COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
633 17th Street, Suite 400
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May Case Law Update

Presented by Judge David Gallivan and Judge John Sandberg

This update covers ICAO decisions issued between
April 17, 2017 to May 5, 2017

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-974-965-02

IN THE MATTER OF THE CLAIM OF

TANYA TSIRLIN,

Claimant,

v.

SPROUTS FARMERS MARKET, INC.,

Employer,

and

ACE AMERICAN INSURANCE,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Allegretti (ALJ) dated October 12, 2016, that denied the claimant's request for temporary benefits subsequent to June 25, 2015. We affirm the order of the ALJ.

The claimant worked as a produce clerk for the employer. On February 3, 2015, the claimant slipped due to a grease spot on the floor at work and landed on her rear. The claimant complained of injury to her right shoulder, wrist, low back and cervical spine. Her treating physician, Dr. Ritzer, assigned the claimant work restrictions. On June 16, 2015, the claimant's restrictions included no lifting over 5 pounds and no overhead use of the right arm. On that date, the claimant expressed to Dr. Ritzer her feeling that her condition had not improved despite treatment. Dr. Ritzer therefore referred the claimant to Dr. Chan for pain management.

Dr. Chan saw the claimant on June 25, 2015. He noted numerous subjective complaints. MRI scans of several body parts did not reveal injury consistent with her work accident with the exception of a partial rotator cuff tear of the right shoulder. Dr. Chan also reviewed a surveillance video, which he noted depicted the claimant lifting a dog out of her car and assisting with the lifting of a filing cabinet into a car. Dr. Chan concluded the claimant was involved in "an unsophisticated attempt to misrepresent her symptoms." The doctor observed the claimant was at maximum medical improvement (MMI) as of June 25, with no permanent impairment and should be released to work on a

full duty and full time basis. Dr. Ritzer spoke with Dr. Chan concerning his evaluation and also saw the claimant on June 25. Dr. Ritzer agreed with Dr. Chan's conclusions and placed the claimant at MMI with no permanent impairment and released the claimant to full duty without restrictions.

The respondents filed a Final Admission of Liability based on Dr. Ritzer's June 25 finding of MMI. The respondents ceased paying the claimant temporary total disability benefits (TTD) as of that date. The claimant requested a Division sponsored Independent Medical Exam (DIME) review of the MMI and impairment rating determination. Dr. Mason performed this review on November 16, 2015. Dr. Mason found the claimant's symptoms pertinent to parts of the body other than the right shoulder were no longer involved. The doctor did rely on an MRI study, which showed the partial rotator cuff tear and determined the claimant was not at MMI pending surgery to repair that tear. Dr. Mason also offered an assessment that the claimant should observe lifting restrictions with her right arm of no more than 5 pounds but would be unrestricted pertinent to her left arm.

The respondents sought to overcome the DIME physician's finding of not at MMI and a hearing was convened on May 5, 2016, before ALJ Felter. ALJ Felter agreed with the MMI finding of Dr. Mason and authorized the recommended shoulder surgery. The ALJ criticized the report of Dr. Chan as misunderstanding the claimant's activity shown in the surveillance video. For this reason the ALJ determined the conclusions and work restrictions removed by Dr. Chan and by Dr. Ritzer to be ill advised and not persuasive. The respondents did not appeal the decision of ALJ Felter but filed a General Admission of Liability. However, the Admission did not reinstate temporary benefits due to the work release provided by Dr. Ritzer on June 25, 2015.

The claimant requested a hearing to obtain temporary benefits after June 25, 2015. ALJ Allegretti heard the issue on August 23, 2016. The ALJ found there was no ambiguity that Dr. Chan and Dr. Ritzer had released the claimant to full duty. While the ALJ acknowledged the DIME physician had suggested work restrictions, the doctor was noted to not be a treating physician. The ALJ resolved that the issue of temporary benefits was not before ALJ Felter at the May 5 hearing. ALJ Felter's determination the claimant was not at MMI was deemed to have no bearing on the request for TTD benefits pending in the August 23 hearing. ALJ Allegretti concluded that pursuant to § 8-42-105 (3) (c) she had no authority to order TTD benefits paid after June 25, 2015. That section provides that temporary benefits shall continue "until … (c) the attending physician gives the employee a written release to return to regular employment." Accordingly, the ALJ denied the claimant's request for TTD benefits.

