COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
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April Case Law Update

Presented by Judge John Steninger and Judge John Sandberg

This update covers ICAO decisions issued between March 8, 2017 to April 7, 2017

Industrial Claims Appeals Office Decisions

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-926-520-05

IN THE MATTER OF THE CLAIM OF:

JAMES CORDOVA,

Claimant,

v.

FINAL ORDER

WALMART STORES, INC.,

Employer,

and

NEW HAMPSHIRE INSURANCE CO.,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Lamphere (ALJ) dated October 12, 2016, that authorized a proposed lumbar fusion surgery as being reasonable and necessary. We affirm the order of the ALJ.

The claimant injured his low back while unloading a truck at work on December 16, 2012. Following conservative therapy and steroid injections, the claimant's continued pain complaints led his physician, Dr. Stanton, to recommend a spinal fusion surgery at the L4-5 level. This procedure was accomplished on October 28, 2013. In January, 2014, the claimant developed pain radiating into his legs. An MRI revealed foraminal stenosis at the L5-S1 level. Dr. Stanton suggested physical therapy and facet injections at this level. In June, 2014, the claimant returned still complaining of worsening pain and lower extremity pain radiation. Dr. Stanton recommended a L5-S1 fusion surgery.

The claimant underwent a repeat MRI in February, 2015. This MRI suggested the presence of metastatic cancer disease at the T-2 and L-1 level of his spine. The claimant was evaluated by Dr. Markus, an oncology expert. Dr. Markus confirmed the diagnosis of metastatic cancer and initiated chemotherapy. The claimant received regular doses of drugs between April and August, 2015. He then continued with maintenance doses. The claimant's markers for cancer activity decreased to a PSA of 17 in January, 2016. That PSA marker rose again to 27 in May and 44 in June, 2016. The claimant continued to

complain of low back pain to Dr. Stanton. In February, 2016, Dr. Stanton again recommended a fusion surgery.

The respondents arranged for an examination of the claimant by Dr. Bernton. Dr. Bernton concluded the proposed spinal fusion surgery was not reasonable. The doctor expressed concerns that the claimant's back pain was caused by both disc degeneration at the L5-S1 level and by cancer present at the L1 level. He noted it could not be determined which level was more involved in the claimant's pain but that despite a successful fusion surgery, the claimant's pain at L1 would continue to progress. Dr. Bernton noted the claimant did not appear to have his activity level impaired greatly by his back symptoms. He observed that the only reason given for the surgery was to lessen pain complaints and not also to increase the claimant's physical functioning. Dr. Bernton noted Dr. Markus' compilation of evidence showing the mean life expectation for a metastatic cancer patient was five years after diagnosis. Relying on the Director's Medical Treatment Guidelines, Dr. Bernton resolved that the fusion surgery could not be justified. He pointed to the lack of any recent MRI or CT scan to monitor the effect of the cancer. The doctor suggested pain medications should be tried prior to surgery. The claimant was said to complain more of back pain than leg pain which could just as easily be caused by the effects of the cancer. Dr. Bernton referenced the likelihood that the claimant could take more than a year to fully recover from the surgery and compared it to the shortened expected life span and the great risk that the surgery will never relieve much back pain to conclude the fusion surgery was not reasonable.

Dr. Markus testified he believed the proposed fusion surgery could be of assistance to the claimant regardless of his cancer diagnosis. Dr. Markus did not believe the location of the cancer at the L1 level would allow it to have migrated to the L5 level. He noted that if the claimant's pain was relieved by the surgery his activity level was likely to increase. Dr. Markus also did not feel the surgery would have the effect of aggravating either the cancer or parts of the body weakened by the cancer.

The ALJ found a significant amount of the claimant's pain complaints are due to the effects of the December, 2012, work injury and not the metastatic cancer. He credited the claimant's testimony that he does not take much pain medication presently for the reason that it causes too many side effects and not because his pain does not merit the medication's use. The ALJ reasoned the proposed fusion surgery had a high probability of relieving the claimant's pain and arresting the claimant's functional decline. He found the surgery to be reasonable and necessary. The fusion surgery was therefore deemed appropriate for authorization.

On appeal, the respondents contend the Medical Treatment Guidelines, W.C. Rule of Procedure 17, 7 Code Colo. Reg. 1101-3, dictate the denial of authorization for the proposed surgery. It is argued the Guidelines require a surgery to improve a claimant's function as well as to relieve pain. Rule 17, exhibit 1, B (General Guideline Principles), (9) (Surgical Intervention). Section G (Therapeutic Procedures-Operative), 4 (spinal fusion) (d) (diagnostic indications), is said to enumerate the necessary diagnostic prerequisites. These include neural arch defect, segmental instability, primary mechanical back pain/functional spinal unit failure, revision surgery for failed previous operations, and other diagnoses. The respondents claim none of these indications are present in this record.

The respondents assert the pain generator in the claimant's back is not sufficiently identified. They note Dr. Bernton testified it could be either the L5 disc impingement or the deterioration resulting from the cancer. The respondents contend a recent MRI, CT scan, bone scan or EMG isrequired prior to approval of a surgery. It is argued the claimant has not completed a trial of available pain or anti-inflammatory medications. The respondents argue that these deviations from the Guidelines must be adequately explained. The failure to do so constitutes a breach of Rule 17. The respondents indicate Rule 17-2 (A) provides health care providers "shall" use the Guidelines. They reason Rule 17-3 (B) specifies that in the event a provider recommends care which deviates from the Guidelines, the necessity for such care must be provided in a written explanation. The respondents note that Dr. Stanton did not provide adequate documentation for such a deviation and the ALJ did not make sufficient findings in that regard. The respondents conclude therefore, that the ALJ's order must be set aside as contrary to the Guidelines and Rule 17.

The Guidelines are developed by the Director pursuant to legislative direction in § 8-42-101(3.5) (a). The statute directs in § 8-42-101(3)(b) that the Guidelines "shall be used by health care practitioners for compliance with this section." The Guidelines themselves provide in Rule 17-2 (A) that "all health care providers shall use the medical treatment guidelines." Accordingly, compliance with the Guidelines is mandatory for medical providers. However, Rule 17-4 (A) acknowledges that "reasonable medical care may include deviations from the Guidelines in individual cases." The provider is therefore allowed to "request prior authorization" in that situation. When the treatment is outside the Guidelines, the provider is directed to Rule 16-9 (F) to make the request to the insurance carrier and then to Rule 16-10 (C) (3) to have any unresolved dispute determined by an ALJ.

Because an ALJ is designated an arbiter for disputes pertinent to treatment requested outside of the Guidelines, § 8-43-201(3) was amended effective July 1, 2014, to provide an ALJ is "not required" to use the Guidelines as the sole basis for a determination that a medical treatment is reasonable or necessary. Were it otherwise, there would be no purpose to a hearing.

Contrary to the contentions of the respondents, the Guidelines are not an enforceable rule in regard to a determination by the Director or an ALJ at a hearing. They are instructed to "consider" the Guidelines. There also is no requirement that an ALJ's decision articulate a basis for deviation from the Guidelines. Here, the ALJ specifically discussed the testimony of Dr. Bernton insofar as the doctor described and explained the requirements of the Guidelines in the context of lumbar fusion surgery. Findings of Fact 33-35. The Guidelines were considered but the ALJ was not persuaded.

As the claimant points out, Dr. Markus testified the claimant did have a pain generator separate from that caused by the claimant's cancer. He stated the surgery proposed by Dr. Stanton was reasonable to alleviate the claimant's pain regardless that the claimant may also suffer some additional pain due to his cancer condition. Dr. Stanton stated in a July 15, 2016, report that the surgery was aimed at improving the claimant's quality of life. The claimant testified at hearing that he had been forced to suspend participation in several recreational and daily life activities secondary to low back pain. The ability to regain that function was central to his wish to undergo the surgery. The ALJ found the report of Dr. Stanton as well as the testimony of Dr. Markus persuasive. He found the surgery necessary to treat the effects of the claimant's work injury aside from the complications of his cancer. This evidence and the corresponding findings represent documentation of reasons to pursue the fusion surgery regardless of whether the surgery deviates from sections of the Guidelines.

Rule 17, Exhibit 1, (G) (4) (d), Diagnostic Indications, state reasons for low back fusion surgery may include "revision surgery" if functional gains are anticipated as well as "tumor" or deformity of the lumbosacral spine that cause intractable pain. These conditions are noted as present in this record. Part (G) (4) (e), Preoperative Surgical Indications, require that (i) pain generators be adequately defined, (ii) medicine and therapy interventions be completed, (iii) an MRI or CT myelography exist which demonstrates spinal stenosis with disc pathology, (iv) spine pathology is limited to two levels, (v) psychosocial evaluation addressing confounding issues and (vi) a recommendation the claimant refrain from smoking for six weeks prior to the surgery. During the four year history of the claimant's back injury all of these prerequisites have occurred or been achieved. There is no specification as to how recent any of them must

be. The ALJ did not make a reference to all of these circumstances in his conclusions of law, but they were noted in his findings of fact. We conclude the ALJ's reasons for approving the proposed fusion surgery are sufficiently manifest.

We must uphold the ALJ's factual determinations if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence which a rational fact finder would accept as adequate to support a conclusion without regard to the existence of conflicting evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). This standard of review is deferential and the scope of our review is exceedingly narrow. *Id.* Moreover, we may not substitute our judgment by reweighing the evidence in an attempt to reach inferences different from those the ALJ drew from the evidence. *See Rockwell Int'l. v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990) (ALJ, as fact finder, is charged with resolving conflicts in expert testimony). Further, it is the prerogative of the ALJ to credit one medical opinion to the exclusion of a contrary medical opinion. *Dow Chemical Co. v. Industrial Claim Appeals* Office, 843 P.2d 122 (Colo. App. 1992).

The weight and credibility to be assigned expert medical opinion is a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The ALJ may accept all, part, or none of the testimony of a medical expert. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968); *see also Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992) (ALJ may credit one medical opinion to the exclusion of a contrary medical opinion). We cannot say the ALJ here has made a decision not reasonably supported by the record. In addition, the ALJ's plausible inferences may not be disturbed if drawn from substantial evidence in the record. We have no authority to substitute our judgment for that of the ALJ concerning the credibility of witnesses and we may not reweigh the evidence on appeal. *Id.*; *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993).

IT IS THEREFORE ORDERED that the ALJ's order issued October 12, 2016 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

3/14/17 by TT .

HEUSER & HEUSER LLP, Attn: GORDON J HEUSER, 625 N CASCADE AVENUE, COLORADO SPRINGS, CO, 80903 (For Claimant)
LEE + KINDER LLC, Attn: M FRANCES MCCRACKEN, ESQ, 3801 EAST FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-001-128-01

IN THE MATTER OF THE CLAIM OF

LINDA CORMIER,

Claimant,

v.

FINAL ORDER

FOUR SAILS, INC, DBA, GREAT CLIPS,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot Jones (ALJ) dated December 9, 2016, that determined the claimant did not have a compensable claim and denied her request for a left sided carpal tunnel release surgery. We affirm the decision of the ALJ.

The claimant worked for the employer as a hairdresser and store manager for 15 years. In early 2015 the claimant began to suffer hand numbness and arm and shoulder pain on both the left and right. An EMG study revealed mild to moderate bilateral median neuropathies. The claimant was evaluated by hand specialist Dr. Sachar who recommended a left sided carpal tunnel release surgery and also noted the eventual need for a similar surgery on the right. Dr. Sachar, Dr. Wasserman and Dr. Plotkin surmised the claimant's activities as a hair dresser either caused or contributed to her symptoms.

The respondents denied the compensability of the claim. The respondents had the request for the carpal tunnel release reviewed by Dr. Sollender. In his report, Dr. Sollender reviewed the medical records. He observed the claimant was 52 years old, right handed, was 5' 8" tall, weighed 259 pounds with a Body Mass Index of 39 (obese), who stated she performed 15-25 haircuts per day. Dr. Sollender noted the claimant's pain complaints were diffuse and spread over an ill-defined area. He found there was an absence of information related to the time it took to complete a haircut, what activities involved force, repetition or awkward posturing. The doctor therefore requested a job

analysis be completed of the claimant's work activities. A job analysis was completed by Jill Adams, a physical therapist, on December 13, 2015. Dr. Sollender examined the job analysis and deduced that the activities the claimant performed did not qualify as occupational causes or aggravations of carpal tunnel syndrome as set forth in the Director's Medical Treatment Guidelines, W.C. Rule of Procedure 17, Exhibit 5, (D) (3), 7 Code Colo. Reg. 1101-3 Cumulative Trauma Conditions (Medical Causation Assessment for Cumulative Trauma Conditions).

At the August 9, 2016, hearing before the ALJ, the clamant testified the job analysis was not completely accurate in regard to her work functions. The jobs analysis, the claimant's testimony and the work data maintained by the employer showed the claimant performed an average of 2.5 to 2.8 haircuts per hour. None of the tools used by the claimant exceeded 2 pounds. During the time allotted to each haircut the claimant also spent time greeting the customer, walking the customer back to the claimant's chair, discussing the cut with the customer, and wetting the hair with a spray bottle. At the conclusion of the haircut the claimant applied hair product, gave the customer a mirror to examine the cut and walked the customer back to the front of the store. The claimant used a variety of tools to perform the haircut. These include scissors, thinning shears, a razor, combs, trimmers and a blow dryer.

At the request of the respondents the claimant was examined by Dr. Thomas Mordick. Dr. Mordick testified at a post hearing deposition. The doctor referenced the Medical Treatment Guidelines and exhibit 5 dealing with cumulative trauma. Dr. Mordick explained that the symptoms identified by the claimant included numbness on the dorsum of the hand which would exclude a diagnosis of carpal tunnel syndrome. He also described how, even if there was assigned a different diagnosis, the Guidelines and the information do not indicate the claimant's symptoms are the result of work activity. Dr. Mordick pointed to the fact that a left sided surgery was requested. In the claimant's testimony she was observed to have stated the only tool she uses with her left hand was a comb. Dr. Mordick compared the claimant's activity to the list of activities specified in the Guidelines that must be present to find an occupational cause for the trauma. These include six hours of greater than 50% maximal force, six hours of lifting 10 pounds or greater more than 60 time per hour, or six hours of use of hand tools weighing two pounds or greater. None of the descriptions of the claimant's job matched these standards. As a result, Dr. Mordick concluded the claimant did not satisfy the criteria from the Guidelines which would allow a finding of an occupational cause or aggravation of the claimant's symptoms. The doctor indicated the claimant did have comorbid conditions which could affect her symptoms. He described the claimant's age, body mass index and genetics as likely factors leading to her complaints.

The ALJ found the testimony and reports of Dr. Mordick and Dr. Sollender to be persuasive. The ALJ concluded the claimant had not shown her symptoms could be fairly traced to employment as a cause of her occupational disease as required by § 8-40-201(14) C.R.S. The ALJ noted those doctors had compared the requirements set forth in the Medical Treatment Guidelines pertinent to a cumulative trauma disorder to the job demands of the claimant's work. The ALJ resolved that although the claimant had disputed in her testimony some details included in Ms. Adams' job analysis, those disputes were still insufficient to allow her job to qualify under the Guidelines' criteria. The ALJ determined there was no evidence justifying a departure from the application of the Guidelines. The ALJ observed the three physicians who had concluded the claimant's symptoms were work related did not have the benefit of the job analysis, or a detailed description from the claimant of her work activities. The ALJ resolved that the opinions of Dr. Sollender and of Dr. Mordick were premised on credible and persuasive applications of the Medical Treatment Guidelines. Accordingly, the ALJ denied the claimant's request for carpal tunnel release surgery and dismissed the claim for compensation.

On appeal, the claimant asserts the job analysis of Ms. Adams was not sufficiently accurate to justify reliance on its conclusions. The claimant argues the Medical Treatment Guidelines are not required to be applied to determine the outcome of every case. The claimant also contends the ALJ was in error by failing to agree with the conclusions of Drs. Plotkin, Sachar and Wasserman that the claimant's cumulative trauma symptoms were work related.

The Guidelines are developed by the Director pursuant to legislative direction in § 8-42-101(3.5)(a). The statute directs in § 8-42-101(3)(b) that the Guidelines "shall be used by health care practitioners for compliance with this section." The Guidelines in W.C. Rule of Procedure 17, 7 Code Colo. Reg. 1101-3, also provide in Rule 17-2 that "all health care providers shall use the medical treatment guidelines." In *Hall v. Industrial Claim Appeals Office*, 74 P.3d 459 (Colo. App. 2003), the court noted that the Guidelines are to be used by health care practitioners when furnishing medical aid. However, the Rule also specifies in 17-5(c) that "the Division recognizes that reasonable medical practice may include deviations from these guidelines, as individual cases dictate." The amendment to § 8-43-201(3), in S.B. 14-19, effective July 1, 2014, provides an ALJ is "not required" to use the Guidelines as the sole basis for a determination that a medical treatment is reasonable or necessary. It is apparent then, that an ALJ has some discretion to determine causation and compensability in a manner which deviates from the Guidelines.

The claimant had the burden to prove the alleged occupational disease was caused, aggravated or accelerated by the claimant's employment or working conditions. § 8-40-201(14), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). The determination of whether there is a sufficient causal relationship between the claimant's employment and the injury or disease is one of fact, which the ALJ must determine based on the totality of the circumstances. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). Because the issue of causation is factual in nature, we must uphold the ALJ's pertinent findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires deference to the ALJ's resolution of conflicts in the evidence, credibility determinations, and plausible inferences drawn from the record. *Wal-Mart Stores, Inc. v. Industrial Claims Office, supra*. In particular, the weight and credibility to be assigned expert medical opinion is a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

We have reviewed the order and the record provided and we do not perceive reversible error. The relative weight and credibility to be assigned competing expert medical opinions is the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). As such, we may not substitute our judgment by reweighing the evidence in an attempt to reach a result that is different from that of the ALJ. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990)(reviewing court is bound by resolution of conflicting evidence, regardless of the existence of evidence which may have supported a contrary result); *see also Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). To the extent the ALJ relied on the evidence provided by Dr. Mordick, Dr. Sollender and the Job Analysis authored by Ms. Adams, the ALJ's determination is supported by substantial evidence in the record. The ALJ's decision to find evidence tending to support work causation as unpersuasive, is a reasonable conclusion for the ALJ to draw. Section 8-43-301(8), C.R.S.

