 P.2d 595, 597 (Colo. App. 1998).

7. If the evidence establishes that the claimant is responsible for her wage loss, then she may be prevented from recovering indemnity benefits. Under Sections 8-42-105(4) and 8-42-103(1)(g), C.R.S., the claimant is precluded from receiving TTD if she is found to be responsible for her wage loss. The concept of "responsibility" in Sections 8-42-105(4) and 8-42-103(1)(g), is similar to the concept of "fA" under the previous version of the statute. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). "FA" requires a volitional act or the exercise of some control in light of the totality of the circumstances. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994). FA does not require willful intent.

Richards v. Winter Park Recreational Association, 919 P.2d 933 (Colo. App. 1996)(unemployment insurance). The claimant is not at fA if the termination is due to claimant's physical or mental inability to perform assigned duties, but poor job performance can be claimant's fA. *Johnston v. Deluxe/Current Corporation*, W.C. No. 4-376-417 (Industrial Claim Appeals Office, June 7, 1999).

8. In W.C. no. 4-723-172, Claimant is responsible for her wage loss. Her excessive tardiness and absenteeism was shown to be a volitional act, which brought about her termination from employment. Furthermore, in W.C. no 4-723-172, work restrictions were not imposed on Claimant for the ankle injury. Therefore, there was no medical reason which prevented Claimant form working.

9. Also, in W.C. no. 4-723-172, Claimant is not entitled to an award of penalties because the evidence did not establish that Respondents directed Claimant's medical care.

10. In W.C. 4-751-391, involving Claimant's claim for carpel tunnel syndrome, Claimant sustained her burden of proof to establish a work related injury.

11. The evidence further established that Claimant was disabled by her work injury and that her authorized treating physicians imposed work restrictions which were not honored by Respondents. The evidence established that Claimant was never offered a position within her restriction and therefore Claimant's wage loss commencing May 18, 2007 was not attributable to a volitional act. Accordingly, it is concluded that Claimant is entitled to TTD commencing May 18, 2007 and continuing.

12. Claimant contends entitled to a penalty against Respondents for failure to admit or deny the claim. The evidence established in W.C. # 4-751-397 Respondents had a duty to admit or deny the claim commencing March 13, 2008. Under Section 8-43-203(2)(a), C.R.S., a penalty in the amount of one day's compensation for each day's failure to admit or deny can be assessed against Respondents for a period not to exceed one year with 50% of the penalty paid to the Subsequent Injury Fund and 50% paid to Claimants.

13. It is found and concluded that Claimant's average weekly wage is $274.12.

ORDER

It is therefore ordered that:

1. In W.C. no. 4-723-172, it is found and concluded that Claimant is not entitled to a penalty nor is entitled to an award of indemnity benefits.

2. In W.C. # 4-751-397, Respondents shall be liable for a penalty under Section 8-43-203(2)(a) for failure to admit or deny the claim, commencing

March 13, 2008 and continue for a period not to exceed one year. Fifty percent of the penalty shall be paid to Claimant and 50% to the Subsequent Injury Fund.

3. Respondents shall be liable to Claimant for TTD benefits commencing May 18, 2007 and continuing until terminated by force of law.

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

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

DATED: Margot W. Jones
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-705-137

ISSUES

1. Whether Claimant has overcome by clear and convincing evidence the Division Independent Medical Examination (DIME) physician's determination that she reached Maximum Medical Improvement (MMI) on January 10, 2006.

2. A determination of Claimant's Average Weekly Wage (AWW).

3. Whether Claimant has established by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits from August 17, 2006 until terminated by statute.

STIPULATION

The parties agreed that Claimant earned an AWW of $305.00.

FINDINGS OF FACT

35. Claimant worked for Employer as a housekeeper. She cleaned between 12-17 hotel suites each day. Claimant's duties involved making beds, cleaning bathrooms and kitchens, moving furniture, mopping floors, vacuuming carpets, washing dishes, and changing linens and towels.

36. On August 5, 2005 Claimant lifted a "roll away" bed and injured her lower back. On October 11, 2007 ALJ Felter issued Findings of Fact, Conclusions of Law and Order

in the present matter. He concluded that Claimant suffered a compensable injury as a result of the incident.

3. Employer referred Claimant to Rosalinda Pineiro, M.D. for treatment. Dr. Pineiro determined that Claimant had suffered a lumbosacral strain. She imposed restrictions that included no repetitive lifting greater than 20 pounds, no pushing/pulling in excess of 20 pounds and no repetitive bending more than six times each hour.

4. Claimant subsequently returned to modified duty employment. On October 14, 2005 Dr. Pineiro released Claimant to return to full duty employment.

5. Claimant continued to obtain treatment from Dr. Pineiro through the remainder of 2005 and into the early part of 2006. During the period, Dr. Pineiro referred Claimant for physical therapy, chiropractic treatment, massage therapy and a physiatry consultation. Dr. Pineiro determined that Claimant reached MMI on January 10, 2006 without any impairment or restrictions.

6. Between December 2005 and mid-May 2006 Claimant worked part-time for Employer. During the period Claimant assisted her daughter with child-care responsibilities.

7. On June 1, 2006 Claimant reported that she had sustained a new work-related injury to her lower back. However, she acknowledged that she did not suffer a specific injury at work and did not know whether her back pain was related to her original injury on August 5, 2005. In ALJ Felter's October 11, 2005 Findings of Fact, Conclusions of Law and Order, he determined that Claimant failed to establish that she suffered a compensable injury on June 1, 2006 and dismissed her claim.

8. Although Respondents denied liability for a June 1, 2006 injury, they referred Claimant to Dr. Pineiro for additional treatment. On August 8, 2006 Claimant visited Dr. Pineiro for an evaluation. Dr. Pineiro recommended physical therapy to relieve Claimant's lower back pain. Claimant subsequently attended three physical therapy sessions before Respondents terminated authorization for treatment. Claimant testified that she benefited from the physical therapy treatment.

9. Beginning in May 2007 Claimant obtained additional physical therapy treatment at her own expense. She explained that physical therapy relieved her lower back symptoms but terminated treatment in August 2007 for financial reasons.

10. On February 1, 2008 Hendrick J. Arnold, M.D. conducted a Division Independent Medical Examination (DIME) of Claimant. He agreed with Dr. Pineiro that Claimant had reached MMI on January 10, 2006 with no impairment or restrictions. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of mo-

tion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Dr. Arnold did not impose any work restrictions and stated that Claimant did not require medical maintenance benefits.

11. Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Arnold's January 10, 2006 MMI determination was incorrect. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of motion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Claimant testified that her physical therapy treatment in May 2006 and August 2007 relieved her lower back symptoms. However, her statements do not constitute unmistakable evidence that Dr. Arnold's MMI determination was incorrect.

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 worker's 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 worker's 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 worker's 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 (2005).

4. MMI exists when "any medically determinable physical or mental impairment as a result of injury has become stable and no further treatment is reasonably expected to improve the condition." §8-40-201(11.5), C.R.S. Fur-

thermore, 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]." *In Re Bson-Rausin,* W.C. No. 3-101-431 (ICAP, Oct. 21, 2004).

5. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, 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 (ICAP, Oct. 4, 2001). The 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 (ICAP, July 19, 2004); *see Shultz v. Anheuser Busch, Inc.*, W.C. No. 4-380-560 (ICAP, Nov. 17, 2000).

6. As found, Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Arnold's January 10, 2006 MMI determination was incorrect. Dr. Arnold reviewed Claimant's medical history, considered her current symptoms, conducted a physical examination and performed range of motion measurements. He diagnosed Claimant with the following: (1) lumbosacral and cervical strain; and (2) somatization and symptom magnification. Claimant testified that her physical therapy treatment in May 2006 and August 2007 relieved her lower back symptoms. However, her statements do not constitute unmistakable evidence that Dr. Arnold's MMI determination was incorrect.

ORDER

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

1. Claimant reached MMI on January 10, 2006.

2. Because Claimant has failed to overcome the DIME physician's MMI determination, she is not entitled to receive TTD benefits subsequent to January 10, 2006.

3. Any issues not resolved in this Order are reserved for future determination.

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-615-836

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the rules of procedure concerning timely payment of medical bills?

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the rules of procedure concerning prior authorization for medical treatment?

¬ Did the claimant prove by a preponderance of the evidence that the insurer should be penalized pursuant to § 8-43-304(1) for violation of the statutory provisions governing the maintenance of workers' compensation insurance?

¬ Did the claimant prove by a preponderance of the evidence that compensation should be increased fifty percent under 8-43-408(1) for failure to maintain workers' compensation insurance as required by the Act?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to reimburse her mother for expenses the mother incurred while providing assistance to the claimant while she was hospitalized?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to pay the claimant's mother for "essential services" that the mother provided to the claimant after she was released for the hospital?

¬ Did the claimant prove by a preponderance of the evidence that the insurer is liable to provide vocational rehabilitation services because such services were "deemed authorized" by the insurer's failure to comply with the rules of procedure concerning prior authorization for medical treatment?

FINDINGS OF FACT

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

1. On May 23, 2004, the claimant sustained serious injuries arising out of and in the course of her employment when the car she was driving was "t-boned" by a police car driving at a high rate of speed. The claimant sustained a traumatic brain injury, various internal injuries, pelvic fractures and low back injuries.

2. The claimant was originally hospitalized at Denver Health and was in a coma for approximately ten days. At some point the claimant was flown to the Vanderbilt Stallworth Rehabilitation Hospital in Tennessee. Although the claimant has some difficulty recalling, she credibly testified that her total hospi-

talization lasted approximately six weeks from the date of injury, and that she was released by July 4, 2004.

3. The claimant testified that while she was hospitalized in Denver, her mother flew from Tennessee to Colorado, and her stepfather drove to Colorado. While in Colorado the claimant's mother and stepfather took care of the claimant's personal affairs such as paying bills, caring for the claimant's cats, and placing the claimant's belongings in storage. The claimant also testified that while she was in the hospital in Denver her mother gave her showers, got food for her and provided "puzzle books."

4. After the claimant was released from the Stallworth Rehabilitation facility the claimant moved to her mother's house in Tennessee. Initially the claimant was confined to a bed and was moved in a wheelchair. Later the claimant progressed to a walker. The claimant's mother provided services to the claimant including cooking, assisting the claimant with showers, changing the bedding, assisting the claimant with clothing, and paying bills. The claimant was unable to perform these activities for herself, but slowly developed the ability to care for herself. By "Halloween" of 2004 the claimant could perform most of these activities for herself.

5. William H. Hartwick testified as an expert witness for the claimant. Mr. Hartwick is a certified vocational rehabilitation specialist and a "certified life care planner." A life care planner has specialized experience and knowledge with respect to providing for the needs of persons that have suffered catastrophic injuries.

6. Mr. Hartwick credibly testified that he would consider the claimant's injury to be catastrophic. Mr. Hartwick credibly testified that based on his experience as a life care planner and his review of the medical records, including those from Stallworth Rehabilitation facility, that after her release from the hospital the claimant needed six months' of assistance with activities of daily living. These services were necessary while the claimant participated in outpatient rehabilitation activities. Mr. Hartwick noted that the Stallworth records stated the claimant needed "supervision in all areas of self care." Mr. Hartwick credibly opined that if the claimant's mother had not provided assistance with activities of daily living at home, it would have been necessary for the claimant to be transferred to a nursing facility or rehabilitation facility while completing rehabilitation. Mr. Hartwick admitted that he did not see a formal "prescription" for "essential services." However, he credibly testified that he has seen a "recommendation" from Dr. Grooms, one of the claimant's physicians at Stallworth Rehabilitation, that she was in need of "supervision in all areas."

7. Mr. Hartwick credibly testified that personal care providers who render the type of care provided by the claimant's mother, are paid $18 to $20

per hour. Mr. Hartwick opined the claimant would have needed care, on the average, for 4 hours per day for six months.

8. The insurance adjuster, Sandra Shefman, credibly testified, that she never received any request for payment of "essential services" from the claimant's parents. She did receive a number of requests for reimbursement of expenses related to meals, gasoline and motels. The ALJ infers these requests related to expenses that were incurred while the claimant's parents were in Denver during the claimant's hospitalization.

9. The services rendered to the claimant by her mother and stepfather, including caring for the claimant's pets, storing her possessions, and paying her bills, do not relate to the claimant's personal health, and do not treat the physical or emotional effects of the injury. Neither did the mother and stepfather render these services as an incident to the provision of medical treatment that the claimant was receiving in the hospital.

10. The ALJ finds the services provided by the claimant's mother while the claimant was in the hospital, such as assisting the claimant with showers and providing food and books were not reasonably necessary. The ALJ infers that because the claimant was hospitalized, these services would have been provided by hospital staff had the mother not provided them herself. Therefore, the mother was not providing any service that would not otherwise have been provided to the claimant and paid for by the respondents, and the provision of the services by the mother did not enable the claimant to be treated, nor were the services incidental to the treatment provided by the hospital. It follows that the expenses incurred by the mother were not incidental to the provision of medical treatment.

11. The ALJ finds from the credible testimony of Mr. Hartwick that Dr. Grooms, one of the claimant's treating physicians at Stallworth Rehabilitation, "recommended" that she receive "supervision" in all activities of daily living. The ALJ construes this "recommendation" as a general referral for medically necessary home health care attendant services. Because of the general nature of the referral, the claimant was authorized to select her mother to provide the services.

12. The ALJ finds that the home healthcare or attendant services provided by the claimant's mother from July 4, 2004, through October 24, 2004, constituted medically necessary attendant care services. The ALJ is persuaded by the recommendation of Dr. Grooms that the claimant receive "supervision" in activities of daily living, as well as Mr. Hartwick's credible testimony that such services were necessary considering the claimant's physical condition and inability to perform many on the basic functions of personal hygiene necessary to continue and augment her recovery. The ALJ is further persuaded of the necessity for these services by Mr. Hartwick's credible testimony that the claimant would have required treatment at a nursing facility or rehabilitation hospital if her mother had not been providing services at home. The ALJ is also persuaded by Mr.

Hartwick's testimony that the claimant needed the services for an average of 4 hours per day, and that the reasonable value of the services is $18 per hour as measured by the pay scale for personal care providers.

13. On August 7, 2007, ALJ Nancy Connick entered an Order Dismissing Application Without Prejudice and Denying Claimant's Motion to Compel. In this order ALJ Connick denied the claimant's request to compel "a copy of the insurance policy and other documents regarding coverage for risk of liability for workers' compensation or of a self-insurance permit." ALJ Connick stated that the claimant was requesting production of these items to "confirm whether the respondents have complied with the insurance provisions of Articles 40-47," and whether compensation should be increased fifty percent for failure to insure. ALJ Connick noted that the claimant had previously received the declarations page of the insurance contract, establishing that the employer was covered on the date of injury. Citing *United States Fidelity & Guaranty, Inc. v. Kourlis,* 868 P.2d 1158 (Colo. App. 1994), and *McManus v. Industrial Claim Appeals Office,* 81 P.3d 1074 (Colo. App. 2003), ALJ Connick ruled that the claimant was not entitled to further discovery because the statutory "language has not been interpreted to allow the penalty claimant seeks under the circumstances alleged, and thus the discovery request does not meet the required relevancy standard."

14. At hearing on October 20, 2008, counsel for the claimant admitted on the record that the he could not prove, without access to the declarations sheet of the insurance policy, that the policy for workers' compensation failed to comply with the insurance provisions of the Act found in § 8-44-101(1), C.R.S., and § 8-44-111(1), C.R.S. As a result, the ALJ granted the respondents' "motion for a directed verdict" dismissing the claim for penalties based on the employer's alleged failure to procure insurance, and the claim for increased compensation based on § 8-43-408(1), C.R.S.

15. On November 11, 2005, the claimant was treated for her industrial injuries at the Center for Neurorehab Service (CNS). The claimant was also treated at CNS on December 13, 2005.

16. The record contains two Health Insurance Claim Forms (HICF) pertaining to November 11, 2005. These HCIF's were signed by Dr. Bennett of CNS and dated May 12, 2006, and September 14, 2006.

17. The record contains two HCIF's pertaining to December 13, 2005. These were signed by Dr. Bennett for CNS on May 12, 2006, and September 14, 2006.

18. The record contains an Explanation of Review (EOR) for the November 11, 2005 service provided by CNS. This EOR reflects four different services were provided on November 11, 2005. The EOR reflects that the bill for services was received by the insurer on October 9, 2006, was forwarded to Cov-

entry WC Services (Coventry) for review and fee scheduling on October 9, 2006, and was reviewed on October 11, 2006.

19. The record contains and EOR for the December 13, 2005 service provided by CNS. The EOR reflects that the bill for service was received by the insurer on October 9, 2006, was forwarded to Coventry for review and fee scheduling on October 9, 2006, and was reviewed on October 11, 2006.

20. The insurance adjuster, Sandra Shefman, credibly testified that CNS would sometimes submit more than one billing for a single date of service, and that CNS did not "always consider them rebilling but additional billings for the same dates of service." This was true because CNS "felt that the HCPC codes did not adequately reimburse them or show the amount of work that they did." Ms. Shefman also explained that the insurer's file contains many EOR forms that were not submitted into evidence.

21. On June 29, 2006, respondents' counsel wrote to claimant's counsel concerning allegedly unpaid medical bills. These included CNS billings for November 11, 2005, and December 13, 2005. Counsel for respondents asserted that the billings for November 11, 2005, and December 13, 2005, had in fact been paid by check.

22. The claimant failed to prove it is more probably true than not that the insurer failed to pay any bills submitted by CNS within 30 days of the date of submission. The ALJ infers from the totality of the evidence and the credible testimony of Ms. Shefman, that CNS probably submitted at least two bills for the dates of service of November 11, 2005, and December 13, 2005. However, the ALJ is not persuaded that the insurer failed to pay any of these bills in a timely manner. Rather, the ALJ is persuaded the insurer paid all bills in a timely fashion, but determined to pay additional amounts after CNS submitted supplemental information concerning the services it provided on these dates.

23. On May 9, 2006, PA-C Douglas Hornberger, PA-C, issued a "To Whom it May Concern" letter. The letter referenced a "recommendation" for a functional capacities evaluation and vocational rehabilitation. In this letter, PA-C Hornberger stated the claimant had "progressed to a level of a Return to Work Plan" and her "therapy team" wished to clarify her work capacity by having her undergo a functional capacities evaluation. He also stated that the claimant would "benefit from vocational rehabilitation services as well." There are no attachments to this letter. The letter bears a stamp stating that claimant's counsel "sent" the document to "respondents" on November 10, 2006.

24. The insurance adjuster, Sandra Shefman, credibly testified that she received PA-C Hornberger's letter dated May 9, 2006, request, although she could not recall when. Ms. Shefman credibly testified that she responded to the letter and that the insurer did not pay for vocational rehabilitation services. Ms.

Shefman explained that she declined to pay for vocational rehabilitation services based on Dr. Pitzer's February 1, 2006, report that the claimant was at MMI, and the absence of any recommendation for vocational rehabilitation services as a form of ongoing treatment after MMI. Ms. Shefman admitted that Dr. Pitzer's examination and opinion concerning MMI was rendered before the date that PA-C Hornberger recommended vocational rehabilitation services.

25. The claimant failed to prove it is more probably true than not that the insurer violated the rules governing prior authorization for medical treatment. The ALJ finds that PA-C Hornberger's May 9, 2006, letter did not constitute a "complete" request for prior authorization as specified by WCRP 16-9 (E). In particular, the letter does not indicate that PA-C Hornberger was requesting the insurer to grant "prior authorization" for vocational rehabilitation. Instead the letter merely contains a "recommendation" of vocational rehabilitation to whoever might be concerned with that issue. Further, the letter contains no detailed explanation of the medical necessity for vocational rehabilitation, but instead contains the bare assertion that the claimant would "benefit" from such services. Finally, the letter does not incorporate any medical documentation relied upon by PA-C Hornberger when making his recommendation for vocational rehabilitation.

26. Further, the claimant failed to prove when the insurer received PA-C Hornberger's May 9, 2006, letter. The stamp on the letter indicating it was "mailed to respondents' does not establish any presumption that the letter was properly mailed to the insurer or any of its agents. Consequently, the evidence is not sufficient to establish when the insurer received the letter and triggered its alleged duty to respond in accordance with WCRP 16-9 (B).

27. At the hearing on July 1, 2008, the parties stipulated that the claimant's average weekly wage is $737.99. The parties agreed to reserve the issue of whether the average weekly wage should be further increased based on health insurance costs. The parties also stipulated that the issue of SSDI offset should be reserved. The ALJ accepted the parties' stipulations.

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, 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.

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. 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).

LAW PERTAINING TO IMPOSITION OF PENALTIES UNDER § 8-43-304(1)

The claimant seeks the imposition of three penalties for alleged violations of the Act and rules of procedure. The claimant argues these penalties should be imposed under § 8-43-304(1), C.R.S. In evaluating the requests for penalties the ALJ has considered and applied general principles of law. Thos principles are as follows.

Whether statutory penalties may be imposed under § 8-43-304(1) involves a two-step analysis. The statute provides for the imposition of penalties of up to $500 per day where the employer, insurer, or an officer or agent of either "violates any provision of article 40 to 47 of [title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or the panel, for which no penalty has been specifically provided, or fails, neglects or refuses to obey any lawful order made by the director or panel…" Thus, the ALJ must first determine whether the insurer's conduct constitutes a violation of the Act, a rule, or an order. Second, the ALJ must determine whether any action or inaction constituting the violation was objectively unreasonable. The reasonableness of the insurer's action depends on whether it was based on a rational argument based in law or fact. *Jiminez v. Industrial Claim Appeals Office,* 107 P.3d 965 (Colo. App. 2003); *Gustafson v. Ampex Corp.,* W.C. No. 4-187-261 (ICAO August 2, 2006), *but see, Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005) (standard is less rigorous standard of "unreasonableness"). However, there is no requirement that the insurer knew that its actions were unreasonable. *Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996).

The party seeking the imposition of penalties bears the burden of proof to establish that there was a violation of the Act or an order. *See Pioneers Hospital v. Industrial Claim Appeals Office, supra*. A party establishes a prima facie show-

ing of unreasonable conduct by proving that an insurer violated a provision of the Act or rule of procedure. If the claimant makes such a prima facie showing the burden of persuasion shifts to the respondents to show their conduct was reasonable under the circumstances. *Pioneers Hospital v. Industrial Claim Appeals Office, supra, Human Resource Co. v. Industrial Claim Appeals Office,* 984 P.2d 1194 (Colo. App. 1999).

PENALTIES FOR DENIAL OF PRIOR AUTROIZATION FOR VOCATONAL REHABILITATION

In her position statement, the claimant argues that the insurer should be penalized under § 8-43-304(1) because it violated the rules of procedure governing prior authorization for medical treatment contained in WCRP 16. The only alleged violation specifically identified in the claimant's position statement is insurer's alleged failure to "appropriately contest" PA-C Hornberger's May 9, 2006, recommendation that the claimant receive vocational rehabilitation services. (Claimant's proposed Finding of Fact 10, and proposed order paragraph 6). The ALJ concludes the claimant failed to prove a violation of the rules of procedure governing prior authorization.

WCRP 16-9(B) provides that a payer "shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request as defined in Rule 16-9(E)." WCRP 16-9(E) states as follows:

> To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

As determined in Finding of Fact 25, PA-C Hornberger's May 9, 2006, letter does not qualify as a "completed request" for prior authorization of vocational services as contemplated by WCRP 16-9(B) and WCRP 16-9(E). The letter does not indicate on its face that it is a request for prior authorization, it is not specifically directed to the insurer, it does not contain any explanation of the necessity for vocational rehabilitation, and it is not accompanied by medical documentation supporting the recommendation. Because the May 9, 2006, letter does not constitute a completed request for prior authorization, the timing and nature of the insurer's responses to this letter cannot constitute a violation of the rules concerning prior authorization. No completed request was ever made so as to trigger the insurer's duty to respond under 16-9(B). It follows that no penalty may be imposed under § 8-43-304(1). See *Skelly v. Wal-Mart Stores, Inc.,* W.C. No. 4-632-887 (ICAO July 31, 2008).

Moreover, the claimant failed to prove when the insurer received the May 9, 2006, letter. The law creates a rebuttable presumption that a letter properly addressed, stamped and mailed was delivered to the addressee. *See Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993). Evidence of a business custom may be sufficient to establish that a notice was sent. *EZ Building Components Mfg., LLC v. Industrial Claim Appeals Office*, 74 P.3d 516 (Colo. App. 2003).

Here, the May 9, 2006, letter does not indicate that PA-C Hornberger mailed a copy to the insurer or its agents at their proper addresses, or that it was even mailed to anyone. The stamp on the letter is inadequate because it does not show that the letter was properly addressed to the insurer or its agents, and is not, by itself, sufficient to establish the business practice of the claimant's counsel when mailing documents.

Consequently, although the insurance adjuster admitted that she received the letter at some point in time, the evidence is not sufficient to establish when she received it. Therefore, the claimant failed to prove when the seven-day response period specified in WCRP 16-9(B) commenced. Because the claimant failed to establish when the insurer allegedly began violating the rule, it is impossible to establish a commencement date for the alleged violation.

PENALTIES FOR FAILURE TIMELY TO PAY FOR MEDICAL SERVICES

The claimant contends the insurer violated WCRP 16-11 by failing to make timely payment for medical bills. Although the claimant originally alleged multiple violations of this rule, the only late payments identified by the claimant in her position statement occurred with respect to services provided by CNS on November 11, 2005, and December 13, 2005. (Claimant's proposed Finding of Fact 11, proposed order paragraph 5

Although not entirely clear, the claimant apparently alleges a violation of WCRP 16-11(A)(2) [formerly WCRP XVI (K)(1)(b)]. That rule provides that unless contested, "all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the bill by the payer."

As determined in Finding of Fact 22, the claimant failed to prove it more probably true than not that the insurer violated the rule of procedure concerning timely payment of medical bills. The ALJ has inferred from the credible testimony of the insurance adjuster that CNS submitted more than one bill for these dates of service, and that each bill submitted was paid in a timely fashion. The ALJ is persuaded that the additional bills were submitted for the two dates of service because CNS wished to provide supplemental information to the insurer concerning the services performed on those dates.

Because the claimant failed to prove any violation of the rule, no penalty may be imposed under § 8-43-304(1).

PENALTIES FOR FAILURE TO PROCURE PROPER INSURANCE

The claimant contends that she is entitled to the imposition of penalties under § 8-43-304(1) for the employer's alleged failure to secure workers' compensation insurance as required by the Act. Specifically, the claimant alleges that the insurance procured by the employer from the insurer does not comply with the requirements of § 8-44-101(1), C.R.S., and § 8-44-111(1), C.R.S. The claimant concedes that the employer procured workers' compensation insurance that covered the injury she sustained in May 2004. This concession is fully supported by the FAL that the insurer filed on June 29, 2006. However, the claimant argues that the insurance policy may not comply with the Act because it was not procured from any of the entities mentioned in § 8-44-101(1), and/or because the deductible may exceed the $5000 per claim limit established by § 8-44-111(1).

The claimant candidly admits in her position statement, as she did at hearing, that she cannot prove that the policy procured by the employer failed to comply with the insurance requirements contained in the Act. Indeed, the claimant's position statement states that, "prior orders entered in this claim preclude the Claimant from seeking discovery of any insurance documents related to the claim, other than the declarations page." The claimant states that the declarations page is not sufficiently detailed to resolve her contentions.

The ALJ concludes the claimant failed to prove it is more probably true than not that the employer violated any provision of the Act by failing to procure insurance in compliance with § 8-44-101(1) and/or § 8-44-111(1). The claimant failed to produce any credible or persuasive evidence that there was a violation of these sections of the Act. Because the claimant failed to prove any violation, no penalty may be imposed under § 8-43-304(1). *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623 (Colo. App. 1995). Therefore, the ALJ concludes that it was appropriate to grant the respondents' "motion for a directed verdict" dismissing the claim for penalties based on failure to procure complying insurance. That order is reaffirmed here.

INCREASE IN COMPENSATION FOR FAILURE TO INSURE

The claimant asserts that admitted compensation should be increased fifty percent under § 8-43-408(1), C.R.S., because the insurer failed to comply with the insurance provisions of the Act. The foundation for this argument is the same as that offered for the imposition of penalties for failure to obtain a complying insurance policy. Therefore, the ALJ reaffirms the denial of the claimant's request for increased compensation for the same reasons that he denied the penalty claim.

COMPENSATION FOR EXPENSES INCURRED BY AND FOR SERVICES PROVIDED BY THE CLAIMANT'S MOTHER AND STEP-FATHER

The claimant contends that the expenses that her parents incurred while in Denver constitute compensable medical expenses. The claimant further seeks compensation for the services that her mother provided while the claimant was staying in her mother's home "though October 31, 2004." The respondents argue that the services were not authorized because there was no request for prior authorization.

Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

Section 8-43-404(5)(a), C.R.S. gives the respondents the right in the first instance to select the authorized treating physician (ATP). Authorization refers to a physician's legal status to treat the industrial injury at the respondents' expense. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006); *Popke v. Industrial Claim Appeals Office,* 944 P2d. 677 (Colo. App. 1997). Once an ATP has been designated the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

Our courts have held that in order for a service to be considered a "medical benefit" it must be provided as medical or nursing treatment, or incidental to obtaining such treatment. *Country Squires Kennels v. Tarshis,* 899 P.2d 362 (Colo. App. 1995). A service is medically necessary if it cures or relieves the effects of the injury and is directly associated with the claimant's physical needs. *Bellone v. Industrial Claim Appeals Office,* 940 P.2d 1116 (Colo. App. 1997). A service is incidental to the provision of treatment if it enables the claimant to obtain treatment, or if it is a minor concomitant of necessary medical treatment. *Country Squires Kennels v. Tarshis, supra.* The determination of whether services are medically necessary, or incidental to obtaining such service, is a question of fact for the ALJ. *Bellone v. Industrial Claim Appeals Office, supra.*

The ALJ concludes the expense incurred by the claimant's mother and stepfather while in Denver does not constitute medical treatment for purposes of § 8-42-101(1)(a). As determined in Finding of Fact 9, the activities of paying the claimant's bills, caring for her pets, and storing her possessions were not medical in nature because they did not treat the effects of the injury, nor were they incidental to providing such treatment. Indeed, the claimant was hospitalized in a full-care treatment facility. Since the services were not medical in nature, or incidental to receiving such services, the expenses incurred while providing them are not compensable. *Kuziel v. Pet Fair, Inc.,* 931 P.2d 521 (Colo. App. 1996).

Neither are the expenses compensable because the mother rendered some services to the claimant while she was hospitalized in Denver. As determined in Finding of Fact 10, the ALJ finds that the hospital personnel would have provided these services to the claimant as part of her overall treatment at the facility had the mother not intervened. While the claimant's mother's activities may have been decent and caring, they were duplicative of services already available to the claimant and paid for by the respondents. Thus, the mother's activities at the hospital do not constitute reasonable and necessary medical or nursing services, and did not enable the claimant to receive treatment she would not otherwise have received.

In light of these determinations the ALJ need not consider whether the expenses incurred by the claimant's parents while in Denver were "authorized."

The claimant also seeks compensation for the "essential services" provided by her mother after she was released from the rehabilitation hospital and moved into the mother's home. For their part, the respondents argue that such services were not authorized because there was no request for prior authorization, and because there was no "itemization" of amounts claimed.

Authorized providers include those medical providers to whom the claimant is directly referred by the employer, as well as providers to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office,* 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). Whether an ATP has made a referral in the normal progression of authorized treatment is a question of fact for the ALJ. *Suetrack USA v. Industrial Claim Appeals Office,* 902 P.2d 854 (Colo. App. 1995). A referral may be general in nature in that it need not be to a specific provider. *Stadig v. Porter Memorial Hospital,* W.C. No. 4-152-098 (ICAO May 16, 2001, *aff'd., Porter Memorial Hospital v. Industrial Claim Appeals Office,* (Colo. App. No. 01CA1027, October 24, 2002) (not selected for publication).

As determined in Finding of Fact 11, the ALJ concludes that Dr. Grooms, an ATP at Stallworth, made a "general referral" for the claimant to receive "supervision" in activities of daily living. The ALJ concludes this referral was made in the normal progression of authorized treatment. The ALJ further concludes that because of the general nature of the referral the claimant was empowered to select her mother as an authorized provider of the services.

The ALJ is not persuaded by the respondents' argument that the failure of Stallworth Rehabilitation, the claimant's mother, or the claimant herself to procure "prior authorization" for the home health services rendered them non-compensable and unauthorized as a matter of law. It is true, as the respondents contend, that former WCRP XVI (E)(1)(b) [currently WCRP 16-5(A)(2)] requires non-physician providers, such as the claimant's mother, to "comply" with the rules regarding prior authorization "when providing all services." However, no rule states that failure to comply with the rules of prior authorization negates the ef-

fectiveness of an otherwise valid legal referral such that reasonable and necessary services rendered by a "non-physician provider" must be denied. To the contrary, it appears that the only explicit sanction for failure to follow the rules regarding prior authorization is imposed on a *payer,* such as the insurer. Specifically, former WCRP XVI (J)(5) [currently WCRP 16-10(E)] provides that "failure of the payer to comply in full with the requirements" of the rules regarding prior authorization "shall be deemed authorization for payment of the requested treatment unless a hearing is requested" within the designated time. The respondents point to no comparable rule that states failure of a provider or the claimant to request prior authorization in accordance with the rule requires that the treatment be "deemed" unauthorized.

The ALJ does not consider the cases cited by the respondents to be supportive of their argument. In *Cross v. Microglide Inc.,* W.C. No. 4-355-764 (ICAO September 2, 2003), the ICAO held that an insurer did not "waive" its right contest authorization for essential services by failing to comply with the rules regarding prior authorization. The ALJ found that the medical provider had never completed a valid request for prior authorization. In these circumstances the ICAO upheld the ALJ's determination that the insurer's failure to contest the defective "request" for prior authorization did not mean that the services were "deemed authorized" under WCRP XVI (J)(5). Thus, *Cross* is concerned with the effect of an insurer's alleged failure to comply with the rules regarding prior authorization, not the effect of the provider's failure to request prior authorization.

Moreover, the ALJ concludes that the holding in *Galacia v. Pietraszek Enterprises, Inc.,* W.C. No. 4-610-668 (ICAO May 9, 2008), supports the conclusion that failure to request prior authorization does not preclude a finding that services were authorized. Insofar as pertinent, the ALJ in the *Galacia* case found that the claimant received three periods of home health care services, and that there was no request for prior authorization for any of these services. However, after the services had been provided, authorized physicians rendered opinions that the services were reasonable and necessary. The ALJ in *Galacia* noted that because the providers were non-physician providers the treatment was subject to the rules governing requests for prior authorization, and the ALJ denied the treatment. Citing *Suetrack USA v. Industrial Claim Appeals Office, supra*, the ICAO stated that it was the "ALJ's prerogative to determine whether the home health care services at issue was authorized treatment." The ICAO further noted that referrals in the normal progression of authorized treatment may render care authorized, but stated that as it read the ALJ's order "he did not find a contemporaneous referral was made in the normal progression of authorized treatment." In these circumstances, the ICAO stated that the ALJ was persuaded that there was no request for prior authorization as required by the applicable regulations, and that it was "apparent from the ALJ's decision that he was not persuaded that the periods of home health care at issue were authorized by rule, estoppel, or otherwise." The ICAO was careful to note that the "existence of evidence which,

if credited," might have supported a contrary result afforded no basis for relief on appeal.

The ALJ infers from the holding in *Galacia* that the ICAO does not view the mere failure to request prior authorization as required by the rules to *require* the conclusion that the disputed treatment was unauthorized. If the ICAO held such a view, it would merely have affirmed the ALJ's conclusion that the treatment was not authorized because there was no request for prior authorization. Instead, the ICAO also considered whether the ALJ found that the treatment had been authorized by some other means, such a "estoppel or otherwise." In *Galacia* the ICAO determined that the ALJ found there was no alternative mechanism of authorization, and concluded that determination was supported by substantial evidence.

Here, in contrast to the *Galacia* case, the ALJ has found that there was a valid referral for home health services rendered by Dr. Grooms *before* the claimant's mother provided the services. The ALJ infers from the holding in *Galacia* that the mere fact that prior authorization was not requested for the services provided by the claimant's mother, as it should have been, does not mean that the services were unauthorized as a matter of law.

As determined in Finding of Fact 12, the ALJ concludes that the services rendered by the claimant's mother commencing July 4, 2004, through October 31, 2004, constituted reasonable and necessary home medical services designed to relieve the claimant from the effects of the injury and assist her in recovering from the injury. The ALJ, crediting the opinion of Mr. Hartwick, concludes these services were reasonably necessary for an average of 4 hours per day, and that they are reasonably valued at $18 per hour. Thus, the insurer shall pay the claimant's mother $8640 for essential services rendered to the claimant (120 days x 4 hours per day x $18 per hour = $8640).

In light of these determinations the ALJ need not consider the claimant's argument that the services provided by her mother were authorized because the insurer refused to designate a provider willing to render the services.

CLAIM FOR VOCATIONAL REHABILITATION AS A MEDICAL BENEFIT

The claimant argues that the request for vocational rehabilitation services was "deemed authorized" by the insurer's failure to respond to the request for prior authorization. Therefore, the claimant argues that the insurer should be ordered to provide vocational services. The ALJ disagrees with this argument.

It is true that WCRP 16-10(E) provides that a payer's failure to "comply in full with the requirement of Rule 16-10(A) or (B) shall be deemed authorization for payment of the requested treatment unless a hearing is requested" within the time prescribed for responding as set forth in Rule 16-10(A) or (B). Rules 16-10(A) and (B) create duties on the part of the payer to take certain actions to contest a "request for prior authorization." The prescribed duties vary depending on

whether the request is contested for medical or non-medical reasons, but the actions must be taken within seven business days of receipt of the "completed request" for prior authorization. Rule 16-10(A) explicitly states that Rule 16(9) (E) defines the term "completed request".

As determined in Finding of Fact 25, and as detailed above, PA-C Hornberger's May 9, 2006, letter did not constitute a "completed request" for prior authorization of vocational services within the meaning of WCRP 16-9(E). It follows that the insurer has not violated WCRP 16-10(A) or (B), and the requested services are not "deemed authorized" within the meaning of WCRP 16-10(E).

The ALJ does not understand the claimant to be arguing that there is any other legal theory that would justify and an award of vocational services as a form of medical benefit. The claimant's position statement does not advance any other argument.

ORDER

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

1. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

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

3. The claimant's requests for the imposition of penalties pursuant to § 8-43-304(1), C.R.S., are denied and dismissed.

4. The claimant's request that compensation be increased fifty percent based on failure to maintain insurance is denied and dismissed.

5. The claimant's request that the insurer reimburse her mother for expense incurred during the claimant's hospitalization is denied and dismissed.

6. The insurer shall pay the claimant's mother the sum of $8640 for essential services provided to the claimant.

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on October 8 and November 10, 2008, in Denver, Colorado. Both sessions of the hearing were digitally recorded (refer-

ence: 10/8/08, Courtroom 4, beginning at 1:36 PM, and ending at 2:12 PM; and, 11/10/08, Courtroom 4, beginning at 8:38 AM, and ending at 9:28 AM). Jesse Moran served as the official Spanish/English interpreter.

At the conclusion of the last session of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Claimant's counsel, to be submitted electronically in 10 working days, or by the close of business on November 25, 2008. None was timely submitted and the ALJ hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern Respondents' challenge to the Division Independent Medical Examination (DIME) of David Yamamoto, M.D., and apportionment. Respondents' burden of proof is by clear and convincing evidence on permanent impairment. Respondents' burden on apportionment is by a preponderance of the evidence.

FINDINGS OF FACT

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

1. The Claimant sustained a work-related occupational disease to his neck with an onset date of April 22, 2002. ALJ Michael Harr entered Findings of Fact, Conclusions of Law and Order on January 2, 2003, determining that Claimant suffered from an occupational disease with an onset date of April 22, 2002; awarding medical benefits; and, awarding the Claimant temporary total disability (TTD) benefits from April 22, 2002. Subsequently, ALJ Bruce Friend, on July 12, 2004, found that Claimant suffered from thoracic outlet syndrome (TOS) and awarded the Claimant medical benefits for this condition. There were no timely appeals of either decision, and both decisions establish the law of the case.

2. The medical records establish that Claimant first report neck pain in 2000 when she was working for a different company. There is no indication that Claimant was off work, or disabled, until April 22, 2002, when she worked for the present Employer. Based on the 2000 manifestation of neck pain, Respondents argue for apportionment. Since ALJ Harr's and ALJ Friend's decisions have established the law of the case, the doctrine of "issue preclusion" prohibits a consideration of this argument.

3. Claimant proved an injurious and disabling exposure to neck problems while employed by the present employer and ALJ Harr so found five years ago. If she had a preexisting neck condition, her employment with the present Employer substantially and permanently aggravated it.

4. On May 6, 2004, J. Stephen Gray, M.D., performed an Independent Medical Examination (IME) of Claimant. Dr. Gray was of the opinion that Claimant was not a maximum medical improvement (MMI), however, he assigned her a tentative rating of 25% whole person.

5. John J. Aschberger, M.D., performed an IME on March 31, 2008, indicating that Claimant was at MMI and rating her permanent medical impairment at 24% whole person. Dr. Aschberger not that "a specific disorder apportionment of 7% is **quite arguable** (emphasis supplied)." The ALJ infers and finds that despite his indication that apportionment was "quite arguable," Dr. Aschberger did not actually apportion 7% out of his 24% whole person rating.

6. David Yamamoto, M.D., performed a DIME on April 22, 2008. Dr. Yamamoto was of the opinion that Claimant reached MMI on February 15, 2007, with ratings of 26% whole person impairment for physical injury, and 4% whole person for psychological injury. When confronted with the medical records indicating neck problems as early as 2000, when Claimant had been working for another employer, Dr. Yamamoto steadfastly declined to apportion.

7. The ALJ finds that Respondents have failed to prove that it is highly probable and free from serious and substantial doubt that Dr. Yamamoto's permanent medical impairment ratings are in error. Therefore, Respondents have failed to overcome Dr. Yamamoto's DIME ratings by clear and convincing evidence.

8. The ALJ further finds that no previous injury has been sufficiently identified, treated and evaluated and rated as a contributing factor in order to trigger an apportionment. Respondents have failed to prove that it is more likely than not that their affirmative defense of apportionment has been proven. Therefore, Respondents have failed to prove apportionment by a preponderance of the evidence.

CONCLUSIONS OF LAW

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

a. The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). It is well established that the DIME physician's determination of MMI and whole person rating is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107 (8), C.R.S. (2008). "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or facts highly prob-

able or the converse, and is free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert, supra.* 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). The question of whether the DIME physician has placed a claimant at MMI or not, the whole person rating of the DIME, and whether these determinations have been overcome are factual determinations for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra.* As found, Respondents have failed to overcome the DIME physician's determinations of MMI and rating of 26% whole person for physical injury and 4% whole person for psychological injury.

b. Section 8-42-107 (7) (b) (III), C.R.S. (2008), provides that mental or emotional stress shall not be combined with a scheduled or nonscheduled injury. Section 8-41-301 (2) (b) limits claims for permanent mental impairment to twelve weeks of medical impairment benefits.

c. An "occupational disease" is a disease resulting directly from the employment as a proximate cause and one that does come from a hazard to which the employee would have been equally exposed outside of the employment. Section 8-40-201 (14), C.R.S. (2008). *See City of Colorado Springs v. Industrial Claim Appeals Office,* 89 P. 3d 504 (Colo. App. 2004). As found, ALJ Harr, in an un-appealed decision of January 3, 2002, determined that Claimant suffered from a compensable occupational disease with an onset date of April 22, 2002.

d. The purpose of Section 8-41-304(1), C.R.S. (2008), is to assign liability for an occupational disease where a claimant has been exposed to the hazards of the disease during successive employments. *Robbins Flower Shop v. Cinea,* 894 P.2d 63 (Colo. App. 1995); *Seyhouwer v. Kristin F. Robbins, D.D.S.* W. C. Nos. 4-462-729, 4-471-878 [Industrial Claim Appeals Office (ICAO), May 20, 2003]. If a claimant proves an injurious exposure with the employer, then she must prove by a preponderance of the evidence that her preexisting condition was substantially and permanently aggravated. *See Monfort Inc. v. Rangel,* 867 P.2d 122 (Colo. App. 1993)*; Fisher v. United Parcel Service,* W.C. Nos. 4-114-768 & 4-221-453 (ICAO, May 8, 1996); *aff'd,* (Colo. App. No. 96CA0943, February 20, 1997) [not selected for publication]. As found, Claimant has proven an injurious exposure while working for the Employer herein; and, she has proven that this injurious exposure substantially and permanently aggravated her preexisting neck condition.

e. Under Section 8-41-304(1), C.R.S. (2008), a injured worker is not required to exactly pinpoint which period of employment most injuriously exposed her to the hazards of the occupational disease; instead, the worker is allowed to recover from the last employer in whose employ the last injurious exposure oc-

curred and resulted in an aggravation that is both permanent and substantial. *Monfort, Inc. v. Rangel*, *supra*. The length of employment with a particular employer continues to be immaterial to a finding of liability; the focus is on both the harmful nature of the concentration of the exposure and the magnitude of the effect of the exposure. As found, Claimant's exposure to the aggravating factors of her neck condition with the Employer herein had a substantial impact on the aggravation of her previous (to beginning work with the Employer herein) neck condition.

f. Section 8-41-304 (1), C.R.S. (2008), also provides that the employer in whose employment the employee was last injuriously exposed and suffered a substantial permanent aggravation of the occupational disease shall alone be liable for the substantial permanent aggravation, without right of contribution. *See Monfort, Inc. v. Rangel, supra*; *Robbins Flower Shop v. Cinea, supra*. Also, where an occupational disease is the proximate cause of the disability, there exists an occupational disease with no apportionment. *Anderson v. Brinkoff,* 859 P.2d 819 (Colo. 1993). This is also true for a substantial, permanent aggravation of a preexisting occupational disease. The *Anderson v. Brinkoff* rule, however, only applies to occupational diseases not accidents. *Lindner Chevrolet v. industrial Claim Appeals Office,* 914 P.2d 496 (Colo. App. 1995). Indeed, there is no right of contribution even though there were other **injurious** exposures with previous employers. *Claimants in the Matter of the Death of Garner v. Vanadium Corp. of America,* 194 Colo. 358, 572 P.2d 1205 (1977). As found, Claimant sustained a **substantial, permanent aggravation** of her previous neck condition, while working for the Employer herein and her date of onset was April 22, 2002.

g. Apportionment is appropriate when a prior injury has been sufficiently identified, treated, evaluated and rated as a contributing factor. *See Askew v. Industrial Claim Appeals Office,* 927 P. 2d 1333 (Colo.1996). Indeed, where successive injuries contribute to disability and the need for medical treatment, an apportionment, based on medical opinions, was held appropriate. *See Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo.App.2004). As found, although a previous neck condition was identified and treated in 2000, it was not sufficiently evaluated and rated as a contributing factor to the April 22, 2002 onset of the compensable occupational disease as determined by ALJ Harr in January 2003.

h. The proponent of a proposition has the burden of proof, by a preponderance of the evidence, of establishing that proposition. Sections 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). 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 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, "apportionment" is in the nature of an affirmative defense and Respondents have failed to prove, by a preponderance of the evidence, that it is warranted in this case.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents having failed to overcome the Division Independent Medical Examination of David Yamamoto, M.D., the degree of Claimant's permanent medical impairment is 26% whole person for physical injury, and 4% whole person for psychological injury. Claimant reached maximum medical improvement on February 15, 2007.

B. Respondents affirmative defense of apportionment is hereby denied and dismissed.

C. Respondents shall pay permanent medical impairment benefits, based on 26% whole person physical injuries, and twelve weeks for 4% psychological impairment, from February 15, 2007 and continuing until paid in full. Respondents are entitled to credit for any permanent disability benefits previously paid

D. Respondents shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

E. Any and all issues not determined herein are reserved for future decision.

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-745-218

ISSUES

The issues for determination are compensability and medical benefits.

FINDINGS OF FACT

1. On December 3, 2007, Claimant was injured during a physical agility test as part of Employer's pre-hire screening for employment. Claimant was at the Employer's employment training center in Salt Lake City, Utah, participating in a physical agility test. During the test, she was required to lift a sixty (60) pound bag with unsecured weights a minimum of four times. Claimant was also required to lift a forty-five (45) pound bag and thirty (30) pound bag as well. When Claimant attempted to lift the sixty pound bag above her shoulders, the weight in the bag shifted and the bag struck her in the chest, leg, and face.

2. Claimant applied for the position as a Cross-Utilized Agent in Grand Junction, Colorado. As part of the application process for Cross-Utilized Agents, candidates are required to submit online applications, undergo a series of interviews, complete criminal background checks and FBI fingerprinting, drug tests, a physical agility test, written examinations, and confirmation of passage of all tests and background checks for Federal Aviation Administration ("FAA") and Transportation Security Administration ("TSA") security clearances. A prospective applicant must complete all of these steps in order to be considered for potential employment with Employer. If an applicant fails any of these steps, the applicant is removed from the application pool for the desired position. Furthermore, per FAA and TSA regulations, employment does not begin for airline employees until the security clearances have been confirmed to allow individuals to work at airport sites. Consequently, if Employer wishes to select an applicant, Employer does not provide an offer of employment until their application requirements are fulfilled and security clearance has been granted.

3. After conducting the interview steps of the applicant process, Claimant was given a "conditional offer of understanding" which identified that she was being considered as a candidate for employment and that she understood the selection process. Additionally, Claimant received a pre-hire policy manual containing information and preparation materials for the additional application steps necessary for all candidates. At no time was a written offer of employment given to Claimant.

4. The application process for Employer included the following: (1) submission of an online application for the position desired; (2) series of interviews by local managers following receipt of an application; (3) required attendance at one of Employer's employment centers in order to conduct the criminal background tests, inclusive of FBI fingerprinting, a physical agility test, and written examinations; and (4) confirmation of passage of all tests, background checks and security clearances.

5. Employer's policy manual indicates that during the application process, all attendees are pre-hire applicant's and are not considered employees. As part of the application process, the applicants are given what is known as the PAR, which is a handbook for the testing and subjects given specific to their position. The PAR manual provides Employer's policies for the application process and other information to be studied for written testing as part of that application process. Specifically, the PAR manual iden-

tifies that applicants receiving and reviewing the manual are "prospective employees." Claimant initialed that she received the PAR manual on November 6, 2007.

6. A "Conditional Offer Understanding" was provided to Claimant as part of the application process. Claimant signed and agreed to the terms on this form. Claimant stated that this is not an offer of a position to an applicant. It is a form used by Employer to provide notice to applicants of the remaining application process. Additionally, Claimant indicated that the form specifically provides that applicants agree that they are being considered for employment and that they must complete the application process in order to receive a position with Employer.

7. Employer's "Orientation/Employment Center's" policy handbook states, "[a]n offer of employment will not be made without successful completion of an [employment center] session (including all required clearances)…."

8. An applicant would not be given any schedules or work assignments until they receive an offer of employment following selection and completion of the application process.

9. A prospective candidate is not considered an employee of Employer until the "bright line" moment where it confirmation is made that a prospective candidate has passed all the tests and background checks in order to have security clearance to work at airport sites. The Department of Transportation ("DOT"), FAA and TSA require that such clearances be confirmed prior to the issuance of any security badge and prior to allowing Employer to permit prospective candidates to become employees and begin work at an airport.

10. Employer uses a hiring procedure checklist as part of its application process. As identified on Employer's hiring checklist, local managers are not allowed to inform the applicants that they can begin work and become employees until after "the applicant's clearance and employee number" is received from Employer. The "hire date" is considered the employee's first day of employment following the application process. During that "new hire date" or first day of employment, a "New Hire I-9" Form is to be completed by a manager and sent to Employment Administration.

11. Claimant pursued employment with Employer by filling out an online application. Claimant applied for the position of a Cross-Utilized Agent.

12. Employer further did not guarantee a position based on passing the agility test or any other single test or part of the application process. No position would be offered to any applicant for a Cross-Utilized Agent position until an applicant would complete all criminal background checks, FBI fingerprinting, DOT drug tests, physical agility tests, written examinations for the position, and basic station training. Failure to pass any of these tests and checks would disqualify a prospective candidate from the application pool. If all tests and checks were completed satisfactory, Employer would offer a position to the candidate.

13. Claimant failed to complete any of the criminal background checks, written tests and exercises. On the first day at the Employment Center, Claimant failed the physical agility test. Claimant did not complete the rest of the application process at the Utah employment center, which included the criminal background checks, the FBI fingerprinting, drug test, and written examinations for the cross-utilized agent position. Claimant was disqualified from the application pool following her failure of the physical agility test.

14. Claimant failed the physical agility test on the first day at the Employment Center. Claimant did not participate in nor complete the BST at the end of the week while in Utah. As a result, Claimant was not paid any wages or any bonus during the application process at the Salt Lake City Employment Center.

15. Claimant was not given either a New Hire form or a written offer of employment from Employer. No badge has been issued by Employer identifying that Claimant had passed the security clearances and was allowed to begin employment with Employer.

16. An applicant is paid for the appliction process when they complete the process and are selected for employment. Payment for the application process, including the process in Utah, is considered a "bonus". Employer's policy states that wages for the application process at the employment center is considered a "bonus because you haven't officially been hired by Employer at the end of BST. Your official Date of Hire…is your first day in the station after you completed BST."

17. Claimant was at Employer's facility in Utah when she was injured under an implied contract of employment. The implied contract was that if she successfully completed the required tests and checks she would be hired by Employer as a Cross-Utilized Agent and would receive a "bonus" for her attendance in Utah. Claimant was an employee when injured, and the claim is compensable.

18. Claimant did not report her injury to an employee of Employer on the day it occurred. Claimant's testimony that she did report her injury to the physical therapist who was conducting the test is credible. Claimant did report the injury to her physician shortly after her return to Colorado, and did report the injury to a supervisor of Employer in Colorado with whom Claimant had interviewed in connection with her application. It is found that Claimant did sustain an injury during a test at Employer's facility in Utah.

19. Claimant was examined on December 10, 2007, by Dr. Craig Stagg. Claimant stated that she had sustained an injury lifting during an agility test. Dr. Stagg described the problem as anterior chest and leg contusion "and question of facial contusion." Dr. Stagg prescribed physical therapy.

20. Claimant had a face lift one year prior to her compensable injury.

21. Dr. Stagg referred Claimant to Dr. Peterson on December 19, 2007.

22. Steven L. Peterson, M.D., examined Claimant on January 2, 2008. He noted that Claimant had "asymmetric marionette lines with markedly increased prominence on right." He stated that correction would require surgical intervention.

23. Kent Hughes, M.D., examined Claimant on February 27, 2008. Dr. Hughes had performed the previous facelift in December 2006. Dr. Hughes noted that Claimant now had facial asymmetry to the right side of her face due to impact from luggage. He stated that Claimant needed additional surgery.

24. Additional surgery to repair the facial asymmetry to the right side of Claimant's face is reasonably needed to cure and relieve Claimant from the effects of the December 3, 2007, compensable injury.

CONCLUSIONS OF LAW

1. Claimant went to Salt Lake City to continue the application process for employment with Employer. On December 3, 2007, Claimant proceeded to take the physical agility test, but failed the test as she was not able to lift the sixty (60) pound bag the required test height. Due to her failure to pass the physical agility test, Claimant was dismissed by Employer and sent home that same day. Claimant did not complete the rest of the application process during the rest of the week at the Utah Employment Center, which included the criminal background checks, the FBI fingerprinting, drug test and written examinations for the cross-utilized agent position. Claimant was removed from the applicant pool and not offered a position at Employer.

2. There was no contract of hire for Claimant to work for Employer as a Cross-Utilized Agent. However, there was an implied contract of hire. Claimant was to be paid a bonus for her attendance at Employer's Utah facility and was to be hired as a Cross-Utilized Agent should she successfully complete the required tests and checks.

3. Respondents argue that Claimant is not an employee under the case of *Younger v. City & County of Denver*, 810 P.2d 647(Colo. 1991). In *Younger*, the claimant was injured while undergoing a pre-employment physical test. The claimant in *Younger* was not guaranteed a position should he have successfully completed the test. Further, even if eventually hired into the position for which he was applying, there was no agreement that the City and County of Denver would pay him for his participation in the test. The facts in this claim are more similar to the facts in *Shields v. Colorado Springs Club Venture,* W.C. No. 4-529-550 (ICAO, 2005). In *Shields*, the claimant was injured during a training program that the employer required the claimant to undergo before beginning work. The employer controlled the time, place and nature of the program. The claimant in *Shields* was determined to be an employee.

4. At the time of her injury, Claimant was in the service of Employer under an implied contract of hire. Section 8-40-202(1)(b), C.R.S. The claim is compensable.

5. Insurer is liable for the medical care Claimant receives from authorized physicians that is reasonably needed to cure and relieve her from the effects of the compensable injury. Section 8-42-101(1), C.R.S. Drs. Stagg and Peterson, and others to whom Claimant was referred in the normal progression of authorized treatment. are authorized. *City of Durango v. Dunagan,* 939 P.2d 496 (Colo.App. 1997). Claimant has established by a preponderance of the evidence that the recommended surgery is reasonably needed to cure and relieve Claimant from the effects of the December 3, 2007, compensable injury. Insurer will be liable for the costs of such surgery, should it be performed by an authorized provider. Liability is limited to amounts established by the Division of Workers' Compensation fee schedule. Section 8-42-101(3), C.R.S.

ORDER

It is therefore ordered that:

1. The claim is compensable.
2. Insurer is liable for the costs of the medical care Claimant receives from authorized medical providers that is reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Insurer will be liable for the proposed facial surgery if an authorized provider performs the surgery.
3. All matters not determined herein are reserved for future determination.

DATED: *December 1, 2008*

Bruce Friend, ALJ

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr. Administrative Law Judge (ALJ), on November 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 11/18/08, Courtroom 3, beginning at 1:30 PM, and ending at 2:30 PM).

At the conclusion of the hearing, the ALJ ruled from the bench to referred preparation of a proposed decision, to be submitted electronically, to Claimant's counsel, giving Respondents 3 working days within which to file objections. The proposed decision was filed on November 24, 2008. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified the proposal and hereby issues the following decision.

ISSUE

The issue to be determined by this decision concerns post maximum medical improvement (MMI) medical maintenance benefits, specifically, whether the Claimant is entitled to an MRI (magnetic resonance imaging) procedure of

her lumbar spine as ordered by Robert I. Kawasaki, M.D., the authorized treating physician (ATP); and, whether the MRI procedure constitutes reasonably necessary maintenance medical care as provided for in *Grover vs. Industrial Comm*, 759 P.2d 705, 711(Colo. 1988).

FINDINGS OF FACT

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

1. Dr. Kawasaki is the Claimant's ATP, and is of the opinion that the Claimant is in need of a repeat lumbar MRI for diagnostic purposes. The ALJ infers and finds that the diagnostic purposes are to prevent the Claimant's condition from deteriorating and to maintain the Claimant at MMI,, as opposed to mere scientific curiosity.

2. Pursuant to the Final Admission of Liability (FAL), dated January 7, 2008, Respondents admitted liability for reasonably necessary medical care related to this claim, as authorized by the ATP.

3. The ALJ finds that the recommendation for an MRI by Dr. Kawasaki constitutes reasonably necessary maintenance medical care related to this claim.

4. Claimant has proven, by a preponderance of the evidence, that a repeat MRI as ordered by the ATP is reasonably necessary post-MMI maintenance medical care.

CONCLUSIONS OF LAW

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

a. 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. Industrial Commission 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. Industrial Claim Appeals Office, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, 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. Industrial Claim Appeals Office, supra*. "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). Indeed, as found, there is no conflicting evidence and the Claimant's ATP has recommended a repeat MRI for diagnostic purposes to prevent a deterioration of her condition.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits, including *Grover* medical benefits. Sections 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial 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); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has met her burden of proof with respect to the reasonable necessity of the repeat MRI ordered by her ATP.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. In addition to other authorized, causally related and reasonably necessary medical benefits, Respondents shall pay the costs of the repeat MRI recommended by Claimant's authorized treating physician, Robert I. Kawasaki, M.D.

B. Any and all issues not determined herein are reserved for future decision.

DATED this _____ day of December 2008.

_____
EDWIN L. FELTER, JR.

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-396

ISSUES

The issue determined herein is compensability.