On appeal, the claimant contends ALJ Allegretti was required by the doctrine of claim preclusion to disregard the return to work release of Dr. Ritzer and to award TTD benefits. The claimant argues work restrictions were a necessary component to Dr. Mason's evaluation of MMI. As a result, it is asserted ALJ Felter's rejection of Dr. Chan's and Ritzer's June 25 report was a judicial determination that there was no applicable return to work release in this case. We are not persuaded.

Claim preclusion bars relitigation not only of all claims actually decided but of all claims that might have been decided in the claim that are tied by the same injury. *Holnam v. Industrial Claim Appeals Office*, 159 P.3d 795 (Colo. App. 2007). For a claim to be precluded from litigation there must exist a finality of the first judgment, identity of subject matter, identity of the claims for relief and identity of the parties to the actions. Here, there is no identity of subject matter nor is there an identity of the claims for relief between the May 5 hearing and that of August 23. On May 5, ALJ Felter was considering the status of MMI. That concept is a point "when no further treatment is reasonably expected to improve the condition." § 8-40-201 (11.5). Deciding that issue in the negative does not necessarily exclude the possibility the claimant could still perform her regular work. The May 5 hearing did not feature a claim for TTD and ALJ Felter did not issue an order in that regard. In addition, pursuant to § 8-42-105 (3)(c) he would not have had jurisdiction to award TTD benefits given his finding that Dr. Ritzer had provided an "opinion that claimant could work without any work restrictions." There is then, no basis in the record to support the application of claim preclusion to ALJ Allegretti's order pertinent to TTD benefits.

ALJ Allegretti relied on the holding in *Burns v. Robinson Dairy, Inc*., 911 P.2d 661 (Colo. App. 1995). In *Burns,* his treating physician also provided the claimant a return to regular work release. In the same fashion as occurred in this matter, the treating physician's determination of MMI was set aside by a DIME review. Nonetheless, the ALJ, the ICAO panel and the Court of Appeals agreed the ALJ was not at liberty due to § 8-42-105 (3) (c) to order additional TTD benefits. "The use of the word "shall" in the statute is presumed to indicate a mandatory requirement. … The effect of this mandate is to limit the scope and frequency of disputes concerning the duration of TTD benefits by treating the opinion of the attending physician as conclusive …." *Id*. at 662. Here, there was no dispute that Dr. Ritzer had submitted a full duty return to work release on June 25. "Indeed, in light of an attending physician's opinion releasing a claimant to full duty, any evidence concerning claimant's self-evaluation of his ability to perform his job [is] irrelevant and should be disregarded by the ALJ." *Archuletta v. Industrial Claim Appeals Office*, 381 P.3d 374, 377 (Colo. App. 2016). Therefore, the ALJ correctly recognized

the statute allowed no alternative but to deny the request for TTD benefits subsequent to that date.

Accordingly, we find no compelling reason to find error in the ALJ's decision denying the request for TTD benefits.

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

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

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Denver, CO 80203

Industrial Claim Appeals Office
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Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
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Denver, CO 80203

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SUSAN D PHILLIPS PC, Attn: SUSAN D PHILLIPS, ESQ, 155 SOUTH MADISON SUITE 237, DENVER, CO, 80209 (For Claimant)
RITSEMA & LYON, P.C., Attn: DAWN M. YAGER, ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-000-569-01

IN THE MATTER OF THE CLAIM OF CYNEATHIA PHILLIPS-ZALAL, Claimant, v. KING SOOPERS, INC., Employer, and SEDGWICK CMS DENVER, Insurer, Respondents.	FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Turnbow (ALJ) dated January 4, 2017, that determined the claimant's claim was compensable and ordered the respondents to pay medical and temporary indemnity benefits. We affirm.

This matter went to hearing on whether the claimant sustained a compensable injury, whether the claimant's earnings from a concurrent employer should be included in the calculation of her average weekly wage (AWW), whether the claimant was entitled to temporary indemnity benefits, what medical treatment was reasonable, necessary, and related to the claimant's alleged work injury, and whether the claimant was entitled to a change of physician.

After the hearing, the ALJ found that the claimant has been employed full time with the respondent employer for 24 years. The claimant's regular job is a "Sanitor" and her duties include cleaning the grocery store and the store's equipment. On November 29, 2015, the claimant was cleaning the flour sifter for the bakery. As the claimant opened the double steel doors on the front of the flour sifter, the left door broke off the hinges and jerked her body injuring the claimant. The doors are steel and weigh approximately 35-45 pounds. The claimant felt immediate pain in her neck and shoulders.