The credibility attributed to expert medical opinion on the issue of causation is within the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Here, the ALJ credited the respondents' expert and resolved the conflicts in the evidence in favor of the respondent, and we perceive no basis on which to disturb her resolution. Section 8-43-301(8), C.R.S. We may not interfere with the ALJ's assessment of the probative value of the evidence. Consequently, we perceive no error in the ALJ's decision to find the claim not compensable and to deny the request for carpal tunnel release surgery.

IT IS THEREFORE ORDERED that the ALJ's order issued December 9, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

4/7/17 by TT .

PINNACOL ASSURANCE, Attn: HARVEY FLEWELLING, ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Insurer)
BURG SIMPSON ELDREDGE HERSH & JARDINE, Attn: BOBBY D GREENE, ESQ, 40 INVERNESS DRIVE, ENGLEWOOD, CO, 80112 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: KATHERINE HR MACKEY, ESQ, 1401 SEVENTEENTH STREET SUITE 900, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-947-815-02

IN THE MATTER OF THE CLAIM OF:

ALVIN GALLEGOS,

Claimant,

v.

FINAL ORDER

BALFOUR BEATTY INVESTMENTS,

Employer,

and

STARR INDEMNITY & LIABILITY COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated October 18, 2016, that affirmed the determination of the Division sponsored Independent Medical Examination (DIME) physician that the claimant has sustained no permanent impairment. We affirm the order of the ALJ.

The claimant fell at work on February 6, 2014, when he slipped on ice. The claimant described for the physician at the Concentra Clinic the next day how he fell straight forward landing on his left elbow. The claimant complained of left elbow, shoulder and neck pain. The claimant was treated with physical therapy and chiropractic treatment. However, in July, 2014, the claimant complained of increased pain all over, including headaches, pain from his neck to his low back and numbness in both legs. The claimant saw Dr. Hattem on August 7, 2014. Dr. Hattem determined that due to the inconsistency between the current complaints and the claimant's initial complaints, the claimant did not have a work related low back or right upper extremity injury. Dr. Hattem referred the claimant for a psychological examination.

The psychological exam provided a diagnosis of an adjustment disorder with depression and anxiety. The claimant underwent pain management treatment including nerve blocks and trigger point injections. The claimant was seen by Dr. Hattem again on November 25, 2014. The doctor concluded the claimant had suffered an aggravation of a preexisting cervical spondylosis at the C5-6 level which had been documented by a

previous MRI. Dr. Hattem determined the claimant had reached maximum medical improvement (MMI) on February 12, 2015. He calculated a permanent impairment rating which included 6% for six months of pain in the cervical spine and 4% for range of motion deficits. This totaled a 10% whole person rating.

The claimant requested a DIME review which was conducted by Dr. Polanco. Dr. Polanco observed the claimant had a normal spinal curvature, could hold his head erect and move it with smooth coordination. The doctor could detect no extraordinary muscle tone, tightness, tenderness, trigger points, or muscle spasm. The claimant had normal range of motion in his upper extremities and his thoracolumbar spine. Dr. Polanco expressed the view that the claimant had not sustained a permanent injury to his cervical, thoracic or lumbar spine, nor had he permanently aggravated a preexisting condition in the spine. Dr. Polanco conducted range of motion measurements of the spine but reasoned that because there was no objective injury, there was no basis to assign a range of motion impairment pursuant to Table 53 of the AMA Guides to Permanent Impairment. Dr. Polanco therefore assigned a 0% rating finding the claimant did not suffer permanent impairment from his February, 2014, fall at work.

The claimant arranged to be evaluated by Dr. Rook. Dr. Rook provided the opinion that the claimant did show evidence of an injury to his cervical spine which represented an aggravation of a preexisting abnormality. This, he found, supported the rating provided by Dr. Hattem pursuant to Table 53. The respondents had the claimant examined by Dr. Ridings. Dr. Ridings noted the claimant displayed full range of motion in this spine and in his extremities. Dr. Ridings found normal tone and an absence of tightness, spasms or rigidity in the claimant's neck and back. He concluded Dr. Polanco was correct in surmising the claimant had not sustained a permanent injury from his fall at work and Table 53 did not apply so as to provide a basis for an impairment rating. Dr. Ridings reasoned the claimant's failure to improve in the face of a considerable variety of medical treatment indicated a likelihood of symptom magnification on the part of the claimant.

The ALJ found there was not clear and convincing evidence presented to overcome the findings of the DIME physician. The ALJ noted Dr. Polanco's findings were in agreement with other examiners who also discerned the claimant lacked the increased muscle tone and rigidity which would characterize permanent injury to the spine. The ALJ observed that Dr. Polanco had conducted a full and adequate DIME review. This included a physical examination, interview of the claimant, range of motion measurements and review of the medical records. The ALJ resolved that the range of motion measurements by Dr. Polanco revealed very little departure from the normal

range suggesting the claimant would not, in any event, qualify for much of a rating on their account. The ALJ therefore affirmed the decision of Dr. Polanco that the claimant's permanent impairment rating was nil.

On appeal, the claimant contends the ALJ erred by failing to consider whether the claimant suffered a permanent aggravation of a preexisting condition. The claimant argues Dr. Hattem and Dr. Rook found that to be the case.

Dr. Hattem's opinion that the claimant had a preexisting degenerative spondylosis at the C5-6 and C6-7 level was derived from an earlier MRI study. However, the ALJ stated he found more persuasive the findings in the medical records, the report of Dr. Polanco and the testimony of Dr. Ridings. That evidence showed that regardless of the claimant's preexisting degeneration of his cervical spine, the claimant did not display sufficient tightness, rigidity and increased muscle tone necessary to conclude the claimant had sustained any permanent injury to his spine. The complaint of the claimant notwithstanding, the ALJ did resolve with his findings the dispute as to whether the claimant had aggravated a preexisting injury to his cervical spine. The ALJ ruled it was not sufficiently shown he had done so.

Under §8-42-107(8), C.R.S., a DIME physician's opinions concerning MMI and permanent medical impairment are binding unless overcome by clear and convincing evidence. *See Leprino Foods Co. v. Industrial Claim Appeals Office*, 134 P.3d 475, 482-83 (Colo. App. 2005). Whether the claimant carried his burden to overcome the DIME physician's opinion involves a determination of the extent of the impairment that is causally related to the industrial injury. Thus, the DIME physician's findings that a causal relationship does or does not exist between an injury and a particular impairment must be overcome by clear and convincing evidence. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

Clear and convincing evidence means evidence which is stronger than a mere preponderance; it is evidence that is highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Therefore, the party challenging a DIME physician's conclusion must demonstrate that it is highly probable that the DIME impairment rating is incorrect. *Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Whether a party has met the burden of overcoming a DIME by clear and convincing evidence is a question of fact for the ALJ's determination. *Metro Moving & Storage v. Gussert, supra*. A fact or proposition has been proved by clear and convincing evidence if, considering all of the evidence, the trier-of-fact finds it to be highly probable and free from substantial doubt.

Metro Moving & Storage, supra. The ALJ's decision was supported by substantial evidence in the record. We may not substitute our judgment by reweighing the evidence in an attempt to reach inferences different from those the ALJ drew from the evidence. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990). Given the nature of the record and the medical dispute involved, we cannot say the ALJ committed error in adopting the DIME impairment determination of Dr. Polanco.

IT IS THEREFORE ORDERED that the ALJ's order issued October 18, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

3/10/17 by TT .

THE MCDIVITT LAW FIRM, Attn: NICOLE SMITH, ESQ, 19 EAST CIMARRON, COLORADO SPRINGS, CO, 80903 (For Claimant)
RITSEMA & LYON PC, Attn: DEREK T FRICKEY, ESQ, 111 SOUTH TEJON STREET SUITE 500, COLORADO SPRINGS, CO, 80903 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-004-869-02

IN THE MATTER OF THE CLAIM OF:

SERGIO GONZALEZ,

Claimant,

v.

FINAL ORDER

CUSTOM CONCRETE SERVICES, INC.,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Sidanycz (ALJ) dated October 25, 2016, that determined the claimant failed to prove he sustained a compensable injury. We affirm.

This matter went to hearing on the issue of compensability and medical benefits. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant worked for the employer as a concrete finisher. The claimant alleged that he sustained an injury on November 5, 2015, when he felt popping and pain in his back while pushing snow off of a tarp. The claimant testified that he reported the incident to the owner of the employer, who told him he needed to stretch more. The claimant continued to work the remainder of his shift on Thursday, November 5, 2015, and worked on Friday November 6, 2015. The claimant was not scheduled to work on Saturday November 7, 2015, or Sunday November 8, 2015. The claimant returned to work as scheduled on Monday, November 9, 2015.

The claimant sought medical treatment at Mountain Family Health Center on that Monday, November 9, 2015. The claimant had a previously scheduled appointment related to his white blood cell count but notified the doctor during that appointment that he had pain in his lower back. Dr. Brown recommended that the claimant use over the counter pain relievers and a muscle relaxer.

The claimant continued to work until January 18, 2016. Although the claimant testified that he did not perform the physically demanding aspects of his job during this time, the claimant's time cards show that he was working full days of physical concrete work, including setting stairs, pouring stairs and tying rebar. The claimant testified that he falsified his time records so that he could be paid.

The claimant sought additional treatment on November 13, 2015, at Valley View Hospital. Dr. Minion stated that the claimant reported low back pain after working "last Thursday." However, Dr. Minion indicated that the claimant also reported a "prior condition." X-rays revealed anterior edge compression at T12 which Dr. Minion deemed to be an old injury. Dr. Minion prescribed ice, ibuprofen, back exercise and Vicodin. The claimant received a $2,000.00 bill from Valley View, which the claimant testified he asked the employer to pay. The claimant testified that the employer agreed to pay the bill.

The claimant continued to report to work and did not seek additional care. The claimant's last day of work was January 18, 2016. The claimant testified that he did not quit and that the owner asked him to leave. The claimant filed a workers' claim for compensation on January 20, 2016.

The claimant sought additional medical treatment on January 30, 2016, at Valley View Hospital and was examined by Dr. Abramson. The claimant reported increased low back pain. Dr. Abramson recommended ibuprofen and prescribed Flexeril.

The claimant underwent an independent medical examination with Dr. D'Angelo. Dr. D'Angelo reported that the claimant sustained a mild lumbar myofascial irritation on November 5, 2015, and has reached maximum medical improvement. Dr. D'Angelo also stated that the claimant does not require any further medical care. Dr. D'Angelo's report also indicated that the claimant told her that he quit his employment on January 18, 2016, because the owner was not paying attention to him and he had reassigned the claimant's work truck to another employee. The claimant also informed Dr. D' Angelo that he continued to perform his normal job duties until he decided to slow down four or five days before January 18, 2016.

Based on these findings the ALJ credited the testimony and report of Dr. D'Angelo and found that the claimant's contradictory testimony was not credible. The ALJ further found that the claimant attended the November 13, 2015, appointment with Dr. Minion with the intent to treat for an old injury and that this was not related to the

alleged incident on November 13, 2015. The ALJ concluded that the claimant failed to prove he sustained a compensable injury and denied and dismissed the claim for benefits.

On appeal the claimant alleges that he continues to need treatment and has not received appropriate medical care to diagnose his condition. The claimant further contends that he had inadequate representation from his attorney and requests an investigation into social security numbers and other workers' compensation claims purportedly filed by him. We, however, have no basis to disturb the ALJ's order.

In order to prove a compensable injury the claimant bears the burden to establish that the injury arose out of and in the course of employment. Section 8-41-301(1), C.R.S.; *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). The ALJ is charged with making pertinent factual determinations, including those concerning liability for benefits, under a preponderance of the evidence standard. Section 8-43-201, C.R.S. Proof by a preponderance of the evidence requires the proponent to establish that the existence of a "contested fact is more probable than its nonexistence." *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). Under this standard, the ALJ assesses the credibility of the witnesses, the weight of the evidence, and determines whether the burden of proof has been satisfied. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). It is solely for the trier of fact to determine the persuasive effect of the evidence and whether the burden of proof has been satisfied. *Id*.

Because the question of whether the claimant met his burden to prove compensability is factual in nature, we are bound by the ALJ's determinations in this regard if they are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. In this case, the ALJ's factual findings are presumed to be supported by substantial evidence in the absence of a transcript of the hearing. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

Here, despite the claimant's argument to the contrary, the ALJ applied the applicable law and determined the claimant failed to satisfy his burden of proving a compensable injury. In support of this determination, the ALJ found that the claimant's testimony was unreliable and not credible. In the absence of a transcript of the hearing, we must presume that the ALJ's factual findings in this regard are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office, supra*. Further, we note that the limited record provided supports the ALJ's finding that the evidence does not support the claimant's allegation of an injury. When asked about her ultimate conclusion at the deposition, Dr. D'Angelo testified that "if the events that the patient described occurred, my conclusion was that he had a mild myofascial irritation of his lumbar

region...” and that he did not need further medical treatment. Dr. D’Angelo depo. at 5. Dr. D’Angelo went on to further testify that she saw evidence in the record that the claimant did not sustain any injury in November of 2015, based on the inconsistent history provided by the claimant. Dr. D’Angelo depo. at 6. We conclude, therefore, that the evidence supports the ALJ's findings, and the findings fully support the conclusions of law and the order that the claimant's claim is not compensable. Section 8-43-301(8), C.R.S. As such, we have no basis to disturb the order.

Nor does the claimant's assertion that he received inadequate legal representation afford grounds for relief on appeal. *See Hereford v. Mr. Steak*, W.C. No. 3-589-581 (October 3, 1996). The panel’s authority to review the ALJ's order is defined in § 8-43-301(8), C.R.S. This statute does not provide us with the authority to consider the "adequacy" of representation provided by a party's attorney. Accordingly, insofar as the claimant argues that the failure to present certain evidence was the result of the ineffective assistance of counsel, we cannot alter the ALJ's order on this basis.

The claimant also requests that we investigate the social security number used by the insurance company claiming that this number was used by someone else to file workers’ compensation claims. The ALJ’s order noted that the claimant confirmed at hearing that he had failed to disclose a period of employment in which he had sustained a prior injury while working for another employer and that he admitted that this prior injury was reported under a different date of birth and a different social security number. Because there are no transcripts we must presume that this was the claimant’s testimony at hearing. *Nova v. Industrial Claim Appeals Office, supra*. The ALJ’s order does not make any reference to the claimant’s contention that other individuals may have used the claimant’s social security number and this was not a factor in the ALJ’s determination. We also note that parties are expected to present all of their evidence at the appointed hearing before the ALJ, and our review is limited to the record before the ALJ. *Frank v. Industrial Commission*, 96 Colo. 364, 43 P.2d 158 (1935); *City of Boulder v. Dinsmore*, 902 P.2d 925 (Colo. App. 1995). Therefore, we have not considered the additional factual assertions made by the claimant on appeal.

The claimant's arguments notwithstanding, it was solely the province of the ALJ to resolve the conflict in the evidence, which she resolved in favor of the respondents. We, therefore, may not disturb the order on review. Section 8-43-301(8),C.R.S.

IT IS THEREFORE ORDERED that the ALJ’s order dated October 25, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

3/8/17 by TT .

SERGIO GONZALEZ, 694 BRISTLECONE WAY, SILT, CO, 81652 (Claimant)
PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING, ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Insurer)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: ANDREW RZEPIENNIK, ESQ, 1401 17TH ST #900, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-626-898-02

IN THE MATTER OF THE CLAIM OF:

KERRY HIEB,

Claimant,

v.

ORDER

DEVEREUX CLEO WALLACE,

Employer,

and

ZURICH AMERICAN INSURANCE COMPANY,

Insurer,
Respondents.

The claimant and respondents seek review of an order of Administrative Law Judge Allegretti (ALJ) dated September 19, 2016, that ordered the respondents to pay for requested maintenance medical benefits and determined that the issue of average weekly wage (AWW) was closed by operation of statute and denied and dismissed the request for medical expenses and mileage reimbursement. We affirm the ALJ's order with respect to the award of maintenance medical benefits and AWW but set aside and remand the matter for further findings and a determination on the issue of medical expenses and mileage reimbursement.

This matter went to hearing on whether continued maintenance medical benefits are reasonable and necessary and whether the issue of AWW was barred by the claimant's failure to object and file an application for hearing on AWW. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant worked for the employer at an inpatient resident treatment facility for high risk individuals. The claimant sustained an admitted industrial injury on March 5, 2003, when she was kicked repeatedly in the head and jaw by a student she was attempting to physically restrain. The parties agree that the claimant reached maximum medical improvement (MMI) on November 18, 2013. The respondents filed a final admission of liability on January 14, 2014, admitting for ongoing maintenance medical benefits and claiming an overpayment. The claimant filed an application for hearing on

the issue of permanent total disability and overpayment but did not list the issue of AWW.

The claimant's counsel sent a letter to defense counsel on May 23, 2014, outlining the amount of social security disability payments the claimant had recently been awarded and the amount that the claimant's counsel felt was appropriate for the offset or overpayment, including the amount owed to the claimant in AWW due to an increase of COBRA benefits. The respondents filed a second undated final admission of liability in December of 2014 again admitting for maintenance medical benefits and the claimed offset and overpayment due to the claimant's receipt of social security benefits. The claimant filed an objection on January 21, 2015, stating that the final admission was invalid due to an incomplete date. (Claimant's Exhibit 9).

