COLORADO
Department of Labor and Employment

Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202-3660
303-318-8700

July Case Law Update

Presented by Judge John Sandberg and Judge Elsa Martinez-Tenreiro

This update covers COA and ICAO decisions issued from
June 3, 2019 to July 5, 2019

Court of Appeals

Industrial Claim Appeals Office

Click here to subscribe to the Case Law Update mailing list.

The Case Law Update is offered as an educational and informational program. The discussions and commentary should not be considered a policy statement by the Division of Workers' Compensation or an indication of how the presenters would rule on any future pending cases.

SUMMARY
June 13, 2019

2019COA88

No. 18CA0748, *Ryser v. Shelter Mutual Insurance* — Insurance — Motor Vehicles — Uninured/Underinsured; Workers' Compensation — Coverage and Liability

In this uninsured/underinsured motorist (UM/UIM) benefits case, a division of the court of appeals concludes that the exclusivity provision of the Workers' Compensation Act of Colorado, section 8-41-102, C.R.S. 2018, and the related co-employee immunity rule, bar a person who was injured in the course and scope of employment by a co-employee's negligence in driving a car from receiving UM/UIM benefits under an insurance policy maintained by another co-employee who owned the car.

COLORADO COURT OF APPEALS **2019COA88**

Court of Appeals No. 18CA0748
City and County of Denver District Court No. 17CV33797
Honorable Robert L. McGahey, Jr., Judge

Kent Ryser,

Plaintiff-Appellant,

v.

Shelter Mutual Insurance Company,

Defendant-Appellee.

JUDGMENT AFFIRMED

Division III
Opinion by JUDGE WEBB
Furman and Márquez*, JJ., concur

Announced June 13, 2019

Killian Davis Richter & Mayle, PC, Nicholas W. Mayle, Damon Davis, Grand Junction, Colorado, for Plaintiff-Appellant

Morgan Rider Riter Tsai, P.C., Sophia H. Tsai, Kelly L. Kafer, Denver, Colorado, for Defendant-Appellee

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2018.

¶ 1 In this uninsured/underinsured motorist (UM/UIM) benefits case, plaintiff, Kent Ryser, appeals the summary judgment entered in favor of defendant, Shelter Mutual Insurance Company, based on the exclusivity provision of the Workers' Compensation Act of Colorado (WCA), section 8-41-102, C.R.S. 2018, and the related co-employee immunity rule. The case requires us to decide whether this immunity bars a person who was injured in the course and scope of employment by a co-employee's negligence in driving a car from receiving UM/UIM benefits under an insurance policy maintained by another co-employee who owned the car.[1] Because of the tortfeasor's coworker immunity, we conclude that Ryser cannot satisfy the UM/UIM statutory requirement of being "legally entitled to recover." On this basis, we affirm the summary judgment.

[1] Answering this question fills a gap between cases in which divisions of this court have addressed the interplay between UM/UIM coverage and tortfeasor immunity in different contexts, such as where the insurance policy belonged to the claimant and where immunity arose under the Colorado Governmental Immunity Act (CGIA) rather than under the WCA.

I. Undisputed Facts and Procedural Background

¶ 2 Ryser suffered serious injuries in a one-car accident. Sherri Babion owned the car. Linda Forster was driving, with Babion's permission. Ryser was a passenger, also with her permission. When the accident occurred, all three of them were Walmart employees acting in the course and scope of their employment. According to Ryser, Forster's negligence caused his injuries.

¶ 3 Babion maintained an auto insurance policy written by Shelter. The policy provided UM/UIM coverage. Because Forster was driving with Babion's consent and Ryser was a permitted passenger, they were both insured under the policy. But the policy's UM/UIM coverage applied only where "the owner or operator of an uninsured/underinsured motor vehicle is legally obligated to pay damages." As well, the policy excluded from the definition of uninsured/underinsured motor vehicle "[t]he described auto," i.e., Babion's car.

¶ 4 Ryser received workers' compensation benefits. He also obtained UM/UIM benefits under his own auto policy on the basis that the co-employee immunity rule rendered Forster an uninsured motorist. Still, he claimed UM/UIM benefits from Shelter to the

extent that Babion's UM/UIM coverage had a higher limit than his own policy.

¶ 5 When Shelter rejected the claim, Ryser brought this action for UM/UIM benefits. He also raised statutory bad faith and unreasonable delay and denial of benefits claims, along with a common law bad faith claim.

¶ 6 Shelter moved for summary judgment. It argued that Forster's co-employee immunity precluded the claim, as did the exclusion of Babion's car from UM/UIM coverage. For purposes of summary judgment, it did not contest that Ryser had been injured or that Forster's negligence had caused his injuries.

¶ 7 Ryser opposed Shelter's motion on the described auto exclusion and filed a cross-motion for partial summary judgment on the co-employee immunity question. He did not assert any negligence as to Babion.

¶ 8 Neither party opposed the other's motion based on disputed issues of material fact. Nor was the co-employee immunity of Forster disputed.

¶ 9 In a written order, the trial court ruled for Shelter and against Ryser based on co-employee immunity, thus ending the case. The

court did not address the described auto exclusion. On appeal, Shelter concedes preservation.

II. Standard of Review

¶ 10 Summary judgment is reviewed de novo, applying the same standard as the trial court. *City of Fort Collins v. Colo. Oil & Gas Ass'n*, 2016 CO 28, ¶ 9. It is appropriate only when no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. C.R.C.P. 56(c); *Martini v. Smith*, 42 P.3d 629, 632 (Colo. 2002). The opposing party is entitled to the benefit of all favorable inferences that may reasonably be drawn from the undisputed facts, and all doubts as to the existence of a triable issue of fact must be resolved against the moving party. *Martini*, 42 P.3d at 632.

¶ 11 Statutory interpretation is a question of law that is also reviewed de novo. *Cont'l Divide Ins. Co. v. Dickinson*, 179 P.3d 202, 204 (Colo. App. 2007). So is the interpretation of an insurance policy. *Smith v. State Farm Mut. Auto. Ins. Co.*, 2017 COA 6, ¶ 5.

¶ 12 Although earlier decisions from divisions of this court are not binding on another division, "the later division should give the prior

decision some deference." *People v. Oliver*, 2018 COA 146, ¶ 24 n.1 (quoting *People v. Bondsteel*, 2015 COA 165, ¶ 14).

III. Law

A. Statutes

¶ 13 In Colorado, statutes regulate UM/UIM coverage. Under section 10-4-609(1)(a), C.R.S. 2018, auto insurers must offer UM/UIM coverage with all liability policies covering the same class of persons who are included in the liability provisions. UM/UIM benefits are available only to persons who are "legally entitled to recover." *Id.* This phrase is not defined. Coverage extends to permissive users. § 10-4-620, C.R.S. 2018.

¶ 14 Nor do the statutes define "uninsured motorist" or "uninsured automobile." An "underinsured" motor vehicle is defined as "a land motor vehicle, the ownership, maintenance, or use of which is insured or bonded for bodily injury or death at the time of the accident." § 10-4-609(4). Under that section, "[u]ninsured motorist coverage shall include coverage for damage for bodily injury or death that an insured is legally entitled *to collect* from the owner or driver of an underinsured motor vehicle." *Id.* (emphasis added). But the phrase "legally entitled to collect" is also undefined.

B. Case Law

¶ 15 The parties primarily focus on three decisions by divisions of this court: *Borjas v. State Farm Mutual Automobile Insurance Co.*, 33 P.3d 1265 (Colo. App. 2001); *Dickinson*, 179 P.3d 202; and *American Family Mutual Insurance Co. v. Ashour*, 2017 COA 67. To a lesser extent, they point to *Aetna Casualty & Surety Co. v. McMichael*, 906 P.2d 92 (Colo. 1995). Unsurprisingly, they read these cases differently. And in any event, at most these cases provide only background.

1. *Borjas*

¶ 16 The plaintiff sought UM/UIM benefits under her personal auto policy for injuries suffered in a collision with a car driven by a police officer. The officer was immune under the CGIA. After examining the policies underlying UM/UIM coverage and governmental immunity, the division allowed recovery. In doing so, it explained that "legally entitled to recover" under section 10-4-609(1)(a) "means that the insured must be able to establish that the fault of the uninsured motorist gave rise to damages and the extent of those damages." *Borjas*, 33 P.3d at 1269.

2. *Dickinson*

¶ 17 The plaintiff, an independent contractor, sustained an injury caused by a co-employee's negligent operation of a motor vehicle. Because he had elected not to be covered by the employer's workers' compensation policy and had not obtained his own coverage, the WCA limited the liability of the employer and the co-employee to a total of $15,000. § 8-41-401(3), C.R.S. 2018. After having been paid that amount, he sought UM/UIM benefits from the employer's insurer.

¶ 18 The division rejected the claim. It held that "[a]llowing an independent contractor, who like Dickinson had not procured workers' compensation insurance, to recover damages in excess of $15,000 through the employer's UM/UIM insurance for injuries sustained in a work-related accident would undercut the[] policies [of the WCA]." *Dickinson*, 179 P.3d at 207. In doing so, the division declined to follow *Borjas* and aligned with what it described as the "majority of jurisdictions that have addressed this issue," holding that "an insured is not 'legally entitled to recover' under the uninsured motorist provisions of an [employer's] insurance policy if the exclusivity provisions of the workers' compensation statute

would bar an action against the tortfeasor." *Id.* at 204 (citation omitted).

3. *Ashour*

¶ 19 The plaintiff was injured at work in a motor vehicle accident caused by a co-employee's negligence. After having received workers' compensation benefits, he sought UM/UIM benefits under his own auto insurance policy. The division held that this claim was "not barred by the exclusivity provisions of the [WCA], or by the 'legally entitled to recover' language" of section 10-4-609. *Ashour*, ¶ 73. As to this phrase, the division followed *Borjas* and held that it means "the insured must be able to establish that the fault of the uninsured motorist gave rise to damages and the extent of those damages." *Id.* at ¶ 63 (quoting *Borjas*, 33 P.3d at 1269). So, it concluded, "allowing [the plaintiff] to claim benefits from his own insurance carrier would not in any way affect the immunity provided to his employer and co-employee by the [WCA]." *Id.* at ¶ 71.

4. *McMichael*

¶ 20 The plaintiff, an employee, sustained injuries while working near his employer's truck and sought UM/UIM benefits under the

employer's insurance policy. The supreme court addressed whether the plaintiff was covered, although he had left the truck before being injured. Unlike *Borjas*, *Dickinson*, and *Ashour*, this case did not involve WCA immunity because the plaintiff was struck by a third-party tortfeasor.

¶ 21 The court addressed the WCA only to the extent of noting that "[t]he Workers' Compensation statute does not bar McMichael from bringing a tort action against the driver who caused the accident." *McMichael*, 906 P.2d at 100 n.7. It held that "insurers must provide UM/UIM coverage for the protection of persons insured under the liability policy that the insurer is issuing." *Id.* at 97. It also held that an exclusion of employer's liability for workers' compensation benefits did not limit UM/UIM coverage.

¶ 22 In sum, whether an employee injured in an auto accident caused by a co-employee's negligence while in the course and scope of employment is "legally entitled to recover" — a condition precedent to obtaining UM/UIM benefits under another co-employee's auto insurance policy — remains unresolved.[2]

[2] Of course, the General Assembly could fill this gap, but it has not done so.

IV. Ryser Is Not Legally Entitled to Recover

¶ 23 Relying on *Borjas* and *Ashour*, Ryser contends he is entitled to UM/UIM benefits under Babion's policy because "he can prove [Forster] was at fault for the collision and that he suffered injuries therefrom." Recall that, for summary judgment purposes, neither fault nor damages are disputed. So, resolving this contention begins with determining the meaning of "legally entitled to recover" under section 10-4-609.[3] After doing this, we conclude that Ryser is not entitled to UM/UIM benefits under Babion's insurance policy.

¶ 24 When interpreting statutes, "we endeavor to give effect to the intent of the General Assembly." *Colorow Health Care, LLC v. Fischer*, 2018 CO 52M, ¶ 11. To divine that intent, we start by

[3] Section 10-4-609(4), C.R.S. 2018, also uses the phrase "legally entitled to collect," when discussing coverage related to an "underinsured motor vehicle." The division in *American Family Mutual Insurance Co. v. Ashour*, 2017 COA 67, ¶ 21 n.2, found "no legally significant difference between the phrase 'legally entitled to recover' and 'legally entitled to collect.'" Shelter's policy uses the phrase, "legally obligated to pay damages," but Shelter does not argue that this language provides less coverage than what is required by section 10-4-609. *See Arline v. Am. Family Mut. Ins. Co.*, 2018 COA 82, ¶ 14 ("[A] term of an insurance policy 'is void and unenforceable if it violates public policy by attempting to "dilute, condition, or limit statutorily mandated coverage"' . . . ." (quoting *Huizar v. Allstate Ins. Co.*, 952 P.2d 342, 345 (Colo. 1998))).

looking to the plain language of the statute, construing words and phrases according to the rules of grammar and common usage. *Roberts v. Bruce*, 2018 CO 58, ¶ 8.

¶ 25 Neither the division in *Borjas* nor that in *Ashour* found the phrase "legally entitled to recover damages from owners or operators of uninsured motor vehicles" to be ambiguous. Still, both divisions interpreted the phrase based on policy considerations. *See Borjas*, 33 P.3d at 1269 ("The contrary line of cases all give a strict interpretation to the statutory language 'legally entitled to recover' that we find inconsistent with the public policy expressed in § 10-4-609."); *see also Ashour*, ¶ 62 ("[W]e choose to adopt the *Borjas* interpretation of that phrase because it is consistent with the policies underlying the UM/UIM statute, the purpose of which is to compensate the injured party 'for injuries received at the hands of one from whom damages cannot be recovered.'" (quoting *Borjas*, 33 P.3d at 1267)).

¶ 26 Neither party argues that section 10-4-609(1)(a) is ambiguous. At least one division of this court has held that it is not. *See Jaimes v. State Farm Mut. Auto. Ins. Co.*, 53 P.3d 743, 746 (Colo. App. 2002) (Referring to "the unambiguous language of the statute itself,"

the division explained "[s]ection 10-4-609(1)(a) plainly states that UM/UIM coverage is 'for the protection of persons insured [under the policy] who are legally entitled to recover damages from owners or operators of uninsured motor vehicles.'"). And where the plain language of a statute is unambiguous and does not conflict with other statutory provisions, we should look no further. *People in Interest of W.P.*, 2013 CO 11, ¶ 11.

¶ 27 That said, what does the plain language of this phrase mean?

¶ 28 Starting with the words "legally entitled," because the General Assembly included the word "legally," it must have meant something more than simply "entitled." *See Colo. Water Conservation Bd. v. Upper Gunnison River Water Conservancy Dist.*, 109 P.3d 585, 597 (Colo. 2005) ("[W]hen examining a statute's plain language, we give effect to every word and render none superfluous because '[w]e do not presume that the legislature used language "idly and with no intent that meaning should be given to its language."'") (citations omitted).

¶ 29 "Legally" means "[i]n a lawful way; in a manner that accords with the law." Black's Law Dictionary 1032 (10th ed. 2014); *see, e.g.*, *Loncar v. Progressive Cty. Mut. Ins. Co.*, 553 S.W.3d 586, 590

(Tex. App. 2018) ("[I]f the insured has no legal right to recover anything from the vehicle's owner or operator, whether because of the motorist's lack of fault, immunity, or some other substantive defense, the insured is not 'legally entitled to recover' any damages against the owner or operator . . . ."); *State Farm Mut. Auto. Ins. Co. v. Hunt*, 856 N.W.2d 633, 638 (Wis. Ct. App. 2014) ("[B]y its terms, the statute mandates underinsured motorist coverage where the insured is legally entitled to obtain damages, by a judgment or other legal process, against the underinsured motorist."). So, any entitlement to damages under section 10-4-609 must be as provided under the law.

¶ 30 Under the morality play of the common law, a person injured by the negligence of another is usually entitled to damages. But the WCA says otherwise, partly in response to the fellow servant rule. *See Williams v. State Farm Mut. Auto. Ins. Co.*, 641 A.2d 783, 787 (Conn. 1994) ("Whether the uninsured motorist was legally liable must be determined in light of any substantive defenses that would have been available to the uninsured motorist."). Through this lens, we take another look at the statutory language.

¶ 31 Section 10-4-609 also uses the word "recover." The definition of this word includes "[t]o obtain (relief) by judgment or other legal process" and "[t]o obtain damages or other relief; to succeed in a lawsuit or other legal proceeding." Black's Law Dictionary 1466; *see Mitchell v. Residential Funding Corp.*, 334 S.W.3d 477, 503 (Mo. Ct. App. 2010) ("We believe 'recover' and 'recovery' have two meanings as relevant to the arguments here. The first, the plain definition, is to get or obtain something under a claim of right, to collect. The second, narrower, definition is to obtain through legal judgment.").

¶ 32 In short, because of coworker immunity, under either the broader or the narrower definition, Ryser cannot recover from Forster.

¶ 33 Consistent with these definitions, Colorado cases hold that "legally entitled" under section 10-4-609 means entitlement as provided under the law. In *Briggs v. American Family Mutual Insurance Co.*, 833 P.2d 859, 861-62 (Colo. App. 1992), for example, the division explained:

> Under the statute, the insurer must pay to the insured, up to the limit of the policy, whatever losses the insured proves he or she is "legally

> entitled to recover" from the uninsured motorist. Thus, the insured has the burden to prove that the uninsured motorist was negligent and the extent of the damages. *This can be done in a judicial proceeding against either the uninsured motorist or the insurer, or in an arbitration proceeding.*

(Emphasis added.) *See State Farm Mut. Auto. Ins. Co. v. Brekke*, 105 P.3d 177, 188 (Colo. 2004) ("However, section 10-4-609's coverage applies only if the insured is 'legally entitled' to damages. Consequently *a finding of no liability or of limited damages* on the part of the uninsured motorist will eliminate or limit a claim under the insurance provider's UM coverage.") (emphasis added); *see also USAA v. Parker*, 200 P.3d 350, 358 (Colo. 2009) ("The language of the UM/UIM statute indicates that its aim is to provide the insured a means to recover from the insurer all of the 'damages' he or she is legally entitled to recover *in an action against the tortfeasor* up to the insured's policy limits.") (emphasis added).

¶ 34 But where WCA immunity protects the tortfeasor, this immunity is "from suit," not just from damages. *See, e.g.*, *Rodriquez v. Nurseries, Inc.*, 815 P.2d 1006, 1008 (Colo. App. 1991) ("As it pertains to the immunity from suit of a complying employer, the exclusivity of the Workers' Compensation Act has been

continually reaffirmed . . . ."). Simply put, Ryser cannot bring a "judicial proceeding" or "an action" against Forster, as section 10-4-609 contemplates ("from owners or operators of uninsured motor vehicles").

¶ 35 Still, what about the interpretations in *Borjas* and *Ashour*, which limited the statutory requirement to proving the tortfeasor's "fault," as could easily be done in a case against a UM/UIM insurer? To be sure, fault is a necessary step. But under the plain language of section 10-4-609, it is not sufficient. Because the tortfeasor may have affirmative defenses, merely showing that the tortfeasor was at fault would not establish a legal entitlement to recover from an owner or operator of an uninsured motor vehicle. And WCA and co-employee immunity are just such defenses. *Bain v. Town of Avon*, 820 P.2d 1133, 1135 (Colo. App. 1991), *overruled on other grounds by Bertrand v. Bd. of Cty. Comm'rs*, 872 P.2d 223 (Colo. 1994).

¶ 36 Given all of this, how does "legally entitled to recover" apply here? Forster was both the "operator" of Babion's vehicle under section 10-4-609 as well as an insured under her policy because Forster was driving with Babion's permission. Likewise, as a

permitted passenger, Ryser was covered by Babion's insurance policy. And he meets the threshold for seeking UM/UIM benefits under her policy because the coworker immunity rule renders the driver uninsured. *See Borjas*, 33 P.3d at 1268 ("Negligent drivers and their employers who are immune from liability . . . may not be financially irresponsible in the sense that they lack the ability to pay, but from the perspective of the injured innocent driver, the lack of legal responsibility has the same effect."); *see also Atl. Mut. Ins. Co. v. Payton*, 682 N.E.2d 1144, 1148 (Ill. App. Ct. 1997) ("A reason that the driver is deemed noninsured is because the Workers' Compensation Act grants immunity from any liability towards a co-employee.").

¶ 37 Even so, these undisputed facts only get Ryser so far. "Uninsured motorist coverage is not triggered unless an insured [Ryser] is legally entitled to recover damages from the [owner or] operator of an uninsured automobile [Forster]." *Parsons v. Allstate Ins. Co.*, 165 P.3d 809, 814 (Colo. App. 2006). In other words, under the plain language of section 10-4-609, Ryser is not entitled to UM/UIM benefits because he is not "legally entitled to recover damages" from Forster by virtue of the co-employee immunity rule.

¶ 38 To Ryser, this outcome seems simplistic and even harsh. But it reflects the dominant view. *See generally* 2A A. Larson, *Workmen's Compensation Law* § 71.23(j) (1983 & Supp. 1987) ("Ordinarily, for the uninsured motorist clause to operate in the first place, the uninsured third person must be legally subject to liability . . . . [I]f the third person is specifically made immune to tort suit by the compensation act's exclusive remedy clause, the uninsured motorist provision does not come into play."); John P. Ludington, Annotation, *Automobile Uninsured Motorist Coverage: "Legally Entitled to Recover" Clause as Barring Claim Compensable Under Workers' Compensation Statute*, 82 A.L.R.4th 1096 (1990) (Where "the uninsured motorist coverage has been bought and paid for by someone other than the injured employee, *the results have been uniform*.") (emphasis added).[4]

[4] Numerous cases are in accord, holding that "where the plaintiff cannot maintain a claim against the [tortfeasor] due to the application of the co-employee rule, the plaintiff is not 'legally entitled to recover' under the uninsured motorist provision." *Kobak v. Sobhani*, 2011-Ohio-13, ¶ 33 (citation omitted); *see, e.g.*, *Medders v. U.S. Fid. & Guar. Co.*, 623 So. 2d 979, 989 (Miss. 1993) ("[T]he clear meaning of the phrase *legally entitled to recover* . . . limits the scope of the coverage mandated by the statute to those instances in which the insured would be entitled at the time of injury to recover

¶ 39 We consider these authorities persuasive and follow them here. As one court explained, "[t]he phrase 'legally entitled to recover' cannot be stretched so far as to cover situations when an insured could have never recovered from the uninsured motorist because the law did not provide for any recovery." *Otterberg v. Farm Bureau Mut. Ins. Co.*, 696 N.W.2d 24, 30 (Iowa 2005) (interpreting "legally entitled to recover" to require "not only that the insured 'suffered damages caused by the fault of the uninsured motorist,' but also that the insured's action against the uninsured motorist was not barred under substantive law") (citation omitted).

¶ 40 Nor is this outcome clouded by cases allowing recovery of UM/UIM benefits from an employer's insurer where the employee was injured by a third-party tortfeasor, who does not enjoy

through legal action."); *Cormier v. Nat'l Farmers Union Prop. & Cas. Co.*, 445 N.W.2d 644, 647 (N.D. 1989) ("[T]he clear meaning of the language, 'legally entitled to recover,' imports a condition precedent to the uninsured motorist insurer's obligation that the insured have a legally enforceable right to recover damages from the owner or operator of the uninsured motor vehicle."); *Aetna Cas. & Sur. Co. v. Dodson*, 367 S.E.2d 505, 508 (Va. 1988) ("The phrase 'legally entitled to recover as damages' interposes, as a condition precedent . . . , the requirement that the insured have a legally enforceable right to recover damages from an owner or operator of an uninsured motor vehicle.").

immunity. *See McMichael*, 906 P.2d at 94. After all, the linchpin of these cases is the tortfeasor's lack of immunity. *See William v. City of Newport News*, 397 S.E.2d 813, 816 (Va. 1990) (employee injured in the course and scope of employment was entitled to UM/UIM benefits "where the injury was inflicted by someone other than a fellow-employee — a stranger to the business"); *Henry v. Benyo*, 506 S.E.2d 615, 621 (W. Va. 1998) (because a plaintiff "has an undisputed statutory right to seek recovery from . . . the third-party tortfeasor chargeable with the motor vehicle accident," the plaintiff is legally entitled to recover UM/UIM benefits under his or her employer's policy). But tortfeasor immunity is alive and well here.

¶ 41 Despite all of this, Ryser points to cases where recovery of UM/UIM benefits is allowed even though the injured party cannot obtain an enforceable judgment against the tortfeasor. Examples include unidentified hit-and-run drivers, *see Farmers Ins. Exch. v. McDermott*, 34 Colo. App. 305, 308-09, 527 P.2d 918, 920 (1974), and bankrupt tortfeasors, *see Wilkinson v. Vigilant Ins. Co.*, 224 S.E.2d 167 (1976). This argument misses the mark because the test for UM/UIM benefits is not whether an enforceable judgment

has been obtained — it is whether the injured plaintiff is legally entitled to recover damages from the tortfeasor.

¶ 42 In *McDermott*, the court explained "[t]here can be no doubt as to the liability of the errant driver here, had his identity been known." 34 Colo. App. at 308, 527 P.2d at 920. Similarly, cases involving bankrupt tortfeasors explain "there is nothing preventing [the injured plaintiff] from establishing that he is legally entitled to recover from [the tortfeasor] on the merits of his claims; instead, [the plaintiff] is merely barred, by operation of [the tortfeasor's] bankruptcy discharge, from actually collecting demonstrated damages from her." *Easterling v. Progressive Specialty Ins. Co.*, 251 So. 3d 767, 775 (Ala. 2017). Again, neither of these examples involves a tortfeasor who is immune from liability.

¶ 43 Not easily deterred, Ryser also cites to *Torres v. Kansas City Fire & Marine Insurance Co.*, 849 P.2d 407, 410 (Okla. 1993), where an employee injured by a coworker received UM/UIM benefits under their employer's policy. The court held, like the *Ashour* division, that the phrase "legally entitled to recover" requires only that "the insured must be able to establish fault on the part of the uninsured

motorist which gives rise to damages and prove the extent of those damages." *Torres*, 849 P.2d at 410.

¶ 44 But Colorado cases have not extended the "establish fault" rationale this far. Both *Ashour* and *Borjas* involved claimants who sought to recover UM/UIM benefits under their own insurance policies. *Ashour*, ¶ 56; *Borjas*, 33 P.3d at 1266. The *Ashour* division explained: "In our view, the fact that Ashour sought recovery of benefits under his own insurance policy is critical . . . . Ashour did not seek to recover additional damages from the immune parties in this case — his employer and co-employee." *Ashour*, ¶ 52; *see Dickinson*, 179 P.3d at 208 ("[W]e acknowledge that the statutory policies which we have reconciled may interact differently if a claimant . . . sought UM/UIM benefits from the claimant's own insurance carrier . . . ."). And Ryser has already received UM/UIM benefits under his own policy.[5] He got what he paid for.

[5] We leave for another division or our supreme court to decide whether our interpretation of "legally entitled to recover" would foreclose future claims like those in *Borjas* and *Ashour*. *See Matarese v. N.H. Mun. Ass'n Prop. Liab. Ins. Tr., Inc.*, 791 A.2d 175, 182 (N.H. 2002) ("New Hampshire's uninsured motorist statute is

¶ 45 Ryser's remaining arguments examine policy considerations related to the WCA and UM/UIM coverage. We decline to follow him down this path because "[p]olicy does not justify disregarding the plain language of [a statute]." *Krol v. CF & I Steel*, 2013 COA 32, ¶ 28 n.6; *see Braata, Inc. v. Oneida Cold Storage Co., LLP*, 251 P.3d 584, 587 (Colo. App. 2010) ("[A]lthough Colorado has a strong public policy favoring arbitration, that policy does not trump statutory plain language."); *Bontrager v. La Plata Elec. Ass'n*, 68 P.3d 555, 561 (Colo. App. 2003) ("We need not address plaintiff's public policy arguments because we view the relevant Colorado statutes as unambiguous . . . .").

V. Conclusion

¶ 46 We conclude that the trial court properly granted summary judgment in favor of Shelter on Ryser's claim for UM/UIM benefits. Having so concluded, we need not address Shelter's alternative

designed to compensate people injured in automobile accidents whose losses would otherwise be uncompensated because the tortfeasor lacked liability coverage or because the tortfeasor's identity was unknown. The underlying purpose of the statute is to provide coverage only where there is a lack of liability insurance on the part of the tortfeasor and the tortfeasor would be legally liable to the injured driver in a tort action; it does not provide coverage in all situations that might go uncompensated.") (citation omitted).

argument based on the "described auto" exclusion in Babion's policy.

¶ 47 The judgment is affirmed.

JUDGE FURMAN and JUDGE MÁRQUEZ concur.

COLORADO COURT OF APPEALS

DATE FILED: June 20, 2019
CASE NUMBER: 2018CA1806

Court of Appeals No. 18CA1806
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-681-113

Joe R. Dickens,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Wagner Equipment, and Ace American Insurance Company,

Respondents.