The claimant treated conservatively with Dr. Sanchez. Dr. Sanchez assessed the claimant's injury as work related. Dr. Sanchez placed the claimant on "no work" from December 4 through December 11, 2015.

The claimant works a second full time job at CU Direct Connect. The claimant works a desk job and it involves light duty/clerical work. The claimant has continued to work full time at CU Direct Connect since the date of her industrial injury.

The claimant continued to experience worsening symptoms in December 2015 and January 2016. Dr. Sanchez kept the claimant on restrictions, medications, and continued to recommend physical therapy. The claimant was not working for the respondent employer.

The respondents eventually denied the claimant's claim in February 2016. Accordingly, the claimant sought treatment with her primary care physician, Dr. Lichfield. Dr. Lichfield noted that the claimant began to have sharp pain in her neck as well as headaches and nausea, and that her neck and lumbar pain became increasingly severe with time. Dr. Lichfield ordered x-rays of the claimant's cervical spine which showed degenerative changes. Dr. Lichfield referred the claimant to Spine One for further evaluation.

On March 29, 2016, the claimant saw Dr. Sonstein at Spine One. Dr. Sonstein's examination revealed moderate trapezius hypertonicity with mild tenderness to palpation on the right side. He noted that extension and to a lesser degree, flexion of the cervical spine was restricted by neck pain. He read the claimant's MRI as showing protrusion to a mild degree at C4-C5 and more significant at C5-C6 and C6-C7. He recommended cervical facet joint injections.

On March 22, 2016, the claimant underwent bilateral C4-C5, C5-C6, and C6-C7 facet joint injections. Dr. Sonstein noted that the claimant's facetogenic pain caused by the cervical disc protrusions from C4 to C7 was 50% improved by the cervical facet joint injections. He recommended medial branch blocks, which the claimant underwent on May 24, 2016. On June 3, 2016, Dr. Sonstein noted that the claimant had an excellent response to the cervical medial branch blocks. He therefore recommended cervical radiofrequency ablation procedure, which the claimant underwent on June 6, 2016.

At the request of the respondents, the claimant subsequently underwent an independent medical examination with Dr. John Burris on May 23, 2016. Dr. Burris noted that the claimant had a similar injury in 1998 in which she experienced numerous

myofascial muscle issues, but that it was remote in time and therefore not significant. Dr. Burris opined that the claimant's mechanism of injury was consistent with a muscle strain or sprain. He opined that surgical injection therapy was not indicated because the claimant's MRI did not show a work-related abnormality, and his examination did not show evidence of radiculopathy. He opined that the claimant was at maximum medical improvement (MMI) as of the date of his examination.

On June 10, 2016, the claimant was evaluated by Dr. Gellrick. Dr. Gellrick opined that the claimant had restricted range of motion in her cervical spine, with pain and tenderness. She opined that it was clear the claimant sustained an injury to her cervical spine at the time of the injury in November 2015. Dr. Gellrick stated that the need for injection treatment was compensable to the claimant as well as the claimant's need for rhizotomies. She opined that the claimant was not at MMI and not able to resume employment.

The ALJ ultimately determined the claimant's claim was compensable. The ALJ found that the opinions of Dr. Gellrick were more persuasive than those of Dr. Burris on the issues of the nature of the injury that the claimant sustained, the reasonable necessity of treatments the claimant has received, and MMI. The ALJ also found that the claimant sustained a previous work injury in 1996 when a 300-pound tie rod machine fell on her, pinning her to a brick floor. However, the ALJ found that the injury was too remote in time, and the claimant did not seek treatment for that injury after 1998. The ALJ further found that at the time of the claimant's injury, she worked two full-time jobs. She found the parties stipulated that the claimant's AWW at King Soopers was $793.17, and her AWW at CU Direct Connect was $705.37 for a total AWW of $1,498.54. The ALJ rejected the respondents' argument that the claimant's wages from her concurrent employer should not be included in her AWW. Accordingly, the ALJ concluded the claimant's total average weekly wage was $1,498.54. The ALJ further found that the claimant was forced to seek medical care outside the workers' compensation system due to the respondents' decision to deny liability for the claim. She found that the claimant's medical treatment with Dr. Lichfield and Dr. Sonstein was directly related to her industrial injury and reasonably necessary to cure and relieve the effects of her industrial injury. Thus, she ordered the respondents liable for paying for all medical care that the claimant received from the date of the injury and ongoing. She also granted the claimant's request for temporary indemnity benefits from the date of the industrial injury and based on an AWW of $1,498.54.