FINDINGS OF FACT

1. Claimant was employed by the employer as a certified nursing aide ("CNA") since July 2001. Since 2004, she has worked the graveyard shift from 11:00 p.m. to 6:30 a.m.
2. Claimant had extensive disciplinary problems, including suffering a reduction in pay at one time. Claimant had been notified that she had to improve her attendance. Claimant also had been notified that she had other performance related problems.
3. On May 5, 2008, Ms. A, the R.N. supervisor, gave claimant a written write-up.
4. On May 8, 2008, claimant received written notification of a Rule 6-10 meeting with the administrator, Mr. B, to discuss her performance problems.
5. Claimant alleges that she suffered an injury at approximately 11:40 p.m. on May 9, 2008, while lifting a patient in bed with a draw sheet. Claimant alleges that she appeared for work at the start of her 11:00 p.m. shift and that she worked with Ms. P to move several patients, but that Ms. P failed to lift her share of a large patient. Claimant alleges that she suffered immediate low back pain and leg pain. She alleges that she cried while continuing to work for another hour before reporting her work injury.
6. Ms. P testified that claimant appeared late for work and had to catch up with Ms. P in the room of the large patient. Ms. P testified that claimant was upset about receiving the notice of the Rule 6-10 meeting and failed to help Ms. P lift the large patient. Ms. P did not see claimant cry at any time.
7. At 12:05 a.m. on May 10, 2008, claimant reported to her supervisor, Ms. V, that she had suffered an injury while working with Ms. P. Ms. Velasquez interviewed Ms. P, who denied that claimant had even helped move the large patient.
8. On May 9, 2008, claimant filed a leave request form, stating that she could not find her badge and had been unable to clock in. Claimant stated that she started work at 11:00 p.m. Ms. V approved the modification to the automated timekeeping system to show that claimant started at 11:00 p.m.
9. On May 13, 2008, Mr. B conducted the Rule 6-10 meeting. On May 15, 2008, Mr. B sent claimant written notification that her employment had been terminated.
10. On May 13, 2008, Dr. McFarland examined claimant, who reported a history of a work injury on May 9 while lifting a large patient. Dr. McFarland noted that claimant was in no acute distress. He diagnosed a lumbar strain, prescribed medications, and excused claimant from work.
11. May 22, 2008, x-rays of the lumbar spine were negative.
12. Claimant's testimony is not credible. The testimony of Ms. P and Ms. V is credible. Claimant had a long history of disciplinary problems. She received notice on May 8, 2008, that she had a Rule 6-10 meeting, which was a pre-disciplinary meeting. Claimant had a motive to fabricate an injury. She did not appear for work at 11:00, contrary to her testimony. She appeared for work late and did not assist Ms. P in lifting the large patient. She did not cry while continuing work. The preponderance of the evidence does not demonstrate that claimant suffered an accidental injury arising out of and in the course of her employment on May 9, 2008.

CONCLUSIONS OF LAW

1. 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). 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). 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, claimant's testimony is incredible. As found, claimant has failed to prove by a preponderance of the evidence that she suffered an injury arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits is denied and dismissed.

DATED: December 4, 2008 Martin D. Stuber, Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-726-043

ISSUES

¬ Did respondents overcome by clear and convincing evidence the determination of Thomas Fry, M.D., that claimant has not reached maximum medical improvement?
¬ Did claimant prove by a preponderance of the evidence that her average weekly wage should be increased based upon concurrent employment?
¬ Did claimant prove by a preponderance of the evidence that she is entitled to temporary disability benefits based upon her wage loss from concurrent employment?

FINDINGS OF FACT

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

1. Employer operates an office cleaning business. Claimant worked as a custodian for employer. OM is employer's area manager. Claimant sustained an admitted injury to her right upper extremity while working for employer on February 4, 2007. Claimant continued working for employer until the last week of October, 2007.

2. Claimant initially sought treatment at the Emergency Department of HealthOne (ER) on February 5, 2007. The ER physician diagnosed a right forearm sprain and applied a splint to claimant's right wrist. The ER physician restricted claimant from using her right hand for work over the following 3 days.

3. Employer referred claimant to Craig Anderson, M.D., who first examined her on February 7, 2007. Claimant reported to Dr. Anderson she experienced immediate pain in the fingers of her right hand radiating into her wrist while attempting to forcefully remove the lid of a container of contaminated substances. Dr. Anderson reviewed reports from the ER and noted:

> Nurse at ER noted [claimant] was observed to use the right hand to answer cell phone and dig through purse with no signs of pain.

Dr. Anderson noted claimant's right hand and wrist appeared normal to inspection. Dr. Anderson diagnosed a right hand and wrist strain, rule out wrist tendonitis, and rule out median nerve neuritis. Dr. Anderson imposed physical activity restrictions precluding claimant from working with her right hand.

4. Dr. Anderson referred claimant to Physiatrist Barry A. Ogin, M.D., who examined her on April 16, 2007. By that time, claimant reported that her primary symptoms involved aching and stabbing pain along her anterior and superior shoulder. During his examination of claimant's shoulder, Dr. Ogin observed her guarding her right arm and displaying extreme pain behaviors. Dr. Ogin noted:

> It is … surprising that she still has fairly severe pain despite the fact that she has not been utilizing her right arm at work.
>
> ****
>
> Neither her mechanism of injury nor her current examination is consistent with rotator cuff pathology.

Dr. Ogin thus ruled out clinical evidence right shoulder pathology but recommended electrodiagnostic testing to rule out peripheral nerve entrapment or radiculopathy.

5. Dr. Ogin performed electrodiagnostic (EMG) testing of the nerves in claimant's bilateral upper extremities on May 1, 2007. Dr. Ogin found evidence of moderate carpal tunnel syndrome (CTS) bilaterally. Dr. Ogin found no electrodiagnostic evidence of cervical radiculopathy or brachial plexus injury. Dr. Ogin suspected claimant's shoulder pain was myofascial in nature. Because claimant's complaints had not improved with treatment, Dr. Ogin referred her for a magnetic resonance imaging (MRI) scan of her right shoulder, which she underwent on May 8, 2007.

6. Dr. Ogin reviewed the results of the MRI scan with claimant on May 9, 2007. Dr. Ogin noted:

> Again her symptom description is quite vague, with pain beginning in her fingers and shooting up to her shoulders.

Dr. Ogin reported that the MRI scan showed no evidence of an acute lesion, but instead showed arthritic changes of the acromioclavicular (AC) joint, tendinopathy, and an old fracture of the glenoid. Dr. Ogin injected claimant's right AC joint with lidocaine, but that failed to provide much relief. Because claimant reported failure of treatment, Dr. Ogin referred her to Orthopedic Surgeon Mark S. Failinger, M.D., for evaluation.

7. Dr. Failinger examined claimant's right shoulder on May 14, 2007, when she reported a different mechanism of injury:

> [Claimant] was **pushing a lot of buckets and just picking them up repetitively** and she had some pain and discomfort in her hand and seemed to go up toward the shoulder. She has had pain since then.

(Emphasis added). Upon examination of claimant's shoulder, Dr. Failinger noted:

> She is fairly dramatic in all presentations, just gentle palpation ….

Dr. Failinger offered a trial injection of cortisone, which claimant rejected. Dr. Failinger noted he had no treatment options to offer, other than surgery. But Dr. Failinger recommended that claimant undergo a psychological evaluation before he would consider any surgical option.

8. Dr. Anderson referred claimant to Psychologist Suzanne Kenneally, Psy.D., for a psychological assessment on June 14, 2007. Claimant reported yet another history of the mechanism of her injury:

> On 02/04/2007, while at work, [claimant] was **taking out 30 gallon trash bins**. She stated there were "35 of them." [Claimant] was again tearful and then stated "I started to get anxious to do a good job and not have any problems." She notes that she began to experience right arm pain after emptying 8-10 of the garbage bins.

(Emphasis added). Dr. Kenneally noted that claimant's affect was labile, ranging from flat to tearful, and that she cried periodically throughout the interview without specific triggers. Dr. Kenneally's testing showed claimant prone to over-report her symptoms, indicative of exaggeration of pain and symptoms, and having a significant contribution of non-physiological factors to her report of pain. Dr. Kenneally reported:

> The over-reporting of psychological and physical symptomatology seen on [claimant's] psychological testing further indicates that **she is a poor candidate for any invasive medical treatment.**

(Emphasis added). Dr. Kenneally cautioned claimant's physicians:

> All treaters are advised to **obtain objective measures of [claimant's] pain symptom and report** and to provide conservative treatment.

(Emphasis added). Dr. Kenneally diagnosed long-standing, preexisting major depressive disorder and anxiety disorder. Based upon Dr. Kenneally's assessment, Dr. Anderson determined claimant is not a surgical candidate.

9. Dr. Anderson prescribed Paxil. According to Dr. Anderson, claimant responded dramatically to the Paxil medication and to psychological intervention with Dr. Kenneally. On August 3, 2007, Dr. Kenneally reported to Dr. Anderson that claimant had markedly improved from counseling for her anxiety and depression. Dr. Anderson planned to restart biofeedback treatment to encourage mobilization of the shoulder and work conditioning. On August 29, 2007, claimant told Dr. Anderson she was interested in another lidocaine injection, which Dr. Ogin performed.

10. With the agreement of Dr. Ogin, Dr. Anderson placed claimant at maximum medical improvement (MMI) on September 5, 2007. Through the course of her medical treatment, Dr. Anderson and Dr. Ogin had referred claimant for physical therapy, biofeedback therapy, shoulder MRI, surgical consultation, and psychological counseling. Dr. Anderson rated claimant's permanent medical impairment at 10% of the upper extremity, based upon abnormal motion. Dr. Anderson opined that claimant's bilateral CTS is unrelated to her work-injury.

11. Insurer filed a Final Admission of Liability on September 19, 2007, admitting liability for permanent partial disability (PPD) benefits based upon Dr. Anderson's 10% upper extremity injury.

12. On September 1, 2007, claimant began working for Solis Cleaning Company performing janitorial work. Although claimant denied any ownership interest in Solis Cleaning Company, the company address and office is located in claimant's residence. The Judge finds that claimant's testimony here lacks credibility and that she became self-employed doing business as Solis Cleaning Company on September 1st, 2007.

13. Claimant requested a leave of absence and last worked for employer during the third week of October, 2007. Claimant wanted leave to help her father through a medical condition. Mr. M testified that he persuaded claimant to allow him to hire someone else to work under claimant's name and social security number. Claimant denied any knowledge of this. Mr. M hired someone who worked under claimant's name and social security number from October through March 14, 2008. During that period of time, Mr. M cashed the other employee's payroll checks, which were made payable to claimant. Mr. M also had another employee work under claimant's name during the 2 to 3 weeks she missed from work following her work-injury. Although Mr. M's testimony was offered to discredit claimant, the Judge finds such manifestly fraudulent conduct on the part of Mr. M instead discredits him and employer.

14. Dr. Kenneally continued to provide psychological counseling to claimant after MMI. On December 20, 2007, Dr. Kenneally recorded the following history from claimant:

> [Claimant] described at great length mopping for an hour at work last Friday. She then experienced significant swelling of her right

> shoulder area and reported being significantly worried. [Claimant] noted using ice and rest on Friday, Saturday and Sunday and she was able to return to her modified duty work on Monday.

Dr. Kenneally counseled claimant to pace herself while working. On January 10, 2008, Dr. Kenneally noted claimant presented in noticeably increased distress, tearful, and emotionally labile throughout the session. Dr. Kenneally noted:

> The cause for [claimant's] heightened distress was reported as the recent relapse in her shoulder pain and swelling following the incident of extensive mopping at work approximately three weeks ago. **[Claimant] was catastrophizing this relapse and focused on a permanent setback in her physical recovery.**

(Emphasis added).

15. Dr. Kenneally testified about the December 20th session with claimant:

> I do remember this fairly clearly because she went over it, certainly twice, if not more than that during the session. She did what she described to me as an entire cafeteria setting, took her at least an hour, maybe a little longer than that.
>
> I don't believe she paced herself or took appropriate breaks. She was under some sort of additional pressure, a coworker hadn't turned up or they were shorthanded … there was some incentive to do this well and to do it quickly. And certainly **her sense was that she pushed herself too far and then had a significant flare-up.**

(Emphasis added). Dr. Kenneally was unaware that claimant had been working for Solis Cleaning Company at the time of the mopping incident.

16. Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation. The division appointed Thomas Fry, M.D., the DIME physician. Dr. Fry examined claimant on January 21, 2008, when she reported the following mechanism of injury:

> Acute onset R hand, wrist, forearm, and elbow pain and right paresthesia when **she had to forcefully lift the top of a plastic trash can** that holds contaminated substances (30-40 gallon container) **patient would pull on the top while holding the container down**. She relates that **she felt a very severe sharp burning pain with tingling needles** … sensation in the arm. **This was immediate and shot all the way down the arm**. She relates there wasinability (sic) to move the arm followed by some recurrence of strength.

(Emphasis added). It appears that the earliest medical record provided Dr. Fry was the February 28, 2007, report of Dr. Anderson. Dr. Fry lacked the ER record and earlier records from Dr. Anderson. It appears from his report that Dr. Fry did

not review Dr. Kenneally's June 14, 2007, psychological assessment of claimant. Claimant failed to report to Dr. Fry any history of the December 2007 mopping incident. Dr. Fry had neither Dr. Kenneally's December 20, 2007, report nor her January 10, 2008, report to review.

17. Dr. Fry ruled out a shoulder injury, but found evidence of a neck injury; he assessed the following:

> [Claimant's] history and physical examination are most consistent with a brachial plexus or neuritic problem. **History of mechanism of injury** are most suggestive of an acute cervical HNP [disk herniation].
>
> ****
>
> I do not think [claimant] has significant shoulder pathology of rotator cuff, biceps tendon or labrum. [Claimant] may have some mild degenerative changes of the [AC] joint which probably are not a significant factor in her current radiating pain.

(Emphasis added). Dr. Fry relied upon the history claimant gave him suggesting a neck injury in determining that she had not reached MMI. Dr. Fry recommended a cervical MRI study and cervical evaluation. Dr. Fry's determination regarding MMI is presumptively correct unless overcome by clear and convincing evidence.

18. Claimant's counsel referred her to John S. Hughes, M.D., for and independent medical examination on June 6, 2008. The earliest medical record provided for Dr. Hughes to review was the February 28, 2007, report of Dr. Anderson. Claimant reported another and different mechanism of injury to Dr. Hughes, this time from <u>closing</u> a container:

> [Claimant] was working in a place that required containerizing bio waste. She describes **closing** up 30-60 pound **containers** …. **She demonstrates that closing these containers requires a strong jerking motion** and **that day, she did not think much of her symptoms** but the following day she recalls "pain was unbearable."

(Emphasis added). Dr. Hughes opined in his report that claimant sustained 2 distinct injuries that led to her persistent symptom complex: A more minor right shoulder strain and a cervical spine injury. Claimant had not told Dr. Hughes about the December 2007 mopping incident. Dr. Hughes agreed with Dr. Fry's determination that claimant had not reached MMI and with Dr. Fry's treatment recommendations.

19. Dr. Hughes testified that claimant is not a good historian and that he prefers a precise description of the mechanism of injury as the basis for his causality analysis. Dr. Hughes stated that Dr. Anderson's initial evaluations of claimant in February of 2007 document different findings from what he and Dr. Fry found. Dr. Hughes stated that

there were no objective findings supporting a cervical spine injury prior to the time Dr. Anderson placed claimant at MMI in September of 2007.

20. Based upon the totality of the evidence, the Judge finds it more probably true that claimant's report of her symptoms and mechanism of injury is unreliable and lacking credibility. The above findings reflect claimant reporting numerous, different mechanisms of injury and resulting symptoms. The Judge credits the psychological assessment of Dr. Kenneally in finding claimant prone to exaggerate her symptoms. Claimant thus lacks credibility.

21. Crediting Dr. Anderson's testimony, the May 1, 2007, EMG testing by Dr. Ogin is the gold standard for testing for cervical radiculopathy. In addition, Dr. Anderson repeatedly performed clinical testing for signs of cervical, thoracic outlet, or brachial plexus injury, all of which were negative during the course of treatment through MMI. When Dr. Anderson examined claimant on November 5, 2007, he found no clinical evidence of any cervical or thoracic outlet injury. According to Dr. Anderson, Dr. Fry used the same testing maneuvers as he had throughout his treatment of claimant. However, Dr. Fry's exam findings were positive, and thus different from the exam findings Dr. Anderson noted throughout his treatment of claimant prior to MMI. Dr. Anderson testified that it is probable claimant had an intervening injury between MMI and the time Dr. Fry examined her on January 21, 2008. Dr. Anderson testified:

> [T]here is such a **marked discrepancy between what [Dr. Fry] has written here and what my findings were and what Dr. Ogin's findings were,** both clinically and with testing, that if [claimant] did suffer an acute cervical disk herniation, it had to have been … a result of … some other incident, but certainly not something that would have occurred at the time I was actively treating her.

(Emphasis added). Dr. Anderson and Dr. Hughes alike testified that the mopping incident could cause claimant's cervical symptoms. Dr. Anderson's testimony was persuasive.

22. Respondents showed it highly probable Dr. Fry erred in determining claimant has not reached MMI. As found, claimant lacks credibility. Because Dr. Fry relied upon claimant's report of a new and different mechanism of neck injury as the basis for his medical opinion that claimant had not reached MMI, his medical opinion lacks credibility and is unpersuasive. As found, Dr. Anderson's medical opinion was more persuasive in showing claimant had no cervical symptoms or findings to support a cervical injury until after his evaluation of claimant on November 10, 2007, *i.e.*, after the mopping incident. Respondents thus overcame Dr. Fry's MMI determination by clear and convincing evidence.

23. Crediting Dr. Anderson's medical opinion, claimant reached MMI on September 5, 2007.

24. Claimant worked for employer and for Liborio Markets at the time of her work injury. Claimant's average weekly wage for employer based upon an average work week of 30.5 hours and the hourly wage of $9.20 plus average overtime, and holiday pay of $53.20 per week for an average weekly wage of $366.80. Claimant average weekly wage from Liborio Markets was $366.52. Claimant showed it more probably true that

her average weekly wage, based upon concurrent employment is $733.32. Claimant last worked for Liborio Markets on February 4, 2007. Liborio Markets terminated claimant on April 11, 2007.

25. Claimant however failed to show it more probably true than not that the no use of the right hand restriction precluded her from performing her regular employment at Liborio Markets after February 4, 2007. Claimant failed to present any persuasive evidence to support a claim for temporary disability benefits.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

A. Overcoming the DIME:

Respondents argue they overcame Dr. Fry's determination on the issue of MMI by clear and convincing evidence. The Judge agrees.

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been

proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Bing Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

Here, the Judge found respondents showed it highly probable Dr. Fry erred in determining claimant has not reached MMI. Respondents thus overcame Dr. Fry's MMI determination by clear and convincing evidence.

The Judge found that claimant lacks credibility. Because Dr. Fry relied upon claimant's report of a new and different mechanism of neck injury as the basis for his medical opinion that claimant had not reached MMI, the Judge found that his medical opinion was unpersuasive. The Judge instead credited Dr. Anderson's medical opinion in finding that claimant had no cervical symptoms or findings to otherwise support a cervical injury until after the mopping incident at Solis Cleaning Company. The Judge thus upheld Dr. Anderson's determination that claimant reached MMI on September 5, 2007.

The Judge concludes that claimant's request for an award of workers' compensation benefits related to her cervical condition should be denied and dismissed.

B. Temporary Disability Benefits:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to temporary disability benefits based upon her wage loss from concurrent employment. The Judge disagrees.

Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. 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).

Earnings from concurrent employment may be included in a claimant's AWW where the injury impairs earning capacity from such employment. *Jefferson County Schools v. Dragoo*, 765 P.2d 636 (Colo. App. 1988). Section 8-42-

103(1), *supra*, requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997).

The Judge found that claimant showed it more probably true that her average weekly wage, based upon concurrent employment is $733.32. Claimant however failed to show it more probably true than not that the no use of the right hand restriction precluded her from performing her regular employment at Liborio Markets after February 4, 2007. Claimant failed to present any persuasive evidence to support a claim for temporary disability benefits.

The Judge concludes claimant's request for temporary disability benefits based her wage loss from Liborio Markets should be denied and dismissed.

ORDER

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

1. Claimant's request for an award of workers' compensation benefits related to her cervical condition is denied and dismissed.

2. Claimant's request for temporary disability benefits based her wage loss from Liborio Markets is denied and dismissed.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _December 8, 2008_

Michael E. Harr,
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-696-533

ISSUES

1. Whether Claimant constitutes a "statutory employee" of Employer pursuant to §8-41-401(1), C.R.S.

2. Whether Claimant's claim is precluded by the two-year statute of limitations in §8-43-103(2), C.R.S.

3. Whether Claimant has established by a preponderance of the evidence that she sustained a compensable injury on December 18, 2003 during the course and scope of her employment with Employer.

4. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

5. A determination of Claimant's Average Weekly Wage (AWW).

6. Whether Claimant has established by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits from December 18, 2003 through March 31, 2004 and from September 13, 2006 until terminated by statute.

FINDINGS OF FACT

1. Claimant worked as a painter for FSP. FSP was a painting company that assigned Claimant to various job locations, dictated her hours of employment and provided her with the necessary equipment and materials to complete her duties. Claimant earned $15.00 per hour and worked 40 hours each week.

2. FSP contracted with Employer to paint a restroom at Employer's store in the Southwest Plaza Mall. FSP directed Claimant and another employee to perform the painting job. On December 17, 2003 Claimant went to Employer's store and observed that the restroom walls were covered in graffiti. She then prepared the restroom for painting.

3. On December 18, 2003 Claimant returned to Employer's store. Claimant and another employee of FSP entered a utility room in Employer's store because the room contained a sink. They intended to run hot water over cans of paint in order to warm them to room temperature. Claimant explained that she was facing the sink with her back to the door. An employee of the company that removes trash for Employer then pushed an empty, wheeled trash cart into the utility room. The trash cart struck Claimant in the back and knocked her to the floor. Claimant testified that she injured her back, neck and shoulder as a result of the incident.

4. Claimant reported her injury to Employer on the day of the incident. Employer prepared a "Non-Associate Accident Report" and an accompanying "Narrative Report of Investigation." The Non-Associate Accident Report specified "in storage room filling paint bucket with water when I was struck from behind with no warning by a large trash bin on rollers into my mid-back." The Narrative Report of Investigation further detailed Claimant's description of the incident and noted that her claim had been reported to Insurer.

5. On December 18, 2003 Claimant visited Jeffrey N. Gerber, M.D. for an evaluation. Dr. Gerber noted that Claimant had suffered "[b]lunt trauma to the posterior thorax and right rib cage areas, moderate to severe" and a "cervical sprain." He prescribed medications, recommended x-rays and excused Claimant from work. Claimant never returned to work for FSP.

6. On December 23, 2003 Claimant obtained medical treatment from personal physician Tracy Saffer, M.D. Claimant reported that she suffered from shoulder and back pain as a result of the December 18, 2003 incident.

7. Claimant testified that she operated her own painting company from approximately April of 2004 until November of 2005. She hired others to perform painting duties while she primarily engaged in sedentary tasks that included payroll and bookkeeping responsibilities.

8. On March 31, 2005 Claimant visited Jeffrey Kleiner, M.D. for an evaluation. Claimant recounted that she had been injured on December 18, 2003 when she was struck from behind by a trash container. In the days immediately after the incident Claimant experienced pain in her low back, neck, left buttocks and leg. Claimant also noted that she began to experience severe migraine headaches as a result of the incident. Dr. Kleiner concluded that Claimant "sustained a whiplash type injury as a consequence of her work-related accident on 12/18/03. She likely has sustained an internal disc disruption problem in her cervical spine which is responsible for the headache symptoms and referred pain to the scapular areas." An April 6, 2005 MRI of Claimant's cervical spine revealed a broad-based bulging of the C5-6 disc.

9. On August 31, 2006 Claimant filed a Workers' Claim for Compensation against FSP as a result of the December 18, 2003 incident.

10. On September 22, 2006 E. Jeffrey Donner, M.D. performed surgery on Claimant. She underwent an anterior cervical C5-6 discectomy, bilateral nerve root decompression and interbody fusion. In his preoperative history and physical evaluation, Dr. Donner noted "the patient is a 41-year-old female who had a work related injury in December 2003. She has had progressive, severe pain unresponsive conservative treatment. An MRI showed a central C5-6 disc herniation."

11. On December 14, 2006 Claimant filed a Workers' Claim for Compensation against Employer regarding the December 18, 2003 incident.

12. On September 7, 2007 Claimant filed a Workers' Claim for Compensation against the Southwest Plaza Mall regarding the December 18, 2003 incident.

13. SS, the General Manager of Southwest Plaza Mall testified through an evidentiary deposition in this matter. Ms. S is responsible for leasing, operations, security, janitorial services, marketing and customer service at the Mall. She credibly explained that Southwest Plaza Mall never contracted with FSP to perform painting services at the Mall. Because Southwest Plaza Mall did not have any contractual relationship with FSP, the Mall did not constitute Claimant's "statutory employer" pursuant to §8-41-401(1), C.R.S.

14. Ms. S also testified that Southwest Plaza Mall contains four "anchor stores," including Employer, that are "stand-alone" businesses responsible for their own interior maintenance. Ms. S explained that all of the "anchor stores" are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide services in the nature of painting houses or businesses.

15. Claimant has failed to establish that Employer constituted her "statutory employer" pursuant to §8-41-401(1), C.R.S. Claimant has not demonstrated that Employer subcontracted out its "regular business," as defined by its "total business operation," to FSP. Ms. S credibly testified that all of the "anchor stores" in the Southwest Plaza Mall, including Employer, are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide painting services. Employer contracted with FSP to remove graffiti and paint a bathroom within its store. Based on Ms. S's credible testimony, the painting of bathrooms was not a routine or regular aspect of Employer's total business operations. Painting the bathroom also was not integral to Employer's business of retail sales. Although Employer determined that the bathroom required painting, the importance of painting the bathroom was ancillary to Employer's business of selling clothing, hardware and appliances. Moreover, the record is devoid of evidence that Employer would have been required to use its own employees to paint the bathroom. Finally, consistent with the purpose of §8-41-401(1)(a), C.R.S., Employer did not seek to avoid workers' compensation liability by contracting out its typical business operations to FSP.

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 in-

jured 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 (2005).

4. Claimant contends that she is entitled to recover workers' compensation benefits through Employer as a result of the December 18, 2003 incident because Employer constituted her "statutory employer." Pursuant to §8-41-401(1)(a), C.R.S. a company that contracts out its work to a subcontractor is the statutory employer of the subcontractor and the subcontractor's employees. The purpose of the statute is to preclude employers from "avoiding responsibility under the workers' compensation act by contracting out their regular work to uninsured independent contractors." *Finlay v. Storage Technology Corp.*, 764 P.2d 62, 64 (1988).

5. The test for whether a contractor that has subcontracted out its work constitutes a statutory employer is satisfied if the contracted services are part of the contractor's regular business as defined by its "total business operation." *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002). In evaluating a contractor's "total business operation" factors to be considered include "routineness, regularity, and the importance of the contracted services to the contractor's business operations." *Id.*; *see M&M Management Company v. Industrial Claim Appeals Office,* 979 P.2d 574, 577 (Colo. App. 1998). There is no specific formula for defining "regularity" and "routineness" in terms of frequency. *Shumiloff v. Frey,* W.C. No. 4-005-377 (ICAP, Apr. 24, 1992). Instead, a service is "regular" and "routine" if it is "an integral part of the contractor's total business operation." *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002). The importance of the contracted services may be ascertained by determining whether the contractor would be required to perform the services using its employees. *Finlay,* 764 P.2d at 66; *Campbell v. Black Mountain Spruce, Inc.,* 677 P.2d 379, 381 (Colo. App. 1983). Application of the "regular business test" is dependent on the facts of each case. *In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002).

6. As found, Claimant has failed to establish that Employer constituted her "statutory employer" pursuant to §8-41-401(1), C.R.S. Claimant has not

demonstrated that Employer subcontracted out its "regular business," as defined by its "total business operation," to FSP. Ms. S credibly testified that all of the "anchor stores" in the Southwest Plaza Mall, including Employer, are large retail businesses. Employer specifically sells clothing, hardware and appliance items. Employer does not provide painting services. Employer contracted with FSP to remove graffiti and paint a bathroom within its store. Based on Ms. S's credible testimony, the painting of bathrooms was not a routine or regular aspect of Employer's total business operations. Painting the bathroom also was not integral to Employer's business of retail sales. Although Employer determined that the bathroom required painting, the importance of painting the bathroom was ancillary to Employer's business of selling clothing, hardware and appliances. Moreover, the record is devoid of evidence that Employer would have been required to use its own employees to paint the bathroom. Finally, consistent with the purpose of §8-41-401(1)(a), C.R.S., Employer did not seek to avoid workers' compensation liability by contracting out its typical business operations to FS P. *See In Re Ferreira,* W.C. No. 4-498-475 (ICAP, Oct. 9, 2002) (concluding that the claimant failed to demonstrate that child placement agency was his statutory employer because agency did not contract out part of its regular business to the claimant's uninsured direct employer).

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.

DATED: December 8, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-499-564 and WC 4-524-611

ISSUES

Whether Respondent-Insurer/Fremont is responsible for Claimant's left total knee replacement surgery on September 17, 2007?

Whether Respondent-Insurer/Pinnacol is responsible for Claimant's right total knee replacement surgery on September 17, 2007?

FINDINGS OF FACT

1. Claimant suffered admitted knee injuries one to the left knee and one to the right knee.

2. The left knee injury is the subject of WC 4-499-564, for which Respondent-Insurer/Fremont was responsible and the right knee is the subject of WC 4-524-611, for which Respondent-Insurer/Pinnacol was responsible.

3. On or about September 17, 2007 Claimant underwent bilateral total knee replacement surgery conducted by Dr. Timothy O'Brien. In neither claim was proper prior authorization sought by the Claimant. In the one attempt at prior authorization Claimant's counsel wrote to counsel for the Respondent-Insurer/Fremont indicating that Claimant was scheduled to undergo bilateral knee replacement surgery on September 17, 2007 and requesting authorization. This request did not comply with the Workers' Compensation Rules of Procedure. Respondents' counsel wrote to Claimant's counsel the next day and delivered the letter by facsimile that day, indicating that prior authorization was denied.

4. Dr. O'Brien is not an authorized treating physician in either claim. Claimant did not seek approval for a change in physician to Dr. O'Brien in either claim.

5. Claimant's bilateral total knee replacement took place when each of the claims was closed. The claims were reopened pursuant to a hearing that occurred three and a half weeks *after* the surgery, by order dated November 28, 2007. Claimant underwent bilateral total knee replacement surgery conducted by an unauthorized physician and without properly seeking prior authorization.

6. The bilateral total knee replacement that Claimant underwent on September 17, 2007, was not authorized by either the Respondent-Insurer/ Fremont or by Respondent-Insurer/Pinnacol.

CONCLUSIONS OF LAW

Once a claim is closed, no further benefits may be awarded unless the claimant establishes grounds to reopen the claim. *Burke v. Industrial Claim Appeals Office*, 905 P. 2d 1 (Colo. App. 1994). Section 8-43-303 C.R.S. 2007, allows reopening upon proof the claimant's physical condition from the industrial injury worsened after MMI. *Anderson v. Longmont Toyota Inc.*, 102 P.3d 323 (Colo. 2004). Here, Claimant independently sought, and underwent total knee replacement surgery while both of the claims hereunder were closed and without seeking proper prior authorization from either of the Respondent-Insurers. Claimant's hearing on reopening occurred after the Claimant had the total knee replacement surgeries.

Claimant has failed to establish by a preponderance of the evidence that Respondent-Insurer/Fremont is responsible for payment of the Claimant's left total knee replacement surgery and attendant care.

Claimant has failed to establish by a preponderance of the evidence that Respondent-Insurer/Pinnacol is responsible for payment of the Claimant's right total knee replacement surgery and attendant care.

ORDER

It is therefore ordered that:

1. Claimant's request to hold Respondent-Insurer/Fremont responsible for payment of the Claimant's left total knee replacement surgery and attendant care is denied and dismissed.

2. Claimant's request to hold Respondent-Insurer/Pinnacol responsible for payment of the Claimant's right total knee replacement surgery and attendant care is denied and dismissed.

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

December 4, 2008
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-736-478

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered industrial injuries during the course and scope of his employment with Employer on September 17, 2005.

2. Whether Claimant's claim is precluded by the two-year statute of limitations in §8-43-103(2), C.R.S.

3. Whether Claimant is precluded from receiving workers' compensation benefits because Colorado lacks jurisdiction over his claim.

4. Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries.

FINDINGS OF FACT

1. On February 1, 2003 Claimant began working for Employer as a field interviewer and data collector. The contract of employment was formed in Nevada.

2. Claimant traveled approximately 48 weeks each year in order to perform his job duties. His extensive travel schedule required him to stay in hotels each night.

3. On September 16, 2005 Claimant traveled from Salt Lake City, Utah to Denver, Colorado to perform his job duties. He checked into the Town Place Suites based on instructions from his Employer.

4. Claimant noticed that the bed in his hotel room was in poor condition. He credibly testified that he fell asleep in the bed but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. Claimant experienced numbness from his right shoulder down to his hand.

5. Two days after the incident Claimant reported the injury to his supervisor. However, the supervisor did not refer Claimant for medical treatment.

6. Claimant did not initially obtain medical treatment because he believed his symptoms would improve. He first sought treatment for his symptoms on October 25, 2005. Claimant's complaints included "wrenched back 4 weeks past" and "3 weeks past R arm went numb." He was diagnosed with back pain.

7. Claimant next sought medical treatment on November 30, 2005 with Richard Graham, M.D. in Long Beach, California. Claimant explained that his problems with his right arm began approximately nine weeks earlier upon abruptly awakening. Dr. Graham diagnosed Claimant with right inferior brachial plexopathy. Dr. Graham stated, "[p]resumed transient compressive process related to sleep posture with marked deficit onset upon awakening."

8. On December 7, 2005 Claimant again visited Dr. Graham for an evaluation. Dr. Graham opined "all signs, symptoms and history suggestive of right inferior brachial plexopathy caused by prolonged sleeping positioning."

9. From March 23-28, 2006 Claimant received physical therapy treatment for his right arm and back symptoms. The physical therapist's notes reflect

that Claimant reported a pinched nerve in his right arm that had been caused by sleeping with his right arm over his head in September 2005.

10. On May 17, 2007 Claimant filed a Claim for Compensation in Nevada. He credibly explained that he filed the claim in Nevada because he was instructed by Employer's human resources specialist to file the claim in the state in which he lived. Claimant was a resident of Nevada at the time.

11. Claimant subsequently discovered through research that he should have filed his claim for compensation in Colorado because that was the state in which his injury occurred. He filed his Colorado claim on September 21, 2008. The time of filing was several days after the two-year anniversary of his injuries.

12. On August 22, 2008 Claimant underwent a medical evaluation with John S. Hughes, M.D. Dr. Hughes opined that Claimant sustained a back strain injury that caused a lower trunk brachial plexopathy. He noted that Claimant's injury "commonly occurs with impaction of the shoulder."

13. Claimant has demonstrated that it is more probably true than not that he suffered compensable industrial injuries to his right upper back. neck and arm during the course and scope of his employment with Employer on September 17, 2005. Employer required Claimant to travel extensively and stay in specified hotels in order to complete his job duties. Claimant credibly explained that he went to sleep on September 16, 2005 but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. He experienced numbness from his right shoulder down to his hand. The medical records of Dr. Graham are consistent with Claimant's account of his injury and reflect that Claimant suffered right inferior brachial plexopathy caused by a prolonged sleeping position. Moreover, the physical therapist's notes are also consistent with Claimant's account of the injury. Although Claimant was sleeping at the time of his injury, his activity was reasonably incidental to the conditions of his employment. Respondents have not demonstrated that Claimant engaged in a distinct departure that resulted in a personal deviation from the scope of his employment.

14. Employer's human resources specialist misadvised Claimant to file his claim for workers' compensation in Nevada because he lived in Nevada. The erroneous information from Employer constituted a reasonable excuse for Claimant to file his claim in Colorado several days after the expiration of the two-year deadline. Moreover, Employer's rights were not prejudiced by Claimant's minimal delay in filing his claim in Colorado. Because Claimant filed his claim within three years after September 17, 2005, his claim is not precluded by the statute of limitations in section 8-43-103(2), C.R.S.

15. Claimant promptly notified his supervisor of the September 17, 2005 industrial injury, but Employer failed to designate a medical provider. The right to select an Authorized Treating Physician (ATP) thus passed to Claimant.

16. Claimant has established that it is more probably true than not that he received medical treatment that was reasonable and necessary to cure and relieve the effects of his industrial injuries. The medical records reveal that Claimant's medical treatment beginning October 25, 2005, continuing with Dr. Graham and culminating with physical therapy were designed to alleviate the effects of his industrial injuries.

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 (2005).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). An employee whose business requires travel away from the employer's premises is considered to be continuously acting within the course of his employment throughout the trip unless he makes a "distinct departure on a personal errand and is therefore engaged in a substantial, personal deviation." *In Re Torres*,

W.C. No. 4-701-752 (ICAP, Sept. 6, 2007); *see Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9, 11 (Colo. App. 1995). An employee is not required to be actually engaged in job duties in order to suffer a compensable injury while in travel status. *Hirst*, 905 P.2d at 12. Instead, a traveling employee suffers a compensable injury "if the injury arises out of a risk which is reasonably incidental to the conditions and circumstances of the particular employment." *Id.* When the claimant is in travel status, the burden of proof is on the respondents to establish a distinct departure resulting in a personal deviation from the scope of employment. *In Re B*, W.C. No. 4-657-213 (ICAP, May 11, 2006); *Pacesetter Corp. v. Collett*, 33 P.3d 1230, 1233 (Colo. App. 2001). The existence of a substantial, personal deviation is a question of fact for the ALJ. *See In Re Torres*, W.C. No. 4-701-752 (ICAP, Sept. 6, 2007).

5. As found, Claimant has demonstrated by a preponderance of the evidence that he suffered compensable industrial injuries to his right upper back. neck and arm during the course and scope of his employment with Employer on September 17, 2005. Employer required Claimant to travel extensively and stay in specified hotels in order to complete his job duties. Claimant credibly explained that he went to sleep on September 16, 2005 but was awakened at approximately 2:00 a.m. by a loud popping in his right arm. He experienced numbness from his right shoulder down to his hand. The medical records of Dr. Graham are consistent with Claimant's account of his injury and reflect that Claimant suffered right inferior brachial plexopathy caused by a prolonged sleeping position. Moreover, the physical therapist's notes are also consistent with Claimant's account of the injury. Although Claimant was sleeping at the time of his injury, his activity was reasonably incidental to the conditions of his employment. Respondents have not demonstrated that Claimant engaged in a distinct departure that resulted in a personal deviation from the scope of his employment.

Statute of Limitations

6. Section 8-43-103(2), C.R.S. provides that a notice of a claim for compensation must be filed with the Division of Workers' Compensation within two years from the date of the injury. However, the two-year time limitation may be extended to three years if there is a reasonable excuse for the late filing and the employer's rights have not been prejudiced by the delay.

7. As found, Employer's human resources specialist misadvised Claimant to file his claim for workers' compensation in Nevada because he lived in Nevada. The erroneous information from Employer constituted a reasonable excuse for Claimant to file his claim in Colorado several days after the expiration of the two-year deadline. Moreover, Employer's rights were not prejudiced by Claimant's minimal delay in filing his claim in Colorado. Because Claimant filed his claim within three years after September 17, 2005, his claim is not precluded by the statute of limitations in section 8-43-103(2), C.R.S.

Improper Jurisdiction

8. Relying on Denver Truck Exchange v. Perryman, 134 Colo. 586, 307 P.2d 805 (1957), Respondents assert that Claimant is ineligible to receive workers' compensation benefits because Colorado lacks jurisdiction over his claim. However, Respondents' reliance is misplaced because *Perryman* involves whether Colorado has jurisdiction over injuries that are suffered out of the state. *Perryman* provides that Colorado does not have jurisdiction over an "out-of state injury" unless the claimant proves two of the following three criteria: (1) a contract of employment created in Colorado; (2) employment in Colorado under a contract created outside the state; and (3) substantial employment in Colorado. *See In Re Clendening,* W.C. Nos. 4-724-056 & 4-724-057 (ICAP, Aug. 6, 2008). Because it is undisputed that the September 17, 2005 incident occurred while Claimant was staying in a Denver, Colorado hotel, Respondents' contention of "improper jurisdiction" fails.

Medical Benefits

9. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

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

11. As found, Claimant promptly notified his supervisor of the September 17, 2005 industrial injury, but Employer failed to designate a medical provider. The right to select an ATP thus passed to Claimant.

12. As found, Claimant has established by a preponderance of the evidence that he received medical treatment that was reasonable and necessary to cure and relieve the effects of his industrial injuries. The medical records reveal that Claimant's medical treatment beginning October 25, 2005, continuing with Dr. Graham and culminating with physical therapy were designed to alleviate the effects of his industrial injuries.

ORDER

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

1. Claimant suffered compensable injuries on September 17, 2005 during the course and scope of his employment with Employer.

2. Claimant is entitled to receive medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries.

3. Any issues not resolved in this order are reserved for future determination.

DATED: December 9, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-491-883

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that she suffered a worsened condition that would justify reopening the claim?
¬ If the claim is reopened, did the claimant prove by a preponderance of the evidence that Botox injections constitute reasonable and necessary medical treatment to cure and relieve the effects of the injury?

FINDINGS OF FACT

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

1. The claimant sustained an admittedly compensable injury on March 17, 2000, when she was involved in a motor vehicle accident (MVA). This injury affected the claimant's neck and back, and she experienced headaches.

2. In August 2000, an MRI was performed on the low back. It revealed early degenerative changes at L4-5 and mild annular bulging at L1-2. A cervical MRI was performed in September 2000. The cervical MRI indicated "reversal of the normal mid-cervical lordosis secondary to fairly advanced mid-cervical spondylosis." In November 2000 the claimant underwent a cervical dis-

cogram and the impression was “negative discography for pain reproduction” and “multi-level degenerative change.”

3. In July 2001, the claimant first came under the care of Dr. Edwin Healey, M.D. Dr. Healey is board certified in occupational medicine and neurology. Dr. Healey diagnosed severe lumbar, thoracic and cervical myofascial pain.

4. In April 2002, Dr. David Wong, M.D., performed surgery on the claimant’s low back. This surgery consisted of a fusion at L5-S1 with instrumentation and decompression at L4-5.

5. On January 13, 2003, Dr. Healey placed the claimant at maximum medical improvement (MMI) with 28 percent whole person impairment of the spine. Dr. Healey opined the claimant should be restricted to lifting, carrying, pushing or pulling 20 pounds occasionally, sitting for 30 minutes and standing for 10 to 15 minutes. Dr. Healey recommended medical maintenance care to include three years of trigger point injections for the claimant’s myofascial pain, and psychiatric care.

6. In April 2003, Dr. George Kohake, M.D., performed a Division-sponsored independent medical examination (DIME). Dr. Kohake noted the claimant continued to have “diffuse back complaints involving both the upper and lower back” three years after the work-related MVA. The claimant reported her pain ranged from 5 to 8 on a scale of 10 (5-8/10), and that it had increased since she returned to work as a “closing escrow coordinator.” The claimant was taking Mobic twice per day and Flexeril three timed per day. Dr. Kohake placed the claimant at MMI on January 17, 2003, and assigned 25 percent whole person impairment for her spinal condition and 1 percent impairment for a psychological disorder.

7. In 2004, Dr. Wong performed additional surgery to remove the hardware installed during the 2002 surgery. Dr. Healey continued to treat the claimant until December 2004, when he left to work for a different medical provider.

8. On November 9, 2004, Dr. Healey noted the claimant had again reached MMI after surgical removal of the hardware with no change in her permanent impairment rating. Following Dr. Healey’s report, the insurer filed a Final Admission of Liability (FAL) on March 3, 2005. This FAL admitted for ongoing medical benefits (*Grover* medicals) after MMI.

9. In 2005 Dr. Kristin Mason, M.D., became the authorized treating physician for purposes of providing *Grover* medical treatment to the claimant. The claimant continued to experience back pain. Dr. Mason prescribed an extensive course of physical therapy and trigger point injections. On May 8, 2006, during the course of the treatment, the claimant advised Dr. Mason that she was

experiencing a pain level of 5-6/10. In June 2006, the claimant advised Dr. Mason that she was continuing to experience back spasms when walking, and had aching in her legs. In November 2006, the claimant advised Dr. Mason that she had experienced increased pain after accepting a new job that required more sitting and computer work. In March 2007, the claimant reported that she experienced severe spasms on the right side of her back, which she attributed to her sedentary work as a mortgage closer. In September 2007, the claimant reported that her pain level was 5 or 6/10. Additional trigger point injections were performed. On November 19, 2007, the claimant reported pain at a level of 6/10.

10. In February 2008, the claimant advised Dr. Mason that she was working a new job that was even more sedentary than her previous job, but was experiencing "some exacerbations of pain above the level of her fusion." On March 3, 2008, the claimant reported to Dr. Mason that she had improved some after additional physical therapy, but was now worse and had cut her work hours to 32 per week. On March 24, 2008, the claimant advised Dr. Mason that she was "worse by 15%" and had quit her job because she was too symptomatic to continue.

11. On April 2, 2008, Dr. Healey performed and independent medical examination (IME) at the request of the claimant's attorney. Dr. Healey reported the claimant's thoracolumbar pain had become much more severe over the last year, and that the claimant reported an average pain level of 5-6/10. Dr. Healey diagnosed a "recent increase in thoracolumbar myofascial pain, with increased spasms and trigger points, and chronic cervicothoracic myofascial pain with secondary headaches and underlying diagnosis of cervical spondylosis." Dr. Healey opined the claimant had a "noticeable increase in the spasms in her thoracolumbar musculature" and gave a "subjective history of an increase in her symptoms." Dr. Healey recommended that the claim be reopened to provide the claimant a trial of Botox injections that "might result in significant improvement in both her pain and functional status." However, Dr. Healey noted that the claimant's "lumbar range of motion is essentially unchanged from the time I performed an impairment rating in 2003."

12. On April 15, 2008, the claimant filed a petition to reopen the claim based on a worsened condition. The petition was supported by Dr. Healey's April 2008 report.

13. On April 8, 2008, Dr. Wong examined the claimant upon referral from Dr. Mason. The claimant reported that her pain ranged from 5 to 8/10, and that it was 5-6/10 on the date of the examination. Dr. Wong noted "minor spasms" and opined the claimant was "primarily having mechanical low back pain secondary to multilevel degenerative changes in the thoracic and lumbar area." Dr. Wong also noted a "moderate scoliosis which has increased over time," and minor residual radicular radiation that "has not substantially changed."

Dr. Wong noted the claimant was "feeling much better with less activity now she is off work," and opined she "should continue symptomatic care."

14. On June 16, 2008, Dr. Jeffrey Sabin, M.D. performed an IME at the request of the respondents. Dr. Sabin is board certified in orthopedic surgery and focuses on treatment of the spine. Dr. Sabin reviewed the claimant's medical records, except there was a "gap" of 19 months between Dr. Kohake's April 2003 DIME report and November 14, 2005. Dr. Sabin opined the claimant remained at MMI.

15. On July 28, 2008, the claimant underwent a lumbar MRI. The impression was "postoperative changes from L4-5 and L5-S1 laminectomy with apparent removal of reported fusion hardware." The report also noted mild multilevel degenerative joint disease without focal protrusion or high grade stenosis, with the exception of a shallow broad-based protrusion at T11-12 producing effacement of the CSF space."

16. On August 21, 2008, Dr. Wong reviewed the July 2008 MRI. Dr. Wong stated that the MRI scan demonstrated "desiccated discs at all lumbar segments," unchanged scoliosis, and a mild bulge at T11-12 with "no major impingement." Dr. Wong diagnosed mechanical low back pain secondary to multilevel degenerative changes above the old fusion.

17. On August 19, 2008, Dr. Mason expressed uncertainty as to whether the T11-12 disc protrusion to the industrial injury. Dr. Mason also stated that the claimant's reported increase in symptoms "may indicate an overall worsening of her myofascial pain." The ALJ concludes that this statement is equivocal and does not amount to a persuasive opinion that the claimant has sustained a worsened condition.

18. Dr. Sabin reviewed the MRI results and they did not change his opinion expressed on June 16, 2008.

19. On October 22, 2008, Dr. Healey performed an additional examination of the claimant. The claimant reported her thoracolumbar pain ranged between 6-7/10. Dr. Healey reiterated the opinion that Botox injections might relieve some of the claimant's thoracolumbar myofascial pain. He also opined that the claimant's permanent medical impairment had increased since Dr. Kohake placed the claimant at MMI in April 2003. Dr. Healey stated that claimant's lumbar impairment had increased 7 percent, based on 1 percent impairment for the hardware removal and 6 percent additional impairment for reduced range of motion. Dr. Healey also opined the claimant's thoracic impairment had increased 1 percent based on reduced range of motion.

20. Dr. Healey testified at the hearing on November 20, 2008. Dr. Healey opined the claimant was no longer at MMI because of an increase of

symptoms that was not responsive to the previous forms of treatment, and that further treatment could allow her to return to work. Dr. Healey opined the claimant's major problems have been severe trigger points and spasms. According to Dr. Healey, recent medical literature indicates that the claimant would benefit from a trial of lumbosacral injections of Type A Botox neurotoxin. Dr. Healey opined that the increase in the claimant's cervical and thoracolumbar symptoms was directly related to the industrial MVA in March 2000.

21. Dr. Healy also testified that between 2003 and 2008 the claimant's permanent medical impairment has increased 7 percent. Dr. Healey attributed the increase to the additional surgery to remove the hardware and a reduction in the claimant's lumbar ranges of motion.

22. On cross-examination Dr. Healey stated that the benefits of Botox injections usually last about 3 months, and that the claimant could require such injections indefinitely.

23. Dr. Sabin testified for the respondents at the hearing on November 20, 2008. Dr. Sabin testified that because the claimant's principal diagnosis is myofascial pain without identification of any specific pain generator, it is reasonable to expect the claimant's symptoms to wax and wane, and it is reasonable to expect the claimant to experience "exacerbations" of her pain. Dr. Sabin explained that the mere exacerbation of pain does not require the conclusion that the claimant is no longer at MMI. Dr. Sabin opined there is no real objective evidence that the claimant's condition has changed since she was put at MMI, that she remains at MMI, and that she needs maintenance care.

24. The claimant failed to prove it is more probably true than not that her physical condition has worsened. The persuasive evidence demonstrates that the claimant's symptoms and condition have not significantly worsened since she was placed at MMI in November 2004, after she underwent the surgery to remove the instrumentation. The ALJ credits medical reports showing that, although the claimant subjectively believes her symptoms have become worse since she was placed at MMI, she has rather consistently reported pain in the range of 5 to 7 on a scale of 10, both before and after MMI. Indeed, when Dr. Healey examined the claimant on October 22, 2008, she stated her thoracolumbar pain was 6 to 7 on a scale of 10. This is not significantly different than the pain levels of 5 to 8 on a scale of 10 that she reported to Dr. Kohake in April 2003, or the levels of pain that she reported to Dr. Mason from 2005 through 2007. Moreover, the medical records demonstrate the claimant has consistently experienced varying levels of back spasms since she was placed at MMI. The claimant reported back spasms to Dr. Mason in 2006, and severe spasms in 2007.

25. The ALJ credits the opinion of Dr. Sabin that the claimant remains at MMI, and does not need any additional treatment except for "maintenance

care." Dr. Sabin credibly testified that considering the claimant's history and diagnoses, including myofascial pain and degenerative disc disease, it is reasonable to expect that her symptoms will wax and wane, and that the she will experience exacerbations of pain. Dr. Sabin credibly stated that there is no real objective evidence that the claimant's condition has changed since she was placed at MMI.

26. The ALJ is not persuaded by Dr. Healey's opinions that the claimant's condition has worsened, and that she needs Botox treatments to return to MMI. In this regard the ALJ notes that Dr. Healey has stated that the claimant may need Botox treatments every three months for the remainder of her life, and that these injections would allow her to return to work. The ALJ infers from this testimony that the objective of the proposed Botox treatments is not to provide any curative or lasting improvement of the claimant's underlying myofascial pain and degenerative disc disease, but instead to provide the same temporary and palliative relief she previously received from maintenance care in the form of physical therapy and trigger point injections. In this sense, the proposed Botox treatments would not amount to any more than maintenance care designed to alleviate the ongoing effects of the injury, for which the respondents have already admitted liability.

27. The ALJ is not persuaded that the claimant has sustained any increase in permanent impairment that evidences a worsened condition. Dr. Healey stated that some of the increase in permanent impairment between 2003 and 2008 was attributable to the surgery for removal of the hardware performed in 2004. However, the claimant was placed at MMI for the hardware removal in November 2004, and an FAL was filed in 2005. Thus, if the claimant wished to contend that there was a worsening of condition caused by the surgery, and that she was entitled to additional permanent partial disability benefits, she was free to challenge the FAL at that point in time. The alleged increase in impairment from the surgery does not represent any worsening of condition since the claimant was last placed at MMI in November 2004.

28. Neither is the ALJ persuaded that the claimant has sustained any reduced range of motion that evidences a worsened condition. Although Dr. Healey opined that the claimant's lumbar range of motion measurements were worse in October 2008 that they were in 2003, and that this difference warranted an increased impairment rating, the ALJ is not persuaded that these differences represent an actual worsening of the claimant's condition. Instead, the ALJ has credited the opinion of Dr. Sabin that the claimant's symptoms wax and wane, and that she will experience exacerbations of pain. The ALJ therefore infers that the claimant's range of motion measurements may vary from time to time, depending on her current level of symptoms. Indeed, in April 2008 Dr. Healey expressly stated the claimant's lumbar range of motion *had not changed* since 2003.

29, The claimant failed to prove it is more probably true than not that she has sustained a worsening of condition that has resulted in a greater "industrial disability" than she experienced at the time of MMI. The ALJ is persuaded by the testimony of Dr. Sabin that the objective medical evidence does not support the conclusion that the claimant's condition is any worse than it was at the time of MMI. Although the claimant may have subjectively experienced a worsening of her symptoms, such exacerbations are to be expected considering the claimant's condition. The ALJ is not persuaded that the claimant's decision to stop working is more than a personal decision based on her reaction to her symptoms, and is certainly not credible and persuasive evidence that the claimant's condition has in fact worsened.

30. Evidence and inferences inconsistent with or contrary to these findings of fact are not credible and persuasive.

CONCLUSIONS OF LAW

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

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. 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.

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

REOPENING BASED ON WORSENED CONDITION

Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. The claimant shoulders the burden of proving her condition has changed and her entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985).

If the claimant proves a worsening of condition, reopening is warranted if the claimant establishes that additional medical treatment and/or disability benefits are warranted. *Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000); *Dorman v. B & W Construction Co.,* 765 P.2d 1033 (Colo. App. 1988). However, a mere recommendation for additional medical treatment does not require the ALJ to conclude that the claimant's condition has worsened so as to warrant reopening. This is true because there is a difference between care needed to assist the claimant in obtaining MMI by curing and relieving the effects of the injury, and post-MMI maintenance care designed to relieve symptoms or prevent further deterioration of the claimant's condition. *Story v. Industrial Claim Appeals Office,* 910 P.2d 80 (Colo. App. 1995).

As determined in Findings of Fact 24 through 26, the ALJ concludes the claimant failed to prove it is more probably true than not that her condition has worsened since she was most recently placed at MMI in November 2004. The ALJ credits the medical records showing that, although the claimant may have experienced a subjective worsening of her condition, her overall pain complaints and symptoms have not significantly changed since November 2004. Moreover, Dr. Sabin credibly testified that it is reasonable to expect that a person with the claimant's history and medical diagnoses will experience symptoms that wax and wane over time. Dr. Sabin credibly opined the claimant remains at MMI and does not need any additional treatment except maintenance care.

As determined in Finding of Fact 26, the ALJ is not persuaded that the claimant has proven a worsened condition because, as suggested by Dr. Healey, she needs a course of Botox treatments in order to reach MMI. Although the ALJ takes no position on whether Botox treatments might be reasonable and necessary, he does conclude that such treatments would represent nothing more than *Grover*-style maintenance treatments designed to afford relief from the ongoing effects of the injury. The ALJ notes from the testimony of Dr. Healey that the proposed Botox treatments would be given every three months and might last indefinitely. The ALJ infers from this testimony that the Botox treatments would not produce any curative or lasting improvement in the claimant's myofascial pain and degenerative disc disease, but would merely provide another form of palliative care designed to provide temporary relief from the effects of the underlying

conditions. Consequently, the Botox treatments would simply replace other forms of palliative care for which the respondents have already admitted liability, and do not prove the claimant's condition has worsened so as to warrant additional treatment. *See Richards v. Industrial Claim Appeals Office, supra* (fact that claimant's condition temporarily deteriorated while undergoing a change in post-MMI medications did not require finding of worsened condition); *Nunn v. JAD Electric,* W.C. No. 4-205-093 (ICAO August 23, 2005) (reopening not required where ALJ found claimant's condition waxed and waned and there was nothing that could be done other than provide maintenance treatment for which respondents had admitted liability).

As determined in Findings of Fact 27, the ALJ concludes the claimant has not shown an increase in medical impairment that would warrant the conclusion that the claimant sustained any worsening of condition. As a general matter, the fact that a physician has opined that the claimant's impairment rating has increased does not require the ALJ to conclude as a matter of law that the claimant's condition has worsened and she is entitled to reopen the claim. *See Heinicke v. Industrial Claim Appeals Office*, __P.3d__ (Colo. App. No. 07CA1640, September 8, 2008).

With respect to the alleged increase in impairment resulting from the 2004 surgery to remove the hardware, this increase in impairment should have been known to the claimant before the insurer filed the FAL in March 2005. If the claimant had desired to challenge the impairment rating, it was incumbent upon her to object to the FAL and seek a hearing. *See* § 8-43-202(2)(b)(II), C.R.S. In any event, the fact that the claimant did not challenge the impairment rating based on the surgery certainly does not establish that her condition worsened between November 2004, when she was last placed at MMI, and 2008.

As determined in Finding of Fact 28, the ALJ concludes that Dr. Healey's testimony concerning the change in the claimant's lumbar range of motion measurements does not establish that the claimant's condition worsened between November 2004 and 2008. The ALJ has credited Dr. Sabin's testimony that the claimant's symptoms are likely to wax and wane. The ALJ infers from this fact that the claimant's range of motion measurements may vary from time to time, based on the severity of the claimant's symptoms. This inference is corroborated by the fact that in April 2008, Dr. Healey himself noted there had been no change in the claimant's lumbar range of motion measurements since 2003. The claimant has not shown it is more probably true than not that her condition has worsened so as to warrant additional medical impairment benefits.

As determined in Finding of Fact 29, the claimant failed to prove it is more probably true than not that her condition has worsened so as to cause an increase in her "industrial disability." The ALJ is persuaded that although the claimant may have subjectively believe her condition is worse, that conclusion is

not supported by the weight of the medical evidence concerning her symptoms, and is not supported by the credible testimony of Dr. Sabin.

In light of the ALJ's determination that the claimant failed to prove that she sustained a worsened condition that would warrant reopening, the ALJ need not consider the parties' other arguments, including those concerning the cause of the claimant's condition. Further, the ALJ was not asked to rule on whether Botox injections constitute reasonable and necessary *Grover* medical treatment, and has not considered that issue. The ALJ merely determines the claimant failed to prove that the claimant has suffered a worsened condition as shown by the alleged need for Botox. The issue of Botox treatments as a form of maintenance care is reserved for future determination.

ORDER

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

1. The claimant's petition to reopen W.C. No. 4-491-883 is Denied and Dismissed.

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

DATED: December 9, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-571

ISSUES

The following issues were raised for consideration at hearing:

1. Compensability; and

2. Medical benefits.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant testified that on the afternoon of May 16, 2008 he was walking from his car into the Employer's offices after a break. As he walked

across a drain cover set in the sidewalk outside the building, it flipped up, collapsed, and caused him to fall and injure himself. At hearing, Claimant further testified that he injured his left ankle, left hip and knee. The ALJ found Claimant's testimony not to be credible.

2. Claimant provided several different statements to different sources about the mechanism of injury, location of the injury and the body parts affected. This undermined Claimant's credibility. There were no witnesses to Claimant's alleged fall. Claimant's claim for compensation, signed and dated by him, states that he walked on the drain structure when it collapsed and he landed forward. Other reports state that Claimant fell backward. When initially reporting the claim to his supervisor CR, Claimant identified several different areas inside the building where he fell on the carpet. Not until the following day did Claimant state he fell outside the building. At the time he initially reported an incident to Mr. R, he complained only of a scratch on his knee, and not of an ankle, back, or hip injury. At hearing, Claimant stated that he was not pursuing a claim for back injury or hip injury. However, his Workers' Claim for Compensation, signed and dated by him, and several medical reports indicate his assertion that those body parts were affected. Diagnostic testing was done in these additional areas, presumably because of Claimant's assertion to his physicians that they were affected by the work incident. Claimant's removal of these body parts as at issue at hearing brings into question both his motivation and sincerity at hearing and with the physicians treating his alleged work injury.