ORDER AFFIRMED

Division VI
Opinion by JUDGE FOX
Freyre and Welling, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced June 20, 2019

Cristiano Law, LLC, Francis V. Cristiano, Englewood, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., Richard A. Bovarnick, Denver, Colorado, for Respondents Wagner Equipment and Ace American Insurance Company

¶ 1 In this workers' compensation action, claimant, Joe R. Dickens, seeks review of a final order of the Industrial Claim Appeals Office (Panel), affirming the decision of an administrative law judge (ALJ) denying his petition to reopen and dismissing his claim for additional benefits. We hold that Dickens should have taken all the necessary steps to challenge the final admission of liability (FAL) within thirty days of receiving it and therefore affirm the Panel's order.

I. Background

¶ 2 The relevant facts are generally undisputed.

A. Factual Background

¶ 3 Dickens sustained an admitted, compensable injury to his right knee in 2006 while working for employer, Wagner Equipment Company. He underwent extensive medical treatment, including knee replacement surgeries covered by Wagner's workers' compensation insurer, ACE American Insurance Company (collectively "Wagner"). A physician who performed a division-sponsored independent medical examination (DIME) placed Dickens at maximum medical improvement (MMI) on September 23, 2010.

¶ 4 Because Dickens continued to experience pain, the parties voluntarily reopened the case in 2011 or 2012. Dickens then underwent a revision right knee surgery to remove hardware to which he was allergic. An authorized treating physician placed Dickens at MMI for a second time on August 8, 2013, with a scheduled impairment of 37% of the right lower extremity.

¶ 5 Although no physician had rated Dickens' back condition as part of his 2006 work injury, Dickens complained of back pain to his treating providers. He reported having back pain since he fell and hurt his knee in 2006. At least two physicians opined that Dickens' low back pain was caused by and related to the chronic antalgic gait he developed secondary to his work-related knee injury. Because of the antalgic gait, he has walked with a cane since the injury.

¶ 6 Dickens later underwent a lumbar fusion intended to ease his back pain but claimed that the fusion surgery did not help him. Indeed, he testified that "none" of the treatment he has received since his 2006 work-related fall has helped his condition or made him "better" and that he believes he has "been totally disabled since March 7, 2006."

¶ 7 A physician Wagner retained in 2016 to perform an independent medical examination, Dr. Eric Ridings, confirmed that Dickens experienced an "aggravation of his underlying degenerative changes of the lumbar spine as a result of his antalgic gait." However, Dr. Ridings concluded that Dickens' back fusion surgery was unrelated and unwarranted. Dr. Ridings also noted that, given that several medical reports commented on Dickens' symptom magnification, and based on

> documentation of near normal range of motion of the right knee under anesthesia at a time that patient was demonstrating only minimal right knee range of motion preoperatively in the clinic . . . it is difficult to support a clear-cut cause and effect relationship between the patient's antalgic gait and his complaints of low back pain.

¶ 8 In sum, although Dr. Ridings agreed that Dickens experienced increased symptoms in his low back, he ultimately concluded that Dickens' gait did not "necessarily worsen any of the degenerative changes in his spine."

B. Relevant Procedural History

¶ 9 On November 13, 2013, Wagner filed a FAL based on Dickens' treating physicians' August 2013 MMI date and 37% impairment rating of the lower extremity.

¶ 10 It is undisputed that neither Dickens nor his counsel were properly served the 2013 FAL. Dickens' counsel obtained a copy of the FAL directly from the division of workers' compensation on April 28, 2014. On May 22, 2014, within thirty days of receiving the FAL from the division, Dickens filed an objection to it. However, Dickens did not file an application for hearing at that time, as required by section 8-43-203(2)(b)(II)(A), C.R.S. 2018.

¶ 11 Instead, more than thirty days later, on June 23, 2014, Dickens filed an application for hearing on the following sole issue: "Whether Respondent's [FAL] was properly served, and if so, when, and based upon such whether Claimant's Objection to [FAL] was timely." A hearing was scheduled for October 2014, but Dickens withdrew this application for hearing "to pursue ongoing discovery and potential settlement before going to hearing."

¶ 12 Months later, on August 4, 2015, Dickens filed a petition to reopen on the grounds of error, mistake, and a change in his condition — an alleged deterioration of his lower back. He withdrew

that petition to reopen but reasserted it in applications for hearing filed in June 2016, November 2016, and February 2017. Those three applications for hearing also endorsed Dickens' challenge to Wagner's service of its November 2013 FAL, which he first raised in his June 2014 application for hearing.

¶ 13 The matter finally proceeded to hearing before ALJ Peter Cannici on May 16 and June 2, 2017. The only issues before ALJ Cannici were:

> 1. Whether Claimant properly received notice and thus had an opportunity to object to Respondents' November 19, 201[3] Amended [FAL] pursuant to [section] 8-43-203(2)(b)(II)(A).
>
> 2. If Claimant received proper notice, whether he has established by a preponderance of the evidence that he should be permitted to reopen his March 7, 2006 Workers' Compensation claim based on a worsening of condition pursuant to [section] 8-43-303(1), C.R.S. [2018].

ALJ Cannici found that employer mailed the November 2013 FAL to an incorrect address and that claimant never received it. He further found that Dickens' counsel received a copy of the FAL when he visited the division of workers' compensation on April 28, 2014. He concluded that "[b]ecause Claimant did not receive proper notice of

the Amended FAL until April 28, 2014 through [his counsel] and timely objected, his claim has not closed and remains viable."

Based on these findings, ALJ Cannici entered the following orders:

> 1. Claimant's Workers' Compensation claim for his March 7, 2006 right knee injury remains open.
>
> 2. Because Claimant's claim remains open, it is unneccesary to address whether he should be permitted to reopen the claim based on a worsening of condition pursuant to [section] 8-43-303(1), C.R.S.

¶ 14 Thereafter, on August 22, 2017, Dickens filed another application for hearing identifying numerous issues he had not previously endorsed, including compensability; medical benefits; authorized provider; reasonably necessary medical treatment; disfigurement; temporary total disability (TTD) benefits from August 7, 2013, forward; permanent partial and total disability benefits; and, another petition to reopen the claim. Wagner did not challenge the timeliness of this application for hearing. In response to the application for hearing, and in motions for summary judgment and to dismiss, Wagner asserted that Dickens' requests for medical and disability benefits were "closed by operation of law"

because Dickens failed to file an application for hearing within thirty days of receiving the FAL.

¶ 15 The ALJ presiding over this hearing, Glen Goldman, considered whether: (1) Wagner's motion to dismiss should be granted; and (2) Dickens established "that his claim should be reopened." As pertinent here, ALJ Goldman accepted that Dickens received the FAL on April 28, 2014, because ALJ Cannici resolved the question. In addition, ALJ Goldman recognized that ALJ Cannici found Dickens' claim viable and open because Dickens filed an objection to the FAL within thirty days of receiving it. ALJ Goldman noted, though, that the question whether Dickens timely filed an application for hearing after receiving the FAL was not before ALJ Cannici and therefore "was not addressed or resolved by" him. ALJ Goldman further concluded that although Dickens had filed an objection to the FAL, he was also obligated to seek a hearing within thirty days of receiving the FAL; that he failed to file a timely application for a hearing; and, that Wagner's FAL therefore automatically closed barring Dickens' benefits claims.

¶ 16 Having determined that the FAL had automatically closed due to Dickens' "failure to properly contest the FAL within 30 days of

the receipt of the FAL," ALJ Goldman addressed Dickens' petition to reopen based on a change in condition, error, or mistake. ALJ Goldman found Dr. Ridings' opinion that Dickens required no further treatment for his low back condition and remained at MMI persuasive. In contrast, ALJ Goldman found Dickens' pain complaints inconsistent and unreliable, and deemed Dickens' testimony not credible. ALJ Goldman therefore found that "Claimant did not injure his back on March 7, 2006, when he fell at work"; that "Claimant's altered gait did not cause or aggravate his back condition"; and, that his "altered gain did not . . . necessitate the need for medical treatment or cause additional disability." Because he found Dickens' condition had not worsened, ALJ Goldman denied Dickens' request to reopen on that ground. Similarly, ALJ Goldman found neither mistake nor error to support reopening and denied the petition to reopen on those grounds.

¶ 17 Dickens petitioned the Panel for review of ALJ Goldman's order, raising several arguments in support of his contention that ALJ Goldman erred. In particular, he argued that:

1. Under a strict and proper reading of section 8-43-203(2)(b)(II), his claim had automatically closed thirty days

after Wagner filed the FAL in November 2013 because the statute does not expressly permit a claimant to object within thirty days of receiving a FAL;

2. His claim remained closed until it was reopened by ALJ Cannici's order of July 13, 2017;
3. Because his claim was closed, he could not seek any medical or disability benefits until the case was reopened as asserting unripe claims is prohibited;
4. The doctrine of claim preclusion barred ALJ Goldman from reexamining when his claim closed; and,
5. The result was overly "harsh," violated the principles of proportionality, and imposed an undue burden on him.

The Panel rejected all these arguments. It noted that, where service of an FAL is deficient, the time period for challenging the FAL commences when the claimant actually receives notice of the FAL. Although observing that Dickens failed to preserve the claim preclusion argument, the Panel held claim preclusion inapplicable because Dickens could not prove several elements of the claim. Finally, the Panel held that because substantial evidence supported

ALJ Goldman's denial and dismissal of Dickens' petition to reopen, it could not set aside the decision.

II. Timeliness of Application for Hearing

¶ 18 We first address the timeliness of Dickens' application for hearing. Dickens contends that because his claim automatically closed thirty days after Wagner filed its FAL, he could not apply for a hearing on medical or disability benefits until the claim was reopened. He argues that the statute's strict language mandates closure of claims even when a claimant has not received an FAL. We disagree.

A. Standard of Review

¶ 19 To consider this argument, we must interpret the governing statute. "The interpretation of a statute is a question of law subject to de novo review." *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff'd*, 145 P.3d 661 (Colo. 2006).

¶ 20 When we interpret statutes, "[a]lthough we defer to the agency's determinations of fact, we review its conclusions of law de novo." *Colo. Dep't of Labor & Emp't v. Esser*, 30 P.3d 189, 193 (Colo. 2001). Nevertheless, we "'give considerable weight to an agency's interpretation of its own enabling statute'; however, we set

aside actions or interpretations that are clearly erroneous, arbitrary, or otherwise not in accordance with the law." *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1029 (Colo. 2004) (quoting *Esser*, 30 P.3d at 193). We will set aside a Panel's interpretation "only 'if it is inconsistent with the clear language of the statute or with the legislative intent.'" *Zerba v. Dillon Cos., Inc.*, 2012 COA 78, ¶ 37 (quoting *Support, Inc. v. Indus. Claim Appeals Office*, 968 P.2d 174, 175 (Colo. App. 1998)).

B. Governing Law

¶ 21 Section 8-43-203 of the Workers' Compensation Act (Act) provides that

> (1)(a) The employer or, if insured, the employer's insurance carrier shall notify in writing the division and the injured employee . . . within twenty days after a report is . . . filed with the division . . . whether liability is admitted or contested.
>
> (2)(b)(II)(A) An admission of liability for final payment of compensation must include a statement that this is the final admission by the workers' compensation insurance carrier in the case, that the claimant may contest this admission if the claimant feels entitled to more compensation, to whom the claimant should provide written objection, and notice to the claimant that *the case will be automatically closed as to the issues admitted in the final*

> *admission if the claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing*, including the selection of an independent medical examiner pursuant to section 8-42-107.2 if an independent medical examination has not already been conducted.

§ 8-43-203(1)(a), (2)(b)(II)(A) (emphasis added). Thus, under the plain and unambiguous language of the statute, a claimant must be given notice of a FAL, and to contest it, must file an objection to the FAL contesting it *and* an application for hearing, or the claim automatically closes and becomes final thirty days after the issuance of a FAL. "The automatic closure of issues raised in an uncontested FAL is 'part of a statutory scheme designed to promote, encourage, and ensure prompt payment of compensation to an injured worker without the necessity of a formal administrative determination in cases not presenting a legitimate controversy.'" *Leewaye v. Indus. Claim Appeals Office*, 178 P.3d 1254, 1256 (Colo. App. 2007) (quoting *Dyrkopp v. Indus. Claim Appeals Office*, 30 P.3d 821, 822 (Colo. App. 2001)). Once a FAL has closed, the issues raised therein cannot be litigated further unless the claim is

reopened pursuant to section 8-43-303. *See Berg v. Indus. Claim Appeals Office*, 128 P.3d 270, 272 (Colo. App. 2005).

C. Where Service of FAL Improper, a Claimant Must Respond Within Thirty Days of Receiving FAL

¶ 22 Dickens contends that he relied on this statutory language unambiguously mandating that objections must be filed within thirty days of a FAL's issuance.[1] He argues that the statutory language leaves no avenue for a claimant to respond to a FAL which has automatically closed, even if the claimant was unaware of the FAL's issuance. In our view, though, Dickens reads the statute too narrowly.

¶ 23 For a FAL to be effective, it must be served on a claimant at the claimant's home address. Specifically, "[section] 8-43-203 and Rule XI(B) require that a final admission be mailed to a claimant's home address, unless the claimant designates another location as the mailing address." *Bowlen v. Munford*, 921 P.2d 59, 61 (Colo. App. 1996). In 1996, when *Bowlen* was announced, Rule XI(B) of the Workers' Compensation Rules of Procedure provided "that,

[1] Dickens clarified, post-argument, his position that the thirty-day deadline does not run until (1) the issue identified for hearing is ripe, and (2) a claimant has been properly served with the FAL.

whenever a document is filed with the Division, a copy of the document shall be mailed 'to each party to the claim' and attorneys of record." *Bowlen*, 921 P.2d at 60. The current version of the rules of procedure incorporates nearly identical language, requiring that "[w]henever a document is filed with the Division, a copy of the document shall be mailed to each party to the claim and attorney(s) of record, if any." Dep't of Labor & Emp't Rule 1-4(A), 7 Code Colo. Regs. 1101-3:1. Mailing a FAL to an incorrect address thus does not effectuate proper service under the applicable rules. *Id.*

¶ 24 The parties do not dispute that the November 2013 FAL was improperly served. Indeed, neither party challenges ALJ Cannici's finding that Dickens received the FAL on April 28, 2014. ALJ Cannici and ALJ Goldman used this receipt date as the trigger for Dickens' timeline to challenge the FAL. Dickens implicitly argues that this was error. Under the express language of the statute, he reasons, the date he received the FAL is meaningless because the only date imbued with any statutory significance is the FAL's mailing date. He goes so far as to argue, without supporting authority, that "defectively served FALs are void, and need to be

amended with a new date and re-served to become effective." But, Dickens' interpretation results in unintended, harsh consequences.

¶ 25 By requiring that claimants receive a copy of a FAL at their home address, *Bowlen* advances the goal of "provid[ing] a method whereby claims arising out of industrial accidents can be speedily resolved." *Bellendir v. Kezer*, 648 P.2d 645, 647 (Colo. 1982). *Bowlen* clarified the service requirement to maximize the "likelihood a claimant will receive notice, without any additional expense to the employer, thereby furthering the legislative goal of assuring the quick and efficient delivery of benefits at a reasonable cost to employers." *Bowlen*, 921 P.2d at 61. *Bowlen*'s interpretation applies a common-sense approach to the statute's implementation and effectuates the service rule.

¶ 26 Interpreting section 8-43-203(2)(b)(II) strictly as claimant insists — imposing a thirty-day deadline to respond to a FAL regardless of if and when a claimant receives it — results in harsh consequences, cutting off claimants who, through no fault of their own, never received notice of a FAL. Moreover, such an interpretation ignores Rule 1-4(a)'s mandate that claimants be served with the FAL. A better approach, which the Panel followed

here, recognizes the need for service and grants improperly served claimants thirty days to respond to an FAL after receiving it.

¶ 27 We are unpersuaded by Dickens' argument that this interpretation of section 8-43-203(2)(b)(II) improperly reads provisions into the Act. It is generally true that we may "not read nonexistent provisions into the . . . Act," *Kraus v. Artcraft Sign Co.*, 710 P.2d 480, 482 (Colo. 1985), and that the "legislature is presumed to be aware of the judicial precedent in an area of law when it legislates in that area." *Vaughan v. McMinn*, 945 P.2d 404, 409 (Colo. 1997). And, courts must "interpret statutes to avoid absurd or illogical results, and 'strive to interpret statutes in a manner that avoids rendering any provision superfluous.'" *The Triple Crown at Observatory Vill. Ass'n v. Vill. Homes of Colo., Inc.*, 2013 COA 150M, ¶ 11 (quoting *Qwest Corp. v. Colo. Div. of Prop. Taxation*, 2013 CO 39, ¶ 16).

¶ 28 The legislature amended subsection (2)(b)(II) in 2010 but took no steps to remove the receipt rule applied in *Bowlen* even though the legislature is presumed to have known about this precedential authority when it amended section 8-43-203(2)(b)(II). *See* Ch. 66, sec. 1, § 8-42-203(2)(b)(II), 2010 Colo. Sess. Laws 232. The

legislature may have recognized it would be absurd and illogical to automatically close a FAL and prevent a claimant from responding to it when the FAL was improperly served and not received. The Act's goal of assuring "the quick and efficient delivery of disability and medical benefits to injured workers," section 8-40-102(1), C.R.S. 2018, is best served by allowing a claimant to respond to an improperly served FAL within thirty days of actually receiving it.

¶ 29 Accordingly, we adopt the Panel's receipt rule and hold that when a FAL has been improperly served, the thirty-day time period mandated by section 8-43-203(2)(b)(II) for a claimant to respond to the FAL begins from the date on which the claimant actually received the FAL. Whether and when a claimant actually received an improperly served FAL is a question of fact to be determined by the ALJ.

D. Applying Receipt Rule to Claimant's Applications for Hearing

¶ 30 ALJ Cannici and ALJ Goldman found that claimant received Wagner's November 2013 FAL on April 28, 2014. The thirty-day window to challenge the FAL started running on April 28, 2014. Dickens timely filed an objection to the FAL on May 22, 2014, but he did not file an application for hearing until June 23, 2014.

Dickens' June 2014 application for hearing only asked the ALJ to determine whether the FAL had been properly served and whether he had timely objected to it. Not until August 2017 — more than three years later — did Dickens request a hearing on claims for medical or disability benefits, more than three years after the deadline had expired. Consequently, Dickens' claims for those benefits closed and could only be asserted if his claim was reopened.

¶ 31 Dickens counters that *Berg* prohibited him from asserting any claims for medical or disability benefits until ALJ Cannici "reopened" his case in July 2017. To be sure, *Berg* specified that "[o]nce a case has closed, the issues resolved by the FAL are not subject to further litigation unless they are reopened pursuant to [section] 8-43-303." *Berg*, 128 P.3d at 272. It is also true that the Act expressly prohibits the assertion of unripe issues: "If an attorney requests a hearing or files a notice to set a hearing on an issue that is not ripe for adjudication at the time the request or filing is made, the attorney may be assessed the reasonable attorney fees and costs of the opposing party in preparing for the hearing or setting." § 8-43-211(3), C.R.S. 2018. Dickens was

undeniably prohibited from asserting unripe claims, then, and risked penalties if he did so.

¶ 32 Contrary to Dickens' assumption, the FAL had not closed thirty days after Wagner issued it because Wagner had not properly served it on him as required by section 8-43-203(1) and Rule 1-4(A). Wagner's improperly served FAL remained open for thirty days after Dickens received it on April 28, 2014.

¶ 33 Within that thirty-day window, Dickens filed an objection to Wagner's FAL. But he neglected to also file an application for hearing. His first application for hearing — which did not challenge the substance of the FAL — was not filed until nearly two months after he received the FAL. And, that application for hearing did not challenge any of the issues addressed in the FAL. The FAL thus automatically closed on May 28, 2014, thirty days after Dickens received it.

¶ 34 Accordingly, we hold that ALJ Goldman and the Panel correctly concluded that Wagner's FAL closed in May 2014 because Dickens did not file an application for hearing challenging the issues raised in the FAL within thirty days of receiving it on April 28, 2014.

III. Claim Preclusion

¶ 35 As we understand Dickens' next argument, he contends that claim preclusion barred Wagner from asserting before ALJ Goldman that Dickens had "lost his right to claim any benefits by not listing them as ripe issues in his original application for hearing" because Wagner had not raised this defense before ALJ Cannici. In other words, Dickens essentially argues that Wagner should have raised a defense to his claims for medical and disability benefits before ALJ Cannici, even though he had not yet asserted them. He reasons that Wagner was barred from raising this defense because the doctrine of claim preclusion bars a party from reasserting, in a later proceeding, claims raised and claims it could have raised in the previous action.

¶ 36 We need not address this contention, however, because, as Wagner and the Panel point out, although Dickens raised claim preclusion in his brief to the Panel, he did *not* raise this argument before ALJ Goldman. The failure to raise an issue before the ALJ renders the issue unpreserved. *See City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997).

¶ 37 Because claimant did not raise the issue of claim preclusion before ALJ Goldman, he did not preserve the issue for our review, and we decline to address it further. *Id.*

IV. Proportionality

¶ 38 Dickens next contends that ALJ Goldman's order violated principles of proportionality because it effectively deprived him of medical and disability benefits. He argues that ALJ Goldman's "very harsh" application of the law based on a "harmless technical flaw" deprived him of the opportunity to "full[y] and fair[ly] explor[e]" the merits of his claims. We are not persuaded.

¶ 39 First, the proportionality rule upon which Dickens relies applies to discovery sanctions imposed pursuant to C.R.C.P. 37(c)(1). *See Catholic Health Initiatives Colo. v. Earl Swensson Assocs., Inc.*, 2017 CO 94, ¶ 15 ("[W]e hold that the harm and proportionality analysis under Colorado Rule of Civil Procedure 37(c)(1) remains the proper framework for determining sanctions for discovery violations." (citing *Todd v. Bear Valley Vill. Apartments*, 980 P.2d 973, 978 (Colo. 1999))). It is not, as Dickens suggests, a general principle of fairness to be applied to all cases. Rather, the doctrine ensures fairness in discovery sanctions.

¶ 40 Second, even if we applied the doctrine here, we would not reach a different result. In addressing the goals achieved by the automatic closure of claims, a division of this court observed

> [Section 8-43-203(2)(b)(II)] is part of a statutory scheme designed to promote, encourage, and ensure prompt payment of compensation to an injured worker without the necessity of a formal administrative determination in cases not presenting a legitimate controversy. Applying time limits to a claimant's right to contest closure is rational and advances that purpose.

Olivas-Soto v. Indus. Claim Appeals Office, 143 P.3d 1178, 1179 (Colo. App. 2006). Disregarding this objective in favor of fairness and proportionality as Dickens asks us to do would thus frustrate one the Act's goals.

V. Reopening

¶ 41 Having determined that Dickens' claim closed thirty days after he admittedly received it, we proceed to Dickens' final contention: that ALJ Goldman erred in denying his reopening request. Dickens argues that (1) his petition to reopen was "rendered moot" by ALJ Cannici's "reopen[ing of] the case based upon his conclusion of defective notice of the FAL" and that ALJ Goldman therefore should not have ruled upon it; and (2) in ruling on the petition to reopen,

ALJ Goldman improperly imposed the burden of proof on Dickens. Specifically, he argues that his physicians' "assessments concerning the relatedness of Claimant's injuries and treatment should control, unless disproved by Respondents." Neither of these arguments persuade us to set aside this portion of the Panel's Final Order.

A. Law Governing Reopening

¶ 42 As we stated above, "[o]nce a case has closed, the issues resolved by the FAL are not subject to further litigation unless they are reopened pursuant to [section] 8-43-303." *Berg*, 128 P.3d at 272. To reopen a claim, a claimant must show error, mistake, or change in condition. § 8-43-303(1); *Berg*, 128 P.3d at 272. Importantly, the party seeking to reopen a claim bears the burden of proving the need to reopen. *See* § 8-43-303(4).

B. Mootness

¶ 43 "Mootness instructs courts not to grant relief that would have no practical effect upon an actual and existing controversy." *Bd. of Dirs., Metro Wastewater Reclamation Dist. v. Nat'l Union Fire Ins. Co.*, 105 P.3d 653, 656 (Colo. 2005). The doctrine "prevents a court from deciding a case when there is no 'actual or existing controversy.'" *Developmental Pathways v. Ritter*, 178 P.3d 524, 530

(Colo. 2008) (quoting *Metro Wastewater Reclamation Dist.*, 105 P.3d at 656)). "Whether an appeal is moot is a question of law that we review de novo." *People v. Fritz*, 2014 COA 108, ¶ 20.

¶ 44 We have already determined that Dickens' claims for medical and disability benefits closed when he failed to file an application for hearing within thirty days of receiving Wagner's FAL. ALJ Cannici's order addressed whether Dickens' objection to the FAL was timely — it was — but did not consider the timeliness or scope of Dickens' application for hearing. Indeed, as we have already noted, Dickens did not file an application for hearing requesting medical and disability benefits until more than three years after receiving the FAL. Consequently, the FAL was closed and a petition to reopen was appropriate and not moot. ALJ Goldman therefore did not violate the principles of mootness by ruling on reopening.

C. Burden of Proof

¶ 45 Dickens asserts — without any supporting authority — that Wagner bore the burden of disproving Dickens' entitlement to benefits. He is mistaken.

¶ 46 The Act unambiguously places the burden of proving the need to reopen a claim on the party seeking reopening. The Act

mandates that "[t]he party attempting to reopen an issue or claim shall bear the burden of proof as to any issues sought to be reopened." § 8-43-303(4); *accord. Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323, 330 (Colo. 2004) ("A claimant has the burden of proof in seeking to reopen a claim for a worsened condition."); *Kilpatrick v. Indus. Claim Appeals Office*, 2015 COA 30, ¶ 43; *Heinicke v. Indus. Claim Appeals Office*, 197 P.3d 220, 222 (Colo. App. 2008); *Berg*, 128 P.3d at 272. In addition, the Act places the burden of proving entitlement to benefits on injured workers requesting them: "A claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence." § 8-43-201(1), C.R.S. 2018.

¶ 47 We decline Dickens' invitation to stray from the statutorily-mandated burden of proof placed upon him, and hold that ALJ Goldman committed no error when he imposed the burden of proving the need to reopen on Dickens.

D. Substantial Evidence Supports the Denial of Dickens' Petition to Reopen

¶ 48 Last, although Dickens professes not to have appealed "the validity of [ALJ Goldman's] factual determinations," he nevertheless

argues that ALJ Goldman denied his reopening request over the opinions of two physicians who related Dickens' back condition to his "11 year history of a chronic antalgic gait secondary to his knee injury." To the extent Dickens is challenging ALJ Goldman's findings of fact regarding reopening, we may not reweigh the evidence. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995).

¶ 49 The reopening statute provides that an ALJ "*may* . . . review and reopen any award . . . ." § 8-43-303(1) (emphasis added). Because reopening is permissive, section 8-43-303 "leaves to the ALJ's sound discretion the question of whether reopening is warranted in a particular case." *Heinicke*, 197 P.3d at 223. An ALJ's decision to grant or deny a petition to reopen may therefore "be reversed only for fraud or clear abuse of discretion." *Wilson v. Jim Snyder Drilling*, 747 P.2d 647, 651 (Colo. 1987). "In the absence of fraud or clear abuse of discretion, the ALJ's decision concerning reopening is binding on appeal." *Heinicke*, 197 P.3d at 222.

¶ 50 As Dickens points out, two of his treating physicians opined that his chronic antalgic gait led to his back condition. But, Dr.

Ridings, Wagner's retained medical expert, expressed a contrary opinion. Although he agreed Dickens "had increased complaints of low back pain," he doubted Dickens' antalgic gait "worsen[ed] any of the degenerative changes in his spine." Likewise, he disagreed that Dickens' spinal fusion was warranted or related to the work injury. The record, then, contains evidence countering Dickens' treating physicians' opinions.

¶ 51 Reopening is permitted for a *change* in condition. Dickens himself testified that his condition has remained unchanged since the accident. He conceded that he has walked with an antalgic gait necessitating a cane since his 2006 surgery; he has "had these problems with [his] back since [he] fell and hurt [his] knee in 2006"; the spinal fusion surgery "didn't help" him; "nothing that the doctors have done" has improved his condition; and, importantly, his condition has been "bad" and he has been "totally disabled" since the accident. This testimony — particularly that his condition has remained "bad" since 2006 — undercuts Dickens' claim that his condition worsened and warranted reopening.

¶ 52 Because evidence in the record supports ALJ Goldman's decision, we conclude that he neither abused his discretion nor

committed fraud when he denied Dickens' petition to reopen. *See id.*

VI. Conclusion

¶ 53 For the reasons set forth above, we hold that Wagner's improperly-served FAL closed in 2014 because Dickens failed to file an application for hearing challenging the issues raised in the FAL within thirty days of receiving it. In addition, we perceive no basis for setting aside the denial of Dickens' petition to reopen his claim.

¶ 54 The Panel's order is affirmed.

JUDGE FREYRE and JUDGE WELLING concur.

DATE FILED: June 20, 2019
CASE NUMBER: 2018CA1990

SUMMARY
June 20, 2019

2019COA94

No. 18CA1990, *Baum v. Industrial Claim Appeals Office* — Labor and Industry — Workers' Compensation — Benefits — Wage Continuation Plans

In this workers compensation case, a division of the court of appeals interprets the phrase "other similar benefits" used in connection with "earned vacation leave" and "sick leave" in section 8-42-124(2)(a), C.R.S. 2018, of the of the Workers' Compensation Act (Act). The division concludes that earned benefits that an employee can exercise only in the event that he or she suffers a work-related injury and that cannot otherwise be converted to any other use or cashed out at separation do not fall within the scope of "other similar benefits" as used in section 8-42-124(2)(a).