The respondents filed an application for hearing on January 21, 2016, listing the issues of medical benefits, authorized treating provider and reasonably necessary modification of maintenance care and the request to de-authorize a treating physician. In response to that application, the claimant listed the issues raised by the respondents but also added the issue of AWW stating that she wanted her AWW calculation to include her medical benefits and her temporary total and permanent partial disability benefits adjusted accordingly.

At hearing the parties presented conflicting evidence concerning the claimant's need for continued maintenance medical benefits. The ALJ credited the claimant's testimony and the opinion and testimony of the claimant's treating physician, Dr. Leimbach, to find that the claimant required injections in conjunction with physical therapy and that she needed to continue her current medication regimen in order to alleviate her pain and allow her to function. The ALJ therefore ordered the respondents liable to provide these medical benefits.

The ALJ also determined that the issue of AWW was closed by operation of 8-43-203(2)(b)(II)(A), C.R.S., because the claimant did not file an application for hearing on the issue within 30 days from either the January 2014 or the December 2014 final admissions of liability. The ALJ also rejected the claimant's assertion that she was entitled to reimbursement of medical expenses and mileage determining that those issues were not listed as issues for the hearing, nor were those issues tried by consent.

On appeal the respondents contend that the ALJ's award of the maintenance medical benefits is contrary to the Medical Treatment Guidelines and the award is not supported by substantial evidence. The claimant also appealed the ALJ's determination

that the issue of AWW is closed by operation of statute and the issue of medical expenses and mileage reimbursement. We affirm the ALJ's order with the exception of the denial and dismissal of the claimant's request for medical expenses and mileage reimbursement which we remand for further findings.

I.

A claimant may receive maintenance medical benefits that are reasonable, necessary and related to relieve the effects of the industrial injury or to prevent further deterioration of the claimant's condition. See § 8-42-101(1)(a), C.R.S.; *Grover Industrial Commission*, 759 P.2d 705 (Colo. 1988). The burden of proof to establish entitlement to these benefits is on the claimant. *Id.* In order to receive such benefits, the claimant must present substantial evidence that the medical treatment is or will be reasonably necessary to relieve the claimant from the effects of the injury or to prevent deterioration of the claimant's condition. *See Hanna v. Print Expediters, Inc.*, 77 P.3d 863 (Colo. App. 2003); *Stollmeyer v. Industrial Claim Appeals Office*, 916 P.2d 609 (Colo. App. 1995). The question of whether the claimant met the burden of proof to establish entitlement to maintenance medical benefits is one of fact for determination by the ALJ. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999).

Because these issues are factual in nature, we must uphold the ALJ's resolution if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Under the substantial evidence standard of review, we must view the evidence in the light most favorable to the prevailing party, and defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *See Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003).

The respondents rely on Dr. Steinmetz's opinion as support for their contention that the ALJ erred in awarding the requested medical treatment. Dr. Steinmetz performed a medical records review at the respondents' request. In Dr. Steinmetz's opinion the requested injections were not reasonably necessary maintenance medical treatment. Dr. Steinmetz noted that the DIME did not recommend the injections as maintenance medical treatment and that continued injections were not recommended under the Medical Treatment Guidelines. Dr. Steinmetz also noted a lack of objective independent documentation of functional improvement after the prior injections.

The ALJ rejected Dr. Steinmetz's opinion in favor of Dr. Leimbach who explained that he recommends the Botox injections for the claimant's migraine headaches and muscle spasms and stated that these have helped the claimant by providing 3-4

months of reduction of headaches and relief from cervical pain/spasm allowing the claimant to reduce her medications and completely wean off of narcotics. Dr. Leimbach also recommended continued use of Botox injections. Dr. Leimbach stated without these injections, the claimant's pain is debilitating and that this affects her ability to engage in household activities. Dr. Leimbach further testified that the DIME incorrectly stated that he did not see any a decrease in medicine utilization because at the time of the DIME the claimant had weaned off of narcotics. Dr. Leimbach also stated that the claimant's functional gains could be demonstrated by the claimant's cervical range of motion measurements which had increased when the claimant received injections. Contrary to Dr. Steinmetz, Dr. Leimbach testified that the claimant meets the criteria for injections under the medical treatment guidelines because she has tried multiple medications classes that have been unsuccessful. Moreover, Dr. Leimbach testified that the Medical Treatment Guidelines relied on by Dr. Steinmetz to not address maintenance medical benefits but rather, are directed towards pre-MMI treatment. Dr. Leimbach also stated that the ESI injections are necessary for the claimant as they also helped the claimant to stop taking opioids.

The claimant testified that she needs Hyalgan injections, epidural steroid injections, Botox injections and physical therapy to stay at an increased functioning level. She further testified that the injections work best when they are done about every two to three months and the physical therapy works best after a series of the Hyalgan injections and occasionally in between injections when there is a flare-up. She also testified that she needs to continue to take her medications along with the injections.

The respondents' argument notwithstanding, we may not interfere with the ALJ's credibility determinations except in the extreme circumstances where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000). Nor may we interfere with the ALJ's assessment of an expert witness's testimony because where, "as here, expert testimony is presented, the weight to be accorded . . . the testimony is a matter exclusively within the discretion of the [ALJ] as fact-finder." *Rockwell Int'l v. Turnbull*, 802 P.2d at 1183. Although Dr. Steinmetz expressed opinions contrary to that of Dr. Leimbach, we conclude that his opinion is insufficient to overwhelmingly rebut Dr. Leimbach's opinion.

Also, contrary to the respondents' contention, the Medical Treatment Guidelines do not mandate a different result. The respondents point to W.C.R.P. 17, Exhibit 8 as support for their contention that Botox injections are not reasonable and necessary treatment in this case. Although this section does state that Botox injections are no

longer recommended for cervicogenic or other headaches, the ALJ was persuaded by Dr. Leimbach's testimony that this recommendation did not apply to this case or to the provision of maintenance medical treatment in general based on page four of Exhibit 8 which states that "some patients may require treatment after MMI has been declared in order to maintain their functional state." The rule further states that "[t]he recommendations in this guideline are for pre-MMI care and are not intended to limit post-MMI treatment."

In any event, it is well settled that while it is appropriate for an ALJ to consider the Medical Treatment Guidelines in deciding whether a certain medical treatment is reasonable and necessary for the claimant's condition, the ALJ's consideration of the Medical Treatment Guidelines may include deviations from them where there is evidence justifying the deviations. Rule 17-4 (A) *Logiudice v. Siemans Westinghouse*, W.C. No. 4-665-873 (January 25, 2011). Additionally §8-43-201(3), C.R.S. was amended effective July 1, 2014, to provide an ALJ is "not required" to use the Medical Treatment Guidelines as the sole basis for a determination that a medical treatment is reasonable or necessary.

Given the ALJ's consideration of the evidence, we therefore may not disturb her order. We may not substitute our judgment for that of the ALJ concerning the inferences to be drawn. *See City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). Where the medical evidence is subject to conflicting inferences, it is the ALJ's sole prerogative to resolve the conflict. *See Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995)(if two equally plausible inferences may be drawn from medical evidence, we may not substitute our judgment for that of ALJ). The claimant's and Dr. Leimbach's testimony provide substantial evidence and valid support for the ALJ's determination to award the requested treatment. Because the ALJ's order is supported by the evidence, we have no basis to disturb the ALJ's order in this regard. §8-43-301(8), C.R.S.

II.

We are also not persuaded the ALJ erred in her determination that the issue of AWW was closed by operation of §8-43-203(2)(b)(II), C.R.S.

Pursuant to § 8-43-203(2)(b)(II), C.R.S., the claimant had 30 days from the filing of the respondents' final admission of liability to dispute the final admission of liability and request a hearing on any disputed issues. Whether the final admission of liability at issue here is determined to be the January 14, 2014, final admission of liability or the

undated December 2014, final admission of liability, the claimant did not file an application for hearing on the issue of AWW within 30 days of either final admission of liability.

The failure to file a written objection to a final admission and an application for hearing on the disputed issues within 30 days closes the claim on all admitted issues. *Dyrkopp v. Industrial Claim Appeals Office*, 30 P.3d 821 (Colo. App. 2001) (emphasis added). Accordingly, the claimant's failure file an application for hearing on the issue of AWW closed the issue. *See Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006); *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261 (Colo. App. 2004). Thus, we conclude that the law supports the ALJ's order.

The claimant cites to *Casias v. Interstate Brands Corporation*, W.C. No. 4-740-818 (March 25, 2013) and *Noyes v. Wal Mart Stores*, W.C. No. 4-692-745 (October 24, 2011) to support her argument that she should be allowed to litigate the AWW issue. The claimant's reliance on these cases is misplaced because in both of these cases the issue of reopening to adjust the claimant's AWW for terminated health insurance was endorsed as an issue for hearing. Here, the issue of reopening was not listed as an issue for hearing in this case, nor was it tried by consent. We, therefore, agree with the ALJ that the effect of the claimant's failure to file an application for hearing endorsing AWW was to close the claim with respect to that issue. *See Olivas-Soto v. Industrial Claim Appeals Office*, *supra; Leprino Foods v. Industrial Claim Appeals Office*, 134 P.3d 475 (Colo. App. 2005); *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261 (Colo. App. 2004).

III.

The claimant also argues on appeal that she is entitled to medical expenses and mileage reimbursment. The ALJ concluded that the issue of mileage and expenses was not properly endorsed or tried by consent and denied and dismissed the issue. We disagree with the ALJ's determination.

At the beginning of hearing the claimant's counsel stated that the issues for hearing included unpaid medical bills and mileage and receipts as part of the issue of reasonable and necessary medical benefits. Tr. at 18-19. The ALJ also stated that this, "still comes under reasonable and necessary." Tr. at 18. The respondents' counsel did not object to this issue going forward. Tr. at 19. The claimant also provided a detailed list of unpaid expenses and mileage requests in Exhibit 13 which was admitted into evidence without objection from the respondents. Tr. at 21. The claimant also provided testimony, without objection, on the issue of mileage and medical expenses. Tr. at 62-63.

Under these circumstances the issue was properly before the ALJ and we therefore remand the matter for further findings and a determination on this issue.

IT IS THEREFORE ORDERED that the ALJ's order dated September 19, 2016, is set aside and remanded only for a determination on the claimant's request for medical expenses and mileage reimbursement. The order is otherwise affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

3/15/17 by TT .

FURUTANI & MERKEL, Attn: BARBARA J FURUTANI, ESQ, 1732 RACE STREET, DENVER, CO, 80206 (For Claimant)
TREECE ALFREY MUSAT PC, Attn: JAMES B FAIRBANKS, ESQ, 633 17TH STREET SUITE 2200, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-824-259-05

IN THE MATTER OF THE CLAIM OF

BRYAN HOLCOMBE,

Claimant,

v.

FINAL ORDER

FEDEX CORP,

Employer,

and

SELF-INSURED,

Insurer,
Respondent.

The respondent seeks review of an order of Administrative Law Judge Spencer (ALJ) dated October 31, 2016, that determined the respondent did not overcome the opinion of the Division-sponsored independent medical examination (DIME) physician on maximum medical improvement (MMI), and that ordered it liable for medical benefits. We affirm.

This matter went to hearing on overcoming the DIME physician's opinion that the claimant is not at MMI, and whether the recommended left elbow transposition revision surgery was reasonable and necessary treatment for the claimant's admitted injury.

After the hearing, the ALJ found that the claimant was employed for the respondent employer for 21 years as an Automotive and Diesel Vehicle Technician. The claimant's job duties included repair and maintenance of over-the-road and local delivery trucks. He sustained admitted injuries to his bilateral upper extremities on April 30, 2010, while performing maintenance work on a vehicle.

The claimant's injuries lead to a lengthy course of medical treatment involving conservative measures and surgical intervention. In the early portion of his claim, treatment was focused primarily on the claimant's bilateral shoulders. Dr. Weinstein diagnosed bilateral rotator cuff tendinitis, bilateral acromioclavicular joint inflammation, and right elbow lateral epicondylitis. He recommended a right shoulder arthroscopic

subacromial decompression and a distal clavicle resection, as well as a steroid injection to the right elbow. Dr. Weinstein performed right shoulder surgery on December 9, 2010.

On March 28, 2011, the claimant saw Dr. Worwag for an independent medical examination (IME) at the request of the respondents. Dr. Worwag opined that the claimant's bilateral shoulder and bilateral elbow diagnoses were causally related to his work. She concluded the claimant was at MMI for the right shoulder and bilateral elbows. She also opined there was not a reasonable expectation that any surgery with respect to the elbows would lead to any "meaningful lasting functional gains."

The claimant started treating with Dr. Larsen, an orthopedic surgeon, on May 23, 2011. Dr. Larsen diagnosed bilateral cubital tunnel syndrome and bilateral epicondylitis. He recommended a left lateral tennis elbow debridement and left ulnar release surgery. For the right elbow, Dr. Larsen recommended cubital tunnel decompression surgery. On July 7, 2011, the claimant underwent left shoulder arthroscopic subacromial decompression and left arthroscopic distal clavicle resection surgery. During the same surgery, the claimant had a left elbow cubital tunnel release and left elbow lateral upper condyle debridement.

Dr. Larsen subsequently noted that the claimant was recovering relatively well on the left side. He indicated that the claimant was ready to proceed with the right elbow surgery. The claimant ultimately underwent right in-situ ulnar neurolysis on March 6, 2012.

The claimant returned to see Dr. Larsen on December 5, 2012. The claimant described persistent right lateral elbow pain, similar to the pain on the left side for which he had surgery. He described difficulty with gripping and grasping activities. Dr. Larsen noted he could proceed with additional surgery for his right elbow pain, which would be scheduled on receipt of authorization.

The claimant subsequently underwent a DIME with Dr. Higginbotham on January 14, 2013. Dr. Higginbotham opined that the surgery proposed by Dr. Larsen was reasonable and necessary and would benefit the claimant. Accordingly, the DIME physician determined the claimant was not at MMI.

The respondent challenged the DIME physician's MMI determination. In support, the respondent relied upon the opinion of its IME physician, Dr. Sachar. Dr. Sachar opined that the surgery was not reasonable or necessary. He explained that the claimant had not demonstrated significant functional improvement as a result of the previous

surgeries and concluded that the potential for regaining significant function and significant pain relief from the recommended surgery was "extremely guarded."

Hearings were held before ALJ Walsh in September and November 2013. ALJ Walsh determined the respondent failed to overcome the DIME physician's opinion regarding MMI. He further found that the right elbow surgery proposed by Dr. Larsen was reasonable, necessary, and related to the industrial injury.

The claimant underwent revision of the right ulnar nerve at the elbow, a right submuscular ulnar nerve transposition, and a right lateral tennis elbow debridement with Dr. Larsen on February 11, 2014. The claimant reported he was doing very well with complete resolution of numbness and tingling in his right hand. However, the claimant's lateral epicondylar pain still persisted on the left side. After the claimant subsequently underwent EMG/NCV testing, Dr. Larsen concluded there was "not much left" for him to do regarding the lateral epicondyle. He surmised that he would "not advocate for a revision on the left side unless [the claimant] got far worse."

Dr. Castrejon performed an IME on January 5, 2015, at the request of the respondent. Dr. Castrejon opined the claimant was at MMI as he did not expect further surgery to result in any significant functional gains. Dr. Castrejon noted that additional surgery carried a "high risk for functional loss and worsening chronic pain."

Dr. Larsen placed the claimant at MMI on January 26, 2015. He recommended maintenance care.

On April 20, 2015, the claimant returned to Dr. Larsen complaining of worsening left upper extremity symptoms. The claimant described tenderness along the course of his ulnar nerve as well as pain and numbness in the ring and small fingers. Dr. Larsen opined that the claimant's presentation was consistent with ulnar nerve irritation or ulnar neuritis of the left elbow. Dr. Larsen requested authorization for left arm surgery to include a revision ulnar neurolysis and submuscular transposition. This is the same procedure the claimant previously had on the right elbow.

A hearing was held before ALJ Lamphere on December 2, 2015, regarding whether the left elbow revision surgery was reasonable and necessary. ALJ Lamphere ultimately concluded that the surgery was not reasonable and unnecessary. Accordingly, he denied and dismissed the claimant's request for the surgery. Neither party appealed ALJ Lamphere's order.

Thereafter, on April 25, 2016, the claimant saw Dr. Higginbotham for a follow-up DIME. Dr. Higginbotham noted that the claimant had received benefit from the revision ulnar transposition surgery on the right elbow. He further noted that the left ulnar neuritis has worsened since the initial left elbow surgery from a clinical and symptomatic standpoint. The DIME physician opined that beyond a reasonable degree of medical probability, Dr. Larsen's recommendation for the left ulnar nerve transposition surgery was necessary and reasonable. He therefore concluded that the claimant was not at MMI until after the proposed surgery.

The respondent applied for a hearing to contest the DIME physician's recommendation for the revision surgery and his determination that the claimant was not at MMI until after the proposed surgery.

Dr. Castrejon performed a second IME on August 2, 2016, at the request of the respondent. Dr. Castrejon disagreed with the DIME physician's determination that the claimant was not at MMI and he did not believe further surgery was likely to improve the claimant's condition or functional capacity.