3. At hearing, Claimant testified that he had no prior injury to his ankles, back or hip. The records show reports of pain, treatment, and history of prior injury to these body parts, along with conflicting prior statements made by claimant. Records show prior left hip complaints. The medical evidence is replete with prior back complaints and treatment. Claimant's testimony regarding the lack of prior injury is not credible. In fact, despite his clear and repeated denial of prior left ankle injury, Claimant, in the context of another injury claim, stated that he was previously in a wheelchair six months as a result of two broken ankles. Claimant was confronted with a recorded statement made by him that provided this information of prior severe ankle injury. Mr. R testified that Claimant told him that he injured his ankles and was in a wheelchair several years prior to May 16, 2008. Several medical records from separate providers reflect that Claimant had previous arthroscopic surgery to his left ankle. This fact may explain why Claimant's ankle appeared swollen to examiners after the alleged fall on May 16, 2008.

4. At hearing, Claimant removed his socks, shoes, and an air cast he wore on his left ankle in order to show the absence of operative scars. It is difficult for the ALJ to conclude whether there was a scar present or not. However, medical records reflect that examinations by physicians throughout the course of several years have led those medical professionals to conclude that surgery did occur. In any case, this display did not bolster Claimant's credibility; for either he

was telling untruths about his left ankle medical history to the court, or had been telling untruths to various medical professionals for years.

5. Respondents' witness, GS, was credibly surprised to learn that Claimant wore an air cast, as he never saw Claimant wear an air cast following the alleged accident. Mr. R gave similar credible testimony regarding the absence of an air cast at work following the alleged injury. In addition to the inconsistencies in Claimant's testimony and the medical record, cross-examination revealed that Claimant entered into a settlement agreement in relation to a claim for injuries to his low back and bilateral ankles. This was done just a few weeks prior to this hearing on September 19, 2008, and approved October 20, 2008.

6. Mr. R credibly testified at hearing. He was claimant's supervisor on May 16, 2008. He stated that Claimant came into his office on May 16, 2008. At that time, Claimant had a scrape on his knee, below the kneecap, which was approximately as big as a fifty-cent piece. Claimant first told Mr. R that he fell outside the office due to a bump or tear in the carpeting. Mr. R suggested that he and Claimant go to the bathroom and wash off Claimant's knee. Mr. R testified that he saw no dirt or debris in Claimant's knee. On the way down the hall to the bathroom, Mr. R asked Claimant to show him where he fell. Claimant first indicated he fell outside the doorway to the Employer's office. As they progressed down the hall, Claimant pointed to an area outside the elevators and stated that was, instead, where he had fallen. Mr. R accompanied Claimant to the restroom, dampened a towel and handed it to Claimant. Claimant balanced himself on one leg, brought his left ankle up to the counter, and held his weight on the left ankle as he blotted off the scrape on his knee. He did not have difficulty doing this, and did not complain of pain as he held his weight on the left ankle. Mr. R testified that during the course of their discussion on May 16, 2008, Claimant did not complain of ankle, back or hip pain. He also testified that that there was no blood on any of the various areas of carpeting that Claimant identified as the site(s) of the fall during that first discussion on May 16, 2008. Mr. R credibly testified that Claimant asked for a band-aid, and there was none available at the office. Mr. R testified that the time was approximately 3:00 p.m., and that Claimant's shift was over at 4:00 p.m. Claimant asked permission to leave work to get a band-aid, and Mr. R allowed him to do so. Mr. R testified that he did not provide a referral for medical treatment because Claimant did not appear to need medical treatment and did not ask for a referral.

7. Claimant's testimony concerning his referral to his family physician on May 16, 2008 was considered and deemed not to be credible. The ALJ finds that any visit Claimant made to his physician and physical therapist was not reasonable or necessary to cure and relieve the effects of any incident at work that occurred on May 16, 2008.

8. Mr. R testified that his next discussion with Claimant about the alleged injury was the next day, Saturday, May 17, 2008. In the morning, Mr. R

was sitting outside the building smoking, when Claimant arrived at the building. Claimant was not scheduled to work. Claimant had no work-related reason to be at the building. Claimant got out of his car and sat on the curb, next to the drain cover. At that time, Claimant changed his story regarding the mechanism and location of his alleged fall, and told Mr. R that he fell outside the building, at that spot, due to the drain cover. After a discussion with Claimant, Claimant took photographs of the area with his cell phone.

9. DL testified that he is a maintenance employee of the building owner. He testified credibly that it was not possible for the drain cover in question to flip up or collapse as Claimant described.

10. Mr. L testified that it was his job to take remedial action when a fall was reported on the premises. Consequently, he covered the area with a cone where Claimant alleged he tripped, to prevent any other falls.

11. Claimant was in an automobile accident (MVA) on May 23, 2008, and claimed to have a whiplash injury, chipped upper tooth, pain in the upper jaw, daily headaches, and lower back pain. Dr. Rhim saw Claimant on the same day, May 23, 2008, for his initial evaluation of Claimant. Dr. Rhim dictated two separate reports on May 23, 2008, one discussing the MVA, and one discussing the alleged trip and fall at work of May 16, 2008. Many of the same symptoms and complaints attributed to the MVA were later attributed by Claimant to his alleged workers' compensation injury

12. Co-worker GS testified credibly at hearing. He testified that Claimant appeared at work following the alleged fall using a cane and used the cane only sporadically over the next few weeks. Mr. S testified that, on one occasion, while using the cane due to Claimant's alleged workers' compensation injury, Claimant was distracted by a police chase and ran across the street to observe the activity.

13. The totality of the credible and persuasive evidence presented at hearing causes the ALJ to conclude that Claimant failed to sustain his burden of proof to establish that a compensable work injury occurred on May 16, 2008 in the course and scope of Claimant's employment for the Employer.

CONCLUSIONS OF LAW

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

1. The purpose of the Workers' Compensation Act of Colorado (Act), 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, For a claim to be compensable under the Act, a claimant has the burden of proving that he or she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. Section 8-41-301(1) (c), C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp*., 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for the determination of the Judge. *Faulkner*, 12 P.3d. at 846.

5. The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undesigned occurrence. Section 8-40-201(1), *supra*. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one, which results in an injury requiring medical treatment or causing disability. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990).

6. Here, the Judge found Claimant failed to show it more probably true than not that he sustained an injury requiring medical treatment or causing disability, which arose out of the course and scope of his employment on May 16,

2008. Claimant thus failed to prove by a preponderance of the evidence that he sustained a compensable injury.

ORDER

It is therefore ordered that:

1. Since Claimant failed to sustain his burden of proof, his workers' compensation claim is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: _____

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-218

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that on July 23, 2008, he sustained an injury arising out of and in the course of his employment?
¬ Did the claimant prove by a preponderance of the evidence that his disability and need for medical treatment were proximately caused by the alleged injury?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to temporary total disability benefits commencing July 26, 2008, and continuing?
¬ What is the claimant's average weekly wage?
¬ Did the claimant prove by a preponderance of the evidence that he is entitled to reasonable, necessary and authorized medical treatment as a result of the alleged injury?
¬ Did the respondents prove by a preponderance of the evidence that they are entitled to an offset for unemployment insurance benefits received by the claimant?

FINDINGS OF FACT

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

1. The claimant was employed as a plumber for the employer. He was assigned to work with his supervisor, JH.

2. The claimant testified that on Wednesday, July 23, 2008, he and Mr. H were installing a water cooler at a business. The claimant stated that the box containing the cooler was just below his belt line. The claimant recalled that he leaned over the box to lift the cooler. As he was lifting the cooler out of the box he twisted to the right and felt the immediate onset of groin pain. According to the claimant, he immediately told Mr. H that he thought he had hurt himself inside. The claimant testified that Mr. H told him to "take it easy" for the remainder of the day.

3. The claimant testified that on July 23, 2008, he developed a "bulge" in his groin area.

4. The claimant testified that he returned to work on Thursday, July 24, 2008, and told Mr. H that he had hurt himself yesterday and did not know what was wrong. The claimant stated that Mr. H allowed him to perform light duty.

5. The claimant testified that he did not have any trouble performing his job until the incident of July 23, 2008.

6. The claimant testified that on Friday, July 25, 2008, he again returned to work, but told Mr. H that he might not be able to complete the entire day. The claimant recalled that he was allowed to go home early on July 25, 2008.

7. The claimant testified that on Saturday, July 26, 2008, Mr. H came to his home to check on him. According to the claimant Mr. H directed him to see his doctor because neither of them knew what was wrong. The claimant recalled that he still had the bulge in his groin area, but the bulge would become smaller when he took a hot bath.

8. The claimant testified that on Monday, July 28, 2008, he advised Mr. H that he was in too much pain to work. The claimant stated that Mr. H directed him to call BW, the owner of the company. The claimant called Mr. W who told the claimant to see his own doctor.

9. The claimant's wife made an appointment for the claimant to see his personal physician, "Dr. Stephanie," at South Federal Family Practice, P.C. (SFFP).

10. The claimant was examined a SFFP on Monday, July 28, 2008. The ALJ is unable to ascertain from the record of this visit the name and qualifications of the person that examined the claimant. The note states the claimant reported that he experienced "Thursday pain in right leg, testicle swollen, numbing & tingling pain." The note further states the claimant "was lifting something heavy on Wednesday," and that the claimant "lifted water cooler @ work foreman

observed" the claimant. The claimant was noted to be walking with a cane, was suffering tenderness along the right groin, and had no palpable mass. The claimant was referred back to the employer's "work comp clinic" for treatment of a "work comp injury" with a possible hernia.

11. The employer referred the claimant to Health One Occupational Medicine and Rehabilitation for treatment of the alleged injury. On Tuesday July 29, 2008, Dr. John W. Dunkle, M.D., examined the claimant at Health One.

12. Dr. Dunkle's note from July 29, 2008, records that the claimant gave a history significantly different than the claimant's testimony at the hearing. According to Dr. Dunkle's July 29 note, the claimant reported that he sustained an injury on Wednesday when pulling a drinking fountain from a box. Dr. Dunkle noted that the claimant stated that he "felt fine" at the time of the incident, and that he first experienced symptoms when he woke up on Thursday with pain in the front of the right leg at the groin. The claimant reported that he performed his "normal work" on Thursday and "felt okay." Dr. Dunkle recorded that on Thursday night the claimant reported he could not sleep, but then contradicted himself by saying that he had to sleep on his left side. The claimant advised Dr. Dunkle that on Friday he was dragging his leg and his supervisor asked him what had happened. The claimant replied that he "did not know." The claimant advised Dr. Dunkle that on Saturday he had a "big lump in the groin area" that resolved after a hot bath. Dr. Dunkle further noted that on Saturday the claimant spoke with a "coworker" who advised the claimant that "he had seen [the claimant] straining himself when taking the water cooler out," and advised the claimant to "turn it in to workers' compensation since he did not have insurance." The claimant told Dr. Dunkle that he had no insurance and did not know what he was going to do.

13. The claimant advised Dr. Dunkle that he had bilateral hernia surgeries in 1989, and that this was not the result of a work related injury.

14. Dr. Dunkle recorded the results of his July 29, 2008, physical examination of the claimant. On examination thee claimant reported pain over the medial groin, pain over the right buttocks, and high pain over the gluteal area which the claimant had not previously noticed. There was also pain along the right thigh that the claimant was not previously aware of. Examination of the abdomen and genitalia was normal, and there was no hernia deficit, bulge or evidence of weakness.

15. Dr. Dunkle assessed a transient and painful inguinal bulge without "an objective finding for which to provide a diagnosis." Dr. Dunkle noted the claimant did not report experiencing any symptoms until July 24, 2008, and was "not able to report any straining incident." Dr. Dunkle stated the claimant began to associate his condition with lifting the water cooler "after talking with a coworker, who told him he was straining to do this." Dr. Dunkle further assessed resolving high pain in the posterior pelvis, hip and right lower extremity, of grad-

ual onset, associated with no accident, injury, or abnormal activities at his job." Considering the circumstances, Dr. Dunkle stated that he could not "deem probable causality for work-relatedness."

16. At hearing, the claimant testified that he did not recall Dr. Dunkle asking him a lot of questions at their first appointment. The claimant also disputed the history recorded by Dr. Dunkle in his note of July 29, 2008. The claimant stated that he first experienced symptoms on July 23, 2004, not July 24 as recorded by Dr. Dunkle. The claimant stated that he did not know where Dr. Dunkle got the idea that he told his supervisor that "he did not know" what had happened. The claimant stated that Mr. H had known what caused the problem since Wednesday, July 23, 2008.

17. In August 2008, the claimant returned to Dr. Dunkle to obtain a release to return to work. Dr. Dunkle declined to release the claimant.

18. After Dr. Dunkle declined to treat the claimant, the claimant sought treatment from Denver Health.

19. In November 2008, Rosa Nunez, a physician's assistant at Denver Health, authored a "To Whom It May Concern" letter. The note stated that the claimant had been receiving treatment at Denver Health since September 2008. PA Nunez stated the claimant's evaluation had been "extensive" and that he had been diagnosed with atherosclerosis and partial occlusion of the right femoral artery, multi-level disc protrusions, and small bilateral inguinal hernias. PA Nunez noted the claimant had been evaluated by a surgeon for his "peripheral vascular disease" and was scheduled to see an orthopedic surgeon concerning his back problems.

20. The record does not contain any other medical records or reports concerning the claimant's evaluation and treatment at Denver Health.

21. The claimant admitted that he has been receiving treatment from Denver Health for atherosclerosis, a partial occlusion of his right femoral artery, and that he has been diagnosed with vascular disease. The claimant stated that he has severe pain from his right knee to his groin. The claimant stated that he has received "pills" for treatment of these conditions. The claimant also admitted that he has been diagnosed with multi-level disc protrusions, and has been referred to an orthopedic surgeon for an examination.

22. The claimant failed to prove it is more probably true than not that he sustained an injury arising out of and in the course of his employment when he lifted the water cooler out of the box on July 23, 2008. The ALJ finds that the claimant's testimony that he sustained an injury on July 23, 2008 is not credible. Although the claimant states that he immediately suffered pain after lifting the water cooler and told his supervisor that he believed he had hurt himself, this tes-

timony is contradicted by important passages contained in the medical records. The SFFP note from July 28, 2008, does not mention that the claimant reported suffering any immediate pain upon lifting the water cooler. To the contrary, the SFFP note does not mention the occurrence of any pain or symptoms until "Thursday."

23. The ALJ is persuaded that Dr. Dunkle accurately reported the history that the claimant gave during the examination of July 29, 2008. The ALJ finds there is no credible or persuasive evidence in the record that would establish a motive or reason for Dr. Dunkle to falsify his report concerning the history given to him by the claimant. The history the claimant gave to Dr. Dunkle contradicts the claimant's testimony in several important ways. The claimant testified to immediate symptoms after lifting the water cooler. However, he told Dr. Dunkle that he did not have any immediate symptoms after he lifted the cooler, and did not experience any symptoms until Thursday morning when he woke up with right leg pain. Although the claimant testified he was allowed to work limited duty on Thursday, the claimant told Dr. Dunkle that he performed his usual duties on Thursday and did "okay." The claimant testified that Mr. H was fully aware of the injury from the time it happened, and had allowed the claimant to work limited duties on Thursday and Friday. However, the claimant told Dr. Dunkle that on Friday his supervisor asked why he was dragging his leg and the claimant replied that he did not know. Moreover, Dr. Dunkle noted the claimant did not connect his symptoms to lifting the water cooler until Saturday, after he spoke with a co-worker (presumably Mr. H) who thought the claimant was straining to lift the cooler.

24. The claimant also failed to prove it more probably rue than not that if there was an incident on July 23, 2008, that the incident was the proximate cause of his subsequent disability and need for medical treatment. Dr. Dunkle credibly and persuasively opined that the claimant's condition could not with any degree of probability be linked to the alleged injury of July 23, 2008. Dr. Dunkle persuasively notes that the claimant did not report sustaining any symptoms until the day after the alleged incident. Moreover, the report from PA Nunez provides several alternative explanations for the claimant's symptoms, including peripheral vascular disease resulting in an occlusion of the right femoral artery, and/or protruding discs in the back. Significantly, PA Nunez does not opine that the claimant's multiple diagnoses are in any way related to an alleged injury on July 23, 2008. Moreover, the claimant told Dr. Dunkle that he did not have any insurance, providing the claimant with motivation to testify that the symptoms were immediately associated with the incident on July 23, 2008.

25. At the hearing the parties stipulated that if the claim is found compensable that the claimant's average weekly wage is $680. The parties further stipulated that if the claimant is found compensable the claimant would return to Health One for authorized treatment, but would not be treated by Dr. Dunkle. The parties further agreed that they would file a stipulation concerning any appli-

cable offset for unemployment insurance. No stipulation concerning unemployment has been filed.

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, 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.

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. 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 OF ALLEGED INJURY

The claimant contends that he proved by a preponderance of the evidence that he sustained and injury arising out of and in the course of his employment on July 23, 2008, when he lifted the water cooler from the box. The claimant further contends he proved by a preponderance of the evidence that this injury was the proximate cause of his subsequent need for treatment and alleged disability. The ALJ disagrees.

The claimant was required to prove by a preponderance of the evidence that at the time of the injury he was performing service arising out of and in the course of the employment, and that the alleged injury was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S. A pre-

existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). The question of whether the claimant met the burden of proof to establish a compensable injury is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

The ALJ concludes the claimant failed to prove it is more probably true than not that he sustained any injury on July 23, 2008, when he lifted a water cooler while performing service arising out of and in the course of his employment. As determined in Findings of Fact 22 and 23, the claimant's testimony that he sustained an injury on July 23, 2008, is not credible. As found, the claimant's testimony is contradicted by the history he gave at SFFP on July 28, 2008, and even more significantly contradicted by the history he provided to Dr. Dunkle on July 29, 2008. While the record does not contain any persuasive evidence that would lead the ALJ to believe that Dr. Dunkle falsified his report concerning the claimant's history, the claimant himself admitted to Dr. Dunkle that he did not have insurance and was worried about paying for treatment. Thus, the claimant had a significant incentive to testify that there was an immediate temporal relationship between his symptoms and his work activities on July 23, 2008. even through the claimant told Dr. Dunkle there were no immediate symptoms. Moreover, the ALJ is persuaded that he claimant did not begin alleging any relationship between his symptoms and lifting the water cooler until this idea was suggested to him by Mr. H on Saturday, July 26, 2008.

The ALJ further concludes that, even if the claimant did feel some "strain" when he lifted the water cooler out of the box, the claimant failed to prove that this incident was the proximate cause of his subsequent disability and need for treatment. As determined in Finding of Fact 24, Dr. Dunkle credibly opined that there is probably not any relationship between the claimant's work activities and the symptoms. Moreover, the evidence, including the report of PA Nunez, demonstrates there are alternative explanations for the claimant's symptoms including vascular disease and/or a degenerative back condition. Finally, the claimant has a substantial motive to link his symptoms to his employment because he admitted to Dr. Dunkle that he did not have insurance to pay for treatment.

The claim for workers' compensation benefits must be denied. In light of this conclusion the ALJ need not address the other issues raised by the parties, including entitlement to medical and temporary disability benefits.

ORDER

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

1. The claim for workers' compensation benefits in W.C. No. 4-766-218 is Denied and Dismissed.

DATED: December 10, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-252

ISSUES

The issues of reasonably necessary and related medical benefits were raised for consideration at hearing.

FINDINGS OF FACT

Having considered the evidence presented at hearing and considered the parties' post hearing position statements, the following Findings of Fact are entered.

1. On September 1, 2007, Claimant sustained admitted injuries during the course and scope of her employment. Claimant was working when she twisted her right ankle, lost balance, and fell to the ground on her right shoulder. She immediately knew something was wrong with her right ankle and right shoulder. Claimant was taken to the emergency room.

2. After the September 1, 2007, fall, the problems in Claimant's right shoulder have been continuous. Claimant was initially reluctant to have surgery and worked to rehabilitate the right shoulder with physical therapy and exercises. After therapy was discontinued, Claimant began to get worse. Claimant and her physicians made the decision that surgery for her right shoulder was her only option. Claimant proceeded with the surgery, because her shoulder was getting worse, even though the Insurer denied payment. Claimant had improvement in her right shoulder since her surgery on September 17, 2008.

3. Claimant had problems while she was being treated for her work related injuries at Heritage Park Nursing Home (Heritage Park), a skilled nursing care facility. At Heritage Park, Claimant pulled herself up with the pole beside the bed. Her right shoulder was in a sling, her leg was in a cast, and she was having abdominal pain related to some difficulties with medications. She pulled herself up by the pole with her left arm, pulling on her left shoulder, and causing some pain and discomfort. Then, while Claimant used crutches, the crutches caused further problems with her left shoulder and neck. Claimant was in physical therapy for some time and was taught how to use muscles in her chest, back, and

neck to compensate for the loss of her right rotator cuff. The therapy also caused an aggravation of her neck and shoulder muscles due to overcompensation.

4. Claimant did have preexisting underlying degenerative disease of her shoulder and cervical spine. However, before her fall on September 1, 2007, Claimant did not have the problems she currently has. In 2002, she had a small tear of her right rotator cuff but she only had difficulty with the right shoulder when she overused it, especially when using crutches. She obtained therapy or injections, and the problems resolved.

5. Claimant requires ongoing physical therapy for her right shoulder to rehabilitate her shoulder following the arthroplasty and also for her left shoulder and neck. Claimant also requires treatment for her neck, including injections, which she had undergone prior to the shoulder replacement. These injections helped her neck discomfort.

6. X-rays of Claimant's right shoulder, taken on September 1, 2007, showed a bony fragment believed to be a fracture of the greater tuberosity of the humerus. Claimant was also diagnosed with a spiral fracture of the lateral malleolus with widening of the medial mortise, based upon an x-ray of her right ankle, taken on September 1, 2007.

7. Claimant was admitted to Heritage Park and prescribed treatment for activities of daily living, therapy, and activity exercises. On September 6, 2007, a Heritage Park nurse reported that Claimant complained of numbness and tingling, needed someone to assist with transfers and ambulation, used a crutch on the left side to ambulate, and had multiple bruising to the left arm.

8. September 10, 2008, Dr. Derkash opined that in addition to the two fractures, Claimant possibly had a rotator cuff tear as her right shoulder was significantly stiff. On September 17, 2007 a nurse at Heritage Park reported that Claimant was complaining of pain behind her right shoulder. On September 19, 2007 the Heritage Park nursing notes reported that Claimant was having problems of the left acromioclavicular (AC) joint. On September 21, 2007 the therapist noted problems with the left rotator cuff tendon.

9. On October 18, 2007, an MRI of Claimant's right shoulder revealed, the following: 1. arthrosis of the acromioclavicular joint; 2. a large tear of the supraspinatus infraspinatus tendons with muscular atrophy. There was a focus of ossification attached to the superior aspect of the medially retracted infraspinatus tendon likely due to an avulsion fracture of the greater tuberosity. 3. lobular foci of fat with surrounding edema in the proximal humeral shaft and metaphysic that may be related to the avulsion fracture of the infraspinatus tendon.

10. Kathleen Ann Denson, the president and owner of the Employer, credibly testified corroborating Claimant's testimony about the work injury, Claimant's treatment, and Claimant's efforts at recovery.

11. On October 19, 2007, Dr. William Sterett stated that his advice to Claimant was to continue with rehab for a couple of months until she got over her ankle fracture. Dr. Sterett stated, "If in fact she does not do well from non-operative means and she is off of crutches from her ankle injury than [sic] I think her only reasonable option would be a reverse shoulder arthroplasty." In another note of October 19, 2007, Dr. Sterett stated, "If physical therapy fails to work at that point her only option would be for a reverse total shoulder arthroplasty." On October 29, 2007, Dr. Sterett noted that Claimant was there for a left shoulder injection. Dr. Sterett noted that he had been following Claimant for her right shoulder and right ankle, but her left shoulder had become more of a problem.

12. On December 12, 2007, Dr. Sterett stated that because of the significant fatter infiltration into Claimant's rotator cuff muscles and the marked retraction, he thought there was only a 50% chance that her function would be significantly improved by repairing her rotator cuff. Dr. Sterett stated, "Her only other option surgically would be for a reverse total shoulder plasty." Dr. Sterett stated that if Claimant had persistent decreased function an arthroscopic evaluation and attempt to repair could and should be the next step; however, he stated that Claimant may end up with a reverse shoulder prosthesis.

13. On December 17, 2008, Mr. David Honda noted in his physical therapy notes that Claimant was having left greater than right shoulder pain secondary to overuse. On January 14, 2008, in a progress note Mr. Honda indicated that Claimant was complaining of left shoulder pain due to overuse.

14. On January 21, 2008, Dr. Sterett stated, "Regarding her right shoulder it is [sic] a very large tear with an infraspinatus avulsion. It may not be repairable [sic] lesion. I think I have given her a counsel that it has about a 50%-60% chance of staying intact, however, that may be a reasonable option given the fact that her left shoulder is now bothering her significantly." Dr. Sterett noted that Claimant underwent an open rotator cuff repair on the left shoulder in 1992. It did well until recently when Claimant was lifting herself up on a pole and now had both pain and weakness. Dr. Sterett stated that he needed to get an MRI of Claimant's left shoulder and follow-up on her rotator cuff to see what kind of tear she had and the quality of tissue. Dr. Sterett stated, "Based on the results of the MRI on her left shoulder it may be more beneficial to repairing the right shoulder than her left since she has a history of infection and open rotator cuff repair in the distant past."

15. On January 25, 2008, an MRI of Claimant's left shoulder revealed an area of discontinuity of the distal supraspinatus tendon extending for 8 mm anterior posterior and 18 mm medial to lateral. The defect was not filled with fluid, but rather granulation tissue. There was also moderate glenohumeral chondromalacia.

16. On January 29, 2008, Dr. Steven Yarberry noted that Claimant's left shoulder is being bothered by compensation.

17. On February 3, 2008 David Honda, PT, noted that Claimant's left shoulder was injured when she pulled herself up in bed with an overhead trapeze bar while she was in the extended care facility immediately following her injury in September 2007. He noted that the shoulder had also been aggravated by using crutches and by general overuse since she could not at that time, and still could not fully use her right arm in daily activities. Mr. Honda also noted that Claimant had complaint of short-term lumbar and cervical pain due to upper and lower extremity compensation. Mr. Honda reported that Claimant could not elevate her arm above her head in any plane with a straight elbow past 45 degrees. He stated, "This latter maneuver is also accomplished with moderate scapular substitution." Mr. Honda noted that Claimant could not comb or wash her hair without severe cervical compensation. Subsequent notes entered by Dr. Honda in February 2008 reflect that Claimant is experiencing neck pain with reaching, overhead use, and right upper extremity use.

18. On February 29, 2008, Dr. Steven Yarberry noted that Claimant was in a pretty good mood in that she had somewhat of a breakthrough at physical therapy and can move both her right and left shoulders much better than she had in the last several months. Dr. Yarberry stated that Claimant should continue physical therapy three times weekly as per Dr. Sterett's advice.

19. In April 2008, Dr. Sterett noted improvement with physician therapy and recommended continued therapy. He also continued his recommendation for reverse shoulder arthroplasty as Claimant's only option. In April 2008, Mr. Honda noted Claimant's complaints of short-term lumbar and cervical pain due to upper and lower extremity compensation. On April 25, 2008, Claimant was active in her work at the Employer and at her home. When Claimant saw Dr. Steven Yarberry on April 25, 2008, he noted that Claimant was not at MMI. Dr. Yarberry recommended continuing physical therapy. On April 28, 2008 Dr. Sterett referred Claimant for physical therapy evaluation and treatment for her bilateral shoulders.

20. On May 15, 2008, Mr. Honda noted he was transitioning Claimant into a fully independent in her exercise program through July 2008. Claimant was making slow, but steady progress in her ability to raise her right arm above her head. Mr. Honda noted improvement in both Claimant's arms and leg.

21. On June 9, 2008, Dr. William Sterett wrote a prescription for physical therapy for the right shoulder and trapezius pain. On June 23, 2008 Dr. William Sterett noted that Claimant had had some cervical spine issues. Dr. Sterett's impression was that Claimant had cervical spine degenerative disc disease with acute muscular strain. The doctor recommended continued work with physical therapy for the right shoulder and referred Claimant to Dr. Peter Millett for evaluation for possible right shoulder reverse shoulder replacement secondary to rotator cuff arthropathy. Dr. Sterett further recommended for Claimant's cervical

spine, an MRI to further delineate any pathology and then referral to Dr. David Karli for the cervical spine issue. On June 24, 2008 Dr. Steven Yarberry noted that Dr. Sterett recommended continuous physical therapy and Dr. Yarberry recommended continued physical therapy three times a week.

22. Based on Dr. Sterett's June 2008 request, a cervical spine MRI was performed on August 8, 2008. A cervical spine MRI revealed degenerative disc disease, fusion of the C3-4 vertebral body, and broad-based osteophyte formation at the C6-7 level.
In August 2008, Claimant was experiencing pain symptoms in the right shoulder, neck, and upper back. On August 27, 2008 Dr. Peter Millett recommended rotator cuff repair surgery.

23. A September 2008 MRI of Claimant's right shoulder showed a humeral head shaft superiorly luxated, touching acromial undersurface. There was also a full-thickness tear defect of the supraspinatus and infraspinatus tendons with increased medial retraction and about 5 cm wide defect. It was reported that there may be increased fatty replacement and atrophy about the retracted muscles and muscle tendon junctions at the medical field of view.

24. On September 8, 2008, Claimant was seen by Dr. David Karli for her cervical spine/neck pain. He performed facet blocks. On September 12, 2008 Dr. Peter Millet evaluated claimant for her greater tuberocity avulsion fracture that displaced the rotator cuff and produced deficiency and weakness. He reviewed the MRI, which showed a large rotator cuff tear through the supraspinatus and infraspinatus tendons as well as the displaced greater tuberosity avulsion fracture and chondral changes in the glenohumeral joint. He recommended arthroscopic debridement and rotator cuff repair. Dr. Millet opined that if repair was not possible, then total shoulder arthroplasty was needed.

25. Based on the totality of the record, including Claimant's hearing testimony, it was established that Claimant could not lift her right arm with any weight in her hand due to the significant pain, she learned to use other muscle structures including neck muscles to compensate for the loss of the rotator cuff in performing range of motion of her shoulder and arm, however, she still could not use the right arm functionally, and Claimant could no longer stand the pain. Claimant had no more options other than proceed with surgery.

26. Dr. Millet gave a postoperative diagnosis of right shoulder chronic greater tuberosity fracture with massive rotator cuff tear. The doctor proceeded with reverse total shoulder replacement to restore function to right shoulder.

27. Dr. Sterett credibly opined in his deposition on October 1, 2008 that Claimant's September 1, 2007 injury caused the fracture and the tearing of the tendon off the bone where the rotator cuff attached to the bone. He further credibly opined that the work injury turned a small tear into a massive or irreparable tear. The doctor further credibly opined that the need for the total shoulder replacement was caused by the Claimant's September 1, 2007 fall. He opined that

when a patient has this kind of massive injury to a joint such as the shoulder, it causes overuse of other parts of the body. Dr. Sterett noted that physical therapy for Claimant's shoulder caused an aggravation of her underlying neck conditions. Dr. Sterett referred Claimant to treat for the neck problems with Dr. Karli who provided injections, a standard type of treatment for the neck.

28. Dr. Sterett credibly testified in his deposition that Claimant has not reached maximum medical improvement. The doctor opined that Claimant requires further physical therapy for the ankle to improve range of motion and reduce swelling; for the shoulder for strengthening and range of motion; and for the neck to decrease the inflammation of the soft tissue surrounding the neck.

29. Dr. Jeffrey Wunder is not persuasive in his opinion. His opinion that Claimant does not require further medical treatment related to her injuries sustained on September 1, 2007 and any subsequent aggravations of her pre-existing conditions was not supported by the medical records or the testimony of witnesses, both lay and expert.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the following Conclusions of Law are entered.

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 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). The issue of whether medical treatment is necessitated by a compensable aggravation or a worsening of the claimant's pre-existing condition is one of fact for resolution by the ALJ based upon the evidentiary record. *See Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970); *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). "Compensation is not dependent on the state of an employee's health or her freedom from constitutional weakness or latent tendency." *Peter Kiewit Sons' Co. v. Industrial Commission*, 124 Colo. 217, 236 P.2d 296, 298 (1951). "When a pre-existing condition is aggravated by an employee's work, the resulting disability is a compensable industrial disability." *Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. 1990).

5. In this case, claimant clearly had an underlying degenerative arthritic condition to her right shoulder. However, further treatment is needed to cure and/ or relieve the claimant of the irreparable rotator cuff tear caused by the industrial injury and will serve to also treat some of the underlying arthritis condition.

6. It is concluded that even though Claimant fell because she twisted her ankle, her shoulder would not have been injured to the degree that it was, including breaking of the greater tuberosity and the massive rotator cuff tear, but for the fact of the fall. But for the fall, Claimant would not have needed the total shoulder arthroplasty according to Dr. Sterett. Claimant's left shoulder and neck aggravations arose out of her admitted work-related injury and are therefore causally related to the September 1, 2007 work injury.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related medical benefits as a result of the September 1, 2007 work injury. Respondents shall be liable for medical benefits for Claimant's bilateral shoulders and neck caused by Claimant's September 1, 2007 injury.

All matters not determined herein are reserved for future determination.

DATED: December 10, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-756-024

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment?

FINDINGS OF FACT

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

1. Employer manufactures safety equipment. BP is employer's operations manager. Claimant's date of birth is August 20, 1964; her age at the time of hearing was 44 years. Claimant works for employer assembling such safety equipment as glow-worms and goggle protectors. Overall, claimant has worked for employer for some six years; her most recent period of employment has lasted some four years. Claimant however was off work from May through August of 2007 because of a pregnancy. The Judge adopts the stipulation of the parties in finding that claimant's average weekly wage is $667.00.

2. Claimant's workstation is comprised of a height-adjustable chair, where she sits while assembling and gluing small plastic pieces on a table directly in front of her. Claimant uses both upper extremities to assemble the safety equipment. Crediting claimant's testimony, the Judge finds: Claimant began experiencing symptoms of aching pain in her right upper extremity after returning from leave in August 2007. Claimant's symptoms were unassociated with any acute trauma; her symptoms increased over time from August 2007 through December of 2007. Claimant noticed that her symptoms were more associated with assembling the goggle protectors.

3. Employer referred claimant to Arbor Occupational Medicine, where Physicians Assistant Paul V. Springer, PA-C, examined her on January 10, 2008. Claimant reported the following history to PA-C Springer:

> [Claimant] comes in today complaining of pain in her upper right extremity. There was no associated injury with this. The patient states it just seemed to start with aching up in her shoulder and now the whole arm is aching, but a lot of it seems to be up in the shoulder and neck muscles.

PA-C Springer diagnosed shoulder/arm syndrome secondary to repetitive motion at work. PA-C Springer recommended a work-site evaluation, referred claimant

for physical therapy, and imposed work restrictions, which allowed her to take a 10-minute break from repetitive tasks every hour.

4. At Arbor, several physicians in addition to PA-C Springer examined claimant over the ensuing months. Those physicians were William Alexander, M.D., Sander J. Orent, M.D., and Marc-Andre Chimonas, M.D. Claimant's diagnoses included myofascial pain, shoulder bursitis, rotator cuff tendonitis, and lateral and medial epicondylitis. On March 5, 2008, claimant reported to PA-C Springer that physical therapy was helping. PA-C Springer administered an injection of anesthetic medication into the subacromial space of claimant's right shoulder, which only relieved her pain for several days. On April 3, 2008, PA-C Springer recommended that claimant undergo a magnetic resonance imaging (MRI) scan of her right shoulder. Claimant underwent the MRI arthrogram of her right shoulder on April 4, 2008, which showed mild degenerative changes of the acromioclavicular (AC) joint, mild tendinosis of the biceps tendon, and a large tear of the supraspinatus tendon.

5. Dr. Chimonas reviewed the MRI findings with claimant on April 8, 2008; he recommended evaluation by an orthopedic surgeon. Orthopedic Surgeon Joseph Hsin, M.D., evaluated claimant's right shoulder on April 16, 2008, and recommended arthroscopic surgery to repair the rotator cuff and to decompress the shoulder. Dr. Hsin scheduled surgery for May 1, 2008.

6. On April 23, 2008, insurer wrote a letter to Dr. Chimonas asking for his medical opinion concerning causation of claimant's torn rotator cuff. Insurer questioned how claimant could sustain a rotator cuff tear without a discreet injury and whether it was medically probable the tear was pre-existing and not work-related. Insurer pointed out that the MRI scan showed what could be a complete rotator cuff tear with scarring and granulation, possibly indicating a preexisting tear.

7. In response to insurer, Dr. Chimonas authored a letter of April 24, 2008. Dr. Chimonas wrote that PA-C Springer and Dr. Orent initially questioned whether claimant's shoulder condition was work-related and thus requested a work-site evaluation to objectively assess causation. According to Dr. Chimonas, employer stonewalled their repeated requests for a work-site evaluation. Dr. Chimonas therefore interviewed claimant by telephone to obtain her description of her job duties and the nature of her injury. Dr. Chimonas learned that claimant began having problems with her right shoulder a year before she came to the clinic. Claimant's symptoms initially involved pinching sensation in her right shoulder which would only occur at work for the first few months. Later, the pain in her shoulder got worse and would also occur with forceful movements at home when performing her with activities of daily living.

8. Dr. Chimonas reported the following based upon his conversation with claimant:

> [Claimant] said although the parts were small and did not weigh much, often they did not fit very well and she would require a lot of strength to force them together. Often she would have to stand up and use her entire weight and shoulder to push down on a part to get it to fit. She would do this repeatedly throughout the day. Although the objects were not over her head, they were in front of her and she would use her shoulder a lot and have to rotate internally in order to actually get the part to fit appropriately. She would also have to do some lifting of 10 to 20 pounds throughout the day, however this was infrequent. She would frequently have to assemble these parts that did not fit appropriately. Sometimes she would even require pliers to get a better hold on the piece to force it into place.

Based upon this history, Dr. Chimonas opined that claimant's right shoulder condition arose out of her work activities. Dr. Chimonas explained:

> This rotator cuff tear is secondary to a long-standing impingement syndrome which was ultimately caused by her having to do **repeated forceful movements of the shoulder**. It is well documented that the leading cause of a rotator cuff tear is in fact impingement and not an acute injury.
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> ****
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> **Based on the history that [claimant] gives me about using forceful motions over and over and over again at work, not having to do this motion at home**, and the gradual buildup of pain in her shoulder, I do believe that her rotator cuff tear is secondary to an impingement.

(Emphasis added). Dr. Chimonas thus determined that claimant's work activity presented a hazardous exposure involving repeated forceful movements of the shoulder.

9. Claimant and Mr. P demonstrated at hearing how to assemble the glow-worms and goggle protectors – plastic loops that fit on fire helmets to retain safety goggles. Crediting Mr. P's testimony, an average employee produces some 50 to 75 glow-worms per day. Assembling glow-worms is a three-step process, where each step requires a day. The most difficult stage is gluing the cap on the glow-worms. Employees typically glue caps on the glow-worms every third working day, but sequencing is left to the discretion of the assembler. Claimant is one of employer's highest producers.

10. When assembling glow-worms, claimant sits at her table working immediately in front of her. The work involves constant reaching and grasping

with her upper extremities to put together small pieces of plastic. Claimant forcefully manipulates the caps she glues onto the glow-worms by using her hands to twist them or by pounding them on the table, sometimes more than once to make them fit snugly. This is done repeatedly throughout the day when performing this stage of the assembly.

11. When assembling goggle protectors, claimant uses a vise-like tool, which is some eight inches high and attaches to her worktable. Claimant uses the vise to clamp a piece of plastic stripping so that she can work on each end. This requires claimant to reach at shoulder height and above twice per loop in order to attach each end of the stripping to the next piece.

12. Nicholas K. Olsen, D.O., performed an independent medical examination of claimant on September 26, 2008. Dr. Olsen attended the hearing, listened to the lay testimony, and observed claimant and Mr. P demonstrate how one assembles a glow-worm and a goggle protector. Dr. Olsen testified as an expert in Physical Medicine and Rehabilitation and electrodiagnostic medicine. Dr. Olsen agrees with Dr. Chimonas opinion that rotator cuff tears often occur without trauma.

13. Dr. Olsen persuasively explained: Claimant's right shoulder impingement syndrome more probably is the result of age-related changes that occur in the general population from age 30 onward as blood supply decreases. Reduced blood supply to the shoulder decreases the subacromial space, causing a decrease in the functioning space of the rotator cuff. With use of the shoulder over time, impingement typically causes tears to the rotator cuff. The Judge infers from Dr. Olsen's testimony that claimant's impingement syndrome involves an underlying, progressive disease process that eventually causes tearing of the rotator cuff.

14. Dr. Olsen and Dr. Chimonas disagree about the cause of claimant's rotator cuff tear. Dr. Olsen testified that the work activity claimant demonstrated at hearing was markedly different from the history she reported to Dr. Chimonas. The Judge credits Dr. Olsen's testimony here as persuasive in finding that the history claimant gave Dr. Chimonas fails to comport with what she demonstrated at hearing. Because he relied upon that history as the basis for his medical opinion, Dr. Chimonas's medical opinion regarding causation of claimant's rotator cuff tear is unreliable and unpersuasive.

15. Dr. Olsen relied upon the *Shoulder Injury Medical Treatment Guidelines* (Treatment Guidelines) promulgated by the Division of Workers' Compensation as the basis for his causation opinion. Crediting Dr. Olsen's medical opinion, the Judge finds: The Treatment Guidelines advise physicians that a history of sudden trauma or one of repetitive overhead work is necessary to find a causal relationship between work and a shoulder injury. All physicians agree that, by history, claimant's shoulder injury is not the result of sudden trauma at work. The

causation analysis next focuses on the type of motion involved in claimant's work activities to determine if her work presents a special hazard of employment associated with increased likelihood of tearing the rotator cuff. Repetitive motion that causes a shoulder injury must involve repetitive work with the arm extended above 60 degrees. Claimant performs the majority of her work using her upper extremities below the 60-degree level. While claimant occasionally reaches above the 60-degree level, that reaching is not sufficiently frequent to be considered repetitive. The Judge credits Dr. Olsen's medical opinion in finding it medically improbable that claimant's use of her upper extremities at work is associated with causing, intensifying, or, to a reasonable degree, aggravating the progressive disease process in her right shoulder.

16. Claimant failed to show it more probably true than not that her upper extremity activities at work present a hazard of employment that caused, intensified, or, to a reasonable degree, aggravated the progressive disease process in her right shoulder. Analysis of the cause of claimant's rotator cuff tear largely involves a question of medical causation. The Judge credited the medical opinion of Dr. Olsen over that of Dr. Chimonas. The Judge found it medically improbable that claimant's use of her upper extremities at work caused, intensified, or, to a reasonable degree, aggravated the progressive disease process in her right shoulder.

CONCLUSIONS OF LAW

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

Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease type injury arising out of the course and scope of her employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), *supra*, as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, **and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.**

(Emphasis added). This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993).

The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found that claimant failed to show it more probably true than not that her upper extremity activities at work presented a hazard of employment that caused, intensified, or, to a reasonable degree, aggravated the

progressive disease process in her right shoulder. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease type injury.

As found, analysis of the cause of claimant's rotator cuff tear largely involved a question of medical causation. The Treatment Guidelines advise physicians that a history of sudden trauma or one of repetitive overhead work is necessary to find a causal relationship between work and a shoulder injury. All physicians agreed that, by history, claimant's shoulder injury was not the result of sudden trauma at work. The Judge instead found that claimant's impingement syndrome represents an underlying, progressive disease-process that eventually causes tearing of the rotator cuff.

The causation analysis next focuses on the type of motion involved in claimant's work activities to determine if her work presents a special hazard of employment associated with increased likelihood of tearing her rotator cuff. Repetitive motion that causes, intensifies, or, to a reasonable degree, aggravates a shoulder injury necessarily involves repetitive work with the arm extended above 60 degrees. Claimant performs the majority of her work using her upper extremities below the 60-degree level. While claimant occasionally reaches above the 60-degree level, that reaching is not sufficiently frequent to be considered repetitive. The Judge thus found it medically improbable that claimant's use of her upper extremities at work is associated with causing, intensifying, or, to a reasonable degree, aggravating the progressive disease process in her right shoulder.

The Judge concludes claimant's claim for workers' compensation benefits should be denied and dismissed.

ORDER

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

1. Claimant's claim for workers' compensation benefits is denied and dismissed.

DATED: _December 11, 2008__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-768-753

ISSUES

The following issues were raised for consideration at hearing:

1. Compensability; and
2. Medical benefits.

The parties stipulate and agree that, if the Claimant's claim is found compensable, Concentra is the authorized medical provider.

FINDINGS OF FACT

Having considered the evidence presented at hearing, and the parties' closing arguments, the following Findings of Fact are entered.

1. On August 15, 2008, Claimant was employed by the Employer as a leadman in a business that constructs roof tresses. Claimant was supervised by JR.

2. In September 2007, Claimant suffered a low back injury in the course and scope of his employment for the Employer. Claimant had worked for the Employer for three years at the time of the 2007 injury. In 2003 or 2004, Claimant was involved in a motor vehicle accident in which he was not injured.

3. On August 15, 2008, Claimant suffered another injury in the course and scope of his employment for the Employer when he was carrying six or seven pieces of eight foot long wood. He jumped from one table to another table, and when placing weight on his right foot he felt back pain in the same location as he experienced during the September 2007 back injury.

4. Claimant reported the injury to his supervisor, Mr. R, who referred Claimant for medical treatment at Concentra. Claimant was taken off work by a Concentra physician. Claimant remained off work under the care of the authorized provider of medical care, and did not return to the workplace until September 15, 2008 when he was released from medical care without restrictions.

5. Claimant credibly testified that he continues to require medical attention for his back as a result of the August 15, 2008 work injury. Claimant's need for continued medical treatment was shown to be reasonable, necessary, and related to the August 15, 2008 work injury. Respondents are liable for this treatment.

6. Respondents presented evidence through the testimony of JR, which was found to be less credible and persuasive than the testimony of Claimant. Mr. R could not speak directly to the issues raised for consideration at hearing. Respondents argued, through counsel, that it was suspicious that Claimant was scheduled to be laid off and that he claimed a work injury. It was further argued as suspicious that Claimant is alleged by Mr. R to have inquired whether he could be laid off, if he had a work injury. Further, Respondents asserted that other suspicious occurrences point to secondary gain as Claimant's motivation

for claiming a work injury. Because Mr. R' testimony was largely built on suspicions, it was not deemed to carry sufficient weight to rebut Claimant's credible and persuasive testimony concerning a work injury and the continued need for medical treatment.

CONCLUSIONS OF LAW

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

1.The Workers' Compensation Act is intended to be "remedial and beneficent in purpose, and should be liberally construed" in order to accomplish these goals. *Davison v. Industrial Claim Appeals Office & Mobley v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflict in the evidence, make credibility determinations, determine the weight to be accorded to the expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002).

2.The injured worker has the burden of proof, by a preponderance of the evidence, of establishing all aspects of his claim and entitlement of benefits. Section 8-43-201 and 8-43-210, C.R.S. *See City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000); *Lutz v. Industrial 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).

3.In determining credibility of witnesses, the fact finder should consider, among other things, the consistency 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 (1936); Colorado Jury Instructions Civil, 3:16 (2005).

4.The Act provides that every employer shall furnish such medical, surgical, dental, or nursing, and hospital treatment and supplies as may be reasonably needed at the time of the injury or occupational disease and during the disability to cure and relieve the employee from the effects of the injury. Section 8-42-101, C.R.S. Respondents are liable for medical treatment, which is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related medical benefits to cure and relieve Claimant of the effects of the August 15, 2008 work injury to his back.

All matters not determined herein are reserved for future determination.

DATED: December 12, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-702-503

ISSUES

The issues determined herein are petition to reopen, medical benefits, and temporary total disability ("TTD") benefits.

FINDINGS OF FACT

1. In 1991, claimant began work for the employer as a crew leader.
2. In February 2001, claimant suffered a back injury in a motor vehicle accident. Dr. Jenks provided treatment for disc injuries at L4-5 and L5-S1. Dr. Lazar provided a surgical consultation, but recommended only that claimant change jobs. A September 26, 2002, magnetic resonance image ("MRI") showed a bulge at L1-2 and a normal disc at L2-3. The MRI also showed bulges and disc dessication at L3-4 through L5-S1. In October 2002, Dr. Nichols recommended surgery at L5-S1, but claimant declined. Dr. Jenks continued to provide treatment, including epidural steroid injections through November 10, 2005.
3. On October 5, 2006, claimant suffered an admitted industrial injury to his low back when he moved a spa.
4. An October 20, 2006, MRI showed a large disc herniation at L1-2 with severe central canal stenosis, retrolisthesis of L2 over L3, moderate degenerative changes at L4-S1.
5. On January 23, 2007, Dr. Jatana performed surgery at L1-2. The surgery relieved the groin pain that claimant had experienced since the work injury, but claimant continued to have back and leg pain.
6. Claimant returned to light duty work in the warehouse for the employer until his employment was terminated.
7. Dr. Ford continued to provide epidural steroid injections and facet injections.

8. Dr. Ford requested authorization to perform a rhizotomy at L5-S1. Dr. Shih provided a record review for respondents and approved the rhizotomy. Claimant continued to suffer leg and back pain.
9. On December 3, 2007, Dr. Jatana recommended fusion surgery at L4 through S1, but claimant declined.
10. On December 4, 2007, Dr. Reasoner determined that claimant was at maximum medical improvement ("MMI") with 25% impairment for disc injuries at L1-2 and L4-S1. Dr. Reasoner imposed permanent restrictions against lifting over 50 pounds or carrying over 20 pounds. He recommended continuing post-MMI medical treatment.
11. On January 28, 2008, the insurer filed a final admission of liability for the permanent partial disability benefits and for post-MMI medical benefits.
12. Dr. Maisel provided post-MMI medical care. In May 2008, claimant suffered a flareup of symptoms that never resolved. On May 20, 2008, Dr. Maisel noted that claimant had suffered an acute exacerbation, although he remained at MMI.
13. On June 16, 2008, Dr. Jatana reexamined claimant and recommended a repeat MRI. The MRI showed worsened retrolisthesis at L2-3.
14. On June 27, 2008, Dr. Jatana recommended trial of a spinal cord stimulator. Dr. Maisel agreed with this recommendation.
15. Dr. Scott performed a record review for respondents. Dr. Scott was of the opinion that claimant only injured L1-2 in the work injury. Consequently, Dr. Scott recommended denial of the trial of the spinal stimulator.
16. On July 25, 2008, claimant filed his petition to reopen based upon a change of condition.
17. On September 24, 2008, Dr. Lambden performed an independent medical examination for respondents. Dr. Lambden concluded that claimant's current symptoms were not related to the work injury because claimant injured only his L1-2 disc in the work injury. Dr. Lambden agreed that claimant was worse, especially at L2-3. Dr. Lambden did not recommend a spinal stimulator for claimant because he suffered mechanical as well as neuropathic pain and he had multi-level degenerative disc disease. Dr. Lambden agreed that some treatment was still needed for the work injury.
18. At hearing, Dr. Lambden admitted that claimant was substantially worse than at MMI, although Dr. Lambden thought that the worsening was not due to the work injury. He recommended selective nerve root blocks, flexion-extension x-rays, and a psychological evaluation.
19. Dr. Reasoner testified by deposition that claimant was worse and that the L2-3 injury was part of the work injury. Dr. Reasoner noted the absence of retrolisthesis until after the work injury and he noted that claimant had been able to work full-time at a heavy job until the work injury. Dr. Reasoner agreed that claimant needed a psychological evaluation before determination of the feasibility of a spinal stimulator trial.
20. Claimant has proven by a preponderance of the evidence that he suffered a change of condition since MMI and that the change was a natural consequence of the admitted work injury. Claimant's testimony is credible. The opinions of Dr. Reasoner are persuasive. Claimant injured his L2-3 disc in the admitted work injury. That level has suffered rapid progression and needs additional treatment.
21. The parties stipulated that claimant needed medications, x-rays, lower extremity electromyography studies, nerve blocks, and a psychological evaluation.

22. Claimant has failed to prove by a preponderance of the evidence that trial of a spinal stimulator is reasonably necessary at this time. Even Dr. Reasoner agreed that claimant needed a psychological evaluation before proceeding with the trial.
23. Claimant has failed to prove by a preponderance of the evidence that he suffered increased disability in spite of his change of condition. Dr. Reasoner provided the permanent restrictions. No physician has offered new restrictions. Claimant never attempted to return to work in any occupation. The record evidence does not show that he has increased loss of labor market access compared to his status at MMI.

CONCLUSIONS OF LAW

1. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. *See Ward v. Ward*, 928 P.2d 739 (Colo. App. 1996) (noting that change in condition has been construed to mean a change in the physical condition of an injured worker). Claimant must prove that his change of condition is the natural and proximate consequence of the industrial injury, without any contribution from another separate causative factor. *Vega v. City of Colorado Springs,* W.C. No. 3-986-865 & 4-226-005 (ICAO, March 8, 2000). As found, claimant has proven by a preponderance of the evidence that he suffered a change of condition as a natural consequence of his admitted work injury.

2. 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). The parties stipulated to various medical treatments. As found, claimant has failed to prove by a preponderance of the evidence that he is entitled to a trial of a spinal stimulator at this time.

3. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637 (Colo. App. 1997) bars additional TTD benefits as of June 16, 2008, unless claimant demonstrates increased temporary disability since the original MMI date. As found, he has failed to prove by a preponderance of the evidence that he suffered increased disability since MMI. Consequently, he is not entitled to additional TTD benefits. The offset request pursuant to *Donald B. Murphy Contractors, Inc. v. Industrial Claim Appeals Office*, 916 P.2d 611 (Colo. App. 1995) is moot.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is granted.
2. The insurer shall pay for all of claimant's reasonably necessary medical treatment from authorized providers, including medications, x-rays, lower extremity electromyography studies, nerve blocks, and a psychological evaluation.
3. Claimant's request for an order to provide a trial of a spinal stimulator is denied.
4. Claimant's request for TTD benefits commencing June 16, 2008, is denied and dismissed.
5. All matters not determined herein are reserved for future determination.

DATED: December 15, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-991

ISSUES

1. Did Claimant prove by a preponderance of the credible evidence that his low back, neck and right shoulder conditions are related to the admitted industrial injury?
2. Did Claimant prove by a preponderance of the credible and persuasive evidence that he was entitled to Temporary Total Disability (TTD) benefits from May 19, 2008 and ongoing?
3. What is Claimant's Average Weekly Wage (AWW)?

FINDINGS OF FACT

1. Claimant worked a total of 117.75 hours during the months of October and November 2007 and April and May 2008. During this time Claimant earned $838.07. Thus, his average hourly rate was $7.12 during this period.
2. Claimant worked sporadically for the Respondent-Employer over this period of time. Claimant worked 26.75 hours in October 2007, 8 hours in November 2007; Claimant did not work in December 2007, January 2008, February 2008, or March 2008. Claimant then worked 42 hours in April 2008 and 41 hours in May 2008.
3. Claimant agreed to perform modified duty on May 12, 2008 at the rate of $7.16 for a 22-hour week amounting to $157.52 per week. This closely matches the Claimant's work history with the Respondent-Employer.
4. The ALJ finds that an AWW of $157.52 is a fairly determined AWW for the Claimant.
5. Claimant sustained a work-related injury to his right ankle, neck, right shoulder and low back on May 8, 2008 while carrying very heavy partition board for Respondent-Employer. Claimant incurred the injuries when he fell into a hole that was approximately 2 feet deep and 2 feet wide which caused him to fall to the ground on his buttocks and the wall that he had been carrying came down on top of him pushing his head to the left.
6. CD, Branch Manager for Respondent, offered the Claimant modified duty on May 12, 2008. Claimant began working modified duty on May 13, 2008.
7. An employee's work restrictions and specific work duties while on modified duty for Respondent-Employer are determined based on the work restrictions provided by the employee's physician. Claimant's work restrictions included sitting 95% of the time. Claimant was given a chair with rolling wheels on the bottom that he was to use in completing his job duties. Claimant stood no more than 2-3% of the time in completing his modified duties.

8. All transitional (modified) duty employees are paid on the 15th and last day of each month by the Respondent-Employer. Claimant received his first modified duty paycheck according to this schedule. Claimant received his first modified duty paycheck after he had worked only two (2) days of modified duty.

9. On May 16, 2008 Claimant questioned Ms. D regarding why he was paid for only two (2) days of work in his first modified duty paycheck when according to the Transitional Duty Offer he was supposed to receive $157.52 per week. Ms. D explained that because he had only worked two (2) days he would only be paid for two (2) days. The remainder of the week would be paid to him on his next paycheck. Claimant became very upset about the paycheck and left the office. Claimant has not returned to the office since, has not called the office since and has not had any contact with Ms. D or her staff since walking out on May 16, 2008.

10. Claimant is still considered an "active" employee. Respondent-Employer has not terminated Claimant's employment. Claimant merely walked out and up to the date of the hearing has voluntarily not returned to work.

11. Modified duty continued to be available to Claimant after May 16, 2008 at his pre-injury rate of pay and pre-injury hours.

12. Had Claimant continued to work the modified duty available to him, instead of walking out and not returning, Respondent would have had modified duty available for him at his pre-injury rate of pay and pre-injury hours after October 9, 2008 when Claimant's restrictions were made less restrictive.

13. The ALJ specifically finds Ms. D's testimony on all points to be credible and persuasive.

14. Dr. Albert Hattem testified, via deposition, that the specific modified duty offered to Claimant by Respondent-Employer was within his work restrictions. Dr. Hattem opined

> If he was able to do his job duties in a rolling chair, his injuries should not have precluded him from carrying out those job responsibilities.

The ALJ specifically finds that the modified duty offered to Claimant by Respondent-Employer was within Claimant's work restrictions.

15. The ALJ specifically finds Dr. Hattem's testimony to be credible.

16. The ALJ specifically finds the Claimant credible with respect to the extent and nature of his work-related injuries and, in conjunction with the medical evidence including Dr. Albert Hattem's opinions as expressed in his deposition in this matter, finds that Claimant's injuries to his low back, neck, and right shoulder are proximately caused by his work-related injury and are compensable.

17. The ALJ specifically finds that Claimant voluntarily abandoned his modified duty position by failing to return to the Respondent's workplace subsequent to May 16, 2008. The ALJ finds that Respondent was no longer responsible for TTD benefits once Claimant returned to modified employment. Subsequent to his return to modified employment Claimant then abandoned his position. The ALJ finds that Claimant in this matter is less credible than evidence introduced by Respondent.

CONCLUSIONS OF LAW

1. 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. (2008). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 529 P.2d 792 (Colo. 1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). 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 employer's rights. §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 issue involved; the Judge does not need to address every piece of evidence that might lead to a conflicting conclusion, or he has rejected evidence contrary to the findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course of employment. §8-41-301(1)(c), C.R.S. "Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded." *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000).

4. Whether a claimant has 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). In deciding whether or not an injured worker has met his burden of proof, the ALJ is empowered to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the record. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999).

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

6. Section 8-42-102(2), C.R.S. sets forth certain methods of calculating the AWW. Section 8-42-102(3), C.R.S. permits the ALJ discretion in the method of calculating the AWW if the nature of employment or the fact that the injured employee has not worked a sufficient length of time, has been ill or self-employed, or for any other reason, the specific methods do not fairly compute the AWW.

7. A claimant is entitled to TTD benefits where he has proven that he suffered an industrial injury that causes total disability that lasts more than three (3) working days duration. §8-42-105(1), C.R.S. Entitlement to TTD benefits terminates once the employee returns to regular or modified employment. §8-42-105(3)(b), C.R.S.

8. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant met his burden of proof concerning causation of his alleged injuries. The preponderance of the credible evidence supports Claimant's claim that his low back, neck and right shoulder conditions are related to the admitted industrial injury.

9. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant did not meet his burden of proof concerning the issue of TTD benefits. Claimant was offered and accepted modified duty within his work restrictions and he began modified duty on May 13, 2008. Claimant has not proven that he did not voluntarily abandon his employment with Respondent. The preponderance of the credible evidence does not support Claimant's claim that he is entitled to TTD benefits.

10. It is specifically concluded as a matter of law based on the credible evidence in the record that Claimant's AWW on the date of injury was $157.52.

ORDER

It is therefore ordered that:

1. Respondent-Insurer is responsible for Claimant's medical care of his low back, neck, and right shoulder symptoms as are reasonable and necessary to cure or relieve Claimant from the effects of his work-related injury.
2. Claimant's request for TTD benefits is denied and dismissed.
3. Claimant's AWW is $157.52.
4. Respondent-Insurer shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.
5. All matters not determined herein are reserved for future determination.

DATE: December 15, 2008
/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-712-593

ISSUES

1. Does the ALJ have jurisdiction in this matter?

2. Has claimant established by a preponderance of the evidence that she is entitled to permanent partial disability (PPD) benefits?