The respondents have petitioned to review the ALJ's order. In their petition, the respondents endorsed all issues determined by the ALJ. However, on April 18, 2017, the

respondents submitted their "Opposed Motion to Withdraw their Petition to Review and Designation of Record On All Issues Except Average Weekly Wage." The respondents' Motion is granted.

On appeal, the respondents argue that the ALJ erred in computing the claimant's AWW by including wages from her concurrent employment. They argue that the claimant has not been prevented from working at and has not lost any wages at her concurrent employer as a result of her work injury. They therefore contend that by combining the wages from the claimant's concurrent employment, the calculation creates the potential for a windfall. We are not persuaded the ALJ erred.

Pursuant to §8-42-102, C.R.S., average weekly wage generally is determined by the wage the injured worker received at the time of the injury. The formulas that are applicable for calculating the average weekly wage are set forth in §8-42-102, C.R.S., and vary depending on the method of payment used to recompense the claimant. However, the overall purpose of the statutory scheme is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Thus, if the specified method of computing the claimant's average weekly wage will not render a fair computation of wages for any reason, the ALJ has discretionary authority under §8-42-102(3), C.R.S. to use an alternative method to determine AWW. *Id.* This includes the discretion to include concurrent wages in the average weekly wage. *See Broadmoor Hotel v. Industrial Claim Appeals Office*, 939 P.2d 460 (Colo. App. 1996); *see also Jefferson County Public Schools v. Dragoo*, 765 P.2d 636 (Colo. App. 1988); *see also St. Mary's Church & Mission v. Industrial Commission*, 735 P.2d 902 (Colo. App. 1986).

We may not disturb the ALJ's determination of the average weekly wage unless an abuse of discretion is shown. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). An abuse of discretion exists where the order "exceeds the bounds of reason," such as where it is not in accordance with applicable law, or not supported by substantial evidence in the record. *Rosenberg v. Board of Education of School District #1*, 710 P.2d 1095 (Colo. 1985); *Jefferson County Public Schools v. Dragoo*, *supra*; *St. Mary's Church & Mission v. Industrial Commission*, *supra*. Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence. Application of this standard requires that we defer to the ALJ's credibility determinations and her assessment of the sufficiency and probative weight of the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

As recognized by the claimant in her Brief In Opposition, in *Broadmoor Hotel v. Industrial Claim Appeals Office*, 939 P.2d 460 (Colo. App. 1996), the Colorado Court of Appeals addressed a situation that is similar to that presented here. In that case, the claimant worked concurrently for the respondent employer, the Broadmoor, and the United States Army when she sustained an industrial injury while working at the Broadmoor. Due to her injuries, the claimant lost time from work at the Broadmoor, but continued to receive her regular wages from the Army. The ALJ calculated the claimant's AWW using the combined weekly earnings from both the Broadmoor and the Army. The employer appealed, arguing that wages from the claimant's concurrent employment should not have been used to determine the temporary total disability rate for calculation of the claimant's permanent medical impairment because she suffered no temporary wage loss from the Army. The Court rejected the employer's argument, holding that the ALJ properly calculated the claimant's medical impairment based upon a temporary total disability rate that included her wages from both the Broadmoor and the Army. The Court reasoned that §8-42-107(8), C.R.S. did not restrict an award of permanent partial disability benefits to those claimants who received temporary benefits, nor did it restrict the calculation to the actual amount of the temporary disability benefits awarded.