Based on this interpretation of the statute and the rejection of the claimant's constitutional challenges to the Act, the division affirms the order of the Industrial Claim Appeals Office.

COLORADO COURT OF APPEALS **2019COA94**

Court of Appeals No. 18CA1990
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-961-870

Jason Baum,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and United Airlines,

Respondents.

ORDER AFFIRMED

Division VI
Opinion by JUDGE WELLING
Freyre and Márquez*, JJ., concur

Announced June 20, 2019

Turner, Roepke & Mueller, LLC, Robert W. Turner, Greenwood Village, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., Alana S. McKenna, M. Holly Colvin Herring, Denver, Colorado, for Respondent United Airlines

*Sitting by assignment of the Chief Judge under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2018.

¶ 1 Claimant, Jason Baum, appeals the final order of the Industrial Claims Appeal Office affirming the summary judgment of the director of the Division of Workers' Compensation in favor of self-insured employer, United Airlines (UAL).

¶ 2 This workers' compensation action calls on us to clarify the boundary between where an employer can and cannot take credit for having an approved wage continuation plan under section 8-42-124, C.R.S. 2018. Here, UAL paid Baum full pay under its wage continuation plan after he sustained an admitted work-related injury, but UAL also claimed a credit on its final admission of liability (FAL) for the comparable temporary total disability (TTD) benefits it would have otherwise been statutorily required to pay Baum. This credit increased Baum's reported TTD benefits, pushing them over the statutory cap set by section 8-42-107.5, C.R.S. 2018. Baum challenged UAL's right to take the credit. But both the director of the Division of Workers' Compensation (Division) and the Industrial Claim Appeals Office (Panel) held that UAL acted within its rights in taking the credit. Because we, too, conclude that UAL was entitled to take the credit, we affirm.

I. Background Facts

¶ 3 Baum sustained admitted, work-related injuries on September 7, 2014. His injuries caused him to be temporarily totally disabled and off work until July 2016. He was placed at maximum medical improvement (MMI) with a permanent impairment rating of 2% of the whole person on September 25, 2016.

¶ 4 For the first nine months after his injury — until June 17, 2015 — UAL paid Baum his full salary under its wage continuation plan. After Baum's earned benefits under the wage continuation plan ran out in June 2015, UAL paid him TTD benefits pursuant to section 8-42-105, C.R.S. 2018, until July 29, 2016. Unlike the benefits Baum received under UAL's wage continuation plan, the TTD benefits he received from June 2015 to July 2016 were paid at the lower statutorily mandated rate of two-thirds of Baum's average weekly wage. *See* § 8-42-105.

¶ 5 In the FAL it filed after Baum reached MMI, UAL calculated that it had overpaid Baum TTD benefits by $1459.83.[1] It also took

[1] The Director correctly determined that UAL miscalculated the overpayment by $1.16. The correct overpayment amount is $1458.67.

the position that Baum was not entitled to any compensation for his 2% whole person permanent impairment because the calculated TTD payments exceeded the statutory cap set by section 8-42-107.5 for combined TTD and permanent partial disability (PPD) benefits. UAL calculated this sum by adding the amount it had paid Baum in TTD benefits from June 2015 to July 2016 ($48,944.85) and the amount it *would have paid* Baum in TTD benefits from September 2014 to June 2015 ($33,949.49) had it not been paying him his full salary during those nine months under its wage continuation plan. In other words, UAL took credit on the FAL for TTD payments it would have made but for its wage continuation plan. The calculated TTD benefits totaled $82,894.34, which exceeds the applicable statutory cap of $81,435.67 by $1458.67.

¶ 6 Baum objected to UAL's claim of an overpayment, imposition of the statutory cap, and claimed credit for TTD benefits he did not receive. He filed an application for hearing, seeking TTD from the date of his injury until June 17, 2015, the day he exhausted his wage continuation benefits, as well as full payment of the PPD benefits he would otherwise receive for his 2% whole person impairment.

¶ 7 UAL filed a motion for summary judgment, arguing that its wage continuation plan was valid and had been approved by the director and in constant operation since 1973. It also argued that because Baum received his full pay under the plan and the plan "did not impair . . . [his] earned sick or vacation benefits," it was expressly entitled to claim a TTD credit by section 8-42-124(2)(a).

¶ 8 The director of the Division agreed. He rejected Baum's contention that benefits paid under the wage continuation plan were similar to vacation or sick leave. Instead, the director concluded that because benefits under the wage continuation plan could not be accessed at an employee's discretion or for a purpose other than compensation for a work-related injury — a UAL employee can tap benefits earned under the wage continuation plan "only when they have suffered an injury 'covered by the applicable state workers' compensation law'" — the benefits were *not* similar to vacation or sick leave. Therefore, their accrual and exercise did not bar UAL from taking the claimed TTD credit. The director further concluded that because UAL properly claimed the credit, Baum's benefits exceeded the statutory cap and he was not entitled to

receive any PPD benefits or TTD benefits for the period September 8, 2014, to June 17, 2015.

¶ 9 The Panel affirmed on review. It, too, rejected Baum's argument that wage continuation benefits accrued under UAL's plan are "similar" to vacation or sick leave. Because it concluded that wage continuation benefits are different from vacation and sick leave, UAL properly took the credit for TTD benefits and Baum was not entitled to any additional benefits.

II. Wage Continuation Plans

¶ 10 To give context to how we address Baum's contentions, a brief explanation of wage continuation plans authorized by section 8-42-124 of the Workers' Compensation Act (Act) is helpful. Although most injured workers receive TTD benefits under the Act, it authorizes — and to some extent, incentivizes — employers to adopt a plan that pays injured workers *more* benefits than they would have received in TTD benefits. In this regard, the Act states as follows:

> Any employer . . . who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the [TTD] benefits prescribed by articles 40 to 47 of this title to any employee

> temporarily disabled as a result of any injury arising out of and in the course of such employee's employment *and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits* shall be reimbursed if insured by an insurance carrier or *shall take credit if self-insured to the extent of all moneys that such employee may be eligible to receive as compensation or benefits for temporary partial or temporary total disability* under the provisions of said articles, subject to the approval of the director.

§ 8-42-124(2)(a) (emphasis added). As pertinent here, the provision expressly permits an employer to establish a plan that pays an injured worker unable to work because of a temporarily disabling work injury more than the worker would have received in TTD benefits under section 8-42-105.

¶ 11 The Act incentivizes employers to create such plans by permitting the participating self-insured employers to "take credit" on their admission forms for the equivalent amount the employer would have paid in TTD or temporary partial disability benefits if not for the employer's wage continuation plan. § 8-42-124(2)(a). Insured participating employers are entitled to a reimbursement from the insurer of the equivalent TTD amount. *Id.* However, if the employer "charge[s]" the injured worker "with any earned vacation

leave, sick leave, *or other similar benefits*" during the time of disability — in other words, if the employer makes the worker use vacation time or sick time while unable to work because of the work-related injury — then the employer *cannot* take advantage of the credit on its admission form or seek reimbursement from the insurer. *See id.*

¶ 12 With this framework in mind, we turn first to Baum's constitutional challenges to section 8-42-124, followed by the statutory interpretation issue previewed at the start of this opinion.

III. Constitutional Challenges

¶ 13 Baum first argues that section 8-42-124 is unconstitutional "on its face and as applied" because the plan was approved by the director without the opportunity for injured workers to challenge the plan in court. He contends that the lack of "appellate review" denied him his property interest in workers' compensation benefits without due process. He further contends that the absence of appellate review of approved wage continuation plans renders the statute unconstitutional on its face and violates the separation of powers in Article 3 of the Colorado Constitution. We are not persuaded by these arguments.

A. Law Governing Due Process Analysis and Standard of Review

¶ 14 "The fundamental requisites of due process are notice and the opportunity to be heard by an impartial tribunal." *Wecker v. TBL Excavating, Inc.*, 908 P.2d 1186, 1188 (Colo. App. 1995). "The essence of procedural due process is fundamental fairness." *Avalanche Indus., Inc. v. Indus. Claim Appeals Office*, 166 P.3d 147, 150 (Colo. App. 2007), *aff'd sub nom. Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008); *see also Kuhndog, Inc. v. Indus. Claim Appeals Office*, 207 P.3d 949, 950 (Colo. App. 2009) (Due process "requires fundamental fairness in procedure.").

¶ 15 A claimant asserting that a statute is unconstitutional must demonstrate that the statute "is unconstitutional beyond a reasonable doubt." *Peregoy v. Indus. Claim Appeals Office*, 87 P.3d 261, 265 (Colo. App. 2004). And, when analyzing the statute's constitutionality, we must begin with the presumption "that the statute is valid." *Calvert v. Indus. Claim Appeals Office*, 155 P.3d 474, 477 (Colo. App. 2006).

¶ 16 "This court has initial jurisdiction to address constitutional challenges to the [Act]." *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 8.

B. Baum Cannot Establish That He Was Deprived of a Protected Interest Without Due Process

¶ 17 To prove a due process claim, a claimant must first meet the threshold burden of establishing a deprivation of a protected interest:

> "The first inquiry in every due process challenge is whether the plaintiff has been deprived of a protected interest in 'property' or 'liberty.'" It is necessary to consider whether a property right has been identified, whether government action with respect to that property right amounted to a deprivation, and whether the deprivation, if one is found, occurred without due process of law.

Whatley v. Summit Cty. Bd. of Cty. Comm'rs, 77 P.3d 793, 798 (Colo. App. 2003) (quoting *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 59 (1999)).

¶ 18 Baum cannot meet this burden. He asserts that he was deprived of a property interest without due process when the director approved UAL's wage continuation plan. We agree with Baum that "once an admission of liability was entered" he had a vested property right under the Act, albeit not a fundamental right. *See Dillard v. Indus. Claim Appeals Office*, 134 P.3d 407, 413 (Colo. 2006) ("Access to Workers' Compensation benefits is not a

fundamental right."); *Whiteside v. Smith*, 67 P.3d 1240, 1247 (Colo. 2003) ("The substantive right to workers' compensation is a constitutionally protected property interest.").

¶ 19 Baum contends, though, that he was deprived of his right to benefits without due process when the director "establish[ed] and approve[d] [UAL's] wage continuation plan without appellate review." The fatal flaw in Baum's argument, however, is that it fails to account for the fact that UAL's plan was adopted and approved long before he sustained any injury. The record reflects that the director approved the plan in 2006 and renewed it in 2017. The 2017 approval letter the director sent to UAL stated, "Our records indicate that your plan was originally effective September 14, 1973 and was updated July 21, 2006." Importantly, when UAL's plan was approved in 1973 or even in 2006, Baum *did not have a property right*. This is so because he was not injured, and UAL did not admit liability, until September 2014. And the record indicates that the 2006 approval was simply continued in 2017 because any changes to the plan were minimal. Consequently, Baum cannot meet the threshold test of being deprived of a property interest

without due process when the plan was approved because he had no such interest at that time. *See Whatley*, 77 P.3d at 798.

¶ 20 Baum attempts to sidestep this issue by highlighting distinctions between the plan approved in 2006 and that approved in 2017, implying that additional measures, up to and including a hearing, should have occurred in 2017. The wage continuation plan in place in 2014 was part of the negotiated 2013-2016 Fleet Services Agreement reached between UAL and the International Association of Machinists and Aerospace Workers (IAMAW). Representatives of both UAL and the IAMAW signed the agreement, which went into effect November 1, 2013. However, according to the affidavit of the assistant general chairman of the IAMAW, the only substantial difference between the agreement in effect in 2006 and the 2013-2016 Fleet Services Agreement is that the applicable benefits under the latter are deducted at the rate of forty hours per week, rather than at the rate of thirteen and one-third hours per week as they were in 2006. According to the assistant general chairman, the change was made because previously benefits under the wage continuation plan — called occupational injury leave or

OIL[2] — supplemented TTD benefits to make an injured worker's salary whole. Under the 2013 agreement, "the occupational bank is used in place of payment of any TTD benefits."

¶ 21 Baum contends that this change — which inarguably depletes his bank of OIL benefits at a faster rate than before — deprived him of his protected property interest because neither he nor any other worker was given an opportunity to challenge the plan and its approval in court. But, as UAL points out, the change was not imposed by UAL alone. Rather, it was a negotiated agreement approved by representatives of the IAMAW. Thus, through his union representatives, Baum had a seat at the table at which the agreement modifying the plan was negotiated.

¶ 22 As pertinent to Baum's due process challenge, though, the plan's adoption did not necessitate appellate or judicial review because it did not create any protected property rights; instead, the wage continuation plan simply establishes a means for UAL to administer benefits to its injured employees — and to do so at a

[2] OIL is not a term of art under the Act. Instead, it is simply the nomenclature used by UAL to describe the benefits it provides its employees under its wage continuation plan.

rate greater than TTD benefits required to be paid under the Act. Conversely, adoption of the 2013-2016 Fleet Services Agreement could not deprive Baum of any property right because his property right in the benefit did not arise until his work-related injury — which occurred after UAL and the IAMAW adopted the agreement.

¶ 23 Accordingly, we reject Baum's contention that he was deprived of a property right without due process. *See id.*

C. Baum Cannot Establish a Violation of the Separation of Powers Doctrine

¶ 24 Baum's separation of powers challenge also fails. He argues that the legislature violated the separation of powers doctrine when it approved section 8-42-124 without including a process for judicial review of wage continuation plans. We disagree.

¶ 25 As Baum acknowledges, "the Act has been previously subjected to separation of powers scrutiny by the courts." No court has ever determined that the Act violates the doctrine. To the contrary, each time the Act has been challenged for allegedly violating the separation of powers doctrine, no constitutional violation was found. In each case, a division of this court concluded that appellate review of workers' compensation claims

ensures that any errors committed by administrative law judges (ALJ) or the Panel can be corrected by a court. *See Sanchez v. Indus. Claim Appeals Office*, 2017 COA 71, ¶¶ 11-12; *Dee Enters. v. Indus. Claim Appeals Office*, 89 P.3d 430, 433 (Colo. App. 2003); *MGM Supply Co. v. Indus. Claim Appeals Office*, 62 P.3d 1001, 1004 (Colo. App. 2002).

¶ 26 Even so, Baum contends that no court has considered whether the lack of judicial review for approval of wage continuation plans under section 8-42-124 violates the separation of powers. "Article III of the Colorado Constitution prohibits one branch of government from exercising powers that the constitution vests in another branch." *Dee Enters.*, 89 P.3d at 433. "The separation of powers doctrine does not require a complete division of authority among the three branches, however, and the powers exercised by different branches of government necessarily overlap." *Id.*

¶ 27 The separation of powers doctrine does not, as Baum contends, guarantee that the judicial branch will be granted oversight over every action taken by any governmental entity in the state. Rather, it prohibits one governmental branch from usurping or exercising powers vested in another branch. *Id.*

¶ 28 In adopting section 8-24-124, the legislature did not grant itself the power to approve wage continuation plans. Instead, it vested that authority in another branch — the executive branch — by making wage continuation plans subject to the director's approval. § 8-42-124(2)(a). The plan at issue here, with minor changes, has been continuously approved by the director since 1973.

¶ 29 And, contrary to Baum's premise, the judicial branch has not been excluded from reviewing these plans or section 8-42-124. We are, in fact, reviewing aspects of UAL's plan in this very case, and aspects of other wage continuation plans have been reviewed extensively by previous divisions of this court. *See City & Cty. of Denver v. Indus. Claim Appeals Office*, 107 P.3d 1019, 1022 (Colo. App. 2004) (permitting employers who provide wage continuation plans to take credit for TTD payments by reinstating earned vacation or sick benefits after determining that an injury is compensable under the Act); *Pub. Serv. Co. v. Johnson*, 789 P.2d 487, 489 (Colo. App. 1990) (rejecting the employer's contention that prohibiting employers who charge injured workers with earned sick or vacation leave while the worker is disabled from taking a TTD

credit results in double compensation). Such subsequent court review of an agency action is appropriate because any review conducted earlier in the process — before property rights arise — would violate the prohibition against courts considering a matter absent an actual case or controversy. *See Colo. Gen. Assembly v. Lamm*, 700 P.2d 508, 515-16 (Colo. 1985) ("Whether a particular plaintiff has standing to invoke the jurisdiction of the courts is a preliminary inquiry designed to ensure that the judicial power is exercised only in the context of a case or controversy.").

¶ 30 For these reasons, we conclude that the approval of section 8-42-124 did not violate the separation of powers doctrine.

IV. Statutory Interpretation

¶ 31 Baum next contends that the Panel erroneously affirmed the director's grant of summary judgment to UAL. He argues that the director misinterpreted section 8-42-124 when he concluded that UAL's wage continuation program benefits did not fall under the statute's residual provision of "other similar benefits." *See* § 8-42-124(2)(a). As explained above, section 8-42-124(2)(a) entitles UAL to take TTD credit for the period it paid Baum OIL under its wage continuation plan, so long as it did not charge Baum for vacation

leave, sick leave, "or other similar benefits" during the period he was unable to work.

¶ 32 Baum argues that the similarities between OIL benefits, on the one hand, and sick and vacation leave, on the other hand, render the OIL benefits sufficiently similar to land them under the canopy of "other similar benefits." He notes that like vacation and sick leave, OIL benefits under UAL's wage continuation plan are earned and accrue at the rate of eight hours per month — coincidentally the same rate that Baum accrues sick leave. Also, like sick leave, OIL is used up at the rate of forty hours per week when an injured worker is unable to work. Finally, Baum points out that if a worker runs out of OIL, sick leave can be converted to OIL, and vacation leave can be converted to sick leave. In other words, a worker short on OIL can — but is not required to — dip into earned benefits from the sick and vacation banks to extend OIL. Listing these similarities, Baum asks, then, "are the benefits indeed not similar in nature?" Like the director and the Panel, we conclude that these similarities are insufficient to categorize OIL as "other similar benefits."

A. Law Governing Summary Judgment and Standard of Review

¶ 33 "[S]ummary judgment may be sought in a workers' compensation proceeding before the ALJ." *Fera v. Indus. Claim Appeals Office*, 169 P.3d 231, 232 (Colo. App. 2007). Under Office of Administrative Courts Rule of Procedure (OACRP) 17, 1 Code Colo. Regs. 104-3, a party may move "for summary judgment seeking resolution of any endorsed issue for hearing." Like a motion for summary judgment pursued under C.R.C.P. 56, summary judgment may be granted in a workers' compensation case if "there is no disputed issue of material fact and . . . the party is entitled to judgment as a matter of law." OACRP 17; *see also Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 802 (Colo. App. 1988) (noting that the Colorado Rules of Civil Procedure apply to workers' compensation proceedings unless inconsistent or in conflict with the procedures and practices followed under the Act).

¶ 34 We review an ALJ's legal conclusions on summary judgment de novo. *See A.C. Excavating v. Yacht Club II Homeowners Ass'n*, 114 P.3d 862, 865 (Colo. 2005). However, we may only set aside an ALJ's factual findings if they are unsupported by substantial evidence in the record. § 8-43-308, C.R.S. 2018.

> We must therefore accept the ALJ's statements of undisputed facts . . . if substantial evidence in the record supports that statement of facts, but we must set aside the grant of summary judgment in an employer's favor if we determine that conflicts in the evidence are not resolved in the record or the order is not supported by applicable law.

Fera, 169 P.3d at 233.

B. Rules of Statutory Construction and Standard of Review

¶ 35 When we analyze a provision of the Act, "we interpret the statute according to its plain and ordinary meaning" if its language is clear. *Davison v. Indus. Claim Appeals Office*, 84 P.3d 1023, 1029 (Colo. 2004). In addition, "when examining a statute's language, we give effect to every word and render none superfluous because we 'do not presume that the legislature used language idly and with no intent that meaning should be given to its language.'" *Lombard v. Colo. Outdoor Educ. Ctr., Inc.*, 187 P.3d 565, 571 (Colo. 2008) (quoting *Colo. Water Conservation Bd. v. Upper Gunnison River Water Conservancy Dist.*, 109 P.3d 585, 597 (Colo. 2005)).

¶ 36 We review issues of statutory construction de novo. *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff'd*, 145 P.3d 661 (Colo. 2006). Although we defer to the Panel's

reasonable interpretations of the statute it administers, *Sanco Indus. v. Stefanski*, 147 P.3d 5, 8 (Colo. 2006), we are "not bound by the Panel's interpretation" or its earlier decisions, *United Airlines v. Indus. Claim Appeals Office*, 2013 COA 48, ¶ 7; *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006). "The Panel's interpretation will, however, be set aside 'if it is inconsistent with the clear language of the statute or with the legislative intent.'" *Town of Castle Rock v. Indus. Claim Appeals Office*, 2013 COA 109, ¶ 11 (quoting *Support, Inc. v. Indus. Claim Appeals Office*, 968 P.2d 174, 175 (Colo. App. 1998)), *aff'd*, 2016 CO 26.

C. OIL Benefits Do Not Constitute "Other Similar Benefits" Under Section 8-42-124(2)(a)

¶ 37 Baum maintains that the similarities he describes make OIL benefits analogous to sick and vacation leave under UAL's Fleet Service Agreement. But, the director and the Panel reached a different conclusion. Although we interpret statutes de novo, we give considerable weight to the Panel's interpretation of the Act and stray from it only if the Panel's construction is inconsistent with the

clear language of the statute or the legislative intent. *See Town of Castle Rock*, ¶ 11.

¶ 38 We conclude that the Panel's and the director's interpretation is consistent with the legislature's objectives and intent. In our view, a critical difference removes OIL from under the umbrella of "other similar benefits" under section 8-42-124. That significant difference, which both the director and the Panel found compelling, is that that OIL benefits can *only* be accessed by an injured worker once UAL has admitted a work-related injury is compensable or an ALJ has found a claim to be compensable. The Fleet Services Agreement states that it applies only to injuries or illnesses "covered by the applicable state Workers' Compensation law, and must be verified in writing by the employee's treating physician." Unlike vacation and sick leave, then, use of OIL is not discretionary or flexible. Simply put, it can be accessed under one circumstance only: when a worker has suffered a compensable work-related injury.

¶ 39 Another difference between OIL and vacation or sick leave under UAL's Fleet Service Agreement is that a UAL worker who separates from employment is paid a lump sum for unused vacation

leave. OIL, in contrast, is simply lost: "If an employee's employment ceases for any reason, all of his or her credit for [OIL] will be cancelled, and no payment for such accumulated credit will be made at any time."

¶ 40 Notably, too, as a division of this court observed in *Public Service Co.*, the very nature of OIL benefits sets them apart from "vacation leave, sick leave, or other similar benefits." *Pub. Serv. Co.*, 789 P.2d at 488. "Indeed, it is generally recognized that vacation and sick pay are benefits earned by virtue of past services rendered and that, as such, these 'earned' benefits should not be impaired by the employee's work-related injury." *Id.* at 489. In contrast, OIL benefits — while, in this case, earned — are expressly intended to be used when — and only when — a worker suffers a work-related injury; their use does not "impair" the use of other earned benefits that can be exercised under other circumstances or cashed out at separation. Put differently, by using his OIL when he suffered a work-related injury, Baum did not impair or make his OIL benefit unavailable for another use.

¶ 41 Nor did Baum have to sacrifice any of his earned vacation or sick leave during his time of disability because OIL is drawn from a

separate pool of benefits. It is drawn from a separate bank and its use insulates workers from depleting their sick or vacation leave because of a compensable work-related injury.

¶ 42 Baum suggests that because UAL's wage continuation plan permits injured workers to convert sick leave into OIL, the benefits are "similar" under the statute.[3] However, UAL never requires a worker to use sick leave in this way. Although a worker who exhausts his or her earned OIL "may elect to convert any remaining sick bank hours into occupational injury hours," no injured worker is required to do so. An injured worker may instead choose to keep all his or her earned vacation and sick leave for future use or payout. Conversion is therefore entirely within the injured worker's discretion and its use does not forcibly "impair" the worker's earned benefits. *See id.*

[3] Baum's conversion argument would pack some persuasive punch if he were able to convert OIL into vacation or sick leave. But the conversion option is a one-way street: from vacation to sick leave and from sick leave to OIL — not the other direction. Thus, OIL does not enjoy the conversion flexibility accorded by UAL to its vacation and sick leave.

¶ 43 These differences are significant enough to exclude OIL benefits from the umbrella of "other similar benefits" under section 8-42-124(2)(a).

¶ 44 We note, too, that accepting Baum's characterization of UAL's OIL benefit would swallow wage continuation plans, rendering section 8-42-124(2)(a) practically meaningless. If plans like UAL's OIL benefit are barred from enjoying a TTD credit, then we have trouble envisioning what plan would fall within the statute's purview. Section 8-42-124's TTD credit was intended to motivate and encourage employers to fully compensate injured workers over and above the two-thirds average weekly wage guaranteed by the Act. *See* § 8-42-105. Any incentive an employer has for creating wage continuation plans — which unquestionably benefit workers by paying them more than TTD or even, as here, their full salary while disabled — would vanish if the mere fact that wage continuation plan benefits are accrued and earned makes them too similar to vacation and sick leave to qualify for the TTD credit. Baum's proposed interpretation would, thus, violate the prohibition against rendering a statutory provision meaningless. *See Chavez v.*

People, 2015 CO 62, ¶ 21 ("We strive to avoid interpretations that would render statutory language meaningless.").

¶ 45 For these reasons, we agree with the Panel and the director and reject Baum's contention that OIL benefits paid him under UAL's wage continuation plan constituted "other similar benefits" under section 8-42-124(2)(a). *See Town of Castle Rock*, ¶ 11.

D. UAL Did Not Garner a Windfall

¶ 46 Last, we address Baum's contention that UAL enjoys a windfall unless it is barred from taking a credit for TTD benefits under this circumstance. It is undisputed that taking credit for TTD benefits during the time Baum was paid OIL benefits triggered the statutory cap and eliminated any PPD benefits Baum may have otherwise received. § 8-42-107.5. But that does not constitute a windfall in UAL's favor. Baum received his full pay while being paid OIL. The legislature sought to encourage employers to implement wage continuation plans so that workers could receive a full salary even while disabled by a work-related injury. We do not perceive that by taking the statutorily authorized credit, UAL enjoyed a windfall. Indeed, during a portion of Baum's absence from work UAL paid him more than the minimum required by the Act.

¶ 47 To the extent Baum is also demanding payment of the TTD benefits to him, these would be over and above the full salary he received under OIL while on work-related disability leave. In other words, Baum would receive nearly $34,000 *more* than his salary, *plus* a PPD benefit payout in excess of $9000. That could be characterized as a windfall benefiting Baum.

¶ 48 In summary, we conclude that neither the director nor the Panel misinterpreted section 8-42-124 when ruling that UAL was entitled to take a credit for the $33,949.49 Baum would have received in TTD payments during the time he was paid OIL benefits. *Id.*

V. Conclusion

¶ 49 The order is affirmed.

JUDGE FREYRE and JUDGE MÁRQUEZ concur.

COLORADO COURT OF APPEALS

DATE FILED: June 27, 2019
CASE NUMBER: 2018CA952

Court of Appeals No. 18CA0952
Industrial Claim Appeals Office of the State of Colorado
WC No. 3-840-625

Christel Schroeder,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Thorn EMI North America; and Federal Insurance Company,

Respondents.

ORDER AFFIRMED

Division V
Opinion by JUSTICE MARTINEZ*
Bernard, C.J. and Rothenberg*, J., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced June 27, 2019

Christel Schroeder, Pro se

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., Kristin A. Caruso, Denver, Colorado, for Respondents Thorn EMI America and Federal Insurance Company

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2018.

¶ 1 In this workers' compensation case, claimant, Christel Schroeder, appearing pro se, seeks review of a final order of the Industrial Claim Appeals Office (Panel), affirming and modifying the order of an administrative law judge (ALJ) denying and dismissing claimant's claim for medical maintenance benefits from July 26, 2015, through November 15, 2017. We affirm.

I. Background

¶ 2 Claimant sustained admitted, compensable injuries in a fall at work in 1986. She began receiving temporary total disability benefits within two weeks of her fall. In 1989, claimant, her employer Thorn EMI North America, and employer's insurer, Federal Insurance Co. (collectively employer), reached a settlement of the indemnity portion of claimant's claim, resolving all issues but post-maximum medical improvement (MMI) medical maintenance benefits. The parties agreed that "[c]laimant's right to medical benefits for injuries sustained in this compensable accident shall remain open and available to her." The record demonstrates that claimant received significant medical care for back and neck pain over the ensuing decades.

¶ 3 As pertinent here, in 2017, claimant applied for a hearing seeking reasonably necessary medical benefits. In response, employer argued that claimant was not entitled to additional medical maintenance benefits because, it alleged, any treatment she received was no longer related to her 1986 work injury.

¶ 4 In support of its position, employer highlighted that on October 9, 2015, claimant was involved in a motor vehicle accident, after which she complained of neck stiffness and said her head felt "funny." Some months later she complained of fatigue, dizziness, neck and back pain, headaches, and chest pain, all of which she associated with the motor vehicle accident. It also introduced medical records from several of claimant's treating physicians. The more pertinent entries can be summarized as follows:

- Dr. Zhengyu Hu, August 26, 2015: expressed concern that claimant, who was eighty-one years old at the time, was "basically on 30 mg of OxyContin twice a day and that started several years ago by Dr. Gannon in Arizona."
- Dr. Zhengyu Hu, August 25, 2015: claimant "had relatively non-significant cervical and lumbar MRI studies."