FINDINGS OF FACT

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

1. Claimant, age 55 at the time of the hearing, began working for employer in 1995 as a cashier at the parking facility at Denver International Airport. She worked as a traffic agent from 1997 to 2005, when she resumed her duties as a cashier.

2. In approximately 2006, claimant began experiencing problems in her upper extremities. She reported these problems to her employer in May, 2006, and was referred to Denver Health Medical Center at Denver International Airport. Rick Artist, M.D., claimant's authorized treating physician, first evaluated claimant on May 30, 2006. Dr. Artist is Level II accredited, has been licensed since 1983, and has been an instructor at Colorado University School of Medicine since 1995. Dr. Artist diagnosed claimant with bilateral carpal tunnel syndrome and mild right lateral epicondylitis.

3. Jurisdictional Findings. On April 27, 2007, Respondents filed a General Admission of Liability.

4. On January 11, 2008, Dr. Artist found claimant to be at maximum medical improvement (MMI) with no permanent impairment. Claimant filed a Physician's Report of Worker's Compensation Injury (first impairment rating).

5. On January 22, 2008, in response to the first impairment rating, Respondents filed a Final Admission of Liability (FAL). Respondents denied liability based on Dr. Artist's rating. Pursuant to Section 8-43-203(2)(b)(II), C.R.S., the FAL provided in part "If you disagree with the benefits admitted or not admitted you must do the following: 1. Within 30 days, complete the attached objection form…stating that you object to this admission. You must also file an application for hearing with the Office of Administrative Courts on any disputed issues. 2. Within the same 30 days, if you disagree with the date of MMI or whole person impairment rating, complete the attached Notice and Proposal to Select an Independent Medical Examiner Form and send it to the insurance carrier or self-insured employer and the Division. 3. If an IME is requested, you are not required to file an application for hearing until after the IME is completed."

6. After the first impairment rating, claimant telephoned Dr. Artist and talked to him on the telephone twice. She questioned why he had issued a zero permanent impairment rating and pointed out to him her symptoms. Dr. Artist performed no additional physical examination.

7. On January 26, 2008, Dr. Artist filed a revised impairment rating, finding permanent impairment of 50% upper extremity, converted to 30% whole person (revised impairment rating). Dr. Artist now believes that the revised impairment rating most accurately reflects the claimant's condition.

8. In issuing the revised impairment rating, Dr. Artist used Table 15 of the American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Ed. Rev. (AMA Guides). He found an entrapment neuropathy, right radial nerve, of 10% and right median nerve 25% upper extremity impairment. He combined that for a 33% right upper extremity impairment. He found a left arm radial nerve impairment of 8% and median nerve of 20%, which he found to yield a 26% upper extremity impairment. He then combined 33% right upper extremity with 26% left upper extremity to yield a 50% upper extremity impairment. Using Table 3, he found that this yields a 30% whole person impairment. Dr. Artist noted claimant's complaints of pain and stated that she was using ibuprofen and Tylenol frequently and may need strong pain medicine on occasion.

9. Respondents did not file any revised or second FAL or request for an independent medical examination (IME) in response to the revised impairment rating.

10. On February 15, 2008, in relation to the first impairment rating, claimant filed an Objection to Final Admission of Liability and a Notice and Proposal to Select an Independent Medical Examiner.

11. On June 2, 2008, claimant filed an Application for Hearing.

12. On June 8, 2008 Respondents filed a Notice of Failed IME negotiation.

13. Claimant never obtained a DIME and agreed to proceed to hearing without having a DIME.

14. Respondents filed a Motion to Strike Claimant's Application for Hearing. Respondents contended that claimant's failure to respond to the FAL or to seek a DIME within 30 days after the failure of the parties to agree on an IME physician deprived the ALJ of jurisdiction and closed the case subject to a Petition to Re-Open.

15. Claimant filed a Response arguing that Respondents' obligation to file a Notice of Failed Negotiation within 30 days of the parties' failure to agree on an IME physician procedurally preceded claimant's obligation to file an Application for IME and that the matter never became ripe for hearing.

16. On June 20, 2008, Judge Friend entered an Order denying Respondents Motion to Strike.

17. <u>Treatment History and Evaluations.</u> After his initial treatment of claimant, Dr. Artist referred claimant to Dr. In Sok Yi of Hand Surgery of Colorado. Dr. Yi first examined Claimant on August 10, 2006, and diagnosed her with bi-lateral carpal tunnel syndrome, bi-lateral CMC arthritis and right lateral epicondylitis. On January 19, 2007, Dr. Yi performed a left carpal tunnel release.

18. Claimant progressed well after her surgery. On January 25, 2007, claimant reported to Dr. Yi that her numbness and tingling were significantly better on her left side. On March 15, 2007, claimant reported to Dr. Yi no numbness or tingling and continuing improvement of the soreness around the incision site.

19. Dr. Yi performed a right carpal tunnel release on April 6, 2007. By April 18, claimant reported an absence of night pain. By May 24, 2007, claimant reported no numbness or tingling but some soreness around the incision site with some weakness. Dr. Yi's physical examination revealed good sensation to touch in the median nerve distribution.

20. By July 5, 2007, 13 weeks after the surgery, Dr. Yi noted that claimant was experiencing no numbness or tingling and was pleased with the surgical results for her right carpal tunnel release. Claimant was continuing to experience some elbow pain. Claimant stated that her left hand was doing well. Dr. Yi noted that claimant was "mildly tender over the right lateral epicondyle with some pain with resisted wrist extension." Dr. Yi discharged claimant to full work status on July 5, 2007, with a plan for her to use her hand as tolerated since the elbow pain is something she could tolerate.

21. On December 6, 2007, Dr. Yi last evaluated claimant for a follow-up of her upper right lateral epicondylitis. Claimant reported to Dr. Yi that the pain was constant, 3 on a scale of 10. On physical examination, Dr. Yi found tenderness over the later epicondyle but good sensation to touch in the median nerve distribution. Dr. Yi found some pain with resisted wrist extension.

22. Claimant returned to restricted duty following the second carpal tunnel release surgery. She received physical therapy. Claimant continued to receive treatment from Dr. Artist after her surgeries and to demonstrate continued improvement, with some complaints. On May 8, 2007, Dr. Artist noted that claimant was not taking Vicodin for pain and Claimant had good strength in left and fair strength in her right hand. On June 14, 2007, Dr. Artist noted full range of motion of the wrist, pretty good grip strength, no wincing when she squeezed tightly. At this time, claimant reported to Dr. Artist that the sensation in her fingers was a little dull and fuzzy and some weakness with heavier objects.

23. On July 20, 2007, claimant reported to Dr. Artist that her carpal tunnel symptoms continued to improve albeit slowly and that most of the time she did not have any numbness and tingling. She did report occasional, intermittent numbness and tingling in three fingers on both hands and some difficulty with strength. Both were more prominent in her left hand. Objectively, Dr. Artist noted "good range of motion of the wrist, good grip strength bilaterally, tenderness over the right lateral epicondylar area particularly superior portion of the lateral epicondyle." On August 21, 2007, Dr. Artist noted "left hand pretty good, right had still a little achy, sore, particularly with writing and mouse activity." Objectively, Dr. Artist noted "well-healed scars on the wrist. Very difficult to actually see. Good grip strength bilaterally."

24. On October 19, 2007, Dr. Artist noted that the carpal tunnel surgeries and symptoms were doing quite well, although a little funny sensation persisted at night. He also noted pain and soreness in the right lateral elbow. In general, he noted that symptoms were doing quite well. Objectively, "good range of motion of both hands and wrists. Good grip strength." The following week, October 24, 2007, claimant told Dr. Artist that her "wrists are doing okay." Objectively, "good range of motion at the wrists and hand. Good grip strength." Dr. Artist noted claimant's condition was stable. On November 16, 2007 Dr. Artist noted "good range of motion at wrists. Good grip strength."

25. Dr. Artist examined claimant numerous times before he issued the first impairment rating on January 11, 2008. He changed the impairment rating because claimant called to his attention her symptoms.

26. Dr. Artist's revised impairment rating was based on his assertion of an entrapment neuropathy at the right radial nerve, right median nerve, left arm radial nerve impairment, and median nerve. Dr. Artist admits that there is no objective evidence to support an entrapment neuropathy of claimant's right radial nerve, right median nerve or left radial nerve.

27. At the request of respondents, Allison M. Fall, M.D. performed an independent medical examination of claimant on July 24, 2008. Dr. Fall is Level II accredited and an expert in physical medicine and rehabilitation and in rating those with carpal tunnel syndrome and epicondylitis. The ALJ found Dr. Fall's testimony to be persuasive. Dr. Fall opined, and the ALJ finds, that claimant did not have a permanent impairment based on her surgically-treated carpal tunnel syndrome. Both carpal tunnel releases were successful and eliminated any nerve entrapment. Further, it is improper to rate for an entrapment that has been successfully relieved by surgery.

28. Dr. Artist's revised impairment rating was not supported by objective evidence on physical examinations. According to Dr. Fall, Level II training strongly recommends against use of Table 15, and thus Dr. Artist improperly used this table in rating claimant. The ALJ adopts this opinion.

29. Based on the testimony of Dr. Fall, an impairment rating based on pain alone is inappropriate. There was no documentation of objective abnormalities such as sensation loss, weakness of muscles or other test results. With regard to the carpal tunnel syndromes, no permanent medical impairment for claimant was appropriate because there was no documented objective abnormality. Dr. Artist's revised impairment rating of January 26, 2008 was improper and not supported by credible evidence.

30. Based on her review of medical records and her independent medical examination, Dr. Fall opined and the ALJ finds that there is objective evidence of a permanent medical impairment due to the right lateral epicondylitis. Pursuant to the Cumulative Trauma Disorder Matrix, Dr. Fall determined a 6% upper extremity impairment but no objective evidence of a functional limitation beyond the situs of the injury. The ALJ adopts Dr. Fall's opinion in this regard and finds that claimant sustained a permanent medical impairment, that is, a 6% scheduled upper extremity impairment, as a direct and proximate result of her occupational disease.

31. Claimant failed to establish by a preponderance of the evidence that her functional limitation went beyond the arm at the shoulder. As such, her impairment is limited to a scheduled impairment.

32. In January, 2008, the time of the revised impairment rating, claimant was experiencing some pain in her hands and wrists. Since 2007, she has been working a modified work assignment as a traffic agent making courtesy traffic calls and as a receptionist answering the telephone. She was having trouble sleeping, although she was not experiencing tingling or numbness in her hands. She was also experiencing pain in her elbow.

CONCLUSIONS OF LAW

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

1. Jurisdiction. Respondent contends that the ALJ lacks jurisdiction to hear the issue of PPD as raised in the claimant's application for hearing because the case was automatically closed as to benefits admitted or not admitted in the FAL as of February 23, 2008. Respondents therefore contend that claimant must file a petition to reopen pursuant to Section 8-43-303. Respondents assert that pursuant to Section 8-43-203(2)(b)(II), C.R.S., claimant's failure to file an application for hearing within 30 days of the January 22, 2008 FAL resulted in the closure of the case as of February 23, 2008.

The ALJ disagrees. Section 8-43-203(2)(b)(II) provides that a case will "automatically be closed as to the issues admitted in the final admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing, including the selection of an independent medial examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted." It further provides, however, that "[i]f an independent medical examination is requested pursuant to section 8-42-107.2, the claimant is not required to file a request for hearing on disputed issues that are ripe for hearing until after completion of the divisions' independent medical examination."

On February 15, 2008, claimant filed a timely Notice and Proposal to Select an Independent Medical Examiner, as outlined in Section 8-42-107.2. She therefore *requested* a DIME, as specified in Section 8-43-203(2)(b)(II). Under these circumstances, she was not required to file an application for hearing within 30 days of the January 22, 2008 FAL. Claimant's application for hearing on June 2, 2008, was therefore timely. The case did not automatically close.

Claimant had a right in this matter to request a DIME. She objected to the January 22, 2008 FAL's determination of no permanent impairment. At the same time, claimant was asserting, based on Dr. Artist's revised impairment rating, a whole person impairment. There was thus a significant dispute at the time claimant requested the DIME as to whether claimant had a non-scheduled impairment. *See Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo.App. 2000). The fact that claimant ultimately did not obtain a DIME is irrelevant, as the Act only refers to a request for a DIME.

2. Applicability of *Res Judicata.* Claimant relies on the doctrine of *res judicata* to argue that the Order Re: Motion to Strike Application For Hearing dated June 20, 2006 precludes respondents from raising the above jurisdictional argument, which was asserted in their Motion to Strike Application for Hearing. At hearing on September 10, 2008, the undersigned ALJ ruled that ALJ Bruce Friend's Order of June 20, 2008, was not a final judgment the merits. ALJ Friend

ruled in part that "Respondents seek to close the case and deny clmt further benefits, not merely a procedural order. Respondents must file a Motion for Summary Judgment to obtain an order foreclosing further benefits. Rule 17 OACRP."

The doctrine of *res judicata,* or claim preclusion, does not apply here. Claim preclusion bars relitigation of matters that were decided in a prior proceeding, as well as matters that could have been decided in the prior proceeding but were not. Application of the doctrine requires, among other things, the finality of the first judgment. *Holnam, Inc. v. Industrial Claim Appeals Office,* 159 P.3d 795 (Colo. App. 2006). ALJ Friend's Order did not constitute a final judgment on the issue of jurisdiction. Rather, ALJ Friend only ruled that respondents had chosen an inappropriate procedural vehicle to bring this matter before the tribunal.

3. Effect of Respondents' Failure to File Second FAL. Claimant contends that respondents are precluded from challenging the revised impairment rating because it failed to file a second or revised FAL within 30 days of the revised impairment rating. In support of this contention, claimant cites Rules 5-5 (E) and (H), WCRP, which require insurers for medical impairments and scheduled injuries to either file an admission of liability or set the matter for hearing with the Office of Administrative Courts within 30 days. Claimant also cites *Leprino Foods, Inc. v. Industrial Claims Appeals Office,* 134 P.3d 475 (Colo.App. 2005), which precludes an insurer who did not either contest the DIME report within 30 days or admit in accordance with the report from thereafter challenging the report before an ALJ.

The situation addressed in *Leprino Foods* in not directly analogous to that presented here. The insurer here did file a FAL in relation to the first impairment rating, and claimant then filed an objection to that FAL and a Notice and Proposal to Select an Independent Medical Examiner in relation to the first impairment rating. The workers' compensation statutes and rules do not directly address the insurer's responsibility in relation to the revised impairment rating. While claimant seeks to bar respondents from disputing that rating based on their failure to file a second FAL, they point to no specific statutory or regulatory requirement for respondents to do so. In the absence of such a requirement, the ALJ declines to impose this sanction. Claimant has requested that the revised impairment rating be deemed admitted, and that request is denied.

4. Due Process Claim. Claimant contends that respondents' failure to admit or deny the revised impairment rating deprives her of her due process right to a hearing. Since claimant agreed to proceed to hearing in this matter and had a full and fair opportunity to present evidence and cross-examine witnesses, the ALJ finds this contention unpersuasive.

5. PPD. Section 8-42-107, C.R.S., establishes different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and subsection (8) provides a DIME process for whole person ratings. The threshold issue is the appli-

cation of the schedule and is a determination of fact for the ALJ based upon a preponderance of the evidence. *Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2001); *Johnson-Wood v. City of Colorado Springs,* W.C. No. 4-536-198 (ICAO June 20, 2005). At issue here is subsection (2)(a), which provides for scheduled compensation based on "loss of an arm at the shoulder." Claimant bears the burden of proof by a preponderance of the evidence to establish functional impairment beyond the arm at the shoulder and the consequent right to PPD benefits awarded under Section 8-42-107(8)(c).

In relation to the alleged entrapment neuropathy, the ALJ found unpersuasive Dr. Artist's opinion of such a permanent impairment. Dr. Artist had examined and evaluated claimant numerous times before his initial impairment rating. The initial and revised impairment ratings reflect a very dramatic change. Dr. Artist's explanation for his change of opinion from a zero impairment rating on January 11, 2008, to a 30% whole person impairment rating on January 26, 2008, is that claimant explained to him her symptoms. This is not convincing. Further, the ALJ found persuasive Dr. Fall's testimony that Dr. Artist's revised opinion was based on an improper table, one not designed for surgically-treated carpal tunnel syndrome. In addition, the lack of objective evidence to support entrapment neuropathy is significant. Further, claimant failed to establish by a preponderance of the evidence functional limitation that went beyond the arm at the shoulder. In contrast, the ALJ found persuasive the testimony of Dr. Fall, who examined claimant and found that she had no permanent impairment associated with her treated carpal tunnel syndrome. While claimant has some pain symptoms, she has failed to establish permanent medical impairment in relation to entrapment neuropathy.

The only permanent medical impairment established by claimant is that due to the right lateral epicondylitis. The ALJ found credible Dr. Fall's determination at 6% upper extremity impairment. There is no objective evidence of a functional limitation beyond the situs of the injury. Claimant has therefore sustained a 6% scheduled impairment and is entitled to PPD based on that permanent impairment.

ORDER

It is therefore ordered that:

1. The ALJ has jurisdiction to hear this matter.
2. Insurer shall pay claimant PPD benefits for her occupational disease based on a 6% scheduled impairment of the right upper extremity.
3. All matters not determined herein are reserved for future determination.

DATED: December 15, 2008

Nancy Connick
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-761-816

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he sustained compensable industrial injuries during the course and scope of his employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

3. Whether Claimant has proven by a preponderance of the evidence that he is entitled to recover Temporary Total Disability (TTD) benefits from August 1, 2008 until terminated by statute.

STIPULATION

The parties agreed that Claimant earned an Average Weekly Wage (AWW) of $842.14.

FINDINGS OF FACT

1. Employer is an on-line school that teaches students from around the state of Colorado. On August 21, 2004 Claimant began working as a teacher for Employer. He was promoted to a lead teacher position in 2006.

2. Claimant testified that on May 28, 2008 he was carrying two suitcases of tests and curriculum down a flight of stairs as part of his job duties for Employer. While shifting his legs in order to hold onto the suitcases, his arms and hands became numb. He also experienced a sharp pain in the middle of his back approximately two inches above his belt line.

3. On August 22, 2008 the parties conducted the evidentiary deposition of Claimant is this matter. Although Claimant maintained that he suffered an injury at work on May 28, 2008, he could not identify an incident that caused his back pain. He stated that his back bothered him on many days and his pain became unbearable in January 2008. Claimant explained that he took pain relievers to control the pain.

4. Claimant reported his injuries to Employer and was referred to Concentra Medical Centers. On the date of the incident Claimant visited Joel Boulder, M.D. for an evaluation. Dr. Boulder noted that Claimant began to experience back pain in February 2008 as a result of sitting at his work desk. Claimant's back pain subsequently fluctuated in severity. However, on May 28, 2008

he was carrying "a heavy box of portfolios down a flight of stairs" and began to experience back pain and spasms. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds.

5. Dr. Boulder referred Claimant for additional medical evaluations and treatment. However, Claimant never completed his treatment because Insurer filed a Notice of Contest on June 13, 2008 to conduct additional investigation. Insurer subsequently denied further medical treatment.

6. Claimant continued to perform his job duties as a teacher for Employer until June 6, 2008. He was paid through the end of the school year on July 31, 2008. However, Employer did not ask Claimant to return to work for the following academic year.

7. Employer's school principal SA testified at the hearing in this matter. Ms. A explained that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Ms. A explained that Claimant had exhibited a substandard work performance during the 2007-08 academic year. She thus notified Claimant approximately one week prior to his May 28, 2008 injury that he would not be asked to return to Employer for the following academic year.

8. Claimant has established that it is more probably true than not that he suffered industrial injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008. Claimant credibly explained that while he was carrying two suitcases of tests and curriculum down a flight of stairs he experienced pain in his back and numbness in his arms and hands. Claimant's account is consistent with his report to Dr. Boulder on the date of the incident. Although Claimant could not identify a specific incident that caused his injuries during his evidentiary deposition, he nevertheless maintained that he suffered an injury on May 28, 2008 that caused back pain. Claimant's credible testimony is thus sufficient to demonstrate that he suffered injuries during the course and scope of his employment with Employer on May 28, 2008.

9. Claimant has demonstrated that it is more probably true than not that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries. On the date of the incident, Employer referred Claimant to Concentra Medical Centers for treatment. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds. He subsequently referred Claimant for additional evaluations and medical treatment. Claimant's treatment with Dr. Boulder and subsequent referrals constituted reasonable and necessary medical

treatment that was designed to cure and relieve the effects of Claimant's May 28, 2008 industrial injuries.

10. Claimant has failed to prove that it is more probably true than not that he suffered a wage loss as a result of the May 28, 2008 incident. Claimant acknowledged that he was paid for his teaching duties until the conclusion of the academic year on July 31, 2008. Ms. A credibly testified that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Based on Claimant's substandard job performance issues, Ms. A notified Claimant approximately one week prior to his May 28, 2008 injuries that he would not be asked to return to Employer for the following academic year. Because Employer did not ask Claimant to return to work for the next academic year, he has not established a causal connection between his May 28, 2008 injuries and a wage loss subsequent to August 1, 2008. He is thus not entitled to receive TTD benefits.

CONCLUSIONS OF LAW

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

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

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

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has established by a preponderance of the evidence that he suffered industrial injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008. Claimant credibly explained that while he was carrying two suitcases of tests and curriculum down a flight of stairs he experienced pain in his back and numbness in his arms and hands. Claimant's account is consistent with his report to Dr. Boulder on the date of the incident. Although Claimant could not identify a specific incident that caused his injuries during his evidentiary deposition, he nevertheless maintained that he suffered an injury on May 28, 2008 that caused back pain. Claimant's credible testimony is thus sufficient to demonstrate that he suffered injuries during the course and scope of his employment with Employer on May 28, 2008.

Medical Benefits

6. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. As found, Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injuries. On the date of the incident, Employer referred Claimant to Concentra Medical Centers for treatment. Dr. Boulder determined that Claimant suffered a back strain and "right and left upper extremity sensory disturbances." He prescribed medications, physical therapy and an EMG study. Dr. Boulder also issued work restrictions of no lifting, pushing or pulling in excess of 10 pounds. He subsequently referred Claimant for additional evaluations and medical treatment. Claimant's treatment with Dr. Boulder and subsequent referrals constituted reasonable and necessary medical treatment that was designed to cure and relieve the effects of Claimant's May 28, 2008 industrial injuries.

Temporary Total Disability Benefits

8. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (Colo. 1995). 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, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair a claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595, 597 (Colo. App. 1998).

9. As found, Claimant has failed to prove by a preponderance of the evidence that he suffered a wage loss as a result of the May 28, 2008 incident. Claimant acknowledged that he was paid for his teaching duties until the conclusion of the academic year on July 31, 2008. Ms. A credibly testified that Employer evaluates teachers' performances at the end of every school year and makes decisions about whether they should return for the following academic year. Based on Claimant's substandard job performance issues, Ms. A notified Claimant approximately one week prior to his May 28, 2008 injuries that he would not be asked to return to Employer for the following academic year. Because Employer did not ask Claimant to return to work for the next academic year, he has not established a causal connection between his May 28, 2008 injuries and a wage loss subsequent to August 1, 2008. He is thus not entitled to receive TTD benefits.

ORDER

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

1. Claimant suffered compensable injuries to his back, arms and hands during the course and scope of his employment with Employer on May 28, 2008.

2. Respondents are financially responsible for all of Claimant's reasonable and necessary medical treatment that is related to his May 28, 2008 injuries.

3. Claimant's request for TTD benefits is denied.

4. Any issues not resolved by this Order are reserved for future determination.

DATED: December 15, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-746-176

ISSUE

The issue raised for consideration at hearing is compensability.

FINDINGS OF FACT

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

1. Claimant was employed by North Suburban Medical Center as a staff registered nurse in the neonatal department on December 28, 2007 when she aggravated her pre-existing low back condition. Claimant's job involved attending to premature babies and well babies, and she typically worked the 7 a.m. to 7 p.m. shift.

2. Claimant credibly testified that on Friday, December 28, 2007 she was in the supply room preparing to restock cribs for the next shift. Claimant also credibly testified that the stock room is extremely narrow making movement in the room difficult. She was in the process of bending over to pick up a bag of diapers for newborns when she experienced a pull in her low back. She yelled out and her co-worker, AW, came to her aid. Ms. W credibly testified that she heard Claimant yell "ow" and asked her what was wrong. Claimant told Ms. W that she had "pulled something in her back." Claimant was holding her back and Ms. W finished stocking the supplies for the next shift. Claimant completed the usual paperwork required at the end of her shift.

3. Claimant also credibly testified that the resupplying and restocking of the cribs for the next shift did involve working in the narrow stock room twisting, bending, and scanning supplies. Claimant was in the act of bending over to access supplies for the cribs when she felt pain in her back.

4. Claimant treated the year before with Dr. Stephen Shogan and underwent surgery on December 12, 2006 to repair her disc at L5-S1. Claimant was released at regular duty on January 31, 2007. The surgery that Dr. Shogan performed at L5-S1 was a microdiscectomy performed to fix Claimant's herniated disc.

5. On January 1, 2008, the Claimant was taken to Rose Medical Center Emergency Department by ambulance for her acute low back pain. Claimant was seen by Dr. Sho-

gan in the Emergency Room on January 2, 2008 and he reported that she was standing and reaching for an object when she experienced the onset of severe pain in her low back. The MRI of January 1, 2008, showed either a residual or recurrent disc herniation at L5-S1.

6. Claimant reported to the adjuster in this matter, Monica Westlund, on January 9, 2008 that she was bending down to pick up supplies when she experienced pain in her low back. Further, Claimant completed a form for the adjuster asking what had caused her injury, and she reported that she was bending over.

7. Claimant underwent a second surgery by Dr. Stephen Shogan to her L5-S1 disc on January 3, 2008. Dr. Shogan noted the procedure to be a "re-do right-sided L5-S1 disc excision." The pre-operative diagnosis was a recurrent herniated disc at L5-S1 and the post-operative diagnosis was a recurrent herniated disc at L5-S1. Claimant continued to see Dr. Shogan for treatment after the surgery and he noted on April 8, 2008 that the Claimant had been asymptomatic with regard to her lumbar spine since her surgery in 2006 until she was at work and began to experience significant low back pain. Dr. Shogan concluded that it would be "entirely possibly" that the Claimant's most recent disc herniation occurred at work

8. Claimant saw Dr. John Hughes at the request of Respondents for an independent medical evaluation on April 30, 2008. Dr. Hughes concluded that Claimant had sustained a natural progression of her pre-existing lumbar spondylosis post-hemilaminotomy and discectomy at L5-S1. Dr. Hughes testified further at hearing that it is more common for a recurrence of a disc herniation after a microdiscectomy procedure. Dr. Hughes's testimony was found less credible than the testimony of the Claimant with regard to whether her injury arose out of her employment.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, *et seq.* C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably truer 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 the favor of the rights of 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 that is disposi-

tive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

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

4. An injury is compensable if it "arises out of" and "in the course of" employment. Section 8-41-301, C.R.S.; *Price v. Industrial Claims Appeals Office of the State of Colo.,* 919 P.2d 207 (Colo. 1996). The "course of employment" requirement is satisfied when it is shown that the injury occurred within the time and place limits of the employment relationship. However, the "arising out of" requirement is narrower than the course of employment, and is a test of causation which requires that the injury have its origin in an employees work related function and be sufficiently related thereto so as to be considered part of the employees' service to the employer. *Gutierrez v. Wal-Mart Store, Inc*., (W.C. # 4-432-838) (November 30, 2000). The determination of whether there is a sufficient causal relationship between the Claimant's employment and the injury is one of fact, which the ALJ must determine, based on the totality of the circumstances. *Gutierrez, supra, citing, In re question submitted by the U.S. Court of Appeals*, 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Company v. Del Valle*, 934 P.2d 861 (Colo. App. 1996).

5. Special rules apply in the event an injury is "precipitated" by some preexisting condition brought by the claimant to the workplace. Where the precipitating cause of an injury is a pre-existing condition suffered by the claimant, the injury is not compensable unless a "special hazard" of the employment combines with the pre-existing condition to cause or increase the degree of injury. *See National Health Laboratories v. Industrial Claim Appeals Office*, 844 P.2d 763 (Colo. App. 1992). This principle is known as the "special hazard" rule. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). In addition, to be considered an employment hazard for this purpose, the employment condition must not be a ubiquitous one; it must be a special hazard not generally encountered. *See Ramsdell v. Horn* 781 P.2d 150 (Colo. App. 1989) (high scaffold constituted special employment hazard to worker who suffered epileptic seizure and fell); *Gates Rubber Co. v. Industrial Commission, supra* (hard level concrete floor not special hazard because it is a condition found in many non-employment locations). The rationale for this rule is that unless a special hazard of employment increases the risk or extent of injury, an injury due to the claimant's pre-existing condition does not bear sufficient causal relationship to the employment to "arise out of" the employment. *Gates v. Rubber Co. v. Industrial Commission*, 705 P.2d 6 (Colo. App.

1985); *Gaskins v. Golden Automotive Group, L.L.C.,* W.C. No. 4-374-591 (August 6, 1999) (injury when pre-existing condition caused the claimant to stumble on concrete stairs not compensable because stairs were ubiquitous condition).

6. In this case, the special hazard rule, described above, does not have application. Here, Claimant's injury arose out of her employment to the extent that Claimant aggravated her pre-existing condition while performing the action of bending over in the narrow supply room to reach for supplies for the cribs, an action which was required by her employment.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for Claimant's compensable work injury of December 28, 2007 to her back.

All matters not determined herein are reserved for future determination.

DATED: December 16, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-749-423

ISSUES

The following issues were raised for consideration at hearing:

1. Whether the Respondents shall have the right to withdraw their Admission of Liability;

2. Temporary total disability benefits (TTD) from March 22, 2008, through August 24, 2008; and

3. Medical benefits, reasonable and necessary.

FINDINGS OF FACT

Having reviewed the evidence presented at hearing and the parties post hearing position statements, the following Findings of Fact are entered.

1. Claimant is a fifty-four (54) year old married engineer with two children who began working as a project manager for Employer in June 2008. Employer was in the business of doing the cement structural frame for commercial buildings. The particular building for which Claimant was hired was scheduled to have three (3) stories underground and eight (8) stories above ground. Claimant testified and Respondents' General Admission admits that Claimant's average weekly wage is $1,515.

2. Prior to Claimant's work injury, which is the subject of this claim on October 15, 2007, Claimant led an active lifestyle both on the job and off the job. He typically arose around 5:00 a.m. and went to the gym, which opened at 5:30 a.m. At the gym, Claimant exercised, including walking on a treadmill. Thereafter he would return home, have breakfast with his family, and then go to work. After work and on weekends, he recreated including long walks with his family, hikes in the mountains, mountain biking, skiing, and other recreational activities.

3. On October 15, 2007, Claimant was attempting to move a concrete stressing machine weighing approximately one hundred (100) pounds from the back of his SUV to a pickup truck. During the process of moving this concrete stressing machine, he felt a pull in his back and began to experience low-level back pain. Claimant did not report this to his supervisor because he assumed he would improve with time. Additionally, Claimant had been told by one of the owners of Employer that there were too many employees complaining of work injuries and claiming workers' compensation benefits. At a later meeting, the safety manager of the Employer told Claimant that when someone had a work injury, as soon as the workers' compensation process was completed, the Employer let the employee go.

4. After his work injury of October 15, 2007, Claimant continued to exercise and stretch in the mornings and he continued to work. Claimant's condition, however, gradually worsened. On November 13, 2007, Claimant saw his private doctor, Dr. John Hudson, complaining of an earache. At that time, Claimant mentioned he was experiencing some low-back pain and that the onset of the pain had been approximately a week before. Claimant testified that the conversation with Dr. Hudson about his back and the onset of disability was an after thought and that the doctor did not ask him how he had hurt his back. Nor did Dr. Hudson offer any treatment for Claimant's back. Claimant credibly testified that he made a mistake about his onset of disability. The mistake was premised on several factors including: the seeming insignificance of the back pain, the lack of any immediate need for treatment, the extremely busy schedule Claimant kept, and the fact that with aging the Claimant compressed time.

5. Claimant's back pain continued to gradually worsen. Claimant continued to go to the gym and stretch and exercise every morning, but his after work walks with his family got shorter and shorter. Claimant had customarily

purchased a ski pass, but did not in the fall of 2007 because of increasing back pain.

6. In early January 2008 during one of his regular morning workouts, at a period of time when his pain had increased to the point where it was very bothersome, he was walking on the treadmill trying to loosen up. A few minutes into his workout on the treadmill, Claimant realized that his pain and stiffness was not loosening up. The pain was significant enough that Claimant stopped his workout. Thereafter he made an appointment with his private doctor, Dr. Kevin Boehm, whom he saw on January 16, 2008. Dr. Boehm's medical note of January 16, 2008, indicates that the onset of the pain was four (4) months ago (i.e. October 2007), that the severity level was seven (7), that it occurred occasionally, and that the problem was worsening.

7. Dr. Boehm referred Claimant for a lumbar spine MRI, which took place on January 28, 2008. The MRI note indicates the onset of disability as October 2007. The MRI demonstrated significant multi-level problems. The radiologist asked Claimant, for the first time, what had caused his onset of disability. When Claimant explained that the onset occurred while moving a concrete stressing machine for his job, the radiologist advised him to immediately notify his Employer.

8. When Claimant notified his employer of his work injury, his Employer wanted to know the exact date. In order to designate the exact date, Claimant credibly testified that he reviewed records he kept in his desk to pinpoint the time he moved the concrete stressing machine. Based on those records, Claimant pinpointed October 15, 2007 as the exact date of his onset of disability. The Respondents filed a General Admission of Liability on February 11, 2008, admitting for medical benefits.

9. Claimant was seen at Employer's designated clinic, Mile Hi Occupational Medicine, which later merged with Concentra, on the same day he reported his injury, January 29, 2008. Claimant was prescribed Darvocet and was advised to take "precaution on safety sensitive activities while taking pain meds". Ongoing medical records from Mile Hi Occupational Medicine indicated Claimant was working "most" of his regular duties but felt unsteady on ladders. On February 22, 2008, he was given a restriction advising "minimal use of ladders".

10. Claimant was slow in his job performance because of his pain medications and his pain. The restriction of only minimal use of ladders made Claimant's job difficult to perform adequately since ladders were the only method of getting from deck to deck in the unfinished project he was in charge of. When Claimant missed work in order to get authorized epidural steroid injections (ESI), his supervisor was unhappy with him and left Claimant with the perception that Claimant was expected to return to work immediately after getting the injection. Claimant was given ESI on February 1, 2008; February 7, 2008; February 15, 2008; and March 13, 2008. Dr. Robert Kawasaki gave Claimant written instructions to be

driven to the office for each injection and then to be driven home from the office after each injection.

11. On March 21, 2008, seven (7) days after his fourth ESI, Claimant was laid off with the single explanation that the Employer was going in a "different direction". Claimant testified that he believed that his lay off was due to his slower speed at work, his restrictions regarding ladders, and the amount of time he had to miss work as a result of his ESI's. Based on the totality of the evidence, it is found and concluded that Claimant's termination was due to his diminished job performance caused by his work injury.

12. Claimant applied for and received unemployment benefits at the rate of $450 per week beginning April 6, 2008. Unemployment benefits continued until August 22, 2008, at which time the Claimant was re-employed. Claimant's new employment paid him a higher AWW than he was earning at Employer, so Claimant was no longer suffering a wage loss as of August 25, 2008.

13. Claimant's daughter credibly testified at hearing corroborating Claimant's testimony about his limitations on recreational activities with his family.

14. Claimant was seen by various doctors through the workers' compensation system. Dr. Andrew Castro saw Claimant for a surgical consultation. In Dr. Castro's last note of June 12, 2008, Dr. Castro commented that the Claimant was still having some ongoing back and leg pain, which he describes as "intolerable, and difficulty getting around." . . . Dr. Castro continued that "because of the advanced nature of the degenerative changes in his lumbar spine, correction of all these problems may entail one or two levels of fusion as I am not sure a decompressive procedure could fully alleviate the foraminal stenoses."

15. Claimant was then seen for a psychological examination by Dr. Ron Carbaugh on June 25, 2008. Dr. Carbaugh noted that "Mr. Clark would be considered a fair surgical candidate".

16. Prior to embarking on a surgical course of action, Claimant was seen for a second opinion by Dr. David Wong on July 3, 2008. In Dr. Wong's evaluation, Dr. Wong stated: "Patient dates onset of his present difficulties to an incident which occurred 10/5/07 [sic]. He was apparently dragging a one hundred twenty (120) pound stress machine from one vehicle to another when he noted onset of low back pain. His symptoms were exacerbated around 1/08 possibly related to working out on a treadmill. . . ."

17. After receiving Dr. Wong's second opinion report indicating Claimant's symptoms were possibly exacerbated by working out on the treadmill, Respondents filed an Application for Hearing on July 23, 2008, seeking to withdraw their admission of liability.

18. The medical note of Dr. Matt Miller dated July 14, 2008, indicated "we did place the patient on work restriction. We have not had him on restrictions but he is reporting that he has tried to find work but cannot work secondary to the pain." Claimant's new work restriction was "no lifting over 15 pounds".

19. On September 25, 2008, Brian Lambden, M.D., performed an independent medical evaluation (IME) on Claimant at Respondents' request. Dr. Lambden's IME report indicated the Claimant told him about the worsening of symptoms that occurred in January 2008 while working on a treadmill. Dr. Lambden characterized it in his note as a severe increase in back pain. Dr. Lambden's IME noted that Claimant stated his low back pain was variable and "waxes and wanes". The IME characterized the Claimant as being "pleasant and cooperative" with "no obvious pain behaviors" and "no positive non-organics". Dr. Lambden's Medical Summary Opinion as set forth in paragraph four of his IME was that Claimant had suffered a "Work-related incident 10/15/07 when he reports lifting a 120 pound stress analysis machine with mild lumbar strain and then gradually increasing low back pain over the next several months."

20. Dr. Lambden testified that although it was possible to suffer an injury while walking on a treadmill, that an injury such as Claimant's was more likely to happen as described by the Claimant in the stress machine lifting incident of October 15, 2008. Dr. Lambden commented on Page 9 of his IME report that "if I was going to relate pathology to his recent incident [the October 13, 2007, injury], I would relate it to his L1-2 disc protrusion." In the Recommendations Section of his IME, Dr. Lambden did not state that no treatment should be rendered since the claim was not a work-related injury. Instead he recommended "more aggressive exercise to include some form of aerobic exercise, as well as lumbar stabilization." He also indicated "if symptoms are not improving over the next 4 to 6 months, I would consider decompression of the right L1, L2 nerve roots." It is clear based on both the testimony and the IME report of Dr. Lambden, that Dr. Lambden did not consider the treadmill incident to be an intervening injury. In fact, in his testimony and his report, Dr. Lambden's opinion was that walking and exercise was the best thing that Claimant could be doing for his back injury.

21. Dr. Lambden did not have the medical records of Dr. Hudson and Dr. Boehm at the time he examined the Claimant and then dictated his IME report. When questioned regarding the onset of disability dates referenced in the medical records of Dr. Boehm and Dr. Hudson, Dr. Lambden stated his opinion that the date discrepancy could be significant and that it was unusual to have such a date discrepancy. He also testified that it was unusual to not ascribe a cause to the onset of the disability.

22. Dr. John Burris, one of Claimant's treating doctors at Concentra, indicated in his report of October 21, 2008, that he felt the inconsistency in onset of disability dates in the medical notes of Dr. Hudson and Dr. Boehm was significant and he would expect the cause of the disability would have been passed

along to the primary care physician at the initial visit on November 13, 2007, and at the follow up two (2) months later on January 16, 2008. Dr. Burris did not ascribe any importance to the supposed treadmill incident as an intervening cause.

23. Claimant was seen by Dr. David Yamamoto for an IME requested by Claimant on September 9, 2008. Dr. Yamamoto commented in his report, "It is my opinion that the exacerbation referenced by Dr. Wong in his July 3, 2008, report was of minor consequence. The main injury clearly is the October 15, 2007, injury, as prior to this time he was having essentially no problems with his lower back. I am frankly quite surprised at the opinion of the insurance carrier to deny treatment based on a normal activity of walking on a treadmill that has had, in my opinion, minimal to no impact on this case".

24. Based on Claimant's credible testimony and the medical records, it is found and concluded that Claimant did not suffer an intervening event in January 2008 when he was walking on the treadmill. Claimant injured himself on October 15, 2007 when he was removing a concrete stressing machine from his vehicle. The injury progressed and worsened in the ensuing months to the point that it became debilitating in January 2008. Since there was not intervening event that caused Claimant's injury, Respondents are not entitled to withdraw the admission of liability.

25. Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve him of the effects of the October 15, 2007 work injury. Respondents shall be liable for this medical treatment.

26. Claimant is further found to be entitled to indemnity benefits during the period of disability commencing March 22, 2008 and continuing to August 24, 2008 when he found employment. Claimant was not responsible for his wage loss during this period. To the contrary, it is found that his employment was terminated because of his work injury and the resulting loss of Claimant's ability to perform his job duties.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, *et seq.* C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of

the evidence, to find that a fact is more probably truer 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 the favor of the rights of 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 that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

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

4. Respondents contend that the evidence establishes that Claimant's treadmill workout in January 2008 caused his back injury and constitutes an efficient intervening cause severing the causal connection between the October 15, 2007 work injury and the claimant's need for workers' compensation benefits. 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. *Post Printing & Publishing Co. v. Erickson,* 94 Colo. 382, 30 P2d 327 (1934). Whether a particular condition is the result of an independent intervening cause is a question of fact for resolution by the ALJ. *See Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

5. In this case, the credible and persuasive evidence presented through the testimony of Claimant, his daughter, and the medical records, it is found an concluded that Claimant did not suffer an efficient intervening injury in January 2008 and therefore there is no basis to grant Respondents' request to withdraw its admission of liability.

6. The 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).

7. Claimant is entitled to reasonably necessary and related medical benefits to cure and relieve him of the effects of the October 15, 2007 work injury. Respondents shall be liable for this medical treatment.

8. To obtain TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 639 (Colo. App. 1997). A claimant must establish a causal connection between a work-related injury and a subsequent wage loss. Section 8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546, 546 (Colo. 1995). The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earnings capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.,* 964 P.2d 595, 597 (Colo. App. 1998).

9. Claimant established that he was disabled from his usual employment commencing March 22, 2008 and continuing to August 24, 2004. Claimant's separation from employment with the Employer was shown to be due to his failure to perform his job to the pre-injury level. Claimant's disability continued to August 24, 2008 when he found employment.

ORDER

It is therefore ordered that:

1. Respondents' motion to withdraw its admission of liability is denied.
2. Respondents shall be liable for reasonably necessary and related medical benefits for the October 15, 2007 work injury
3. Respondents shall be liable to Claimant for TTD from March 22, 2008 to August 24, 2008.

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.

DATED: December 16, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-701-864

ISSUES

The sole issue determined herein is maximum medical improvement ("MMI"). The parties stipulated to medical benefits and to an average weekly wage of $905.77

FINDINGS OF FACT

1. In June 2006, claimant began work for the employer as a laborer.

2. On October 15, 2006, claimant sustained an admitted industrial left foot crush injury and a right ankle fracture when a piece of machinery ran over his legs.

3. On October 15, 2006, claimant underwent an open reduction internal fixation ("ORIF") of bimalleolar fracture of the right ankle by Dr. Steven Waskow.

4. On October 16, 2006, claimant underwent a closed reduction, external fixation of the left foot third, fourth, and fifth tarsometatarsal fracture dislocations, closed reduction, external fixation of left foot comminuted cuboid fracture, lateral column injury by Dr. John Shank.

5. Dr. Shank continued to care for claimant's right ankle and left foot injuries up to and including October 7, 2008.

6. On November 6, 2006, claimant underwent an ORIF of the left comminuted cuboid fracture, ORIF of left third tarsometatarsal fracture dislocation, ORIF of left fourth tarsometatarsal fracture dislocation, ORIF of left fifth tarsometatarsal fracture dislocation, allograft bone graft of the left cuboid fracture and revision external fixation of the left mid-foot fracture dislocation by Dr. Shank.

7. On January 11, 2007 claimant underwent deep hardware removal of the left foot lateral column K-wires, including the third, fourth and fifth tarsometatarsal wires by Dr. Shank.

8. On March 20, 2007, in a letter to claims adjuster for Gallagher Bassett Services, Inc., Amy Funderburk, Dr. Shank noted that claimant had a very severe injury to his lateral column, which might lead to eventual arthritis and arthrosis of his lateral column.

9. On April 19, 2007, claimant underwent deep K-wire removal of the left foot due to one loose K-wire causing deep-seated pain adjacent to the cuboid.

10. On June 22, 2007, claimant came under the care of Dr. Darrell Quick and Concentra Medical Centers for primary occupational physician management.

11. On October 30, 2007, Dr. Shank reexamined claimant, who complained of painful hardware bilaterally and requested hardware removal. Bilateral foot and ankle radiographs demonstrated healed fractures with some mid-foot and Lisfranc arthrosis about the left foot.

12. On November 28, 2007, claimant underwent hardware removal of his left foot by Dr. Shank.

13. On December 14, 2007, in a letter to Ms. Funderburk, Dr. Shank determined that claimant was at MMI. Dr. Shank did not anticipate any future treatment with regard to claimant's right ankle, other than the yearly office visits and radiographs to assess his progress. As to claimant's left foot, Dr. Shank indicated that possible future anticipated care included left foot arthrodesis with realignment, in addition to the yearly office visits and radiographs to assess his progress.

14. On December 18, 2007, Dr. Shank noted that radiographs showed "significant degenerative changes" noted about the left foot and early arthritic changes about the right ankle.

15. On January 14, 2008, claimant was seen by Dr. Quick and was placed at MMI, with 5% right lower extremity impairment and 4% left lower extremity impairment. Dr. Quick recommended post-MMI medical treatment in accordance with Dr. Shank's recommendations, including surgical after care, annual x-rays, and possible left foot fusion in the future. Dr. Quick ordered a Functional Capacity Evaluation ("FCE") to clarify permanent work restrictions.

16. The FCE on February 8, 2008, determined that claimant could work in a heavy level of work, walking and standing intermittently or as tolerated, crawling as tolerated, kneeling infrequently to occasionally, guarded working on a ladder, and occasional climbing stairs.

17. On February 11, 2008, Dr. Quick recommended permanent restrictions in accordance with the FCE.

18. On February 15, 2008, Dr. Shank reexamined claimant and noted that he had healed completely with no new complaints and was doing well. Dr. Shank released claimant to activity as tolerated and to follow up in October 2008 for radiographs of his right ankle and left foot.

19. In mid-February 2008, claimant began working for the U.S. Post Office as a rural carrier associate. His job duties consist of collecting, assembling, and distributing mail. He must stand and walk intermittently for 2½ to 5 hours per day to collect and assemble. He then must distribute the mail, which consists of intermittent walking and driving while getting in and out of his mail truck the remaining 3 to 4 hours per day. His job duties require him to lift 20 to 30 pounds. He has worked with no restrictions during his entire employment with the U.S. Post Office. Claimant is not taking pain medication.

20. On May 22, 2008, pursuant to claimant's request, he underwent a Division Independent Medical Examination ("DIME") with Dr. Linda Mitchell. Claimant's chief complaint was left foot pain and right ankle pain. On physical examination, his right ankle was without effusion, tenderness, or crepitus with no lateral or medial instability. Claim-

ant's left foot was without tenderness or crepitus and had trace edema present. There was no lateral or medial hindfoot instability. There was negative drawer sign and claimant had no tenderness or deformity of the MTP joints bilaterally. Claimant's stance revealed flattening of the medial arches, right greater than left. His gait was slightly broad-based, but not antalgic. He was able to do a deep squat to the floor. His heel walking, toe walking and tandem gait were normal. Romberg was negative.

21. Dr. Mitchell diagnosed right distal tibia/fibula fracture and left second and third metatarsal fractures, third, fourth and fifth tarsometatarsal dislocations and cuboid fracture. Dr. Mitchell found claimant to be at MMI as of February 11, 2008, for his right ankle and left foot fractures, finding a 9% right lower extremity impairment and a 12% left lower extremity impairment. Dr. Mitchell agreed with Dr. Shank that claimant's development of arthritis/arthrosis would require arthrodesis at some point in the future. Dr. Mitchell recommended that claimant be able to see Dr. Shank as needed for follow-up. Otherwise, no other maintenance care was indicated.

22. On June 19, 2008, the insurer filed a final admission of liability for the permanent disability benefits and for post-MMI medical benefits.

23. Claimant did not seek treatment for his right ankle and left foot fractures again until October 7, 2008, when he was seen in follow-up with Dr. Shank for repeat evaluation of his left Lisfranc fracture, dislocation of lateral column injury. Dr. Shank noted that claimant continued to have global pain mostly localized to the third, fourth and fifth tarsal metatarsal joints and a component of second tarsal metatarsal joint pain as well. Radiographs taken that day demonstrated significant end-stage arthritic changes about the second, third, fourth and fifth tarsal metatarsal joint. Dr. Shank diagnosed claimant with end-stage post-traumatic Lisfranc arthritic changes with gastroc equines, and offered claimant the option to undergo arthrodesis to relieve the pain symptoms of his arthritic condition.

24. On October 13, 2008, Dr. Shank requested authorization for left foot gastroc slide Lisfranc arthrodesis, possible tibial/calcanial autograft, and fourth and fifth tarsal metatarsal steroid injection for end-stage post-traumatic Lisfranc arthritic changes.

25. Claimant noted that he has developed balance problems due to his left foot injury.

26. Claimant has failed to prove by clear and convincing evidence that the MMI determination by the DIME, Dr. Mitchell, is incorrect. Dr. Shank, Dr. Quick, and Dr. Mitchell all determined that claimant was at MMI for his admitted work injury. Claimant did not introduce any conflicting medical record evidence. Dr. Shank, Dr. Quick, and Dr. Mitchell all noted the possibility of future left foot fusion surgery. The insurer admitted liability for the surgery. Claimant has not alleged a change of condition since MMI. He has not demonstrated that it is highly probable that Dr. Mitchell was incorrect in determining MMI on February 11, 2008. Claimant might disagree with that determination, but the record evidence does not come close to meeting the high burden of proof placed on claimant to challenge the MMI determination by the DIME.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence. A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In this case, the DIME, Dr. Mitchell, determined that claimant was at MMI on February 11, 2008. Consequently, claimant must prove by clear and convincing evidence that this determination is incorrect.

2. "Maximum medical improvement" is defined in Section 8-40-201(11.5), C.R.S. as:

> A 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. 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 maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement.

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. *Villela v. Excel Corporation*, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, claimant has failed to prove by clear and convincing evidence that the MMI determination by Dr. Mitchell is incorrect. Consequently, pursuant to section 8-42-105(3)(a), C.R.S., claimant is not entitled to any additional TTD benefits. Claimant did not file a petition to reopen and that issue is not addressed.

ORDER

It is therefore ordered that:

1. Claimant's request for additional periods of TTD benefits is denied and dismissed.
2. The insurer shall pay for the left foot surgery requested by Dr. Shank.
3. The insurer shall pay benefits for all admitted periods of time based upon an average weekly wage of $905.77.

DATED: December 17, 2008

Martin D. Stuber
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-513-392

ISSUES

1. Whether Claimant has demonstrated that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his ulcerative colitis condition.

2. Whether Claimant has established by a preponderance of the evidence that he is entitled to recover penalties for Respondents' failure to timely pay Permanent Partial Disability (PPD) benefits.

FINDINGS OF FACT

1. On August 19, 2001 Claimant suffered an admitted industrial injury to his back during the course and scope of his employment with Employer. On November 3, 2003 he underwent an anterior discectomy and an anterior spinal fusion at the L5-S1 level. On May 19, 2004 Claimant reached Maximum Medical Improvement (MMI) and received a 24% whole person impairment rating.

2. In October 2005 Claimant began to develop recurrent back problems. A discography revealed a positive discogram at the L4-L5 level. On March 11, 2006 Claimant thus underwent a posterior spinal fusion at the L4-L5 level. Although Claimant's back condition improved after surgery, he continued to experience recurrent left-sided low back pain that radiated into his left leg.

3. Claimant testified that subsequent to his March 11, 2006 surgery he developed constipation and required laxatives to treat his condition. During August 2006 his constipation worsened and he began to experience abdominal pain. On August 16, 2006 Claimant was diagnosed with ulcerative colitis. He underwent an abdominal colectomy and ileostomy on August 17, 2006 for his condition. Although the procedures provided temporary relief, his colitis symptoms returned. Claimant subsequently underwent additional procedures to relieve his colitis symptoms.

4. On August 3, 2007 Claimant again reached MMI. He received a 16% whole person impairment after subtracting his previous rating.

5. On March 4, 2008 Claimant underwent a Division Independent Medical Examination (DIME) with Scott A. Burke, M.D. Dr. Burke agreed that Claimant had reached MMI and assigned a 28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders as a result of Claimant's two back surgeries. Claimant's impairment also included a 15% rating based on range of motion deficits.

6. Dr. Burke specifically considered Claimant's ulcerative colitis condition but did not assign Claimant an impairment rating for the condition. Dr. Burke commented that Claimant suffered constipation shortly after his surgery but his symptoms resolved. Claimant then developed colitis at a later date. Dr. Burke also stated that Claimant's doctors had been unable to ascertain the cause of the ulcerative colitis. He concluded that Claimant suffered from colitis with an unknown etiology.

7. On May 14, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Burke's 28% whole person impairment rating. The FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due."

8. On June 4, 2008 the Division of Workers' Compensation (DOWC) sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. The DOWC mailed additional correspondence to Insurer about the matter on June 27, 2008 and July 1, 2008.

9. On June 17, 2008 Claimant filed an application for a lump sum payment of his PPD benefits. On July 2, 2008, based on a recalculation, Insurer paid Claimant lump sum PPD benefits in the amount of $55,279.95. On July 3, 2008 Insurer filed an amended FAL based on the recalculation of PPD benefits.

10. Insurer sent the PPD payment directly to Claimant's old address. However, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys. In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys.

11. On August 1, 2008 Claimant filed an objection to the amended FAL and an application for hearing. Claimant requested the payment of medical benefits related to his ulcerative colitis condition and sought penalties for Insurer's failure to timely pay his PPD benefits.

12. Claimant has failed to demonstrate that he is entitled to reasonable and necessary medical treatment to cure and relieve the effects of his ulcerative colitis condition. DIME physician Dr. Burke determined that Claimant suffered a

28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders and a 15% rating based on range of motion deficits. However, Dr. Burke concluded that Claimant suffered from colitis with an unknown etiology and did not assign him an impairment rating for the condition. His determination constituted a part of his diagnostic assessment that comprises the DIME process. Dr. Burke's impairment rating is thus entitled to deference and must be overcome by clear and convincing evidence. Although Claimant attributed his ulcerative colitis to his March 11, 2008 spinal fusion surgery, the ulcerative colitis did not begin until approximately five months after the surgery and he has failed to present any medical evidence demonstrating a causal connection between his colitis and his surgery. Claimant's testimony is thus simply insufficient to overcome Dr. Burke's determination by clear and convincing evidence. Because Claimant's ulcerative colitis condition was not caused by his industrial injury, he is not entitled to medical benefits to treat the condition.

13. Claimant has failed to prove that it is more probably true than not that he is entitled to recover penalties pursuant to §8-43-304(1), C.R.S. and WCRP 5-6(c) for Respondents' failure to timely pay PPD benefits. WCRP 5-6(c) is inapplicable because Insurer's initial FAL did not award PPD benefits. The May 14, 2008 FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due." Because the FAL did not specifically award additional PPD benefits, WCRP 5-6(c) did not require payment of PPD benefits within five days. Furthermore, even if Respondents' somehow violated WCRP 5-6(c) in the May 14, 2008 calculation of PPD benefits, Claimant has failed to demonstrate that any deficiency in the initial calculation was objectively unreasonable. Therefore, Claimant is not entitled to recover penalties pursuant to §8-43-304(1), C.R.S. for a violation of WCRP 5-6(c).

14. Claimant has failed to establish that it is more probably true than not that he is entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S. for Respondents' failure to timely pay TPD benefits. On June 4, 2008 the DOWC sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. Based on the DOWC's letter, Insurer had notice that a recalculation of PPD benefits was required. Insurer subsequently recalculated Claimant's PPD benefits and paid Claimant lump sum PPD benefits in the amount of $55,279.95 on July 2, 2008. However, because Insurer sent the PPD payment directly to Claimant's old address, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys. In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys. The chronology of events reveals that Insurer paid Claimant additional PPD benefits in accord with the DOWC's notice within 30 days as required by §8-43-401(2)(a), C.R.S. Although the payment was made to Claimant's old address, Claimant has failed to demonstrate that Insurer acted with deliberate intent and willfully withheld the payment of PPD bene-

fits by mailing the payment to an incorrect address. Claimant is thus not entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S.

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. 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 (2005).

Medical Benefits

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

5. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect.

Qual-Med, Inc. v. Industrial Claim Appeals Office, 961 P.2d 590, 592 (Colo. App. 1998). In other words, 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 (ICAP, Oct. 4, 2001). The DIME physician's determination that Claimant's ulcerative colitis condition was not included in his overall impairment "constituted a part of the diagnostic assessment that comprises the IME process." *See Qual-Med, Inc.,* 961 P.2d at 592.

6. As found, Claimant has failed to demonstrate that he is entitled to reasonable and necessary medical treatment to cure and relieve the effects of his ulcerative colitis condition. DIME physician Dr. Burke determined that Claimant suffered a 28% whole person impairment rating. The impairment included a 15% rating based on diagnostic specific disorders and a 15% rating based on range of motion deficits. However, Dr. Burke concluded that Claimant suffered from colitis with an unknown etiology and did not assign him an impairment rating for the condition. His determination constituted a part of his diagnostic assessment that comprises the DIME process. Dr. Burke's impairment rating is thus entitled to deference and must be overcome by clear and convincing evidence. Although Claimant attributed his ulcerative colitis to his March 11, 2008 spinal fusion surgery, the ulcerative colitis did not begin until approximately five months after the surgery and he has failed to present any medical evidence demonstrating a causal connection between his colitis and his surgery. Claimant's testimony is thus simply insufficient to overcome Dr. Burke's determination by clear and convincing evidence. Because Claimant's ulcerative colitis condition was not caused by his industrial injury, he is not entitled to medical benefits to treat the condition.

Penalties

7. Section 8-43-304(1), C.R.S. is a general penalty provision under the Act that authorizes the imposition of penalties up to $500 per day where a party violates a statute, rule, or lawful order of an ALJ. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). The term "order" as used in §8-43-304 includes a rule or regulation promulgated by the Director of the DOWC. §8-40-201(15), C.R.S.; *see Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176, 177 (Colo. App. 2002). WCRP 5-6(c) governs the payment of PPD benefits. The Rule provides, in relevant part, "[p]ermanent disability benefits awarded by admission are retroactive to the date of maximum medical improvement and shall be paid so that the claimant receives the benefits not later than 5 calendar days after the date of the admission."

8. The imposition of penalties under §8-43-304(1) requires a two-step analysis. *See In re Hailemichael,* W.C. No. 4-382-985 (ICAP Nov. 17, 2004). The ALJ must first determine whether the disputed conduct violated a provision of the Act or rule. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623, 624

(Colo. App. 1995). If a violation has occurred, penalties may only be imposed if the ALJ concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 907 P.2d 676, 678-79 (Colo. App. 1995). The reasonableness of an insurer's actions depends upon whether the action was predicated on a "rational argument based on law or fact." *In re Lamutt,* W.C. No. 4-282-825 (ICAP, Nov. 6, 1998).

9. As found, Claimant has failed to prove by a preponderance of the evidence that he is entitled to recover penalties pursuant to §8-43-304(1), C.R.S. and WCRP 5-6(c) for Respondents' failure to timely pay PPD benefits. WCRP 5-6(c) is inapplicable because Insurer's initial FAL did not award PPD benefits. The May 14, 2008 FAL specifically noted "Claimant previously paid $50,001.56 in PPD benefits. No further PPD benefits due." Because the FAL did not specifically award additional PPD benefits, WCRP 5-6(c) did not require payment of PPD benefits within five days. Furthermore, even if Respondents' somehow violated WCRP 5-6(c) in the May 14, 2008 calculation of PPD benefits, Claimant has failed to demonstrate that any deficiency in the initial calculation was objectively unreasonable. Therefore, Claimant is not entitled to recover penalties pursuant to §8-43-304(1), C.R.S. for a violation of WCRP 5-6(c).

10. Section 8-43-401(2)(a), C.R.S. is a specific penalty provision in the Act that authorizes the imposition of a penalty equal to ten percent of wrongfully withheld benefits "[i]f any insurer . . . willfully withholds permanent partial disability benefits within thirty days of when due." Penalties may be imposed pursuant to §8-43-401(2), C.R.S. even if penalties are also available under §8-43-304(1), C.R.S. *Holliday v. Bestop Inc.,* 23 P.3d 700, 706-07 (Colo. 2001).