Here, we perceive no abuse of discretion in the ALJ's calculation of the claimant's AWW using the combined earnings from the respondent employer and CU Direct Connect. Consistent with the holding in *Broadmoor Hotel*, the fact that the claimant suffered no lost time and no lost wages at her concurrent employer due to the industrial injury did not preclude the ALJ from calculating AWW using her combined earnings. The ALJ properly exercised her discretionary authority under §8-42-102(3), C.R.S. in determining that the claimant's AWW should be fairly measured by including the earnings from her concurrent employment. Based on our review of the record, we are unable to say that the ALJ exceeded the bounds of reason in this regard. Consequently, 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 January 7, 2017, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

Kris Sanko

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THE FRICKEY LAW FIRM, Attn: ADAM MACLURE, ESQ, 940 WADSWORTH BLVD 4TH FLOOR, LAKEWOOD, CO, 80214 (For Claimant)
HALL & EVANS, LLC, Attn: DOUGLAS J. KOTAREK, ESQ, 1001 17TH STREET SUITE 300, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-915-969-03

IN THE MATTER OF THE CLAIM OF NINA KAZAZIAN, Claimant, v. VAIL RESORTS, Employer, and SELF-INSURED, Insurer, Respondent.	FINAL ORDER

The claimant seeks review of a supplemental order of Administrative Law Judge Mottram (ALJ) dated February 6, 2017, that found her claim to be closed due to her untimely request for a Division Sponsored Independent Medical Exam (DIME). We reverse the decision of the ALJ.

The claimant worked for the employer as a ski instructor. On April 1, 2013, she fell while working and sustained a concussion. The claimant continued working but she did experience hearing loss due to her fall. In August 2015, the claimant paid a return visit to her audiologist. The audiologist diagnosed deteriorating hearing loss and prescribed hearing aids. The claimant contacted the workers' compensation claims administrator concerning this prescription and was informed her claim had been closed by a Final Admission of Liability (FAL) filed by the respondent on September 6, 2013. The claims adjuster sent the claimant a copy by email on September 18, 2015. The claimant objected and requested a DIME review on September 21, 2015. The respondent refused to provide additional benefits to the claimant asserting her claim was closed by the September 2013, FAL.

The claimant filed an application for a hearing on May 5, 2016, requesting medical benefits and temporary disability benefits. A hearing convened on August 11, 2016. The respondent's claims adjuster identified a copy of the September 6, 2013, FAL. The FAL admitted liability for no temporary disability benefits. That admission bore an

attached medical statement from Dr. London dated August 22, 2013. Dr. London diagnosed the claimant with a concussion featuring hearing loss and tinnitus. The doctor determined the claimant had reached maximum medical improvement (MMI) on August 22, 2013, with no permanent impairment. The claims adjuster testified the FAL was mailed in the normal course of business to the Division and to the claimant at her last known address on September 6, 2013. The claimant testified she never received the FAL and she believed this was because the respondent was not using her correct zip code.

Prior to the hearing, the parties agreed to limit presentation to the ALJ the issue of whether the claim was closed by the 2013 FAL. At the outset of the hearing the ALJ noted "… it is the question in this case whether or not the case is closed pursuant to Section 8-43-203 (2) (b) (II)." Tr. at 20. "And if she proves that she didn't receive [the FAL], then the case is not closed under Section 8-43-203(2) (b) (II) because it can't be closed unless she has notice." Tr. at 21. Following the hearing, the ALJ submitted supplemental findings and an order on February 6, 2017. The ALJ determined the respondent had shown the FAL was properly filed and proper service made on the claimant when the FAL was mailed to her last known address of record on September 6, 2013. The claimant's request for a DIME review made in 2015 was deemed not timely filed pursuant to statute. The ALJ referenced the terms of § 8-43-203(2)(b)(II) to conclude that "the case will be automatically closed … if the claimant does not, within thirty days after the final admission, contest the final admission in writing and request … the selection of an independent medical examiner …" The claimant appealed the original order and the February 6, 2017, supplemental order. Although the ALJ granted the respondents' motion to strike the claimant's brief, this does not bar review of the case. " *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986)(Failure to file a brief is not a jurisdictional defect).

We have previously decided in *Maloney v. Ampex Corporation*, W.C. No. 3-952-034 (February 27, 2001), that an order finding a claim closed by a FAL is subject to review as provided in § 8-43-301(2). In *Maloney* we noted that the ALJ's finding the claimant failed to timely object to an FAL effectively closed the claim, and precluded the claimant from recovering any further benefits without presenting the proof required by § 8-43-303 to reopen the claim. Accordingly, the finding in this matter that the objection to the FAL was not timely filed represents a denial of benefits which is also reviewable pursuant to § 8-43-301(2).