- Dr. Haseeb Ahmed, July 26, 2015: admitted claimant to hospital "with chronic pain, low back pain, worse with ambulation," but an MRI of the spine did "not show severe disease."
- Dr. Brian Hornung, May 26, 2015: described claimant as "a difficult individual . . . [who] bec[a]me irate each time for what seems to be minimal concerns. . . . This is an individual who will not be welcomed back in our practice."
- Dr. Jenna Dees, March 25, 2013: MRI of cervical spine showed "mild to moderate facet osteoarthritis."

¶ 5 Employer also offered a report prepared by Dr. Barry Ogin. The parties agree that Dr. Ogin did not examine claimant; according to employer, claimant refused to travel to Colorado for the appointment. Dr. Ogin nevertheless conducted an extensive review of claimant's medical records and summarized hundreds of pages of medical reports. For example, Dr. Ogin described a 2012 report by Dr. Gannon that "indicated the patient was doing worse despite just having had a cervical epidural. In December of 2012, Dr. Gannon indicated the patient was doing worse, with more peripheral

neuropathy. . . . He stated that she was suffering from a peripheral neuropathy that was 'probably not related.'" Upon completing the records review, Dr. Ogin concluded that

> The need for the patient's interventional spine treatment, such as injections, as well as her hospitalizations over the years for somatic complaints such as syncope, hearing loss, or dizziness, are not related to her injury in 1986. Her need for chronic pain medication could possibly be related to her spinal pathology, but this is degenerative in nature and it was not present in 1986 or 1987. Plain medication management should be handled outside of this claim.
>
> * * * * *
>
> I do not see any evidence of spinal pathology that would contribute to or cause her diffuse pain complaints. . . . Of note, in reviewing the Colorado Medical Treatment Guidelines, [claimant] clearly does not meet the indications to receive lumbar or cervical epidural steroid injections for radicular pain or spinal stenosis.
>
> * * * * *
>
> As 30 years have passed, it is probable that she has developed facet arthropathy. However, development of facet pain would be due to arthritic degeneration of her facet joints, and was not caused by her fall in 1986. Pursuing future facet blocks, therefore, would be handled outside of this claim.
>
> * * * * *

> [Claimant] is now over 80 years old. It is certainly possible that she may have cardiac or cerebral issues contributing to problems such as dizziness or cognitive issues. . . . An extensive workup, including most notably a cardiac workup, may have been indicated, but would not be attributable to her work injury in 1986. Similarly, her variable complaints of back and neck pain, as well as extremity pain, were not related to her injury in 1986.

¶ 6 After conducting a hearing — the transcript of which is not included in the record before us — the ALJ found Dr. Ogin's opinions persuasive and credible, expressly finding that "[e]ach provider is credible and persuasive on the fact that the [c]laimant's present condition and need for medical care and treatment, including her opioid prescription, is not proximately caused by the industrial injury of September 17, 1986. Indeed, their opinions are undisputed." Based on his credibility determination, the ALJ concluded that claimant failed to establish that "her post-MMI medical maintenance care and treatment, since July 26, 2015, is proximately and causally related to her industrial injury of September 17, 1986." The ALJ therefore ordered that "all claims for post-[MMI] medical maintenance benefits after July 25, 2015, are hereby denied and dismissed."

¶ 7 After the claimant appealed the order of the ALJ, the Panel modified the order, limiting the denial of ongoing medical maintenance benefits to the period from July 26, 2015, through the date of the hearing, November 15, 2017. The Panel held that although the evidence supported the denial of claimant's medical maintenance benefits from the date of her hospitalization for back pain through the date of the hearing, the ALJ had improperly imposed the burden of proof on claimant to establish her entitlement to ongoing benefits. Rather, if employer was seeking to modify its admission to provide post-MMI medical maintenance benefits, it bore the burden of proving such a modification was warranted. Under the Panel's modified order, claimant can receive ongoing medical maintenance benefits, but employer retains the right to challenge the relatedness of particular treatments and medical care.

¶ 8 Despite the modification to the ALJ's order preserving her entitlement to ongoing post-MMI medical maintenance benefits, claimant appeals the Panel's final order. As employer did not seek review of the Panel's modified order, the preservation of claimant's entitlement to ongoing post-MMI medical maintenance benefits is

final and unappealable. Claimant nevertheless challenges the validity of Dr. Ogin's opinions, questions the ALJ's interpretation of the medical records, and maintains that she has "outstanding medical prescription[s that have] not [been] paid for years from 2015 to present." She asserts that her medical benefits award was to "remain open and available for life," and she does not understand why the "judgment has been taken from me." In light of the parameters of the Panel's final order, we construe the issue before us as whether the Panel erred in affirming the ALJ's denial and dismissal of post-MMI medical maintenance benefits from July 26, 2015, through the date of the hearing, November 15, 2017.

II. Limitations of Appellate Review

¶ 9 The Workers' Compensation Act (Act) expressly limits this court's review of a Panel's decision. The Act states:

> Upon hearing the action, the court of appeals may affirm or set aside such order, but only upon the following grounds: That the findings of fact are not sufficient to permit appellate review; that conflicts in the evidence are not resolved in the record; that the findings of fact are not supported by the evidence; that the findings of fact do not support the order; or that the award or denial of benefits is not supported by applicable law. If the findings of fact entered by the director or administrative

> law judge are supported by substantial evidence, they shall not be altered by the court of appeals.

§ 8-43-308, C.R.S. 2018. To the extent claimant asks us to conduct a hearing, section 8-43-308 strictly prohibits us from doing so.

¶ 10 Nor are we permitted to consider some of the numerous documents that claimant has attached to her brief. Although some of the documents can be found in the record, others cannot. The newly offered documents which appear to be absent from the record include a letter dated December 14, 2015, from attorney Paul Haller to claimant; medical bills from St. Luke's Health System; consultation notes prepared by Dr. Joel Ackerman; an article entitled "Doctors Accused of Fraud," from the *Gazette Telegraph*; reports prepared by the Mayo Clinic of Arizona; and a June 26, 2016, letter from attorney Kristin Caruso to Dr. Ackerman. We are limited in our review to the record before the ALJ which the Panel provides to us and are not at liberty to look beyond that record in our review. *See City of Boulder v. Dinsmore*, 902 P.2d 925, 927 (Colo. App. 1995) ("[B]ecause these documents were not presented to the ALJ, they are not a part of the appellate record and they will not be considered in this appeal."). We therefore may not review or

consider any documents that were not admitted into evidence by the ALJ or are not part of the record forwarded to us by the Panel. Consequently, we may not consider the additional documents claimant has attached to her brief.

III. Standard of Review and Governing Law

¶ 11 A claimant is entitled to seek medical maintenance benefits post-MMI if he or she shows that future medical treatment will be "reasonably necessary to relieve the claimant from the effects of the industrial injury or occupational disease even though such treatment will not be received until sometime subsequent to the award of permanent disability." *Grover v. Indus. Comm'n*, 759 P.2d 705, 710 (Colo. 1988). For maintenance benefits to be "related" they must have "an inherent connection" to the work injury. *See Horodyskyj v. Karanian*, 32 P.3d 470, 476 (Colo. 2001) (Incidents which are "inherently related to employment, are those that have 'an inherent connection with employment and emanate from the duties of the job.'" (quoting *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991))).

¶ 12 The right to receive post-MMI medical maintenance benefits is not unlimited. Employers retain the right to challenge the "need for

continued medical benefits," *Snyder v. Indus. Claim Appeals Office*, 942 P.2d 1337, 1339 (Colo. App. 1997), "on the basis that such treatment is unrelated to the industrial injury or occupational disease." *Grover*, 759 P.2d at 712. Under the Act, employer bore the burden of proof to modify future medical maintenance benefits. § 8-43-201(1), C.R.S. 2018.

¶ 13 Whether the requested continued medical maintenance care is related, reasonable, and necessary is a question of fact for the ALJ's determination. *See Snyder*, 942 P.2d at 1339 ("[W]hether the medical treatment was reasonably necessary to cure and relieve the effects of the injury and temporary disability benefits . . . is a question of fact for resolution by the ALJ."). Because this determination is one of fact, an ALJ's finding on this issue may not be set aside where it is supported by substantial evidence in the record. *See Holly Nursing Care Ctr. v. Indus. Claim Appeals Office*, 992 P.2d 701, 704 (Colo. App. 1999).

IV. Substantial Evidence Supports the ALJ's Finding That Some of Claimant's Post-MMI Medical Maintenance Is Unrelated to Her Work Injury

¶ 14 In modifying the ALJ's order, the Panel affirmed only that portion of the ALJ's order finding that medical treatment claimant

received from July 26, 2015 — when she was hospitalized for back pain — through the hearing on November 15, 2017, was unrelated to her 1986 work injury. As we understand claimant's contention, she essentially asks us to reweigh the evidence to reach a finding contrary to the ALJ's conclusion that treatment from July 2015 through November 2017 was unrelated, arguing that her post-MMI medical maintenance treatment during that time period should have been covered. However, we may not reweigh the evidence. *See Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995). Further, "we may not interfere with the ALJ's credibility determinations" unless the evidence is "overwhelmingly rebutted by hard, certain evidence" to the contrary. *Arenas v. Indus. Claim Appeals Office*, 8 P.3d 558, 561 (Colo. App. 2000); *see also Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46 ("Nor may we set aside a ruling dependent on witness credibility where the testimony has not been rebutted by other evidence."). The weight to be given expert medical testimony is within the ALJ's sound discretion. *See Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990).

¶ 15 Here, we cannot review the entire record before the ALJ because the transcript of the hearing is not part of the record before us. Where a transcript is not included in the record, we must presume that the ALJ's resolution of the issue is supported by the evidence. *Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 801 (Colo. App. 1988).

¶ 16 Nevertheless, even if we exclude the hearing testimony from our analysis, medical reports and written opinions contained in the record amply support the decision. Dr. Ogin's report expressly stated that claimant's pain complaints and need for treatment "were not related to her injury in 1986." He observed that although claimant's injury occurred in 1986, she "did not require any epidural steroid injections" until 2002. He also noted that claimant is "over 80 years old," the "development of a degenerative disk condition is a ubiquitous and normal part of aging. In this case, [claimant's] degenerative disk disease is consistent with her age and was not caused by her injury."

¶ 17 Claimant has not pointed us to any medical report or opinion countering Dr. Ogin's conclusions, and we have found none. Indeed, no medical report contained in the record ties any of

claimant's treatment since July 2015 to her admitted work injury. As the ALJ wrote, Dr. Ogin's view that claimant's recent treatments were unrelated to her 1986 work injury is "undisputed." Because the ALJ is vested with discretion to weigh an expert's opinion, we may not set aside the ALJ's decision finding Dr. Ogin credible and persuasive and may not set aside the Panel's decision on this basis. *See Rockwell Int'l*, 802 P.2d at 1183.

¶ 18 Accordingly, we conclude that the evidence amply supports the ALJ's factual findings and legal conclusions. We therefore perceive no basis for setting aside the Panel's order holding that medical treatment she received "from July 26, 2015, up to the date of the hearing" was unrelated to her 1986 work injury. *See* § 8-43-308; *Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999); *Metro Moving & Storage*, 914 P.2d at 415.

III. Conclusion

¶ 19 The order is affirmed.

CHIEF JUDGE BERNARD and JUDGE ROTHERBERG concur.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-911-782-001

IN THE MATTER OF THE CLAIM OF:

BRANDON HUMPHREY,

Claimant,

v.

ORDER

FED EX FREIGHT INC,

Employer,

and

INDEMNITY INSURANCE CO OF NORTH AMERICA,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated December 3, 2018, that denied the claimant's Motion to Strike the Respondents' Final Admission of Liability. We set aside the order of the ALJ and remand the matter for further findings and a new order.

The claimant was injured on February 18, 2013, when the forklift he was driving was hit by another forklift driven by a second employee. The claimant complained of injuries to his shoulders and to his cervical, thoracic and lumbar spine. The claimant was paid temporary partial disability benefits until July 26, 2013. On that date his authorized treating physician (ATP), Dr. Hawke, provided a return to regular work release based on a normal reading of an EMG nerve conduction study. Dr. Hawke concluded the claimant was at maximum medical improvement (MMI) on August 23, 2013. The MMI report noted the claimant continued to complain of intermittent pain across the middle and upper back. The doctor believed the claimant was experiencing myofascial pain. It was determined the claimant had sustained no permanent impairment.

The respondents filed a Final Admission of Liability (FAL) on August 28, 2013. The FAL stated it was based upon an attached report of August 23, 2013, from Dr. Hawke which indicated no permanent impairment but did admit for maintenance medical benefits described in the report. The claimant did not object to the FAL.

In September and October of 2016, the claimant returned to the clinic complaining of resurgent pain in the lumbar spine and in the left arm. The claimant asserted the pain represented a worsening of his February 18, 2013, work injury. The claimant requested his claim be reopened and that additional chiropractic treatment be authorized. A hearing regarding reopening and medical treatment was conducted before the ALJ on September 27, 2018.

Before the ALJ issued an order pertinent to the hearing, the claimant submitted a motion on October 10, 2018, requesting the ALJ strike the August 28, 2013, FAL due to its failure to attach a medical report stating the claimant was at MMI. The claimant contended the August 23 MMI report was not attached. Instead, he argues the respondents attached the July 26 report releasing the claimant to regular work and stating the date of MMI was unknown at that time. In a summary order dated December 3, 2018, the ALJ entered an order stating in its entirety: "ORDERED that this motion shall be and hereby is DENIED."

In the interim, following the motion but before denying it, the ALJ submitted an order with full findings on November 27, 2018, that denied the claimant's request to reopen his claim. The ALJ found the claimant's current complaints were not shown to be related to the February 18, 2013, work accident.

The claimant initially appealed both orders. He subsequently withdrew his appeal of the November 27 order and now seeks review solely of the December 3 order denying his request to strike the FAL.

The claimant essentially is pursuing a collateral attack on the November 27 decision of the ALJ. The withdrawal of the appeal of the November 27 decision has made that decision final, including its finding of an absence of a causal link between the work injury and the claimant's current symptoms. A striking of the preceding FAL would allow the claimant to request a Division sponsored Independent Medical Examination (DIME). The use of the DIME procedure to functionally reverse a prior decision of an ALJ is not a novel tactic. *See, Goff v. Schwan's Home Services, Inc.,* W.C. No. 4-947-521-03 (August 9, 2017), *aff'd Schwans's Home Services, Inc. v. Industrial Claim Appeals Office,* (Colo. App. No. 17CA1546, July 26, 2018)(not selected for publication), *Holcombe v. Fedex Corp*., W.C. No. 4-824-259 (March 24, 2017); *Sharpton v. Prospect Airport Services*, W.C. No. 4-941-721-03 (November 29, 2016); *Jackson v. Select Comfort Corp*. W.C. No. 4-914-418-03 (November 16, 2016); *Madrid v. Trinet Group, Inc*., W.C. No. 4-851-315-03 (April 1, 2014); *Ortega v. JBS, USA, LLC*, W.C. No. 4-804-825 (June 27, 2013); *Braun v. Vista Mesa*, W.C. No. 4-637-254 (April

15, 2010). Similarly, the passage of additional time coupled with further changes in the claimant's condition may also lead to a subsequent reversal of outcome concerning the claimant's request for medical treatment. *See Penny v. Trinity Packaging*, W.C. No. 4-899-523-06 (May 22, 2017); *Goff, supra*; *Zolman v Horizon Home Care LLC*, 4-626-044 (November 3, 2010).

The respondents oppose the motion to strike the FAL arguing the denial of the motion by the ALJ is not an order subject to review pursuant to § 8-43-301(2). The respondents contend the claimant has waived any right he has to complain of defects in the FAL. They also contend the issue of whether a proper medical report was attached to the FAL and whether the respondents substantially complied with § 8-43-203(2)(b)(II) is a question of fact not subject to resolution without a hearing.[1]

The denial of a motion to strike an FAL has been determined a reviewable order. Section 8-43-301(2) allows an appeal of an order only when the order requires "any party to pay a penalty or benefits or denies a claimant any benefit or penalty." In *Maloney v. Ampex Corp*., W.C. No 3-952-034 (February 27, 2001), the Panel held such an order satisfied the § 8-43-301(2) prerequisites:

> Initially, we reject the respondents' contention the ALJ's order is interlocutory and not subject to review. … Because it is undisputed the claimant failed timely to object to the December 1999 final admission, the ALJ's order effectively closed the claim, and precluded the claimant from recovering any further benefits without presenting the proof required by § 8-43-303 C.R.S. 2000 to reopen the claim. *See Brown & Root, Inc. v. Industrial Claim Appeals Office*, 833 P.2d 780 (Colo. App. 1991). Consequently, the ALJ's order denied the claimant benefits and is reviewable.

[1] The FAL was admitted into evidence without objection as claimant's exhibit 1 at the September 27, 2018, hearing. "… when a party fails to object to the admission of a document or offers it into evidence himself, as plaintiff did in this case, he is held to have waived the need for any evidence authenticating its genuineness, …", *Fink v. Montgomery Elevator Co*., 161 Colo. 342, 424 P.2d 735, 349 (1966).

Similar determinations were featured in *Valenzuela v. Best Car Buys*, W.C. No. 4-664-544 (January 23, 2007) and in *Coxen v. Laidlaw Transit*, W.C. No. 4-674-208 (April 10, 2012). Accordingly, the ALJ's December 3, 2018, denial of the Motion to Strike the FAL is an order subject to review.

In *Paint Connection Plus v. Industrial Claims Appeals Office*, 240 P.3d 429 (Colo. App. 2010), the court ruled an FAL accompanied by a medical report stating the claimant was not at MMI was an invalid admission which did not serve to close the claim. *See also* Director's Rule 5-5(A), and (E), 7 Code Colo. Reg. 1101-3.

Further, in *McCotter v. U.S. West Communications*, W.C. No. 4-430-792 (March 25, 2002) the FAL submitted by the respondents was found insufficient when it failed to include the DIME report on which it was based. The invalidity of the FAL prevented the claim from being closed. The presence of a valid FAL was deemed a jurisdictional prerequisite to a claim's closure. Due to its jurisdictional nature, an objection to an invalid FAL could be raised at any point during the proceedings. In *Avila v. Universal Forest Products*, W.C. No. 4-477-247 (August 25, 2004), the claimant complained of the invalidity of the respondents' FAL approximately two years after it was filed. The ALJ agreed the FAL was insufficient in its reference to the supporting medical report. However, the ALJ determined the claimant failed to preserve his objection when he did not challenge the FAL within the statutory 30 day time period. The Panel however, ruled the requirements in § 8-43-203(2) are:

> … jurisdictional in scope, and if an issue remains open because of the respondents' failure to close the issue under subsection 2, [8-43-203(2)(b)(II)] the ALJ may consider the issue. … the FAL was legally insufficient to close the claim regardless of whether the claimant filed a timely objection. Consequently, the claimant was not required to object to the FAL to "preserve" his contention that the FAL was invalid and the claim remained open. Under these circumstances, the ALJ erred in requiring the claimant to prove a worsened condition to establish his entitlement to additional medical benefits.

The determination that valid FALs are jurisdictional requirements, and their inadequacy may be raised at any time has been repeatedly stated. *Reed v. Demetre Painting*, W.C. No 3-069-138 (January 15, 1993); *Bargas v. Special Transit*, W.C. No. 4-534-551 (June 4, 2004); *Roddam v. Rocky Mountain Recycling*, W.C. No. 4-367-003

(January 24, 2005). The Court of Appeals noted in *Cramer v. Industrial Claim Appeals Office*, 885 P.2d 318 (Colo. App. 1994), "[t]he procedural requirements for review in the Workers' Compensation Act constitute limitations on administrative jurisdiction, and these jurisdictional limitations cannot be waived or eliminated by consent and cannot be avoided by estoppel." 885 P.2d at 319.

We are not however, advised as to the reason the ALJ was led to deny the motion to strike the FAL in this case. While not characterized as a motion for summary judgment, the requirement in OAC Rule 17 that an order addressing such a motion include findings of fact, conclusions of law and an order would be reasonably appropriate in the resolution of the claimant's motion. We therefore remand the matter to the ALJ to make those findings and conclusions.

IT IS THEREFORE ORDERED that the ALJ's order issued December 3, 2018, is set aside and the matter is remanded to the ALJ for further findings as discussed above.

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

6/3/19 by TT .

THE FRICKEY LAW FIRM, Attn: ADAM MCCLURE ESQ, 940 WADSWORTH BLVD 4TH FLOOR, LAKEWOOD, CO, 80214 (For Claimant)
POLLART MILLER LLC, Attn: BRAD MILLER ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-073-689-001

IN THE MATTER OF THE CLAIM OF:

MARY K OLVERA,

Claimant,

v.

AIR CLEANSHEEN LLC,

Employer,

and

PHOENIX INSURANCE COMPANY,

Insurer,
Respondents.

ORDER

The claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated September 27, 2018, that denied compensability of the claim. We set aside the order of the ALJ and remand the matter for further findings.

The claimant worked for the employer laundering sheets and towels through the use of a commercial laundry. The employer's business provides clean linens to bed and breakfast and other short-term rental locations. The claimant was injured on November 8, 2017, in an automobile accident while transporting the employer's laundry in her car.

The employer patronized a commercial laundry that required cash. The patron would then insert the cash into a vending machine and the employer's account would be credited for the deposit. To accomplish this, the claimant's supervisor routinely made wireless transfers of the necessary funds to the claimant's personal bank account. The claimant would then use her debit card to withdraw cash for use at the laundry.

The claimant testified that her usual supervisor, Jackie Mitchell, left work on maternity leave on December 1, 2017. In Ms. Mitchell's place, the claimant was temporarily supervised by Megan Gonzalez. On November 8, claimant picked up the dirty laundry, drove back to her home to get the debit card, and then drove toward the bank to obtain cash for the laundry. While driving to the bank, she was involved in an auto accident when another driver ran a stop sign.

The claimant called Ms. Gonzalez and reported she had the motor vehicle accident (MVA). The claimant went to the emergency room complaining of injuries to her back. She then treated with the Antero Medical Group. The employer did not offer her any physicians from which she could choose a treating doctor. The claimant returned to work shortly after the MVA. She indicated she had trouble performing her duties due to continuing back pain. She left her job in late December and eventually took a less physically demanding job with the Salvation Army.

Ms. Gonzalez testified the claimant had no need of her debit card on November 8 because Ms. Gonzalez had obtained $100 in cash and left it for the claimant with the dirty laundry on November 7 at the employer's work site.

The claimant's medical treatment was paid for by the other driver's automobile insurance. When those funds reached their $25,000 limit, the claimant filed a Worker's Claim for Compensation on April 5, 2018.

The respondents argued the claimant was not in the course and scope of employment on November 8 when she had the MVA. Respondents asserted the claimant had no need for her debit card or access to her bank account because her supervisor had already left her cash at the employer's facility and had not made a deposit to her bank account.

The ALJ ruled in his September 27, 2018, order that the claim was not compensable. However, he did not find the claimant was outside the course and scope of employment when the MVA occurred. The ALJ concluded: "Contrary to the Respondents' theory that this case is not compensable because the auto accident happened on a detour that took the claimant outside the course of employment, the ALJ finds that the case turns on overall credibility and, as found herein above, the claimant's claim is not credible." Finding of Fact ¶ 16. "Even if the practice of driving from her home to the bank was within the course and scope of work, the claimant's testimony and the credibility of the claimant's claim is undercut by her own evidence." Conclusions of Law ¶ (b). The ALJ found "On the way to the bank from her home the Claimant was in a car accident caused by another driver (hereinafter 'Tortfeasor'). The Claimant sustained injuries from the accident but returned to work, full time, shortly after." F of F ¶ 6.

The ALJ instead, found significant the statement by the doctor treating her on January 15, 2018, that as concerns: OCCUPATIONAL HISTORY: The patient denies any history of work injuries." The ALJ then points to eight typed health insurance claim

forms submitted by the clinics treating the claimant between December 15, 2017, and January 15, 2018. These eight forms contain a box titled PATIENT'S CONDITION RELATED TO: and then provides three boxes, designated 'employment' (yes or no), 'auto accident' and 'other accident'. The boxes corresponding to employment and other accidents are completed with a typed 'X' in the 'no' box, while auto accident has a typed 'X' in the 'yes' box. Finally, the ALJ observed the claimant did not submit a Worker's Claim for Compensation until April, 2018.

> (d). As found, the Claimant's own evidence explains that she sought worker's compensation benefits months after the auto accident, because the Tortfeasor's insurance cap of $25,000 on medical benefits either ran out or was about to run out. … As found, during the hearing, the Claimant testified that the Tortfeasor's insurance would only pay for $25,000 of medical bills. The ALJ drew a plausible inference that the Claimant decided to pursue a worker's compensation claim several months after the car accident. … (e) … As found, it was not credible that the Claimant's injuries arose out of or occur within the course and scope of the Claimant's employment with Employer.

The ALJ states that because the claimant initially treated for her injury while characterizing it as a MVA, and submitted a claim initially with the other driver's auto insurance before she pursued a worker's compensation claim, she necessarily excluded any work relationship to her accident. Accordingly, the ALJ concluded the claimant's subsequent worker's compensation claim represented an inconsistent version of the origin of her injuries. The ALJ determined this change of her story supported the finding the claimant was not being truthful or credible. Consequently, the compensability of her claim was denied. We conclude the findings of fact do not support the order.

Section 8-41-203(1)(a), specifies: "If any employee entitled to compensation under articles 40 to 47 of this title is injured or killed by the negligence or wrong of another not in the same employ, such injured employee … may take compensation under said articles and may also pursue a remedy against the other person to recover any damages in excess of the compensation available under said articles." The Supreme Court characterized this section to allow: "An employee who suffers a compensable injury at the hands of a third party may pursue his remedies against the third person even though the employee has filed a claim under the workmen's compensation act. *In re Death of Peterkin*, 729 P.2d 977, 980 (Colo. 1981).

Without more, the fact that the claimant pursued both a claim for damages against a negligent third party as well as a later claim for worker's compensation benefits does not represent an inconsistent election of remedies. In the alternative, even if the claimant was unaware that a MVA could also qualify as an injury sustained in the course and scope of employment, her manner of proceeding in this matter does not indicate any waiver of rights or prejudice to the claim for worker's compensation. Here, the ALJ found the claimant was injured in a MVA on November 8, 2018, driving on her way to the bank from her home. The ALJ also found the respondents' claim that the trip to the bank might be a detour from an otherwise work related trip was not a reason to deny the claim. While other statements of the claimant found not credible may lead to the denial of specific benefits, such as temporary disability benefits or some medical benefits, the ALJ has identified no statements of the claimant that were not believed that would also support a denial of the claim's compensability when compared to the other findings made by the ALJ. Therefore, we set aside the September 27 order of the ALJ and remand the matter for a reconsideration of the legal conclusion or for additional findings to determine compensability of the claim.

IT IS THEREFORE ORDERED that the ALJ's order issued September 27, 2018, is set aside and the matter remanded for additional findings as discussed above.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

John A. Steninger

CERTIFICATE OF MAILING

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

6/4/19 by TT .

KAPLAN MORRELL LLC, Attn: RONDA K CORDOVA ESQ, 6801 WEST 20TH STREET SUITE 201, GREELEY, CO, 80634 (For Claimant)
RAY LEGO & ASSOCIATES, Attn: GREGORY W PLANK ESQ, 6060 SOUTH WILLOW DRIVE SUITE 100, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-058-044-001

IN THE MATTER OF THE CLAIM OF:

QUINCY BRYANT,

Claimant,

v.

ORDER

TRANSIT MIX CONCRETE,

Employer,

and

TRAVELERS INDEMNITY COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order and supplemental order of Administrative Law Judge Edie (ALJ) dated November 19, 2018, and March 4, 2019, respectively, that determined the respondents overcame the permanent impairment ratings of the Division-sponsored independent medical examiner (DIME) physician, and that determined the respondents were not barred from asserting a safety rule violation under §8-42-112(1)(a), C.R.S. We affirm in part, set aside in part, and remand the matter for new findings and a new order on the issue of whether the respondents have overcome the DIME physician's impairment ratings for the cervical and lumbar spinal regions.

The ALJ made the following pertinent factual findings. On September 11, 2017, the claimant suffered admitted work-related injuries when he rolled the cement mixer he was operating for the employer. The claimant was seen by Steven Byrne, PA-C at CCOM on the date of the industrial incident. He was diagnosed with "laceration left eyelid" and "laceration left hand."

Two days later, the claimant reported to the emergency room (ER) complaining of neck pain, although his range of motion in the neck was described as "normal." Imaging showed no acute abnormalities and conservative care was recommended. Intake reports from the ER note that at the time of the rollover, the claimant was unrestrained.

The claimant returned to CCOM on September 18, 2017. He reported he was "feeling much better but still having considerable amount discomfort through the left cervical paraspinal and posterior shoulder girdle."

The claimant's initial visit with his authorized treating physician, Dr. Neubauer, was on September 25, 2017. The claimant reported lower back and left leg pain. The claimant's neck paraspinals were tender to palpation, with pain in all planes upon range of motion. The paraspinals were tender in his lower and upper back. Physical therapy continued to be recommended.

The claimant underwent a short course of physical therapy. He reported cervical pain, pain in both shoulders, and lower back pain. As of his physical therapy visit on October 6, 2017, the claimant still was reporting a high level of pain with end range cervical motion and difficulty sleeping due to neck pain. He also reported that he continued to have low back pain and stiffness.