ALJ Spencer ultimately determined that the respondent failed to overcome the DIME physician's determination that the claimant was not at MMI. ALJ Spencer also rejected the respondent's argument that issue preclusion applied. ALJ Spencer found that while three of the four factors pertaining to issue preclusion were met, the fourth factor- whether the issue sought to be precluded is identical to an issue actually determined in the prior proceeding- was not met. The ALJ held that the issues decided by ALJ Lamphere were not identical to the issues he was deciding. ALJ Spencer reasoned that the issue he was deciding, whether the respondents overcame the DIME physician's determination on MMI, involved a different burden of proof than ALJ Lamphere's determination on whether the surgery was reasonable or necessary. He explained that the burden of proof he was deciding was clear and convincing, and the burden of proof applicable before ALJ Lamphere was preponderance of the evidence. Accordingly, he ordered the respondent liable for the revision left ulnar transposition surgery recommended by Dr. Larsen.

The respondent has petitioned to review ALJ Spencer's order. The respondent initially argues that the doctrine of issue preclusion prevented ALJ Spencer from considering whether the claimant was entitled to left elbow transposition revision surgery. It reasons that since ALJ Lamphere already determined the surgery was not reasonable or necessary, then ALJ Spencer could not determine the efficacy of such surgery. The respondent further reasons that the claimant was seeking payment for a left

elbow revision surgery at both hearings, and the DIME report did not provide any new rationale different from what the claimant presented in the first hearing. The respondent also argues that since the need for left elbow surgery was the "sole basis" for Dr. Higginbotham's opinion that the claimant was not at MMI, substantial evidence does not support ALJ Spencer's determination that it failed to overcome the DIME physician's determination that the claimant is not at MMI. The respondent reasons that ALJ Lamphere previously determined the left elbow surgery was not reasonable and necessary. We disagree.

Issue preclusion is an equitable doctrine that bars relitigation of an issue that has been finally decided by a court in a prior action. *Bebo Construction Co. v. Mattox & O'Brien*, 990 P.2d 78, 84 (Colo. 1999). Its purpose is to relieve parties of the burden of multiple lawsuits, to conserve judicial resources, and to promote reliance upon and confidence in the judicial system by preventing inconsistent decisions. *Id.* Although issue preclusion was conceived as a judicial doctrine, it has been extended to administrative proceedings, where it "may bind parties to an administrative agency's findings of fact or conclusions of law." *Sunny Acres Villa, Inc. v. Cooper*, 25 P.3d 44, 47 (Colo. 2001); *see also Holnam, Inc. v. Industrial Claim Appeals Office*, 159 P.3d 795 (Colo. App. 2006). In *Sunny Acres Villa*, the Colorado Supreme Court held that issue preclusion bars relitigation of an issue if: (1) the issue sought to be precluded is identical to an issue actually determined in the prior proceedings; (2) the party against whom estoppel is asserted has been a party to or is in privity with a party to the prior proceeding; (3) there is a final judgment on the merits in the prior proceeding; and (4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. *Id*. at 47.

I.

The respondent argues that substantial evidence does not support ALJ Spencer's determination that it did not overcome the DIME physician's opinion on MMI. The respondent reasons that this is because ALJ Lamphere previously determined the left elbow surgery was not reasonable and necessary. We disagree with the respondent's argument, however.

The Colorado Court of Appeals previously has held that issue preclusion may not apply where the burdens of proof involved in the two adjudications are not the same. In such a circumstance, the issues cannot be considered identical. In *Holnam*, the Court explained that in the case of claim preclusion, a differing standard of proof was not significant. However, the situation would be the reverse if the consideration was issue preclusion. The Court explained that "issue preclusion (collateral estoppel) may be

affected by the difference in the burden of proof, *see* Restatement, *supra*, §28(4), that principle does not translate to the realm of claim preclusion." *Id*. at 799. Additionally, in *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002), the Court held that only those opinions of a DIME physician delegated to the physician by statute, MMI and permanent impairment, need be overcome by clear and convincing evidence as opposed to a preponderance of the evidence. Therefore, a DIME physician's determination regarding the existence of a compensable injury had no standing in the face of a prior ALJ decision of no compensable injury because they both were subject to a preponderance of the evidence standard. However, the DIME physician's opinion concerning the cause of a particular component of a claimant's overall impairment must be overcome by clear and convincing evidence. *See Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *see also Braun v. Vista Mesa*, W.C. No. 4-637-254 (April 15, 2010)(ALJ's prior order determining claimant sustained compensable injury of thoracic outlet syndrome did not serve as issue preclusion when DIME doctor later determined claimant did not have thoracic outlet syndrome and was at MMI); *Ortega v. JBS, USA, LLC*, W.C. No. 4-804-825 (June 27, 2013)(issue preclusion inapplicable).

Here, we reject the respondent's argument that issue preclusion applies here. The respondent contends that the burden of proof at both hearings was identical because the issue to be decided at both was the efficacy of the left elbow revision surgery. The respondent reasons that during both hearings, the claimant had the burden to prove, by a preponderance of the evidence, that the proposed left elbow revision surgery was reasonable and necessary. It is true, as the respondent argues, that a DIME physician's recommendation for future medical treatment has no presumptive weight. *Cf. Cordova v. Industrial Claim Appeals Office, supra*.

Additionally, as argued by the respondent, the key dispute at both hearings was the proposed left elbow revision surgery. However, the context in which this dispute was presented at both hearings was quite distinct. As explained above, during the hearing before ALJ Lamphere, the issue to be decided was whether the claimant proved, by a preponderance of the evidence, that the revision surgery was reasonable or necessary. The claimant bears the burden of proof to establish the right to specific medical benefits by a preponderance of the relevant evidence. Section 8-43-201, C.R.S. However, during the subsequent hearing before ALJ Spencer, the respondents had the burden of overcoming the DIME physician's opinion, by clear and convincing evidence, that the claimant was not at MMI because he had not yet undergone the revision surgery. *Cordova v. Industrial Claim Appeals Office, supra*. As detailed above, the opinions of a DIME physician have been given presumptive effect when expressly required by statute,

which includes MMI and permanent impairment. *Id*. Thus, ALJ Spencer was asked to review a determination of a DIME physician regarding whether the claimant was at MMI because he had not yet undergone the revision surgery. ALJ Spencer's order was based upon a clear and convincing evidence standard. Consequently, the issue determined by ALJ Lamphere was not identical to the later issue decided here by ALJ Spencer. Consistent with our prior decisions, therefore, issue preclusion is inapplicable because the issue decided by ALJ Lamphere was not identical to the issue determined by the ALJ in this matter. *Braun v. Vista Mesa, supra; see also Madrid v. Trinet Group, Inc*., W.C. No. 4-851-315-03 (April 1, 2014).

The respondent also argues that substantial evidence does not support ALJ Spencer's determination that the DIME physician's opinion on MMI was not overcome. To the extent the respondent argues that the DIME physician's opinion on MMI is overcome because it rests solely on the recommendation for surgery that previously was adjudicated to be not reasonable or necessary, we disagree. As detailed above, issue preclusion is inapplicable here because the issue decided by ALJ Lamphere was not identical to the issue determined by ALJ Spencer in this matter. *Braun v. Vista Mesa, supra; see also Madrid v. Trinet Group, Inc., supra*. Nevertheless, we conclude that substantial evidence supports ALJ Spencer's determination that the respondents did not overcome the DIME physician's opinion on MMI. His conclusion is supported by Dr. Larsen's opinions and the claimant's testimony. Ex. 1 at 2, 4-5; Depo. of Dr. Larsen at 26-28; Tr. at 29. Section 8-43-301(8), C.R.S.

II.

To the extent the respondent argues that issue preclusion barred ALJ Spencer from considering whether the recommended left elbow transposition revision surgery was the liability of the respondent, we disagree for two reasons. First, the issue decided by ALJ Lamphere is not the same as that resolved by ALJ Spencer. This is because the claimant's condition was shown to have changed during the interval between the December 2015 hearing before ALJ Lamphere and the October 2016 hearing conducted by ALJ Spencer. Second, an element of the claim relied upon by ALJ Lamphere, i.e., the cause of the carpal tunnel syndrome, was the subject of the DIME evaluation which came to a different conclusion.

In his decision of February 3, 2016, following a hearing on December 2, 2015, ALJ Lamphere determined the proposed ulnar nerve revision surgery on the left elbow was unreasonable and unnecessary for two reasons. First, the ALJ noted the claimant's testimony that the ulnar nerve revision surgery on the right did not result in functional

gain. Accordingly, the ALJ reasoned it was unlikely that the claimant would realize much functional benefit from the same surgery on the left. Second, the ALJ relied on the testimony of Dr. Castrejon to find the claimant's carpal tunnel syndrome, the basis for the nerve revision surgery, was not caused by work related activity or by treatment for that activity.

However, in the October 18, 2016, hearing before ALJ Spencer, the claimant enumerated specific tasks he could now perform with his right arm that he could not accomplish at the time of the December 2015 hearing. These included using his right arm to fish and to operate a manual transmission while driving a car. The claimant also described the recovered ability to open jars, perform cooking tasks, and vacuuming. Therefore, the record before ALJ Spencer was distinct from the record considered by ALJ Lamphere. The claimant's condition had changed in such a manner as to likely affect ALJ Lamphere's finding 10 months earlier that the claimant sustained very limited improvement from his right sided surgery. The issue then, had also changed. This point was made in *El Paso County Department of Social Services v. Donn*, 865 P.2d 877, 880 (Colo. App. 1993):

> These doctrines, however, are useless when determining whether a prior order in a workers' compensation case constitutes an 'award' for purposes of reopening. This is so because whenever a party asserts that a claimant's condition has changed since the date of the last order, the issue is necessarily different from the issue previously determined.

Second, the hearing before ALJ Lamphere occurred prior to the DIME evaluation on April 16, 2016. ALJ Lamphere's finding of no causation was inconsistent with the DIME's ruling the claimant's carpal tunnel condition was work related. This finding by the DIME raises the presumption the condition was caused by work. The Court of Appeals observed in *Brownson-Rausin v. Industrial Claim Appeals Office*, 131 P.3d 1172, 1179 (Colo. App. 2005): "Because an MMI determination requires the DIME physician to ascertain the cause of the claimant's medical conditions, the DIME physician's determination of causation must also be overcome by clear and convincing evidence." Because the finding on causation is now controlled by a different evidentiary standard than that applied by ALJ Lamphere, it has now ceased to be the same issue as was decided by ALJ Lamphere. *Madrid v. Trinet Group, supra*. Thus, for these reasons, we conclude the issue decided by ALJ Lamphere was not the same issue determined by ALJ Spencer. Accordingly, the defense of issue preclusion does not apply to prevent ALJ Spencer from finding the nerve revision surgery on the left reasonable, necessary, and the liability of the respondent.

IT IS THEREFORE ORDERED that the ALJ's order dated October 31, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

3/24/17 by TT .

DARRELL S ELLIOTT P.C., Attn: ROBER F JAMES, ESQ, 1600 PENNSYLVANIA ST, DENVER, CO, 80202 (For Claimant)
RITSEMA & LYON P.C., Attn: PAUL KRUEGER, ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

.INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-984-216-02

IN THE MATTER OF THE CLAIM OF:

SUSAN JATERKA,

Claimant,

v.

ORDER OF REMAND

JOHNSON & JOHNSON,

Employer,

and

INDEMNITY INS. CO. OF N. AMERICA,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Edie (ALJ) dated November 23, 2016, in which the ALJ concluded he lacked the authority and jurisdiction to address the claimant's argument that her claim should be reopened. We set aside the ALJ's order and remand the matter for further findings and new order.

This matter went to hearing on the issues of reopening, and the claimant's entitlement to medical benefits, temporary total disability benefits, and permanent partial disability benefits for the claimant's alleged shoulder injury. The respondents contended at hearing that the claimant was jurisdictionally barred from raising these issues because she did not object to the final admission of liability, or request a Division Independent Medical Examination (DIME), or file an application for hearing. After hearing the ALJ made factual findings that for purposes of review can be summarized as follows. Since 2006 the claimant worked for the employer as a documents controller. The claimant went to Concentra Medical Center on September 15, 2014, complaining of pain in the left wrist and shoulder from her work duties of turning pages and data entry. According to the claimant, the pain started in her left wrist and then radiated up to the left shoulder. The treating physician assessed wrist sprain, lateral epicondylitis of the left elbow, biceps tendinopathy and impingement syndrome of the shoulder. The claimant was prescribed physical therapy and medications and was released to return to work.

The claimant continued treating at Concentra for her left wrist, elbow and shoulder pain. An MRI for the left shoulder revealed a partial thickness tear and also showed an anterosupralateral labral tear. Shoulder surgery was recommended on April 20, 2015.

The respondents filed a notice of contest on June 4, 2015,[1] disputing the compensability of the claimant's shoulder injury. On June 15, 2015, the claimant was placed at maximum medical improvement (MMI) by Dr. Larimore for her wrist and elbow complaints with no impairment, no work restrictions, and no need for medical treatment to maintain MMI. Dr. Larimore also stated that after extensive review of the claimant's job site evaluation, EMG, MRI and all of the past notes, "my opinion is that there is a >50% likelihood that the left shoulder complaints are not work-related." The insurer filed a final admission of liability on June 29, 2015, admitting liability consistent with Dr. Larimore's report for the wrist and elbow.

The claimant did not object to the June 29, 2015, final admission nor did she file a notice and proposal to select a DIME or an application for hearing on any issues. The claimant then sought treatment with her personal provider, Dr. Pak, at Front Range Orthopedics for her left shoulder complaints. The claimant eventually underwent surgery for her left shoulder on August 9, 2016. The claimant testified at hearing that she filed a Petition to Reopen the claim based on her belief that she was inappropriately placed at MMI and compensability of the shoulder was inappropriately denied.

The ALJ found that the claimant presented no credible evidence to support an award for medical, temporary, or permanent partial disability benefits. The ALJ went on to find that the claimant's request to reopen the claim to prove compensability of her shoulder injury was an attempt to circumvent the DIME provisions and the statutory requirements in §8-43-203(2)(b)(II)(A), C.R.S., which operate to close a claim unless the claimant files an objection, requests a DIME, or files an application for hearing on any ripe and disputed issues. The ALJ concluded that the claimant's failure to object and timely request a DIME or file an application for hearing meant that he lacked the authority or jurisdiction to address the claimant's petition to reopen.

On appeal the claimant contends the ALJ erred in denying her requests. The claimant further asserts that the ALJ erred in not reviewing all of the evidence she submitted, specifically the MRI report which she attaches to her brief in support. The claimant also contends that the ALJ encouraged her not to proceed with the hearing and

[1] The ALJ's order mistakenly states that the respondents' notice of contest was filed on June 5, 2015.

that the ALJ's order is very similar to the respondents' position statement and contains inaccurate dates. The claimant, however, does not specify what dates are inaccurate.

We note that the transcript was not made part of the record on appeal and, therefore, in the absence of a transcript, we must assume the ALJ's findings of fact are supported by substantial evidence in the record. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

The respondents object to the MRI report attached to the claimant's brief. The ALJ's order, however, indicates that the parties' exhibits were admitted into evidence. The claimant submitted a packet listed as "Exhibit 1" containing several documents, including the MRI report, which the order stated were admitted with the proviso that after review by the ALJ, any records beyond medical and employment records would be excluded. There is nothing further said about the exhibit in the order. The MRI report was in the claimant's admitted exhibit and as such, we presume that the ALJ reviewed the report. The ALJ is not required to cite and discuss every piece of evidence prior to crediting contrary or other evidence. *Crandall v. Watson-Wilson Transportation System*, 171 Colo. 329, 467 P.2d 48 (1970). Rather, evidence not specifically discussed is implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Moreover, because the report was admitted below, we are not precluded from considering the document on review.

Insofar as the claimant raises allegations against ALJ's conduct towards her at the hearing, without a transcript we are unable to say that the ALJ's conduct at hearing was anything other than appropriate. *Wecker v. TBL Excavating, Inc.*, 908 P.2d 1186 (Colo. App. 1995)(ALJ is presumed to be competent and unbiased in the conduct of the hearing unless the record shows to the contrary). Additionally, the fact that the ALJ may have adopted the respondents' proposed order as his own is not a basis for disturbing the order on review. *See Ficor, Inc. v. McHugh*, 639 P.2d 385 (Colo. 1982); *Uptime Corp. v. Colorado Research Corp*., 161 Colo. 87, 93, 420 P.2d 232, 235 (1966)("[I]f, [a]fter careful study, the trial judge concludes that the findings prepared by a party correctly state both the law and the facts, then there is no good reason why he may not adopt them as his own.")

We do agree, however, that that the ALJ misapplied the law in this case when he determined that he lacked the authority or jurisdiction to address the claimant's request to reopen her claim. We therefore set aside the ALJ's order and remand for further findings.

Pursuant to §8-43-303, C.R.S., any award may be reopened on the grounds of error, mistake, or a change in the claimant's condition. The intent of the reopening statute is to provide relief to claimants who are entitled to awards of any type of benefits. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The ALJ has wide discretion to determine whether a mistake has occurred that justifies reopening the claim. O*sborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). We may not interfere with the ALJ's order reopening the claim in the absence of a clear abuse of discretion. The standard on review of an alleged abuse of discretion is whether the ALJ's order exceeds the bounds of reason, as where it is not supported by the evidence or the law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993); *Rosenberg v. Board of Education of School District* #1, 710 P.2d 1095 (Colo. 1985).

The ALJ here agreed with the respondents' argument that the claimant was required to timely request a DIME or file an application for hearing to determine the compensability of the claimant's shoulder condition, and the claimant's failure to do so deprived the ALJ of jurisdiction to address the claimant's petition to reopen. This, however, is an in correct statement of the law.

As the court of appeals recognized in *Berg v. Industrial Claim Appeals Office*, 128 P.3d 270 (Colo. App. 2005) , the statutory authority to reopen "any award" is broad and nothing in the subsequently enacted DIME procedures was intended to restrict that authority. The issues inherent in challenging a DIME report are not identical to those regarding reopening and, therefore, the ALJ did have jurisdiction to address the claimant's request to reopen her claim.