11. Under §8-43-401(2)(a), C.R.S. "willful" is conduct that is the result of "deliberate intent" and "wrongful" means "unlawful or unjust action." *Miller v. Industrial Claim Appeals Office,* 49 P.3d 334, 336 (Colo. App. 2001). If an Insurer acts reasonably under the circumstances, its conduct is neither willful nor wrongful. *See In re Martin,* W.C. No. 4-453-804 (ICAP, Oct. 10, 2004). The question of whether a party's conduct was reasonable is a factual determination for the ALJ. *Miller,* 49 P.3d at 337.

12. As found, Claimant has failed to establish by a preponderance of the evidence that he is entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S. for Respondents' failure to timely pay PPD benefits. On June 4, 2008 the DOWC sent a letter to Insurer regarding Insurer's PPD calculation. The letter stated that, because Claimant was a minor at the time of his industrial injury, his PPD benefits required a recalculation. Based on the DOWC's letter, Insurer had notice that a recalculation of PPD benefits was required. Insurer subsequently recalculated Claimant's PPD benefits and paid Claimant lump sum PPD benefits in the amount of $55,279.95 on July 2, 2008. However, because Insurer sent the PPD payment directly to Claimant's old address, Claimant instructed Insurer to stop payment on the check and issue a new check in the care of his attorneys.

In accord with Claimant's instructions, Insurer issued a new PPD check on July 15, 2008 directly to Claimant's attorneys. The chronology of events reveals that Insurer paid Claimant additional PPD benefits in accord with the DOWC's notice within 30 days as required by §8-43-401(2)(a), C.R.S. Although the payment was made to Claimant's old address, Claimant has failed to demonstrate that Insurer acted with deliberate intent and willfully withheld the payment of PPD benefits by mailing the payment to an incorrect address. Claimant is thus not entitled to recover penalties pursuant to §8-43-401(2)(a), C.R.S.

ORDER

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

1. Claimant's request for medical benefits to cure and relieve the effects of his ulcerative colitis condition is denied.

2. Claimant's request for penalties for Respondents' failure to timely pay PPD benefits is denied.

3. Any issues not resolved in this order are reserved for future determination.

DATED: December 17, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-709-198

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant overcame the impairment rating given by the Division Independent medical examiner (DIME) by clear and convincing evidence; and

2. Whether Claimant is entitled to ongoing maintenance medical care including chiropractic and massage therapy.

FINDINGS OF FACT

Based on the evidence presented at hearing and the parties post hearing position statements, the ALJ makes the following Findings of Fact:

1. Claimant was involved in a compensable industrial motor vehicle accident on September 5, 2006. As a result of such accident, Claimant has not lost any compensable time from work.

2. Claimant's primary care provider is Jim Dudley, M.D. Dr. Dudley referred Claimant to Dr. Tobey and for physical therapy. Dr. Tobey recommended physical therapy, which Claimant declined. Dr. Dudley advised Claimant on July 12, 2007 that workers' compensation would not pay for additional chiropractic care, massage and acupuncture and Claimant "asked for me to write a script so she could pay with her own insurance."

3. Dr. Dudley is not Level II accredited and referred Claimant to Cliff Gronseth, M.D. for an impairment rating. Dr. Gronseth saw the Claimant on December 20, 2007 and agreed she was at maximum medical improvement. Dr. Gronseth noted that Claimant "reports she is improving and yet she presents with significant spine range of motion measurements, seemingly worse than when she first presented to the other physicians. There are no objective neurologic findings on examination…there may be some secondary and tertiary gain issues involved with this claim." Dr. Gronseth provided a rating of 42% as a whole person.

4. A DIME was performed by Justin Green, M.D. on April 21, 2008. Dr. Green agreed with the MMI date of November 14, 2007 and provided Claimant a rating of 28% as a whole person.

5. Respondents filed a Final Admission of Liability on June 12, 2008 admitting to the impairment rating given by the DIME doctor, which amounted to $98,345.27.

6. At the time of hearing, Claimant indicated that she is presently working for a new employer. She continues to see her chiropractor, Dr. Criste, one time per week and also sees a massage therapist in his office one time per week. She has been receiving such care for over two years. Claimant indicated that she still has daily pain and muscle spasms that cause her vertebrae to "come out of place." She is requesting ongoing weekly chiropractic and massage therapy.

7. According to Claimant, her job involves extensive driving and lifting, which causes her back to go into spasms. She complains of daily pain.

8. Claimant was involved in a new motor vehicle accident on November 18, 2008. At that time she was going sixty-five miles per hour and was hit by an-

other vehicle. As a result of such motor vehicle accident she again came under the care of Dr. Criste and additional x-rays were taken.

9. Testimony was presented from the chiropractor, Dr. Criste, who has not received Level II accreditation. Dr. Criste is not familiar with the Medical Treatment Guidelines and indicated that he has a "passing familiarity" with the *AMA Guides to the Evaluation of Permanent Impairment*, Third Edition Revised, (*AMA Guides*). He testified that he has never done an impairment rating for Claimant or any other patient. Dr. Criste acknowledged that he has been seeing the Claimant one time per week for over two years and that a massage therapist in his office has also been treating the Claimant on a weekly basis during that period of time. He indicated that the Claimant is "permanently injured in her spine and has extensive degenerative changes at all levels." He believes that she needs lifetime massage therapy and chiropractic care on a weekly basis.

10. Dr. Criste believes that the Claimant's present job is aggravating the Claimant's condition and causing her to need ongoing treatment. He feels that he actually needs to see her more than one time per week. He is now seeing her for her "severe car accident" which occurred on November 18, 2008 and has sent her for x-rays due to that new accident.

11. Dr. Dudley and Dr. Tobey did not believe that the Claimant required chiropractic and massage therapy. Dr. Tobey had recommended physical therapy, which as was previously noted, Claimant declined. Neither Dr. Gronseth nor Dr. Green has recommended ongoing and weekly massage therapy and chiropractic care.

12. Dr. Criste's opinions were not credited as he is not Level II accredited, his chiropractic opinion about Claimant's condition and need for medical treatment does not carry sufficient weight to overcome the opinions of the DIME, and Dr. Criste, as the provider of the continued treatment Claimant seeks to have ordered, has a pecuniary interest in the outcome of this claim.

CONCLUSIONS OF LAW

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

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, et seq. C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that

a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of Claimant nor in favor of the rights of Respondents. Section 8-43-201, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJs factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. The Colorado Workers' Compensation Act requires that all physical impairment ratings be performed in accordance with the *AMA Guides*. See 8-42-101(3.7) C.R.S. The DIME's medical impairment rating is binding unless overcome by clear and convenience evidence. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(A) C.R.S. Clear and convincing evidence is that which shows that it is highly probable that the DIME's opinion was incorrect. Whether a DIME physician has correctly applied the *AMA Guide* is a question of fact for determination by the ALJ. *Wackenhut Corp. v. Industrial Claim Appeals Office*, 17 P.3d. 204 (Colo. App. 2002); *McClain Western v. ICAO*, 996 P.2d 263 (Colo. App. 1999).

4. In this case, Claimant failed to sustain her burden of proof by clear and convincing evidence that Dr. Green erred in providing his rating. Neither the testimony of Dr. Criste nor the testimony of the Claimant in any way indicated that Dr. Green erred in his performance of the rating or that the rating was not properly provided under the *AMA Guides*. Dr. Criste is a chiropractor and is not Level II accredited. He has not performed any impairment ratings and is not qualified under the statute to provide ratings. In addition he himself admitted he only has a "passing familiarity" with the *AMA Guide*.

5. The ALJ finds that Claimant has presented insufficient evidence to establish any error in the rating provided by Dr. Green. Although Claimant's counsel argued as to the errors in the report of Dr. Green, Claimant did not present any evidence to substantiate that any error was made. Therefore, the ALJ finds that Claimant has failed to overcome the DIME.

6. The ALJ also finds that Claimant has failed to sustain her burden of proof by a preponderance of the evidence that she is entitled to lifetime weekly chiropractic care and massage therapy. The ALJ does not find the testimony of Dr.

Criste to be persuasive. In fact Dr. Criste has indicated that the Claimant's need for ongoing treatment is due to the job activities she is performing in her present job. In addition, she was involved in a "severe" motor vehicle accident on November 18, 2008 for which she is now treating with Dr. Criste.

7. Dr. Dudley and Dr. Tobey did not believe that the Claimant required chiropractic and massage therapy. Dr. Tobey had recommended physical therapy, which the Claimant declined. Neither Dr. Gronseth nor Dr. Green has recommended ongoing and weekly massage therapy and chiropractic care. In addition, the ALJ notes that Dr. Criste is not familiar with the Medical Treatment Guidelines and has been paid for providing weekly chiropractic care for the Claimant for over two years. The ALJ does not find Claimant is in need of such ongoing care as a result of the 2006 industrial injury.

8. Section 8-42-101(1)(a), C.R.S. 2008, provides that Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of the industrial injury. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). A Claimant may be entitled to medical benefits after MMI if there is substantial evidence in the record to support a determination that future medical treatment will be reasonable and necessary to relieve the effects of the industrial injury or prevent a deterioration of the Claimant's condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The ALJ finds that the Claimant has failed to establish by a preponderance of the evidence that she is in need of future chiropractic and massage therapy to relieve the effects of the industrial injury or to prevent a deterioration of her condition. Therefore her request for such care is denied.

ORDER

IT IS THEREFORE, ORDERED THAT:

1. Claimant failed to overcome the opinion of the DIME by clear and convincing evidence.

2. Claimant's request for ongoing weekly chiropractic care and weekly massage therapy is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 17, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-761-501

ISSUES

1. Did Claimant prove by a preponderance of the evidence that he sustained an occupational disease arising out of the course and scope of his employment?

2. Did Claimant prove by a preponderance of the evidence that he is entitled to reimbursement for medical treatment and for ongoing reasonable and necessary medical benefits?

3. Did Claimant establish by a preponderance of the evidence that he is entitled to temporary total disability benefits?

FINDINGS OF FACT

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

1. Claimant was born on May 25, 1952. Claimant began working for Employer in September of 2000. He has worked exclusively for this Employer as a pest control technician. Claimant is asserting he injured his bilateral shoulders. Claimant claims his pain began in his right shoulder and then migrated to his left.

2. Claimant claims he serviced 20% commercial, 80% residential. This testimony was contradicted by Employer. Claimant claims he made eight to twelve stops per day in the summer and six stops in the winter.

3. Claimant starts each workday at the Employer offices. He goes into the garage of the offices and punches in to a time clock. He opens his locker and obtains his tools, including his B & G sprayer and other equipment. It would take Claimant anywhere from 10 minutes to 45 minutes between the time he punches in and his arrival at his first stop. Claimant agreed most of his stops would be places he had visited previously, either on quarterly, monthly, or weekly service calls. These locations would have already had previous pest control treatments. Claimant meets with the homeowner or business owner and discusses what services need to be done and if there are any new pest complaints. Claimant uses the equipment to treat the pest at the location. Every stop is different and every application is different where buildings are different heights, have different structures, different square footage, and different pests. At the conclusion of the stop, Claimant would meet with the homeowner or business owner to discuss the findings. He also has to complete paperwork that identifies the chemical that was used, the pest controlled, the time of application and pest

location. The business owner or residential customer then signs the ticket. Claimant returns to his truck and completes paperwork for Employer and then identifies his next stop. Claimant drives his vehicle to the next stop. Claimant also has the opportunity to take a break or a lunch though he may eat in his truck. Claimant also has occasions where he goes to the jobs and the customer is not ready. Claimant calls the office and learns if he can wait until the customer is ready. If he cannot wait, the customer is rescheduled and claimant may be given a new stop. A typical application takes Claimant approximately 30-45 minutes. Performing bee jobs requires climbing up a 24-foot ladder to second story eaves. He then has to reach overhead to spray into the area where the bees are located.

4. Claimant used a B & G Sprayer for the vast majority of his work. The B&G Sprayer has a canister that is held in Claimant's left hand and a wand is carried in his right. The wand has a rubber hose, approximately 2 ½ feet long. The canister is pumped up with the left hand to increase the pressure in the can. Claimant uses his right hand to move the wand to control where the spray goes. The canister itself weighs six to eight pounds. It is then filled up with one gallon of water and weighs 13-15 pounds. Claimant also utilized ladders, dust sticks, bee suit, a fogger for roach jobs, and atom mister for crawl spaces in houses. Claimant is spraying the chemicals as fast as he can walk. The majority of the spraying applies pesticide where the wall hits the floor. Claimant sprays the ground where the wall meets the floor throughout the interior of each floor of the building and around the exterior of the building. In a basement of a residence that is unfinished, Claimant would also spray along the ceiling joists. On the exterior of the building, Claimant may also spray in the eaves or where a gutter meets the wall. The B & G sprayer permits the applicator to increase the pressure within the canister to increase the distance the chemical can be sprayed. The B & G sprayer has a fan spray and a pin spray. The applicator does not need to touch the wand where the wall meets the ceiling, but can instead use the pressure to apply the chemical some distance away from the wand tip.

5. Claimant testified he had an incident of shoulder pain beginning in July 2007. Claimant testified he went to the doctor frequently in 2007, and also underwent a surgery in 2007. When Claimant treated in 2007 for other conditions, Claimant made no mention of his shoulder pain. Claimant agreed he saw a physician at Kaiser on August 31, 2007, October 5, 2007, and December 12, 2007. Claimant agreed he did not describe any shoulder problems to his Kaiser doctors on those dates despite the fact that Claimant testified he had contemporaneous shoulder pain.

6. Claimant statements to his medical providers about when his symptoms arose have varied over time and are therefore not credible and persuasive. Claimant was seen at Kaiser Permanente on January 17, 2008 by Troy Long, M.D. for shoulder pain. Claimant stated his pain was in both shoulder, with the pain starting "three weeks ago with L then went to r as well." This is contrary to

Claimant's testimony at hearing and statement to Dr. Olsen that his pain began in his right arm and then went to his left. Claimant agreed he did not advise Dr. Long that he suffered any discrete incident and made no mention of previous episodes of pain.

7. Claimant was seen by physical therapist Kirsten Fischer on January 23, 2008 at Kaiser Permanente. Despite testimony to the contrary, Claimant also advised Ms. Fischer that his problems were in the left arm first and then the right. Claimant stated he did not recall any injury. The therapist asked Claimant what types of movements he was doing with his shoulder. Ms. Fischer's states, "Patient remembered that his shoulders may have actually started hurting when lifting ladders on and off the truck a lot at work during the summer." Claimant stated the therapist told him she thought it was overuse at work. The Claimant then advised the Employer on February 8, 2008 that he felt his condition was work-related.

8. The Employer sent Claimant to see Michael Ladwig MD and was seen on February 12, 2008. Claimant knew Dr. Ladwig was a workers' compensation physician. He had treated with Dr. Ladwig in the past and felt comfortable discussing his medical conditions with Dr. Ladwig. Claimant told Dr. Ladwig there had been no accidents at work. Dr. Ladwig's report does not state which shoulder had problems first, but simply reports problems in both shoulders. Dr. Ladwig's report stated, "He operates a spray can and wand during <u>the entirety of his shift</u>." (emphasis added). Claimant advised Dr. Ladwig there was nothing at work he could recollect which caused his injuries to his shoulders. There was no mention of problems beginning in the summer of 2007 or in October/November 2007.

9. Claimant provided a different explanation for the onset of his symptoms when answering interrogatories. Claimant agreed he advised that his <u>first</u> work-related complaints began in October or November of 2007. Claimant failed to provide in his answers to interrogatories details of pain he described which occurred in the summer of 2007. Claimant stated his pain began when he reached up to remove the Vector flytrap from the ceiling. These incidents were not described to Dr. Long, Kirsten Fischer, PT, or Dr. Ladwig.

10. Dr. Ladwig returned Claimant to full duty. When Claimant went to Kaiser Permanente on July 29, 2008, he had not returned to Dr. Ladwig. Claimant never contacted Dr. Ladwig's office to make an appointment. Claimant was never refused medical treatment by Dr. Ladwig's office despite the bills not having been paid. Claimant brought in a note to Employer dated July 29, 2008 from Kaiser Permanente assigning lifting restrictions.

11. MR has been employed with Employer since 1986. Mr. R is an owner of the business and is General Manager. Mr. R has held all of the posi-

tions at Employer and continues to do pest control application occasionally while serving as General Manager.

12. Claimant has had prior workers' compensation claims with Employer. These reports were either reported to Mr. R or eventually routed to Mr. R. Claimant was familiar with the process or reporting a work injury and being sent for treatment. Claimant was always immediately sent for treatment with Dr. Ladwig. Claimant reported the current claim to Mr. R on February 8, 2008. Claimant advised Mr. R he had gone to his personal physician through Kaiser and they indicated to him he needed to see a workers' compensation doctor. Prior to reporting the injury on February 8, 2008, Claimant had never come to Mr. R and advised that he was going to Kaiser to treat for a shoulder injury. When Claimant advised Mr. R he felt he had a work-related condition, Mr. R immediately sent Claimant to Dr. Ladwig. When Claimant reported the incident in February of 2008, he did not state it was caused by a specific incident.

13. Mr. R, who is familiar with the route done by Claimant, stated the distribution is 60% commercial and 40% residential. Claimant has a number of quarterly and monthly accounts where he is the requested technician. Mr. R has serviced most of the accounts that Claimant serviced. Mr. R also reviews the documentation that spells out Claimant's daily route. Mr. R is familiar with the account names as he reviews the documentation. Mr. R has also had to fill in for Claimant on occasion. Based on this understanding, Mr. R knows how long it takes to do the applications performed by Claimant. Mr. R credibly testified that the majority of time, it takes longer to drive to the stop than to perform the specified application. The pressure in the sprayer permits the spray to reach the ceiling without having to touch the ceiling. This allows the arm to be lower. The B & G sprayer should get lighter throughout the day as the chemical is being dispensed.

14. Katie Montoya prepared a job analysis on August 20, 2008. She noted Claimant's equipment included B & G hand-held sprayer, ladders, company vehicle, fogging device, extension pole, and protective equipment. Her report notes a pest control service technician is described and observed in the light duty work classification as defined by the Department of Labor. The position requires frequent walking and standing. There is driving required to customers' locations, totaling possibly 30% of the workday. The technician would be seated during this timeframe. Mr. R estimated there was usually about 30 minutes of drive time and then 45-60 minutes at each location. Climbing up ladders is required. There are multiple types of ladders to choose from. Twisting at the neck and waist would be occasional. Bending at the waist is occasional as well. Squatting and kneeling are occasional. Crawling is not required. Reaching above the shoulder level is required on an occasional basis when high spraying is needed or for replacement of some flytrap devices. There is no requirement for repetitive motion of the bilateral upper extremities. However, the upper extremities are used on a frequent basis. Ms. Montoya was also provided with

Claimant's interrogatory responses, and included that information in her analysis. "Occasional" is defined as "1%-32% of the work day.

15. Dr. Ladwig opined Claimant's condition is work-related. Dr. Ladwig's opinion that Claimant's condition is work related is not persuasive. Dr. Ladwig's opinion is based on the facts offered by Claimant regarding his job duties. Dr. Ladwig did not review the job analysis from Katie Montoya. He did not review the records from Kaiser Permanente. He also did not review the report from Dr. Olsen. Dr. Ladwig was under the mistaken impression that Claimant operated a spray can and wand during the entirety of his shift. However, the credible and persuasive evidence shows that Claimant spent up to 30% of his day driving between locations and spent additional time completing paperwork for each job. Finally, Dr. Ladwig's opinions were not consistent with the *Medical Treatment Guidelines* when evaluating causation for Claimant's case.

16. Dr. Nicholas Olsen testified as an expert for Respondents and his report dated August 21, 2008 was accepted into evidence. Claimant reported to the Kaiser doctor and therapist that his problems started on the left and then occurred in his right shoulder. Claimant reported to Dr. Olsen that his symptoms started in the right and moved to the left. Claimant also told Dr. Olsen that his problems started when removing the Vector flytrap. Dr. Olsen's report and testimony persuasively demonstrated the different histories Claimant offered to various health care providers concerning the onset of symptoms.

17. Dr. Olsen reviewed the *Medical Treatment Guidelines*. Dr. Olsen explained the shoulder guidelines describe a history that the provider should expect to see when evaluating causation. He also reviewed the medical literature. Dr. Olsen reviewed the National Institute of Occupational Safety and Health (NIOSH) study done in the mid to late '90s surveying the medical literature. Dr. Olsen opined the NOISH studies are often referenced by the *Medical Treatment Guidelines* and Colorado looks to these studies when considering evidence-based medicine. Dr. Olsen opined that he applies the *Medical Treatment Guidelines* and medical literature when analyzing causation of Claimant's shoulder injuries.

18. Dr. Olsen concluded this was an occupational disease. Dr. Olsen explained to evaluate whether or not a person suffers an occupational disease of the shoulders, both the *Medical Treatment Guidelines* and the literature require there be <u>chronic repetitive overhead use</u> while in the job. Dr. Olsen stated the *Medical Treatment Guidelines* refer to "highly repetitive" but does not do a good job of defining "repetitive" as is done in other sections of the *Guidelines*. He looked to the medical literature, including the NIOSH study that is referred to in the *Medical Treatment Guidelines*. Dr. Olsen explained the NIOSH studies state overhead use occurs when using the arm above eye-level and working in that posture greater than 50% of the day. In addition, the work would need to be cy-

clical where the arm would raise several times in a minute to be considered highly repetitive. Dr. Olsen stated the medical literature requires that if a worker does not have highly repetitive tasks overhead more than 50% of the day, they do not meet the definition "highly repetitive" to be causative for an occupational disease in the shoulder. Dr. Olsen's testimony in this regard is persuasive.

19. Dr. Olsen's testimony is more persuasive than that of Dr. Ladwig because he had a better and more accurate history of the job duties performed by the Claimant than did Dr. Ladwig. Dr. Olsen stated, based on the job description he received from the Claimant in the office and hearing the testimony of Claimant and Mr. R, he would agree with Katie Montoya that Claimant's overhead work was "occasional," which might be 20% of the day. "Occasional" is defined as a maximum of 33% of the day. Claimant's duties did not meet the criteria of working repetitively overhead more than 50% of the day. Dr. Olsen opined that Claimant's work overhead was not more than 50% of the time. Any work Claimant did overhead was in a comfortable posture where he was not having to use a tool or apply pressure. Since that work is less than occasional, which is less than 1/3 of the day, this would be less than the definition required by the literature and the *Medical Treatment Guidelines* to constitute repetitive.

20. Dr. Olsen persuasively opined that Claimant's job did not cause, aggravate or accelerate Claimant's preexisting degeneration arthritis found in his shoulder. Dr. Olsen noted the NIOSH studies took age into consideration and did not apply different criteria for the different ages. Even with pre-existing degenerative arthritis, the studies required there still needed to be repetitive overhead use or frequent cyclical use of the upper extremity overhead for there to be a relationship between the work activity and the shoulder problems. Dr. Olsen persuasively opined that Claimant's work did not aggravate or accelerate Claimant's underlying degenerative rotator cuff disease.

CONCLUSIONS OF LAW

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. §8-40-102(1),C.R.S. Claimant shoulders 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 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. §8-43-201, C.R.S.

2. For an injury to be compensable, the claimant has the burden to prove by a preponderance of the evidence that his injury arose out of and in the course of his employment. §8-43-201 C.R.S. "Arising out employment" deals with the causal connection between the employment and the injury. *General Cable Co. v. Industrial Claims Appeals Office*, 878 P.2d 118 (Colo. CT App. 1994). "Course of employment" deals with the time, place, and circumstances of claimant's alleged injury. *Wild West Radio, Inc. v. Industrial Claims Appeals Office*, 905 P.2d 6 (Colo. App. 1995). Under the preponderance of the evidence standard, where evidence weighs evenly on both sides in a controversy, the fact finder must resolve the question against the party who has the burden of proof. *People v. Taylor*, 618 P.2d 1127, 1135 (Colo. 1980).

3. 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, interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. The *Medical Treatment Guidelines* are applicable to this case and are found in the Department of Labor and Employment's Rule 17, 7 Code Colo. Reg. 1103-3. The statement of purpose of the *Medical Treatment Guidelines* is contained in WCRP 17-1(A), 7 Code Colo. Reg. 1101-3 at 103, which provides as follows:

> In an effort to comply with its legislative charge to assure appropriate medical care at a reasonable cost, the Director of the Division has promulgated these medical treatment guidelines. This Rule provides a system of evaluation and treatment guidelines for high cost or high frequency categories of occupational injuries received to assure appropriate medical care at a reasonable cost.

5. The use of the *Medical Treatment Guidelines* is contained at WCRP 17-2(A) and provides as follows: "All healthcare providers shall use the medical treatment guidelines adopted by the Division." The *Medical Treatment Guidelines* are regarded as accepted professional standards for care and evaluation of injuries. Rule 17, Exhibit 4, involving the shoulder, states at Subsection D that history taking should address at least the following for each shoulder injury diagnosis: "Occupational relationship and history of non-occupational injury in avocational pursuits." The *Medical Treatment Guidelines* then address what should be present to identify the "occupational relationship" based on the diagnosis. Impingement syndrome would be considered occupationally related if there is "established repetitive overuse of the upper extremity; many times this is seen with constant overhead motion." Rule 17, Exhibit 4(D)(6)(a)(i)) Similarly, the *Medical*

Treatment Guidelines with regard to the shoulder state that a rotator cuff tear would be occupationally related if there is "chronic overuse with repetitive overhead motion with internal or external rotation." Rule 17, Exhibit 4(D)(7)(a)(i)) Rotator cuff tendinitis is deemed occupationally related by the *Medical Treatment Guidelines* when there is "repetitive use of the shoulder." Rule 17, Exhibit 4(D)(8)(a)).

6. Claimant did not meet his burden of proof on compensability. Dr. Olsen's opinion on causation was found to be persuasive. Claimant did not suffer an occupational disease of the bilateral shoulders while working for Employer. Claimant did not aggravate or accelerate his preexisting arthritis while working for Employer.

ORDER

It is therefore ordered that:

1. Claimant failed to establish by a preponderance of the evidence that he suffered a compensable injury to his bilateral shoulders.

2. Claimant's claim is denied and dismissed.

DATED: December 17, 2008

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-750-935

ISSUES

¬ Did claimant prove by a preponderance of the evidence that he was performing services for employer at the time of his work-related injury?
¬ Did claimant prove by a preponderance of the evidence that employer should pay his medical and temporary disability benefits?

FINDINGS OF FACT

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

1. Employer operates an over-the-road trucking company. OF (Oscar Senior) is President. Oscar Senior's two sons, L Favela and OF (Oscar Junior),

also work for employer. L is Vice President; Oscar Junior is maintenance lead. At the time of hearing, claimant was 38 years old.

2. Claimant fractured his right ankle in an accidental fall to the ground from the bed of a dump truck on January 12, 2008. At the time of the accident, claimant was unloading the dump truck on a farm owned by NK. Claimant was working under the direction of Oscar Junior at the time of his accident. Claimant contends he was working as an employee of employer at the time of his accident. It is uncontroverted that claimant was performing work for Oscar Junior at the time of his work-related accident.

3. K transported claimant to East Morgan County Hospital in Brush, Colorado, for medical treatment. Later on January 12th, L drove claimant from Brush to Denver Health Medical Center, where claimant underwent 2 surgeries and periodic evaluations through August 29, 2008. Denver Health and various physicians have outstanding charges of some $27,300.00. Medicaid paid for a portion (some $7,600.00) of claimant's treatment at Denver Health. Claimant paid some $675.00 toward his medical expenses.

4. Crediting L's testimony, the Judge finds: While Oscar Junior can refer prospective employees or drivers to L, only L has the authority to hire employees. The process of hiring a driver takes 3 days to 1 week to complete. A prospective driver completes an application and must have a valid commercial drivers license (CDL). L then checks the applicant's motor vehicle record, places the applicant's name in a drug-screen pool, performs a criminal background check, checks references, and asks for a copy of the applicant's social security card. Employer hires drivers who allegedly agree to work as independent contractors and who are paid by the mile, with some differential pay for the number of times the driver has to place or remove a tarp over the load.

5. In the past, claimant held a CDL issued by the State of Utah, which had expired. At all times relevant to his claim, claimant lacked a valid CDL. Claimant's friend, AV, applied for a driving position with employer on November 27, 2007. While claimant accompanied V when he applied for a driving position with employer, claimant could not apply for lack of a valid CDL. Claimant told L he did not have a valid CDL. L only hired V, who worked through the Christmas Holiday. Employer does not hire teams of drivers, unless both drivers have a valid CDL.

6. Claimant testified that he accompanied V on various over-the-road trips for employer and that he helped drive the truck, even though he was unlicensed to drive a commercial vehicle. Claimant says he worked with V through the end of calendar year 2007, when they stopped working. While claimant subjectively believes he was an employee while driving with V, there was no persuasive evidence showing a contract of employment between claimant and employer.

7. Oscar Junior testified that claimant called him in January of 2008, saying that he had been unable to find work for 3 weeks, that he needed work, and that he needed money for food. Oscar Junior offered claimant work cleaning tomato vines from the ranch where Oscar Junior lived. Claimant agreed to work for Oscar Junior for $100.00 per day.

8. Oscar Senior owns the ranch, which is a separate property from the yard where employer operates its trucking business. The tomato vines were refuse from a side project Oscar Junior pursued to earn extra money. The county had ordered Oscar Junior to remove the tomato vines because they were illegal. Oscar Junior hired claimant to load the vines on a dump truck and to drive it some 40 miles to a farm across the county line.

9. Oscar Junior worked with claimant on January 11th. Claimant loaded the vines onto the truck using a front-end loader. Oscar Junior drove the truck to the farm. Claimant rode as a passenger in the truck. Because Oscar Junior had to drive one of employer's loads on January 12th, he asked claimant to work by himself on the ranch. As found, claimant was performing services for Oscar Junior at the time of his injury.

10. L testified that, when he drove claimant to Denver Health on the date of the accident, he paid claimant $300.00 in cash for his work. On January 21, 2008, L issued a check to claimant in the amount of $500.00, which was written on a check from employer's business account. L stated that claimant, his wife, and his 4 kids showed at employer's office needing money. L telephoned Oscar Junior, who told him to give claimant 50% of his salary that week to help him out. Oscar Senior signed the check, which was the only check payable to claimant from employer's business account. Claimant failed to show it more probably true that the check issued from employer's business account constitutes an admission that claimant was an employee at the time of his work-related injury.

11. Claimant failed to show it more probably true than not that he was an employee performing services for employer at the time of his injury on January 12, 2008. As found, claimant subjectively believes he was employer's employee while driving with V. Even if there were some express or implied contract of employment between claimant and employer, claimant no longer worked for employer after the end of calendar year 2007. The Judge however found no persuasive evidence showing a contract of employment between claimant and employer. Indeed, L and Oscar Junior both testified that employer never employed claimant as a driver. This testimony is supported by employer's detail of transactions from its business account, showing all payments to drivers during calendar year 2007. While the detail shows checks paid to V, there were no checks paid to claimant. When Oscar Junior hired claimant to work on the ranch, he agreed to pay claimant cash, and not to pay him by the mile as per employer's custom-

ary practice with drivers it employed. Since the hearing involved only claimant's claim against employer, and not against Oscar Junior as putative employer, the Judge does not reach the question whether Oscar Junior was an employer under the statute.

CONCLUSIONS OF LAW

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

Claimant argues he has proven by a preponderance of the evidence that he was an employee of employer at the time he sustained his work-related injury. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment with this employer. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). Section 8-40-202(2)(a), *supra,* provides that an individual performing services for another is deemed to be an employee. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Here, the Judge found claimant failed to show it more probably true than not that he was an employee performing services for employer at the time of his work-related injury on January 12, 2008. Claimant thus failed to prove by a pre-

ponderance of the evidence that he was an employee of employer at the time he sustained his work-related injury.

Even though claimant subjectively believes he was employer's employee while driving with V, he no longer worked with V after the end of calendar year 2007. The Judge found no persuasive evidence showing a contract of employment between claimant and employer. Indeed, L and Oscar Junior both testified that employer never employed claimant as an over-the-road driver. This testimony was credible and amply supported by employer's detail of transactions from its business account, showing all payments to drivers during calendar year 2007. While the detail shows checks paid to V, there were no checks paid to claimant. And when Oscar Junior hired claimant to work on the ranch, he agreed to pay claimant cash, and not to pay him by the mile as per employer's customary practice with drivers it employed.

The Judge concludes that claimant's claim against employer for workers' compensation benefits should be denied and dismissed. Since the hearing involved only claimant's claim against employer, and not against Oscar Junior as putative employer, the Judge does not reach the question whether claimant was Oscar Junior's employee at the time of his injury on January 12, 2008.

ORDER

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

1. Claimant's claim against employer for workers' compensation benefits is denied and dismissed.

2. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _December 17, 2008_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-742-250

ISSUES

The issue determined herein is compensability. The parties stipulated to an average weekly wage of $153.75, to medical benefits from Memorial Hospital, and to the first twelve treatments by Smith Chiropractic.

FINDINGS OF FACT

1. Claimant contacted the employer's representative on the internet in response to an advertisement for a job. On August 21, 2007, the employer's representative called claimant and described the job of making sales calls in person to local businesses. Claimant could not recall the name of the person who called her. Claimant informed the caller that claimant did not have a driver's license. The caller informed her that it did not matter as long as claimant can make all of the sales visits.
2. On August 21, 2007, LC from CPP Recruiting e-mailed claimant an application and other documents. The trier-of-fact infers that Ms. C called claimant on August 21, 2007.
3. On August 21, 2007, claimant submitted the application for employment. On the application, claimant indicated that she had a currently valid Colorado driver's license.
4. Claimant submitted signed releases for the employer to conduct a criminal background check.
5. On August 24, 2007, the employer hired claimant as a merchant sales consultant. The employer and claimant signed an employment agreement for at-will employment. The written agreement did not require that claimant drive herself to all sales visits or even that she must maintain a valid driver's license. The employer also provided claimant with a "checklist" that was not part of the employment agreement. Claimant initialed next to each item on the checklist, including the statement that claimant was responsible for maintaining a valid driver's license and insurance requirements for the state of claimant's residence. The employer also provided claimant with an employee handbook, which was designated as merely a "guide" and not part of the "written employment contract." None of the employment documents required that claimant could only travel to sales visits by driving herself.
6. The employer provided claimant with at least three contacts for sales visits each day. Claimant was also encouraged to contact any businesses for which she was a customer and also attempt to sell the employer's credit card processing services to those businesses. Her supervisor was NE, who was located in Texas. Claimant was required to call Mr. E after each sales visit that she made.
7. As a result of a conviction in 2002 for driving while abilities were impaired, claimant had lost her driver's license in Colorado.
8. Because claimant did not have a valid Colorado driver's license, she hired CC, a friend, to drive claimant to her sales visits and paid her approximately $25 per day.
9. On September 7, 2007, claimant made her first assigned sales visit to a business in Security, Colorado. Claimant then traveled to Trendzy Nails, a business for which she was a customer. The owner told claimant to come back later. Claimant then traveled to her next assigned sales visit in Colorado Springs. Claimant and Ms. C then had lunch at Latina Salsa at approximately 4:30 p.m. Claimant also tried to market the employer's services to Latina Salsa, but the manager declined. Ms. C then drove claimant back to Trendzy Nails while claimant called Mr. E to update him about her sales visits. En route to Trendzy Nails, Ms. C's vehicle was rear-ended by another vehicle, causing injury to claimant's right arm and back. The investigating police officer completed a report showing that the accident occurred at 5:00 p.m.

10. At approximately 7:00 p.m. on September 7, 2007, claimant sought treatment at Memorial Hospital. She reported a history of the motor vehicle accident at 5:00 p.m. that day. Computerized tomography ("CT") scan showed decreased disc height at C4-5. The physician diagnosed cervical strain and right shoulder contusion and prescribed medications and heat.

11. On Sunday, September 9, 2007, claimant returned to Trendzy Nails and made a sale of the employer's services.

12. On Monday, September 10, 2007, claimant informed Mr. E about the accident and her injuries. The employer did not refer claimant to a medical provider.

13. On September 18, 2007, claimant sought treatment at Smith Chiropractic. Dr. Smith was not level I certified by the Division of Workers' Compensation.

14. On an unknown date, the employer, through Mr. E, terminated claimant's employment due to her lack of a valid driver's license. Claimant informed Mr. E that she still had a few more sales visits to make and Mr. E agreed.

15. On October 3, 2007, claimant suffered additional injuries in another motor vehicle accident. She suffered increased headaches and had to seek additional chiropractic treatment.

16. On December 1, 2007, the employer completed a First Report of Injury, indicating that claimant was injured on September 7, 2007, while between sales calls.

17. Claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 7, 2007, arising out of and in the course of her employment. Claimant was engaged in the sales activities for which she was hired at the time of her accident. Although claimant misrepresented the status of her driver's license on the application, the employment agreement did not require that claimant drive herself to the mandatory sales visits as long as she was able to make all of the visits. Claimant's use of a hired driver for the sales visits was not a deviation from the contract of hire; it was only her own personal choice as to the manner of performing the services for which she was hired. Claimant's travel conferred a benefit on the employer: she made sales visits to the designated potential customers.

CONCLUSIONS OF LAW

1. 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). 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).

2. Respondents argue that claimant's travel to sales visits by a means other than driving herself was not contemplated by the employment contract and her injuries do not arise out of and in the course of the employment. That argument is unpersuasive. As found, the contract of hire did not require that claimant drive herself to the sales visits.

The contract of hire certainly contemplated travel. *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). In fact, the entire employment agreement centered on claimant's obligation to travel. The agreement did not specify the manner of travel. Contrary to respondents' argument, claimant's travel most certainly conferred a benefit on the employer: she made sales visits to the designated potential customers. The fact that claimant misrepresented her driver's license status on the application for employment does not defeat claimant's claim for compensation. *Kraus v. Artcraft Sign Co.*, 710 P.2d 480 (Colo. 1985). As found, claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 7, 2007, arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment from authorized providers for the work injury, including Memorial Hospital and the first twelve treatments by Smith Chiropractic.
2. All matters not determined herein are reserved for future determination.

DATED: December 18, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-051

ISSUES

1. Did claimant prove by a preponderance of the evidence that he sustained a shoulder injury arising out of the course and scope of his employment on November 20, 2007, while skiing before line-up as a ski instructor?

2. Did claimant prove by a preponderance of the evidence that he is entitled to temporary partial disability benefits (TPD) from November 21, 2007, and continuing?

3. Did the claimant prove by a preponderance of the evidence that he is entitled to authorized, reasonable and necessary medical benefits for treatment of the alleged injury, including treatment provided by Breckenridge Medical Center and Dr. Abbott?

FINDINGS OF FACT

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

1. Claimant, age 56 at the time of the hearing, was a ski instructor with employer working at Breckenridge Ski Area (Breckenridge) on November 20, 2007, when he injured his right shoulder. Breckenridge is operated by employer.

2. At the time of his injury, claimant had worked as a ski instructor at Breckenridge since March, 2007, had been skiing since 1957, and had previously been a ski coach and instructor in Massachusetts. He is Level II certified with the Professional Ski Instructors Association (PSIA).

3. On Monday, November 19, 2007, the day before his injury and the beginning of Thanksgiving week, claimant gave ski lessons at Breckenridge to three individuals, including beginner skier SB. At the end of the day, Ms. B asked claimant if he would be available for a ski lesson the following day. Tuesday was claimant's day off, and claimant told Ms. B that he was unsure but would check to see if he could come in to teach her on Tuesday.

4. That afternoon claimant approached SE, Operations Supervisor, in the hallway and asked for permission to work on Tuesday, November 20, 2007, due to Ms. B's request for a return lesson. Mr. E was claimant's supervisor at the time. Mr. E told claimant he could come to work on Tuesday.

5. Claimant understood that he had no guarantee of being assigned a lesson on November 20, 2007, even if Ms. B did return for another lesson. Ski instructors report for line-up at 9:45 a.m. for lessons that begin at 10:00 a.m. The supervisor then assigns those lessons based on a seniority system. Claimant had very low seniority. One of the factors that a supervisor can consider in assigning lessons, however, is whether students have returned from a prior day. Claimant thought that there was a chance he would be assigned a lesson with Ms. B. It was reasonable for claimant to expect that he might be assigned Ms. B if she returned for a lesson on November 20.

6. Claimant never had any further contact with Ms. B after the end of her lesson on November 19, 2007. According to employer records that track lift usage, SB did not ski at Breckenridge on November 20, 2007.

7. Claimant was hopeful that he would be assigned to teach a lesson including Ms. B. Ms. B was in a Level II novice group on November 19, but she had athletic ability and had made quite a bit of progress by the end of the day on Monday. Claimant believed that Ms. B was ready, if she retained this progress, to ski an intermediate or "blue" run on November 20.

8. On Tuesday, November 20, claimant arrived at Breckenridge sometime before 8:37 a.m. He dressed in his uniform and went out to ski a blue run,

Bonanza, to scout the terrain for Ms. B (scouting run). Claimant did so because he believed it was important to check out the ski conditions on the blue runs before reporting for work in case he was assigned to teach Ms. B. As claimant was skiing down the Bonanza run, at approximately 9:10 a.m., he fell and injured his shoulder. Claimant was taken to the Breckenridge Medical Center and did not report to line-up that day.

9. After he was released from the medical center, claimant reported the accident to employer. He was told that he was "free skiing" and that his injury was not compensable. At the time, claimant accepted this answer. He returned to work several days later and taught skiing for the remainder of the season. Claimant then filed a workers' compensation claim, which employer denied based on an assertion that the injury was not work-related.

10. Claimant treated with Dr. Cunningham of Vail-Summit Orthopedics after the accident. Dr. Cunningham recommended shoulder surgery for a rotator cuff repair and possible tendon biceps tendonesis. Claimant wishes to continue treatment for his shoulder injury.

11. A ski instructor's work day at Breckenridge begins at line-up. At the time of his injury, claimant was "not on the clock" and was not receiving pay. Ski instructors do not clock-in until line-up at 9:45 a.m. Claimant did not expect to get paid while skiing the scouting run and in fact was not paid for any work on November 20, 2007.

12. Employer provides ski instructors grooming and terrain reports regarding snow conditions on the mountains by positing this information in the locker room and on supervisors' doors. These reports are generated at 5:30 a.m. daily. Snow conditions can change significantly from the time of the grooming and terrain reports until the ski instructors take their ski students out on the slopes. If there are major terrain issues, supervisors address these during the safety portion of the line-up.

13. The PSIA manual states as follows: "One of your top priorities as a snowsports instructor is to ensure your students are safe . . . . Be sure to take weather and snow conditions into account. Even the easiest terrain can be challenging under some conditions. Make a habit of checking a trail report and try and make your own warm-up runs on the slopes where you will be teaching." Breckenridge does not require its ski instructors to use the PSIA manual.

14. The Breckenridge Ski and Ride School Policy and Procedures Manual addresses ski conditions as follows: "Getting Started: Evaluate environment – snow conditions, weather forecast, grooming reports, etc." This language does not require a ski instructor to ski on the runs he or she will be using before a ski lesson begins.

15. The Breckenridge manual also contains this language: "Warm-up runs with your group- 2 warm-up runs daily: first thing in AM and after lunch; muscles need blood flow and need to be warm to prevent injuries, 'warm to perform.'" This language refers to warm-ups a ski instructor takes with his students and does not require or recommend that an instructor take a warm-up run before teaching students.

16. It is very important to employer to provide a safe and positive experience for students taking ski lessons at Breckenridge. Employer stressed safety in its orientation for ski instructors, which claimant attended. The orientation included a mock trial involving a fact situation when an instructor took a young child on terrain the instructor was unfamiliar with and that was unsuitable for the student. An accident occurred resulting in a fractured skull when the student ran into en electrical box. The lesson imparted was that the instructor should be aware of where he was bringing students and of their ability, because he was responsible for the safety of the student. The orientation did not direct ski instructors to check out the terrain by doing a ski run in advance.

17. No supervisor instructed claimant on November 20, 2007, to check out the terrain before giving a ski lesson that morning. Employer was not aware of claimant's scouting run to check out terrain and exercised no supervisory control over it.

18. Claimant was aware of employer's '"free skiing" policy for the 2007-2008 ski season, which is stated in the "Breckenridge Ski & Ride School Policy and Procedures Manual and Training Manual 2007/2008" as follows:

> Pros released from work duty for the day must change out of uniform before going free skiing or riding. <u>Free skiing/riding prior to morning line up is permitted in uniform</u>. Pros who are required to check back for afternoon line up who have a minimum Level 2 certification (or equivalent) can free ski/ride in uniform. All other pros must change out of all uniform pieces to free ski/ride. Pros told to check-in within 1 hour can remain and free ski/ride in uniform. <u>When free skiing, even if in uniform, pros are not covered by</u> <u>Workers'Comp</u>.

(Emphasis added.)

19. Procedures Manual and Training Manual 2007/2008" as follows:

> **Pros are NOT considered to be within the course and scope of their employment and, therefore, are not covered by Workers' Compensation when**:

° "Free skiing/riding," including, but not limited to, free skiing/riding before and after work assignments.

° While available and checking in with a supervisor for assignments.

20. Employer provided claimant a ski pass as part of his employment. Claimant used the ski pass on November 20, 2007, to get access to Bonanza run.

21. Claimant signed an "Employee Ski Pass/ID card from" in which he acknowledged that use of his ski pass beyond "specifically enumerated or directed employment duties" would constitute "recreational use and/or non-employment-related of the pass card". Further, he acknowledged recreational and/or non-employment-related use of the pass includes usage "(2) prior to the commencement or after the cessation of employment duties."

22. When claimant skied the scouting run on November 20, it was anticipated that he would provide a benefit to Ms. B, should he be assigned to teach her that day, and therefore to employer. He would have first-hand and up-to-date information regarding ski conditions on that run. Employer would benefit both in terms of a positive experience for Ms. B and her safety. In this case, those benefits were remote for two reasons. Employer had an established means to alert ski instructors to ski conditions. In addition, the chances of claimant's teaching a lesson to Ms. B, on this blue run, and at a time when this updated information would be relevant were low.

23. When supervisor E was a ski instructor many years before claimant was hired, he performed scouting runs before giving lessons by his own choice.

CONCLUSIONS OF LAW

Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and in the scope of his employment. Section 8-41-301(1), C.R.S. (2005); *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999); *Price v. Industrial Claim Appeals Office,* 919 P.2d 207 (Colo. 1996). The question of whether a claimant meets his burden of proof is one of fact for determination by the ALJ. *Lerner v. Wal-Mart Stores, Inc.,* 865 P. 2d 915 (Colo.App. 1993). 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).

Claimant asserts that his ski run to assess ski conditions before line-up was "sufficiently interrelated to the conditions and circumstances under which the employee usually performs his job that the activity may reasonably be characterized as an incident of employment" to be compensable. *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985; *Lori's Family Dining, Inc. v. ICAO,* 907 P.2d 715

(Colo.App. 1995). Respondents, on the other hand, contend that claimant's ski run was voluntary, recreational "free skiing."

In weighing these arguments, the ALJ must consider the statutory definitions of "employee" and "employment" in the workers' compensation statute, which exclude persons participating in recreational activities. Sections 8-40-301(1) and 8-40-201(8), C.R.S., provide in relevant part as follows:

> (1) Employee excludes any person … while participating in recreational activity, who at such time is relieved of and is not performing any duties of employment, regardless of whether such person is utilizing, by discount or otherwise, a pass, ticket, license, permit or other device as an emolument of employment.
>
> (8) "Employment"… shall not include … the employee's participation in a voluntary recreational activity or program, regardless of whether the employer promoted, sponsored, or supported the recreational activity or program.

In applying these statutory definitions and the law regarding compensability, the Supreme Court has set forth a number of factors that should be considered: (1) whether the injury occurred during working hours; (2) whether the injury occurred on the employer's premises; (3) whether participation in the activity was required; (4) whether the employer initiated, organized, sponsored, or financially supported it; and (5) whether the employer derived a benefit from it. *Price v. ICAO, supra; Dover Elevator Company v. ICAO,* 961 P.2d 1141 (Colo.App. 1998). The first two factors are particularly strong indicators of whether an injury arose out of and in the course of employment. *Price v. ICAO, supra.*

In relation to factor (1), claimant's injury did not occur during working hours. Even had claimant been assured of working on November 20, 2007, which he was not, his work day did not begin until line-up. Claimant was injured at approximately 9:10 a.m., 35 minutes before line-up, before working hours.

In relation to factor (2), claimant's injury did occur on the employer's premises. It occurred on the Bonanza ski run at Breckenridge, a ski area operated by employer.

In relation to factors (3) and (4), whether participation in the activity was required and whether the employer initiated, organized, sponsored or financially supported it, the ALJ first concludes that claimant's activity of skiing a scouting run was voluntary. The record is clear that no one directed claimant to ski a scouting run. In fact, employer had a policy that claimant was familiar with that free skiing before line-up was not in the course and scope of employment and would not be covered by workers' compensation.

Claimant contends that a number of factors combined to making a scouting run before line-up essentially part of claimant's work duties. Claimant points to employer's emphasis on safety during orientation, the PSIA's recommendation to check the trail and make a warm up run on the slope where an instructor will be teaching, the Breckenridge policy to evaluate the snow conditions; the possibility that grooming and terrain reporting completed at 5:30 a.m. would change; and the practice of E when he was an instructor to take a scouting run. Claimant contends that despite its written policies, employer has effectively enlarged the scope of employment to include and require a scouting run.

The record does not support this contention. An employer's emphasis on safety does not translate to permitting an employee to take all actions that the employee may deem appropriate to carry out that goal. Here, employer had a system for providing information about snow conditions to instructors via terrain and grooming reports, with possible updates at line-up in case of major terrain issues. Employer had not adopted the PSIA's recommendations, as shown in the Breckenridge policy. The orientation stressed safety but did not recommend taking scouting runs. The fact that the a single instructor who later became Operators Supervisor performed scouting runs years before claimant's employment by his own choice does not support an enlargement of the scope of employment by employer. Rather, claimant's acted unilaterally in making the scouting run.

In determining whether an activity is voluntary, the ALJ should also consider evidence regarding whether the employer sponsored, promoted, or supported the recreational activity. Such evidence is relevant to a determination of whether the employer enlarged the scope of employment by its affirmative act of embracing various recreational and social activities. *Price v. ICAO, supra;* 2 *Larson's Workers' Compensation Law* §§ 22.20 and 22.24(c) (1997). The only evidence of support here is employer's provision of a ski pass to claimant. Employer was unaware of claimant's pre-line-up skiing the morning of the injury and exercised no supervisory control over his activities at that time. It had not directed claimant to scout out terrain in anticipation of a lesson. Employer took no affirmative act to embrace a recreational activity. Breckenridge policy for ski instructors specifically provides that free skiing is not covered by workers' compensation.

In relation to factor (5), whether employer derived a benefit from the activity, claimant's scouting run was expected to benefit employer, but that benefit was remote due to the circumstances. There was an existing method to alert ski instructors to ski conditions, and claimant's chances of teaching a lesson to Ms. B, on this blue run, and at a time when the updated information derived from the scouting run would be relevant were low.

Based on an analysis of these five factors as a whole and giving weight to the first two factors, the ALJ concludes that claimant has failed to establish by a

preponderance of the evidence that his scouting run was "sufficiently interrelated to the conditions and circumstances under which he employee usually performs his job that the activity may reasonably be characterized as an incident of employment, even though the activity itself is not a strict obligation of employment and does not confer a strict benefit on the employer." *City of Boulder v. Streeb*, *supra*. Claimant has failed to establish that he was in the course and scope of employment at the time of his injury. Instead, he was engaged in the voluntary recreational activity of free skiing.

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits based on a November 20, 2007 injury is denied and dismissed.

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

DATED: December 18, 2008

Nancy Connick
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-421-048

ISSUE

The issue to be determined is whether Respondents may offset the permanent partial disability (PPD) benefits paid against the temporary disability benefits owing pursuant to Section 8-42-107.5, C.R.S., and *Murphy Contractors v. ICAP,* 916 P.2d 611 (Colo.App. 1995).

FINDINGS OF FACT

1. Claimant sustained compensable injuries on May 3, 1999. He initially reached maximum medical improvement (MMI) on October 26, 2001. At that time, Claimant had a 43% whole person impairment. Respondents admitted liability for permanent partial disability benefits based on the 43% whole person impairment. The claim was reopened as of July 19, 2004. Up to that date, Respondents paid PPD benefits in the amount of $19,468.56. The current temporary total disability (TTD) rate is $382.92 per week. TTD benefits paid to date exceed $120,000.00.

2. Claimant is not yet at MMI for his worsened condition. Peter N. Reusswig, M.D., in report dated September 17, 2008, stated that Claimant will not be able to earn any wages in the employment he held at the time of his injury or in any other employment. Robert H. Meier, III, M.D., in a report dated September 25, 2008, stated that he cannot imagine that there is any job that Claimant could consistently perform. The ALJ credits these opinions of Dr. Reusswig and Dr. Meier. Claimant will be a candidate for permanent total disability benefits when he is placed at MMI again.

CONCLUSIONS OF LAW

The facts in *Murphy Contractors v. ICAP,* 916 P.2d 611 (Colo.App. 1995) are distinguishable from the facts in this claim. First, in *Murphy Contractors*, the claimant had less than 25% impairment at the time he originally reached MMI. Accordingly, the court stated the holding of the case as follows:

> In the absence of statutory guidance, for the reasons set forth below, we conclude that, when further benefits are sought after the twenty-five percent or less limit of *§ 8-42-107.5* has been applied, the petitioners are entitled to offset any permanent partial benefits paid against temporary total disability benefits.

Murphy Contractors_ supra, 916 P2d at 614. Here, Claimant's impairment is more than 25%. The court's ruling in *Murphy Contractors* does not reach the offset issue in the more serious injury cases when a claimant's impairment at the time of initial MMI exceeds 25%.

More significantly, in *Murphy Contractors* the claimant did not allege that he would be a candidate for permanent total disability benefits upon reaching MMI. In fact, in that case, the claimant's surgeon opined that the new surgery after reopening would not significantly alter claimant's impairment rating of 17%. Here, the medical evidence from Dr. Reusswig and Dr. Meier establish that when he reaches MMI, Claimant will be a candidate for permanent total disability benefits. Therefore, the facts here militate in favor of not disrupting the flow of Claimant's benefits, the countervailing consideration to the Respondents' interest in avoiding an overpayment in the event Claimant is found not permanently totally disabled after he reaches MMI the second time. Therefore, *Murphy Contractors* does not govern the present case.

ORDER

1. Respondents may not offset the PPD benefits paid against the temporary disability benefits due.
2. Any and all issues not determined herein are reserved for future decision.

DATED: *December 18, 2008*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-571

ISSUES

The issues determined herein are compensability and medical benefits.

FINDINGS OF FACT

1. Claimant was employed as a caregiver for the employer. She had to wake patients, help them with dress and hygiene, transport them to the bathroom and transport them to meals.

2. On September 10, 2008, claimant suffered an injury while transferring a patient out of a wheelchair into a chair. Claimant was bending at her knees and waist over the patient and the patient had her arms around claimant's neck. The patient pulled claimant down to her chest. This caused claimant to fall to her knees on the floor, landing with her chest in the patient's lap. Claimant felt a "pull" in her neck, but the symptoms were not bad at that time.

3. Claimant told a coworker, S, about the incident, but she did not otherwise report the injury at that time.

4. Claimant worked the rest of that day and then had three days scheduled off work. During her time off, she suffered increasingly severe symptoms of pain radiating from her neck into her arm. She awoke on September 11, 2008, with pain in her neck and shoulder. By September 13, 2008, claimant was experiencing excruciating pain.

5. On September 14, 2008, claimant awoke in a lot of pain. She returned to work at 6:00 a.m. She informed her supervisor, Ms. J, about the work injury. Ms. J confirmed at hearing that claimant appeared to be in pain and had difficulty moving her neck. Ms. J telephoned her own supervisor, Ms. H-J, to report claimant's injury. Ms. H-J advised Ms. J to have claimant seek treatment for the injury. When the shift was over, Ms. J accompanied claimant to Emergicare, where Dr. Reasoner examined her.

6. Dr. Reasoner referred claimant to Colorado Springs Imaging for a magnetic resonance image ("MRI") and recommended a course of physical therapy at Excel Physical Therapy. Dr. Reasoner's office contacted Excel Physical Therapy and Excel later called claimant to set up an appointment.

7. The September 15, 2008, MRI showed mild degenerative changes of the C5-6 disc with dessicated disk bulge and mild cord compression, mild degenerative changes at C6-7 causing bilateral neural foraminal narrowing, and C4-5 degenerative changes with a minimal posterior dessicated disk bulge.

8. On October 1, 2008, Dr. Reasoner diagnosed cervical strain with radiculopathy. He imposed restrictions against lifting over 20 pounds. Ms. J received the restrictions. Claimant continued to work without missing any time. Claimant received only a portion of the scheduled physical therapy sessions. Treatment was interrupted when the insurer denied authorization for the treatment.

9. Claimant has proven by a preponderance of the evidence that she suffered an accidental injury on September 10, 2008, arising out of and in the course of her employment with the employer. Claimant's testimony is supported by the testimony of her supervisor, Ms. J, and is found credible.

10. The preponderance of the evidence demonstrates that the treatment by Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging was authorized and was reasonably necessary to cure or relieve the effects of the work injury. Claimant reported the injury to her employer, who failed to refer her to a specific provider. Claimant was impliedly authorized to choose her provider. Dr. Reasoner then referred claimant to Excel Physical Therapy and Colorado Springs Imaging, who are also authorized providers.

CONCLUSIONS OF LAW

1. 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). 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).

2. 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). Respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial*

Commission, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. As found, all of the treatment by Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging was authorized and reasonably necessary to cure or relieve the effects of claimant's work injury.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for the work injury, including the bills of Dr. Reasoner, Excel Physical Therapy, Colorado Springs Imaging, according to the Colorado fee schedule.
2. All matters not determined herein are reserved for future determination.

DATED: December 19, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-709-664

ISSUES

¬ Are the respondents relieved of liability for the claimant's back surgery, intensive care treatment, and detoxification treatment because the claimant "fraudulently" concealed pertinent medical information, concerning his use of illegal narcotics and tobacco, from his treating physicians?

¬ Did the claimant prove by a preponderance of the evidence that the intensive care treatment and the detoxification treatment were causally related to the industrial injury, and that these treatments were reasonable and necessary?

¬ Did the respondents prove by a preponderance of the evidence that the claimant's use of tobacco constituted an injurious practice justifying reduction of his temporary disability benefits under § 8-43-404(3)?

¬ Are the respondents relieved of liability for the claimant's temporary total disability benefits because the claimant's "worsened condition" was procured by fraud?

FINDINGS OF FACT

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

1. The claimant sustained an admittedly compensable low back injury on December 27, 2006. The claimant was involved in a motor vehicle accident (MVA) when his car was sideswiped by a hit and run driver.

2. The claimant was ultimately diagnosed with an L2 compression fracture and disc protrusion at L3-4.

3. Dr. Sander Orent, M.D. became an authorized treating physician (ATP) on May 14, 2007. In July 2007, Dr. Orent referred the claimant to Dr. Michael Shen, M.D. for a surgical opinion. Dr. Shen diagnosed signs of an L3-4 disc herniation and an L2 "burst fracture" resulting in spinal instability. Dr. Shen recommended surgical intervention consisting of fusion at L2 and decompression of the L3-4 disc space.

4. The respondents disputed the cause of the need for the surgery, as well as the reasonableness and necessity for the surgery. The ALJ takes administrative notice that the issue of the respondents' liability for the surgery proceeded to hearing February 13, 2008. The ALJ further takes notice that on April 15, 2008, he entered Findings of Fact, Conclusions of Law, and Order directing the respondents to pay for the proposed surgery and the reasonable and necessary expenses ancillary to the surgery.

5. The ALJ infers that there was no appeal of the April 15, 2008, order, since Dr. Shen proceeded with the recommended surgery on June 9, 2008, and the respondents have not asserted that they appealed the order.

6. Prior to the June 9, 2008, surgery the claimant's treating physicians prescribed narcotic pain medications for relief of the injury-related back and leg pain. On September 6, 2007, Dr. Orent expressed concern that because the proposed surgery had been delayed and the pain was being controlled by oxycodone, the claimant was developing an iatrogenic addiction to narcotic pain medication.

7. The claimant also smoked cigarettes for many years prior to his industrial injury. On July 20, 2007, Dr. Chen warned the claimant that it was important that he stop smoking before surgery. The claimant admitted at hearing that he "knew they would not do the surgery" if any tests demonstrated the presence of nicotine in his body and that it was important to quit smoking.