The claimant returned to Dr. Neubauer on October 9, 2017, complaining of ongoing neck and back pain. It was noted the claimant was having pain with activity and the back was specifically described as being tight. Physical examination documented pain in the neck with all planes of motion. Examination of the back documented tenderness to palpation in the low back and buttocks and decreased/painful forward flexion, extension, rotation, and lateral flexion; the mid-back symptoms were no longer noted. At a subsequent appointment with Dr. Neubauer, the claimant had ongoing complaints of back and neck pain that was described as "aching/stiffness/tightness" and he was having pain/stiffness with activity and movement of the back and neck. Dr. Neubauer recommended continued therapy and referred the claimant to Dr. Abercrombie for chiropractic care.

The respondents filed a General Admission of Liability (GAL) on October 18, 2017, admitting for medical benefits but denying temporary total disability benefits on the basis that the "claimant was responsible for his own termination."

By October 23, 2017, the claimant was reporting 2-3 out of 10 pain, which he described as mild pain and consisting mostly of aching/stiffness/tightness.

At his initial visit with Dr. Abercrombie on October 26, 2017, the claimant reported overall improvement, but still had "some lower back, neck and left shoulder pain." Moderately reduced range of motion was noted in his lumbar and cervical regions.

On November 29, 2017, Dr. Neubauer documented that the claimant still was reporting 3 out of 10 neck and low back pain, and that he continued "to have stiffness with motion of the neck and low back. . . ."

On January 4, 2018, Dr. Neubauer noted that the claimant was reporting low back pain and tightness. His closing comments indicated that the claimant still had neck and low back tightness, but he nevertheless placed the claimant at maximum medical improvement (MMI) with no impairment and instructions to finish chiropractic care. Dr. Neubauer's final note from January 24, 2018, indicated the claimant was greatly improved, but that he continued to have minimal objective residual problems.

On January 24, 2018, after his release at MMI, the claimant's chiropractor, Dr. Abercrombie, also released the claimant. Dr. Abercrombie's final note from January 24, 2018, indicated the claimant was greatly improved but that he continued to have minimal objective residual problems as noted in his report:

> Overall, he has responded very well to treatment noting very minimal symptoms at this time. He had some lower back stiffness this past week of unknown cause however denies pain, and the stiffness resolved. Otherwise, he denies neck or mid back symptoms. He is performing at this time all activities of daily living without difficulty…
>
> Examination on today's visit reveals normal spinal/paraspinal symmetry. Range of motion is full and all cervical, thoracic and lumbar planes and (sic) without symptoms.

The respondents submitted a Final Admission of Liability (FAL) admitting for 0% impairment. The FAL indicated the claimant received TTD from September 12, 2017, through December 13, 2017, the date he was released to work without restrictions. The respondents' FAL made no mention of any alleged violation of a safety rule. The FAL admitted to a general award of maintenance care. The FAL appeared to be a "reversal" of the respondents' prior position in the GAL wherein all TTD had been denied due to the claimant's termination for cause.

The claimant objected to the respondents' FAL and sought a DIME. Dr. Higginbotham performed the DIME on April 24, 2018. In his report, Dr. Higginbotham cited to the claimant's symptom subjective checklist: "[c]licking and popping and pain of the jaw; asthma with shortness of breath; muscle cramps; joint swelling, pain, and

stiffness; depression and nervousness." The claimant also reported "nausea, blurred vision, tingling of the hands and feet; swelling of the feet; trouble falling asleep and staying asleep; and mood swings." The claimant further reported that his "lower back feels stiff and tight, and he feels a sharp pull about the left side of the neck and back and lower extremity when he increases his physical activity." Dr. Higginbotham provided impairment ratings of 7% for the cervical spine resulting from 4% range of motion deficit, combined with 4% from Table 53(II)(B). He also assigned 10% for the lumbar spine, noting 5% from Table 53(II)(B) and 5% range of motion deficit. These two ratings combined for a 16% impairment rating of the whole person. Dr. Higginbotham's narrative of his physical examination made several references to tenderness in the claimant's lumbar and cervical regions.

The respondents subsequently filed their application for hearing, endorsing the issues of "Overcoming Division IME; Failure to Utilize Safety Device/Violation of a Safety Rule; Causation; Set-offs."

At the request of the respondents, Dr. McCranie performed a medical record review. Dr. McCranie explained that Dr. Higginbotham's DIME report did not comply with the AMA Guides and Level II training, which require "objective" findings in order to provide an impairment rating. More specifically, Dr. McCranie opined that "Impairment Ratings are given when a specific diagnosis and objective pathology is identified." Dr. McCranie stated that the claimant's records were devoid of any objective findings of pathology, and only reflected the claimant's subjective complaints of pain and occasional stiffness. Dr. McCranie instead found that the claimant's sole diagnosis was muscular strains. Dr. McCranie stated that by their nature muscle strains are temporary.

During the hearing, Dr. McCranie testified that the records demonstrated what should be expected from diagnosed muscular strains, with a progression of conservative care to a release at MMI, but without any residual range of motion deficits. She stated that the lack of residual range of motion deficits is echoed in Dr. Neubauer's MMI report, finding full range of motion in the back. She further stated that the post-MMI release report of Dr. Abercrombie indicated transient low back stiffness "of unknown cause" with a complete resolution of symptoms and full range of motion in the lumbar, thoracic, and cervical spines. She opined that findings of mild tenderness and tightness on palpation are not objective findings that would support a rating under the AMA Guides or Level II training. Dr. McCranie further testified that the available medical records, including Dr. Higginbotham's report, were devoid of objective evidence to support an impairment rating in accordance with the AMA Guides and Level II training. That is, the claimant's subjective complaints of stiffness and pain, coupled with the diagnosis of

muscular strain injuries were insufficient to support a Table 53 rating. She further opined that if the claimant was not entitled to a Table 53 rating, a range of motion rating would be inapplicable.

The claimant obtained an independent medical examination with Dr. Rook. In his report dated September 3, 2018, Dr. Rook stated that upon rolling his cement truck, the claimant fell six feet from the driver's seat to the passenger door, rotating as he fell and struck the back side of the passenger side door. Upon physical examination of the neck, Dr. Rook found moderate to severe tenderness associated with increased muscle tone on palpation of the left sternocleidomastoid muscle. Evaluation of the lower back documented increased muscle tone with moderate tenderness of the left-sided lower paralumbar musculature overlying the L4, L5, and S1 facet joints. Back pain was increased when elicited with spinal extension and bending to the left. The same maneuver was negative on the right. Dr. Rook addressed the final chiropractic report from Dr. Abercrombie dated January 24, 2018. He explained that Dr. Abercrombie's report documented increased muscle tone in the same muscles that Dr. Rook had identified eight months later. Dr. Abercrombie also found problems with the left-sided facet joints based on provocative testing at that visit. Dr. Rook identified those same findings on his examination. He stated "[t]hese constitute objective findings and therefore "Dr. Higginbotham was correct in providing the patient with a table 53 rating." Dr. Rook disagreed with Dr. McCranie's opinion on a lack of objective findings, and stated that her opinions constituted a mere difference of opinion with the DIME physician.

The claimant testified during the hearing. He testified he found the seatbelt to be difficult to put on. The claimant admitted he was not wearing a seatbelt at the time of the incident.

The ALJ ultimately determined that the respondents overcame Dr. Higginbotham's DIME opinions by clear and convincing evidence. He found that Dr. Higginbotham improvidently applied Table 53(II)(B) to the claimant, stating:

> H. The medical records contain sufficient references to pain-*and rigidity*- from the date of the accident, up through Claimant's final visit with his chiropractor on January 24, 2018- a period of just over 4 months. The DIME exam occurred just over 7 months after the accident. All Dr. Higginbotham was required to do to support a Table 53IIB impairment rating was medically document some kind of

> *rigidity* in his physical exam of Claimant for his cervical and lumbar regions. *This he did not do.* At most, he noted Claimant's self-reported complaints of stiffness. Without further explanation or sufficient documentation of objective pathology, he then combined Claimant's range of motion values (which the ALJ finds have not been overcome) with the additional ratings from Table 53IIB. *This he cannot do.* Pain for 6 months is not enough to qualify, even when combined with 6 months of *self-reported* rigidity.
>
> I. The ALJ concurs with Dr. McCranie in this case that there is simply no basis to apply Table 53IIB with the objective evidence available. There is not 6 months of medically documented *objective* pathology-expressed as *rigidity*-here. While Dr. Rook purports to have noted some objective evidence of rigidity at his IME months later, this was not known to Dr. Higginbotham at his DIME exam, since this report didn't yet exist. There is no evidence that Dr. Higginbotham supplemented his findings based upon what Dr. Rook may have observed. The ALJ finds, by clear and convincing evidence, that Dr. Higginbotham's DIME opinion has been overcome by Respondents, due to his improvident application of Table 53IIB to Claimant. (emphasis in original)

The ALJ further ruled that the DIME physician erred in combining the claimant's range of motion values with the additional ratings from Table 53(II)(B). After finding that the DIME physician's report was overcome, he then calculated the claimant's impairment rating to be 0%. The ALJ also held that the respondents were barred from asserting the safety rule violation because they did not raise the issue in their FAL. He also determined the equitable relief of waiver also prevented the respondents from raising the issue of a safety rule violation.

After the parties filed their petitions to review and briefs in support and opposition, the ALJ issued a supplemental order. The ALJ "withdrew" his prior determination that the respondents had waived the right to assert a safety rule violation by failing to address it in the FAL. He also "withdrew" his determination that the respondents had waived the right to assert a safety rule violation. Instead, the ALJ ruled that even though the respondents did not raise the issue of a safety rule violation in their

FAL, they nevertheless did not waive the right to assert the issue at hearing. He further held the respondents did not expressly or impliedly waive their right to assert a safety rule violation under §8-42-112(1)(a), C.R.S.

I.

On appeal, the claimant argues that the ALJ erred in determining he was not entitled to cervical and lumbar impairment ratings due solely to a lack of documented objective rigidity by the DIME physician. The claimant contends that the ALJ's interpretation of "rigidity" and what is necessary to demonstrate "rigidity" are not supported by the AMA Guides. The claimant further argues that contrary to the ALJ's determination, there is no requirement that the claimant's documented pain and rigidity be objective. We agree.

Section 8-42-107(8)(c), C.R.S., provides that the DIME physician's finding of medical impairment "may be overcome only by clear and convincing evidence." Under this statute, the question of whether the DIME physician properly applied the AMA Guides in determining the impairment rating, and whether the rating was overcome by clear and convincing evidence are questions of fact to be determined by the ALJ. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). Proof of a deviation from the rating protocols provides some evidence from which the ALJ may infer that the DIME physician's rating has been overcome. *See Id.; see also Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003). An ALJ must consider the deviation in the context of all other relevant evidence, and need not find that the rating has been overcome unless the deviation casts substantial doubt on the overall validity of the rating. *See Id.; see also Wilson v. Industrial Claim Appeals Office, supra.* Because the issue of whether the DIME physician impairment rating has been overcome by clear and convincing evidence is factual, we must uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This narrow standard of review requires us to defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and the plausible inferences he drew from the evidence. *Metro Moving and Storage Co. v. Gussert, supra*.

As pertinent here, Table 53(II)(B) of the AMA Guides permits the examiner to rate specific disorders of the cervical, thoracic, and lumbar spine if the injured person has an intervertebral disc or other soft-tissue lesion which is "[u]noperated, with medically documented injury and a minimum of six months of medically documented pain and rigidity with or without muscle spasm, associated with *none-to-minimal* degenerative changes on structural tests." (emphasis in original.) In *McLane Western Inc. v. Industrial Claim Appeals Office*, 996 P.2d 263 (Colo. App. 1999), the Colorado Court of

Appeals held that the AMA Guides do not require that the pain and rigidity occur before MMI in order to award a rating under Table 53.

Moreover, the Division of Workers' Compensation Desk Aid #11 for Impairment Rating Tips provides in pertinent part as follows:

> **General Principles**
>
> **1. Impairment Ratings Based on Objective Pathology**: Impairment ratings are given when a specific diagnosis and objective pathology is identified. *(Reference: C.R.S. §8-42-107(8)(c))* . . . .
>
> * * *
>
> **Spinal Rating**
>
> **1. Table 53 and Application of Spinal Range of Motion**: In order to be assigned a spinal rating, the patient must have objective pathology and impairment that qualifies for a numerical impairment rating of greater than zero under Table 53. Spinal range of motion impairment must be completed and applied to the impairment rating only when a corresponding Table 53 diagnosis has been established. (References: Spine section of the *AMA Guides, 3rd Edition (rev.)*; Level II Accreditation Curriculum, Spinal Impairment). (emphasis in original)

Thus, under Table 53(II)(B) of the AMA Guides and Desk Aid #11, the examiner may assign an impairment value for impairment or a specific disorder of the lumbar or cervical regions of the spine, so long as the medical evidence establishes the presence of a specific diagnosis, objective pathology, and six months of medically documented pain and rigidity.

Here, the ALJ is reading an objective standard as to "rigidity" where none exists in Table 53(II)(B) of the AMA Guides, Desk Aid #11, or Level II Accreditation. By imposing such a standard, the ALJ has erred. Nowhere in Table 53(II)(B) does it implicitly or explicitly require that the six months of medically documented rigidity be objective. Further, while Desk Aid #11 provides that impairment ratings are given when a specific diagnosis and "objective pathology" are identified, it does not state that there must be six months of medically documented rigidity which must be objective. Our interpretation of "objective pathology" cited to in Desk Aid #11, is referring to the identification of a problem, injury, disorder, condition, or disease that can be identified

by virtue of objective signs or analysis. Further, the term "objective pathology" is in addition to the "six months of medically documented pain and rigidity."[1] The "objective pathology" identified in Desk Aid #11 is not referring to the "six months of medically documented pain and rigidity." This is supported by the Division of Workers' Compensation Level II Accreditation principles, which do not require that the six months of rigidity be objective:

> Use Table 53 (p.80) (Specific Disorders of the Spine) to determine if the patient qualifies for a spinal impairment. *According to Table 53, the lowest level to qualify for impairment is 6 months of treatment for medically documented pain and rigidity. There is currently not an accepted definition for rigidity, thus the documented need for treatment over 6 months is the main criteria.* On occasion treatment may not have continued up to six months, however; no further treatment is necessary despite new functional improvement. Only the primary diagnosis related to the work injury should be considered for rating on Table 53. Table 53 spine rating is in whole-person units. (emphasis added)

See Division of Workers' Compensation Level II Accreditation, Spine Impairment General Principles at p. 132 (rev. 02/2018).[2]

Consequently, we conclude that the ALJ erred in applying an incorrect basis when determining whether the respondents overcame the DIME physician's cervical and lumbar permanent impairment ratings. We therefore remand the matter for the ALJ to apply the correct basis when determining whether the respondents have overcome, by clear and convincing evidence, the DIME physician's cervical and thoracic permanent impairment ratings. That is, on remand, the ALJ shall determine whether the medical evidence establishes the presence of a specific diagnosis, objective pathology, and six months of medically documented pain and rigidity. Again, it is not required by Table 53(II)(B) of the AMA Guides, Desk Aid #11, or the Division's Level II Accreditation that the six months of medically documented rigidity be objective. The ALJ may conduct

[1] We recognize that under §8-42-107(8)(c), C.R.S., a medical impairment rating for chronic pain shall not be rendered without anatomic or physiologic correlation, and that anatomic correlation must be based on objective findings. *See also* §8-42-101(3.7), C.R.S. However, here, we are not addressing chronic pain under §8-42-108(c), C.R.S. Instead, we are addressing cervical and lumbar spinal ratings under Table 53(II)(B) and the six months of medically documented rigidity required for such ratings.

[2] The Division of Workers' Compensation Level II Accreditation subsequently was revised in January 2019.

such further proceedings, as in his discretion, he considers appropriate to comply with this remand. Nothing in this order should be construed as dictating any particular outcome on remand.

II.

Next, the claimant argues the ALJ erred in finding that the respondents did not waive their right to assert a safety rule violation. As we understand the claimant's argument, he reasons that the record shows the respondents received documentation that the claimant was an unrestrained driver two days after the accident occurred, and this record was received months before the respondents filed their FAL. Since the respondents filed their FAL admitting to pay the full amount of TTD and failing to assert any safety rule violation, the claimant contends the respondents, therefore, have intentionally relinquished the right to assert the safety rule violation. We disagree.

In general, once an employer admits liability, the employer is bound by that admission and must pay benefits accordingly. Section 8-43-203(2)(b)(I), C.R.S.; *see e.g. Cibola Construction v. Industrial Claim Appeals Office*, 971 P.2d 666 (Colo. App. 1998)(employer admitting liability bound by admission and must pay, accordingly). And, issues admitted to in a filed FAL are closed unless the claimant timely objects. Section 8-43-203(2)(b)(II)(A), C.R.S.

Here, the respondents filed an FAL admitting to TTD from September 12, 2017, through December 13, 2017, and to a general award of maintenance care. In their FAL, the respondents did not specifically assert a safety rule violation. However, the claimant subsequently objected to the respondents' FAL and sought a DIME. After the DIME physician provided his permanent impairment ratings, the respondents then filed an application for hearing on the issues of overcoming the DIME, failure to utilize a safety device/violation of a safety rule, causation, and set offs. In *HLJ Management Group, Inc. v. Kim*, 804 P.2d 250, 253 (Colo. App. 1990),[3] the Colorado Court of Appeals held that "if an admission of liability is contested by either party, the determination of the matter thus placed in issue is subject to determination by the ALJ at the adversarial hearing. The admission is binding only until the controverted issue is determined after the hearing."

[3] In *Simpson v. Indus. Claim Appeals Office*, 219 P.3d 354, 357 (Colo. App. 2009), *rev'd on other grounds*, 232 P.3d 777 (Colo. 2010), the Colorado Court of Appeals explained that part of the holding in *HLJ Management*, which is not at issue here, is no longer good law. That holding involved when an employer's mistake in an admission results from its own erroneous calculation, it cannot retroactively withdraw or modify the admission and is bound thereby, at least until an ALJ enters an order as to prospective payments. The Court explained in 1997, the General Assembly amended §8-43-303(1) & (2)(a), C.R.S. 2008, to permit reopening of an award on grounds of "overpayment," and specified that the reopening would not affect an earlier award as to money already paid "except in cases of overpayment."

Thus, *HLJ Management* holds that a respondent may controvert its own admission of liability by timely applying for a hearing. Consequently, when the claimant here objected to the respondents' FAL and sought a DIME, the respondents' FAL did not become final, and the case was not closed. The respondents then contested the DIME and their own previous admission of liability by timely applying for a hearing, and endorsing as an issue the claimant's failure to utilize a safety device/violation of a safety rule. Under these circumstances, we agree with the respondents that they were free to raise the issue of the claimant's safety rule violation when they filed an application for hearing. As explained in *HLJ Management*, the claimant here cannot seek to enforce liability under the very admission he initially sought to contest. *See also Franco v. Denver Public Schools*, W.C. No. 4-818-579 (April 23, 2013)(respondent may controvert its own previous admission of liability by timely applying for a hearing); *see also Bauer v. Boulder County*, W.C. No. 4-020-145 (March 22, 1993). Thus, we conclude the respondents did not waive the issue of a safety rule violation.

IT IS THEREFORE ORDERED that the ALJ's order and supplemental order dated November 19, 2018, and March 4, 2019, respectively, are affirmed, in part, to the extent they determined the respondents were not barred from asserting a safety rule violation under §8-42-112(1)(a), C.R.S.;

IT IS FURTHER ORDERED that the ALJ's order and supplemental order are set aside, in part, and remanded for new findings and a new order on the issue of whether the respondents have overcome the DIME physician's impairment ratings for the cervical and lumbar spinal regions consistent with the views expressed herein.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

CERTIFICATE OF MAILING

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

6/5/19 by TT .

MCDIVITT LAW FIRM PC, Attn: AARON S KENNEDY ESQ, 19 E CIMARRON ST, COLORADO SPRINGS, CO, 80903 (For Claimant)
NATHAN DUMM & MAYER PC, Attn: TIM R FIENE ESQ, 7900 E UNION AVE SUITE 600, DENVER, CO, 80237 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-026-699

IN THE MATTER OF THE CLAIM OF:

DAIRI Y ARDON GALLEGO,

Claimant,

v.

ORDER

WIZBANG SOLUTIONS,

Employer,

and

NON INSURED,

Respondent.

The respondent seeks review of a supplemental order of the Director of the Division of Workers' Compensation (Director) dated March 8, 2019, that imposed a daily penalty of $71.94 from October 31, 2018, and continuing for its failure to comply with a previous order entered by the Director. We affirm in part, set aside in part, and remand in part for additional findings and a new order regarding the respondent's argument that the penalty imposed is "unconstitutionally excessive."

This matter commenced as a result of the respondent's failure to satisfy its mandatory obligation to maintain workers' compensation insurance coverage. *See* §§8-43-409, 8-44-101, 8-47-111, C.R.S. After the claimant was injured while working on August 31, 2016, the parties entered into a settlement agreement. The settlement agreement included a set penalty schedule for the respondent's failure to comply with its terms.

The respondent ultimately breached the settlement agreement. Following the breach, the claimant filed with the Division of Workers' Compensation (Division) a motion seeking enforcement of the settlement agreement and a request for penalties. The claimant requested penalties totaling $60,285.55, as of June 29, 2018, and payment of $28,000 pursuant to the settlement agreement. The Director issued an order directing the respondent to show good cause why the claimant's motion should not be granted.

The respondent filed a response, arguing that it had timely mailed payments to the claimant's counsel pursuant to the settlement agreement, and that in any event, the penalties requested by the claimant had been miscalculated. However, the respondent did not provide any supporting documentation in support of its arguments.

The Director subsequently ruled it was not clear if the respondent's response was filed to the claimant's motion or to the show cause order he previously had issued. So, on August 6, 2018, the Director issued another order giving the respondent another opportunity to be heard. He ordered the respondent to respond and provide documentation that all amounts required to be paid pursuant to the settlement agreement had been timely paid. He also noted that all documentation supplied shall be accompanied by an appropriate affidavit.

In response to the Director's August 6, 2018, order, the respondent argued that due to "unforeseen financial difficulties," it initially was unable to make the first few payments under the settlement agreement. But, in March 2018, it began attempting to "catch up the past due payments" by sending $1,000 checks to the claimant at the address the respondent had received. However, it stated those checks were returned undeliverable. And, due to "administrative oversight," those payments were not resent. Yet, once the error was realized, the respondent stated it promptly sent the claimant a check for $5,000. The respondent then sent an additional $1,000 check to the claimant on August 27, 2018. The respondent also stated it sent another check to the claimant in the amount of $4,500 on August 29, 2018, and this demonstrated its best efforts to cure the late payments. Citing to the Colorado Court of Appeals' opinion in *Dami Hospitality, LLC v. Industrial Claim Appeals Office*, 2017 COA 21 (Feb. 23, 2017)[1], the respondent argued that in determining whether and how much to fine or penalize, the Director must consider whether the fine is constitutionally excessive. The respondent argued that among the several factors to be considered includes its inability to pay. Attaching the affidavit of its president, the respondent stated that if the fine were imposed it "may need to seek bankruptcy protection." The respondent therefore argued that the Director should deny the claimant's motion and not impose a penalty.

On September 10, 2018, the Director entered an order, imposing penalties in accordance with the terms of the settlement agreement entered into by the claimant and respondent. The penalties the Director imposed totaled $71,940.00, which was apportioned 75% to the claimant and 25% to the Colorado Uninsured Employers' (CUE)

[1] After the respondent filed its response, the Colorado Supreme Court issued its decision in *Dami Hospitality, LLC v. Industrial Claim Appeals Office*, 2017 COA 21 (Feb. 23, 2017), reversing the Colorado Court of Appeals' opinion. *See Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC*, 2019 CO 47 (June 3, 2019).

Fund. As pertinent here, the Director ordered that the respondent shall, within 30 days, pay to the claimant the amount of $53,955 and pay to the CUE Fund the amount of $17,985. The Director also ruled that the excessive fine argument raised by the respondent did not apply because the settlement agreement was voluntarily entered into by the respondent. Regardless, the Director ordered that to the extent the *Dami* holding applied, it was waived by the respondent since the respondent voluntarily agreed to be subject to the penalties at issue. No petition to review was filed with the Division, and the Director's September 10, 2018, order became final.

However, on October 1, 2018, the respondent filed a petition to review with the Office of Administrative Courts (OAC), arguing that the Director erred in entering a fine since "uncontroverted evidence" showed payments were submitted timely and correctly to the claimant's counsel for several of the months. The respondent also argued the fine violated the Excessive Fines clause of the United States Constitution.

Then, on November 7, 2018, the Director entered another order, on his own motion, finding that payment of the penalty was due on October 30, 2018, or 30 days after his prior September 10, 2018, order had become final. As of the date of his November 7, 2018, order, however, no payment had been received. The Director ruled that pursuant to §8-43-304, C.R.S., the failure to comply with a Director's order was punishable by penalties of up to $1,000 per day. The Director found that the respondent had failed to comply with his September 10, 2018, order regarding the portion of the penalty payable to the CUE Fund. Nevertheless, the Director provided the respondent an opportunity to respond and show cause why additional penalties for its failure to comply with the September 10, 2018, order should not be imposed.

In response, the respondent argued that good cause existed for why penalties should not be imposed. The respondent argued that it timely filed a petition to review with the Office of Administrative Courts so the Director's September 10, 2018, order was not final. Alternatively, the respondent requested permission to file the petition out of time since any error in filing the petition was solely that of its counsel and should not be held against the respondent. So, the respondent argued that no penalties should be entered against the respondent for not paying penalties as directed by the Director's order.

Thereafter, on December 10, 2018, the Director issued his order, rejecting the respondent's argument that its petition to review was timely filed. The Director ruled that pursuant to §8-43-301(2), C.R.S., a petition to review an order entered by the Director is required to be filed with the Division of Workers' Compensation. Since it

was filed with the OAC and not the Division, the Director ruled it was not timely filed, and his September 10, 2018, order became final and was no longer subject to appeal. The Director also rejected the respondent's request for an extension of time to file the petition. The Director held that the statutory requirements for filing a petition to review are jurisdictional and he had no authority to extend the time limit. Lastly, the Director held the respondent failed to comply with his prior order imposing total penalties of $71,940.00 and had not established a reasonable basis for its action. He therefore ruled that a daily penalty of $71.94 was appropriate from October 31, 2018, and continuing until the respondent complied with his September 10, 2018, order.

The respondent then timely petitioned to review the Director's December 10, 2018, order. In its petition, the respondent argued it was unable to pay the original fine, its failure to pay the prior fine was due to its belief the Director's prior order was not yet final, and the amount of the current fine is "unconstitutionally excessive" under the Excessive Fines Clause of the United States Constitution. In its brief in support, the respondent argued the Director erred in holding he lacked the authority to retroactively extend the deadline to file a petition to review for his earlier order dated September 10, 2018. The respondent also argued that the fine imposed on December 10, 2018, is "unconstitutionally excessive." The respondent contended that the Director failed to consider the factors enunciated in the Colorado Court of Appeals' decision in *Dami* when imposing the fine. The respondent argued that the Director failed to consider that it is unable to pay the fine, that the failure to pay the fine was not its fault, and that there was a large disparity between the potential harm to the claimant and the fine imposed.

The Director then issued his supplemental order on March 8, 2019, rejecting the respondent's arguments. The Director held that he could not ignore binding precedent that a party that misses the 20-day statutory time limit for filing a petition for review is jurisdictionally barred from obtaining further review. Thus, he held the respondent's argument failed as a matter of law. The Director then addressed the factors enunciated in the Colorado Court of Appeals' decision in *Dami*. First, he held that the penalty imposed was less than 10% of the statutorily permitted maximum and is on the low end of the reprehensibility scale. Second, he ruled that the penalties constituted a mere 1% of the total amount the respondent had failed to pay. Thus, he held that there was proportionality between the harm caused and the penalty assessed. Third, he held that the fine was reasonable since the respondent repeatedly had failed to comply with his orders. The Director explained that as a matter of practice insurers that fail to comply with procedural orders issued by the Division are typically penalized $60 per day for the second such offense within any given 12 month period. Since the respondent's conduct occurred within the same case and within a short timeframe, the penalty of $71.94 was

reasonable. The Director also held that to the extent the respondent previously had raised its inability to pay the fine; he held that the respondent failed to provide documentation to support this allegation other than a conclusory statement in an affidavit made by its president.

The respondent has petitioned to review the Director's March 8, 2019, supplemental order.

I.

On appeal, the respondent reiterates its argument that the Director erred in holding he lacked authority to retroactively extend the deadline to file a petition to review of his prior order dated September 10, 2018. Relying on Judge Russell's dissent in *Speier v. Industrial Claim Appeals Office*, 181 P.3db 1173 (Colo. App. 2008), and the language of §8-43-207(1)(i), C.R.S., the respondent contends that the Director is empowered to grant reasonable extensions of time to extend the deadline to file a petition to review. The respondent further argues that the Colorado Court of Appeals' holding in *Youngs v. Industrial Claim Appeals Office*, 316 P.3d 50, 55 (Colo. App. 2013), that a party that misses the 20-day statutory time limit for filing a petition for review is jurisdictionally barred from obtaining further review of the order, was wrongly decided. We are not persuaded by the respondent's arguments.