In *Berg* the respondents filed a final admission of liability based on a DIME report. The claimant objected, seeking surgery for his back, but failed to file an application for hearing in conjunction with the objection. The claimant subsequently filed a petition to reopen alleging that the claimant's treating physicians and the DIME physician were mistaken regarding the cause of his back symptoms. The ALJ granted the petition to reopen, finding that the doctors had been mistaken both about MMI and about the relatedness of the claimant's back condition to his industrial injury. The panel set aside the ALJ's order, reasoning that permitting reopening based upon the "mistake" of an uncontested DIME report would subject a DIME physician's determination of MMI to collateral attack under a diminished burden of proof. The Colorado Court of Appeals, however, set aside the panel's order, holding that there is nothing in the statutory DIME procedures that limits the reopening provisions. The court also rejected the panel's reasoning that permitting reopening under these circumstances encouraged efforts to

circumvent the DIME procedures, with the attendant higher burdens of proof. The court noted the reopening statute was designed to apply even in these circumstances where the determination of the DIME physician is sought to be questioned.

The principles announced in *Berg* are applicable to the facts of this case. Although the respondents in *Berg* had obtained a DIME and argued that the claimant "circumvented" it through reopening, the court's reasoning is equally applicable to the present case, where the claimant failed to obtain a DIME prior to reopening. We are bound by the published authority issued by the court of appeals. C.A.R. 35(f).

A review of the record here indicates that the claimant raised factual issues concerning whether her claim should be reopened under §8-43-303, C.R.S., and the ALJ erred by not making corresponding findings to address the issue of reopening. It is therefore necessary to remand this matter to the ALJ for further proceedings to determine the issue of reopening. The ALJ must first determine whether there has been an error or mistake or change of condition. If there is, then the ALJ must determine whether it is the type of error, mistake or change of condition which warrants a reopening. *See Klosterman v. Industrial Commission*, 694 P.2d 873 (Colo. App. 1984). For example, when determining whether a mistake warrants reopening, the ALJ may consider whether it could have been avoided by the timely exercise of appropriate procedural or appellate rights. *Industrial Commission v. Cutshall*, 164 Colo. App. 240, 433 P.2d 765 (1967); *Klosterman v. Industrial Commission, supra*. The failure to exercise procedural or appellate rights, however, is not dispositive of whether the claimant has established an error or mistake which justifies reopening the claim. *Renz v. Larimer County School District Poudre R-1, supra*. To the contrary, the ALJ may exercise his discretion to reopen a claim if he determines that the overall circumstances warrant reopening. *Standard Metals Corp. v. Gallegos*, 781 P.2d 142 (Colo. App. 1989). In reaching this result, we should not be understood as expressing any opinion on the resolution of the reopening issue. The ALJ retains the discretion to grant or deny the petition to reopen. The ALJ, however, must exercise that discretion and not forgo the determination because of a perceived lack of jurisdiction. *See Justiniano v. Industrial Claim Appeals* Office, 83 COA 2016. Whether the ALJ needs to consider any additional issues for hearing endorsed by the parties depends on his resolution of the reopening issue.

IT IS THEREFORE ORDERED that the ALJ's order dated November 23, 2016, is set aside and remanded for further findings and a new order.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

3/22/17 by TT .

SUSAN JATERKA, 4465 LAREDO MEADOW POINT APT 104, COLORADO SPRINGS, CO, 80922 (Claimant)
LEE + KINDER, Attn: M FRANCES MCCRACKEN, ESQ, 3801 EAST FLORIDA AVE SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-978-510-02

IN THE MATTER OF THE CLAIM OF

SINKE MULGETA,

Claimant,

v.

FINAL ORDER

ISS FACILITY SERVICES INC,

Employer,

and

XL SPECIALTY INSURANCE CO,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Michelle E. Jones (ALJ) dated October 31, 2016, that determined the claimant failed to overcome the zero permanent impairment rating assessed by the Division-sponsored independent medical examination (DIME) physician, and that denied and dismissed her request for penalties. We affirm.

The claimant worked for the respondent employer as a janitor. On February 24, 2015, the claimant sustained pain in her right shoulder and back while pulling a trash bag out of a trash container. The next day, the claimant reported the injury to the respondent employer and was referred for medical treatment. The claimant was evaluated by Dr. Sobanski and diagnosed with trapezius muscle strain and low back pain and was released to work with a 10 pound lifting and a 20 pound push-pull restriction.

The claimant continued to work without missing time and was paid her full wages. The claimant continued to receive conservative medical treatment from February 27, 2015, through August 24, 2015.

On April 30, 2015, the respondents filed a general admission of liability admitting for medical benefits only. The respondents did not admit for or initiate any temporary disability benefits as the claimant had continued working and had not missed any time or wages due to the injury. Under the remarks, the general admission of liability listed,

without more, as follows: "Admitting for medical benefits: Lower back pain, lumbar strain, trapezius strain"

The claimant subsequently was evaluated by Dr. Hattem on August 24, 2015. Dr. Hattem noted the claimant's diffuse total body pain and refusal to flex her lumbar spine. He opined there likely was a very significant myofascial component to the claimant's pain complaints. Dr. Hattem also noted that the claimant had diffuse and migrating pain complaints and significant dissatisfaction against her employer. Considering the claimant's anger, he opined it was not likely that further physical interventions would be helpful. He also noted that the numerous laboratory studies ruled out a medical condition as causing the claimant's diffuse pain complaints. Dr. Hattem placed the claimant at maximum medical improvement (MMI) and provided a 5% whole person impairment rating under Table 53 of the AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition Revised, for having six months of medical documented pain with none to minimal degenerative changes on structural test. Dr. Hattem stated that the claimant did not qualify for range of motion impairment because when instructed to flex or extend her lumbar spine she refused which was not consistent with her essentially normal MRI. Dr. Hattem opined that the claimant was likely self-limiting her motion. He provided permanent work restrictions of no lifting more than 10 pounds, no pulling more than 20 pounds, and remaining seated 50% of the work day.

The respondents subsequently filed for a DIME.

On September 2, 2015, the respondent employer provided the claimant a letter advising her that they could not accommodate her permanent work restrictions and that she was eligible for 84 days of Family Medical Leave Act (FMLA) leave. The letter also advised the claimant that at the end of her FMLA leave, her employment status and eligibility for any other applicable leave under the company's leave of absence policies would be reevaluated. The claimant declined FMLA leave and her employment ended.

The claimant underwent an independent medical examination with Dr. Bernton. Dr. Bernton noted the claimant's obvious anger with the respondent employer. Dr. Bernton reported the claimant had marked non-physiologic findings on examination and inconsistencies and marked discrepancies in examination. Dr. Bernton opined that the claimant persisted with diffuse pain complaints of great severity that were inconsistent with findings on physical examination, the nature of the original injury, and radiographic studies. He further opined that there were not any objective abnormalities on examination that would support findings of permanent physical impairment or permanent

restrictions. Dr. Bernton stated the claimant was at MMI and no further medical treatment was required.

On March 3, 2016, the claimant underwent the DIME with Dr. Chen. Dr. Chen stated that the claimant likely had a muscular strain while picking up trash from a container at work. She opined that the claimant reached MMI on August 24, 2015. Dr. Chen further opined that the claimant showed no pain or limitation in body movement before examination but then dramatic diffuse pain that made her unable to finish the complete motor strength test or perform range of motion testing. She agreed with Dr. Hattem that the claimant had non-physiological pain behavior. Dr. Chen opined that the claimant had no permanent impairment from the February 24, 2015, work injury and had no physiological deficit that would restrict her function.

On March 23, 2016, the respondents filed a final admission of liability (FAL) consistent with Dr. Chen's report. On May 25, 2016, the claimant objected to the FAL and filed an application for hearing. In her application, the claimant endorsed the following issues: temporary partial disability benefits from 9/2/15 to 3/23/16, permanent partial disability benefits, and a penalty for "discharged on September 2, 2015 as a direct result of medical restrictions issued by treating physician, conduct violated 8-43-304."

Further, on August 9, 2016, the claimant responded to the respondents' interrogatories and alleged a penalty pursuant to WC Rule 5-5(B) for the respondents' failure to state a position on temporary disability benefits on their April 30, 2015, general admission of liability.

The ALJ ultimately determined that the claimant failed to overcome the zero permanent impairment rating of the DIME physician by clear and convincing evidence. The ALJ found that the DIME physician's ultimate opinion that the claimant suffered no permanent partial disability due to the work injury was consistent with other providers who noted discrepancies and inconsistencies in the claimant's presentation. She found that Dr. Chen, Dr. Bernton, and Dr. Hattem all noted the claimant's extreme and diffuse pain complaints without objective findings to support the complaints. The ALJ further denied the claimant's request for penalties. She found that the claimant continued to work her regular hours and earn her regular wages until the date she was placed at MMI by her treating provider on August 24, 2015. She therefore found that the claimant was not entitled to any temporary indemnity benefits as her injury did not cause a disability lasting more than three work shifts or that caused her to have actual wage loss. Since the claimant failed to establish entitlement to temporary indemnity benefits from September 2, 2015, through March 23, 2016, the ALJ rejected her argument that penalties should be

imposed for the respondents' failure to pay indemnity benefits. The ALJ further rejected the claimant's request for penalties for the respondents' failure to state on the general admission of liability grounds for not paying indemnity benefits, in violation of WCRP 5-5(B). The ALJ found that the claimant knew or should have known of the facts giving rise to the penalty on April 30, 2015. Finding that the claimant did not endorse the violation as a penalty issue for hearing until August 9, 2016, over a year later, she concluded her request for penalties was barred by the one year statute of limitations set forth in §8-43-304(5), C.R.S.

The claimant has petitioned to review the ALJ's order, alleging several arguments of error.

I.

The claimant contends that she overcame the zero percent permanent impairment rating of Dr. Chen by clear and convincing evidence. She reasons that the DIME physician failed to conduct a proper spinal examination and failed to follow the required AMA Guides to the Evaluation of Permanent Impairment. We are not persuaded the ALJ erred.

Section 8-42-107(8)(c), C.R.S. provides that the DIME physician's finding of MMI and medical impairment is binding unless overcome by clear and convincing evidence. The question of whether a party has overcome the DIME by clear and convincing evidence is one of fact for the ALJ's determination. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Clear and convincing evidence has been defined as evidence which demonstrates that it is highly probable the DIME physician's opinion is incorrect. *Qual-Med, Inc., v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). A party has met the burden of establishing that a DIME impairment rating and diagnosis are incorrect if the party has demonstrated that the evidence contradicting the DIME is "unmistakable and free from serious or substantial doubt." *Leming v. Industrial Claim Appeals Office*, 62 P.3d 1015, 1019 (Colo. App. 2002).

The standard of review is whether the ALJ's findings of fact are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S; *Metro Moving & Storage Co. v. Gussert, supra*. This standard of review is deferential and the scope of our review is exceedingly narrow. *Id*. We must defer to the ALJ's resolution of conflicts in the evidence, her credibility determinations, and the plausible inferences she drew from the record. If two inferences are equally plausible, it is for the ALJ to determine the correct inference. *Metro Moving and Storage Co. v. Gussert, supra*. Further, the ALJ is the sole

arbiter of the weight and credibility to be accorded expert medical opinion. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990).

Here, we perceive no reversible error in the ALJ's determination that the claimant failed to overcome the DIME physician's zero permanent impairment rating. It is true, as the claimant argues, that Dr. Chen was unable to fully perform the range of motion testing. The ALJ found, however, that the claimant's failure to perform such testing was not due to her injury or to any objective limitation from an injury, but was due to her own decision not to perform the tests. The ALJ's findings are supported by Dr. Chen's DIME report wherein she specifically explains as follows:

> SPINE EXAM: . . . She was tearing after 5 minutes of examination. At last she would not let be touched (sic) to her shoulder blades and go further examination including range of motion test.
>
> NEUROLOGICAL EXAMINATION:
>
> . . . She would not lift her right arm up above her shoulder level due to pain and fatigue. She would not give effort in right arm strength test, including right hand because she felt pain and weak. She cried and asked for break after 5 seconds of motor exam. She could not complete the full motor strength test in arms and legs.

Dr. Chen opined that the claimant gradually developed non-physiological diffuse pain out of distribution of her injury and out of proportion to the mechanism of injury. She agreed with Dr. Hattem's assessment that the claimant had non-physiological pain behavior. Dr. Chen also noted that the claimant's psychologist, Dr. Cohen, had made a diagnosis of somatoform element affecting the claimant's pain control and generalized anxiety disorder that was not injury related. Dr. Chen opined that the claimant showed the same diffuse pain behavior during her examination. While Dr. Chen stated that the claimant showed no pain or limitation in her body movement before her examination, she opined that the dramatic diffuse pain made her unable to finish the complete motor strength test and perform range of motion. She concluded that the claimant had no permanent impairment from the work injury. Ex. B at 5-6. The claimant's argument notwithstanding, the ALJ's finding that the claimant was self-limiting in her testing was a reasonable inference from the DIME report. Regardless, the ALJ further found that Dr. Chen's inability to complete the range of motion tests was not significant. The ALJ reasoned that Dr. Chen had reviewed all available evidence and found no objective basis for the claimant's reported limitations, and that no permanent impairment existed. Ex. B.

Since the ALJ's findings and determinations are supported by substantial evidence, we may not disturb her order. Section 8-43-301(8), C.R.S.

The claimant further argues that the DIME physician failed to follow the AMA Guides and this provides grounds for finding her opinions as being overcome. It is true, as the claimant argues, that Colorado's Workers' Compensation Act requires all physical impairment ratings be conducted in accordance with the AMA Guides. Section 8-42-101(3.7), C.R.S. Whether a rating physician has complied with the AMA Guides and whether the rating itself has been overcome are questions of fact for determination by the ALJ. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2004). Inherent in this rule is the concept that a deviation from the AMA Guides rating protocols does not automatically mean the DIME physician's rating has been overcome as a matter of law. *Wilson v. Industrial Claim Appeals Office, supra* (proof that DIME deviated from AMA Guides by failing to record range of motion measurements did not require conclusion that measurements were invalid). Because these issues are factual in nature, we must uphold the ALJ's resolution if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

Here, within her sole prerogative as the fact finder, the ALJ resolved that Dr. Chen's failure to continue with range of motion testing was not due to the DIME physician's error, but instead was due to the claimant's self-imposed limitations, which she found not to be based on any objective pathology of findings. Nevertheless, as explained above, the ALJ also found that this was not "significant." She concluded that Dr. Chen reviewed all the available evidence- medical records, a physical examination, and objective testing- and found no objective basis for the claimant's reported limitations and found no permanent impairment existed. These findings are supported by substantial evidence. Ex. B; Ex. A; Ex. 10 at 3-4. We therefore have no basis to disturb the ALJ's order on this ground. Section 8-43-301(8), C.R.S.; *see Wilson v. Industrial Claim Appeals Office*, *supra*; *see also Adams v. Manpower*, W. C. No. 4-389-466 (Aug. 2, 2005)(DIME physician acted properly when excluding range of motion measurements from overall rating, and this determination was not overcome by clear and convincing evidence).

II.

The claimant also argues that the ALJ erred in denying her claims for penalties. With regard to her penalty claim during the period of February 24, 2015, through September 2, 2015, for the respondents' failure to state a basis in their general admission for denying temporary benefits, the claimant objects to the ALJ's finding that the claim for penalties was not filed within the statute of limitations. The claimant also contends

that she is entitled to penalties for the time period of September 2, 2015, through March 23, 2016, and beyond because the respondents were obligated, but failed, "to admit and convert the Claimant's wages to permanent partial disability compensation in compliance with the MMI disability rating" or obtain "an order from the Division to terminate benefits during the pendency of the DIME process." Brief In Support at 11. The claimant explains that once she reached MMI, the respondents were obligated to commence payment of benefits, either temporary partial disability or permanent partial disability. We disagree.

A.

The claimant initially argues that the ALJ incorrectly found that the claimant knew of the respondents' omission in their general admission on or about April 30, 2015. She contends that there are no facts which would support this finding, and she argues the ALJ failed to determine when she "first knew or reasonably should have known" that the respondents' general admission violated WC Rule 5-5(B) (an admission filed for medical benefits only shall state basis for denial of temporary and permanent disability benefits within the remarks section of admission). As such, she contends her claim for penalties is not barred by the statute of limitations set forth in §8-43-304(5), C.R.S.

Under §8-43-304(5), C.R.S., a request for penalties must be filed within one year of the date a party "first" knows or reasonably should know "the facts giving rise to a possible penalty." Section 8-43-304(5), C.R.S. 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. *Spracklin v. Industrial Claim Appeals Office*, 66 P.3d 176 (Colo. App. 2002).

Here, we perceive no reversible error in the ALJs' dismissal of the claimant's request for a penalty under WC Rule 5-5(B) on the ground that it was barred by the one year statute of limitations set forth in §8-43-304(5), C.R.S. During the hearing, the claimant was asked about the respondents' general admission of liability. She was asked whether the respondent employer mailed the general admission to her and whether she understood the general admission when she received it. The clamant responded in the affirmative to both questions. Tr. at 34; Ex. 2. Further, the general admission provides that it was mailed to the claimant at her listed address on April 30, 2015. Ex. 2. While the claimant now argues that she did not review the general admission with an attorney at this time and, therefore, could not have understood the omission, a *pro se* claimant nevertheless is presumed to know applicable statutes and relevant law and is required to act accordingly. *Paul v. Industrial Commission*, 632 P.2d 638 (Colo. App. 1981). Moreover, while the claimant did not testify about the specific date she received the

general admission, we nevertheless conclude that it was reasonable for the ALJ to infer from the claimant's testimony and the corresponding evidence that the claimant knew or should have known on April 30, 2015, of the circumstances that constituted a violation giving rise to a penalty. Moreover, the claimant's argument notwithstanding, the ALJ did, in fact, specifically find that the claimant knew or should have known on April 30, 2015, that the respondents' general admission constituted a violation giving rise to a penalty. Order at 9 ("Claimant knew, or reasonably should have known, of the facts giving rise to a penalty for the technical violation of WCRP 5-5(B) on April 30, 2015..."). Since the claimant did not endorse the violation of Rule 5-5(B) as a penalty issue until August 9, 2016, over one year later, the claimant's request for a penalty was barred by the one year statute of limitations set forth in §8-43-304(5), C.R.S. Consequently, we will not disturb the ALJ's order on these grounds. Section 8-43-301(8), C.R.S.