8. On September 6, 2007, the claimant advised Dr. Orent that he had quit smoking.

9. On February 19, 2008, Dr. Lawrence Lesnak, D.O., saw the claimant on referral from Dr. Orent. Dr. Lesnak had previously been involved in the claimant's care. On Feburary 19, the claimant advised Dr. Lesnak that his analgesic medications, including MS Contin, were not working as well as they had in

the past. Dr. Lesnak stated that in light of the claimant's worsening symptoms "he most likely is building up somewhat of a tolerance to his opioid medication."

10. The anesthesia record for the surgery performed on June 9, 2008, states the claimant gave a history that he quit smoking two months ago.

11. Following the surgery the medical providers had extreme difficulty controlling the claimant's pain. The claimant was transferred to the intensive care unit where he was treated with narcotic medications.

12. On June 10, 2008, Dr. Philip Emrie, M.D., examined the claimant for consultation concerning "medical critical care issues postoperatively after spine surgery." At the time of the examination the claimant was sedated and unable to give an accurate history. However, Dr. Emrie noted that the claimant's "girlfriend" gave a history of chronic severe pain for which the claimant was receiving morphine and Dilaudid, and that the claimant had been "supplementing with illegally obtained fentanyl and Oxycontin." The history further states the claimant had been consuming significant quantities of vodka (1L per day). The note further states the claimant was a long-time smoker and he "continued to smoke until this hospitalization." Dr. Emerie's impression was narcotic dependence, a history of alcohol abuse with withdrawal symptoms, and tobacco abuse."

13. On June 10, 2008, the Dr. Phillip Engen, M.D., also examined the claimant. Dr. Engen's note states that the claimant had severe postoperative pain and "on the evening of his surgical procedure he did admit to nursing staff and physicians that he utilized opioid analgesics and he obtained these from illegal sources." Dr. Engen further noted the claimant "verbalized that he obtained approximately 100 to 300 mg of morphine and an unknown quantity milligram amount of Delaudid every day from an individual that he described as a man from Germany." The claimant advised Dr. Engen that he "spent approximately $150 or $200 a day obtaining these medications and he utilized his own savings and then borrowed money from his sisters to obtain this daily opioid analgesic." Dr. Engen diagnosed primary substance abuse "opiate analgesics and/or alcohol." Dr. Engen stated that these conditions would need to be addressed before the claimant left the hospital because he would not be in a position to utilize opiod medications appropriately. Dr. Engen referred the claimant to "West Pines" for "alcohol and opioid addiction eval and detox."

14. On June 21, 2008, the claimant was treated at the Exempla Lutheran emergency department for what he believed was a wound infection. At that time the claimant gave a history of smoking .3 packs of cigarettes per day, and denied drug abuse.

15. Dr. Orent credibly testified that he advised the claimant before surgery that he needed to be off tobacco in order to maximize the likelihood of hav-

ing a successful procedure. Dr. Orent "monitored" the claimant's use of tobacco by history, but did not perform any urinary continine tests before surgery.

16. Dr. Orent credibly testified that on June 23, 2008, the claimant admitted to him that he had been "abusing pharmaceuticals" that were probably narcotic, and had been abusing alcohol.

17. Dr. Orent credibly opined that the claimant's complications after surgery, including treatment in the ICU were "in part" caused by the abuse of narcotics, some of which were prescribed and some of which were purchased "on the street." Dr. Orent explained that he believed the claimant's "opiate receptors were taken up by these narcotics and it was very difficult to get pain relief and sedation simply because he had enough on board that – or the body gets resistant to it; it develops a tolerance to these medications." Dr. Orent testified that he would have considered it a "material fact" that the claimant was using non-prescribed narcotics, and that if he had known that fact the surgery would probably have been delayed pending detoxification.

18. Dr, Orent credibly testified that if the claimant continued smoking up to the time of the surgery, and if he had known of that fact, he would have recommended that surgery be delayed until after the claimant quit smoking. Dr. Orent credibly testified that tobacco use can hamper the claimant's recovery from surgery by interfering with the process of bone fusion.

19. Dr. Shen credibly testified that chemicals in cigarettes have been shown to decrease the rate of bone fusion, and are associated with wound complications and infections.

20. Dr. Shen testified that if he had known before surgery that the claimant was using illegally obtained medications he would have considered the fact to be material information, and he probably would not have proceeded with the surgery.

21. Dr. Shen credibly testified at his deposition held on September 18, 2008, that the claimant had just undergone a drug and nicotine screen. According to Dr. Shen, the results showed the presence of prescribed medications, which Dr. Shen considered normal, as well as the presence of "traces of nicotine." Dr. Shen credibly opined that the presence of nicotine was of concern because "it could absolutely decrease his chances of successful fusion, successful outcome."

22. The claimant testified that he had quit smoking, although he admitted that he sometimes takes a few "puffs" on cigarettes provided by friends. The ALJ finds the claimant's testimony that he has stopped smoking is not credible. The claimant's testimony is not credible because he has repeatedly misrepresented the truth about his smoking habits. Although the claimant told Dr. Orent

that he had quit smoking in September 2007, the anesthesiology notes reflect the claimant gave a history that he quit smoking only two months before the June 2008 surgery. The history obtained by Dr. Emrie from the claimant's "girlfriend" shows the claimant actually continued smoking up to the date of surgery. The claimant told the Exempla emergency room staff that he was still smoking .3 packs per day 12 days after the surgery. The tests provided by Dr. Shen in September 2008 showed the presence of nicotine in the claimant's system.

23. The claimant proved it is more probably true than not that the industrial injury was a proximate cause of the need for treatment in the ICU, and for the detoxification treatment recommended by Dr. Engen. The ALJ is persuaded that, although the claimant illegally procured narcotic medication and failed to disclose this information to Dr. Orent and Dr. Shen, the claimant's activities were not the sole cause of his addiction to opioid medication and alcohol prior to the surgery of June 9, 2008. The record establishes that well before surgery Dr. Orent and Dr. Lesnak expressed concern that the claimant was becoming tolerant of and perhaps addicted to the narcotic pain medications that they were prescribing for treatment of the injury-related back and leg pain. The ALJ infers from these concerns that the claimant's addiction to narcotic pain medication, and to some extent the consequent need for treatment in the ICU and detoxification, were caused by the industrial injury. Specifically, the injury caused pain, which in turn caused the treating physicians to prescribe large amounts of narcotic medication. These prescriptions contributed to the claimant's addiction and abuse of narcotic pain medication. Although the ALJ finds that the claimant procured drugs illegally, and that these personal activities were part of the cause of the need for treatment in the ICU and for detoxification, the claimant's personal drug seeking activities combined with the effects of the industrial injury to produce the need for treatment in the ICU and for detoxification.

24. The claimant proved it is more probably true than not that the treatment at the ICU and the detoxification treatment were reasonable and necessary treatments. The medical reports of Dr. Engen, as well as the credible testimony of Dr. Orent and Dr. Shen, establish the surgery combined with the claimant's addiction to narcotic pain medication to produce a need for stabilization in the ICU, as well as the need for detoxification.

25. On June 17, 2008, the respondents filed a General Admission of Liability admitting for temporary total disability (TTD) benefits commencing June 9, 2008, the date of the claimant's surgery.

26. The respondents proved it is more probably true than not that the claimant, by continuing to smoke both before and after the surgery, has persisted in an injurious practice that tends to imperil his recovery. Dr, Shen and Dr. Orent credibly testified that smoking tends to impair recovery from fusion surgery by promoting nonunion of the affected bones. The evidence also demonstrates that smoking can increase the likelihood of infection. The claimant admitted that he

was warned that he needed to stop smoking well before the surgery. Despite this warning the claimant continued to smoke until the date of the surgery, and lied to the medical providers concerning his continued smoking. The persuasive evidence including the nicotine test performed by Dr. Shen establishes the claimant has continued to smoke since the surgery. As found, the claimant's testimony that he has stopped smoking is not credible.

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, 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.

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. 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).

DENIAL OF PAYMENT FOR SURGERY BASED ON ALLEGED FRAUD

The respondents contend they are not liable to pay for the surgery performed on June 9, 2008, because the claimant fraudulently induced his physicians to perform the surgery by concealing the fact that he continued to smoke before the surgery, and by failing to disclose his alleged addiction to "illegal pain narcotics." The ALJ concludes the respondents' liability for the surgery was determined by the ALJ's order of April 15, 2008, and the issue may not be reconsidered without the filing of a petition to reopen and proceedings on the petition.

As found, the ALJ entered Findings of Fact and Conclusions of Law on April 15, 2008, that required the respondents to pay for the surgery performed on the claimant's back on June 9, 2008. The ALJ infers the respondents' did not appeal this order since the surgery was performed.

It follows that the ALJ's order became an "award" that closed the issue of the respondents' liability to pay for the surgery. An order becomes an "award" by the exhaustion of or the failure to exhaust administrative review proceedings. *Koch Industries, Inc. v. Pena,* 910 P.2d 77 (Colo. App. 1995). An order that becomes final in this manner precludes any proceedings to increase or decrease benefits beyond those granted by the order absent an appropriate order reopening the proceedings." *Feeley v. Industrial Claim Appeals Office,* __P.3d__ (Colo. App. No. 07CA1389, September 4, 2008); *B & Root, Inc. v. Industrial Claim Appeals Office,* 833 P.2d 780 (Colo. App. 1992).

Although "fraud" constitutes a ground for reopening an award of medical benefits under § 8-43-303, C.R.S., the respondents have not filed a petition to reopen the ALJ's award of April 15, 2008. The ALJ concludes that the failure to file a petition to reopen as contemplated by § 8-43-303 and WCRP 7-3 is fatal to the respondents' argument that they are not liable for the surgery because the claimant procured it by fraud. The requirement to file a petition to reopen is no mere formality in the circumstances of this case. The respondents would be required to establish not only that the claimant engaged in fraudulent conduct that induced the surgery, but also that the claimant's conduct constitutes the type of fraud that warrants exercise of the ALJ's discretionary power to reopen. *See Travelers Insurance Co. v. Industrial Commission,* 646 P.2d 399 (Colo. App. 1981); *Calderon v. SBM Cleaning Co., LLC,* W.C. No. 4-526-764 (ICAO, February 18, 2004).

The evidence presented in this case raises at least a plausible argument that even if the claimant concealed information from his physicians his conduct is not the type of "fraud" that would warrant reopening under the circumstances. There is evidence, including the October 2007 deposition of Dr. Orent, that the claimant's smoking habit was well known to his physicians, and to the respondents, long before surgery. Similarly, the September 2007 medical records of Dr. Orent express concern about the claimant's possible addiction to narcotic medications. It could be argued that these issues should have been investigated and raised at the February 2008 hearing. Because the respondents have never filed a petition to reopen the issue of their liability for surgery decided by the ALJ's order of April 15, 2008, the claimant has not been afforded a fair opportunity to present evidence and make argument with respect to the discretionary aspect of the reopening issue. Therefore, this is not a case in which the ALJ will treat the respondents' application for hearing as a *defacto* petition to reopen. *Cf. Lewis v. Scientific Supply Co., supra*.

DENIAL OF PAYMENT FOR ICU AND DETOX TREATMENT BASED ON ALLEGED FRAUD

The respondents allege that they are not liable for the ICU treatment and post-surgery detoxification treatment he received because the claimant fraudulently concealed the fact that he continued smoking before surgery, and concealed his pre-surgery addiction to narcotic pain medication. The ALJ concludes that the respondents may not avoid liability for these medical benefits on the ground of fraud because the claimant's alleged misconduct falls within the ambit of § 8-43-404(3), C.R.S., and that statute does not provide for reduction or suspension of medical benefits as a remedy for engaging in an injurious practice or refusing reasonable medical treatment.

Section 8-43-404(3) 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. (Emphasis added).

Prior to 1997, the Act contained no explicit remedy for respondents in cases where a claimant procured workers' compensation benefits by committing "fraud." Rather, a remedy for fraudulent conduct existed only to the extent that such a remedy could be inferred or implied by existing provisions of the Act. *See Kraus v. Artcraft Sign Co.,* 710 P.2d 480 (Colo. 1985); *Lewis v. Scientific Supply Co.,* 897 P.2d 905 (Colo. App. 1995). The only exception to this rule existed where the claimant provided materially false information to the employer or insurer on which they relied when filing an admission of liability. In such cases the admission could be found "void *ab initio*." *Vargo v. Industrial Commission,* 626 P.2d 1164 (Colo. App. 1981). However, in 1997 the General Assembly amended § 8-43-303, the reopening statute, to provide that "fraud" is a ground for reopening, and providing that a reopening based on fraud may affect moneys already paid. 1997 Colo. Sess. Laws, ch. 45, at pp. 114–115.

The ALJ concludes that prior to 1997 § 8-43-404(3), at least implicitly, provided remedies for specific types of claimant misconduct that could be classified as "fraudulent." Specifically, in cases where a claimant misrepresented to his treating physicians material facts concerning his health, and these misrepresentations tended to imperil or retard the claimant's recovery, such conduct could be sanctioned under § 8-43-404(3) as an "injurious practice." Similarly, if a claimant misrepresented his habits or physical condition to the treating physicians, and these misrepresentations were material to the physicians' choice of treatment, such misrepresentations could be sanctioned as a deliberate "refusal" to submit to reasonably essential medical care. Indeed, it may be safely assumed that

most medical treatment is predicated, at least in part, on the patient's truthful rendition of his health history as solicited by the physician. Further, falsification or concealment of one's medical history upon request for a history by the treating physician is as much a refusal to submit to reasonable care as is intentionally missing prescribed physical therapy appointments.

Of course § 8-43-404(3) expressly limits the remedies for persisting in an injurious practice or refusing to submit to treatment to reduction or suspension of "compensation." The term "compensation" as it is used in the Act has usually been construed as excluding medical benefits, particularly where the statute in question is in the nature of a "penalty" statute. *See Support Inc. v. Industrial Claim Appeals Office,* 968 P.2d 174 (Colo. App. 1998); *Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 905 P.2d 6 (Colo. App. 1995) (*Wild West* II), *reaffirming Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 886 P.2d 304 (Colo. App. 1994) (*Wild West* I). As explained in *Wild West* I, the two primary purposes of a loss-distribution system such a workers' compensation are to make the victim whole and see that the loss falls on the actual wrongdoer. Further, in workers' compensation, the "policy of making the worker whole is more important than placing the cost on the wrongdoer." (*Wild West* I).

The ALJ concludes that the term "compensation" as it is used in the last sentence of § 8-43-404(3) does not authorize the reduction or suspension of medical benefits. As with the statutes at issue in *Support Inc.* and *Wild West* I & II, § 8-43-404(3) is in the nature of a "penalty" statute because it permits the reduction or suspension of compensation based on misconduct of the claimant rather than the compensability of the injury itself. Moreover, to disallow medical benefits based on the claimant's misrepresentations to a treating physician might well place the ultimate loss on the physician, not the claimant as wrongdoer.

The ALJ concludes that the fraudulent conduct alleged by the respondents in this case, the claimant's misrepresentation and/or concealment of material facts from the treating physicians, constitutes a form of "injurious practice" tending to imperil or retard the claimant's recovery from surgery within the meaning of § 8-43-404(3). Similarly, these actions constitute a form of refusal to submit to reasonable medical treatment. Indeed the respondents acknowledge this fact since the basis of their argument is that if the claimant had disclosed his smoking and drug use the surgery would not have occurred. If the surgery had not occurred then the claimant would not have needed detoxification or treatment in the ICU, and his recovery from the surgery would not have been imperiled.

It follows from this discussion that the Act now contains at least two provisions that arguably address the remedy for the particular type of fraud that is alleged to have occurred in this case. First there is the general authority to redress fraud by ordering repayment as provided in § 8-43-303. Second there is the authority to sanction injurious practices and refusal to submit to treatment as provided in § 8-43-404(3).

The question arises whether the remedy for the type of fraud alleged in this case encompasses an order absolving the respondents of all liability for the resulting medical treatment, or whether the remedy is limited to reducing or suspending "compensation" under § 8-43-404(3). As a general matter, the object of statutory construction is to effectuate the legislative intent by giving words and phrases their plain and ordinary meanings. *Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176 (Colo. App. 2002). Statutes that address the same subject matter should be construed together. *Spracklin v. Industrial Claim Appeals Office, supra*. Further, a specific statutory provision prevails over a general provision unless the general provision was enacted later in time and the General Assembly demonstrated a clear intent that the general provision should prevail. *Freemeyer v. Industrial Claim Appeals Office,* 32 P.3d 564 (Colo. App. 2000).

Here, § 8-43-303 permitting a case to be reopened based on fraud is a general statute that was enacted later than § 8-43-404(3). Section 8-43-404(3) is a specific statute providing remedies to respondents for injurious practices by a claimant that tend to imperil or retard recovery. As noted, fraudulent concealment of relevant medical information from treating physicians can constitute such an injurious practice where it imperils or retards recovery or may constitute refusal to submit to treatment. The ALJ perceives no indication that by enacting § 8-43-303 the General Assembly intended to enlarge the scope of remedies available to respondents for conduct that amounts to an injurious practice under § 8-43-404(3) merely because such conduct might also meet the technical definition of fraud. *Cf. Wild West Radio, Inc. v. Industrial Claim Appeals Office,* 905 P.2d 6 (Colo. App. 1995) (where statute provides a 50% reduction in compensation when an injury results from intoxication the General Assembly has not evidenced an intent to preclude all compensation for injuries resulting from intoxication).

Therefore, the ALJ concludes that even if the claimant fraudulently misrepresented or concealed his smoking and narcotic addiction from Dr. Orent and Dr. Shen, and these actions caused the doctors to proceed with a surgery they would not otherwise have performed, such fraud would not excuse the respondents from liability for the surgery or the subsequent ICU treatment and detoxification treatment. Rather, such concealment is a form of injurious practice that tends to imperil or retard recovery, and a form of refusal to submit to reasonable treatment, and the remedies for such actions are specifically limited by § 8-43-404(3). Those remedies do not include relief of liability for medical treatment.

CAUSE OF NEED FOR ICU AND DETOXIFICATION TREATMENT

The respondents contend the claimant failed to prove that the need for the ICU and the detoxification treatment recommended by Dr. Engen are causally related to the industrial injury. Rather, the respondents assert that the cause of the need for these treatments was the claimant's personal addiction to alcohol and narcotics. The ALJ disagrees with this argument.

Section 8-41-301(1)(c), C.R.S., requires that an injury be "proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment." Thus, the claimant must prove a causal nexus between the need for treatment and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). However, the industrial injury need not be the sole cause, or even the predominant cause, of the need for medical treatment if it is a significant, direct, and consequential factor in the need for treatment. *Resources One v. Industrial Claim Appeals Office,* 148 P.3d 287 (Colo. App. 2006); *Joslins Dry Goods Co. v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001); *Seifried v. Industrial Commission,* 736 P.2d 1262 (Colo. App. 1986); *Nicholl v. Canino Sausage Co., Inc.,* W.C. No. 4-473-725 (ICAO March 10, 2003). 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).

As determined in Finding of Fact 23, the claimant proved it is more probably true than not that industrial injury was a proximate cause, although not the sole cause, of the need for treatment in the ICU and for detoxification treatment. The ALJ has found that the industrial injury caused pain, which in turn caused the treating physicians to prescribe large amounts of narcotic pain medication. Indeed, prior to surgery two of the treating physicians expressed concern about the amount of addictive medication being prescribed to the claimant. Thus, the fact that the claimant became resistant to opioids was, in part, attributable to the prescribed treatment for the industrial injury. In these circumstances, the claimant established the requisite causal connection between the industrial injury and the need for treatment in the ICU and for detoxification. *Cf. White v. Platte River Plumbing,* W.C. No. 4-399-491 (ICAO July 25, 2000).

REASONABLENESS AND NECESSITY FOR ICU TREATMENT AND DETOXIFICATION TREATMENT

The respondents also argue the claimant failed to prove the ICU treatment and detoxification treatment were reasonable and necessary medical treatment. Essentially, this argument is a reiteration of the argument that the treatment was solely for purposes of treating the personal aspect of the claimant's addictions.

Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treat-

ment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

The ALJ has determined the claimant proved a causal connection between the industrial injury and need for the ICU and detoxification treatments. Further, as determined in Finding of Fact 24, the claimant proved the ICU treatment and detoxification treatment were reasonably necessary to relieve the effects of the injury.

SANCTIONS FOR INJURIOUS PRACTICE

The respondents contend the evidence establishes the claimant persists in using tobacco, and that the continued use of tobacco constitutes an injurious practice that tends to imperil or retard his recovery from the injury and surgery. Relying on § 8-43-404(3) the respondents seek an order reducing the claimant's indemnity benefits based on the injurious practice. The ALJ concludes the claimant's temporary total disability benefits should be suspended until such time as he establishes that he has stopped smoking, or that smoking no longer imperils and/or retards his recovery.

As noted above, § 8-43-404(3) grants the ALJ discretionary authority to reduce or suspend compensation where the claimant persists in any injurious practice tending to imperil or retard recovery. Because this statute provides for a reduction or suspension of compensation to which the claimant is otherwise entitled, the respondents bear the burden of proof to establish the facts permitting imposition of the statutory sanctions. *See Padillo v. F. H. Linneman Construction Co.,* 29 Colo. App. 137, 479 P.2d 990 (1971).

As determined in Finding of Fact 26, the respondents proved it is more probably true than not that the claimant persists in the practice of smoking, and this practice tends to imperil his recovery from the fusion surgery. The ALJ, in the exercise of his discretion, concludes the claimant's TTD benefits should be suspended commencing the date of this order and continuing until such time as the claimant establishes that he has stopped smoking, or that the continuance of smoking no longer imperils his recovery. The ALJ declines to impose an absolute reduction in the claimant's compensation since the ALJ is not persuaded that the continuance of the smoking has actually interfered with or damaged the claimant's recovery. The persuasive testimony of Dr. Orent and Dr. Shen is to the effect that there is a risk to the claimant's recovery, not that the risk has actually been realized.

ENTITLEMENT TO TTD BENEFITS

The respondents state that they admitted liability for TTD benefits commencing June 9, 2008, the date of surgery, based on the decision in *Anderson v. Longmont Toyota, Inc.,* 102 P.3d 323 (Colo. App. 2004). According to the respondents, they demonstrated at the previous hearing that the claimant was re-

sponsible for "his termination after he took dozens of roses from his employer's refrigerator." The respondents assert that because claimant's "surgery was procured as a result of fraudulent statements to his treating physicians," his "worsened condition can not be held to be related to his industrial injury."

This argument appears to be a reiteration of the respondents' argument that the claimant's allegedly fraudulent statements severed any causal relationship between the industrial injury and the subsequent disability and need for treatment. The ALJ has already rejected the argument on grounds that the causal interaction between the treatment for the injury and the effects of the claimant's personal misconduct does not sever the requisite causal relationship. Rather, under the Act, the claimant's injurious practices tending to imperil or retard recovery are subject to the discretionary sanctions permitted under § 8-43-404(3).

ORDER

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

1. The insurer shall pay for the claimant's surgery on June 9, 2008, his ICU treatment, and any detoxification treatment related to the surgery and its aftermath.

2. The claimant's right to receive temporary total disability benefits shall be suspended as of the date of this order, and that suspension shall continue in effect until the claimant demonstrates that he is no longer engaged in the injurious practice of using tobacco, or that tobacco use no longer imperils and/or retards his recovery.

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

DATED: December 22, 2008

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-755-149

ISSUES

¬ Has claimant proven by a preponderance of the evidence that her ongoing shoulder complaints are related to her work activities?

FINDINGS OF FACT

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

1. Since 1995, claimant has worked for employer as a data specialist at the remittance processing center, processing payment of bills. A data specialist generally operates various machines to sort customer payments and to extract payment coupons and checks from envelopes. Once the payment coupons and checks have been extracted, the information on these coupons and checks are digitally captured. Finally, a data specialist will input the digitally captured data into a computer with the use of a keyboard (keying).

2. Since January of 2006, claimant has only worked on one of the rapid extraction machines, the OPEX 51 (hereinafter referred to as the "RED" machine). Claimant has also only worked in keying. Consequently, claimant has not performed the full range of duties of a data specialist since January of 2006. Employer assigned claimant to the RED machine and to keying in order to accommodate physical activity restrictions imposed because of a prior, work-related, lower back injury.

3. On March 21, 2008, claimant filed a Workers' Claim for Compensation (WCC), claiming an occupational disease-type injury to her right shoulder and arm allegedly caused by repetitive motion from opening mail and keying. Claimant testified:

> [W]hen you extract a lot of mail and you're using your arm a lot, your hand, you're reaching out, you're constantly. **It just started aching my whole arm. And it just starting swelling up this day that I just couldn't even move it.** My hand and my arm.

(Emphasis added). Although her testimony here was vague, claimant more likely attributes her right upper extremity symptoms to constant reaching with her right arm. Claimant alleges a date of onset of symptoms of January 10, 2008.

4. BG is claimant's supervisor. Although Ms. G completed a job profile for the data specialist position, claimant's work on the RED machine and keying is physically less demanding. The job profile thus fails to adequately describe the less physically demanding work claimant has performed on the RED machine and keying since January of 2006.

5. Ms. G testified about the physical demands of working on the RED machine. Essentially, the operator sits at the station on an adjustable chair. At this station, the operator performs the majority of activity at table level. The RED machine opens each envelope, one at a time, and places the envelope at table

level directly in front of the operator. The RED machine opens the envelope in such a manner that the operator can easily pull the contents out, separate them, and place them in their respective receptacles, all at table level. This activity involves very little reaching. The operator occasionally reaches for scissors, staple remover, or other tools. This Judge finds that Ms. G's testimony regarding the physical demands of working on the RED machine is persuasive.

6. Ms. G credibly testified that, in order to comply with restrictions from her lower back injury, claimant would rotate activity every two hours between opening mail on the RED machine and keying. In performing keying, claimant's physical activities involved nothing more than using a keyboard on a computer to enter data. Claimant was required to do no reaching at or above shoulder level. Crediting Ms. G's testimony concerning the level of exposure to operating the RED machine versus keying, the Judge finds: In 2006, claimant worked less than 30% of her hours on the RED machine, and over 70% keying. In 2007, claimant worked less than 25% of her hours on the RED machine, and over 75% keying.

7. Respondents' Exhibit A is a videotape that depicts an individual performing the job activities on the RED machine and keying. Exhibit A corroborates Ms. G's testimony as to claimant's activities on the RED machine and the data entry position.

8. Respondents' submitted performance summaries for claimant's job as a data specialist for the calendar years 2006 and 2007. These performance summaries document the length of time that claimant worked on particular machines for the calendar years 2006 and 2007. A clock is installed on each piece of equipment at the remittance processing center. Each data specialist has an ID that is used when they log into work at that particular piece of equipment. The clock captures the amount of time that each employee works on each piece of equipment during the day. The performance summaries generated for claimant in 2006 demonstrated that she worked on the RED machine for no more than 30% of the time. The 2007 performance summary documents that claimant only worked on the RED machine for 25% of the time. These performance summaries corroborate Ms. G's testimony that claimant worked no more than 30% of the time on the RED machine in 2006, and no more than 25% on the RED machine in 2007. Claimant's co-worker, CZ, testified at hearing that the clocks on these machines may not provide completely accurate information at all times. However, Ms. Z's testimony failed to persuasively show that claimant's performance summaries are unreliable for purposes of providing information showing her relative exposure to certain work activities at work.

9. Claimant testified that she believed she spent her entire 8-hour shift working on the RED machine in 2007. Claimant's testimony is markedly discrepant from the performance summaries showing she at most worked some 25% of her time operating the RED machine in 2007. Claimant's testimony concerning

her exposure to certain work-related activity, such as operating the RED machine, was unreliable and contrary to the weight of other credible evidence.

10. Employer referred claimant to Julie Parsons, M.D., who first examined her on January 14, 2008. Claimant reported to Dr. Parsons a history of progressive right arm pain for several years that worsened over the prior weekend. Dr. Parsons diagnosed right shoulder, forearm, and wrist strain. Dr. Parsons referred claimant for physical therapy and restricted her from using her right upper extremity. Dr. Parsons discontinued physical therapy on January 22, 2008, when claimant reported it making her arm considerably worse. Dr. Parsons nonetheless instructed claimant to use her right arm while alternating repetitive activities. Dr. Parsons reduced claimant's restrictions to no overhead work with the right arm.

11. On February 6, 2008, claimant reported to Dr. Parsons worsening right shoulder symptoms from walking activity the previous Saturday. Claimant reported that her right wrist and forearm symptoms were resolving. Dr. Parsons recommended claimant undergo a magnetic resonance imaging (MRI) scan of her right shoulder to rule out impingement or other shoulder pathology. Dr. Parsons reevaluated claimant on February 13, 2008, and reported that the MRI showed only mild tendinosis of the anterior supraspinatus, but was otherwise a normal shoulder study.

12. Because of claimant's complaints of worsening shoulder symptoms, Dr. Parsons referred her to Orthopedic Surgeon Christopher Isaacs, D.O., for an evaluation on February 19th. Dr. Isaacs administered a diagnostic/therapeutic steroid injection and continued her physical therapy. Claimant reported to Dr. Isaacs on March 10, 2008, that the injection did not help and that physical therapy was aggravating her shoulder. Claimant reported that she was deteriorating rather than improving. Based upon the history claimant gave him, Dr. Isaacs attributed claimant's shoulder symptoms to her work at employer. Dr. Isaacs recommended arthroscopic surgery to decompress the subacromial space of claimant's right shoulder. Because Dr. Isaacs based his causation opinion upon what claimant reported, and not upon the videotape, the Judge finds Dr. Isaacs's medical opinion unreliable.

13. In a report dated March 11, 2008, Dr. Parsons stated that claimant's work activities were the cause of her shoulder symptoms. There is no suggestion in Dr. Parsons' March 11, 2008, report that, as part of the data that she used in her causality analysis, she reviewed any video of an individual performing claimant's work activities, or that she spoke directly with Ms. G to obtain Ms. G's description of what claimant was actually doing for the period of time two years before the onset of her symptoms. Because Dr. Parsons did not base her causation opinion on any video of someone actually performing claimant's job for the last two years, nor on any information obtained directly from Ms. G, the Judge finds Dr. Parsons' medical opinion unreliable.

14. Employer referred claimant to Physiatrist Nicholas K. Olsen, D.O., for an independent medical examination on June 27, 2008. Claimant reported to Dr. Olsen that she spent 90% of her time working on the RED machine and 10% using the 10-key. Claimant reported that her symptoms began in the fall of 2007. Claimant reported that the injection by Dr. Isaacs temporarily increased her pain and then did not help. Upon physical examination, claimant stated to Dr. Olsen that she was unable to raise her right arm due to pain. Claimant reported that her arm swells and turns purple at times. As part of his evaluation, Dr. Olsen also reviewed a videotape of Claimant's work activities. Dr. Olsen, in his deposition, acknowledged that Exhibit A was the same videotape that he reviewed during his evaluation. Dr. Olsen noted that the videotape of claimant's work activities allowed her to keep her upper extremities well below shoulder height. Dr. Olsen opined it medically improbable that work activity depicted on the videotape caused her shoulder symptoms; he wrote:

> One would anticipate tendonitis developing in an individual who does over-the-shoulder/head work on a repetitive basis. These type of activities are not demonstrated in the video … and not reported by [claimant].

Dr. Olsen noted that the MRI scan was benign and failed to show any surgical lesion. Dr. Olsen opined that claimant is not a surgical candidate and that her symptoms were best addressed with the physical therapy program she already underwent.

15. Employer referred claimant to Orthopedic Surgeon Mark S. Failinger, M.D., for a second opinion and examination on August 25, 2008. Dr. Failinger, during his September 12, 2008, deposition, acknowledged that he was not specifically asked to address the causality of Claimant's right shoulder problems as part of his evaluation. Rather, Dr. Failinger was only asked to provide a second opinion as to whether Claimant was a surgical candidate. Nevertheless, Dr. Failinger obtained a detailed history of claimant's work activities, which she described as reaching in front of her body and repetitively reaching to eye level or above. Based upon this history, Dr. Failinger opined it medically probable claimant could have developed supraspinatus tendonitis from this frequent reaching activity. Dr. Failinger however expressed significant concerns about claimant undergoing arthroscopic decompression. Dr. Failinger opined that claimant's symptoms were diffuse and increasing when they should be decreasing because of inactivity. Dr. Failinger further wrote:

> A further concern is her diffuse nature of pain and discomfort including tingling and numbness and **significant pain reaction from**

> **what is in general a mild to moderate problem** in the face of no major rotator cuff tears or major inflammation shown on the MRI.

(Emphasis added). Dr. Failinger opined that claimant's presentation and response to treatment militated against surgical intervention because he felt it unlikely she would improve from surgery.

16. Dr. Failinger later reviewed a videotape of claimant's work activities at the employer. During his deposition, Dr. Failinger also verified that Exhibit A was the videotape that he had reviewed. Based on his review of the videotape, Dr. Failinger changed his opinion on causation. In his September 3, 2008, report, Dr. Failinger wrote the following:

> The video appeared to contradict the history given to me by [claimant] in which she stated that she reaches consistently and repetitively, reaching to head level or above. I did not observe any reaching overhead to pick up trays …. In the videotape, the person reaching for the mail intermittently would reach to approximately 50-60 [degrees] and, otherwise, had repetitive activities with her forearms and elbows and wrists, with shoulders in very low ranges of forward flexion. In the computer data entry, I did not see any significant reaching of the shoulder except in the very low ranges.

Dr. Failinger's above-quoted description is consistent and supported by the videotape depiction. Dr. Failinger opined it medically improbable that claimant's work activities caused any persistent rotator cuff tendonitis.

17. Dr. Olsen testified as an expert in Physiatry, Electrodiagnostic Medicine, and Level II Accreditation. Dr. Olsen testified:

> We haven't really defined what pathology needs to be addressed in surgery. There was a cortisone injection performed which didn't offer a lot of help. And given that the symptoms aren't classic for rotator cuff, that there isn't really any pathology in the MRI that would respond to surgery, it really raises doubt whether or not surgery is the best step in [claimant's] case. And I really think the MRI … suggests that surgery is not appropriate because we have a normal configuration.

(Emphasis added). Dr. Failinger offered an orthopedic opinion that supports that of Dr. Olsen. Dr. Failinger wrote:

> Assuming that the MRI reading is correct, one would be concerned about the relief provided from an arthroscopic decompression, especially given the fact that [claimant] did not have relief from the cortisone injection ….

Dr. Olsen questions Dr. Isaac's diagnosis of impingement syndrome. Dr. Olsen stated that the MRI scan fails to show impingement anatomy and claimant's failure to respond to a cortisone injection, which should at least temporarily relieve the symptoms from impingement, militates against such a diagnosis.

18. Claimant failed to show it more probably true than not that her work activities caused, increased, or to a reasonable degree aggravated her right shoulder tendinosis or impingement syndrome. The Judge credits the medical opinions of Dr. Olsen and Dr. Failinger as persuasive and supported by the videotape and Ms. G's testimony concerning claimant's activities at work. Crediting the medical opinions of Dr. Olsen and Dr. Failinger, there is no persuasive medical evidence otherwise showing claimant's complaints or symptoms are the result of any lesion or other pathology in her right shoulder. Crediting the medical opinions of Dr. Olsen and Dr. Failinger, there is no persuasive medical evidence otherwise showing claimant's complaints or symptoms are reasonably caused, increased, or aggravated by her activities at work.

CONCLUSIONS OF LAW

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

Claimant argues she has proven by a preponderance of the evidence that she sustained an occupational disease-type injury to her right shoulder arising out of her work activities. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues

involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), C.R.S. (2002), as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, **and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.**

(Emphasis added).

This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found claimant failed to show it more probably true than not that her work activities caused, increased, or to a reasonable degree aggravated her right shoulder tendinosis or impingement syndrome. Claimant thus failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease-type injury to her right shoulder.

In so finding, the Judge credited the medical opinions of Dr. Olsen and Dr. Failinger as persuasive and supported by the videotape and Ms. G's testimony concerning claimant's activities at work. The Judge credited the medical opinions of Dr. Olsen and Dr. Failinger in finding no persuasive medical evidence other-

wise showing claimant's complaints or symptoms are the result of any lesion or other pathology in her right shoulder. The Judge further credited the medical opinions of Dr. Olsen and Dr. Failinger in finding no persuasive medical evidence otherwise showing claimant's complaints or symptoms are reasonably caused, increased, or aggravated by her activities at work.

The Judge concludes claimant's claim for workers' compensation benefits related to her right shoulder condition should be denied and dismissed.

ORDER

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

1. Claimant's claim for workers' compensation benefits related to her right shoulder condition is denied and dismissed.

DATED: _December 23, 2008__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-654-557

ISSUES

The sole issue determined herein is respondents' request for penalties against claimant.

FINDINGS OF FACT

Claimant suffered an industrial injury on June 8, 2005. Claimant applied for a hearing.

On March 17, 2008, the Judge granted respondents' motion to compel claimant to answer interrogatories and request for production of documents within seven days.

Claimant withdrew the application for hearing. Claimant applied for another hearing.

On September 22, 2008, the Judge granted respondents' motion to compel claimant to answer interrogatories and request for production of documents within 10 days.

On November 24, 2008, claimant informed counsel for respondents that claimant was withdrawing his petition to reopen. Respondents objected and the parties appeared for hearing. The Judge granted Claimant's request to withdraw his petition to reopen.

Respondents have failed to prove by a preponderance of the evidence that claimant committed an unreasonable violation of the March 17 and September 22, 2008, orders compelling answers to respondents' discovery requests. The record evidence consists only of the two orders and the November 24 correspondence.

CONCLUSIONS OF LAW

Respondents seek a penalty pursuant to section 8-43-304(1), C.R.S. due to claimant's alleged violation of the March 17 and September 22, 2008, orders to provide discovery answers. Section 8-43-304(1), C.R.S. provides in pertinent part for penalties of up to $500 per day if respondent "violates any provision of articles 40 to 47 of this title, or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel . . ." Analysis of the penalty under section 8-43-304(1) is appropriate. *Holliday v. Bestop, Inc.*, 23 P.3d 700 (Colo. 2001) ("*Holliday II")* held that the phrase "for which no penalty has been specifically provided" referred to the third category of violations, failing to perform a duty lawfully enjoined, but it did not refer to penalties for failure to obey a lawful order of the director or panel. *Pena v. Industrial Claim Appeals Office of the State of Colorado,* 117 P.3d 84, (Colo. App. 2004) held that the limiting phrase applied to the first three categories, not just the third category. In any event, the fourth category, violating an order of the director, subjects the violator to a possible penalty under section 8-43-304(1), C.R.S., even if specific penalties may also be available. "Order" is defined in section 8-40-201(15), C.R.S. as including a rule: "'Order' means and includes any decision, finding and award, direction, rule, regulation, or other determination arrived at by the director or an administrative law judge." Under section 8-43-304(1), respondents must first prove that the disputed conduct constituted a violation of statute, rule, or order. *Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995); *Villa v. Wayne Gomez Demolition & Excavating, Inc.*, W.C. No. 4-236-951 (ICAO, January 7, 1997). Second, if the claimant committed a violation, penalties may be imposed only if the respondent's actions were not reasonable under an objective standard. *Pioneers Hospital of Rio Blanco County v. Industrial Claim Appeals* Office, 114 P.3d 97 (Colo. App. 2005); *Jiminez v. Industrial Claim Appeals Office*, 107 P.3d 965 (Colo. App. 2003); *Pueblo School District No. 70 v. Toth*, 924 P.2d 1094 (Colo. App. 1996). The standard is "an objective standard measured by the reasonableness of the action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676, (Colo.App., 1995). As found, respondents have failed to prove by a preponderance of the

evidence that claimant committed an unreasonable violation of the March 17 and September 22, 2008, orders compelling answers to respondents' discovery requests. The record evidence consists only of the two orders and the November 24 correspondence.

ORDER

It is therefore ordered that:

1. Respondents' request for a penalty against claimant is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATED: December 23, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-738-898

ISSUE

The issue for determination is compensability.

FINDINGS OF FACT

1. Claimant filed an Application for Hearing on August 12, 2008. Claimant listed only the issue of "Compensability." Claimant gave his address as 11876 Lafayette St, Northglenn, CO 80233. The hearing was set to occur in Denver on December 23, 2008. Notice of the hearing was mailed to Claimant at that address and Respondents' counsel on September 29, 2008.
2. Claimant did not appear for the hearing. No evidence was introduced.

CONCLUSIONS OF LAW

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. No evidence was introduced. Claimant has failed to show by the evidence that he was injured as a result of his employment. The claim is not compensable.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *December 23, 2008*

Bruce Friend, ALJ
Office of Administrative Courts

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-768-654

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2006.

2. Whether Claimant has established by a preponderance of the evidence that he is entitled to reasonable and necessary medical benefits that are designed to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

1. Claimant worked for Employer as a computer-assisted ordering coordinator. His duties involved ordering products, reviewing grocery shelves and re-packing or counting inventory.

2. Claimant testified that on July 18, 2008 he was re-packing inventory. He lifted an approximately 20 pound case of product from the floor and twisted to place the case in a "u-boat." Claimant explained that he immediately experienced excruciating pain in his lower back, dropped the case and fell to the floor. He remained on the floor for approximately one to two minutes. Claimant then attempted to complete his job duties but was unsuccessful.

3. Claimant advised night foreman TD that he had injured his back as a result of the incident. Mr. D offered to drive Claimant to an emergency room for medical treatment. However, Claimant declined and drove himself to the Poudre Valley Hospital Emergency Room.

4. At the emergency room Claimant reported that he suffered from a history of back pain as the result of a motor vehicle accident and had undergone a laminectomy in January 2008. He explained that he had been lifting a box at work and that his "back gave way." The emergency room physician stated that Claimant had a normal neurologic examination and concluded that he had suffered a muscle spasm in his left lumbar region.

5. On July 19, 2008 Claimant returned to the Poudre Valley Hospital Emergency Room. He recounted that he had fallen at work on the previous day when his back "gave out." Claimant stated that the incident caused pain in his neck and may have jarred his previous back fusion. He did not request any additional medication but "wanted to have it noted that his symptoms had changed overnight" and he was now having "numbness and tingling down his right arm and his right leg."

6. Employer referred Claimant to Ann K. Yanagi, M.D. for additional medical treatment. On July 21, 2008 Claimant visited Dr. Yanagi for an evaluation. She explained that, approximately three to four weeks earlier Claimant had visited personal physician Monica Serrano Toy, M.D. for an evaluation. A July 3, 2008 note from Dr. Toy reflects that Claimant complained of neck and back pain. Dr. Toy recommended physical therapy and adjusted his medications.

7. Dr. Yanagi reviewed Claimant's extensive history of prior back problems. The record reveals that on September 1, 2006 Dr. Toy commented that approximately three to four weeks earlier Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. On September 19, 2006 John Viola, M.D. examined Claimant and determined that he suffered from "symptoms of a C6 radiculopathy on the right side related to disc and osteophyte at C5-6 and C6-7." Because Claimant reported that he was suffering worsening symptoms, Dr. Viola subsequently performed an anterior diskectomy and fusion at C5-6.

8. Claimant continued to suffer from persistent neck and back pain. On October 22, 2007 Claimant told Dr. Serrano Toy that he experienced low back pain after being involved in a motor vehicle accident. On November 5, 2007 Dr. Serrano Toy advised Claimant that he suffered from multi-level disc disease in the lumbar spine that affected his right side nerve root. On November 19, 2007 Dr. Viola noted that an MRI scan revealed Claimant suffered from degenerative disc disease predominantly at the L4-5 and L5-S1 levels. He diagnosed Claimant with "symptoms related to lumbar degenerative disc disease, most marked at L4-5, as well as some disc protrusion at the L4-5 level on the right, causing mild radiculopathy." On January 2, 2008 Claimant thus underwent surgery that consisted of a "laminectomy and discectomy." At the time of the surgery, Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he could not tolerate the symptoms.

9. In a July 31, 2008 report Dr. Yanagi considered whether Claimant's back and neck symptoms were caused by the July 18, 2008 industrial incident or were related to his pre-existing condition. Dr. Yanagi thus referred Claimant to Jeffrey A. Wunder, M.D. for a causality determination.

10. Dr. Wunder evaluated Claimant on August 12, 2008 and August 26, 2008. He also testified at the hearing in this matter. Based on a review of Claimant's prior medical history, Dr. Wunder noted that Claimant suffered from pre-existing upper and lower back symptoms. He commented that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008.

11. Dr. Wunder compared Claimant's lumbar MRI's from November 2, 2007 and August 19, 2008. The August 19, 2008 MRI revealed degenerative disc disease at L5-S1. The MRI also demonstrated a broad disc bulge at L4-5 that had improved significantly as a result of Claimant's January 2, 2008 surgery. The findings at L4-5 on the August 19, 2008 MRI were thus "predominantly post-operative" and did not occur on July 18, 2008.

12. Dr. Wunder summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his underlying condition. Dr. Wunder thus concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms. He summarized that Claimant's condition was "100% preexisting."

13. Claimant has failed to demonstrate that it is more probably true than not that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2008. Although Claimant experienced back and neck symptoms while working for Employer on July 18, 2008, his employment did not aggravate, accelerate, or combine with his pre-existing condition to produce a need for medical treatment. The record is replete with evidence that Claimant suffered an extensive history of back and neck problems. In approximately August 2006 Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. Subsequent testing revealed lumbar degenerative disc disease that ultimately resulted in an anterior diskectomy and fusion at C5-6. On January 2, 2008 Claimant also underwent a laminectomy and discectomy. Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he was unable to tolerate the symptoms. In fact, approximately two weeks prior to July 18, 2008 Claimant visited personal physician Dr. Serrano Toy because he was experiencing neck and back pain.

14. Dr. Wunder persuasively testified that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008. Dr. Wunder also noted that the findings on an August 19, 2008 MRI were "predominantly postoperative" and did not occur on July 18, 2008. He thus summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his

underlying condition. Dr. Wunder credibly concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms and that Claimant's condition was "100% preexisting." Claimant's need for medical treatment was thus not caused by the aggravation of a pre-existing condition while working for Employer but was more likely caused by the natural progression of his chronic back condition.

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 worker's 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 worker's 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 worker's 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 (2005).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered an industrial injury during the course and scope of his employment with Employer on July 18, 2008. Although Claimant experienced back and neck symptoms while working for Employer on July 18, 2008, his employment did not aggravate, accelerate, or combine with his pre-existing condition to produce a need for medical treatment. The record is replete with evidence that Claimant suffered an extensive history of back and neck problems. In approximately August 2006 Claimant began suffering from the insidious onset of pain in his right shoulder, arm and neck area. Subsequent testing revealed lumbar degenerative disc disease that ultimately resulted in an anterior diskectomy and fusion at C5-6. On January 2, 2008 Claimant also underwent a laminectomy and discectomy. Dr. Viola advised Claimant that the surgery had a reasonable chance of improving his symptoms but that he could "require much more extensive surgical decompression and fusion" if he was unable to tolerate the symptoms. In fact, approximately two weeks prior to July 18, 2008 Claimant visited personal physician Dr. Serrano Toy because he was experiencing neck and back pain.

7. As found, Dr. Wunder persuasively testified that Claimant's physical examination, specifically straight leg raises, yielded comparable results before and after the July 18, 2008 industrial incident. Furthermore, Claimant's subjective pain levels did not change after July 18, 2008. Dr. Wunder also noted that the findings on an August 19, 2008 MRI were "predominantly postoperative" and did not occur on July 18, 2008. He thus summarized that the July 18, 2008 incident caused a temporary aggravation of Claimant's symptoms but did not impact his underlying condition. Dr. Wunder credibly concluded that there was no evidence that the July 18, 2008 incident caused an aggravation of Claimant's prior back and neck symptoms and that Claimant's condition was "100% preexisting." Claimant's need for medical treatment was thus not caused by the aggravation of a pre-existing condition while working for Employer but was more likely caused by the natural progression of his chronic back condition.

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.

DATED: December 23, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-736-105

ISSUES

The issues determined herein are maximum medical improvement ("MMI"), additional surgery, and permanent partial disability ("PPD") benefits.

FINDINGS OF FACT

1. Claimant was employed by the employer as a housekeeper. On June 3, 2007, claimant sustained an admitted industrial injury to her left knee when she was kneeling down in the restroom to clean and her left knee popped and she felt pain.

2. On June 4, 2007, Dr. Dern examined claimant, who had full range of motion, negative x-rays, and was diagnosed with left knee strain.

3. On June 12, 2007, a magnetic resonance image ("MRI") of claimant's left knee revealed normal medial lateral meniscus and ligaments, but chondromalacia with focal full thickness articular cartilage defect involving the medial femoral condyle and heterogeneous signal surface irregularity involving articular cartilage of the patella, and small to moderate joint effusion.

4. On June 15, 2007, Dr. William Ciccone performed an orthopedic examination of claimant. He diagnosed left anterior knee pain with chondromalacia. Dr. Ciccone noted that most of her pain was coming from the areas of cartilage thinning about her knee. Prior to seeing Dr. Ciccone, claimant reported on the intake form that she had a previous injury to her knee three years ago, including pain when she would bend.

5. Claimant was treated only with medication and physical therapy.

6. On August 7, 2007, Dr. Ciccone reexamined claimant, who reported worsening pain in the knee. Dr. Ciccone administered an injection to the left knee and continued physical therapy.

7. On August 28, 2007, Dr. Ciccone reexamined claimant, who reported persistent pain over the anterior aspect of her knee. Dr. Ciccone noted that the MRI scan showed mild chondromalacia within the patella, but the condition was not operative. Dr. Ciccone believed that claimant's pain at that point would not respond to operative treatment. He felt that she was approaching MMI at that time.

8. On September 12, 2007, claimant was seen by J.S. Walia, M.D., at which time she was placed at MMI for left knee chondromalacia. Dr. Walia found claimant to have claimant no pain, full range of motion, and no definite tenderness or effusion. Dr. Walia determined 20% impairment of the lower extremity pursuant to *American Medical Association Guides to Evaluation of Permanent Impairment, Third Edition Revised* Table 40. Dr. Walia released claimant to return to her regular job, which she had been performing for the last few weeks without difficulty. Maintenance care in the form of continuation of home exercise program was recommended. Dr. Walia noted that no surgery was anticipated at the time of MMI.

9. In reply to correspondence from the workers' compensation adjuster, Dr. Walia declined to change his impairment rating of 20% and referred to the MRI results.

10. Claimant continued to perform her regular duty work and did not seek additional medical treatment for her left knee injury.

11. On April 2, 2008, Robert McCurry, D.O. performed a Division Independent Medical Examination ("DIME") of claimant. Dr. McCurry noted that claimant was favoring her left knee with ambulation and stiffness and, at times, an exaggerated limp and gait. She had no sign of swelling bilaterally or increased warmth about the left knee compared to the right. Dr. McCurry determined that claimant had reached MMI on September 12, 2007, as determined by Dr. Walia. Dr. McCurry, however, determined that Dr. Walia's rating of 20% impairment of the lower extremity, the highest rating that can be given for chondromalacia, was excessive. Dr. McCurry noted that claimant was able to return to a near non-painful state at modified duty post injury, the mechanism of injury from a single squat is inconsistent with patient's severity of complaints, there is a high probability that claimant was already experiencing periodic knee discomfort, the full thickness articular cartilage defect as seen on the MRI is relatively small, and claimant's diagnosis of chondromalacia indicates that the condition is a process over time rather than acute problem. Consequently, Dr. McCurry rated claimant with 10% impairment of lower extremity due to her continued knee discomfort and abnormality on the MRI scan. This extremity rating converts to 4% whole person impairment. Dr. McCurry found no impairment due to range of motion. Dr. McCurry recommended maintenance care after MMI, including anti-inflammatory medication and a patellar stabilization knee brace.

12. On April 9, 2008, Dr. Castrejon examined claimant. He noted that claimant had a normal gait with mild diffused tenderness. Her range of motion was 124 to 134 degrees, improving with distraction. He did not feel that her subjective level 10/10 pain was supported by her visual or physical examination. Dr. Castrejon diagnosed claimant with anterior knee pain consistent with chondromalacia, which is inflammation and a

wear and tear of the cartilage portion of the joint. This is a process over time rather than an acute condition. There were no new findings that would support a need for surgery. Dr. Castrejon concluded that claimant remained at MMI and he determined that 10% impairment of the lower extremity was more reasonable than the 20% determined by Dr. Walia.

13. On April 18, 2008, the employer filed a final admission of liability for PPD benefits based upon 10% of the leg, as well as for post-MMI medical benefits.

14. On May 6, 2008, David Walden, M.D., an orthopedic surgeon, examined claimant, who reported longstanding chronic problems dating back to 2005. Based upon the MRI scan taken shortly after the work related incident, Dr. Walden thought claimant's condition was indicative of osteoarthritis with acute irritation. Dr. Walden concluded that claimant had left knee acute irritation of the medial femoral condyle and patellar chondral defects. He further noted that the mechanism of injury that claimant was describing was unlikely to have produced a significant osteoarthritic change in the knee, but rather it was likely an irritation of the underlying condition. Dr. Walden did not believe that surgical intervention would make a significant difference with regard to claimant's knee, but he suggested that at some point in the future she would need a total knee arthroplasty that would not be due to the workers' compensation injury. Walden recommended viscosupplementation of the left knee, noting that he would then place claimant at MMI.

15. On July 23, 2008, Dr. Castrejon indicated that he agreed that the work injury aggravated claimant's preexisting chondromalacia, causing the need for the viscosupplementation.

16. On August 4, 2008, Dr. Hall performed an IME for claimant. He noted that the medical records did not indicate that claimant had improved with treatment after her work injury. He concluded that she was not at MMI and needed diagnostic arthroscopy.

17. On August 11, 18 and 25, 2008, claimant underwent viscosupplementation, consisting of three injections of hyalgin to attempt to improve cartilage function and joint fluid and provide symptomatic relief for arthritic changes in the knee. At the time of her first injection, her physical examination demonstrated 5 degrees flexion contracture, 130 degrees of flexion, no limp, normal neurologic and vascular exams, and full hip range of motion without pain.

18. On August 27, 2008, Dr. Castrejon indicated that additional surgery would be reasonable for claimant, but it was not due to the work injury.

19. At hearing, claimant admitted that at MMI her knee did not swell so badly and she felt much better. She further testified that she felt very well and did not have any pain until January 2008. Claimant has an active lifestyle and enjoys running, walking, cleaning the house and working. She enjoyed these activities prior to the work incident on June 3, 2007, and continued these activities after MMI on September 12, 2007. She now alleges that she is no longer able to run, walk, or clean house.

20. Dr. Castrejon testified at hearing that claimant had a preexisting problem in her left knee and that the work injury caused a temporary flareup of the preexisting condition. In his opinion, claimant returned to baseline after treatment. She has then experienced a natural progression of the preexisting condition. Dr. Castrejon noted that claimant was able to return to regular duty work for seven months prior to seeking further treatment. Consequently, the additional treatment was not due to the work injury and claimant remains at MMI.

21. Dr. Walden testified by deposition. After being informed that claimant had no pain at MMI, had full range of motion, was released to full duty, and continued to perform her job duties 100% with no pain until January 2008, her condition was stable and she was at MMI. Dr. Walden opined that claimant's current symptoms were due to the natural progression of her underlying condition. Dr. Walden recommended use of ambulatory support such as a cane, anti-inflammatory medications such as Ibuprofen, Tylenol, or similar medications, application of ice, keeping her knee as strong as possible, and altering the way she does activities, as well as a repeat course of viscosupplementation. Dr. Walden concluded that claimant was not a surgical candidate at the present time. He noted that arthroscopy is not indicated for the chondromalacia and claimant had normal menisci and ligaments.

22. Contrary to claimant's testimony that Dr. Castrejon treated her for low back pain, he did not even record any complaints of back pain.

23. No clear and convincing evidence demonstrates that the MMI determination by the DIME is incorrect. Dr. Walia determined MMI as of September 12, 2007, because claimant was stable. Dr. McCurry, the DIME physician, agreed. Dr. Walden's deposition testimony supports that same determination. Dr. Castrejon agreed that claimant was still at MMI. Dr. Hall's lone dissenting view does not demonstrate that it is highly probable that Dr. McCurry is incorrect. In spite of the provision of viscosupplementation after MMI, claimant's condition on September 12, 2007, was stable and unlikely to improve with additional treatment.

24. Claimant has failed to prove by a preponderance of the evidence that arthroscopic surgery is reasonably necessary to cure or relieve the effects of the work injury. Dr. Walden's expert opinion is most persuasive that arthroscopy is not indicated for someone with claimant's chondromalacia and normal menisci and ligaments.

25. Claimant has failed to prove by a preponderance of the evidence that she suffered functional impairment not expressed on the schedule of disabilities. Claimant alleges that she suffered low back pain from the injury, but that allegation is not supported by the medical records. In any event, claimant's permanent impairment is limited solely to the left knee, distal to the hip joint.

26. The preponderance of the evidence demonstrates that claimant suffered 10% impairment of the lower extremity due to the chondromalacia, as determined by Dr.

McCurry and Dr. Castrejon. The determination involves a judgment about the extent of the impairment within a range permitted by the *American Medical Association Guides to Evaluation of Permanent Impairment, Third Edition Revised.* The explanation by Dr. McCurry and by Dr. Castrejon are more persuasive than the unexplained rating by Dr. Walia.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence. A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In this case, the DIME, Dr. McCurry, determined that claimant was at MMI on September 12, 2007. Consequently, claimant must prove by clear and convincing evidence that this determination is incorrect.

2. "Maximum medical improvement" is defined in Section 8-40-201(11.5), C.R.S. as:

> A 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. 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 maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement.

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. *Villela v. Excel Corporation*, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, claimant has failed to prove by clear and convincing evidence that the determination by the DIME is incorrect.

3. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury, including treatment after MMI. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The employer admitted liability for post-MMI medical treat-

ment, but the employer remained free to contest the reasonable necessity of any future treatment. *Milco Construction v. Cowan*, 860 P.2d 539 (Colo. App. 1992). As found, claimant has failed to prove by a preponderance of the evidence that arthroscopic surgery is reasonably necessary to cure or relieve the effects of the work injury.

4. Section 8-42-107, C.R.S., sets forth two different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and Subsection (8) provides a DIME process for whole person ratings. The threshold issue is application of the schedule and this is a determination of fact based upon a preponderance of the evidence. The application of the schedule depends upon the "situs of the functional impairment" rather than just the situs of the original work injury. *Langton v. Rocky Mountain Health Care Corp.,* 937 P.2d 803 (Colo. App. 1996); *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). The heightened burden of proof in Subsection (8) applies only if the threshold determination is made that the impairment is not limited to the schedule. Then, and only then, does either party face a clear and convincing evidence burden to overcome the rating of the DIME. *Webb v. Circuit City Stores, Inc.*, W.C. No. 4-467-005 (ICAO, August 16, 2002). As found, claimant has failed to prove by a preponderance of the evidence that she suffered functional impairment not expressed on the schedule of disabilities. As found, claimant suffered 10% impairment of the leg at the hip. Section 8-42-107(2)(w), C.R.S.

ORDER

It is therefore ordered that:

1. Claimant's claim for medical benefits in the form of arthroscopy is denied and dismissed.

2. Claimant's claim for additional PPD benefits is denied and dismissed.

DATED: December 24, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-358-465

PROCEDURAL BACKGROUND

Hearing in this matter was held before Administrative Law Judge (ALJ) Peter J. Cannici on September 28, 2007 at the Loveland Municipal Court in Loveland, Colorado. The proceedings were recorded in Courtroom M from approximately 2:35 p.m. until 4:00 p.m. The Judge held the record open for the parties to complete deposition testimony and submit position statements by March 25, 2008.

On April 15, 2008 ALJ Cannici issued Findings of Fact, Conclusions of Law and Order (collectively "Order") in this matter. The Order denied Claimant's request for medical benefits from personal provider Kaiser Permanente during the period February 17, 2001 until October 1, 2002 because they were not authorized. The Order awarded Claimant Temporary Total Disability (TTD) benefits for the period August 1, 2001 until November 7, 2001 but denied additional TTD benefits because Claimant failed to demonstrate that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury.

Claimant sought review of the Order based on the denial of medical benefits and the November 7, 2001 termination of TTD benefits. On September 24, 2008 the Industrial Claim Appeals Panel (Panel) remanded the April 15, 2008 Order on two grounds. First, the Panel ordered ALJ Cannici to consider the effects of Claimant's Petition to Reopen on Claimant's entitlement to medical benefits from Kaiser Permanente. Second, the Panel required ALJ Cannici to consider whether there was a statutory condition for terminating Claimant's TTD benefits.

ISSUES

1. Whether Claimant has demonstrated by a preponderance of the evidence that she was entitled to receive authorized medical treatment from February 17, 2001 until October 1, 2002 that was reasonable and necessary to cure and relieve the effects of her industrial injury.

2. Whether Claimant has established by a preponderance of the evidence that she was entitled to receive TTD benefits from August 1, 2001 until terminated by statute.

FINDINGS OF FACT

1. On September 17, 1997 Claimant suffered an admitted industrial injury to her lower back during the course and scope of her employment with Employer.