Section 8-43-301(2), C.R.S. provides in pertinent part as follows regarding petitions to review the Director's order:

> Any party dissatisfied with an order that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty *may file a petition to review with the division, if the order was entered by the director*, or at the Denver office of the office of administrative courts in the department of personnel, if the order was entered by an administrative law judge, and serve the same by mail on all the parties. *The petition shall be filed within twenty days after the date of the certificate of mailing of the order, and, unless so filed, the order shall be final*. (emphasis added)

Further, §8-43-207, C.R.S. provides that the Director and administrative law judges are empowered to "grant reasonable extensions of time for the taking of any action contained in this article." However, in *Speier*, the Colorado Court of Appeals held that neither an ALJ nor the Director has authority to grant an extension of time where the

Workers' Compensation Act sets forth a jurisdictional requirement. *See also Cramer v. Industrial Claim Appeals Office*, 885 P.2d 318 (Colo. App. 1994). The Court held that the statutory time periods within which workers' compensation petitions to review must be filed are jurisdictional. Section §8-43-301(2), C.R.S.; *see also Youngs v. Industrial Claim Appeals Office of Colo., supra*; *see also Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office*, 24 P.3d 1, 2 (Colo. App. 2000)("The statutory time limits governing appellate review of workers' compensation decisions are jurisdictional."); *see also Buschmann v. Gallegos Masonry, Inc.*, 805 P.2d 1193, 1194 (Colo. App. 1991)("The timely filing of a petition to review is a jurisdictional requirement . . . ."). Although the dissent in *Speier* was of the opinion that the Director's authority or an ALJ's authority to grant extensions of time should not be limited to non-jurisdictional actions, we are bound by the majority opinions of the court. Similarly, we have no basis to disregard the Colorado Court of Appeals' holding in *Youngs*. See C.A.R. 35(e). Consequently, the respondent's argument notwithstanding, the Director does not have authority to extend jurisdictional time limits, including the 20-day time limit provided for in §8-43-301(2), C.R.S. in which to file a petition to review. Since the respondent's petition to review of the Director's September 10, 2018, order was filed incorrectly with OAC instead of with the Division, as is required under §8-43-301(2), C.R.S., this order became final and was no longer subject to review. Thus, we have no basis to disturb the Director's order on any of these grounds. Section 8-43-301(8), C.R.S.

II.

The respondent further argues that the Director's penalty is "unconstitutionally excessive." The respondent contends it is unable to pay the fine, and the Director erred in finding the penalty imposed to be proportional and similar to fines imposed in similar cases.

We set aside the Director's supplemental order, in part, and remand the matter for purposes of applying the new test set forth by the Colorado Supreme Court in *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra*. In that case, the Court adopted the "gross disproportionality" test to apply for determining whether a regulatory fine violates the Excessive Fines Clause. *See United States v. Bajakajian*, 524 U.S. 321, 334, 118 S. Ct. 2028, 141 L. Ed. 2d 314 (1998). According to the Court, in assessing proportionality, the Director should "consider whether the gravity of the offense is proportional to the severity of the penalty, considering whether the fine is harsher than fines for comparable offenses in this jurisdiction or than fines for the same offense in other jurisdictions." *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra* p. 38. The Court further stated that when considering the severity of the penalty, the ability of the regulated entity to pay is a relevant consideration. Also, the Court held that

the proportionality analysis should be conducted in reference to the amount of the fine imposed for each offense, and not the aggregated total of fines for many offenses. *See* §8-43-304(1), C.R.S. ("Any employer . . . [who] fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director . . . shall also be punished by a fine of not more than one thousand dollars per day for each offense. . . ."); *see also* §8-43-305, C.R.S. ("Every day during which any employer . . .fails to comply with any lawful order of . . .the director. . . shall constitute a separate and distinct violation thereof. . . ."). Consequently, we remand the matter so that the Director can, as "appropriate or necessary", permit the development of an evidentiary record sufficient to apply the "gross disproportionality" test, to determine whether the per diem fines at issue are proportional to the harm or risk of harm caused by each day of the respondent's failure to comply with the Director's prior order dated September 10, 2018. *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra* p. 37.

IT IS THEREFORE ORDERED that the Director's supplemental order dated March 8, 2019, is affirmed, in part, to the extent it determined that the prior order dated September 10, 2018, was final and was no longer subject to review;

IT IS FURTHER ORDERED that the Director's supplemental order is set aside, in part, and remanded for additional findings and a new order to apply the "gross disproportionality" test as set forth in *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra*.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

6/14/19 by TT .

ADAN CERDA & ASSOCIATES LLC, Attn: ADAN CERDA ESQ, 6000 E EVANS AVE SUITE 3-400, DENVER, CO, 80222 (For Claimant)
SPENCER FANE LLP, Attn: JACOB F HOLLARS ESQ, 1700 LINCOLN ST SUITE 2000, DENVER, CO, 80203 (For Respondents)
DIVISION OF WORKERS COMPENSATION, Attn: TAYLOR DURAN, 633 17TH STREET SUITE 400, DENVER, CO, 80202 (Other Party)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-050-347-01

IN THE MATTER OF THE CLAIM OF:

CHARLOTTE SUOMIE,

Claimant,

v.

FINAL ORDER

SPECTRUM RETIREMENT COMMUNITIES,

Employer,

and

GRANITE STATE INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of the Corrected Order of Administrative Law Judge Margot Jones (ALJ) dated May 3, 2018, that denied to the claimant the statutory right to request a division-sponsored independent medical examination (DIME). We reverse the ALJ's order.

A summary of the factual and procedural history of this case will place the issue before us in proper focus. On July 13, 2017, respondents filed a final admission of liability (FAL) with a date of maximum medical improvement (MMI) of June 7, 2017. The FAL was a so-called "medical-only" FAL as there was no admission for any permanent medical impairment or temporary disability benefits. The claimant timely objected to the FAL and timely submitted a Notice and Proposal to Select a DIME. The claimant subsequently filed an Application for a DIME regarding the impairment rating and the date of MMI.

On August 18, 2017, respondents filed a Motion to Strike Claimant's DIME Process with the prehearing unit at the division. The motion relied upon the Supreme Court's holding in *Harman-Bergstedt v. Loofbourrow*, 320 P.3d 327 (Colo. 2014)(*Loofbourrow*). PALJ Barbo granted the respondents' motion in a summary order dated September 7, 2017. The PALJ added, "Since the DIME process is not ripe the granting of this motion is without prejudice."

The claimant applied for a hearing at the Office of Administrative Courts (OAC) to appeal the PALJ's order. Hearing was held before ALJ Jones on February 1, 2018. The ALJ initially entered Findings of Fact, Conclusions of Law, and Order on May 1, 2018. The ALJ issued a Corrected Order on May 3, 2018. The Corrected Order held that the claimant does not have the statutory right to a DIME.

The ALJ reasoned that based on the ruling in *Loofbourrow*, the filing of the FAL, premised on the finding of MMI with no disability indemnity payable, does not allow claimant the opportunity to begin the DIME process by filing a notice and proposal for a DIME and claimant cannot request a DIME under Section 8-42-107(8)(b)(II), C.R.S. The ALJ affirmed the order of the PALJ and the claimant's request for a DIME was denied.

The claimant timely filed a Petition to Review the Corrected Order. The transcript of the hearing was prepared and filed with OAC on June 20, 2018. Counsel for the claimant moved to withdraw his representation on July 3, such being approved by order of the OAC on July 19. On July 23, the OAC served notice that the transcript had been received and instituted a briefing schedule. (The notice to the claimant was returned as undeliverable.) No briefs were received from either party. On October 17, the OAC served an amended notice that the transcript had been received and instituted a new briefing schedule. No briefs were received from either party. On January 28, 2019, OAC served a 2nd amended notice that the transcript had been received and instituted another briefing schedule. No briefs were received from either party. The ALJ referred the appeal to the Panel on April 30, 2019.[1]

Typically, when the appellant does not submit a brief in support of the Petition to Review, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986). However, the lack of a brief in support of the appeal does not bar the panel from ruling on a timely petition to review. *Jiminez v. Industrial Claim Appeals Office*, 107 P. 965, 967 (Colo. App. 2003).

[1] On June 10, 2019, the respondents submitted to us a copy of an April 12, 2019, Director's Order to Show Cause why the claim should not be closed for failure to prosecute. This submission was not part of the record forwarded from OAC for our review. In addition, we have no knowledge if the claimant responded to the show cause order by the May 13, 2019, 30-day deadline. Our jurisdiction commenced on April 30, 2019, prior to the date of implementation of the show cause order. Regardless of whether or not the claimant responded, we do not view this order as eliminating our jurisdiction to review the claimant's petition to review. In respondents' motion to show cause, they seemed to wrongfully conflate the failure to prosecute a claim (i.e.-file an application for hearing) with the non-filing of a brief in support of a petition to review. We conclude this conflation to be inapplicable to extinguish our jurisdiction to consider the claimant's petition.

Whether the ALJ applied the proper legal standard is a question of law subject to review de novo. *See Indus. Claim Appeals Office v. Softrock Geological Servs., Inc.*, 2014 CO 30, ¶ 9. We conclude that the ALJ did not apply the proper legal standard.

Another panel of the ICAO, has recently held that the expansive concept announced by the *Loofbourrow* court regarding "maximum medical improvement as a statutory term of art" was dicta and did not apply to circumstances involving a FAL when no indemnity is payable. It was further held that the *Loofbourrow* dicta was not persuasive and had deleterious effects in its application, as it has been used to deny claimants the right to a DIME without procedural due process. *See Martinez v. Energy Saving Crew LLC,* W.C. No. 5-055-251-002 (May 31, 2019).

In the aftermath of the *Loofbourrow* decision, the ICAO has addressed its ramifications in multiple situations. It is fair to state that the ICAO decisions have undergone a metamorphosis as the effects of the *Loofbourrow* dicta have become apparent as new claims, with different facts have arisen. We discuss the evolvement below.

Harman-Bergstedt, Inc. v. Loofbourrow

In *Loofbourrow*, the Court was presented a specific factual situation where the claimant sustained an injury, but did not miss at least three working shifts. The respondents voluntarily paid the medical expenses of the claimant until she reached MMI (as determined by the employer designated physician (ATP)). The physician also found no permanent medical impairment. The WC insurance carrier took no further action and filed neither a FAL nor a Notice of Contest. The claimant did not request a DIME, either to challenge the finding of MMI or the extent of any permanent medical impairment. Several months later the claimant's condition worsened and she was unable to perform her job due to physical restrictions that the employer could not accommodate. The claimant sought temporary disability benefits and additional medical treatment.

Ultimately, the Court determined that the claimant's claim for temporary disability benefits was not barred for lack of requesting a DIME to challenge the medical finding of MMI. In its discussion relating to MMI the Court stated:

> 'Maximum medical improvement,' as a statutory term of art, therefore has no applicability or significance for injuries insufficiently serious to entail disability indemnity compensation in the first place. While the concept is defined

> in terms of the ineffectiveness of further medical treatment and may therefore be useful in assessing the extent to which an employer is obligated to continue furnishing medical services to an injured employee, as a statutory term of art with consequences for *(1)* contesting a final admission of liability, *(2)* reopening a closed claim, or, *(3) as in this case*, filing a new claim for an injury that has become compensable for the first time, it can logically have applicability only for injuries for which disability indemnity is payable. (Enumeration added for explanatory purposes below.) (Emphasis added.)
>
> * * *
>
> The statutory consequences of a finding of 'maximum medical improvement' can apply only in injuries as to which disability indemnity is payable. (Internal citations omitted.) 320 P.3d at 331.

In our review of *Loofbourrow* in *Martinez v. Energy Saving Crew LLC, supra.*, we examined the Court's language. The Panel wrote:

> The case which the *Loofbourrow* Court conceded was actually before it, was the case enumerated as number three in the quote immediately above. The first and second enumerated situations did not exist in the claim and were not before the Court. Thus, the Court's application of the "MMI-term of art" beyond the case before it was unnecessary. Being unnecessary for the Court's determination, we view the Court's application of the "MMI-term of art" to the other situations as *obiter dicta* (dicta). The dicta is easily recognizable by the Court's raising a "logical[]" or, in other words, an analogical or hypothetical analysis. Consequently, we are not bound to the dicta under the doctrine of *stare decisis* in our consideration of the instant claim.
> *Martinez* at pg. 7.

We also opined that the *Loofbourrow* Court compounded its dicta by again raising the two scenarios that were not before it when it further stated:

> As will ever be the case with a worsening injury that initially required treatment but did not result in excess of three days' lost work time, no award of temporary disability benefits *or admission of final liability was possible and no claim that could be subject to reopening* was ever opened or closed.
> (Emphasis added.)
> *Id.* at 331.

In the instant claim, the respondents filed a FAL on July 13, 2017. This fact distinguishes this claim from that of *Loofbourrow*. (This situation is the first enumerated situation, described above, that was not before the *Loofbourrow* court.) However, here the ALJ applied the *Loofbourrow* dicta to the claim and denied the claimant the right to a DIME. This result is contrary to the Supreme Court's decision in *Whiteside v. Smith*, 67 P.3d 1240, 1246 (Colo. 2003).

The right to a DIME was examined in detail by the *Whiteside* Court. The Court addressed whether fundamental due process was denied to indigent claimants by requiring them to pay a fee for the DIME process. The Court held that the statutory fee effectively denied indigent claimants their right to a DIME; thereby denying fundamental due process. In doing so, the Court determined that the right to a DIME is a statutory right, denial of which violates the Fourteenth Amendment of the U.S. Constitution.

The *Whiteside* Court stated:

> The substantive right to workers' compensation is a constitutionally protected property interest. For injured workers in Colorado, the Act secures certain benefits and supports claims of entitlement to those benefits.
> *Id.* at 1247.
>
> * * *
>
> Our due process analysis is limited to Colorado's WC Act and the specific administrative and judicial regime of review under the Act that the state has created to ensure that workers are not prematurely denied temporary disability benefits and medical treatment.
> *Id.* at 1248.
>
> * * *

> The fundamental requirement of due process is the opportunity to be heard 'at a meaningful time and in a meaningful manner.'
> *Id.* at 1248.

The *Whiteside* Court struck down statutory provisions requiring indigent claimants to pay for DIME evaluations because it effectively denied them the right to challenge the ATP's opinion. It effectively determined that any statute that precludes full recourse to the DIME process violates a claimant's due process rights.

We conclude that the *Whiteside* reasoning applies equally to a class of injured workers that did not lose more than three days of work and upon whom a potentially biased—employer selected—employer paid—ATP determines that MMI has been reached (terminating medical care) and determines that no permanent medical impairment exists.

Kazazian v. Vail Resorts, W.C. No. 4-915-969-03 (April 24, 2017)

In Kazazian, a panel of the ICAO, relying on the *Loofbourrow* dicta, concluded that a FAL had not closed the claim because the FAL had not admitted for any temporary disability benefits or permanent medical impairment benefits. The Panel expanded the *Loofbourrow* dicta in its interpretation of the Court's holding:

> Claims which do not feature liability for temporary or permanent indemnity benefits cannot be closed through any procedure which applies a finding of MMI. This would include a FAL filed pursuant to W.C. Rule of Procedure 5-5.
> *Kazazian* at pg. 3.
>
> * * *
>
> Without an applicable determination of MMI, no DIME review of the MMI determination may be requested, § 8-42-107(8)(b)(II), no permanent impairment rating may be calculated *nor DIME review initiated*, § 8-42-107(8)(c), and the provisions of Section 8-43-203(2)(b)(II) cannot control because one of the options provided by that section includes the ability to request a DIME. The subsidiary factual dispute presented by the parties, i.e. the date by which the claimant needed to object to the FAL and to request a DIME, does not

> have any bearing on the rights of the parties according to § 8-34-203(2)(b)(II) as that section does not yet apply in this claim. (Emphasis added.)

The Panel set aside the ALJ's order and determined that claimant's objection to the FAL and request for the DIME could not have been untimely, since the FAL was essentially a nullity and thus no time period ever began to run.

The *Kazazian* panel effectively barred a DIME when a medical-only FAL is filed. We view the *Kazazian* holding as unfortunate and, as applied, an unconstitutional deprivation of a property right without procedural due process of law.

Trujillo v. Elwood Staffing, W.C. No. 4-957-118 (June 22, 2017)

In this claim, respondents filed a "med-only" FAL. The claimant objected and requested a DIME. The DIME physician concluded that the claimant was not at MMI. Respondents filed a general admission, reopening the claim for further treatment. After additional treatment, the claimant was again placed at MMI by the DIME as of October 2015 with no impairment. Respondents filed another "med-only" FAL in February 2016. In June 2016, the claimant revisited his physician, reporting his symptoms had worsened. In November 2016, the ATP opined that the claimant was not at MMI and recommended surgery.

At hearing, the claimant sought to overcome the DIME that he had reached MMI in October 2015. The ALJ determined that claimant had not overcome the DIME that he was at MMI on October 2, 2015. The ALJ concluded that the claimant had a change of condition after MMI, and found that the claim had been closed by the February 2016 FAL and the claimant needed to proceed under a reopening procedure.

The Panel set aside the ALJ's order relying on the *Loofbourrow* dicta and ICAO's prior *Kazazian* decision, concluding that a determination of MMI has no statutory significance for non-indemnity claims. The Panel held that the claim could not have been closed by the February 2016 FAL and thus a reopening was not required, only a showing that the recommended medical treatment was reasonable, necessary, and related to the work injury. We view *Trujillo* as an unfortunate, incorrect, and overly broad application of *Loofbourrow* and we choose not to follow it here.

Ramirez-Chavez v. In-Out Field Services, W.C. No. 5-019-466-01 April 12, 2018).

In this claim, respondents filed a med-only FAL in July 2016. The claimant obtained a DIME that upheld the finding of MMI but assigned 10% whole person impairment (on what was previously admitted 0% impairment). Respondents filed a second FAL in December 2016, admitting for 10% whole person impairment. Claimant sought a hearing to overcome the DIME only as to the date of MMI. The ALJ determined that the claimant had overcome the DIME as to MMI and awarded medical benefits. Respondents appealed the decision to the Panel.

The Panel first noted that the July 2016 med-only FAL couldn't be validly filed under the *Loofbourrow* dicta. However, the Panel modified its reasoning from that found in *Kazazian* and *Trujillo*, stating:

> While this prohibition concerning the respondents' inability to file a FAL (in July 2016) affects the validity of that FAL to close the claim or to limit the time within which the claimant is required to request a DIME, it does not serve to restrict the claimant's ability to initiate the DIME process."

A second panel examiner concurred in the result, but issued a concurring opinion disagreeing with the application of *Loofbourrow* to invalidate the July 2016 FAL. The concurring examiner stated: "… the principles announced in *Loofbourrow* are limited to the particular facts of that case and should not be read to invalidate an otherwise [valid] final admission of liability that follows both the statute and the WC rules of procedure."

Nonetheless, the Panel essentially conceded that the *Loofbourrow* dicta had been too broadly applied in *Kazazian* and *Trujillo.*

Gibson v. Atlantic Relocation Systems, W.C. No. 5-020-939-01 (Sept. 5, 2018).

In this claim, the respondents filed a med-only FAL. The claimant objected and requested a DIME. The DIME agreed with the date of MMI, but provided a 19% whole person impairment. Relying on *Loofbourrow*, respondents filed a motion to strike the DIME process altogether (after the fact). At hearing, the merits ALJ denied the motion and the matter proceeded on the merits. The ALJ ultimately rejected the respondents' argument that the holding in *Loofbourrow* barred the claimant from pursuing a DIME. The ALJ held that the respondents' FAL triggered the claimant's time period for applying for a DIME to address MMI and permanent medical impairment. The ALJ upheld the DIME's 19% whole person impairment.

On appeal, the Panel concluded that a claimant, who has not suffered wage loss or lost time and is placed at MMI with a zero percent impairment, is entitled to request a DIME to challenge MMI and the rating. *See* § 8-42-107(8)(c), C.R.S. The Panel also concluded that the "med-only" FAL was sufficient to trigger the claimant's right to request a DIME under § 8-42-107.2, C.R.S. The Panel affirmed the ALJ's order to the extent it denied the request to strike the DIME.

Martinez v. Energy Saving Crew LLC, W.C. No. 5-055-251-002 (May 31, 2019)

In this claim, respondents filed a med-only FAL on June 22, 2018. Therein, respondents admitted for medical benefits provided up to the date of MMI, and denied liability for other benefits (included specific indemnity benefits). The claimant did not file an objection to the FAL or request a DIME until 75 days after the date of the FAL. We held that the FAL was validly filed despite the fact that indemnity was denied in the "med-only" FAL, and that the claimant's failure to timely file an objection to the FAL and a request for a DIME jurisdictionally barred the same. The Panel stated:

> Over time, the *Loofbourrow* dicta has been extensively analyzed and examined and the Panel's decisions have evolved. In retrospect, the dicta appear to us to be facile, i.e. appearing neat and comprehensive only by ignoring the true complexities of the issues. The application of the principles announced in *Loofbourrow* is limited to a very specific factual scenario and concerns the sole issue of the claimant's entitlement to TTD in a case where a claimant had not filed a claim, suffered no wage loss, the injury was not reported to the Division and there was no admission filed. While we agree that MMI is a statutory term of art, it nevertheless has great applicability and significance for all injuries, including those insufficiently serious to entail disability indemnity compensation.

We conclude that the ALJ erred in denying the claimant the right to a DIME. Such denial of the right to a DIME is contrary to the due process rights of the claimant as set forth in *Whiteside*, *supra*.

IT IS THEREFORE ORDERED that the ALJ's corrected order issued May 1, 2018, is reversed. We remand the claim to the ALJ to enter an order reinstating the claimant's Notice and Proposal to Select a DIME and the Application for a DIME.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

Kris Sanko

CERTIFICATE OF MAILING

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

6/14/19 by TT .

CHARLOTTE SUOMIE, 3300 S TAMARAC DR APT 111, DENVER, CO, 80231 (Claimant)
LEE & BROWN LLC, Attn: BRADLEY HANSEN ESQ, 3801 E FLORIDA AVE SUITE 210, DENVER, CO, 80210 (For Respondents)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-032-239-02

IN THE MATTER OF THE CLAIM OF:

EMMA GARCIA,

Claimant,

v.

FINAL ORDER

MV TRANSPORTATION INC,

Employer,

and

INDEMNITY INSURANCE CO OF N AMERICA c/o BROADSPIRE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Turnbow (ALJ) dated June 26, 2018, that denied additional medical benefits and temporary disability benefits. We affirm.

The ALJ conducted the evidentiary hearing over two sessions on January 1 and March 23, 2018. The hearing was held on several issues, including whether claimant was entitled to additional medical care; whether claimant was entitled to temporary partial and total disability benefits; a determination of average weekly wage (AWW); and whether respondents overcame the division sponsored independent medical examination (DIME) report of Dr. Mason on the issue of maximum medical improvement (MMI).

The claimant sustained an admitted injury on January 9, 2015. Treatment was provided to the claimant and on June 2, 2016, Dr. Wakeshima, an authorized treating physician (ATP), determined that claimant had reached MMI.

In her report of May 8, 2017, Dr. Mason, a DIME physician, opined that the claimant "did not remain" at MMI and recommended additional medical treatment. After the additional treatment was authorized and provided, the claimant stipulated that she reached MMI on October 25, 2017, based on a medical report of an IME physician, Dr. Moses. The ALJ found that the claimant had not presented any persuasive evidence that the respondents denied any recommended medical care or that any payment for such care

remains outstanding. The ALJ found that the claimant had not met her burden of proving entitlement to additional medical treatment.

The claimant's injury took place on Friday, January 9, 2015. Claimant received treatment from Dr. Updike, who provided light duty restrictions. Claimant was paid for that day. The claimant did not work over the January 10-11 weekend. On Monday, January 12, the claimant met with the employer's safety and training manager to discuss Dr. Updike's restrictions. Claimant was informed that the employer could accommodate the claimant with light duty work. Claimant was instructed to return early on Wednesday, January 14 so that a written offer of light duty work could be instituted. Nevertheless, the employer paid the claimant for the first three days of lost work. The manager and the claimant met on January 14 at which time the employer offered modified duties. The employer explained the modified job to the claimant that for four hours she was restricted to sitting. During those four hours, claimant would fold laundered uniforms, clean wheelchairs, and sort and file paperwork; all while seated. For the other four hours of work, claimant would perform light janitorial work which meant she would pick up papers and empty light, small trashcans in the office area. Claimant would be provided with a two-wheeled small cart to put trash in and with a reaching tool to eliminate the necessity of bending to pick up trash. The manager showed the claimant a diagram showing the wheeled cart and reaching tool and demonstrated how to perform the tasks.

Claimant refuted the employer's testimony and testified that the employer only offered picking up trash, which she assumed involved bending and hauling bags of trash. She further testified that her notion of light duty was "sitting at a desk putting envelopes into envelopes." Although claimant was only restricted to sitting for four hours, claimant wanted sitting duty for her entire shift. Claimant signed the modified work offer; however, she did not read it. Claimant testified that she told the manager that she wanted "to rest up" and chose to stay home. Claimant declined to do the light duty work that had been offered to her. The manager explained to the claimant that her decision could jeopardize her WC benefits and her employment status.

At the January 14 meeting, the claimant asked the manager if she could use her accrued sick and vacation time instead of working light duty. On January 16, the employer notified claimant that corporate had approved her request to use her accrued time off. She used her eight hours of accrued vacation and 20 hours of accrued sick leave. When claimant had exhausted her accrued leave, she asked the employer if she could take unpaid leave while continuing with her medical treatment and the employer allowed her to do so.

The ALJ found the manager's version of events to be more likely true than claimant's version because of multiple reasons. The ALJ described the claimant as a "poor historian;" that her "testimony tested the limits of credulity;" that claimant forgot a separate claim from the year before wherein she injured the same body parts, although such injury gave rise to a District Court filing; and responded in interrogatory answers that the WC providers were the only doctors who had treated the neck, upper back, and shoulder, despite seeking past medical expenses as an element of her damages in the tort case.

The ALJ also found the claimant's testimony was "often unreasonable and illogical." The ALJ cited two examples. Claimant was confronted with a surveillance video showing her mowing the lawn and testified, "I did it to get my vitamin D." Claimant testified that her shoulder was hurting before her work injury, and that she did not seek treatment because she "thought [her] passengers would have to take care of [her]."

Claimant was released from her restrictions on March 10, 2015. She returned to full-time, full-duty work the next day. She continued to work in that capacity until the employer terminated her employment on March 13, 2018.

The ALJ determined that claimant voluntarily chose to remain off work rather than perform the accommodating light-duty job. The ALJ concluded that the claimant had not met her burden of proving entitlement to any temporary disability benefits, thus rendering the AWW issue moot. The findings of the ALJ implicitly indicate the claimant was responsible for the interruption of her employment on January 14 pursuant to § 8-42-105(4)(a). The claimant was offered a modified duty job corresponding to her suggested work restrictions. The refusal of a claimant to accept an offer of modified work in those circumstances requires that "the resulting wage loss shall not be attributable to the on-the-job injury." *Willhoit v. Maggies's Farm*, W.C. No. 5-054-125-01 (July 26, 2018); *McCloud v. Progressive Insurance*, W.C. No. 4-980-200-01 (April 1, 2016).

In addition, the ALJ concluded that the claimant's stipulation to an MMI date of October 25, 2017, and the fact that the employer provided all appropriate medical treatment prior to the stipulated MMI date, the issue of overcoming the DIME on MMI was also moot.

Based on the foregoing findings, the ALJ denied and dismissed claimant's claim for additional medical treatment. The ALJ also denied and dismissed claimant's claim

for temporary disability benefits. The ALJ determined that the issues of AWW and overcoming the DIME as to MMI were moot.

The claimant filed a petition to review of the ALJ's order on July 16, 2018, asserting that the ALJ did not resolve conflicts in the evidence; that the findings of fact do not support the conclusions of law; and that the conclusions of law are not based on applicable case law. Shortly after the filing of the petition to review, counsel for the claimant withdrew as counsel of record, such being approved by the ALJ on August 24, 2018. Counsel for the respondents thereafter withdrew as counsel of record, such being approved by the ALJ on November 27, 2018. The ALJ also entered an order on February 13, 2019, striking the claimant's request for a transcript because none had been filed within 25 working days of the request or otherwise within the time limit of any extension. Section 8-43-213 (2), C.R.S.; Office of Administrative Courts rule of procedure 26(D), OACRP-1 Code Colo. Reg., 104-3 at 12.

We note that the transcript of the January 1, 2018, hearing had been transcribed and filed prior to the March 23, 2018, hearing, and is in the record. However, the record does not contain a transcript of the March 23 hearing. Absent a transcript of the March 23, 2018, hearing, the effectiveness of our review is severely limited, and we must presume that the ALJ's factual findings are supported by the record. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986); *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988).

In addition, the claimant has not filed a brief in support of her petition to review and, again, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, *supra*. The lack of a brief in support of the appeal does not bar the panel from ruling on a timely petition to review. *Jiminez v. Industrial Claim Appeals Office*, 107 P. 965, 967 (Colo. App. 2003). However, the claimant's contentions are not further developed on appeal, never articulating precisely what facts are being challenged or how the decision is contrary to the applicable law.