B.

Last, relying on former Rule IX, Code Colo. Reg. 1101-03, *American Compensation Ins. Co. v. McBride*, 107 P.3d 973 (Colo. App. 2004), and *Monfort Transp. v. Industrial Claim Appeals Office*, 942 P.2d 1358 (Colo. App. 1997), the claimant argues that she is entitled to penalties because the respondents failed to pay temporary or permanent benefits while the DIME process was being completed, or from September 8, 2015, through March 23, 2016. We disagree.

In *McBride*, the Colorado Court of Appeals cited to former Department of Labor & Employment Rule IV(G)(1), 7 Code Colo. Regs. 1101-3, as requiring an employer to continue paying temporary total disability benefits while awaiting the completion of the DIME process and the assignment of an impairment rating. *See also Monfort Transp. v. Indus. Claim Appeals Office*, *supra* (insurer may not suspend temporary disability benefits even when a claimant reaches MMI if the insurer has not yet admitted or denied liability for permanent disability benefits). *See* WC Rule 6, 7 CCR 1101-3 (Modification, Termination or Suspension of Temporary Disability Benefits).

We conclude, however, that former Rule IX, *McBride*, and *Monfort* are inapposite here. As explained above, it is undisputed that the claimant sustained no wage loss as a result of her industrial injury. During the hearing, the claimant testified she continued to work at her full wage after her injury. Tr. at 31, 34. Further, the claimant's treating physician, Dr. Hattem, placed the claimant at MMI on August 24, 2015, and the DIME physician agreed that the claimant reached MMI on August 24, 2015. As the ALJ correctly found, the claimant therefore was not entitled to recover temporary indemnity benefits after this time period, or for the period of September 8, 2015, through March 23, 2016, as argued by the claimant. Section 8-42-103(1)(a), C.R.S. (if period of disability

does not last longer than three days from date employee leaves work due to injury, no disability indemnity shall be recoverable). Consequently, there can be no penalty here for the respondents' failure to start paying TTD while the DIME process was being completed. *See Moseley v. U.S. Express*, W.C. No. 4-530-546 (Dec. 13, 2002)(penalties not warranted where respondents had no legal duty voluntarily to admit liability for temporary disability benefits and there was no order holding respondents liable for temporary total disability benefits); *Gonsalves v. The Aspen Branch*, W.C. No. 4-324-403 (May 1, 1998)(respondents' failure voluntarily to reinstate temporary total disability benefits did not violate §8-42-105, C.R.S. and no penalties warranted); *Butler v. Bridgemaster, Inc.*, W.C. No. 4-267-417 (March 31, 1998)(respondents' failure voluntarily to reinstate temporary benefits did not violate §8-42-103, C.R.S. or §8-42-105, C.R.S. and, therefore, no penalty warranted under §8-43-304(1), C.R.S.; *Villa v. Wayne Gomez Demolition*, W.C. No. 4-236-951 (Jan. 7. 1997)(respondents' denial of liability not a violation of §8-42-105(2)(a), C.R.S. which would entitle claimant to penalty under §8-43-304(1), C.R.S.).

Further, it is well settled that an ATP makes the initial finding of MMI, and assigns a permanent impairment rating if appropriate. If a party wishes to challenge the ATP's MMI determination, the impairment rating, or both, then the party must request a DIME in accordance with the procedures set forth in §8-42-107.2, C.R.S., §8-42-107(8)(b)(III), C.R.S., and §8-42-107(8)(c), C.R.S. *See Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 190 (Colo. App. 2002). The DIME physician's opinions concerning MMI and permanent impairment then become binding on the parties and the ALJ unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III) and (8)(c), C.R.S.; *Cordova v. Industrial Claim Appeals office, supra*. Here, once the claimant's authorized treating physician placed her at MMI on August 24, 2015, and assessed the 5% permanent impairment rating, the respondents sought a DIME to challenge the rating, consistent with the requirements set forth in §8-42-107.2, C.R.S., §8-42-107(8)(b)(III), C.R.S. and §8-42-107(8)(c), C.R.S. In addition, pursuant to WC Rule 5-5 (E) (a) and (b), the respondents have the option to either file an FAL or request a DIME within 30 days of an ATP's impairment rating. Thus, contrary to the claimant's argument, the respondents satisfied their requirements under the Act, and they were not "obligated to initiate the impairment benefits payments until completion of the time for the DIME." Brief In Support at 11. As such, there can be no penalty here for the respondents' failure to pay PPD benefits while the DIME process was being completed. Since there are no grounds for imposition of a penalty against the respondents, we therefore have no basis upon which to disturb the ALJ's order. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated October 31, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

3/8/17 by TT .

ALSTON LAW FIRM LLC, Attn: NELSON G ALSTON, ESQ, 2851 S PARKER ROAD SUITE 630, AURORA, CO, 80014 (For Claimant)
THOMAS POLLART & MILLER, Attn: ERIC J POLLART, ESQ, C/O: R JAKE JOHNSON, ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-978-459-02

IN THE MATTER OF THE CLAIM OF

TORUCKA NEWTON,

Claimant,

v.

FINAL ORDER

TRUE VALUE COMPANY,

Employer,

and

ZURICH AMERICAN INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Michelle Jones (ALJ) dated October 12, 2016, that ordered permanent partial disability benefits paid pursuant to a scheduled rating and not that of the whole person. We affirm the decision of the ALJ.

The claimant worked for the respondent employer as a fork lift driver. On March 16, 2015, his left hand sustained a crush injury when it was caught between two fork lifts. The claimant was treated with occupational therapy, anti-inflammatory medication, steroids and pain medication. A CT scan of the left hand revealed two fractures.

The claimant displayed symptoms consistent with CRPS, a peripheral nerve injury. The claimant treated at the Concentra Clinic with Dr. Diane Adams. In April, 2015, the claimant was referred by Dr. Adams to Dr. Sachar, a hand surgery specialist. Dr. Sachar determined surgery was unlikely to help the claimant and recommended treatment with a physiatrist. Dr. Adams referred the claimant to Dr. Kawasaki in May, 2015. Dr. Kawaski made treatment suggestions and prescribed steroid medication and occupational therapy. He later modified the prescribed medication to include the use of anti-inflammatories. On September 17, 2015, Dr. Kawaski determined the claimant was at maximum medical improvement (MMI). The doctor noted significant improvement in the claimant's left hand injury but also acknowledged the still considerable disability presented by the crush injury. He described how many of the claimant's pseudo motor

changes had resolved. The doctor deduced his prior suspicions of CRPS were no longer applicable. Dr. Kawaski observed the claimant did not display temperature change, hyperhidrosis or color change when comparing the left to the unaffected right hand. He described the claimant as showing decreased sensation over the radial nerve distribution with hypersensitivity and causalgia (inflamed pain attributed to nerve injuries). Referring to the AMA Guides to the Evaluation of Permanent Impairment, 3d Edition Revised, Dr. Kawaski provided a permanent impairment rating based on injury to the radial nerve in the hand along with range of motion deficits. Combined, this resulted in a 25% impairment of the upper extremity, and upon conversion would approximate a 15% whole person rating.

Dr. Adams evaluated the claimant on October 5. The doctor noted that Dr. Kawaski had assigned a 25% extremity rating. However, Dr. Adams believed the claimant suffered from CRPS. She described the many difficulties the claimant encountered in the activities of daily living. Dr. Adams concluded it was more appropriate to calculate an impairment rating as a spinal cord injury. She referred to the table on page 107 of the AMA Guides to derive a 25% rating of the whole person.

The respondents did not request either a review by a Division sponsored Independent Medical Examination (DIME) physician or a hearing before an ALJ. Instead, the respondents filed a Final Admission of Liability (FAL) for the 25% scheduled extremity rating provided by Dr. Kawaski. The date of MMI was admitted to be October 5. The respondents attached to their FAL the report of Dr. Adams and the rating sheets of Dr. Kawaski. Following the submission of the respondents' FAL, the claimant also declined to request a DIME review. The claimant filed an application for a hearing in regard to converting permanent partial disability benefits to an award based upon a whole person rating.

At the September 13, 2016, hearing in the matter, the claimant asserted that pursuant to the decision in *Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998), the respondents had lost the ability to dispute the rating assigned by Dr. Adams when they did not request a DIME review within 30 days. *See* § 8-74-107(8)(c), C.R.S. and § 8-42-107.2(2)(b), C.R.S. The claimant also contended the location of the claimant's impairment was not on a part of the body listed in the schedule of disabilities referenced in § 8-42-107(2), C.R.S. Accordingly, the claimant argued the 25% whole person rating provided by Dr. Adams necessarily applied.

The respondents replied that *Egan* does not control this case. They argue the respondents in *Egan* sought to dispute that one of the body parts rated by the treating

physician was injured through the claimant's work. The disputed injury was to the neck which was not included in the schedule of disabilities. However, because causation was ruled to be an integral part of the impairment rating decision, the respondents in *Egan* were required to either request a DIME review or to accept the treating doctor's whole person rating as binding. The respondents in this matter indicate they do not dispute the compensability of the left arm. Their dispute is directed at the determination as to whether the arm injury is to be considered a scheduled impairment as opposed to one of the whole person. If the injury is considered to be scheduled, the DIME review provisions are not applicable. Section 8-42-107(1)(a), C.R.S.

The ALJ found the opinion of Dr. Kawasaki and the testimony of the respondents' expert witness, Dr. Striplin, to be persuasive. Those physicians asserted the AMA Guides in this matter required the injury to the left hand to be rated as a disability to the radial and possibly peripheral nerve but limited to the left hand and arm. Neither Dr. Kawasaki nor Dr. Striplin felt a diagnosis of CRPS was ultimately correct. The ALJ reasoned the respondents were not required by *Egan* to accept the impairment rating of Dr. Adams. Dr. Kawasaki was also a treating physician who had provided a competing rating premised on a limitation of the claimant's injury to a scheduled body part. The ALJ noted the claimant has the burden by a preponderance of the evidence to establish his injury is not included on the schedule of disabilities. *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996); *Langton v. Rocky Mountain Health Care Corp*., 937 P.2d 883 (Colo. App. 1996). Finding that the evidence showed the claimant's injury to most likely be included in the schedule as a loss of the arm at the shoulder, § 8-42-107(2)(a), C.R.S., the ALJ deemed the DIME procedures inapplicable and ruled the award of permanent disability benefits was to be measured by the 25% extremity rating of Dr. Kawasaki.

On appeal, the claimant contends the respondents are required by § 8-42-107(8)(c), C.R.S. to admit for the impairment rating assigned by "the" treating physician unless they have requested a DIME review. The claimant asserts the respondents admitted for Dr. Adams' date of MMI and her report was attached to the FAL. Consequently, it is argued the respondents have acknowledged Dr. Adams to be 'the' treating physician and they are bound by Dr. Adams' 25% whole person rating.

We are not persuaded by the claimant's argument. We instead conclude that the Colorado Court of Appeals' decision in *Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000) is instructive here. In *Delaney*, the decision points out that disputes regarding MMI in the case of injuries to scheduled body parts are subject to the DIME procedures § 8-42-107(8)(a), C.R.S. But this is not true in respect to disputes over

the permanent impairment rating, § 8-42-107(8)(c), C.R.S. Section 8-42-107(8) (b)(I) and (II) state that the date of MMI is to be assigned by "an" authorized treating physician. In *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002), the Court deemed this reference to 'an' authorized treating physician meant that when any such physician, and there may be several, concludes the claimant has reached MMI, then a party must either accept that date or else challenge it through a request for a DIME review. A 'treating' physician was described as any of the claimant's doctors that "… examine plaintiff for purposes of medical assistance and not merely in preparation for the … trial". *Id.* at 515. (citing to *Miller v. Lake Forest, Inc*., 370 So.2d 647, 651 (La. Ct. App. 1979). Here, Dr. Kawaski was a treating physician by virtue of his repeated examinations, his recommendations for treatment and his prescriptions for medication designed to cure and mitigate the claimant's injury. Accordingly, the respondents could choose between the competing MMI dates presented by either Dr. Kawaski (September 17) or by Dr. Adams (October 5). Quite possibly to forestall an objection, the respondents agreed to the slightly later date submitted by Dr. Adams and therefore paid three additional weeks of temporary benefits.

However, the Court in *Delaney* held that when an authorized treating physician (ATP) assigns a permanent impairment rating consisting of injuries listed on the schedule, the respondents may either file an FAL for the scheduled ratings or dispute the ratings by requesting a hearing. They need not pursue a DIME review. *See* W.C. Rule of Procedure 5-5 (E)(1)(c), 7 Code Colo. Reg. 1101-3. Such a review is not required by § 8-42-107(1) (a) and (b), C.R.S. The reference to an impairment rating provided by "the" authorized treating physician appears only in § 8-42-107(c), C.R.S. The claimant's reliance on this singular designation of the physician to provide the controlling impairment rating is therefore inapplicable in this matter.

In the case of a dispute as to whether the claimant's injuries are to be considered scheduled or of a whole person, that decision is delegated to the ALJ for final disposition. "Whether a claimant's impairment falls within the schedule in § 8-42-107(2), C.R.S. is a question for the ALJ, whose determination must be upheld on appeal if it is supported by substantial evidence. *Langton v. Rocky Mountain health Care Corp ….*" *Delaney v. Industrial Claim Appeals Office*, 30 P.3d at 693. As a result, the respondents here could choose to file an FAL premised on the extremity rating of ATP Dr. Kawaski. The claimant's contention that permanent disability benefits should be controlled by the whole person rating of Dr. Adams was properly addressed by the ALJ pursuant to the claimant's application for a hearing.[1]

[1] In *Egan*, the only rating involved included both a scheduled rating for a shoulder injury and a whole person rating for an injury to the claimant's cervical spine. The respondents sought to admit for only the shoulder. The decision

The ALJ noted the reports of Dr. Kawaski and the testimony and report of Dr. Striplin. She found this evidence persuasive and influenced her decision to find the location of the claimant's disability limited to the upper extremity. The relative weight and credibility to be assigned competing expert medical opinions is the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). As such, we may not substitute our judgment by reweighing the evidence in an attempt to reach a result that is different from that of the ALJ. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31, 32-33 (Colo. App. 1990)(reviewing court is bound by resolution of conflicting evidence, regardless of the existence of evidence which may have supported a contrary result); *see also Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). To the extent the ALJ relied on the evidence provided by Dr. Kawasaki and by Dr. Striplin the ALJ's determination is supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.

We may not interfere with the ALJ's assessment of the probative value of the evidence. Consequently, we perceive no error in the ALJ's decision to find that permanent disability benefits should be awarded as provided in the FAL submitted by the respondents.

IT IS THEREFORE ORDERED that the ALJ's order issued October 12, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

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held that such a dispute over causation must be submitted to a DIME. Both *Egan* and *Human Resource Co. v. Industrial Claim Appeals Office*, 984 P.2d 1194 (Colo. App. 1999), were decided following the decision in *Mountain City Meat Co. v. Oqueda*, 919 P.2d 246 (Colo. 1996), which held that when impairment ratings include both scheduled and non-scheduled parts of the body, the award of disability benefits was to be calculated using the whole person rating applicable to all affected body parts. That requirement was removed by the General Assembly in 1999 through amendments to § 8-42-107(7)(b)(I) to (III), C.R.S. Following the amendments, permanent benefits are calculated separately according to either the scheduled or whole person rating assigned. Due both to the 1999 amendments and the decision in *Delaney*, we decline to conclude that either *Egan* or *Human Resource Co* control the outcome in this case.

CERTIFICATE OF MAILING

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

4/4/17 by TT .

THE LAW OFFICES OF W. DAN MAHONEY PC, Attn: W DAN MAHONEY, ESQ, 720 17TH STREET SUITE 340, DENVER, CO, 80202 (For Claimant)
LEE + KINDER LLC, Attn: KAREN GAIL TREECE, ESQ, C/O: JESSICA C MELSON, ESQ, 3801 E FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-974-718-03

IN THE MATTER OF THE CLAIM OF:

HEATHER POWELL,

Claimant,

v.

FINAL ORDER

AURORA PUBLIC SCHOOLS,

Employer,

and

JOINT SCHOOL DISTRICTS, C/O CCMSI,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Edie (ALJ) dated October 12, 2016, that determined she failed to overcome the opinion of the Division-sponsored independent medical examination (DIME) physician that she reached maximum medical improvement (MMI) and that denied and dismissed her request for medical benefits. We affirm.

This matter went to hearing on overcoming the DIME physician's opinion that the claimant was at MMI on September 28, 2015, and whether the claimant's request for arthroscopic hip surgery was reasonable, necessary, and related to her work injury.

After the hearing, the ALJ found that the claimant was injured in a work accident on January 27, 2015, when she jumped over a chair while trying to catch a student who had run away. The claimant was treated by Dr. Ramaswamy for a left quadriceps strain, left gluteus strain, and left greater trochanteric bursitis. The claimant subsequently underwent chiropractic treatment. Dr. Ramaswamy placed the claimant at MMI on September 28, 2015, and he noted that the claimant could walk normally, that she was 80% better, and that chiropractic treatment made a significant difference.