2. Claimant subsequently underwent extensive medical treatment for her injuries. On May 7, 1998 she reached Maximum Medical Improvement

(MMI). She was released with permanent work restrictions of no repetitive lifting in excess of 20 pounds.

3. On June 10, 1998 Claimant obtained medical treatment with personal medical provider Kaiser Permanente for the worsening of her lower back condition. On June 22, 1998 Claimant sought to obtain additional evaluations and treatment from Kaiser. However, Insurer denied the request because Kaiser was not an authorized provider.

4. On August 13, 1998 Claimant underwent a Division Independent Medical Examination (DIME) with Douglas E. Hemler, M.D. Dr. Hemler agreed that Claimant had reached MMI and assigned her a 10% whole person impairment rating. He did not recommend any additional medical care or treatment.

5. On September 3, 1998 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Hemler's 10% whole person impairment rating. Claimant did not object to the FAL and her case closed by operation of law.

6. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to provide treatment to Claimant.

7. On August 1, 2001 Claimant underwent lower back lumbar fusion surgery through Kaiser Permanente. On October 8, 2002 she underwent an additional procedure through Kaiser to remove hardware from her back.

8. On October 19, 2002 Claimant suffered additional injuries to her lower back as a result of a motor vehicle accident. She received extensive medical treatment for her injuries.

9. On June 9, 2005 Claimant underwent an independent medical evaluation with John S. Hughes, M.D. Dr. Hughes concluded that Claimant suffered a worsening of condition "as a result of a natural progressive degenerative cascade" between the time she reached MMI on May 7, 1999 and her October 19, 2002 motor vehicle accident. He explained that Claimant's worsened condition included the "development of right lower extremity radiculopathy and segmental instability in conjunction with a true grade 1 spondylolisthesis at L4-L5."

10. On April 24, 2007 ALJ Barbara S. Henk entered Findings of Fact, Conclusions of Law and Order on Remand in this matter. ALJ Henk granted Claimant's Petition to Reopen her claim. ALJ Henk reasoned that Claimant suffered a worsening of her condition that was causally related to her September 17, 1997 industrial injury. She explained that the worsening of Claimant's condition

was limited to the period between the date of the FAL and the October 19, 2002 motor vehicle accident.

11. On September 7, 2007 Ranee Shenoi, M.D. conducted an independent record review of Claimant's case. Dr. Shenoi opined that, between reaching MMI and suffering the intervening motor vehicle accident, Claimant's condition did not naturally progress as a result of her industrial injury. Instead, she opined that Claimant suffered from an underlying pars defect in her lumbar spine and that the natural progression of the defect could be expected to involve periods of waxing and waning. Dr. Shenoi thus concluded that Claimant's fusion surgery through Kaiser was most likely related to the long-term pars defect.

12. On November 5, 2007 the parties conducted the evidentiary deposition of Dr. Shenoi. Dr. Shenoi reiterated her opinion that Claimant did not suffer a worsening of condition between the time she reached MMI and her October 19, 2002 motor vehicle accident. She explained that Claimant suffers from a chronic structural pars defect at L5 that is likely to cause lower back problems for the foreseeable future.

13. Dr. Hughes testified at the hearing in this matter. He explained that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He noted that Claimant's industrial injury caused her to require lumbar fusion surgery on August 1, 2001. Dr. Hughes opined that Claimant was totally disabled for two weeks after her surgery and that Claimant would have had sedentary work restrictions until November 7, 2001. After November 7, 2001 Claimant would have had light duty work restrictions of no lifting in excess of 20 pounds.

14. On February 13, 2008 the parties conducted the evidentiary deposition of Dr. Hughes. Dr. Hughes explained that he agreed with Dr. Shenoi that Claimant had suffered from a pars defect prior to her September 17, 1997 industrial injury. However, he explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability." The industrial injury thus caused an aggravation of the preexisting pars defect. Dr. Hughes commented that Claimant suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." Claimant thus sustained a "natural progression of microinstability" at L5 and benefited from fusion surgery on August 1, 2001.

15. Claimant has established that it is more probably true than not that she received "authorized" medical treatment from personal medical provider Kaiser Permanente for the period February 17, 2001 until October 1, 2002. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to treat Claimant's worsened

condition. The right to select a physician thus passed to Claimant. Claimant's treatment through Kaiser Permanente was therefore authorized.

16. The medical treatment that Claimant received from Kaiser Permanente was also reasonable and necessary to cure and relieve the effects of her industrial injury. Dr. Hughes credibly testified that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability. She sustained a "natural progression of microinstability" at L5. Claimant subsequently suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." She thus required lumbar fusion surgery on August 1, 2001. In contrast, Dr. Shenoi stated that the natural progression of Claimant's pars defect could be expected to involve periods of waxing and waning and concluded that Claimant's fusion surgery was most likely related to the long-term pars defect. However, Dr. Shenoi's opinion is not persuasive because it fails to acknowledge that Claimant did not develop any symptoms from her pars defect until after her industrial injury. Accordingly, Respondents are financially responsible for the treatment that Claimant received from Kaiser Permanente from February 17, 2001 until October 1, 2002.

17. Claimant has established that it is more probably true than not that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury beginning on August 1, 2001. Respondents have failed to produce persuasive evidence that Claimant reached MMI, returned to work, was released to regular employment, or was released to modified employment and failed to accept a written offer of modified employment. Claimant is thus entitled to receive TTD benefits from the date of her fusion surgery on August 1, 2001 until terminated by statute.

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 (2005).

Medical Benefits

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). "Authorization" refers to the physician's legal status to treat the injury at the respondents' expense. *In Re Leibold,* W.C. No. 4-304-437 (ICAP, Jan. 3, 2008). The determination of whether treatment was rendered by an "authorized" treating physician is a question of fact for determination by the ALJ. *In Re Sincavage,* W.C. No. 4-684-642 (ICAP, Mar. 8, 2007).

5. Under §8-43-404(5), C.R.S. the respondents have the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *In Re Leibold,* W.C. No. 4-304-437 (ICAP, Jan. 3, 2008). If the claimant does not obtain proper permission, the treatment provided by personal physicians is not compensable. *In Re Cabela,* W.C. No. 4-701-794 (ICAP, Dec. 10, 2007).

6. When a claim has been closed and a claimant seeks to reopen the claim based on a worsening of condition, the claimant must notify the respondents of her desire to obtain additional medical treatment prior to obtaining the treatment. *In Re Gonzales,* W.C. No. 4-250-651 (ICAP, Nov. 27, 2000). The claimant must notify respondents of the request for treatment because an MMI determination terminates the claimant's right to medical benefits. *Id.* The claimant thus bears the burden of providing notice to the employer that additional benefits are sought. *Id.* The notice triggers the respondent's duty to designate an authorized treating physician. *Id.* The right to select a physician thus only passes to the claimant if the respondents fail to designate a physician after receiving notice that the claimant seeks to reopen the claim. *Id.*; *see Wright v. City and County of Denver,* W.C. No. 4-172-294 (Dec. 4, 1995). Whether a claimant has notified the respondents of her request to reopen the claim prior to the selection of a treating physician and whether the respondents designated a treating physician are questions of fact for the ALJ. *See Ruybal v. University Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988).

7. Claimant requests payment for the medical benefits she received from Kaiser Permanente for the period February 17, 2001 until October 1, 2002. ALJ Henk's Order concluded that Claimant had suffered a worsening of her condition and reopened her claim. However, the Order did not address whether any subsequent treatment was authorized, reasonable or necessary.

8. As found, Claimant has established by a preponderance of the evidence that she received "authorized" medical treatment from personal medical provider Kaiser Permanente for the period February 17, 2001 until October 1, 2002. On February 16, 2001 Claimant filed a Petition to Reopen her claim based on a worsening of her condition. Respondents were thus on notice that Claimant sought additional medical treatment for her lower back condition. Nevertheless, Respondents did not designate a physician who was willing to treat Claimant's worsened condition. The right to select a physician thus passed to Claimant. Claimant's treatment through Kaiser Permanente was therefore authorized.

9. As found, the medical treatment that Claimant received from Kaiser Permanente was also reasonable and necessary to cure and relieve the effects of her industrial injury. Dr. Hughes credibly testified that Claimant suffered from an L5 pars defect that remained clinically silent until her industrial injury. He explained that Claimant became symptomatic after her industrial injury and developed a "segmental instability. She sustained a "natural progression of microinstability" at L5. Claimant subsequently suffered a worsening of her condition based on a "well documented persistence of mechanical back pain." She thus required lumbar fusion surgery on August 1, 2001. In contrast, Dr. Shenoi stated that the natural progression of Claimant's pars defect could be expected to involve periods of waxing and waning and concluded that Claimant's fusion surgery was most likely related to the long-term pars defect. However, Dr. Shenoi's opinion is not persuasive because it fails to acknowledge that Claimant did not develop any symptoms from her pars defect until after her industrial injury. Accordingly, Respondents are financially responsible for the treatment that Claimant received from Kaiser Permanente from February 17, 2001 until October 1, 2002.

TTD Benefits

10. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S.; *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (Colo. 1995). 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, 649 (Colo. 1999). The "impairment of earning capacity" element of disability may be evidenced by a complete inability to work or by restrictions that impair a claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595,

597 (Colo. App. 1998). Once TTD benefits have been awarded based on a worsening of condition, they continue until the respondents demonstrate that claimant has reached MMI, returned to work, was released to regular employment, or was released to modified employment and failed to accept a written offer of modified employment. §8-42-105(3), C.R.S.; *see Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 18 P.3d 790, 792 (Colo. App. 2000).

11. Claimant seeks to obtain TTD benefits beginning on August 1, 2001. ALJ Henk's Order concluded that Claimant had suffered a worsening of her condition and reopened her claim. However, the Order did not address whether Claimant was entitled to TTD benefits for any time period.

12. As found, Claimant has established by a preponderance of the evidence that her worsened condition caused a greater impact on her work capability than she originally sustained as a result of her industrial injury beginning on August 1, 2001. Respondents have failed to produce persuasive evidence that Claimant reached MMI, returned to work, was released to regular employment, or was released to modified employment and failed to accept a written offer of modified employment. Claimant is thus entitled to receive TTD benefits from the date of her fusion surgery on August 1, 2001 until terminated by statute.

ORDER

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

1. Respondents are financially responsible for Claimant's medical treatment from Kaiser Permanente for the period February 17, 2001 until October 1, 2002.

2. Respondents shall pay Claimant TTD benefits for the period August 1, 2001 until terminated by statute.

3. Any issues not resolved in this Order are resolved for future determination.

DATED: December 24, 2008.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-766-877

ISSUES

The issues determined herein are compensability of an occupational disease and medical benefits.

FINDINGS OF FACT

1. Claimant had preexisting problems with bilateral hand numbness and pain. On January 19, 2004, she gave her physical therapist a history of neck, mid-back, and low back pain as well as bilateral hand tingling while holding a book to read. On January 15, 2007, She reported to Dr. Tang that she had fallen a few months before and suffered pain in her upper left arm. X-rays of the left arm were negative. On June 7, 2007, Dr. Tang reexamined claimant, who reported that she had tripped two months earlier and suffered right hand pain.
2. From September 2007 to January 2008, claimant was unemployed. On January 23, 2008, she began work for the employer and was placed as an administrative assistance to collect child support payments in El Paso County. Claimant's duties were varied, but she initially did a lot of data entry work. Claimant's computer keyboard was placed on her desktop. She complained about her keyboard and chair to Ms. S, the executive administrator for the employer.
3. On an unknown date in February or March 2008, claimant awoke with right hand pain. She sought care from her personal physician, Dr. Harris, but she did not provide any medical records as part of the record evidence in the case.
4. On March 17, 2008, Dr. Pise examined claimant. He provided wrist injections, which did not help claimant's symptoms. On April 8, 2008, x-rays of the right hand at Penrose Hospital were negative. The physician suggested evaluation for possible inflammatory arthritis. Dr. Pise referred claimant to Dr. Struck.
5. On April 16, 2008, Dr. Struck examined claimant, who reported a fall in May 2007 with continued symptoms aggravated by lifting, keyboarding, knitting, and reading. Claimant also reported that she was stressed financially. Claimant had positive Tinel's and Phalen's signs bilaterally. Dr. Struck diagnosed pain syndrome with possible bilateral carpal tunnel syndrome. Dr. Struck noted that typing in poor ergonomic conditions aggravated claimant's pain syndrome. Dr. Struck recommended a workplace ergonomic evaluation. At that point, claimant first realized that she had a possible workers' compensation claim.
6. On April 18, 2008, claimant delivered the ergonomic evaluation prescription to Ms. S. Ms. S referred claimant to Memorial Occupational Health Center and later prepared an employer's first report of injury.
7. Claimant later proceeded with surgery on her hands, although no medical reports from that procedure were placed in record evidence.
8. On August 5, 2008, Dr. Lund at Memorial Occupational Health Center discharged claimant at maximum medical improvement. Dr. Lund diagnosed carpal tunnel syndrome and flexor tendonitis. Dr. Lund noted that the conditions were consistent with a work injury. Dr. Lund released claimant to return to work without restrictions.
9. On August 11, 2008, the insurer filed a notice of contest.
10. Claimant has proven by a preponderance of the evidence that she suffered an occupational disease to her bilateral hands arising out of and in the course of her employment with the employer. The record evidence is sparse. That evidence shows that

claimant had preexisting bilateral hand problems, but the poor ergonomic conditions at the employer aggravated claimant's preexisting condition and caused the need for medical treatment.

11. Claimant admitted at hearing that Dr. Pise and Dr. Struck were not authorized. She sought care from those providers before reporting to the employer that she had an alleged occupational disease. The record evidence also shows that Penrose Hospital was unauthorized. Claimant obtained tests at that facility upon referral by Dr. Pise.

12. The treatment by Memorial Occupational Health Center was authorized and was reasonably necessary to cure or relieve the effects of claimant's occupational disease.

CONCLUSIONS OF LAW

1. 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). 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). 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. 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).

2. In this claim, claimant alleges an occupational disease. Section 8-40-201(14), C.R.S. defines "occupational disease" as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond that required for an accidental injury. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). An accidental injury is traceable to a

particular time, place and cause. *Colorado Fuel & Iron Corp. v. Industrial Commission*, 154 Colo. 240, 392 P.2d 174 (1964); *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). In contrast, an occupational disease arises not from an accident, but from a prolonged exposure occasioned by the nature of the employment. *Colorado Mental Health Institute v. Austill*, 940 P.2d 1125 (Colo. App. 1997). Under the statutory definition, the hazardous conditions of employment need not be the sole cause of the disease. A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). As found, claimant has proven by a preponderance of the evidence that she suffered an occupational disease to her bilateral hands resulting directly from the employment or conditions under which work was performed and following as a natural incident of the work.

3. 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). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). As found, the treatment by Dr. Lund and Memorial Occupational Health Center was authorized and reasonably necessary. As found, the treatment by Dr. Pise, Dr. Struck, and Penrose Hospital was unauthorized.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of the reasonably necessary medical treatment by authorized providers for claimant's occupational disease, including the bills from Memorial Occupational Health Center.

2. Claimant's claim for payment of the bills from Dr. Pise, Dr. Struck, and Penrose Hospital is denied and dismissed.

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

DATED: December 29, 2008 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-756-498

ISSUES

The issue presented for determination at hearing was Claimant's claim for temporary total disability ("TTD") benefits for the period from July 4 through and including July 27, 2008.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to the middle or long finger of his right hand on April 8, 2008. Claimant was employed as a shop worker/ warehouseman performing inventory, maintenance and stripping of parts from airplanes for Employer.

2. Claimant initially sought medical treatment from his personal physician, Dr. John Spine, three days after the injury. Dr. Spine then referred Claimant to the emergency room at Tri-County Medical Center.

3. Claimant underwent surgery to his right long finger at Boulder Community Hospital on April 13, 2008. The surgery consisted of an irrigation and debridement of the flexor tendon sheath of the right long finger. The surgery was performed by Dr. Kelly Wear, M.D. who thereafter became Claimant's attending physician.

4. Following an office visit on May 29, 2008, Dr. Wear released Claimant to return to modified work with restrictions of no lifting over 50 pounds; frequent lifting up to 25 pounds; limited gripping and grasping; and limited climbing, bending, twisting. These restrictions are reflected in the Progress and Work Status Form dated May 30, 2008.

5. By letter dated June 17, 2008 from Insurer, Claimant was offered modified employment approved by Dr. Wear and as described in the letter of June 3, 2008 from Employer.

6. Claimant received the written offer of modified duty on June 20, 2008. Claimant then contacted JA, at Employer on June 25, 2008 to discuss his return to work. Claimant and Mr. A discussed that Claimant would be assigned to

painting and that Claimant would start work in the modified position on June 30, 2008.

7. Claimant returned to work on July 1, 2008 as was assigned to painting a large room. Claimant worked on July 2 and 3, 2008 and earned his full wages for each of the days worked from July 1 through July 3, 2008. Claimant has not worked for the Employer since July 3, 2008.

8. The ALJ credits the testimony of JA that Claimant did not show up for work on July 7, 2008 and did not call the Employer. Claimant called Mr. A on July 8, 2008 and left a message at 6:39 AM advising the Employer that his hand hurt and that he would not be in to work. In this message, Claimant did not specify which hand he was referring to as the one that was hurting.

9. Insurer filed a General Admission of Liability dated July 3, 2008 terminating Claimant's TTD benefits as of June 30, 2008 based upon a Supplemental Report of Return to Work from Employer noting Claimant's return to work on July 1, 2008.

10. Dr. Wear again examined Claimant at a follow-up visit on July 23, 2008. Dr. Wear noted that Claimant reported ongoing pain and complained that he could not fully bend or extend the digit. Dr. Wear noted on physical examination that active flexion of the proximal and distal joints of the right long finger were significantly decreased. Dr. Wear stated Claimant would likely need a capsulotomy. Claimant was instructed to continue with hand therapy. Dr. Wear did not provide any different physical restrictions from the ones previously given on May 29, 2008 and reflected in the Work Status Report of May 30, 2008. Specifically, Dr. Wear did not restrict Claimant from continuing to work in the modified position previously approved by Dr. Wear on June 16, 2008.

11. Claimant understood that Dr. Wear would determine his work status although he disagreed with her. The ALJ finds that Claimant's failure to continue the modified work provided by Employer after July 3, 2008 was due to Claimant's subjective assessment of his physical limitations and ability to work.

12. Claimant spoke with Mr. A on July 29, 2008 requesting his assistance because Claimant's TTD benefits had been discontinued. Claimant told Mr. A in this conversation that he had not been going to the doctor because he "had things to do".

CONCLUSIONS OF LAW

13. 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. *Mag-*

netic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

14. 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, 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 (2008) C.R.S.

15. The phrase "attending physician", as used in 8-42-105(3)(c), C.R.S. means a physician within the chain of authorization who assumes care of the claimant. There may be more than one "attending physician" but not all attending physicians are "the attending physician". "The attending physician" is the physician with primary control over the Claimant's treatment. *See, Popke v. Indus. Claims Appeal Office,* 944 P.2d 677, 680-681 (Colo. App. 1997). As found, "the attending physician" for Claimant's treatment for the admitted injury during the time periods at issue here was Dr. Wear.

16. Insurer properly terminated Claimant's TTD benefits effective June 30, 2008 under the provisions of Section 8-42-105(3)(b) based upon Claimant's return to modified employment offered by the Employer and approved by the attending physician, Dr. Wear. As found, Claimant then discontinued this work after July 3, 2008 based upon his own subjective assessment of his ability to continue the work. However, once the attending physician makes a determination of the Claimant's ability to perform regular or modified employment, that determination is dispositive and the Claimant's subjective assessment of his physical limitations is legally immaterial, *Burns v. Robinson Dairy, Inc.,* 911 P.2d 661 (Colo. App. 1995); *Blas Villa v. Harvest Select,* W.C. No. 4-694-064 (October 3, 2008). Therefore, Claimant's own assessment of his ability to continue the modified employment is legally insufficient to re-establish entitlement to TTD benefits after their termination based upon Claimant's return to the modified employment offered by Employer and approved by the attending physician.

ORDER

It is therefore ordered that:

Claimant's claim for TTD benefits from July 4, to and including July 27, 2008 is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 24, 2008

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-965

ISSUES

The issue to be determined by this decision concerns whether the claimant sustained a compensable injury on July 15, 2008.

FINDINGS OF FACT

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

1. This claim involves a dispute over whether Claimant's left knee condition was a result of the worsening of a compensable September 19, 2007 injury while employed with Harvest Meat or whether his left knee condition resulted from a compensable injury at the Employer on July 15, 2008.

2. Claimant received medical treatment for his left knee on July 16, 2008 at Complete Family Care. The medical providers' records reflect Claimant "reinjured" his left knee on July 16, 2008.

3. Claimant treated with Dr. William Cooney, M.D. on July 18, 2008 and Claimant reported that he was injured on July 16, 2008. Claimant further reported that the injury occurred at home. This history was reiterated in Dr. Cooney's July 25, 2008 report.

4. Claimant denied telling his personal care physician at Complete Family Care that he was injured on July 16, 2008. He denies telling Dr. Cooney he was injured at home. He denied telling JP, DF, BO and JH that he was injured at home. Claimant's testimony in this regard was not deemed credible.

5. Claimant testified that he did not work on July 16, 2008, that July 16, 2008 was his regular day off. He admitted that if he was injured on July 16, 2008, it was not compensable.

6. DF testified at the hearing. Mr. F testified he encountered Claimant in the hallway of the Employer on July 17, 2008. He observed Claimant limping badly and asked what happened. Mr. F credibly testified that Claimant told him not to worry, that he had injured himself the day before at home. Mr. F testified that Claimant at no time said he was injured on the job. Mr. F testified that JP handles workers' compensation paperwork for the Employer in the event that an employee reports a work injury. He testified that, if Claimant reported a work injury, he would have referred Claimant to Ms. P.

7. BO credibly testified that he met Claimant in the sales tower of the Employer. Claimant was on crutches wearing a leg brace. Mr. O asked Claimant what had happened. Claimant told O he had injured himself at home gardening. JH was standing next to O at the time of this discussion.

8. JH credibly testified over the telephone that he was in the sales tower talking with Mr. O when the Claimant arrived. Mr. H testified that Claimant denied injuring himself at work. Mr. H testified that the Claimant admitted he had injured himself at home.

9. Ms. P also testified at the hearing. Ms. P is the Human Resources person for the Employer. She credibly testified that she received a telephone call from Claimant on Friday, July 18, 2008. Claimant asked about short-term disability benefits. She asked Claimant why he was interested in short-term disability benefits. Claimant said he had injured himself at home in his garage. P advised Claimant that he did not sign up for short-term disability and, therefore, he could not receive those benefits. A couple of days later, Claimant claimed to have been injured at work.

10. During the November 18, 2008 hearing, Claimant withdrew his Petition to Reopen the September 19, 2007 claim. Claimant did not sustain his burden of proof to establish that he suffered a work injury in the course and scope of his employment for the Employer in July 2008. Claimant's testimony was not found to be credible or persuasive and the medical records and testimony of the Respondents' witnesses contradicted it.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following conclusion of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, et seq. C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out

of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of Claimant nor in favor of the rights of Respondents. Section 8-43-201, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJs factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. Claimant failed to sustain his burden of proof to establish that he sustained a compensable injury while in the course and scope of his employment with the Employer. Medical records offered into evidence at hearing did not support Claimant's claim of a work injury. Respondents' witnesses, DF, BO, JH and JP, all credibly testified that Claimant admitted he injured himself at home, not at work.

ORDER

IT IS THEREFORE ORDERED THAT:

1. Claimant's claim in W.C. No. 4-765-965 is denied and dismissed.

2. Claimant's Petition to Reopen in W.C. No. 4-737-016 is withdrawn.

All matters not determined herein are reserved for future determination.

Dated this _26__ day of December, 2008.

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-718-270

ISSUES

The following issues were raised for consideration at hearing:

1. Division independent medical examiner (DIME) determination of Maximum medical improvement (MMI);
2. Medical benefits;
3. Change of physician;
4. Temporary disability benefits from 2/26/07 through 9/9/07; and
5. Interest

FINDINGS OF FACT

Having reviewed the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. This is an admitted case. Claimant was injured on February 23, 2007 while working as a cable puller for the Employer. She was laying out cable when she tripped over a stack of drywall and landed on her right arm resulting in shoulder pain, arm pain, and wrist pain with paresthesias.

2. Claimant's initial authorized treating physician was Brian Beatty, D.O. However, her authorized treating physician was changed to Clarence Henke, M.D., when Claimant complained that Dr. Beatty injured her upper back in the course of his treatment of her. Dr. Henke works with Dr. Beatty at the Rocky Mountain Medical Group.

3. On September 12, 2007, Claimant was placed at MMI by Dr. Henke with a 0 percent impairment rating. Claimant then requested a DIME. The DIME was performed by Caroline Gellrick, M.D. In her report dated March 18, 2008, Dr. Gellrick stated, the following:

> This examiner agrees basically with the date of MMI put forth on the claim, but what this examiner disagrees with is the entire work-up. This patient had a direct injury to the shoulder. She has crepitus and popping. She should undergo an MRI arthrogram of the right shoulder looking for any pathology that is present and depending on the pathology that is elicited from the MRI the patient should be allowed to see an orthopedic surgeon to review this to see if surgery is recommended. She has been living with the pain and wants it fixed, if it is fixable. We cannot tell this until the MRI arthrogram of the right shoulder is performed, completed and reviewed with orthopedics. If there is a definable surgical lesion that is fixable and

> the patient elects to do surgery, then the date of MMI would change and the case would have to be re-opened at the time of surgery. However, if there is no lesion that is found and there is no surgery that is needed, then the patient stays at MMI and merits consideration of impairment.

4. Dr. Gellrick in the DIME report assigned Claimant a 6% upper extremity rating, or 4% whole person rating, for the shoulder injury, and a 3% whole person rating for the thoracic spine, totaling a 7% whole person impairment.

5. It is found that Dr. Gellrick's determination with regard to MMI was clear and unambiguous in the DIME report. Dr. Gellrick determined that Claimant was at MMI on September 12, 2007 and that she required a MRI arthrogram of the shoulder and an evaluation of that arthrogram by an orthopedic surgeon. Dr. Gellrick clearly states in her report that if the orthopedic surgeon determines that the shoulder requires surgery, and if Claimant elects to undergo that surgery, then Claimant would not be at MMI. If no surgery were performed, then Claimant would remain at MMI. Claimant did not present clear and convincing evidence to overcome the DIME physician's opinion that Claimant is at MMI.

6. Dr. Gellrick's recommendation that the MRI arthrogram should be reviewed by an orthopedic surgeon is reasonably necessary and related maintenance medical benefit to which Claimant is entitled. Dr. Henke is an occupational medicine physician and it is found to be reasonable to allow Claimant to have the MRI arthrogram reviewed by a specialist in the field of orthopedic medicine. Respondents' contention in its Motion for Corrected Order that Claimant did not seek an order awarding her an FCE was found to have merit and therefore these full findings do not award Claimant a FCE.

7. On April 15, 2008, Respondents filed a Final Admission of Liability (FAL) based on the impairment ratings of Dr. Gellrick and an MMI date of September 12, 2007. Respondents also paid PPD benefits at that time. As noted on the FAL, PPD benefits for the whole person impairment were payable from September 12, 2007 through February 2, 2008 and for the scheduled impairment from September 12, 2007 through December 12, 2007. Respondents did not pay interest on these PPD benefits although they were admittedly due months prior to the time they were paid.

8. On August 13, 2008, Claimant had the MRI arthrogram of the right shoulder. According to the radiologist, M. David Solsberg, M.D., the MRI showed "a downsloping acromion which does efface the subacromial-subdeltoid bursa and would predispose to impingement..." The radiologist also noted some minimal tendinosis and a small effusion of the capsule. There was no evidence of a rotator cuff tear or a labral tear.

9. In his reports dated after the MRI, Dr. Henke noted that Claimant has a questionable positive impingement sign with external rotation motion. His assessment is that Claimant's "[r]ight distal acromion process is downsloping causing slight impingement of the subacromial-subdeltoid bursa identified on shoulder MRI examination performed on 8-13-08. This is a developmental process, not caused by any injury to her right shoulder area." Dr. Henke, who is certified in occupational medicine, refused to authorize an evaluation of Claimant by an orthopedist or an orthopedic surgeon. He continues to treat Claimant with medications.

10. Claimant requests a change of physician to a physician not connected with Dr. Henke or Rocky Mountain Medical Group. She gives several reasons for her desire to change physicians, including her lack of confidence in Dr. Henke because he delayed in ordering the shoulder MRI arthrogram as recommended by the DIME, his inconsistent statements to her – first, opining that surgery on the shoulder would not help and then that surgery was the only thing that would help, but that her problem is not work-related, and Dr. Henke's close relationship with her employer. She is also concerned that Dr. Beatty, who apparently caused the injury to her upper back, is in the same medical practice with Dr. Henke.

11. Based on the Final Admission of Liability, the parties' stipulation as to wages earned for the purpose of the Motion for Corrected Findings of Fact, Conclusions of Law and Order, and wage records made part of the record at hearing, Claimant's contention that during the 28 week period from February 26, 2007 to September 9, 2007 she was underpaid temporary partial disability benefits (TPD) was substantiated. The evidence is undisputed that Claimant's admitted average weekly wage (AWW) is 652.76. At the admitted AWW during this 28-week period, Claimant would have earned $18,277.28 ($652.76 X 28). Wage records reflect that Claimant actually earned $10,785.00 during the period from February 26, 2007 to September 9, 2007. The difference between what Claimant should have earned had she not been injured ($18,277.28) and what she actually earned during this 28-week period ($10,785.00) is $7,492.28. The TPD rate is two thirds of the difference between what Claimant should have earned and what she actually earned, or $4,997.35 ($7,492.28 X .667). Respondents admitted liability for TPD during this 28-week period in the amount of $3,611.65. Accordingly, it is concluded that Claimant was underpaid TPD in the amount of $1,385.70 during the period February 26, 2007 to September 9, 2007 ($4,997.35 - $3,611.65). Respondents shall pay Claimant TPD in the amount of $1,385.70.

12. Respondents contend in its' Motion for a Corrected Order that the ALJ's calculation of what Claimant is owed for TPD exceeds the amount that Claimant claimed to be owed in argument in her post hearing position statement. Respondents do not point to an error in the ALJ's calculation of TPD, but only asserts that it is improper to award Claimant an amount, which exceeds the amount

Claimant argued entitlement to. Respondents' argument was considered and determined to be without merit.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the foregoing Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado is to insure 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 8-42-102(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.

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 that not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 237, at 235 (Colo. App. 2004). A workers' compensation case is 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. 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 v. ICAO*, 5 P.3d 385, at 389 (Colo. App. 2000).

3. The credibility of witness testimony and the weight to be given their testimony is within the ALJ's authority to determine. When determining credibility, the fact finder should consider, among other things, 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 Company v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005).

4. The 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).

5. A party has a clear and convincing burden of proof to overcome the medical impairment rating determination of the DIME. Section 8-42-107(8), C.R.S. All of the reports and testimony of the DIME are to be considered in deciding what is the determination of the DIME. Then, the party who seeks to overcome that opinion faces a clear and convincing burden of proof. *Lambert & Sons, Inc. v. Industrial Claim Appeals Office*, 984 P.2d 656 (Colo. App. 1998).

6. In this case, the DIME opinion with regard to MMI is clear, Dr. Gellrick determined that Claimant was at MMI on September 12, 2007. Claimant failed to present clear and convincing evidence to overcome this opinion. Dr. Gellrick further determined that Claimant needed an MRI arthrogram of her right shoulder and that she needed to have the MRI arthrogram reviewed by an orthopedic surgeon. This recommendation was shown to be a recommendation for a reasonably necessary and related maintenance medical benefits for which Respondents are liable.

7. Based on the evidence presented at hearing, as contained in the wage records, which were admitted into evidence at hearing, and the admitted average weekly wage, Claimant is entitled to TPD in the amount of $3,517.79.

8. In order to change physicians, Claimant has a statutory obligation to request that change in accordance with Section 8-43-404(5)(a), C.R.S.; *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). Pursuant to Section 8-43-404(5)(a), C.R.S., a change of physician may be ordered upon a proper showing. *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). A change of physician is not warranted by the mere fact that a claimant has more faith in a specific doctor or lacks confidence in the employer's doctor. 5 *Larson's Workers' Compensation Law* Section 94.02[3] (1999).

9. Claimant, in this case, made a proper showing that she is entitled to a change of physicians. She not only lack confidence in Dr. Henke, but the relationship is further complicated by his conflicting opinions and his business association with Dr. Beatty, who Claimant identifies as being responsible for injuring her in the course of his treatment.

ORDER

It is therefore ordered that:

1. Respondents shall be liable for reasonably necessary and related maintenance medical benefits. Such benefits include evaluation of Claimant and the MRI arthrogram by an orthopedic surgeon.

2. Respondents shall authorize and accept liability for Claimant's treatment by a new physician.

3. Respondents shall be liable for TPD in the amount of $1,385.70.

4. 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.

DATED: December 29, 2008

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 9, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/9/08, Courtroom 3, beginning at 8:43 AM, and ending at 9:14 AM). No testimony was taken and the matter was submitted on the documentary evidence.

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents' counsel, to be submitted electronically and mailed to the Claimant, giving the Claimant 3 working days within which to file objections by fax. The proposed decision was filed on December 10, 2008. Allowing a presumption of 3 days for receipt of mail, objections were due, by fax, on December 18, 2008. No timely objections were filed. After a consideration of the proposed decision, the ALJ has modified the proposal and hereby issues the following decision.

ISSUES

The issues that Claimant designated for hearing and the issues to be determined by this decision concern permanent medical impairment; maximum medical improvement (MMI); and, medical maintenance benefits after MMI.

FINDINGS OF FACT

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

1. Claimant sustained an admitted injury to her left lower extremity (LLE), arising out of and in the course and scope of her employment on August 24, 2007. Respondents provided authorized medical treatment for the Claimant to cure and relieve her of the effects of the injuries.

2. The Claimant's authorized treating physician (ATP) was Nicholas Olsen, D.O., who discharged her from treatment on January 18, 2008. Dr. Olsen was of the opinion that Claimant reached MMI on January 18, 2008, and had sustained zero permanent medical impairment.

3. Respondents filed a Final Admission of Liability on February 5, 2008, based on the above referenced opinion of Dr. Olsen.

4. Claimant filed a timely Objection to the Final Admission on March 4, 2008, indicating thereon that she was proposing the name of a Division Independent Medical Examiner (DIME) and requesting a DIME. Claimant did not file the form entitled "Notice and Proposal to Select an IME" until March 10, 2008. The Notice and Proposal form did not contain the names of any physicians, it was filed more than 30-days after the Final Admission, and the negotiation process was never carried forward. The ALJ infers and finds that Claimant intended to challenge the ATP's opinion by attempting to request a DIME.

5. Respondents filed a "Notice of Failed DIME Negotiations" on September 5, 2008. Subsequent to the Notice of Failed IME Negotiations, Claimant took no further action on the claim, prior to the hearing.

6. Although Claimant objected to the Final Admission and provided notice that it was her intent to request an IME, Claimant failed to file a new and timely Notice and Proposal to Select a DIME within the 30 days of Respondents filing the "Notice of Failed DIME Negotiations" on September 5, 2008.

7. Claimant indicated on the record, but not under oath, that she felt she was permanently disabled from August 24, 2007 LLE injury. She manifested confusion over the procedural posture of her case. She is jurisdictionally precluded from pursuing a whole person rating through a DIME that differs from her ATP's rating of zero.

8. The only evidence contained within the record relating to the issues for determination is the medical report of Nicholas Olsen, D.O., dated January 18, 2008. Therein Dr. Olsen states the opinion that Claimant reached MMI on January 18, 2008, sustained no permanent medical impairment. Dr. Olsen's report is silent on whether the Claimant requires ongoing medical maintenance care. This opinion stands undisputed. Claimant has presented no additional medical evidence of any kind. She has not applied for nor obtained a DIME. The ALJ finds that the Claimant has failed to establish, by a preponderance of the evidence, that she sustained any permanent medical impairment on a whole person basis; that she has **not** reached a point of MMI; or that she requires medical maintenance treatment beyond the date of MMI.

9. Respondents argue that Claimant is now precluded from pursuing a DIME and, thus, a whole person permanent disability award because she ultimately missed the jurisdictional time limits to re-activate the DIME process after Respondents filed their "Notice of Failed DIME Negotiations" on September 5, 2008. Although Claimant may have substantially complied with the DIME procedures at the outset, she failed to substantially comply in the final analysis because she did not re-active the DIME process within 30-days after the "Notice of Failed IME Negotiations," filed on September 5, 2008. This argument is factually accurate. Respondents do **not** argue that Claimant is precluded from pursuing a

scheduled rating that differs from her ATP's schedule rating and which does not require a DIME. Indeed, the issue of permanent scheduled disability never came up at the hearing.

CONCLUSIONS OF LAW

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

a. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, *et.seq*., C.R.S. (2008), 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* Section 8-30-102(1), C.R.S. (2008). The provisions of the Act are designed to be self-executing, with litigation by exception. For instance, an ATP's opinion on permanent medical impairment (whole person), and MMI is the last word on these two subjects unless challenged by a DIME.

b. Section 8-42-107(8)(c), C.R.S. (2008), which concerns whole person medical impairment, states in pertinent part:

> "If either party disputes the authorized treating physician's finding of medical impairment, including a finding that there is no permanent medical impairment, the parties may select an independent medical examiner in accordance with Section 8-42-107.2. The finding of such independent medical examiner shall be overcome by clear and convincing evidence. A hearing on this matter shall not take place until the finding of the independent medical examiner has been filed with the Division."

Section 8-42-107.2(2)(a)(I)(A), C.R.S. (2008) states in pertinent part:

> "…for the claimant, the time for selection of an IME commences with the date of mailing of a final admission of liability by the insurer, or self-insured employer that includes an impairment rating issued in accordance with section 8-42-107." Under subsection (2)(b) it states "if any party disputes the finding or determination of the authorized treating physician, such parties shall request the selection of an IME. The requesting party shall notify all other parties in writing of the request, on a form prescribed by the Division by rule, and shall propose one or more acceptable candidates for the purposes of entering into negotiations for the selection of an IME. Unless such notice and proposal are given within 30 days after the date of mailing of the final admission of liability or the date of

> mailing or delivery of the disputed finding or determination, as applicable pursuant to paragraph (a) of this subsection (2), the authorized treating physicians findings and determinations shall be binding on all parties and on the Division."

As found, although Claimant objected to the Final Admission and provided notice in the Application for Hearing that it was her intent to request a DIME, Claimant failed to file the Notice and Proposal to Select an IME within the 30 day period required by the above statute and, therefore, the ATP's findings and determinations concerning MMI and zero whole person permanent medical impairment should be binding on all parties.

c. Even if Claimant had substantially complied with the notice of DIME provisions in the statute, as found, she did not follow through and Respondents ultimately filed a "Notice of Failed DIME Negotiations" on September 5, 2008. As found, Claimant did nothing to re-activate the DIME process within 30-days after September 5, 2008. Requests for DIMEs are controlled by Rule 11-3 of the Workers' Compensation Rules of Procedure (WCRP), 7 CCR 1101-3(3):

> "The requesting party shall submit an application for an IME according to Rule 11-3(B). If the parties did not agree on the physician, the insurer shall notify the Division and the other party on a prescribed form regarding the failed negotiations within 30 calendar days of their failure to agree. The party disputing the determinations of the authorized treating physician, and seeking review of those determinations (requesting party) shall file an application for IME within 30 days of the date of the failure to agree upon an IME physician. (4)…The requesting party must complete the application for IME."

Rule 11-3(B) states:

> "<u>Form Required:</u> The prescribed form, 'Application for a Division Independent Medical Examination' shall be used in all cases to request an IME."

Therefore, the ALJ concludes that the Claimant, having failed to file the prescribed form at any time following the September 5, 2008 "Notice of Failed IME Negotiation," has failed to substantially comply with the statutory provisions and rules and she is bound by the ATP's findings and determinations, concerning MMI and lack of whole person permanent medical impairment.

d. A DIME is not necessary when the issues involve permanent disability for scheduled injuries. *See* Section 8-42-107(8)(a)-(d), C.R.S. (2008). As found, Claimant was confused concerning the requirements in the permanent disability process. Indeed, Claimant intended to challenge her ATP's zero whole person permanent medical impairment rating.

e. As found, Claimant filed a timely objection to the Final Admission of Liability, thus, preserving her right to object to Dr. Olson's zero PPD rating insofar as a scheduled rating was concerned. As found, no credible, persuasive or substantial evidence was presented to allow a rational fact finder to support a permanency award on a whole person basis above zero. 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." *See Bson-Rausin v. Industrial Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005); *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995).

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. Industrial Commission 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. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. As found, no substantial evidence to support post-MMI medical maintenance benefits (*Grover* Medicals) was presented at the hearing. Therefore, Claimant is not entitled to *Grover* medical benefits.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The findings and determinations of Nicholas Olsen, D.O., are affirmed. Claimant's claim for whole person permanent disability benefits is hereby denied and dismissed. Claimant's claim for ongoing medical maintenance care is hereby denied and dismissed.

B. Claimant reached maximum medical improvement on January 18, 2008, with no whole person permanent partial disability.

C. Any and all issues not determined herein are reserved for future decision.

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 16, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/16/08, Courtroom 3, beginning at 8:42 AM, and ending at 9:50 AM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents' counsel, to be submitted electronically within 5 working days, giving Claimant 3 working days thereafter within which to file objections, electronically. The proposed decision was filed on December 17, 2008. No timely objections were filed. After a consideration of the proposal, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern whether Respondents overcame the Division Independent Medical Examination (DIME) opinion of Robert Mack, M.D., which found the Claimant "not at maximum medical improvement (MMI), by clear and convincing evidence; and, because causal relatedness is inextricably bound into the issue concerning the need for ongoing medical care, whether Claimant has demonstrated by clear and convincing evidence that he is entitled to ongoing medical benefits as recommended in Dr. Mack's DIME report. The issues herein give rise to a more fundamental inquiry, *i.e.,* what is the line between "issue preclusion" after an ALJ's decision and whether a DIME can supplant earlier un-appealed ALJ determinations on causal relatedness.

FINDINGS OF FACT

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

1. The Full Findings of Fact, Conclusions of Law and Order, dated January 22, 2008, are incorporated herein by reference as if fully restated herein.

2. The Employee was a geologist who injured his left shoulder in the course and scope of work on March 16, 2007. The parties went to hearing on

January 8, 2008 on the issues of compensability/causal relatedness and medical benefits. This ALJ previously found as a result of that hearing (Findings of Fact, Conclusions of Law and Order (hereinafter "Order"), dated January 22, 2008, that the Claimant had proven a compensable March 16, 2007 temporary aggravation of a pre-existing, complex left shoulder condition. ("Findings of Fact", ¶13). The ALJ further found that the Claimant failed to prove by a preponderance of the evidence that the need for treatment for extensive humeral head abnormalities and other rotator cuff abnormalities were work-related. (Order, "Findings of Fact", ¶13; *Id*.) The ALJ specifically found that the Claimant had failed to prove that the need for ongoing medical care for the left shoulder, after April 19, 2007, was causally related to the March 16, 2007 work-injury, as opposed to the underlying non-work related complex shoulder problems. (Order, "Findings of Fact", ¶12)

3. Although **not** interlocutory because medical benefits were awarded, the January 22, 2008 Findings of Fact, Conclusions of Law and Order were not appealed.

4. Following the hearing and the Order issued on January 22, 2008, Respondents filed a Final Admission of Liability, and this claim proceeded through the Division IME (DIME) process outlined in Section 8-47-107.2, C.R.S. (2008). Dr. Mack was the DIME physician selected.

5. In contradiction to the previous findings of causality set forth in ¶1, above; Dr. Mack's DIME report concluded that the Claimant was not at MMI, and Claimant needed to be treated for the ongoing shoulder complaints and other rotator cuff abnormalities, implicitly overturning the January 22, 2008 Order as to causality.

6. On September 9, 2008, the parties took the evidentiary deposition of Dr. Mack. Dr. Mack testified that he relied on the Claimant's self-reported history of trauma to form his opinion. (Deposition p. 9: lines 5-16). At the January 8, 2008 hearing, the ALJ did not find this history of trauma fully credible, and so found in the January 22, 2008 Order. Dr. Mack admitted that the he disagreed with the history that Dr. Orgel recorded in his April 19, 2007 report. (Deposition p. 10: lines 12-22). Dr. Mack reiterated that the Claimant's self-reported history was the basis for his disagreement with the reports of the authorized providers. (Deposition p. 13: lines 4-10). Dr. Mack agreed that the x-ray and MRI (magnetic resonance imaging) findings alone could not establish a date when the Claimant's extensive underlying shoulder conditions arose. (Deposition p.15: line 21 through p.16: line14). Dr. Mack maintained that his ultimate opinion and basis for his report was that the shoulder pathology was all caused by the work activity. (Deposition p. 26: lines10-17). When asked to presume the finding of a pre-existing, underlying condition, Dr. Mack declined to consider the impact of the January 22, 2008 Order and/or an underlying condition as part of his consideration of MMI status on this claim. (Deposition p. 30: line 21 through p. 33: line 3). Indeed, the ALJ finds that Dr. Mack, through the DIME process, effectively at-

tempted to overrule or circumvent an appeal of the ALJ's January 22, 2008 Order insofar as causality was concerned.

7. David Orgel, M.D., Claimant's authorized treating physician (ATP), testified at hearing. He was of the opinion that Dr. Mack's assertion that the fracture of Claimant's humeral head, not having been diagnosed by authorized providers, was incorrect. (*See* Deposition p. 5: lines 4-16; *Respondents' Ex. F,* folio no. 0019; compare with *Respondents' D*, folio no. 0013 and *Respondents'* C.) Dr. Orgel stated that nothing in Dr. Mack's report changed the opinions formed and contained in his (Dr. Orgel's) 2007 treatment notes, and as previously testified to at the January 8, 2008 hearing. He explained that pain arising from working with a fractured humeral head was similar to experiencing pain after "hobbling in to work" on a fractured ankle – the activity following a fracture will cause pain to arise, but does not render the initial injury (the fracture) a work related injury. The ALJ infers and finds that Claimant did not establish a substantial, permanent aggravation of his pre-existing condition in the injury of March 16, 2007. The ALJ finds that it is highly probable, and free from serious and substantial doubt, that Dr. Mack's DIME opinion on causality is clearly erroneous. Dr. Mack's DIME report also created a conflict with the January 22, 2008 Order regarding causal relatedness and, as found hereinabove, it was clearly erroneous.

8. The March 16, 2007 injury aggravated and combined with Claimant's pre-existing left shoulder condition to temporarily aggravate the condition until April 19, 2007. Thereafter, Claimant was back to his non-work related baseline.

9. The ALJ finds that the Claimant had a full and fair opportunity to litigate the causal relatedness of the humeral fracture and the continued impingement symptoms at the January 8, 2008 hearing, he did so at the time, and he failed to establish causal relatedness of his left shoulder problems other than a temporary aggravation thereof, which ended on April 19, 2007. The findings in the January 22, 2008 Order became final as to this claim when not timely appealed.

10. The ALJ finds that Respondents have proven, by clear and convincing evidence, that Dr. Mack's DIME finding of "Not at MMI" was in error. The ALJ further finds that it is highly probable, and free from serious substantial doubt, that Dr. Mack erred by determining that Claimant was not at MMI, based on Claimant's history of sequelae to the injury of March 16, 2007, which was rejected in the Order of January 22, 2008. Therefore, the ALJ determines that Claimant reached MMI on April 19, 2007 with no permanent medical impairment caused by the injury of March 16, 2007.

11. The ALJ finds that the Claimant has failed to prove that it is more reasonably probable than not that he requires any ongoing, causally-related

medical benefits beyond April 19, 2007 for compensable injuries sustained as a result of the March 16, 2007 incident. Therefore, Claimant has failed to prove causal relatedness of the need for treatment after April 19, 2007 by a preponderance of the evidence.

CONCLUSIONS OF LAW

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

a. The Conclusions of Law contained in the Order, dated January 22, 2008, are incorporated herein by reference as if fully restated herein.

b. By analogy, guidance may be derived from the proposition that securing a "change of physician" to circumvent the DIME process [*See Story v. Industrial Claim Appeals Office,* 910 P.2d 80 (Colo. App. 1995)] may not be done, a DIME may not be used to circumvent or overrule the previously established law of the case, which was not timely appealed, unless the DIME deals with issues beyond those contemplated in an earlier ALJ decision. As found, insofar as the DIME overturns the January 22, 2008 un-appealed Order concerning causality of continuing left shoulder problems after April 19, 2007, it would effectively circumvent the normal appeal process on the issue of causality.

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. (2008). 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. Section 8-41-301(1)(c), C.R.S. (2008). *See Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). *Also see* Section 8-41-301(1)(c), C.R.S. (2008); *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Industrial Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949). As found, the March 16, 2007 injury aggravated and combined with Claimant's pre-existing left shoulder condition to temporarily aggravate it until April 19, 2007. Thereafter, Claimant was back to his non-work related baseline.

d. The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). The DIME physician's determination of MMI is binding unless overcome by "clear and con-

vincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R.S. (2008). "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.* 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). The question of whether the DIME physician has placed a claimant at MMI or not, and whether that determination has been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, supra. As found, Dr. Mack's DIME opinions have been overcome by clear and convincing evidence, which includes Dr. Mack not taking into account the law of the case, established by the Order of January 22, 2008. Once the DIME opinion on causal relatedness has been overcome, it becomes the Claimant's burden, by a preponderance of the evidence, to establish entitlement to post-MMI medical benefits. *See* 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. Industrial Commission 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. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995); *Grover v. Industrial Commission, supra*. As found, Claimant failed to prove entitlement to maintenance medical care, by a preponderance of the evidence.

Issue Preclusion

e. Causal relatedness of Claimant's shoulder condition was an appropriate issue, designated for the January 8, 2008 hearing. The doctrine of issue preclusion prohibits re-litigation of issues actually litigated in prior proceedings. The doctrine applies when: (1) there is an identity of an issue necessarily adjudicated in a prior proceeding; (2) there is identity of parties involved in the prior proceeding; (3) there was a final judgment on the merits; and (4) there was a full and fair opportunity to litigate the issue in the prior proceeding. *City & County of Denver v. Block 173 Assocs.*, 814 P.2d 824, 831 (Colo. 1991); *Sunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44 (Colo. 2001). Indeed, the doctrine of issue preclusion also prohibits re-litigation of issues that **might** have been litigated and decided. *See Metcalfe v. Bruning Division of AMI,* 866 P.2d 877 (Colo. App. 1993). Re-litigation of an issue in a DIME opinion is encompassed by the doctrine of issue preclusion. As found, the Claimant had a full and fair opportunity to litigate the causal relatedness of his underlying shoulder complaints at the hearing on January 8, 2008. A final order was issued on January 22, 2008, which was not appealed. Therefore the doctrine of issue preclusion bars reconsideration of the causal relatedness of the underlying shoulder complaints to the March 16, 2008 work incident.

f. Recent articulations of the doctrine of "issue preclusion" do **not** yet offer a bright line between an un-appealed ALJ decision and a subsequent DIME opinion. In *Mahana v. Grand County,* W.C. No. 4-430-788 (ICAO, February 15, 2007), this ALJ declined to give preclusive effect to a previous ALJ's decision that the claimant did **not** suffer from sympathetic mediated pain (SMP) or chronic regional pain symdrome (CRPS) and was, therefore, not entitled to medical benefits based on these diagnoses because subsequently a DIME opinion determined that she did, in fact, suffer from these conditions. In *Mahana,* the ALJ noted that the burden of proof and the issues were different at the time of the DIME. ICAO noted, "affording preclusive effect to the ALJ 's previous order regarding the claimant's diagnosis of CRPS would **eviscerate** (emphasis supplied) the DIME process…." The ICAO opinion in *Mahana* contained a lengthy and well-reasoned dissent, based on the strict application of the doctrine of issue preclusion. The Court of Appeals, accepting the rationale of the dissent, reversed ICAO in *Grand County v. Industrial Claim Appeals Office* (Court of Appeals No. 07CA0424, April 24, 2008) [Not published pursuant to C.A.R. 35 (f)]. The Court held that the causal relatedness of the long-term consequences of claimant's work-related injury was identical to the issue before the DIME and this ALJ in the second hearing. The Court noted that claimant *Mahana's* incentive at both hearings was the same, payment for medical treatment of the conditions the first ALJ found not to be causally related. *Grand County, supra,* resolved the matter in the *Mahana* case, but does not answer the question concerning the legitimate place of the DIME in making presumptive determinations of causal relatedness that must be overcome by clear and convincing evidence in the face of A previous ALJ decision that was not timely appealed. *See Leprino Foods Co. v. Indus. Claim Appeals Office,* 134 P.3d 475 (Colo. App. 2005); *Qual-Med. Inc. v. Indus. Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). The underlying rationales of these opinions indicate that "causal relatedness" in the long-term is part and parcel of MMI and permanent impairment determinations. Such would not be so under the *Mahana* rationale because an earlier ALJ decision could preclude a DIME opinion on causal relatedness, despite the different role of the DIME process in determining MMI and permanent medical impairment. Perhaps, as part of the DIME process, the DIME examiner should be given prior ALJ decisions on causal relatedness and instructed to form opinions within the parameters of the law of the case.

Medical Benefits

g. Respondents are liable for authorized medical treatment that is reasonably necessary to cure and relieve the effects of an industrial injury. Section 8-42-101(1)(a), C.R.S. (2008); *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). 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 after April 19, 2007 is **not** causally related to the compensable

injury of March 16, 2007. It is the ALJ's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether a claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999). Once the DIME was overcome by clear and convincing evidence, the "causal relatedness" of post-MMI medical care after April 19, 2007 is by a preponderance of the evidence. *See Grover v. Industrial Commission, supra.* As found, Claimant failed to prove, by a preponderance of the evidence, that he is entitled to ongoing medical treatment, after April 19, 2007, that is reasonably necessary to cure and relieve the effects of his causally related industrial injuries.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Full Findings of Fact, Conclusions of Law and order, dated January 22, 2008, establish the law of the case with respect to the lack of causal relatedness to the March 16, 2007 compensable event of Claimant's left shoulder condition after April 19, 2007.

B. The Division Independent Medical Examination of Robert Mack, M.D., that Claimant had not reached maximum medical improvement has been overcome by clear and convincing evidence. Claimant reached maximum medical improverment on April 19, 2007.

C. Claimant's request for ongoing medical benefits after April 19, 2007 is hereby denied and dismissed.

D. Any and all issues not determined herein are reserved for future decision.

DATED this_____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on December 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/18/08, Courtroom 3, beginning at 1:42 PM, and ending at 2:39 PM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Claimant's counsel, to be submitted electronically within 5 working days, giving Respondents 3 working days within which to file objections, electronically. The proposed decision was filed on December 23, 2008. Respondents indicated they had no objection to the proposed decision on December 29, 2008. After a consideration of the proposal, the ALJ has modified the proposed decision and hereby issues the following decision.

ISSUES

The sole issue to be determined by this decision is whether Claimant's admitted left shoulder (LUE) injury of January 31, 2008, should be converted as to a whole person permanent medical impairment (PPD). At the outset, Claimant does not challenge the four corners of the authorized treating physician's (ATP) opinions, thus, Claimant's burden of proof on the requested conversion is by a preponderance of the evidence.

FINDINGS OF FACT

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

1. Claimant is a delivery driver for AB where he has worked for ten years.

2. This case involves an admitted LUE injury occurring on January 31, 2008, when Claimant was in the course and scope of employment, while stacking beer.

3. Respondents filed a Final Admission of Liability, dated July 18, 2008, admitting for a scheduled impairment of 6% LUE (for a total of $2,959.13 PPD, based on the opinion of Claimant's authorized treating physician (ATP), Lon Noel, M.D. Respondents admitted for a temporary total disability (TTD) benefit rate of $624.35, based on an average weekly wage (AWW) of $936.53.

4. Claimant underwent an MRI (magnetic resonance imaging) arthrogram on March 6, 2008, which demonstrated a partial tear of the supraspinatus tendon with slap lesion. He subsequently underwent surgery with James D. Ferrari, M.D., on April 23, 2008.

5. Claimant's surgery on April 23, 2008, involved multiple procedures including left shoulder arthroscopic subacromial decompression, and a left shoulder arthroscopic debridement of both a superior labral tear and of a partial thickness subscapularis tear.

6. Claimant was eventually placed at maximum medical improvement (MMI) on June 20, 2008, by ATP Dr. Noel. At the time, Claimant was 38 years of age (D.O.B 10/26/1969).

7. At MMI, Dr. Noel, gave the Claimant a 6% LUE impairment rating that Dr. Noel converted to a 4% whole person, pursuant to the mandate of the *AMA Guides to the Evaluation of Permanent Impairment,* 3rd Ed., Rev.

8. Claimant credibly testified, and the ALJ finds, that as a result of his left shoulder injury he has difficulty carrying objects on his left shoulder because of pain he experiences at the site of the surgery on his left shoulder. He also credibly testified, and the ALJ finds, that Claimant's left shoulder pain interferes with both his ability to sleep on his left side, and to lift objects above his head using his shoulder girdle. Additionally, a typical job duty of the Claimant involves carrying kegs of beer into stores on his left shoulder, which he can no longer do because of the admitted, compensable injury. His right shoulder was previously restricted from carrying objects on it.

9. Ronald J. Swarsen, M.D., testified as an expert at hearing. He was of the opinion that the site of Claimant's functional impairment as a result of his January 31, 2008, left shoulder injury was above the arm at the shoulder. Dr. Swarsen's opinion was based on evidence concerning the shoulder structures which were surgically repaired as well as Claimant's testimony concerning the site of functional impairment that he was experiencing.

10. Dr. Swarsen was of the opinion that the Claimant's functional impairment was above the shoulder and not at or below the left arm. Further, Dr. Swarsen noted that the structures that were surgically repaired were above the arm, and part of the shoulder. The ALJ finds that Dr. Swarsen's opinion concerning the site of functional impairment, coupled with the Claimant's testimony concerning functional limitations on top of the left shoulder, credibly support the ATP's conversion to 4% whole person as the appropriate measure of Claimant's PPD.

11. Claimant has proven, by a preponderance of the evidence, that he has suffered an injury which entitles him to a whole person permanent medical impairment for the structures of the shoulder that are above the arm.

CONCLUSIONS OF LAW

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

General

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. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). 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). 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). As found, both the Claimant's and the testimony of Claimant's expert witness, Dr. Swarsen, met the above tests of credibility.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the entitlement to additional benefits beyond those admitted, including for a conversion from a scheduled award to a whole person award, provided the four corners of the ATP rater's opinions are not challenged. Sections 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial 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); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has sustained his burden with respect to Dr. Noel's converted rating of 4% whole person.

SHOULDER CONVERSION

c. When an injury results in a permanent medical impairment not set forth on a schedule of disabilities, an employee is entitled to medical impairment benefits paid as a whole person. Section 8-42-107(8)(c), C.R.S. (2008). As found, the site of Claimant's functional impairment is not listed on the schedule.

d. Section 8-42-107(1)(a), C.R.S. (2008), limits medical impairment benefits to those provided in section (2) where the Claimant's injury is one enumerated on the schedule. The schedule of injuries includes the loss of the "**arm at the shoulder"**. The plain meaning of this is "at or below the shoulder." *See* Section 8-42-107(2)(a). The **"shoulder" is not listed in the schedule of im-**

pairments. *See Martinez v. Albertsons*, W.C. No. 4-692-947 [Industrial Claim Appeals Office (ICAO), June 30, 2008]; *Maree v. Jefferson County Sheriff's Department*, W.C. No. 4-260-536 (ICAO, August 6, 1998); *Bolin v. Wacholtz*, W.C. No. 4-240-315 (ICAO, June 11, 1998). As found, the site of Claimant's functional impairment is above the shoulder.

e. Although Section 8-42-107(2)(a), C.R.S. (2008), does not define a "shoulder" injury, the dispositive issue is whether the Claimant has sustained a functional impairment to a portion of the body listed on the schedule of disabilities. *See Strauch v. PSL Swedish Healthcare*, 917 P.2d 366 (Colo. App. 1996). The ALJ is tasked with determining the site of functional impairment, not necessarily the site of the initial harm, in deciding whether the loss is one listed on the schedule of disabilities or not. As found, the site of Claimant's functional impairment is not listed on the schedule of disabilities. It is on top of the Claimant's left shoulder **not** at or below the shoulder.

f. Pain and discomfort which limit a claimant's ability to use a portion of the body can be considered functional impairment for purposes of determining whether an injury is off the schedule. *See Langton v. Rocky Mountain Healthcare Corp.*, 937 P.2d 883 (Colo. App. 1996); *Eidy v. Pioneer Freightways*, W.C. No. 4-291-940 (ICAO, August 4, 1998); *Beck v. Mile Hi Express, Incorporated*, W.C. No. 4-238-483 (ICAO, February 11, 1997). Not only does Claimant experience pain on top of the left shoulder, above the sites of the surgery, the top of his left shoulder is functionally limited from carrying kegs of beer into stores. Claimant suffers pain at the top of his shoulder that limits his ability to perform the function of carrying objects on his shoulder, lifting above the head, and sleeping. Claimant's functional impairment is above the arm at the shoulder, and not on the schedule of impairments. *See Phase II Company v. ICAO*, (Colo. App. No. 97CA2099, September 3, 1998) [NSOP]. As found, the presence of pain, discomfort and loss of function is to the structures beneath the top of his **shoulder**, not the **arm.**

g. There is substantial evidence that Claimant suffered functional impairment beyond, or above, the **arm** at the **shoulder**. City *Market v. ICAO*, 68 P.3d 601 (Colo. App. 2003). Specifically, Claimant suffers functional loss to areas of the **shoulder** joint, both of which are beyond the arm and at the shoulder. Thus, a whole person award is appropriate. See *B v. City of Aurora*, W.C. No. 4-452-408, (ICAO, October 9, 2002).

h. As found, Claimant's left shoulder causes pain and reduced function in structures that are above the shoulder joint. Thus, Claimant's injury should be compensated, based on a whole person because the site of his functional impairment is **off** the schedule. *See Velasquez v. UPS*, W.C. No. 4-573-459 (ICAO April 13, 2006); *Heredia v. Marriot*, W.C. No. 4-508-205 (ICAO, September 17, 2004); *see also Smith v. Neoplan USA Corporation*, W.C. No. 4-421-202 (ICAO, October 1, 2002); *Colton v. Tire World*, W.C. No. 4-449-005 (ICAO, April 11, 2002); *Guillotte v. Pinnacle Glass Company*, W.C. No. 4-443-878

(ICAO, November 20, 2001); *Copp v. City of Colorado Springs*, W.C. No. 4-271-758; 4-337-778 (ICAO, January 24, 2001); *Olson v. Foley's*, W.C. No. 4-326-898 (ICAO, September 12, 2000); *Gonzales v. City and County of Denver*, W.C. No. 4-296-588 (ICAO, September 10, 1998).