The question of whether the claimant proved an entitlement to medical or indemnity benefits proximately caused by the employment is one of fact for determination by the ALJ. Consequently, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claims Appeals Office*, 989 P.2d 251 (Colo. App. 1999). This standard of review requires us to defer to the ALJ's resolution of conflicts in the evidence, credibility determinations and plausible inferences drawn from the record. *Wal-Mart Stores, Inc., id*. Testimony is not incredible as a matter of law absent extreme

circumstances where the testimony is rebutted by such 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 (Colo. App. 2000). Nor is testimony incredible as a matter of law merely because it is inconsistent or conflicts with other evidence. *People v. Ramirez*, 30 P.3d 807 (Colo. App. 2001). Further, to the extent the testimony of a witness is internally inconsistent, or subject to conflicting inferences, the ALJ may resolve the inconsistency by crediting part or none of the testimony. *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997).

Our review of the record on appeal does not substantiate claimant's claim that the ALJ failed to resolve conflicts in the record. In addition, the claimant has not persuaded us that that the findings of fact do not support the conclusions of law. Nor are we persuaded that the conclusions of law are not based on applicable case law. The ALJ's denial and dismissal of additional medical benefits and temporary disability benefits is supported by substantial evidence in the record, and thus we have no basis to disturb the ALJ's order. We perceive no other error in the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order issued June 26, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

David G. Kroll

CERTIFICATE OF MAILING

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

6/18/19 by TT .

EMMA GARCIA, 4848 BRYANT ST, DENVER, CO, 80221 (Claimant)
CONDIT CSAJAGHY LLC, Attn: CHRISTOPHER CONDIT ESQ, 695 S COLORADO BLVD STE 270, DENVER, CO, 80246 (For Respondents)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-066-095-002

IN THE MATTER OF THE CLAIM OF:

KAREN ANDERSON,

Claimant,

v.

FINAL ORDER

SUMMIT AUTOMOTIVE PARTNERS LLC,

Employer,

and

FEDERATED MUTUAL INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Michelle Jones (ALJ) dated November 30, 2018, that determined the lumbar fusion recommended by Dr. Drewek is reasonable, necessary and causally related to the claimant's April 1, 2017, work injury. We affirm the ALJ's order.

This matter went to hearing on whether the recommended spinal fusion surgery was reasonable, necessary and related to the claimant's work injury. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant worked as a car salesperson for this employer. On April 1, 2017, the claimant was preparing a vehicle for a customer and took the car to wash and vacuum it. The claimant accidentally stepped out of the vehicle without putting it fully into park and the car began rolling away. The claimant attempted to get back into the car to put her foot on the brake and was knocked over by the vehicle. The rear tire rolled over her left leg which caused her to twist and fall onto her back and elbow.

When the paramedics arrived on the scene the claimant reported left knee pain and tenderness and denied any head, neck or back injury. The claimant reported a history of lower back surgery and told the paramedics that she felt like her back was having spasms due to lying on the ground for a while. The claimant was initially diagnosed with a

crushing injury of the left knee, and left lower leg, contusion of the left elbow and pain in the right hip.

The claimant continued to report pain in her left leg and reported right hip pain and low back pain. Dr. Zickefoose questioned whether the SI joint, lumbar spine or hip joint were causing the claimant's leg pain and referred the claimant for an MRI of her lumbar spine. The MRI revealed protrusions and osteophytes and zygapophyseal joint arthritis at T12-L1, L1-2, L2-3 and L3-4, mild right lateral recess stenosis at T12-L1; mild lateral recess and mild canal stenosis at L1-2; mild canal stenosis and severe left lateral recess stenosis at L2-3 with mild inferior left foraminal stenosis, severe canal, severe right and moderate left lateral recess stenosis and mild right foraminal stenosis at L3-4; scoliosis present convex to the right with the apex at the L2-3 level with osteophytes present along the concave aspect of the curve. Dr. Zickefoose did not believe the claimant's pain was coming from the back but wanted Dr. Drewek's opinion.

Dr. Drewek diagnosed the claimant with lumbar spine pain and lumbar stenosis and recommended a bilateral L3-4 epidural injection. Dr. Drewek noted that the claimant had a severe deformity at the L2-3 level toward the left side and opining that the deformity was likely related to the work injury trauma, as the claimant had no symptoms prior to the trauma. In Dr. Drewek's opinion, the claimant clearly needed correction of the deformity at the L2-3 level because of the loss of disc at the L2-3 level on the left side.

Dr. Scott reviewed the surgical request. According to Dr. Scott the claimant did not injure her lower back on April 1, 2017, and the changes the claimant experienced were the result of pre-existing degenerative changes due to a prior fusion and the claimant's scoliosis. Dr. Scott stated that although the lumbar fusion by Dr. Drewek may be reasonable, it was not related to the work injury of April 2017, injury and, therefore, the insurer should deny authorization for the surgery.

The ALJ found that the claimant had a long history of low back pain complaints and issues prior to the April 1, 2017, work injury which included a fusion in 1995, being thrown down a flight of 15 stairs in 2011, a revision of a left total hip arthroplasty in 2014, and an evaluation of radiating neck pain in 2016. The claimant testified at hearing that at the time of the April 1, 2017, injury the focus was on her left knee because it had been run over and that over the next few weeks she had increased pain in her back that was definitely different than any pain she had before her injury.

The ALJ found the claimant's testimony and Dr. Drewek's opinion credible and persuasive concerning the claimant's pain and cause of her current back symptoms. The ALJ specifically rejected Dr. Scott's opinion. The ALJ concluded that the April 1, 2017, work injury resulted in the claimant's severe back symptoms and found that the surgery recommended by Dr. Drewek was reasonable, necessary and causally related to the April 1, 2017 injury.

On appeal the respondents argue that the ALJ erred in relying on Dr. Drewek's opinion because Dr. Drewek's opinion was allegedly based on the claimant's misrepresentation that her back condition was asymptomatic prior to the April 1, 2017, work injury. We are not persuaded the ALJ committed reversible error.

Section 8-42-101(1)(a), C.R.S. requires an employer to furnish reasonable and necessary medical treatment "to cure and relieve the employee from the effects of the injury." *See Owens v. Industrial Claim Appeals Office*, 49 P.3d 1187, 1188 (Colo. App. 2002). The question of whether medical treatment is reasonable, necessary and related is one of fact for determination by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claims Office*, 989 P.2d 251 (Colo. App. 1999). Because these issues are factual in nature, we must uphold the ALJ's findings if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Substantial evidence is that quantum of probative evidence that would support a reasonable belief in the existence of a fact without regard to conflicting evidence or inferences. *See Dow Chemical Co. v. Industrial Claim Appeals Office*, 843 P.2d 122 (Colo. App. 1992).

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 resolution of conflicts in the evidence, credibility determinations, and plausible inferences drawn from the record. If the record supports two possible inferences, it is the ALJ's prerogative to determine which inference to draw. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003). Moreover, the ALJ only need enter specific factual findings concerning the evidence she found to be dispositive, and conflicting evidence and inferences are presumed to have been rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). In resolving inconsistencies the ALJ may credit all, part or none of an expert's testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 165 Colo. 504, 441 P.2d 21 (1968); *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, *supra.*

Here, we perceive no error in the ALJ's order determining that the lumbar fusion surgery recommended by Dr. Drewek is reasonable, necessary and causally related to the

April 1, 2017, work injury. Contrary to the respondents' argument there is ample evidence in this record supporting the ALJ's findings. The claimant's testimony and medical reports constitute substantial evidence supporting the conclusion that the claimant's need for a fusion surgery is related to the April 1, 2017 work injury. As noted above, the claimant testified that her back condition after her work injury was different and worse than prior to her work injury. Tr. at 22. The claimant also testified that lying down for the left knee MRI aggravated her lower back condition and caused her back to go into spasms. Tr. at 23-24. Dr. Drewek indicated that the claimant's problem was most likely related to the trauma from her work-related injury as she describes because she was not having problems prior to that event. Claimant's Ex. 9 at 139 and 143. Even Dr. Scott recognized that the claimant had not had any treatment for her low back in the years and months leading up to the April 1, 2017, injury. Tr. at 46. The claimant's testimony and Dr. Drewek's opinion were credited by the ALJ. Based on the evidence presented it was plausible for the ALJ to infer that the claimant was having low-level symptoms in her back prior to her work injury and that these problems became more severe after the injury.

The ALJ's assessment of the probative value of the evidence and her credibility determinations are matters solely within her province. We may not set aside a credibility determination unless the testimony of a particular witness, although direct and unequivocal, is "so overwhelmingly rebutted by hard, certain evidence directly contrary" that a fact finder would err as a matter of law in believing the witness. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). Consequently, the ALJ's credibility determinations are binding except in extreme circumstances. *Arenas v. Industrial Claim Appeals Office*, 8 P.3d. 558 (Colo. App. 2001). We will neither reweigh the evidence nor substitute our judgment for that of the ALJ regarding the credibility of the competing witnesses. To the extent that the respondents argue that there is evidence which suggests that the fusion is not related to the April 1, 2017, work injury, the ALJ was not required to expressly cite to such evidence before rejecting it as being unpersuasive. *See Magnetic Engineering, Inc. v.* Industrial *Claim Appeals Office, supra.*

The ALJ's findings are supported by the evidence in the record and those findings, in turn, support the ALJ's conclusion. We, therefore, have no basis to disturb the order on review. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated November 30, 2018, 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

6/18/19 by TT .

BURG SIMPSON ELDREDGE HERSH & JARDINE PC, Attn: STEPHAN M MARSH ESQ, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)
NATHAN DUMM & MAYER PC, Attn: TIMOTHY R FIENE ESQ, 7900 EAST UNION AVENUE SUITE 600, DENVER, CO, 80237-2776 (For Respondents)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-886-616-04

IN THE MATTER OF THE CLAIM OF:

YESENIA THOMPSON,

Claimant,

v.

FINAL ORDER

HOME DEPOT,

Employer,

and

LIBERTY MUTUAL INSURANCE COMPANY,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Margot W. Jones (ALJ) dated October 17, 2018, that awarded disfigurement benefits and that determined the claimant failed to overcome the opinion of the Division sponsored independent medical examination (DIME) physician on maximum medical improvement (MMI). We affirm.

This matter went to hearing on whether the claimant overcame the opinion of DIME physician, Dr. Goldman, on MMI for injuries resulting from her May 5, 2012, work injury, and whether the claimant proved entitlement to disfigurement benefits.

After the hearing, the ALJ made the following pertinent factual findings. The claimant sustained an admitted injury when she was lifting a 12 x 12 box of tiles from a cart to a shelf. Upon lifting the box of tiles, the claimant heard a pop in her left shoulder and felt neck stiffness that resulted in pain.

The claimant treated with Dr. Wallace. Dr. Wallace diagnosed the claimant with a torn trapezius, impingement syndrome of the left shoulder, left arm numbness due to myofascial tightness in the trapezius scalenes, and scapular musculature. The claimant also was diagnosed with shoulder bursitis/tendonitis of the left shoulder.

The claimant continued treating with Dr. Wallace who noted continued neck and shoulder blade pain, which kept the claimant from sleeping. The claimant's main pain was at the base of the neck and top of the shoulder. Dr. Wallace made findings consistent with thoracic outlet syndrome (TOS).

At the request of the respondents, the claimant underwent an independent medical examination (IME) with Dr. Fall. Dr. Fall opined the claimant was suffering from left upper quadrant strain with myofascial pain and dysfunction. Dr. Fall noted a prior history of similar symptoms, which previously had resolved in 2007, and subjective complaints outweighed by objective findings. Dr. Fall recommended pursuing an MRI of the cervical spine. She further opined the claimant's injury was a nonsurgical problem.

On December 21, 2012, the claimant sought treatment with Dr. Wallace because of a sudden onset of pain in the left arm, numbness, tightness in the chest, and difficulty breathing during a dry needling therapy session. Dr. Wallace assessed a syncopal episode secondary to stimulation during dry needling, left shoulder and trapezius strain, myofascial thoracic outlet syndrome, and myofascial pain in the upper right quadrant. Due to the claimant's ongoing complaints, she was referred to Dr. Anderson-Oeser for EMG testing of the left upper extremity and Dr. Annest for an evaluation of TOS.

On January 21, 2013, Dr. Annest diagnosed the claimant with left neck, shoulder, and arm pain, neck pain, and upper and lower limb pain. Dr. Annest's assessment was that the claimant's physical findings were consistent with entrapment at left brachial plexus.

On February 11, 2013, Dr. Mechanic performed an EMG and nerve conduction study, which revealed a moderately advanced left distal medial neuropathy consistent with clinical correlation for a fairly clear carpal tunnel syndrome. Dr. Mechanic also noted the claimant had proximal pathology over the lower brachial plexus, and the profile of the study might suggest a more distal plexopathy such as pectoralis minor syndrome.

On January 21, 2013, Dr. Annest diagnosed the claimant with left neck, shoulder, and arm pain, neck pain, and upper and lower limb pain. Dr. Annest's assessment was that the claimant's physical findings were consistent with entrapment and left brachial plexus. Dr. Annest also indicated that the claimant's MRI of the cervical spine revealed "no discogenic or spinal canal compression of nerves." The claimant also had no foraminal disease. However, Dr. Annest stated the claimant had "abnormal MAC on left with normal C8 and both pec and scalene blocks gave significant relief of [symptoms] for

a short time." The claimant wanted to proceed with surgery, and she was advised of the associated risks, including damage to the phrenic nerves.

On April 4, 2013, Dr. Annest and Dr. Sanders performed surgery to repair the claimant's brachial plexus entrapment with chronic left extremity pain. The claimant underwent a transaxillary pectoralis minor tenotomy, exploration and release of brachial plexus chest wall, transaxial first rib resection, neurolysis of C8-T1 nerve roots, neurolysis of lower trunk brachial plexus, and dissection of anterior and middle scalene muscles.

On May 7, 2013, the claimant returned to Dr. Annest reporting pain in the chest and axilla. Dr. Annest assessed a possible resolving hematoma in the left anterior axilla below the incision. The claimant again returned complaining of neck and arm pains. The claimant's incision sight was irritated without apparent infection.

On June 12, 2013, Dr. Wallace diagnosed the claimant with left TOS with paresthesia of the left arm.

On July 9, 2013, Dr. Annest noted that after initial good response with improvement, the claimant had redeveloped pain and difficulty using the left arm. The claimant had been undergoing physical therapy but stopped due to a recurrence of symptoms. Dr. Annest noted recurrent brachial plexus entrapment due to scarring. He recommended surgery. However, he indicated that the risk of nerve injury was increased because the claimant's first surgery occurred a few months earlier.

The claimant began treating with Dr. Anderson-Oeser on January 2, 2014. Dr. Anderson-Oeser noted the claimant underwent a course of conservative treatment, therapy, surgery, and nerve blocks.

The claimant returned to Dr. Annest on March 19, 2014. He noted the claimant had left sided neck, shoulder, and arm pain. Dr. Annest noted scar tissue in the SC fossa and a recurrence of brachial plexus entrapment due to a scar recurrence from her previous surgery. Dr. Annest informed the claimant that her continued symptoms would unlikely resolve without undergoing an additional surgery. The claimant opted to proceed with the second surgery.

On April 30, 2015, the claimant underwent the second surgery to repair her recurrent brachial plexus entrapment. Dr. Annest performed left transaxillary pectoralis major exploration with neurolysis of brachial plexus and chest wall, supraclavicular

exploration of brachial plexus with neurolysis of C5, C6, C7, C8 and T1, long thoracic nerve phrenic nerve, neurolysis of upper middle lower trunk of entrapped scarred brachial plexus, arterial repair intraoperative arterial injury with bovine pericardial patch. During the axilla myofascial entrapment, which apparently was extensive, Dr. Annest removed in SC fossa severe muscular and scar entrapment of entire plexus 2 long thoracic nerves seen and dissected free, large phrenic nerve had to be mobilized in order to resect scarred anterior plexus. During the muscular excision, the claimant's subclavian artery was injured and repaired intraoperatively.

The claimant subsequently complained of neck, shoulder, and arm pain with nerve irritation of brachial plexus. The claimant also showed some weakness of grip and limitation in her range of motion. Dr. Annest suspected additional scar tissue from the April 30, 2015, surgery. He opined the claimant was a candidate "for a Latissimus flap surgery."

On October 10, 2015, Dr. Annest performed a third surgery to repair the claimant's recurrent brachial plexus entrapment due to scarring. However, this surgery resulted in injury to the claimant's phrenic nerve which required repair with a microscope.

At a postoperative appointment, Dr. Annest diagnosed brachial plexus disorder and phrenic nerve palsy. Phrenic nerve palsy typically is observed when a claimant reports experiencing difficulty breathing and shortness of breath.

After the claimant's third surgery, she began experiencing chest pain at night. The first occasion the claimant experienced tachycardia was when she awoke in the recovery room after her second TOS surgery. Shortly after that, she experienced shortness of breath when she undertook mild activity. The claimant explained that her chest pain was accompanied by heart palpitations and shortness of breath.

The claimant continued to complain of chest pain, as well as muscle spasms in the left neck, headaches, crackling noises, intermittent twitching and spasms in the neck with pain shooting down the arm, arm weakness, palpitations, decreased range of motion and strength in the left upper extremity and neck, and tachycardia. The claimant was evaluated for arrhythmias. Dr. Annest opined the claimant's arrhythmia was unrelated, her other symptoms were related to her scarred brachial plexus, and there was no surgical solution to the claimant's symptoms.

The claimant saw a cardiologist, Dr. Cohen, for evaluation of her arrhythmias. The claimant reported palpitations and shortness of breath with activity. The claimant wore a Holter monitor, which revealed sinus tachycardia. Dr. Cohen noted the claimant's symptom diary did not coincide with her reports of arrhythmias.

The claimant attended another IME with Dr. Fall on September 15, 2016. Dr. Fall opined the claimant likely was at MMI after completion of physical therapy. Dr. Fall further opined she agreed with Dr. Annest's opinion that the claimant's cardiac arrhythmia was not work related.

On October 10, 2016, the claimant treated with Dr. Annest. He assessed the claimant's pulmonary and muscular-skeletal complaints were related to the surgical intervention involving the claimant's injury to the phrenic nerve.

On October 20, 2016, Dr. Anderson-Oeser referred the claimant for a QSART test due to the claimant's symptomology and potential for Chronic Regional Pain Syndrome (CRPS).

On December 6, 2016, the claimant saw pulmonologist, Dr. Schwartz. Dr. Schwartz assessed that the claimant's complaints of shortness of breath were related to the left phrenic nerve dysfunction. However, Dr. Schwartz wanted another respiratory evaluation with a chest-x-ray and spirometry, which he noted would require approval from the respondent insurer.

On December 19, 2016, the claimant underwent another IME with Dr. Fall. Dr. Fall noted left upper quadrant strain and myofascial pain and dysfunction, and prior history of similar symptoms had resolved. Dr. Fall opined that the risks of a subacromial injection were low and if it would decrease pain, would be reasonable prior to resuming physical therapy, which would be needed for posture, stretching, and strength. Dr. Fall recommended electrodiagnostic evaluation, if parethesias persisted. Dr. Fall opined there likely were ongoing psychological issues.

On March 10, 2017, the claimant returned to Dr. Schwartz. The claimant was described as stable, yet she continued to have shortness of breath. Dr. Schwarz remained suspicious that the claimant's left hemidiaphragm was paralyzed or paretic. He stated that the claimant still needed a spirometry test.

In her third IME with Dr. Fall on April 12, 2017, the claimant informed Dr. Fall her symptoms were the same since she last saw her on September 15, 2016. Dr. Fall

noted the claimant had undergone thermogram testing, which indicated a temperature difference that could be consistent with CRPS. The claimant underwent a sympathetic block, and the claimant's pain responded to the blocks reducing her pain from five or six out of ten to one out of ten. However, the claimant's pain relief lasted only six days. Dr. Fall opined the claimant was at MMI due to no functional gains since her last IME. Dr. Fall maintained that additional ganglion blocks could continue to be administered as maintenance care.

Dr. Annest subsequently noted the claimant's chronic brachial entrapment of the left upper extremity with pain from the neck into the hand. He assessed the claimant to have brachial plexus disorder, left hand weakness, dyspnea, and CRPS type I of the left upper extremity.

On July 11, 2017, the claimant saw Dr. Schwarz continuing to complain of shortness of breath and shoulder pain. The claimant showed normal left hemidiaphragm and the claimant's spirometry test was normal. Overall, Dr. Schwarz opined that there was no pulmonary basis for the claimant's shortness of breath and no respiratory issue.

On September 21, 2017, the claimant attended a 24-month DIME with Dr. Goldman. The claimant informed Dr. Goldman of her symptoms of shortness of breath and palpitations. Dr. Goldman diagnosed the claimant with the following work-related conditions: 1. Chronic left upper trapezius and shoulder girdles myofascial pain; 2. Left disputed neurogenic TOS; 3. Mild left lower trunk sensory brachial plexitis in the context of a dispute neurogenic thoracic outlet syndrome consistent with a clinically mild CRPS II, partially sympathetically mediated, as a result of diagnosis #2; 4. Iron deficiency anemia hopefully resolved; 5. Intermittent mixed tension/vascular headaches of myofascial origin in association with diagnosis #1 and #2; 6. Sleep dysfunction; and 6. Deconditioning pre-existing and exacerbated, with non-objectified complaints of tachycardia and palpitations.

Dr. Goldman reviewed Dr. Fall's IME reports, and opined the records supported Dr. Fall's opinions, conclusions, and recommendations. Dr. Goldman opined the claimant was at MMI on September 21, 2017, with an 11% whole person permanent impairment rating for her related May 5, 2012, work injury. Dr. Goldman opined there were no work-related, medically probable objective diagnoses to explain the palpitations nor did the medications that have been tried, or are currently being prescribed, seem to be of help. He believed the claimant's palpitations likely reflected somatization and sensitization issues unmasked by the injury in addition to ongoing deconditioning. Dr. Goldman also opined the claimant did not have CRPS type I diagnosis because her

physical examination was not compelling in this respect. Dr. Goldman recommended maintenance medical care consisting of additional ganglion blocks without sedation (3-6), combined with physical therapy, potential for trigger point injections, 6-8 cognitive behavioral sessions, practicing of biofeedback skills, and meditative approaches and follow-up appointments.

The respondents filed an FAL admitting to Dr. Goldman's MMI date of September 21, 2017, and an 11% whole person permanent impairment rating. The respondents also admitted to reasonable and necessary maintenance medical treatment.

The claimant objected to the respondents' FAL and applied for a hearing seeking disfigurement benefits and seeking to overcome Dr. Goldman's DIME report on MMI.

After the hearing, the ALJ determined the claimant failed to prove by clear and convincing evidence that Dr. Goldman's MMI determination was incorrect. She found Dr. Goldman's DIME report was thorough, complete, without error, and he addressed all of the claimant's concerns and medical diagnoses. The ALJ also found Dr. Fall's medical opinions and testimony, in conjunction with the medical records to be more credible and persuasive than the opinions of Dr. Anderson-Oeser. The ALJ awarded the claimant $2,000.00 in disfigurement benefits.

On appeal, the claimant argues that the ALJ incorrectly applied applicable law when concluding she failed to overcome the DIME opinion on MMI. The claimant contends the ALJ failed to address the injury to the phrenic nerve caused from her third surgery to repair the extensive scarring, particularly of the brachial plexus. The claimant argues that the ALJ and Dr. Goldman wrongly assumed that Dr. Cohen's findings regarding the claimant's cardiology conditions- the tachycardia and arrhythmia- were conclusive when they were not. The claimant argues she remains symptomatic for tachycardia, shortness of breath, dizziness, and other cardiac and pulmonology symptoms, which arose after her phrenic nerve was severed. The claimant also argues Dr. Goldman lacked the complete medical record which was available at the time of the hearing. Thus, the claimant contends there is clear and convincing evidence that she is not at MMI and requires additional diagnostic testing. We are not persuaded by the claimant's arguments.

Section 8-42-107(8)(c), C.R.S., provides that the DIME physician's finding of MMI and medical impairment shall be overcome only by clear and convincing evidence. Further, the DIME physician's opinion on the cause of a claimant's disability is an inherent part of the diagnostic assessment which comprises the DIME process of

determining MMI and rating permanent impairment. *Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998). It follows therefore that the party disputing the DIME physician's opinions on the issues of MMI, impairment, and causation bears the burden to overcome the DIME physician's opinions by clear and convincing evidence. Clear and convincing evidence has been defined as evidence which demonstrates that it is highly probable the DIME physician's opinion is incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

Whether the DIME physician's finding of MMI and impairment rating have been overcome by clear and convincing evidence is a question of fact for the ALJ. Consequently, we must uphold the ALJ's order if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard requires that we defer to the ALJ's resolution of conflicts in the evidence, her credibility determinations, and the plausible inferences she drew from the evidence. Accordingly, the scope of our review is exceedingly narrow. *Metro Moving & Storage Co. v. Gussert*, *supra*. Further, we may not substitute our judgment by reweighing the evidence to reach inferences different from those the ALJ drew from the evidence. *See Sullivan v. Industrial Claim Appeals Office*, 796 P.2d 31 (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); *Rockwell Int'l v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990)(ALJ, as fact-finder, is charged with resolving conflicts in expert testimony).

Here, in support of her argument that the ALJ erred in concluding she did not overcome Dr. Goldman's MMI opinion, the claimant cites to testimony from Dr. Anderson-Oeser that the phrenic nerve injury could cause diaphragmatic paralysis and the claimant continues to complain of shortness of breath and tachycardia. However, the ALJ expressly found Dr. Fall's medical opinions and testimony more credible and persuasive than the opinions of Dr. Anderson-Oeser. As noted above, the ALJ, as fact-finder, is charged with resolving conflicts in expert testimony. *Rockwell Int'l v. Turnbull*, *supra*. Regardless, the claimant's argument notwithstanding, in her order the ALJ specifically recognized that the claimant was arguing that further testing needed to be completed to determine whether her sinus tachycardia and shortness of breath were related to her third surgery. Order at 11 ¶4. The ALJ also was aware of the claimant's argument that her cardiac issues had yet to be diagnosed or explained from a work or non-work-related perspective. See Claimant's Position Statement at 8, 10. However, it is apparent that the ALJ was not persuaded by the claimant's arguments. Instead, the ALJ specifically credited Dr. Fall's opinion that the claimant reached an endpoint in treatment and was at MMI, and that Dr. Goldman appropriately determined the claimant reached MMI on September 21, 2017. Order at 12 ¶8. During the hearing, Dr. Fall testified that

the claimant's complaints regarding shortness of breath and tachycardia issues did not prevent her from being placed at MMI. Dr. Fall explained that the claimant already was on a medication from the cardiologist to keep her heart rate down and from having episodes of tachycardia. She further explained that with regard to the claimant's shortness of breath, the claimant was evaluated by a pulmonary specialist, and he found her symptoms to be greater than what was seen on the pulmonary function tests. Dr. Fall testified that there was not any specific treatment required for the claimant's complaints of shortness of breath. She testified that Dr. Goldman was correct in placing the claimant at MMI as of September 21, 2017. Tr. at 55, 60-63, 66; Ex. A at 51; Ex. B at 80. Since the ALJ's determination is supported by substantial evidence in the record, we have no basis to disturb her order in this regard. Section 8-43-301(8), C.R.S.

Throughout her brief in support, the claimant cites to evidence that supports her argument that she is not at MMI, including the suggestion of a possible CRPS type I diagnosis, that Dr. Cohen's findings were equivocal for atrial tachycardia, and that Dr. Goldman lacked the complete medical record which was available at the time of the hearing. However, the mere fact that some of the evidence would support a contrary finding and conclusion affords no basis for relief on appeal. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Additionally, the claimant's argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). 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, as the claimant urges us to do. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). Moreover, an ALJ is not held to crystalline standard in articulating her findings of fact. Rather, the ALJ's findings are sufficient if the basis for ALJ's order is apparent from the findings, and we are able to discern from the order the reasoning that underlies the conclusions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, supra*. The ALJ here has stated the basis for her order, despite the presence of some inconsistencies. Since the evidence the ALJ credited support her findings, the basis for the ALJ's order is apparent from her findings, and we are able to discern the reasoning that underlies her conclusions, we have no basis to disturb her order. Section 8-43-301(8), C.R.S.

To the extent the claimant also argues the ALJ erred in crediting Dr. Goldman and Dr. Fall, we are not persuaded there is any error. The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office, supra*. We may not reweigh the evidence based upon

the claimant's argument that the respondents' expert testimony was not credible. *Rockwell Int'l v. Turnbull*, *supra*. We also 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). Contrary to the claimant's argument, we do not construe the record here as admitting only of the result sought by the claimant. Additionally, to the extent the claimant argues that Dr. Goldman's opinion regarding CRPS is in error because he did not follow the Medical Treatment Guidelines (Guidelines), we again perceive no error. Despite Dr. Goldman's alleged non-compliance with the Guidelines, the weight and credibility to be assigned expert medical opinion remains a matter within the fact-finding authority of the ALJ. *Cordova v. Industrial Claim Appeals Office, supra; Siminoe v. Worldwide Flight Services, Inc.*, W.C. No. 4-535-290 (Nov. 21, 2006)(appropriate for ALJ to consider guidelines; however, deviation from medical treatment guidelines does not compel fact finder to disregard the opinion of that medical expert on issue of causal connection between work related injury and particular medical condition). Thus, we have no basis 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 17, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

CERTIFICATE OF MAILING

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

6/21/19 by TT .