The respondents filed a Final Admission of Liability consistent with Dr. Ramaswamy's report. The claimant timely objected and sought a DIME.

Dr. Fillmore conducted the DIME on January 5, 2016. Dr. Fillmore opined that the claimant was in no acute distress and had only minor residuals of gluteus medius tendonosis and possible left sacroiliac joint irritation. He noted only minor limitations to the claimant's hip range of motion. Dr. Fillmore placed the claimant at MMI on September 28, 2015, and provided the claimant with a 2% lower extremity permanent impairment rating. As pertinent here, when the claimant was found to be at MMI, it also was noted that she had been diagnosed as having kidney stones.

Dr. Ramaswamy subsequently referred the claimant to an orthopedist, Dr. Stull. Dr. Stull noted trochanteric bursitis in the claimant's left hip, and he provided the claimant with an injection in the trochanteric bursa. The claimant's condition, however, did not improve with the injection. Dr. Stull recommended an MRI. After reviewing the MRI on March 31, 2016, Dr. Stull noted a tear in the claimant's superior labrum of the hip. The claimant was referred to Dr. Faulkner for evaluation for potential surgery.

Dr. Faulkner saw the claimant on April 11, 2016. He stated that the claimant was reporting a sharp pain in her groin and over the posterior lateral aspect of the hip. Dr. Faulkner mentioned proceeding with arthroscopic hip surgery based upon the claimant's symptoms. The respondents contested the reasonableness, relatedness, and necessity of the hip arthroscopic labral surgery.

At the request of the respondents, the claimant underwent an independent medical examination with Dr. Lindberg. Dr. Lindberg opined that arthroscopic surgery was not reasonable because there had not been adequate work-up of the claimant's pain complaints to isolate the problem to hip joint pathology. He opined that the claimant needed injections into the hip joint to see if her hip joint was the pain generator. Dr. Lindberg opined that even if the claimant had a labral tear, it was not the result of the work-related injury. He explained that at no time from the time of the injury until the examination by Dr. Faulkner did the claimant complain of groin pain. He opined that since the claimant was asymptomatic in the groin area, after passing a kidney stone, there is no indication of any hip joint dysfunction that can be relieved by arthroscopic labral repair. Dr. Lindberg also opined that it did not appear the labral tear was symptomatic, and it could be explained by the claimant's chronic congenital femoral acetabular impingement syndrome, which was not caused by trauma.

During the subsequent hearing, the claimant testified that she continues to have the same pain over her left lateral hip and gluteal region that she had when she was examined by both Dr. Ramaswamy and the DIME physician, Dr. Fillmore. The claimant also explained that she did have groin pain when she was examined by Dr. Faulkner and that

it was subsequently determined that the groin pain was related to her kidney stones. Once the claimant passed the kidney stones, the groin pain subsided.

The ALJ ultimately determined that the claimant failed to overcome the DIME physician's opinion that she reached MMI on September 28, 2016. He found that the DIME physician's opinion was bolstered by the opinions of Dr. Lindberg. The ALJ found that Dr. Lindberg's opinions were persuasive in showing that the labral tear was not symptomatic, except for a limited interval during which the claimant suffered from kidney stones, and that her groin pain disappeared once the kidney stone issue was resolved. Moreover, the ALJ found that the claimant had not shown that the labral tear appearing in her MRI was caused by the admitted work accident. The ALJ explained that due to the claimant's congenital femoral acetabular impingement syndrome, it was at least equally likely that she suffered this asymptomatic tear at some other time than during the industrial injury. The ALJ further found that while the DIME physician did not have the benefit of the MRI results when he placed the claimant at MMI, the respondents had not clearly and convincingly shown that he would have reached a different conclusion if he had had the MRI results. Consequently, the ALJ concluded that the claimant had not shown that the proposed arthroscopic procedure was reasonable or necessary.

The claimant has petitioned to review the ALJ's order. The claimant contends the ALJ erred in determining she failed to overcome the DIME physician's finding of MMI. According to the claimant, following her industrial injury in January 2015, she consistently complained of left hip and gluteus pain. She argues that the hip pain she experienced at the onset of her injury was the same pain she experienced in September 2015 when she was placed at MMI. Thus, according to the claimant, the labral tear not only was symptomatic, but it also was caused by her admitted work injury to her hip. The claimant also contends that the DIME physician did not have the benefit of the MRI, and he did not have all of the facts necessary before concluding the claimant was at MMI. As such, the claimant contends the DIME physician's report must be stricken, she is not at MMI, and she is entitled to the arthroscopic labral repair surgery. We disagree.

Section 8-42-107(8)(c), C.R.S. provides that the DIME physician's findings of MMI and medical impairment are binding unless overcome by clear and convincing evidence. Both determinations inherently require the DIME physician to assess, as a matter of diagnosis, whether the various components of the claimant's medical condition are causally related to the industrial injury. Therefore, a DIME physician's determinations concerning causation are binding unless overcome by clear and convincing evidence. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo.

App. 2002). "Clear and convincing evidence" has been defined as evidence which demonstrates that it is "highly probable" the DIME physician's opinion is incorrect. *Qual-Med, Inc., v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

The question whether the party challenging the DIME physician's determination of MMI has overcome the report by clear and convincing evidence is generally one of fact for determination by the ALJ. *Metro Moving and Storage Co. v. Gussert, supra*. Consequently, we must uphold the ALJ's resolution if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. The substantial evidence test requires us to view the evidence in a light most favorable to the prevailing party, and to defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences he drew from the record. This standard of review is deferential and the scope of our review in this regard is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert, supra.* We may not substitute our judgment for that of the ALJ regarding credibility matters unless there is such hard, certain evidence contradicting the ALJ's determination that it would be error as a matter of law. *See Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986).

Here, we perceive no error in the ALJ's determination that the claimant failed to overcome the DIME physician's opinion on MMI. During the deposition of Dr. Lindberg, he testified that he agreed with Dr. Fillmore that the claimant is at MMI. Depo. of Dr. Lindberg at 6, 12-13. Based on his review of the medical records, Dr. Lindberg opined that there was no indication the claimant sustained a labral tear in the work incident. He explained that the claimant has a congenital deformity of her hip joint that is known to cause labral tears. He explained that labral tears are not always symptomatic and the fact that the claimant had a labral tear and it was not symptomatic is not an indication for surgery. Dr. Lindberg also testified that had the claimant sustained a labral tear or traumatic injury to the intra-articular portion of her hip joint during the industrial incident, then that would have more likely than not superseded all the other symptoms. However, nothing pointed to the hip joint on multiple examinations over time. He testified that there was no evidence of any intra-articular pathology based on the absence of groin pain or hip pain until 13 months after her industrial injury. Depo. of Dr. Lindberg at 10-11, 15.

Moreover, during cross-examination of Dr. Lindberg regarding whether the claimant had hip pain since the date of her industrial injury, he testified that saying "hip pain" when someone is referring to gluteal pain or the greater trochanteric pain, as the claimant presumably was doing, does not correlate with intra-articular pain. He

explained that there was no evidence the claimant sustained an intra-articular hip injury. Tr. at 20. Dr. Lindberg further explained that to be a candidate for an arthroscopic labral repair, he would need to see identification of an intra-articular cause of her pain. He testified that the examination Dr. Stull performed on the claimant was completely negative for any intra-articular pathology. Depo. of Dr. Lindberg at 9-10. He also testified that after the claimant's kidney stone passed, her groin pain went away and she was therefore not a candidate for surgery. Depo. of Dr. Lindberg at 9-10. Section 8-43-301(8), C.R.S.

Additionally, the ALJ also rejected the claimant's argument that the DIME physician did not have the benefit of the MRI before concluding the claimant was at MMI. As noted above, the ALJ was not persuaded that the DIME physician would have altered his opinion on MMI had he seen the labral tear on the MRI results. Insofar as Dr. Fillmore did not have the MRI results at the time he conducted his examination and reached his opinion on MMI, this evidence goes only to the weight of his opinion. Nevertheless, this did not preclude the ALJ from crediting his opinion. As noted above, the weight and credibility to be assigned evidence is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office, supra*. Since there is substantial evidence supporting the ALJ's order that the claimant failed to overcome the DIME physician's opinion on MMI, we have no basis to disturb it. As such, the ALJ properly concluded that the claimant had not shown that the proposed arthroscopic procedure was reasonable or necessary. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated October 12, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

3/15/17 by TT .

LEVINE LAW LLC, Attn: AUSTIN W WOLFE, ESQ, 4500 CHERRY CREEK SOUTH DRIVE SUITE 400, DENVER, CO, 80246 (For Claimant)
NATHAN BREMER DUMM & MYERS PC, Attn: MARK H DUMM, ESQ, 7900 EAST UNION STREET SUITE 600, DENVER, CO, 80237 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-953-561-02

IN THE MATTER OF THE CLAIM OF:

TIA WALKER,

Claimant,

v.

FINAL ORDER

LIFE CARE CENTERS OF AMERICA,

Employer,

and

OLD REPUBLIC INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of the order of Administrative Law Judge (ALJ) Sidanycz dated November 7, 2016, that ordered the respondents to pay for a consultation with Dr. Annest. We affirm the ALJ's order.

This matter went to hearing on the claimant's request for the respondents to pay for a consultation with Dr. Annest. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury to her right shoulder on May 23, 2014. The claimant underwent two surgeries and was eventually placed at maximum medical improvement (MMI) on May 8, 2015, with a six percent scheduled impairment rating. The respondents filed a final admission of liability and the claimant timely objected and requested a Division Independent Medical Examination (DIME). The DIME physician determined that the claimant reached MMI on June 9, 2015, and gave the claimant a 24 percent scheduled impairment rating. The respondents filed a final admission consistent with the DIME report on December 4, 2015, and also admitted for ongoing maintenance medical benefits. The claimant timely objected to the final admission and applied for a hearing on the issues of permanent partial disability seeking to convert her rating to a whole person rating and disfigurement benefits. A hearing was scheduled for May 3, 2016.

Also during this time, the claimant was referred by her treating doctor, Dr. Lorah,

on November 30, 2015, for physical therapy for thoracic outlet syndrome (TOS). Dr. Lorah also indicated that he would consider a referral for a surgical consultation for possible TOS. The respondent insurer denied continued sessions of physical therapy and the consultation on December 30, 2015. The claimant's counsel contacted the respondents' counsel to discuss endorsing the denial of the neurological consultation for the scheduled May 3, 2016, hearing but the respondents declined. On January 4, 2015, Dr. Sanders diagnosed the claimant with TOS. Dr. Sanders recommended the claimant complete physical therapy and stated if the symptoms did not improve she could be a candidate for TOS surgery. Dr. Lorah agreed and stated that by pursuing physical therapy the claimant could possibly avoid surgery for the TOS.

This case went to hearing before ALJ Mottram on May 3, 2016, on the claimant's application for permanent partial disability and disfigurement. The ALJ awarded the claimant whole person impairment and the order also stated that "all matters not determined herein are reserved for future determination." The claimant applied for hearing on May 5, 2016, on the current issue of whether the recommended surgical consultation with Dr. Annest was reasonable and necessary medical treatment.

In this hearing ALJ Sindanycz credited the claimant's testimony and the opinions of Dr. Sanders and Dr. Lorah to find that the neurological consultation with Dr. Annest was reasonable, necessary and related to the work injury she sustained on May 23, 2014. The ALJ rejected the respondents' contention that the issue was barred by the doctrine of issue preclusion noting that the issues were not identical in the two hearings. The ALJ therefore, ordered the respondents to pay for the consultation with Dr. Annest.

On appeal the respondents contend that the ALJ erred in finding them liable for the consultation. The respondents assert that the issue of medical benefits was closed and the claimant was required to overcome the findings of the DIME by clear and convincing evidence before awarding medical benefits. The respondents also argue that the ALJ should have applied claim preclusion instead of issue preclusion to find that the claimant was barred from seeking further medical benefits. We are not persuaded the ALJ committed reversible error.

The claimant was seeking the consultation with Dr. Annest as ongoing medical maintenance benefits. The claimant stated in her proposed order and at hearing that she was not seeking to overcome MMI or permanent impairment. October 12, 2016, Tr. at 7-9. The respondents' obligation to provide medical benefits ordinarily terminates at MMI, except where 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). However, the claimant need not prove she requires a specific course of treatment at the time of MMI to receive a general award of future medical benefits. Rather, *Grover* contemplates that once the claimant has proven her entitlement to future medical benefits, there be a general admission or a general award requiring the respondent to pay the costs of future medical treatment, subject to the respondents' right to contest liability for any specific treatment modality on grounds the treatment is not related, reasonable or necessary. *See Grover v. Industrial Commission*, *supra*; *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999).

Section 8-43-203(2)(b)(II), C.R.S. provides that a claim is automatically closed as to the issues admitted in the final admission if the claimant does not timely object and requests a hearing on any disputed issues that are ripe for hearing. *Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo. App. 1993). Here, the respondents filed a final admission of liability admitting for ongoing maintenance medical benefits. Because liability was admitted, and because the respondents did not seek to withdraw their admission for maintenance medical benefits, the issue of maintenance medical benefits remains open, and the claimant was only required to apply for a hearing in cases where the respondents refused payment for specific treatment deemed unrelated, unreasonable or unnecessary. See § 8-43-203(2)(d), C.R.S. (once any liability is admitted, payments shall continue according to admitted liability). In other words, because no specific medical benefits were "ripe" for adjudication at the time of the final admission, the claimant's failure to apply for a hearing on maintenance medical benefits following the respondents' admission did not "close" the issue. *See HLJ Management Group, Inc., v. Kim*, 804 p 2d 250 (Colo. App. 1990)(one of the purpose of the admissions process is to secure voluntary payment where there is no legitimate controversy).

Whether the claimant sustained her burden to prove entitlement to maintenance medical benefits is a question of fact. Because these issues are factual in nature, we must uphold the ALJ's resolution if supported by substantial evidence in the record. §8-43-301(8), C.R.S. This standard of review requires us to view the evidence in the light most favorable to the prevailing party, and to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003). The court of appeals has noted that in this context the scope of our review is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

Here, the ALJ credited the claimant’s testimony and the opinions of Dr. Sanders

and Dr. Lorah to find that the claimant should be assessed for the possibility of TOS by Dr. Annest. The panel has consistently recognized that diagnostic procedures constitute a compensable medical benefit that must be provided if such procedures have a reasonable prospect of diagnosing or defining the claimant's condition so as to suggest a course of further treatment. Section 8-42-101(1)(a), C.R.S.; *Jacobson v. American Industrial Service*, W.C. No. 4-487-349 (April 24, 2007); *Villela v. Excel Corp.*, W.C. No. 4-400-281 (February 1, 2001); *Hatch v. John H. Garland Co.*, W.C. No. 4-368-712 (August 11, 2000).

Contrary to the respondents' contention, a DIME physician's opinion has no presumptive weight on the issue of *Grover* medical benefits. *See* *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *see also Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995)(DIME determination of MMI did not preclude change of physician order where only maintenance medical benefits were sought). Rather, the normal rules for establishing entitlement to maintenance medical benefits apply. See *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999). Thus, the ALJ correctly determined that the claimant may be entitled to continuing medical benefits after MMI if she could show "that future medical treatment will be reasonably necessary to relieve the injured worker from the effects of the work-related injury."

As we understand the order, the ALJ implicitly found that the consultation with Dr. Annest was reasonably needed as part of an effort to prevent further deterioration of the claimant's condition and as such was appropriately awarded as a maintenance medical benefit. *See* *Milco Construction v. Cowan*, 860 P.2d 539, 542 (Colo. App. 1992); *Hayward v. Unisys Corp.*, W.C. No. 4-230-686 (July 2, 2002), *aff'd., Hayward v. Industrial Claim Appeals Office*, (Colo. App. No. 02CA1446, January 9, 2003) (knee surgery may be curative or may be a form of Grover-style maintenance treatment designed to alleviate deterioration of the claimant's condition). Because the ALJ's order is supported by substantial evidence in this regard and the respondents do not dispute the sufficiency of the evidence, we have no basis to disturb the order on review. §8-43-301(8), C.R.S.

Nor are we persuaded by the respondents' argument that the ALJ erred in failing to apply the doctrine of claim preclusion. The respondents argued at hearing and in the position statement that the doctrine of claim preclusion barred the claimant's request for maintenance medical benefits. The ALJ's order only addressed issue preclusion finding it not applicable because there was no identity of the issues. Although the ALJ did not explicitly address the applicability of claim preclusion we find this harmless error. §8-43-

310, C.R.S. (harmless error standard for review of workers' compensation cases.) The ALJ is not held to a crystalline standard in articulating her findings. *George v. Industrial Commission*, 720 P. 2d 624 (Colo. App. 1986). Rather, the ALJ's findings are sufficient if the basis for the order is apparent. *Boice v. Industrial Claim Appeals Office*, 800 P.2d 1339 (Colo. App. 1990).

Claim preclusion bars relitigation not only of all claims actually decided but of all claims that might have been decided in the claim that are tied by the same injury. *Holnam v. Industrial Claim Appeals Office*, 159 P.3d 795 (Colo. App. 2007). For a claim to be precluded from litigation there must exist a finality of the first judgment, identity of subject matter, identity of the claims for relief and identity of the parties to the actions. In *Holnam*, the Court discussed the tactical issue involved. The claimant in *Holnam* had injured his shoulder at work. A DIME review found the claimant's cervical spine was not involved in the injury. Following a hearing this determination of the DIME physician was affirmed by an ALJ. The claimant then filed another claim asserting his cervical spine sustained a new injury incurred while performing modified work after the date of MMI determined by the DIME. The Court held that claim preclusion barred the consideration of the subsequent cervical claim. The Court of Appeals determined both claims were dealing with the same injury. The Court reasoned "the same claim or cause of action requirement is bounded by the injury for which relief is demanded, and not by the legal theory on which the person asserting the claim relies." *Holnam* at 798. In *Holnam* the claimant sought in both claims compensability for a cervical injury in conjunction with the same shoulder injury.