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's left shoulder injury of January 31, 2008, shall be compensated, based on the whole person rating of his authorized treating physician, Lon Noel, M.D.

B. Claimant's whole person impairment of 4% entitles him to compensation based on the formula found at Section 8-42-107 (8), C.R.S. (2008), of $14,385.02 (1.44 age multiplier x 400 x $624.35 (the admitted weekly temporary total disability benefit rate) x 4% whole person).

C. Respondents are entitled to credit for previously paid permanent disability benefits pursuant to the Final Admission filed on July 18, 2008.

D. Respondents shall pay the Claimant interest at the statutory rate of eight percent (8%) per annum on all amounts due and not paid when due.

E. Any and all issues not determined herein are reserved for future decision.

DATED this _____ day of December 2008.

Edwin L. FElter, Jr.,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

No further hearings have been held. On November 25, 2008, the Industrial Claim Appeals Office (ICAO) remanded the above-captioned matter for a redetermination of whether the Division independent Medical Examiner's (DIME), Ranee Shenoi, M.D., opinion had been overcome by clear and convincing evidence, in light of Dr. Shenoi's statement in the original DIME report that Claimant's low back, hip and right leg complaints **were related** to her sacrococcygeal fracture. In her "Follow-Up DIME of October 1, 2007, Dr. Shenoi implicitly modi-

fied this indication of causal relatedness (Claimant's Exhibit 16). The Administrative Law Judge (ALJ), Edwin L. Felter, Jr., therefore, on remand adds to and modifies the previous decision. The remand was referred to the ALJ on December 29, 2008.

Hearing in the above-captioned matter was scheduled before ALJ Felter for July 2, 2008, in Denver, Colorado. The day prior to the scheduled hearing, the parties agreed to submit the matter for decision on briefs and documentary exhibits.

ISSUE ON REMAND

The issue on remand concerns whether or not there is substantial evidence to overcome DIME of Dr. Shenoi, specifically, her ultimate opinion in the Follow-Up DIME of October 1, 2007, that Claimant's lumbar spine and right leg problems lacked causal relatedness to Claimant's work-related sacrococcygeal fracture by virtue of the fact, among other facts, that Dr. Shenoi declined to rate the lumbar spine. Claimant agreed to dismiss her claim for a cervical impairment. Claimant also sought an increase in her average weekly wage (AWW). The parties stipulated that Claimant's AWW is $536.44. The ALJ approved and accepted the stipulation on July 1, 2008. Claimant bears the burden of proof, by clear and convincing evidence.

FINDINGS OF FACT ON REMAND

Based on the evidence presented in the documentary exhibits, the ALJ makes the following Findings of Fact:

1. On May 4, 2006, Claimant sustained alleged injuries to her right hip, lower back, neck and right leg when she tripped and fell at work.

2. On May 5, 2006, Lon Noel, M.D., evaluated the Claimant and diagnosed her with a lumbar and sacral strain. Dr. Noel prescribed physical therapy, Celebrex, Methocarbamol, Cyclobenzaprine and a donut seat.

3. On June 2, 2006, Dr. Noel performed a follow-up evaluation of the Claimant after she continued to complain of right-sided lower back pain, which radiated into her right buttock. Dr. Noel referred Claimant for a lumbar MRI (magnetic resonance imaging).

4. The MRI was completed on June 6, 2006 and it showed degenerative disc disease at L2 through S1 (most prominent at L4-5 and L5-S1), mild bilateral facet arthropathy at L4-5 with minimal central canal and bilateral neural foraminal multi-factorial stenosis at L4-5 of uncertain clinical significance.

5. On June 16, 2006, Dr. Noel performed a supplemental evaluation of the Claimant. Dr. Noel requested an MRI of the sacrum and recommended massage therapy, Ibuprofen, tramadol, Methocarbamol and Cyclobenzaprine.

6. On June 23, 2006, Claimant underwent the sacrum MRI that showed a fracture of the sacrococcygeal area with some adjacent edema. There was no sign of displacement or angulation.

7. On July 7, 2006, Dr. Noel performed a follow-up examination. Claimant continued to complain of pain in the lower back with decreased active range of motion of the lumbosacral spine. Dr. Noel's assessment of Claimant's injury changed to a sacral coccygeal fracture and it did not include a lumbar strain.

8. On August 25, 2006, Claimant was referred to Yusuke Wakeshima, M.D., for evaluation. Dr. Wakeshima noted current complaints of right-sided low back and buttock region pain. On physical examination, he observed tenderness to palpation in several areas including: over the right SI joint region, the L4-5 and L5-S1 facet joint region, and the right coccygeal region. He diagnosed the Claimant with subjective right buttock and low back region pain with clinical findings suggestive of right SI joint dysfunction with coccydynia, MRI demonstrating facture of the sacral-coccygeal area with no angulation or displacement, MRI of the lumbar spine demonstrating **degenerative disc disease** most prominent at L4-5 and L5-S1 and mild bilateral facet arthropathy at L4-5 and multifactorial stenosis at L4-5. Dr. Wakeshima offered the opinion that "the trauma she explained that could possibly cause a sacral-coccygeal fracture certainly would be enough to also irritate the SI joint region." The ALJ finds that Dr. Wakeshima's opinion on the causal relatedness of Claimant's then present back condition to the admitted compensable injury is an opinion concerning a "possibility," which, alone, would not permit the ALJ to determine that the causal relatedness of the present back condition to the admitted injury is more reasonably and probable than not.

9. Usama Ghazi, D.O., performed an SI joint injection and right SI arthrogram on September 15, 2006.

10. On September 28, 2006, Dr. Noel placed Claimant at maximum medical improvement (MMI) with no permanent impairment and no future medical care recommendations. Dr. Noel did not give Claimant a lower back impairment rating even though Claimant complained of continued pain in her lower back.

11. On March 19, 2007, Dr. Shenoi performed a DIME. Dr. Sehoi evaluated the tailbone/buttocks area, back, hips left and right lower extremities and neck. She did not believe that Claimant was at MMI and she recommended additional injections and physical therapy. Dr. Shenoi also did not believe that

Claimant sustained an injury to her lumbar spine. As of the March 19, 2007 DIME, Dr. Shenoi was of the opinion that Claimant's low back, hip and right leg complaints were related to the sacrococcygeal fracture. Dr. Shenoi stated at page 6 of her first report (Claimant's Exhibit 17): "…I believe her low back, hip and right leg complaints are related to the sacrococcygeal fracture." Lter, in the same report, Dr. Shenoi states: "…I do not believe the patient had an injury to her lumbar spine.. rather, the right leg symptoms appear to be related to the bursitis and right sacroiliac dysfunction." Nowhere in the March 19 Report does Dr. Shenoi persuasively relate the bursitis as causally related to the compensable injury.

12. In the Follow-Up DIME of October 1, 2007 (Claimant's Exhibit 16), Dr. Shenoi noted: "Right leg **referred** (emphasis supplied) pain related to sacrococcygeal fracture," and lumbar degenerative disc disease. Later in the report, Dr. Shenoi states: "I believe she [Claimant] has sustained permanent impairment to the sacrococcygeal region as a result of her occupational injury….I do **not** (emphasis supplied) believe there has been a lumbar spine injury…hence, I disagree with Dr. Ghazi in this respect. I believe there is impairment **solely** (emphasis supplied) for the sacrococcygeal fracture and **not** (emphasis supplied) the lumbar spine." Fundamentally, the Follow-Up DIME Report is not inconsistent with the original March 19, 2007 DIME Report. The ALJ finds that Dr. Shenoi has rendered an opinion of no injury, nor permanent disability, to the lumbar spine or right leg –merely referred pain to these bodily parts, which does **not** translate to an injury to these bodily parts. Ultimately, Dr. Shenoi gave the Claimant a 5% whole person rating for the sacrococcygeal fracture, implicitly determining that Claimant had reached MMI on October 1, 2007.

13. On June 8, 2007, Usama Ghazi, M.D., conducted a medical consultation. On review, Dr. Ghazi noted strength in Claimant's lower back as 5/5 from L2-S1 with intact gait and negative bilateral straight leg raise. Dr. Ghazi noted that Claimant did not wish to pursue any further injections. In response, Dr. Ghazi recommended repeat impairment rating and to have Claimant placed at MMI.

14. On June 26, 2007, Dr. Ghazi performed a follow-up examination. He was of the opinion that Claimant should not be placed at MMI until she undergoes a surgical evaluation for her sacral fracture. Dr. Ghazi recommended repeat MRIs to the lumbar spine and sacral prior to the surgical evaluation.

15. On July 11, 2007, Dr. Ghazi stated an impairment rating. Dr. Ghazi noted that Claimant did not wish to seek a surgical evaluation and chose to have her case closed. Upon his physical examination, Dr. Ghazi noted strength and sensation intact from L2-S1. He did note pain over the L4-5 and L5-S1 facet joints. Dr. Ghazi assessed Claimant with a 12% whole person impairment rating (7% to the lumbar spine and 5% for the sacral fracture). Dr. Ghazi noted that he disagreed with Dr. Shenoi that the Claimant should receive a cervical versus

lumbar spine rating. The ALJ finds that this difference of opinion with Dr. Shenoi does not make it highly probable, and free from serious and substantial doubt, that Dr. Shenoi is in error. It is a mere difference of opinion.

16. On July 21, 2007, Dr. Noel performed another follow-up examination. Claimant complained of severe muscle spasms and difficulty walking. Claimant also complained of pain to palpation of the mid to lower sacral and coccygeal areas. Dr. Noel continued his assessment of sacral coccygeal fracture.

17. On August 25, 2007, Dr. Wakeshima examined the Claimant again after continued complaints of low back pain and pain in the buttocks. He was of the opinion that the lower back pain symptoms appeared to be related to the SI joint dysfunction and coccydynia. Dr. Wakeshima recommended diagnostic/ therapeutic right SI joint injection and a right coccygeal injection. On September 15, 2006, the SI joint and right coccygeal injections were performed. Again, Dr. Wakeshima's opinion does not rise to the level of making it highly probable, and free from serious and substantial doubt, that Dr. Shenoi's DIME opinion is in error.

18. On October 1, 2007, Claimant underwent a DIME follow-up examination with Dr. Shenoi. **Dr. Shenoi placed Claimant at MMI as of July 11, 2007 and assigned Claimant a 5% whole person impairment rating.** Dr. Shenoi reiterated that Claimant did not sustain an injury to her lumbar spine. Dr. Shenoi, after reviewing the Level II accreditation guidelines, contacted the OTR at the Division of Workers' Compensation (DOWC) to confirm that a lumbar spine range of motion is not measured for injury to the pelvis region. The Medical Treatment Guidelines place an impairment rating for the pelvis in a separate category from the lumbar spine and do not address range of motion for the lumbar region. The ALJ finds that Dr. Shenoi's opinions are especially credible because she had doubts about the relationship of back ratings and pelvic ratings and she contacted the DOWC to resolve those doubts. Dr. Shenoi specifically disagreed with Dr. Ghazi's recommendations because she believed that the impairment should be solely for the sacrococcygeal fracture and not the lumbar spine. Dr. Ghazi further stated that Claimant did not need any future medical care including surgical intervention. Again, Dr. Ghazi's opinions amount to mere differences of opinion with Dr. Shenoi and do not rise to the level of making it highly probable, and free from serious and substantial doubt, that Dr. Shenoi was in error. At best, any problems with the back and/or right leg amounted to referred pain from the sacrococcygeal fracture.

19. Respondent filed a Final Admission of Liability (FAL), dated October 22, 2007, for 5% whole person, with an MMI date of July 11, 2007, based on the DIME opinions of Dr. Shenoi, who agreed with Dr. Ghazi's MMI date of July 11, 2007. Claimant filed a timely objection thereto and sought to overcome Dr. Shenoi's opinions by clear and convincing evidence. Clearly, the Respondent relied

on Dr. Shenoi's Follow-Up DIME Report of October 1, 2007 in its decision to file an FAL. Claimant may implicitly argue that the first DIME Report of March 19, 2007 controls, thus, Claimant's decision to challenge the FAL and the DIME opinion upon which it was based.

20. Claimant failed to establish that it is highly probable, and free from serious and substantial doubt, that the DIME physician's (Dr. Shenoi's) opinion concerning lack of causal relatedness of Claimant's back problems to the admitted compensable injury of May 4, 2006. Claimant implicitly argues that the admitted injury caused a permanent aggravation of Claimant's degenerative back condition. Dr. Shenoi implicitly disagrees. Therefore, the ALJ finds that Claimant has failed to prove, by clear and convincing evidence, that the DIME physician erred in determining that Claimant's present back condition is not causally related to the admitted injury.

CONCLUSIONS OF LAW ON REMAND

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

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. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). 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). 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); COLORADO JURY INSTRUCTIONS, 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 did not observe the Claimant's testimony because the matter was submitted on briefs and documentary exhibits. For this reason, the ALJ makes no credibility determinations concerning the Claimant. To do so, however, would not be germane to the resolution of the issue herein. The ALJ, however, can make a credibility determination concerning DIME physician, Dr. Shenoi. As found, Dr. Shenoi's testimony was consistent throughout, and the fact that she had enough doubts to contact the DOWC on the rating relationship between the back and the pelvis further enhances her credibility. The ALJ finds her opinions, in this regard, more credible than the other medical opinions contained in the documentary exhibits.

b. A **causation** determination by a DIME physician, insofar as it is related to the cause of **permanent** impairment, must be accorded the special deference required by Section 8-42-107 (8) (c), C.R.S. (2008), *i.e.,* the standard of proof to overcome it is "clear and convincing evidence." *Qual-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998). *See also Esquibel v. Denver Public Schools,* W.C. No. 4-329-119 [Industrial Claim Appeals Office (ICAO), February 11, 1999]. As found, Claimant failed to overcome, by clear and convincing evidence, that Dr. Shenoi's opinion that the problems caused by the back condition were not causally related to the admitted injury. The ALJ infers and finds that inherent in Dr. Shenoi's opinion is the proposition that the Claimant's back problems are not ratable. In effect, this is a determination that there was no permanent aggravation, resulting from the admitted injury. If 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. Section 8-41-301(1)(c), C.R.S. (2008), then there is causal relatedness. *See Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo. App. 1997). *Also see* Section 8-41-301(1)(c), C.R.S. (2006); *Parra v. Ideal Concrete,* W.C. No. 4-179-455 [Industrial Claim Appeals Office (ICAO), April 8, 1998]; *Witt v. James J. Keil Jr.,* W.C. No. 4-225-334 (ICAO, April 7, 1998). *See Merriman v. Industrial Commission,* 120 Colo. 400, 210 P.2d 448 (1949). As found, Claimant has failed to establish a permanent aggravation of her degenerative back condition, which was caused by the admitted, compensable sacrococcygeal fracture.

c. A written document, concerning identical subject matter, later in time, absent a manifest intent to the contrary, extinguishes and supersedes the earlier document. *See McKay v. Fleming,* 24 Colo. App. 380, 134 P. 159 (1913). As found, Dr. Shenoi's Follow-Up DIME report of October 1, 2007, superseded her first DIME Report of March 19, 2007, as reflected by the Respondent's reliance on the MMI date of July 11, 2007 and the 5% whole person rating. Claimant's implicit argument that the first DIME Report of March 19, 2007, wherein Dr. Shenoi expressed the opinion that Claimant was not at MMI is without merit.

d. The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). The DIME physician's determination of causation related to MMI and or permanent impairment is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R.S. (2008). "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.* 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). The question of whether the DIME physician's determinations have been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra.* As found, Claimant has failed to sustain her burden of proof in this regard.

ORDER ON REMAND

IT IS, THEREFORE, ORDERED THAT:

Claimant having failed to overcome the Division Independent Medical Examination opinions of Ranee Shenoi, M.D., the Final Admission of Liability, dated October 22, 2007, is hereby affirmed and adopted as part of this decision.

DATED this_____day of December 2008

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-726-431

ISSUES

The issues presented for determination at hearing were Respondents attempt to overcome the opinion of the Division IME physician ("DIME") that Claimant was not at maximum medical improvement ("MMI"), and, if successful, the determination of Claimant's permanent impairment; and liability for medical care after MMI.

By agreement of the parties as reflected in an Order date September 11, 2008, the issue of permanent total disability was held in abeyance.

FINDINGS OF FACT

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

1. Claimant suffered an admitted injury in the course of and arising out of her employment, on May 16, 2007. The injury resulted from claimant pressing hard on 'soft brakes' in two motorcoach 'bus' vehicles she was employed to drive for Employer.

2. Claimant was placed at MMI by Dr. Robert Kawasaki, M.D. on October 22, 2007. Dr. Kawasaki reviewed the results of an MRI done on September 5, 2007 and opined that the MRI findings were probably age-related degenerative

changes. Dr. Kawasaki further stated that Claimant's symptoms appeared to be focused to the sacroiliac ("SI") joints. Dr. Kawasaki opined that the underlying degenerative disc and facet changes were age related and not caused by or related to the episodes of pushing on fAy brakes over a two-day period.

3. At the time he placed Claimant at MMI, Dr. Kawasaki assigned a permanent impairment rating of 8% whole person impairment, resulting from sacroiliac joint ["SI"] dysfunction. Dr. Kawasaki's assessment of impairment was based on a 5% impairment for specific disorder, pursuant to Table 53 (II)(B), of the A.M.A. Guides to the Evaluation of Permanent Impairment, 3rd Edition, Revised ["Guides"], combined with 3% for range of motion deficit.

4. The Insurer filed a Final Admission of Liability dated December 21, 2007 in accordance with the opinion of Dr. Kawasaki. Claimant timely objected to the Final Admission and requested a DIME. Dr. John Hughes, M.D. was selected to perform the DIME.

5. Claimant was examined by Dr. Joseph H. Fillmore, M.D. on February 28, 2008. Dr. Fillmore's diagnostic impression was SI joint dysfunction/ irritation, chronic and lumbar spine degenerative disc disease more likely incidental and not related to a specific injury. Dr. Fillmore concluded that because Claimant had benefited from SI joint injections suggested that her problems were from the SI joints and not the degenerative discs. Dr. Fillmore concluded that claimant had reached MMI. Dr. Fillmore assigned a 15% whole person impairment based on 5% impairment for specific disorder pursuant to Table 53(II)(B) of the Guides, combined with 11% for range of motion deficits.

6. Dr. Hughes evaluated claimant on June 19, 2008, and concluded claimant had not then reached MMI. Instead, he recommended additional tests, specifically repeats of EMG/ nerve conduction studies of the lower extremities, and an MRI of the lumbar spine for further evaluation of Claimant's lumbar spine condition. Dr. Hughes questioned whether the lumbar spine condition was actually an occupational condition at all. Dr. Hughes expressed that he was perplexed by Claimant's decline in function evidenced by reduced mobility in the spine and reduced task tolerance. Dr. Hughes agreed with Drs. Fillmore and Kawasaki that the sacroiliac ("SI") joints were the generator of Claimant's pain. Dr. Hughes opined that in case of pure SI joint dysfunction lumbar spine mobility remains normal or near normal. Although he did not consider Claimant to be at MMI Dr. Hughes provided an estimate of Claimant's permanent impairment as 23% of the whole person. Dr. Hughes' estimate of impairment was comprised of an assessment of 7% for specific disorder under Table 53(II)(B) of the Guides, combined with 17% for range of motion deficits.

7. Claimant was seen and evaluated by Dr. Alexander Jacobs, on September 17, 2008. Dr. Jacobs is of the opinion that claimant had reached MMI on October 22, 2007, concurring with Dr. Kawasaki's assessment. Dr. Jacobs

also concluded claimant has a 12% impairment, based on a 5% specific disorder of the spine pursuant to Table 53(II)(B) of the Guides, combined with a 7% range of motion deficit.

8. Dr. Kawasaki again evaluated Claimant on September 29, 2008. Dr. Kawasaki expressed the opinion that the SI joint dysfunction was the source of Claimant's symptoms and that the mechanism of injury was not causative of acceleration of degenerative disc changes or radiculopathy that developed more recently over one year after the date of injury. Dr. Kawasaki referred Claimant for the MRI and electrodiagnostic testing suggested by Dr. Hughes.

9. Dr. Kawasaki saw Claimant for follow-up on October 13, 2008. Dr. Kawasaki reviewed the result of the recent MRI and electrodiagnostic testing noting that the MRI results were unchanged compared to a prior MRI of September 5, 2007 and the electrodiagnostic tests were normal.

10. At hearing, Dr. Hughes acknowledged that he had now had the opportunity to review the medical records from the further evaluations and diagnostic tests performed subsequent to his evaluation of Claimant. Dr. Hughes now expressed the opinion that Claimant was at MMI. Dr. Hughes placed the date of MMI as the date the Claimant was seen by Dr. Fillmore in February 2008.

11. The ALJ finds that Claimant reached MMI as of October 22, 2007 as originally assessed by Dr. Kawasaki. As stated by Dr. Jacobs, the further testing recommended by Dr. Hughes was for evaluation of the cause and causal relationship of a lumbar spine condition separate and distinct from the SI joint dysfunction related to Claimant's admitted injury. Dr. Hughes admitted in his testimony at hearing, and it is found, that the Claimant degenerative disc disease in the lumbar spine was not caused or accelerated by the admitted injury. The ALJ finds that Respondents have overcome Dr. Hughes' opinion on MMI to the extent that Dr. Hughes assessed MMI as of February 2008. The additional diagnostic testing recommended by Dr. Hughes did not identify any further treatment to improve Claimant's SI joint condition as related to her compensable injury. Dr. Hughes was in error to conclude that Claimant was not at MMI for the effects of her compensable injury on the basis that additional diagnostic testing was needed to evaluate a non-occupational condition.

12. At hearing, Dr. Hughes changed his opinion regarding Claimant's permanent impairment. Dr. Hughes testified, and it is found, that Claimant should receive 5% impairment for specific disorders under Table 53 of the Guide instead of the 7% he originally assessed because Claimant's degenerative disc disease did not contribute to her symptoms as related to the compensable injury.

13. With regard to Claimant's range of motion impairment, Dr. Hughes testified that at the time of his examination of Claimant he wondered if he was seeing inordinately reduced mobility of the spine. Dr. Hughes stated that Claimant's range of motion loss was inflated based upon the pathology involved. Al-

though Claimant produced valid range of motion results under the Guides criteria, Dr. Hughes questioned if the results were "biologically plausible". Dr. Hughes testified, and it is found, that Claimant's loss of function is in excess of what would be expected from the pathology seen.

14. Dr. Hughes further testified that while the Claimant's degenerative disc disease has not been proven to contribute to her symptoms, the degenerative changes in the lumbar spine probably contributed measurably to the decreased range of motion in the lumbar spine.

15. Dr. Hughes testified that his range of motion results obtained at the time of his June 2008 examination were accurate. Dr. Hughes also testified that there is variability in range of motion testing due to the waxing and waning of symptoms. Dr. Hughes testified that while he would stand by his measurements of range of motion, he agreed that the range of motion measurements of Dr. Fillmore could be as accurate and valid as his measurements. Dr. Hughes' opinion on Claimant's permanent impairment from loss of range of motion is ambiguous and conflicting. The ALJ resolves this ambiguity and conflict by finding that Dr. Hughes' true opinion of the Claimant's permanent impairment related to the compensable injury is 5% for specific disorders under Table 53 of the Guides and an 11% impairment for loss of range of motion as assessed by Dr. Fillmore for a combined whole person impairment of 15%, also as assessed by Dr. Fillmore.

16. Respondent's filed a Final Admission of Liability dated December 21, 2007. In this Final Admission, Respondent's admitted liability for post-MMI medical treatment. Respondents have not sought to withdraw this admission.

CONCLUSIONS OF LAW

17. 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).

18. 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, 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 respon-

dents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

19. Respondents bear the burden of proof, by clear and convincing evidence to overcome the opinion of the DIME physician that Claimant was not at MMI. §8-42-107(8)(c), C.R.S. The DIME physicians' opinion consists not only of his written report but also any subsequent opinion given including the physicians' testimony at hearing. *Andrade v. Indus. Claim Appeals Office,* 121 P.3d 328 (Colo. App. 2005); *Lambert & Sons, Inc. v. Indus. Claim Appeals Office,* 984 P.2d 656 (Colo. App. 1998). As found, Dr. Hughes testified at hearing that his opinion is now that Claimant is at MMI. Thus, Respondents have met their burden through the further opinion of Dr. Hughes subsequent to his report.

20. Maximum Medical Improvement is defined as:

> "…a 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. 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 maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement." §8-40-201(11.5), C.R.S.

Claimant's medical condition, *i.e.*, the medical consequence of this injury, is the SI joint dysfunction. That condition became medically stable, and not subject to 'significant improvement by future medical maintenance treatment', on October 22, 2007. While the 'ratings' of impairment differed after that date, no treatment was prescribed, or applied, which altered the SI condition. The repeat MRI and EMG/ nerve conduction testing directed by Dr. Hughes was focused on identifying a different cause, or additional cause or explanation, of claimant's complaints. It was therefore testing for *causation*, rather than for diagnosis or identification of treatment; and the lack of that testing being completed was not inconsistent with claimant having achieved MMI. See: *Brickell v. Overhead Door Co*, W.C. No. 4-586-287 (February 4, 2000); *Hatch v. John H. Harland Company*, W.C. No. 4-368-712, (2000). The burden of proving causation remains with claimant, whether or not the D.I.M.E. physician suggests testing for alternative causation, *Martinez v. Triangle Sheet Metal, Inc.,* W.C.#4-595-741 (ICAO October 8, 2008). As found, the ALJ concludes that Respondents have shown by clear and convincing evidence that Dr. Hughes was in error to conclude that Claimant did not reach MMI as of October 22, 2007.

21. Also as found, Dr. Hughes provided ambiguous and conflicting opinions concerning the extent of Claimant's permanent impairment from the SI

joint condition that is causally related to Claimant's injury. Where a DIME physician offers ambiguous or conflicting opinions concerning impairment the ALJ is to resolve the ambiguity and determine the DIME physicians' true opinion as a matter of fact. *Magnetic Engineering Inc., supra.* In so doing, the ALJ is to consider all of the DIME physicians' written and oral testimony. *Dazzio v. Rice & Rice, Inc.,* W.C. No. 4-660-140 (June 30, 2008). Considering all of Dr. Hughes testimony, the ALJ concludes that Dr. Hughes' ultimate opinion regarding permanent impairment is that Claimant has 15% whole person impairment related to the compensable injury and resulting SI joint dysfunction.

ORDER

It is therefore ordered that:

Respondents shall pay Claimant permanent impairment benefits for 15% whole person impairment commencing October 22, 2007 at the rate of $345.30 per week until paid in full.

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

Respondents are liable for reasonable and necessary medical treatment to relieve and maintain Claimant's condition subsequent to the date of MMI, subject to Respondent's right to challenge the reasonableness and necessity of specific treatment, as well as the cause of the need for any specific treatment proposed or provided;

All matters not determined herein are reserved for future determination.

DATED: December 30, 2008

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ) on December 18, 2008, in Denver, Colorado. The hearing was digitally recorded (reference: 12/18/08, Courtroom 3, beginning at 10:20 AM, and ending at 12:10 PM).

At the conclusion of the hearing, the ALJ ruled from the bench and referred preparation of a proposed decision to Respondents, to be submitted electronically, within 5 working days, giving the Claimant 3 working days within which to submit objections, electronically. The proposed decision was filed on December 23, 2008. No timely objections were filed. After a consideration of the proposal, the ALJ has modified it and hereby issues the following decision.

ISSUES

The issues to be determined by this decision concern whether the Claimant is entitled to temporary total disability (TTD) benefits from July 14, 2008 through September 24, 2008; and, Respondents raised the affirmative defense of whether Claimant was responsible for his wage loss due to his termination of employment with the Employer for cause on July 22, 2008. Initially, the Claimant has the burden of proof, by a preponderance of the evidence, of establishing entitlement to TTD benefits. Once satisfied, Respondents have the burden by preponderant evidence of establishing "responsibility for termination," as defined by the Workers' Compensation Act.

FINDINGS OF FACT

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

1. At the commencement of the hearing, the parties agreed to the following stipulations: (1) Claimant sustained a compensable injury to his left shoulder while in the course and scope of employment with the Employer on July 13, 2008; (2) Claimant's average weekly wage (AWW) as of July 13, 2008 was $766.56. Claimant's AWW, effective September 1, 2008, due to his loss of health insurance increased to $1,021.79; (3) the medical treatment Claimant has received since his July 13, 2008 injury through December 18, 2008, has been reasonably necessary and causally related to his industrial injury and it is not in dispute. These stipulations of the parties are hereby made findings of fact. The ALJ further finds that the AWW of $766.56 yields a TTD rate of $511.03 per week, or $73 per day.

2. Claimant injured his left shoulder while working for his Employer on July 13, 2008. Respondents by stipulation admitted the compensability of Claimant's injury.

3. On July 13, 2008, the Employer employed the Claimant as a delivery driver. When Claimant arrived at work on July 13, 2008, following a vacation, he found trash in the truck he was to drive that day. He threw the trash out of the

truck and into the parking lot of the Employer, and left the premises to complete a delivery run.

4. Upon Claimant's return to the Employer's premises, PB, the Distribution Supervisor, met with Claimant and advised him to pick up the trash. Claimant refused B's directive. B then stated to the Claimant that the Claimant needed to pick up the trash or leave the premises. Claimant refused to pick up the trash or leave, stating that he would pick up the trash when he had time. B then suggested the two of them meet with JK, the Plant Supervisor, to discuss the matter further.

5. Claimant, B and K then met to discuss Claimant's refusal to pick up the trash that Claimant had thrown in the parking lot of the Employer. K advised the Claimant to follow B's directive and pick up the trash, and that his failure to do so was insubordination. Claimant then picked up the trash, and deposited it in the windshield washing buck rather than the trashcan. B credibly testified that the windshield-washing bucket was full of windshield washing fluid at the time. Claimant testified that it was summertime and the bucket was empty. Claimant implied that the empty bucket was a reasonable place to deposit trash. A critical credibility determination turns on the credibility of PB versus Claimant's credibility concerning whether the windshield-washing bucket was full of fluid or empty. The ALJ infers and finds that Claimant's version is not credible because the ALJ infers and finds there is still a need to wash windshields in the summertime, or at any other time of the year. For this reason, Claimant's version of events does not "hold water." It is not inherently reasonable. Considering the Claimant's interest in the outcome of this case and B's disinterestedness, and the inherent unreasonableness of Claimant's version of events, the ALJ credits the testimony of B over that of the Claimant in this regard, and finds that there was fluid in the windshield-washing bucket at the time.

6. It is undisputed that Claimant was previously disciplined by the Employer on four occasions for other violations of company policy and rules of conduct, and the ALJ finds that Claimant's prior disciplinary actions show a heightened awareness on the part of the Claimant as to inappropriate behavior that could result in discipline or termination.

7. The ALJ further infers and finds that the Claimant's refusal to pick up the trash when first directed to do so by B was an act of insubordination, and constituted a volitional act in an of itself. Claimant's subsequent act of throwing the trash in a windshield-wiper bucket with fluid in it was an act of defiance that warranted the Claimant's termination from employment based on a volitional act on Claimant's part.

8. The Claimant engaged in a volitional act over which he maintained a certain degree of control by refusing to follow a reasonable directive of his su-

perior, PB, in refusing to pick up trash he threw in the parking lot on July 13, 2008. Claimant also engaged in an additional volitional act, an act of defiance, when he finally did pick up the trash, but deposited it in the windshield washing bucket – a receptacle clearly not designed to hold trash, which was filled with fluid. The act of refusing to pick up the trash and tell his superior that he would pick up the trash when he got around to it is an act of insubordination, or a volitional act over which the Claimant exercised control, that resulted in his termination. Further, Claimant's act of throwing the trash he eventually picked up into the windshield-washing bucket containing fluid is an act of defiance, or volitional act, that further establishes Claimant's termination for cause. As such, Claimant's resulting wage loss after his date of termination is attributable to his termination for cause, which superseded the direct link between the injury and the wage loss.

9. Claimant has proven, by a preponderance of the evidence, that he was TTD from July 14, 2008 through September 24, 2008.

10. Respondents have proven, by a preponderance of the evidence, that Claimant was "responsible for his termination" for cause, effective July 22, 2008, because of a volitional act on his part on July 13, 2008.

11. Claimant was TTD from July 14 through July 21, 2008, both dates inclusive, a total of 8 days, before his termination for cause.

CONCLUSIONS OF LAW

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

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. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (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 (1936); CJI, Civil, 3:16 (2005). A critical credibility determination turns of the credibility of PB versus Claimant's credibility on whether the windshield-washing bucket was full of fluid or empty. As found, B's version of events was more credible than Claimant's because B was disinterested in the outcome of this case, and B's version of events was more reasonable and likely than Claimant's version, *i.e.,* that the windshield-wiping bucket was full of fluid at the time Claimant threw the trash into it, which amounted to a capping act of defiance after Claimant's repeated refusals to pick up the trash.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. Sections 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). 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 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant satisfied his burden with respect to TTD from July 14, 2008 through September 24, 2008. Respondents, however, satisfied their burden of proof with respect to "responsibility for termination," effective July 22, 2008.

c. Section 8-42-103 (1) (b), C.R.S. (2008), provides that where TTD last longer than two weeks, which it has in this case, benefits are recoverable from the day the injured employee leaves work, the day after which was July 14, 2008. Therefore, Claimant is entitled to TTD benefits of $511.03 per week, or $73 per day, from July 14, 2008, through July 21, 2008, both dates inclusive, a total of 8 days, in the aggregate amount of $584.04.

d. Once a claimant establishes entitlement to TTD and/or TPD benefits, it becomes incumbent upon respondents to prove, by a preponderance of the evidence, that the temporarily disabled employee was responsible for his termination of employment. If proven, the resulting wage loss of the injured worker shall not be attributable to the on-the-job injury. Section 8-42-105 (4), and 8-42-103 (1)(g), C.R.S. (2008). *See Anderson v. Longmont Toyota,* 102 P.3d 323 (Colo. 2004). The statutory provisions have been interpreted to mean that "responsibility for termination" must be through a volitional act on the part of the terminated employee. *Colorado Springs Disposal v. Industrial Claim Appeals Office,* 58 P. 3d 1061 (Colo. App. 2002). A claimant should be held responsible for his separation of employment from an employer if he performed some volitional act, or exercised some control over the circumstances of the termination. *Padilla v. Digital Equipment Corp.,* 902 P.2d 414 (Colo. App. 1994), *opinion after remand* 908 P.2d 1185 (Colo. App. 1985). The determination of the fA issue is ordinarily one of fact for resolution by the ALJ. *Id.* As found, Respondents herein have proven that Claimant was responsible for his termination through a volitional act on his part on July 13, 2008, and his termination was effective as of July 23, 2008.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's July 13, 2008 claim for compensation is compensable.

B. Respondents shall pay the Claimant temporary total disability benefits of $511.03 per week, or $73 per day, from July 14, 2008, through July 21, 2008, both dates inclusive, a total of 8 days, in the aggregate amount of $584.04, which is payable retroactively and forthwith.

C. Claimant's request for temporary total disability benefits from July 22, 2008, through December 18, 2008, is hereby denied and dismissed.

D. Claimant's AWW prior to September 1, 2008 is $766.56, and his AWW following September 1, 2008 is increased to $1,021.79, based on discontinuance of health benefits.

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

F. Any and all issues not determined herein are reserved for future decision.

DATED this _____day of December 2008.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-740-891

ISSUES

I. Whether claimant sustained a compensable injury to his neck on April 18, 2006.

II. Whether claimant sustained a compensable occupational disease to his lumbar spine with onset on or about August 22, 2006.

FINDINGS OF FACT

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

1. Claimant began employment with Employer on January 5, 2006 as a delivery driver. On claimant's job application he indicated that he had a prior back injury in 1992 that resulted in 9% permanent impairment. Claimant did not report any permanent work restrictions on his job application or indicate that he would have any difficulty in performing the delivery driver position.

2. Claimant did not have any problems with his back while working for Employer between January 2006 and April 2006. On or about April 3, 2006 claimant called in to work due to an incident lifting a carpet cleaner at his house. Claimant reported to MG, President of Employer, that he had injured his back while lifting the carpet cleaner at home. While conflicting evidence was presented regarding the date of the carpet-cleaning incident, the testimony of MG that claimant did not report difficulties with his back prior to the carpet cleaner incident is credible and persuasive.

3. After the carpet cleaner incident, claimant complained of difficulty with his back. Employer modified the claimant's job duties and hired an assistant, Daniel Benson, to take over any lifting that needed to be performed.

4. Mr. G specifically instructed the claimant in the beginning of April 2006 that if there was any lifting to be done, Daniel was to do it. Mr. G asked the claimant to look for another job, but due to an upswing in business Mr. G determined Employer could utilize the claimant in positions that did not require lifting.

5. Claimant testified at hearing that he was struck in the head by a roof hatch on April 18, 2006. However, inspection of the claimant's daily logs which were accepted into evidence did not show any reference to an injury having occurred on that date or that the claimant was at the location where he alleged the injury occurred on the date in question. Mr. G testified credibly and persuasively that claimant never reported the April 18, 2006 alleged incident to him. The evidence supports a determination that the April 18, 2006 alleged incident with the roof hatch did not occur or, if it did occur, it did not cause disability or the need for medical treatment.

6. Claimant became dissatisfied with his employment relationship with Employer because of a dispute regarding his earnings. Claimant went to Mr. G on or about August 18, 2006 and demanded an increase in salary or he would quit and begin employment with Grandma's Handyman Services, a company owned by the claimant's mother. Termination documents were filed August 24, 2006 with the reason for leaving indicated that claimant "wanted more money."

7. Mr. G testified credibly and persuasively that claimant did not report any work related injury or request medical treatment prior to voluntarily terminat-

ing his employment with Employer. Mike G credibly and persuasively testified that at the time claimant quit his employment, he appeared fine and was not demonstrating any signs or symptoms of back pain.

8. Claimant began work with Grandma's Handyman Services on August 14, 2006 and worked through September 18, 2006.

9. On October 16, 2007 claimant filed a First Report of Injury alleging onset of an occupational disease to his lumbar spine on August 22, 2006. Claimant also filed a First Report of Injury on October 31, 2007 alleging the specific incident to his cervical spine of April 18, 2006. Both claims were filed over one year after claimant left his employment with Employer.

10. The evidence presented supports a determination that claimant had a longstanding history of cervical and lumbar spine issues dating back to an automobile accident in 1978. Claimant has documented pre-existing conditions in both his cervical and lumbar spine including findings of degenerative disc disease. On June 10, 1991 claimant was involved in a prior workers' compensation claim that resulted in a lumbar discectomy. Claimant received additional treatment for his lumbar spine in June 2002 including an MRI in August 2002 that showed degenerative changes at L3-4 and L4-5 as well as clumping of the cauda equina.

11. On November 9, 2006, claimant was treated by his family physician, Dr. Timothy Judd. Dr. Judd's report indicates claimant is "here for evaluation and management of his chronic neck pain." There is no mention in Dr. Judd's report of the April 18, 2006 alleged incident with the roof hatch, nor is there mention of any low back pain complaints.

12. On May 11, 2007, claimant was evaluated by neurosurgeon, Dr. Mark Bryniarski. Claimant was diagnosed with degenerative disc disease in his lumbar spine. Dr. Bryniarski's report provides an opinion that claimant's degenerative disc disease is secondary to the long-term effects from the 1991 injury, secondary to overall degenerative disease of the spine, and secondary to his long-term smoking history.

13. On November 12, 2007 claimant was evaluated by Dr. Jeffrey Wunder in connection with an application for Social Security disability benefits. Dr. Wunder noted inconsistencies in the claimant's presentation and stated that claimant's complaints "could not be taken at face value."

14. On January 11, 2008 claimant was evaluated, at his request, by Dr. Michael Janssen. Dr. Janssen opined that the claimant's current condition of his lumbar spine was an "exacerbation from his occupational-related injury [at Employer] and more likely than not is occupational related." Dr. Janssen provided deposition testimony consistent with this opinion.

15. On April 28, 2008 claimant was evaluated by Dr. Henry Roth, respondents' retained expert, who opined that claimant's cervical and lumbar complaints were not related to any injury or occupational disease sustained at Employer. Dr. Roth opined that degenerative disc disease is a progressive degenerative condition that will advance on its own. Dr. Roth opined that the claimant's current low back complaints are a reflection of the advanced underlying preexisting biological process of lumbar degeneration. Dr. Roth opined that even if the claimant's report of his activities at Employer was taken at face value, the current state of medical literature does not support a relationship between materials handling including the activities of bending, lifting, and twisting and the progression of degenerative disease of the spine. Dr. Roth opined the current condition of the claimant's spine is the product of the natural progression of his underlying degenerative condition and was not caused, aggravated, or accelerated by the claimant's work at Employer.

16. The opinions of Dr. Roth as to causation are more credible and persuasive than the opinions expressed by Dr. Janssen.

17. At hearing, claimant asserted Dr. Roth was biased in favor of respondents and submitted evidence in support of the assertions of bias including an e-mail from Dr. Roth. Claimant had the opportunity to cross-examine Dr. Roth regarding his alleged bias. Claimant attempted to present testimony from Chad Hemmat, Esq., a letter written by Mr. Hemmat, and other documentary evidence in support of the assertion of bias on the part of Dr. Roth. After considering the arguments of the parties, it was determined that the offered evidence was hearsay, cumulative, and/or not relevant and not admitted into evidence. The Judge also declined to allow Mr. Hemmat's testimony on the basis of respondents' objections as the intended testimony related to alleged hearsay statements made by Dr. Roth and was also cumulative. The evidence does not support a finding that Dr. Roth was biased in this particular case or that Dr. Roth's opinions should be rejected due to the allegations of bias.

18. The claimant's testimony is not credible or persuasive. The opinions expressed by Dr. Roth as to causation are credible and persuasive.

19. Claimant's work at Employer did not cause, aggravate, or accelerate the claimant's pre-existing condition in his lumbar spine. Claimant has not met his burden of proof to demonstrate a compensable occupational disease to his lumbar spine. The alleged incident of April 18, 2006 did not cause, aggravate, or accelerate the claimant's pre-existing condition in his cervical spine. Claimant has not met his burden of proof to demonstrate a compensable injury to his cervical spine. To the extent claimant needs medical care to treat conditions of his cervical or lumbar spine, the need for such medical care is not causally related to the claimant's employment activities at Employer.

CONCLUSIONS OF LAW

1. To recover workers' compensation benefits, the claimant must prove he suffered a compensable injury. A compensable injury is one which arises out of and in the course of employment. §8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origin in an employee's work-related functions, and be sufficiently related thereto so as to be considered part of the employee's service to the employer. It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. §8-43-201, C.R.S.; *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, that a fact is more probable than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

2. No benefits flow to the victim of an industrial accident unless the accident results in a compensable "injury." Claimant bears the burden of proving a compensable injury. *See e.g., Smith v. Dept. of Labor,* 494 P.2d 598 (Colo. App. 1972). Inconsistencies in a claimant's account of an injury or his actions thereafter can provide sufficient basis to conclude the claimant has failed to carry his burden of proof. Under the Act, a compensable injury is one which "requires medical treatment or causes a disability." §8-41-301(1)(c) C.R.S. 2005; *See e.g., Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). The determination of whether the claimant's condition is due to the natural progression of the pre-existing condition or an industrial accident is one of fact for resolution by the ALJ. *Industrial Commission v. Riley*, 441 P.2d 3 (Colo. 1968).

3. A claimant sustains an occupational disease when the injury is the incident of the work, or a result of exposure occasioned by the nature of the work, and does not come from a hazard to which the worker would have been equally exposed outside of the employment. Section 8-40-201(14), C.R.S. The claimant had the burden to prove the alleged occupational disease was caused, aggravated or accelerated by the claimant's employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo. App. 1999).

4. The fact that a claimant experiences pain while performing tasks at work does not compel the ALJ to conclude that the pain is the result of an injury or occupational disease sustained while performing the work. This is particularly true where the claimant's pain is the logical and recurrent consequence of some prior industrial injury or pre-existing condition. *F. R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995). An incident which merely elicits pain symptoms caused by a pre-existing condition does not compel a finding that the claimant sustained a compensable aggravation. *Witt v. James J. Keil, Jr.,* W.C. No. 4-225-334 (ICAO April 7, 1998); *Miranda v. Best Western Rio Grande Inn,* W.C. No. 4-663-169 (ICAO April 11, 2007).

5. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that his work activities at Employer caused, aggravated, or accelerated the pre-existing condition of the claimant's lumbar spine so as to create an occupational disease. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that he sustained a compensable occupational disease to his lumbar spine while employed with the Employer. Claimant's testimony was not credible or persuasive. Testimony presented by Dr. Roth as to causation was credible and persuasive.

6. Claimant failed to sustain his burden of proof to demonstrate by a preponderance of the evidence that he sustained a compensable injury to his cervical spine on April 18, 2006 while employed with the Employer. Claimant failed to demonstrate by a preponderance of the evidence that the alleged April 18, 2006 incident occurred, or even if it did occur, that the incident required medical treatment or caused disability. Claimant failed to prove that the alleged April 18, 2006 incident caused, aggravated, or accelerated the pre-existing condition of claimant's cervical spine. Claimant's testimony was not credible or persuasive. Testimony presented by Dr. Roth as to causation was credible and persuasive.

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

ORDER

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits under the Workers' Compensation Act is hereby denied and dismissed.

DATED: December 30, 2008

Barbara S. Henk
Administrative Law Judge

O F F I C E O F A D M I N I S T R A T I V E C O U R T S

STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-720-435

ISSUES

1. Whether Claimant has overcome by clear and convincing evidence the Division Independent Medical Examination (DIME) physician's determination that her lower back condition was not caused by her employment with Employer.

2. Whether Claimant is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of her industrial injury.

3. A determination of Claimant's Average Weekly Wage (AWW).

4. Whether Claimant is entitled to receive Temporary Total Disability (TTD) benefits from May 1, 2007 until September 6, 2007.

FINDINGS OF FACT

1. Claimant worked for Employer in various production positions from 1979 until May 1, 2007. She performed approximately 10-12 different jobs during the course of her employment.

2. Claimant has suffered an extensive history of lumbar spine problems. She primarily received treatment from Ann T. Colgan, M.D. and Hans C. Coester, M.D.

3. The medical records reveal that Claimant began suffering from documented lower back pain in September 2001. Claimant did not know the cause of her symptoms.

4. Claimant continued to experience lumbar spine pain and visited Dr. Colgan in November 6, 2002. Dr. Colgan recommended a lumbar MRI. The MRI revealed degenerative disc disease at the L5-S1 level.

5. Dr. Colgan also referred Claimant to Dr. Coester for an evaluation. Dr. Coester offered Claimant treatment recommendations that included injections, medications and possible surgery. Claimant declined surgery at the time.

6. Despite ongoing medical care, Claimant's lower back condition continued to deteriorate. On August 2, 2004 Claimant returned to Dr. Coester and reported pain in both legs. An MRI reflected a broad based disc protrusion with severe left-sided L5-S1 foraminal narrowing and moderate to severe right-sided L5-S1 foraminal narrowing. Claimant also had degenerative disc disease at the L4-L5 level. Claimant decided to proceed with surgery.

7. On August 27, 2004 Dr. Coester performed an L5-S1 decompression and fusion on Claimant. The surgery involved the insertion of hardware into Claimant's back. Claimant initially reported an improvement in her condition and Dr. Coester returned her to full duty work for Employer.

8. Claimant again began to experience lower back pain during the summer of 2005. An August 2005 MRI of Claimant's lumbar spine showed surgical changes but did not reflect evidence of any recurrent disc problems. Claimant subsequently underwent a series of epidural steroid injections.

9. In February 2006 Claimant transferred to Employer's 35mm motion picture department. A machine placed a roll of film on a table in front of Claimant. She then slid the roll of film off of the table, carried the roll a couple of steps and placed it on a pallet elevator. The elevator could be adjusted vertically to maintain a stacking height at waist level. Each roll of film weighed approximately 30-35 pounds. Claimant also explained that, approximately seven to eight times each year, employees were required to label and restack pallets.

10. On February 13, 2006 Claimant was involved in a motor vehicle accident. Claimant reported to Dr. Colgan that her back pain was "much worse." X-rays of Claimant's lower back were unremarkable and she was treated with muscle relaxers and non-steroidal anti-inflammatory medications. The medical records reveal that during the summer and fall of 2006 Claimant continued to report lower back pain.

11. On March 5, 2007 Claimant visited Dr. Colgan for an evaluation. Claimant reported continuing lower back pain. Dr. Colgan ordered another lumbar MRI. A March 13, 2007 lumbar MRI revealed postoperative changes at L5-S1 with no significant differences relative to previous MRI's. The MRI also demonstrated a protrusion at L4-L5 that reflected some changes compared to previous MRI's.

12. Claimant testified that on March 5, 2007 she suffered an occupational disease to her lower back as a result of her repetitive lifting activities while working for Employer. Employer referred Claimant to Authorized Treating Physician (ATP) Brian Thompson, M.D. On March 21, 2007 Claimant visited Dr. Thompson for an evaluation. Dr. Thompson noted that Claimant had been transferred to a position as a "T-perf operator." He stated that her position involved frequent lifting and palletizing of 30-pound rolls of film for 10 hours each day. He commented that Claimant had begun to experience increasing lower back pain over the previous five months. After reviewing Claimant's medical history, Dr. Thompson concluded that Claimant had suffered a lower back strain and released her to full duty employment.

13. On April 25, 2007 Claimant again visited Dr. Thompson for an evaluation. He assigned Claimant work restrictions that included only sedentary activities, no lifting and no repetitive bending or lifting.

14. On May 1, 2007 Claimant resigned from Employer. She testified that she ceased employment because her occupational disease prevented her from performing her job duties.

15. After Claimant received additional medical treatment, ATP Dr. Thompson determined that she had reached Maximum Medical Improvement (MMI) on September 13, 2007. He assigned Claimant a 20% whole person impairment rating for her March 5, 2007 occupational disease. Respondent subsequently filed a Final Admission of Liability (FAL) consistent with Dr. Thompson's 20% whole person impairment rating.

16. Claimant timely objected to the FAL and sought a DIME. Robert Kawasaki, M.D. performed the DIME on February 27, 2008. Dr. Kawasaki reviewed Claimant's complete medical history and performed a physical examination of Claimant that included range of motion measurements. Based on his review of Claimant's medical history, Dr. Kawasaki stated "it appears that [Claimant] has had a continuum of low back pain, the initial disc protrusion at L5-S1, and degenerative disc changes at L4-5 and L3-4." He explained that there had been no significant change in Claimant's "symptomatology over the course of many years." Because there had been no "appreciable change" during March 2007, Dr. Kawasaki opined that Claimant did not suffer a work-related injury.

17. After reviewing Claimant's case and performing a causation analysis, Dr. Kawasaki explained that Claimant's chronic pain was not caused or substantially altered by her work activities for Employer. He commented:

> It is medically probable [Claimant's] symptoms would be similar with or without the stated work activities. Based on the extensive work up that was repetitive as far as x-rays of the hip and lumbar spine, MRI's and more recent diagnostic interventional procedures, it appears [Claimant's] main pain generator may be due to hardware from her prior fusion. There is also epidural and perineural fibrosis related to the prior surgeries.
>
> With the above-identified pain generation, which would be specifically related to postoperative changes and sequelae from the surgery, it is within medical probability that the need for treatment including potentially removing the hardware would not be related to [Claimant's] reported work activities. Work activities would result in a temporary aggravation of the ongoing chronic pain syndrome. Chronic pain syndrome is a result of nonspecific degeneration of [Claimant's] lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively.

Dr. Kawasaki thus concluded that Claimant's back condition was not caused by her work activities for Employer. He noted that Claimant reached MMI on March 21, 2007 and did not suffer any permanent impairment.

18. On April 2, 2008 Claimant underwent surgery to remove the hardware in her lumbar spine.

19. On August 4, 2008 Greg Reichhardt, M.D. performed an independent medical examination on Claimant. Dr. Reichhardt reviewed all of Claimant's medical records. He agreed with Dr. Kawasaki that, to a reasonable degree of medical probability, Claimant's lower back condition was not caused by her work activities. He noted that Claimant had significant ongoing back complaints after her 2004 fusion surgery. Dr. Reichhardt also stated that Claimant's February 13, 2006 motor vehicle accident aggravated and may have contributed to her condition. Dr. Reichhardt also agreed with Dr. Kawasaki that Claimant's chronic lower back problems preexisted her reported work injury and that there was no substantial change in her status as a result of her work activities. He thus determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

20. On October 13, 2008 Claimant underwent an independent medical examination with David Yamamoto, M.D. Dr. Yamamoto noted that Claimant had a long history of lumbar pain and suffered from degenerative disc disease. Nevertheless, he concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. He commented that Claimant had been "doing relatively well" and was able to perform her regular job duties after her lumbar fusion in 2004. Dr. Yamamoto also stated that he disagreed with the conclusions of Dr. Kawasaki and Dr. Reichhardt that Claimant's lower back condition was not related to her job duties for Employer. He nevertheless determined that Claimant had reached MMI and assigned her an 18% whole person impairment rating.

21. On November 11, 2008 the parties conducted the evidentiary deposition of ATP Dr. Thompson. Dr. Thompson stated that he disagreed with Dr. Kawasaki because there are many factors that can aggravate chronic lower back pain. He explained that Claimant's condition was substantially altered by her work activities. Dr. Thompson thus disagreed with Dr. Kawasaki's causation determination.

22. Although Dr. Thompson determined that Claimant's lower back condition was caused by her employment activities, he acknowledged that he did not review medical records that existed prior to Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Because Dr. Thompson's opinion was based in part on the temporal proximity of Claimant's occupational disease claim, he agreed that a review of prior medical records could change his causation determination. Dr. Thompson also acknowledged that Dr. Kawasaki offered a reasonable opinion and that Claimant may have suffered a temporary aggravation of her condition. He also conceded that his determination merely constituted a difference of opinion with Dr. Kawasaki.

23. Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Kawasaki's causation determination was incorrect. The medical records reveal that Claimant has suffered an extensive history of lower back problems that began in 2001. She underwent lumbar fusion surgery on August 27, 2004 and continued to suffer from chronic, intermittent back pain. Claimant was also involved in a February 13, 2006 motor vehicle accident that exacerbated her lower back condition and required additional medical treatment. Dr. Kawasaki persuasively determined that Claimant's chronic pain was not caused or substantially altered by her work activities for Employer. He commented that Claimant's work activities caused a temporary aggravation of her ongoing chronic pain syndrome. Dr. Kawasaki also noted that Claimant's chronic pain was caused by "nonspecific degeneration of the patient's lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively." Dr. Kawasaki thus concluded that Claimant's back condition was not related to her work activities for Employer. Claimant thus reached MMI on March 21, 2007 and did not suffer any permanent impairment. Moreover, Dr. Reichhardt agreed with Dr. Kawasaki that Claimant's chronic low back problems preexisted her reported work injury and that there was no substantial change in her physical condition as a result of her employment duties. He thus also determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

24. Dr. Yamamoto and ATP Dr. Thompson disagreed with Dr. Kawasaki's causation determination. Dr. Yamamoto acknowledged that Claimant had suffered from a long history of lumbar pain and degenerative disc disease but concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. Dr. Thompson testified that he disagreed with Dr. Kawasaki's causation determination but acknowledged that he did not review medical records predating Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Dr. Thompson conceded that Dr. Kawasaki offered a reasonable opinion and that his determination merely constituted a difference of opinion with Dr. Kawasaki. The opinions of doctors Yamamoto and Thompson do not constitute unmistakable evidence establishing that Dr. Kawasaki's causation determination was incorrect. Their opinions merely constitute a difference of opinion regarding the cause of Claimant's lower back problems.

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 worker's 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 worker's 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 worker's 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 (2005).

4. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004); *see In Re Backes,* W.C. No. 4-677-535 (ICAP, Sept. 22, 2008) (stating that, a "DIME physician's determination that an impairment is or is not caused by the industrial injury is also subject to the clear and convincing evidence standard"). "Clear and convincing evidence" is evidence that demonstrates that it is "highly probable" the DIME physician's rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). In other words, 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 (ICAP, Oct. 4, 2001). The 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 (ICAP, July 19, 2004); *see Shultz v. Anheuser Busch, Inc.*, W.C. No. 4-380-560 (ICAP, Nov. 17, 2000).

5. As found, Claimant has failed to produce clear and convincing evidence to establish that it is highly probable that Dr. Kawasaki's causation determination was incorrect. The medical records reveal that Claimant has suffered an extensive history of lower back problems that began in 2001. She underwent lumbar fusion surgery on August 27, 2004 and continued to suffer from chronic, intermittent back pain. Claimant was also involved in a February 13, 2006 motor vehicle accident that exacerbated her lower back condition and required additional medical treatment. Dr. Kawasaki persuasively determined that Claimant's chronic pain was not caused or substantially altered by her work activities for

Employer. He commented that Claimant's work activities caused a temporary aggravation of her ongoing chronic pain syndrome. Dr. Kawasaki also noted that Claimant's chronic pain was caused by "nonspecific degeneration of the patient's lumbar spine resulting in the 08/04 surgery with failed back syndrome postoperatively." Dr. Kawasaki thus concluded that Claimant's back condition was not related to her work activities for Employer. Claimant thus reached MMI on March 21, 2007 and did not suffer any permanent impairment. Moreover, Dr. Reichhardt agreed with Dr. Kawasaki that Claimant's chronic low back problems preexisted her reported work injury and that there was no substantial change in her physical condition as a result of her employment duties. He thus also determined that Claimant did not suffer any impairment as a result of her work activities for Employer.

6. As found, Dr. Yamamoto and ATP Dr. Thompson disagreed with Dr. Kawasaki's causation determination. Dr. Yamamoto acknowledged that Claimant had suffered from a long history of lumbar pain and degenerative disc disease but concluded that the proximate cause of Claimant's lower back symptoms was her change in job duties during February 2006. Dr. Thompson testified that he disagreed with Dr. Kawasaki's causation determination but acknowledged that he did not review medical records predating Claimant's occupational disease claim. He specifically commented that he did not review Claimant's medical records that preceded and followed her fusion surgery. Dr. Thompson conceded that Dr. Kawasaki offered a reasonable opinion and that his determination merely constituted a difference of opinion with Dr. Kawasaki. The opinions of doctors Yamamoto and Thompson do not constitute unmistakable evidence establishing that Dr. Kawasaki's causation determination was incorrect. Their opinions merely constitute a difference of opinion regarding the cause of Claimant's lower back problems.

ORDER

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

1. Claimant has failed to overcome Dr. Kawasaki's DIME determination that her lower back condition was not caused by her work activities for Employer.

2. Because Claimant's lower back condition was not caused by her employment activities, she is not entitled to receive medical benefits or TTD benefits.

3. All issues not resolved in this Order are reserved for future determination.

DATED: December 30, 2008.

Peter J. Cannici
Administrative Law Judge