ADAN CERDA & ASSOCIATES LLC, Attn: ADAN CERDA ESQ, 6000 E EVANS AVE SUITE 3-400, DENVER, CO, 80222 (For Claimant)
LEE & BROWN LLC, Attn: JESSIE M TASSELMYER ESQ, C/O: SHEILA TOBORG ESQ, 3801 E FLORIDA AVE SUITE 210, DENVER, CO, 80210 (For Respondents)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-981-806-001

IN THE MATTER OF THE CLAIM OF:

TIMOTHY CONGER,

Claimant,

v.

ORDER

JOHNSON CONTROLS INC,

Employer,

and

INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Lamphere (ALJ) dated February 6, 2019, that ordered the respondents to pay penalties in the amount of $200 per day for 114 days for a total penalty of $22,800 for violation of an ALJ's order. We affirm in part, set aside in part, and remand in part for additional findings and a new order regarding the respondents' argument that the penalty imposed is excessive.

This matter went to hearing on the issues of change of physician, penalties pursuant to §8-43-304(1), C.R.S., for violation of an ALJ's order and for dictating medical care in violation of §8-43-503(3), C.R.S., and whether the respondents cured the claimant's penalty allegations. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted industrial injury on October 25, 2014. On this date the claimant was working as a maintenance technician, cleaning a large ice machine with a cleanser that contained phosphoric acid. The acid splashed onto his forearms above his protective gloves, causing chemical burns. The claimant subsequently began breaking out into rashes and hives and experienced swelling and difficulty breathing.

The parties disputed the cause of the allergic reaction and the best way to treat it. Dr. Volz saw the claimant for an independent medical examination on November 17, 2016. Dr. Volz recommended omalizumab (Xolair) to treat the claimant's hives after testing the claimant's Vitamin D levels.

The parties went to hearing in front of ALJ Spencer to determine whether the claimant was entitled to ongoing treatment for chronic urticarial and immunological symptoms including omalizumab therapy. In an order dated March 29, 2017, ALJ Spencer concluded that the claimant was entitled to the additional treatment. ALJ Spencer found that the claimant is entitled to reasonable, necessary and related treatment to cure and relieve ongoing allergic and immunological problems and specifically that the claimant was entitled to omalizumab treatment. Although the ALJ was not persuaded that the claimant needed to wait for additional testing before initiating the omalizumab therapy, the ALJ also determined that Dr. Volz' recommendation for testing levels of vitamin D, B12, folate, iron, methylmalonic acid in homocysteine, along with testing for the MTHR gene were reasonable and necessary as well. Consequently, the ALJ ordered:

1. Respondents shall authorize and pay for omalizumab therapy.
2. Respondents shall pay for all reasonable and necessary medical treatment to cure and relieve the effects of the claimant's injury, including additional diagnostic testing suggested by Dr. Volz if the Claimant chooses to pursue the same.

The parties did not appeal ALJ Spencer's March 29, 2017, order and the order became final. Section 8-43-301(1), C.R.S.

After the hearing the parties agreed to designate Dr. Volz as the claimant's authorized treating provider. ALJ Lamphere found that the change of physician to Dr. Volz occurred on December 18, 2017, when Leigha Nikolas, paralegal to respondents' counsel responded to a request to gather medical records and send them to Dr. Volz' office. The claimant saw Dr. Volz on January 4, 2018. Sar Seang from Dr. Volz' office emailed Ms. Nikolas indicating that diagnostic needed to be done and she asked how she was to get approval for the testing. Ms. Nikolas responded, "[e]verything will go through the adjuster, contact below." Ms. Nikolas provided the contact information for Susan Bond with Sedgwick CMS.

On January 8, 2018, Ms. Seang emailed Ms. Nikolas again stating that she had attempted to contact Ms. Bond twice already with no response. Ms. Seang further stated that everything was on hold until the blood work was completed. Ms. Nikolas responded indicating that she would pass the information along to the respondents' counsel.

The claimant filed an application for hearing endorsing the issue of penalties in the amount of $1000.00 per day from March 29, 2017, through the present and ongoing

pursuant to §8-43-304(1), C.R.S., for failure to comply with ALJ Spencer's March 29, 2017, order that respondents shall pay for all reasonable and necessary medical treatment to cure and relieve the effects of the claimant's injury, specifically the additional diagnostic testing suggested by Dr. Volz. The claimant notified the respondents' counsel of his decision to file an application for hearing endorsing penalties by email dated April 10, 2018, at 11:44 am. At 11:53 am on April 10, 2018, the respondents' counsel emailed the claimant's counsel stating that a new adjuster, Christina Smith at Sedgwick, CMS, was assigned to the claim. The email further stated that Ms. Smith and her supervisor had authorized treatment but not the lab requests of Dr. Volz. Respondents' counsel further advised the claimant's counsel that he had spoken with Ms. Seang in Dr. Volz' office to provide her with Ms. Smith's authorization for treatment and telephone number to "confirm anything necessary."

On April 12, 2018, the respondents' counsel sent an email to the claimant's counsel asking if he was still having lab scheduling issues.

On May 1, 2018, Ms. Smith verbally authorized the use of Xolair to "rule out causation issues" as evidenced by an email message generated by Dr. Volz' office. On May 3, 2019, Ms. Smith sent an email to authorize an office visit, allergy skin testing, spirometry and any labs that need to be ordered. The ALJ concluded that this email effectively transmitted the insurer authorization for the additional testing requested by Dr. Volz on January 4, 2018. Unable to resolve the issue with Dr. Volz' office, the claimant eventually sought treatment with Dr. Webber in the interim. The claimant received the Xolair treatments and by his second round of treatment he was no longer breaking out in hives and his breathing issues had slightly subsided.

Ms. Smith testified by deposition. She stated that she took over the claimant's claim around the end of March or the beginning of April 2018 because Ms. Bond was on medical leave. Ms. Smith testified that she had absolutely no knowledge of whether anybody with the insurer was covering for Ms. Bond's claims while she was out on medical leave. The last notes in the file were from Ms. Bond. The ALJ was not persuaded by Ms. Smith's claims that she authorized the requested treatment prior to May 1st, in view of Ms. Smith's conflicting testimony that she verbally authorized treatment on May 1st and put it in writing on May 3th.

On the issue of penalties, ALJ Lamphere determined that the respondents violated ALJ Spencer's order requiring payment of all reasonable and necessary medical treatment, specifically the additional diagnostic testing requested by Dr. Volz. The ALJ imposed penalties beginning January 8, 2018, the date that Dr. Volz' office put all

treatment, including diagnostic testing, on hold pending authorization. The ALJ awarded penalties for a period of 114 days from January 8, 2018, through May 2, 2018, when the treatment was authorized. The ALJ further determined that the respondents' violation of ALJ Spencer's order was not objectively reasonable. The insurer failed to provide a response to Dr. Volz' request for authorization and the ALJ was not persuaded by the respondents' contention that ALJ Spencer's order was so vague and ambiguous that they did not know what medical treatment they needed to pay for.

ALJ Lamphere also denied the claimant's request for a change of physician and the request for penalties for dictating medical care which are not at issue on appeal.

On appeal the respondents dispute the ALJ's findings that the penalty claim was pled with specificity and assert that they had no notice of legal and factual basis for the penalty claim. The respondents also renew their arguments at hearing that the penalty violation was cured on April 10, 2018, and that there was a rational basis for their actions because Dr. Volz treatment recommendation was not part of the March 29, 2017 order. The respondents also assert that the ALJ erred in picking January 8th to begin the penalty period. Finally, the respondents contend that the $200 per day penalty is excessive and the ALJ failed to make findings on this issue. We affirm the ALJ's imposition of the penalty but remand the matter for further findings concerning the excessiveness of the penalties.

A. Specificity

We agree with the ALJ's determination that the claimant's penalty claim was pled with the requisite specificity. Section 8-43-304(4), C.R.S., requires "in any application for hearing … the applicant shall state with specificity the grounds on which the penalty is being asserted." The instructions on the application for hearing form required by the Office of Administrative Courts advise the party to "Describe with specificity the grounds on which a penalty is asserted, including the order, rule or section of the statute allegedly violated, and the dates on which you claim the violation began and ended."

The claimant met the specificity requirement here. The claimant stated in the application for hearing that he was seeking penalties beginning March 29, 2017, through the present and ongoing pursuant to §8-43-304(1), C.R.S., for failure to comply with ALJ Spencer's Order that respondents shall pay for all reasonable and necessary treatment to cure and relieve the effects of the claimant's injuries, specifically the additional diagnostic testing suggested by Dr. Volz for $1000 per day. The claimant's penalty

statement is sufficient pursuant to §8-43-304(4), C.R.S. to place the respondents on notice of the basis for the penalty by noting that the alleged conduct resulting in the penalty allegation was the purported violation of ALJ Spencer's order, specifically that portion which required respondents to pay for additional diagnostic testing. The respondents had notice of the legal and factual basis for the penalty claim so that their rights to present evidence, confront adverse evidence, and present argument in support of their position were protected. *See Ortega v. Industrial Claim Appeals Office*, 207 P.3d 895 (Colo. App. 2009).

B. Cure provision

We reject the respondents' contention that the ALJ erred in his determination that the respondents did not cure the penalty violation until May 3, 2018, when the adjuster emailed Dr. Volz's office providing written confirmation authorization of the care and diagnostic work-up.

Section 8-43-304(4), C.R.S. states that if a party cures a violation within 20 days and the "party seeking such penalty fails to prove by clear and convincing evidence that the alleged violator knew or reasonably should have known such person was in violation, no penalty shall be assessed." Thus, the cure statute adds an element of proof to a claim for penalties in cases where a cure is proven.

We agree with the ALJ's assessment that authorization for the requested diagnostic work up did not come until 23 days after the claimant mailed the April 10, 2018, application for hearing. Although the respondents contend that the email exchange between respondents' counsel and claimant's counsel on April 10, 2018, was an "authorization," to cure the alleged violation, the ALJ was not persuaded. The ALJ noted that the April 10th email from the respondents specifically stated that the lab and diagnostic work was not yet authorized. The respondents, therefore, did not effectively cure the alleged violation within 20 days a required by §8-43-304(4), C.R.S.

C. Penalty

We also agree with the ALJ's analysis for the imposition of the penalty. Section 8-43-304(1), C.R.S., allows an ALJ to impose penalties of up to $ 1000 per day against any party "who violates any provision of articles 40 to 47 of [Title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically

provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel or any judgment or decree made by any court."

The imposition of penalties under § 8-43-304(1), C.R.S., is a two-step process. The ALJ must first determine whether the disputed conduct constituted a violation of the Workers' Compensation Act, of a duty lawfully enjoined, or of an order. If the ALJ finds such a violation, he may impose penalties if he also finds that the actions were objectively unreasonable. *City Market, Inc. v. Industrial Claim Appeals Office*, 68 P.3d 601(Colo. App. 2003); *see also Pioneers Hospital of Rio Blanco v. Industrial Claims Appeals Office*, 114 P.3d 97 (Colo. App. 2005)(court required to determine whether insurers conduct was reasonable).

Under the circumstances presented here, the ALJ determined that the insurer unreasonably violated ALJ Spencer's Order by failing to authorize Dr. Volz' requests for diagnostic work. At the time of the claimant's first visit to Dr. Volz' office for treatment, Ms. Bond was the claims adjuster assigned to the case. Ms. Bond, however, was out on medical leave and Ms. Smith did not take over the claim until the end of March or early April of 2018. The ALJ concluded it was the insured's duty under the March 29, 2017, order to provide a response to Dr. Volz' office for the requested treatment. The ALJ also noted that the respondents' counsel's office informed Ms. Seang to contact Ms. Bond for authorization and nothing was done by the respondents to authorize the requested tests until May 3, 2018. The ALJ was also unpersuaded by the respondents' contention that there was no harm to the claimant because his lab tests were normal and the claimant was unaffected by the delay. Thus, the ALJ concluded that the respondents' actions in the failure to comply with ALJ Spencer's order for 114 days were not objectively reasonable.

Further, the respondents contend the ALJ's decision to begin the penalty on January 8, 2018, is arbitrary since the claimant requested that the penalty begin on March 29, 2017. The ALJ began the penalty on January 8, 2018, rather than the requested date of March 29, 2017, because he found this was the date the claimant established Dr. Volz put all treatment, including diagnostic testing, on hold for lack of authorization to perform blood testing and pulmonary function tests. Order at 10-11 ¶M. The ALJ fully explained the basis for starting the penalty on January 8, 2018, which is supported by the record. Moreover the respondents acknowledged at hearing that there was a "colorable penalty argument" beginning in January after the agreement was made to authorize Dr. Volz. Tr. at 20-21. We therefore perceive no error in his determination in this regard.

Because the issue of whether the insurer acted unreasonably is a factual question for the ALJ, we are bound to apply the substantial evidence test in determining whether

the evidence supports the ALJ's findings of fact. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). We must, therefore, uphold the ALJ's factual findings, if supported by substantial evidence and the plausible inferences drawn therefrom. Under this standard we must view the evidence as a whole and in the light most favorable to the prevailing party, and we must also defer to the ALJ's credibility determinations and resolution of conflicts in the evidence. *See Id.*

We have reviewed the record and conclude there is substantial evidence to support the ALJ's finding of unreasonable conduct by the respondents. Although the ALJ could have drawn different inferences from the evidence, the question to be resolved was factual in nature. We conclude that the finding of unreasonableness made by the ALJ was supported by the evidence and we have no basis to disturb the ALJ's conclusion on appeal. Section 8-43-301(8), C.R.S.

D. Excessiveness

The respondents further argue that the penalty is unconstitutionally excessive and violates fundamental fairness. We set aside the ALJ order, in part, and remand the matter for purposes of applying the new test set forth by the Colorado Supreme Court in *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC*, 2019 CO 47 (June 3, 2019). In that case, the Court adopted the "gross disproportionality" test to apply for determining whether a regulatory fine violates the Excessive Fines Clause. *See United States v. Bajakajian*, 524 U.S. 321, 334, 118 S. Ct. 2028, 141 L. Ed. 2d 314 (1998). According to the Court, in assessing proportionality, the ALJ should "consider whether the gravity of the offense is proportional to the severity of the penalty, considering whether the fine is harsher than fines for comparable offenses in this jurisdiction or than fines for the same offense in other jurisdictions." *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC*, *supra* p. 38. The Court further stated that when considering the severity of the penalty, the ability of the regulated entity to pay is a relevant consideration. Also, the Court held that the proportionality analysis should be conducted in reference to the amount of the fine imposed for each offense, and not the aggregated total of fines for many offenses. *See* §8-43-304(1), C.R.S. ("Any employer . . . [who] fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director . . . shall also be punished by a fine of not more than one thousand dollars per day for each offense. . . ."); *see also* §8-43-305, C.R.S. ("Every day during which any employer . . .fails to comply with any lawful order of . . .the director. . . shall constitute a separate and distinct violation thereof. . . .).

Consequently, we remand the matter so that the ALJ can, as "appropriate or necessary," permit the development of an evidentiary record sufficient to apply the "gross disproportionality" test, to determine whether the per day penalties at issue are proportional to the harm or risk of harm caused by each day of the respondent's failure to comply with ALJ Spencer's March 29, 2017 order. *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra* p. 37.

IT IS THEREFORE ORDERED that the ALJ Lamphere's order dated February 6, 2019, is affirmed, in part, to the extent it determined that the respondents violated the March 29, 2017 order and that penalties are appropriate.

IT IS FURTHER ORDERED that the ALJ Lamphere's order is set aside, in part, and remanded for additional findings and a new order to apply the "gross disproportionality" test as set forth in *Colorado Dep't of Labor & Empl. v. Dami Hospitality, LLC, supra*.

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

7/1/19 by TT .

MCDIVITT LAW FIRM, Attn: AARON S KENNEDY ESQ, 19 EAST CIMARRON STREET, COLORADO SPRINGS, CO, 80903 (For Claimant)
TREECE ALFREY MUSAT PC, Attn: JAMES B FAIRBANKS ESQ, 633 17TH STREET SUITE 1600, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-022-155-04

IN THE MATTER OF THE CLAIM OF:

KIM NELSON,

Claimant,

v.

FINAL ORDER

QUALITY CORPORATION,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated May 30, 2018, that denied the claimant's petition to reopen and determined that the claimant had failed to overcome the Division sponsored independent medical examination (DIME) regarding maximum medical improvement (MMI) and zero percent permanent medical impairment. We affirm.

An evidentiary hearing took place over three sessions on November 8, 2017; January 19, 2018; and April 6, 2018. Both parties appeared and participated with counsel.[1] The ALJ's findings of fact are summarized below.

On July 18, 2016, the claimant walked into a handle of a floor safe which poked into the claimant's right knee below the kneecap. She did not fall or injure any other part of her body at that time. The injury was immediately reported and the claimant was designated an authorized treating physician (ATP), Dr. Updike. Dr. Updike evaluated the claimant on July 19, 2016, noting no visible sign of injury. On September 8, 2016, Dr. Updike's exam findings documented no warmth, redness, or swelling; diffuse nonfocal tenderness, and questionable effort.

[1] Counsel for the claimant withdrew as attorney of record on an unknown date after the entry of the order. Thereafter, the claimant—then self-represented—filed a Petition to Review.

On November 4, 2016, Dr. Ogin—a pain management specialist—noted a possible somatization disorder and the claimant's physical exam was benign other than hypersensitivity. On November 8, 2016, Dr. Updike placed the claimant at MMI, reporting symptom magnification and delayed recovery concerns.

The claimant returned to Dr. Ogin for a maintenance care evaluation on February 22, 2017. Claimant reported allodynia and altered sensation diffusely throughout her right leg anteriorly and posteriorly into her calf, foot, and ankle. Dr. Ogin's impression was possible neuropathic pain/CRPS (chronic regional pain syndrome) with minimal objective findings of anything, and possible somatization disorder. Dr. Ogin suggested moving ahead with autonomic testing to fully rule out CRPS. He further indicated that he suspected the testing would be normal. He postulated that even if the testing was normal, the claimant would be resistant to the suggestion that her pain is nonphysical.

A DIME physician, Dr. Winslow, evaluated the claimant on March 21, 2017. He noted that although the claimant was complaining of severe pain, there were no objective findings, no swelling, no redness, no skin color changes, no palpable temperature changes, and full range of motion. The doctor commented that the claimant seems to magnify her symptoms and reactions to her injuries. Dr. Winslow's ultimate opinion was that the claimant did not have CRPS. Rather, she had at most a right knee contusion. The doctor concluded that the claimant was at MMI as of November 8, 2016, with no impairment, and no work restrictions. A corresponding Final Admission of Liability was filed on July 10, 2017.

Although maintenance care was admitted, the claimant did not follow-up with either Dr. Updike or Dr. Ogin. Instead, the claimant sought evaluation and treatment outside of the WC system. At hearing, the claimant admitted that she did not provide any of her new physicians with any of her WC claim related medical records. On September 20, 2017, Dr. Oh evaluated the claimant. He did not render a definitive diagnosis. He referred the claimant to a pain specialist unaware that the claimant had already been under the care of Dr. Ogin, who is a pain specialist. On November 27, 2017, the claimant returned to Dr. Ogin for a maintenance visit. Dr. Ogin indicated that there was a remote possibility that the claimant had a neuropathic component to her pain. He indicated that autonomic testing and thermography were warranted and reasonable, but that if the testing was negative, he would not have further recommendations.

The respondents obtained a physician advisory review, through Dr. Raschbacher, of the request for autonomic testing. He opined that the CRPS testing was not reasonably necessary. Thereafter, respondents provided Dr. Ogin with the claimant's prior medical

records showing hypersensitivity, as well as the MMI report from Dr. Updike, and the DIME report of Dr. Winslow. Dr. Ogin was requested to review these additional records and provide an updated opinion. On December 13, 2017, Dr. Ogin noted, "I have seen no clinical evidence of CRPS and I remain convinced about potential nonorganic cause of her knee pain." He discussed the additional records and withdrew his request for additional testing for CRPS and agreed that the testing was not medically necessary or reasonable or directly attributable to the occupational injury.

The claimant filed a petition to reopen the claim on January 9, 2018, alleging a worsened condition. As support the claimant attached a report of Ms. Bock, PA-C, co-signed by Dr. Leo, noting complaints of severe knee pain. There was no indication of a baseline of when and if the claimant's condition worsened nor was there any indication that Ms. Bock or Dr. Leo was made aware of the claimant's previous medical history. The ALJ found that the report was neither persuasive nor credible on the issue of changed condition.

Rather, the ALJ found the opinions of ATPs Drs. Updike and Ogin; DIME Dr. Winslow; and IME physician Raschbacher to be highly persuasive and credible. The ALJ found that these opinions "outweigh the conjecture of Dr. Oh, whom the claimant sought on her own—without making Dr. Oh aware of her previous medical history." The ALJ relied on the opinions of the ATPs and the DIME that the claimant sustained a minor injury and has continued to exhibit symptom magnification behaviors ever since. The ALJ discounted the claimant's testimony and any implications of Drs. Oh and Leo that the claimant did not reach MMI on November 8, 2016.

Ultimately, the ALJ concluded:

> Based on a totality of the evidence, the ALJ finds that the claimant has failed to prove by a preponderance of the evidence that she did **not** reach MMI on November 8, 2016; that her permanent partial disability (PPD) exceeded zero percent; and, that her condition changed or worsened since she was declared to be at MMI. Also, she has not overcome the DIME of Dr. Winslow by clear and convincing evidence, in response to her timely objection to the FAL, however, this proposition is moot in light of the claimant's Petition to Re-Open, dated January 8, 2018, which the claimant has failed to sustain by preponderant evidence.

The ALJ denied and dismissed the claimant's petition to reopen. The ALJ determined that the claimant had not overcome the DIME opinions regarding MMI on November 8, 2016, and zero percent permanent medical impairment.

On June 20, 2018, the then self-represented claimant filed a petition to review of the ALJ's order listing 12 alleged errors and objections to the order:

1. The ALJ incorrectly stated that claimant failed to overcome the DIME when overcoming the DIME was not an issue to be determined.
2. The ALJ improperly relied on sole medical reports of his choosing but not of all that was placed in front of him. For reasons that they were not prescribed by a Pinnacol Doctor and deemed them not creditable. All doctors' notes should be considered when we are considering the health of a human and her welfare.
3. I was place[d] at MMI in error because my injury had not been diagnosed and left my body in a weekend (sic) condition proximate cause of further injury to the injured worker to cause a casually connected injury to the compactable (sic) injury.
4. I showed my condition had worsened on numerous occasions. Starting Sept 2017 when my injured right knee failed and I lost my balance and injured my back that shows casually connected to the compactable (sic) injury.
5. Also in Sept 2017 when my blood vessels were bulging and changing color.
6. In January 2017, I was not able to put any weight on my right leg could not use cane had to use churches (sic) or walker.
7. On 11/22/2016, I was examined by William D. Boyd and found No thought disorder was noted.
8. In February 2017 Dr. Ogin was the first Doctor to reference CRPS and suspected CRPS and requested testing to be done for CRPS, it was denied by Pinnacol.
9. The ALJ improperly omitted referencing Dr. Arthur (Pinnacol doctor) report. On or about 6/29/2017 I was seen by Dr. Arthur at Orthopedic Consultant at that time he ordered an EMG test to be done, and I was never offered the test to be done.

10. Since I had never been diagnosed with any condition about 7/2017 I tried to get a change of Doctor through Pinnacol and they would not approve that change.
11. September 2016 I did seek out opinions of Doctors with a fresh set of eyes and findings. They were outside of Pinnacol Insurance to try and get a diagnoses and I did tell these Doctors that my knee injury was a workman comp claim and they did not ask to see any findings or records from any Doctor I had been seen by on my workers comp claim Doctors. During this trial nobody including the ALJ ask me if I had informed the Doctors I found on my own, if I informed them of the workers comp claim and if records were requested.
12. I did see Dr. Oh MD Neuromuscular Disorder, EMG General Neurology (Found on my own) September 2017 and he listened to my symptoms he said it sounded like CRPS and he did perform an EMG test and said I have nerve damage. And asked if I was . . .
(this marked the end of the claimant's 12th allegation of error as it was not continued on the following page).

The claimant has not filed a brief in support of her petition to review and, therefore, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986). The lack of a brief in support of the appeal does not bar the panel from ruling on a timely petition to review. *Jiminez v. Industrial Claim Appeals Office*, 107 P. 965, 967 (Colo. App. 2003). The appealing party, however, must advance sufficient legal argument to indicate the basis of claims for relief. *See Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186, 191 (Colo. App. 2002). The claimant lists 12 grounds, none of which we determine to be a valid legal basis to disturb the ALJ's order.

Initially, the claimant correctly asserts that overcoming the DIME was not an issue at hearing. The claimant conceded at hearing that she was not challenging the DIME report regarding MMI and impairment. Tr. 11/8/2017 at 9, 12. Rather, the claimant raised the sole issue of reopening at the hearing (and, if reopened, other ancillary issues including temporary disability and medical benefits). Here, the result is the same regardless of whether claimant decided not to challenge the DIME or if she tried and failed to overcome the DIME. Thus, the ALJ's invocation of the DIME issue was

unnecessary and harmless in its effect. *See* § 8-43-310, C.R.S. (2018) (harmless error is to be disregarded).

The claimant's remaining 11 allegations of error are simply factual assertions which she feels warrants reversal of the ALJ's findings of fact.

To reopen a claim pursuant to § 8-43-303(1), C.R.S., the claimant must prove a worsening of her condition that is causally related to the industrial injury. Moreover, the worsened condition must warrant further benefits. *Cordova v. Industrial Claim Appeals Office*, *supra*; *Richards v. Industrial Claim Appeals Office*, 996 P.2d 756 (Colo. App. 2000). The determination whether to reopen a claim is discretionary with the ALJ and, absent fraud or a clear abuse of that discretion, we may not disturb the ALJ's order. *Osborne v. Industrial Claim Appeals Office*, 725 P.2d 63 (Colo. App. 1986). An abuse of discretion is only shown where the order exceeds the bounds of reason, such as where it is unsupported by substantial evidence or is contrary to law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993).

The claimant essentially asks us to reweigh the evidence to reach a different result by arguing that she submitted evidence that is contrary to the ALJ's interpretation. However, we may not reweigh the evidence. See *Metro Moving & Storage*, 914 P.2d at 415. Further, "we may not interfere with the ALJ's credibility determinations" unless the evidence is "overwhelmingly rebutted by hard, certain evidence" to the contrary. *Arenas v. Indus. Claim Appeals Office*, P.3d 558, 561 (Colo. App. 2000); see also *Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶46 ("Nor may we set aside a ruling dependent on witness credibility where the testimony has not been rebutted by other evidence."). The weight to be given expert medical testimony is within the ALJ's sound discretion. See *Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990).

We must uphold the ALJ's findings of fact if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claims Appeals Office*, 989 P.2d 251 (Colo. App. 1999). This standard of review requires us to defer to the ALJ's resolution of conflicts in the evidence, credibility determinations and plausible inferences drawn from the record. *Id.* Testimony is not incredible as a matter of law absent extreme circumstances where the testimony is rebutted by such hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Arenas v. Industrial Claim Appeals Office*, *supra*. Nor is testimony incredible as a matter of law merely because it is inconsistent or conflicts with other evidence. *People v. Ramirez*, 30 P.3d 807 (Colo. App. 2001). Further, to the extent the testimony of a witness is internally inconsistent, or subject to conflicting inferences, the ALJ may resolve the inconsistency

by crediting part or none of the testimony. *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997).

The fact that claimant may have presented some evidence which, if credited, could support a result contrary to that reached by the ALJ provides no basis for relief on appeal. *Cordova v. Industrial Claim Appeals Officer, supra.* The ALJ is not required to cite or discuss every piece of evidence before crediting evidence to the contrary. *Crandall v. Watson-Wilson Transportation System, Inc.*, 171 Colo. 329, 332-333, 467 P.2d 48, 49 (1970). Evidence not cited is implicitly rejected as unpersuasive. *Mouser v. Style Drywall & Construction, Inc.*, W.C. No. 4-631-640 (September 15, 2006).

The medical opinions of the ATPs and the DIME physician, along with the IME opinion of Dr. Raschbacher are ample and substantial evidence which support the ALJ's findings of fact and conclusions of law.

We are confined to our applicable statutory standard of review and we may only correct, set aside, or remand an order if the findings of fact are not sufficient to permit appellate review, if conflicts in the evidence are not resolved, if the findings of fact are not supported by the evidence, if the findings of fact do not support the order, or if the award or denial of benefits is not supported by the applicable law. §8-43-301(8), C.R.S. On review, we have no basis to disturb the ALJ's order in this case.

IT IS THEREFORE ORDERED that the ALJ's order issued May 30, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

David G. Kroll

CERTIFICATE OF MAILING

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

7-5-19 by KG .

KIM NELSON, 775 MACON ST, AURORA, CO, 80010 (Claimant)
PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Insurer)

NOTE: For clarification, the following entities have not been served with this Order. However, if you appeal a Final Order, you **MUST** include a copy of your appeal to the parties at the addresses listed above **AND** to the following parties:

COLORADO COURT OF APPEALS
2 EAST 14TH AVENUE
DENVER, CO 80203

OFFICE OF THE ATTORNEY GENERAL
STATE SERVICES SECTION
RALPH L. CARR COLORADO JUDICIAL CENTER
1300 BROADWAY 6TH FLOOR
DENVER, CO 80203

INDUSTRIAL CLAIM APPEALS OFFICE
P.O. BOX 18291
DENVER, CO 80218-0291