The respondents argue the DIME determination of Dr. Price did not include a diagnosis of TOS. This is characterized as a form of quasi-judicial determination pertinent to the limits of the claimant's May, 2014, work injury. The respondents assert that when the claimant did not request a hearing within 30 days of the respondents' Final Admission adopting Dr. Price's conclusions, those conclusions became binding just as would a judicial ruling. § 8-43-203 (2)(b)(II) and (d). The respondents assert this matter is in all significant respects identical to *Holnam*. They reason the same claim for which relief is requested has been determined adverse to the claimant and she may not pursue subsequent litigation for that relief. The respondents contend the claimant did not raise the claim of TOS with Dr. Price (or an ALJ within 30 days) and therefore cannot now litigate TOS as related to the May, 2014, injury through a request for post MMI medical treatment.

The difficulty we see to this argument, however, is the extent to which it overlooks the June 7, 2016, decision of ALJ Mottram. The claimant sought conversion of her

scheduled impairment rating for loss of the arm at the shoulder to a whole person rating not limited to the arm. ALJ Mottram noted he was to decide "whether the claimant has sustained a functional impairment to a part of the body that is not contained on the schedule." He observed "[d]iscomfort which interferes with the claimant's ability to use a portion of h[er] body may be considered impairment." *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). In his diagnosis of TOS, Dr. Sanders relied on the claimant's complaints of pain in the neck, right shoulder girdle, anterior chest wall, and pain and weakness in her right hand. Ex. 3. Dr. Price recorded similar complaints of the claimant to include pain in the right shoulder front and back, right arm, numbness in all her fingers, and pain and spasms in her neck. Dr. Price stated she excluded only neck pain as a component of the claimant's work injury. ALJ Mottram observed that the claimant testified on May 3, 2016, in regard to pain in her scapular area, trapezius area and pain into her neck. The ALJ then made a determination of fact that this testimony was credible and persuasive and the claimant's symptoms of trapezius, scapular and neck pain were impairments related to the claimant's May, 2014, work injury. On that basis the ALJ resolved the claimant's impairment rating would be converted to a whole person rating. These impairments involving the neck, right shoulder girdle, chest wall (trapezius and scapular areas) and the right arm coincide with the impairments Dr. Sanders associated with TOS. Whereas in *Holnam* litigation resulted in an adjudication that the claimant's cervical symptoms were not related to the work injury, here litigation resulted in a ruling that the portions of the body implicated by possible TOS were indeed affected by the claimant's work injury. Accordingly, we cannot say ALJ Sidanycz' order that the respondents are liable for a surgical consultation to address these symptoms is barred by the doctrine of claim preclusion.

We conclude that substantial evidence supports the ALJ's findings and those findings, in turn, support the ALJ's conclusions of law. We have no basis to disturb the ALJ's order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated November 7, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

3/30/17 by TT .

WITHERS SEIDMAN RICE & MUELLER PC, Attn: SEAN E P GOODBODY, ESQ, 101 SOUTH THIRD STREET SUITE 265, GRAND JUNCTION, CO, 81501 (For Claimant)
THOMAS POLLART & MILLER, Attn: R JAKE JOHNSON, ESQ, C/O: ERIC J POLLART, ESQ, 5600 S QUEBEC STREET SUITE 220-A, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

FEIN: 45-1756174

IN THE MATTER OF:

ORDER OF REMAND

T-REX ROOFING &
CONSTRUCTION, LLC,

Respondent.

The respondent seeks review of a supplemental order of the Director of the Division of Workers' Compensation (Director) dated January 13, 2017, that imposed a $63,990 fine for the respondent's initial violation of failing to meet its statutory obligation to maintain workers' compensation insurance coverage. We set aside the Director's supplemental order and remand the matter for reconsideration of the fine based on the analysis set forth in *Dami Hospitality, LLC v. Industrial Claim Appeals Office*, 2017COA21 (Feb. 23, 2017).

The respondent is a limited liability company (LLC) that performs roofing and construction work. On and/or after October 1, 2007, the respondent contracted for the performance of construction work on construction sites. On May 11, 2016, the Director sent a Notice to Show Compliance to the respondent to provide proof of workers' compensation insurance coverage or proof of rejection of such coverage for itself and for the individuals with whom it contracted. The respondent was given 20 days to provide such proof and was advised of its opportunity to present evidence to the Division of Workers' Compensation (Division) regarding the issue of insurance coverage or exemption, and regarding the issue of default. The respondent also was advised of and afforded the opportunity to request a prehearing conference regarding these issues.

Thereafter, on October 3, 2016, the Director issued his order. He found that the respondent failed to provide the Division with satisfactory proof of workers' compensation insurance coverage or the rejection of such coverage from all persons with

whom it contracted to perform work for all relevant times periods, did not request a prehearing conference, and failed to satisfactorily demonstrate why it was exempt from the insurance requirements of Colorado's Workers' Compensation Act (Act). Consequently, pursuant to §8-41-404(3), C.R.S., §8-43-409(1)(b), C.R.S., and the formula adopted by the Division under §8-43-409(1)(b), C.R.S. in W.C. Rule of Procedure 3-6, 7 Code Colo. Reg. 1101-3 (Rule 3-6), the Director imposed a fine for each day the respondent was in default. The Director identified the time period as being from August 3, 2013, through October 3, 2016. The total fine the Director imposed amounted to $37,265. The Director also advised the respondent that if its default continued beyond the date of his order then it would be required to pay $250 per day for each day until the required insurance was obtained with proof of coverage being provided to the Director, or until it obtained an order from the Director relieving it of its obligation to pay the continuing fines imposed.

The respondent petitioned to review the Director's fine, arguing that it subcontracts all of its work out and always has filed a letter of exemption for all the counties in which it works.

On January 13, 2017, the Director entered his supplemental order addressing the arguments raised by the respondent in its petition to review. The Director held that the respondent previously had a policy of workers' compensation coverage through Pinnacol Assurance from May 14, 2011, through November 5, 2013, when the policy was cancelled for "nonpayment of premium." The Director further found that the members of the LLC, Jason Trexel and David Gallo, were employees of the respondent and no statutory LLC member rejection exemption applied to relieve the respondent from its obligation to have workers' compensation insurance coverage for its employees until the election to reject coverage was received at the Division effective June 13, 2014. The Director also held that the respondent had contracted with an independent contractor, BT Roofing, to perform construction work. This finding was based on a Completed Independent Contractor Questionnaire signed by Amelia Torrealva on August 3, 2016, wherein she states she has worked for the respondent for three years. The Director found that the respondent, however, did not exercise due diligence in ensuring that BT Roofing and every person with whom it had a direct contract for the performance of construction work on a construction site, was covered by workers' compensation insurance or had properly rejected such coverage. He accordingly imposed a fine for the period of on and after August 3, 2013. The fine the Director imposed was calculated based on §8-43-409(1)(b)(I), C.R.S. and the formula set forth in Rule 3-6(B). He imposed a $5.00 per day fine for the period of August 3, 2013, through May 6, 2016, a $10.00 per day fine for the period of May 7, 2016, through May 11, 2016, a $30.00 per day fine for the period of

May 12, 2016 through May 16, 2016, a $50.00 per day fine for the period of May 17, 2016, through May 21, 2016, a $100.00 per day fine for the period of May 22, 2016, through May 26, 2016, and a $250.00 per day fine for the period of May 27, 2016, through January 13, 2017. The total fine imposed amounted to $63,990.

The respondent has petitioned to review the Director's supplemental order, arguing that in 2013, it had met with its insurance provider to review and renew its business insurance. The respondent asserts that at this time it was told it was not required to continue carrying workers' compensation insurance due to having no employees. As such, it rejected insurance coverage for its two owners. The respondent also argues that it "requested and received proof of insurance from the subcontractor prior to hiring them (sic)." Further, the respondent argues that it is a small business with limited asserts and has been the victim of a large amount of theft in the past year. It therefore asserts that it would be impossible to pay the fine and it would be forced to dissolve.

In *Dami*, the Colorado Court of Appeals addressed a large fine of $841,200 that the Director imposed on a small employer for having failed, on at least two occasions over several years, to maintain workers' compensation insurance coverage. The employer appealed the fine, raising several arguments of error, including that the fine was unconstitutionally excessive as applied. The Court agreed with the employer that application of §8-43-409, C.R.S. violated the employer's constitutional protections against excessive fines. The Court reasoned that because the constitutional factors, as set out in *Associated Business Products v. Industrial Claim Appeals Office*, 126 P.3d 323 (Colo. App. 2005), were not sufficiently incorporated into Rule 3-6, the implementing provision for §8-43-409, C.R.S., the Director abused his discretion in failing to consider facts specific to employer. In holding that the fine was excessive, the Court explained that the Director failed to apply the excessive fine factors adopted under the Eighth Amendment to the particular facts that the employer presented. Consequently, the Court set aside the Director's fine and remanded the matter for the Director to consider the following factors when reconsidering the fine to be imposed: (1) the degree of the defendant's reprehensibility or culpability; (2) the relationship between the penalty and the harm to the victim caused by the defendant's actions; and (3) the sanctions imposed in other cases for comparable misconduct. The Court ordered the Director to consider these factors on a case-by-case basis with consideration given to the employer's unique situation. The Court specifically noted that facts relevant to the Director's application included the employer's ignorance that the required insurance had lapsed, the failure to notify the employer of the lapse for almost half a decade, and the employer's ability to pay.

While the fine imposed on the respondent in this action is for an initial violation under §8-43-409(1)(b)(I), C.R.S and Rule 3-6(B), as opposed to the fine imposed on *Dami* for a subsequent violation under §8-43-409(1)(b)(II), C.R.S. and Rule 3-6(D), we nevertheless conclude the Court's analysis in *Dami* is directly applicable here. This is because the Director calculated both fines using similar formulas outlined in Rule 3-6. As explained above, the Court concluded that application of §8-43-409, C.R.S. violated the employer's constitutional protections against excessive fines because the excessive fine factors were not sufficiently incorporated into Rule 3-6. Consequently, the holding in *Dami* requires us to set aside the Director's fine in this matter. As such, the matter must be remanded for the Director to reconsider the fine by applying the factors enunciated in *Associated Business Products* to the respondent's specific situation. As argued by the respondent here, facts relevant to the Director's reconsideration include, for instance, the respondent's reliance on its insurance provider's advice that it was not required to continue carrying workers' compensation insurance, its reliance on its "subcontractor" that it had proof of insurance, its limited assets, and its inability to pay the fine. Moreover, as explained by the Court in *Dami*, if necessary, the Director may set the matter for hearing on the issue of the respondent's default. Section 8-43-409(1), C.R.S.

IT IS THEREFORE ORDERED that the Director's supplemental order dated January 13, 2017, is set aside and the matter is remanded for reconsideration of the fine in light of the holding in *Dami*.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

4/4/17 by TT .

T-REX ROOFING AND CONSTRUCTION LLC, 674 S JOAQUIN R, PUEBLO WEST, CO, 81007 (Employer)
DIVISION OF WORKERS' COMPENSATION, Attn: TROY DUMAS, 633 17TH STREET 4TH FLOOR, DENVER, CO, 80202 (Other Party)
DIVISION OF WORKERS' COMPENSATION, Attn: PAUL TAURIELLO, 633 17TH STREET SUITE 400, DENVER, CO, 80202 (Other Party 2)

INDUSTRIAL CLAIM APPEALS OFFICE

FEIN: 84-1546794

IN THE MATTER OF:

ORDER OF REMAND

K & K EXTERIORS, INC.,

Respondent.

The employer seeks review of a supplemental order of the Director of the Division of Workers' Compensation dated January 13, 2017, that ordered the employer to pay a fine of $62,885.00, pursuant to § 8-43-409(1)(b)(I), C.R.S. in regard to a default in its workers' compensation insurance coverage. We set aside the Director's supplemental order and remand the matter for reconsideration of the fine based on the analysis set forth in *Dami Hospitality, LLC v. Industrial Claim Appeals Office*, 2017 COA 21 (Feb. 23, 2017).

The employer operates a roofing business. On July 6, 2016, the Director sent the employer a Notice to Show Compliance and requested that the employer complete, within 20 days, a questionnaire which inquired as to whether the employer was actively conducting a business with employees, if the employer currently had insurance coverage, and to provide proof of that coverage. The Notice also advised the employer of the opportunity to request a prehearing conference on the issue of default prior to the expiration of 20 days. The employer completed the questionnaire which was received by the Division on August 2, 2016. In the response, the employer stated that it did not have employees but worked with an independent contractor D&H Company. The employer did not request a pre-hearing conference.

The Director sent out another Notice to Show Compliance on August 3, 2016, requesting that the employer provide, within 20 days, a list of all individuals the company has or had direct contracts to perform construction work on construction sites and all workers' compensation insurance policies or proof of rejection of coverage. The employer again was advised of the opportunity to request a pre-hearing.

The Director issued an order on October 7, 2016. The order found the employer did not have required insurance coverage for the periods of July 1, 2005 through October 15, 2009 and February 20, 2010 through April 19, 2012 and June 19, 2012 and continuing. Pursuant to §8-43-409(1)(b)(I), the Director assessed a penalty of $38,385, noting that the fine would continue to accrue at the rate of $250.00 per day until the employer obtained the required insurance.

In letter dated October 27, 2016, Kenny Caid, owner of the employer, stated that the dates for which fines were assessed were incorrect. The Director treated the employer's letter as a petition to review and on January 13, 2017, issued the supplemental order now under review.

In the supplemental order the Director relies on a prior workers' compensation claim from Kenneth Lyon against the employer as a non-insured employer in W.C. No. 4-946-455. In that case an ALJ found that the claimant was an employee of the employer and not an independent contractor and ordered the employer to pay medical and temporary disability benefits and penalties as a non-insured employer. The ALJ's order was affirmed by the Industrial Claim Appeals Office in an order dated April 22, 2015. Based on these orders the Director concluded that Lyon was an employee from August 2010 through January 24, 2014. The Director also concluded that employer owner Kenny Caid did not reject coverage pursuant to §8-41-202(1), C.R.S., to relieve the employer from its obligation to provide workers' compensation insurance coverage for its employees. The Director further relied on the proof of coverage records of the National Council on Compensation Insurance ("NCCI") to show the dates the employer did not have workers' compensation coverage. The Director applied the schedule for fines specified in W.C. Rule of Procedure 3-6(B), 7 Code Colo. Reg. 1101-3 ("Rule 3-6") and increased the amount of the fine to $62,885.00, noting that the employer had not yet secured coverage.

On appeal of the supplemental order Kenny Caid again states that the dates used in the Director's order are incorrect, citing to dates that he worked for another company and stating that he filed for Chapter 7 bankruptcy in July of 2008. Kenny Caid also requested that his financial circumstances be taken into consideration in the imposition of the fine. We set aside the Director's order and remand the matter for further findings and a new order.

In *Dami*, the Colorado Court of Appeals addressed a large fine of $841,200 that the Director imposed on a small employer for having failed, on at least two occasions over several years, to maintain workers' compensation insurance coverage. The

employer appealed the fine, raising several arguments of error, including that the fine was unconstitutionally excessive as applied. The Court agreed with the employer that application of §8-43-409, C.R.S. violated the employer's constitutional protections against excessive fines. The Court reasoned that because the constitutional factors, as set out in *Associated Business Products v. Industrial Claim Appeals Office*, 126 P.3d 323 (Colo. App. 2005), were not sufficiently incorporated into Rule 3-6, the implementing provision for §8-43-409, C.R.S., the Director abused his discretion in failing to consider facts specific to employer. In holding that the fine was excessive, the Court explained that the Director failed to apply the excessive fine factors adopted under the Eighth Amendment to the particular facts that the employer presented. Consequently, the Court set aside the Director's fine and remanded the matter for the Director to consider the following factors when reconsidering the fine to be imposed: (1) the degree of the defendant's reprehensibility or culpability; (2) the relationship between the penalty and the harm to the victim caused by the defendant's actions; and (3) the sanctions imposed in other cases for comparable misconduct. The Court ordered the Director to consider these factors on a case-by-case basis with consideration given to the employer's unique situation. The Court specifically noted that facts relevant to the Director's application included the employer's ignorance that the required insurance had lapsed, the failure to notify the employer of the lapse for almost half a decade, and the employer's ability to pay.

While the fine imposed on the employer in this action is for an initial violation under §8-43-409(1)(b)(I), C.R.S and Rule 3-6(B), as opposed to the fine imposed on *Dami* for a subsequent violation under §8-43-409(1)(b)(II), C.R.S. and Rule 3-6(D), we nevertheless conclude the Court's analysis in *Dami* is directly applicable here. This is because the Director calculated both fines using similar formulas outlined in Rule 3-6. As explained above, the Court concluded that application of §8-43-409, C.R.S. violated the employer's constitutional protections against excessive fines because the excessive fine factors were not sufficiently incorporated into Rule 3-6. Consequently, the holding in *Dami* requires us to set aside the Director's fine in this matter. As such, the matter must be remanded for the Director to reconsider the fine by applying the factors enunciated in *Associated Business Products* to the respondent's specific situation.

As argued by the employer here, the facts relevant to the Director's reconsideration include employer's ability to pay and the specific circumstances of the employer's case. Moreover, as explained by the Court in *Dami*, the Director may set the matter for hearing on the issue of the employer's default. Section 8-43-409(1), C.R.S.

IT IS THEREFORE ORDERED that the Director's supplemental order dated January 13, 2017, is set aside and the matter is remanded for reconsideration of the fine in light of the holding in *Dami*.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

CERTIFICATE OF MAILING

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

4/4/17 by TT .

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