The respondent's FAL filed on September 6, 2013, admitted for no temporary disability benefits and for no permanent impairment benefits. As a result, the claim was not closed by the FAL. The Supreme Court in *Harman-Bergstedt, Inc. v. Loofbourrow*,

320 P.3d 327 (Colo. 2014), held that 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, 7 Code Colo. Reg. 1101-3. The Court in *Loofbourrow* explained:

> "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. See § 8-42-107(8) (b) (I). … as a statutory term of art with consequences for contesting a final admission of liability, reopening a closed claim, or, 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. *Id.* at 331. … whether or not the division finds it useful for billing and recording purposes to "close" cases based on a determination that no further treatment is likely to improve the employee's condition, without regard to whether the injury was ever compensable, see, e.g. 7 Colo. Code Regs. 1101-03:16, Rule 16-7(E) - - the statutory consequences of a finding of "maximum medical improvement" can apply only to injuries as to which disability indemnity is payable. *Id.* at 331.

Therefore, the respondents' FAL premised on a finding of MMI, and which found that no disability indemnity was payable, cannot implicate "consequences for contesting a final admission of liability." *Thibault v. Ronnie's Automotive Services*, W.C. No. 4-970-099-01 (August 2, 2016).[1] Without an applicable determination of MMI, no DIME review of the MMI determination may be requested, § 8-42-107(8)(b)(II), no permanent

[1] The *Loofbourrow* decision undermines the effectiveness of a FAL filed pursuant to W.C. Rule of Procedure 5-5 where no indemnity benefits are payable. In those circumstances case closure must be obtained through an alternative procedure such as W.C. Rule 7-1 (abandonment of the claim or an absence of activity in the claim), § 8-43-207 (n) (failure to prosecute a claim) or FAL form 153 (final payment of death benefits).

impairment rating may be calculated nor DIME review initiated, § 8-42-107(8)(c), and the provisions of § 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 § 8-43-203(2)(b)(II) as that section does not yet apply in this claim. As the *Loofbourrow* court specifically stated, " [a]s 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." 320 P.3d at 331.

The respondent argues *Thibault, supra,* and *Barrera v. ABM Industries*, W.C. Nos. 4-849-952-01 & 4-865-048 (June 10, 2016), do not apply for the reason that maintenance medical benefits are still open in this matter and the ALJ was only asked to make factual findings which are not subject to appeal. Those two decisions previously held that an FAL present in a claim that does not feature the payment of indemnity benefits would not serve to close the claim. *Thibault* involved a decision in which the ALJ ordered medical benefits under a maintenance standard. Upon the respondents' appeal, we ruled the claim had not been closed by the FAL and the medical benefits need not be limited to those necessary to maintain the claimant's condition. *See*, *Chism v. Walmart*, W.C. No. 4-809-103-3 (January 9, 2017) (medical treatment designed to 'cure' rather than 'maintain' the claimant's condition is not compensable pursuant to a post MMI admission for medical benefits). Accordingly, the fact that the respondent in this case admitted for post MMI medical benefits does not obviate disputes over the claimant's request for medical benefits, for which the respondent, in fact, denied authorization. As discussed above, the ALJ noted the reason the factual dispute pertinent to the claimant's receipt of an FAL and the timely submission of her DIME request was relevant to a "matter arising under articles 40 to 47 of this title", § 8-43-201(1), was because it would dictate whether "the case is not closed under Section 8-43-203(2)(b)(II) …". Pursuant to our decision in *Maloney*, *supra*, such a dispute is subject to review pertinent to § 8-43-301(2).

Accordingly, we reverse and set aside the ALJ's order that the claimant's objection to the FAL and request for a DIME were not timely, since no time period ever began to run. We also set aside the finding the claim was then closed by the September 6, 2013, FAL as not supported by the evidence.

IT IS THEREFORE ORDERED that the ALJ's supplemental order issued February 6, 2017, is reversed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

- A complete copy of this final order, including the mailing date shown, must be attached to the notice of appeal, and you must provide a copy of both the notice of appeal and the complete final order to the Colorado Court of Appeals.

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Colorado Court of Appeals
2 East 14th Avenue
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Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

________4/24/17______________ by _________TT_____________ .

NINA KAZAZIAN, PO BOX 1952, VAIL, CO, 81658 (Claimant)
RITSEMA & LYON, P.C., Attn: PAUL KRUEGER, ESQ, 999 - 18TH STREET, SUITE 3100, DENVER, CO, 80202 (For Respondents)

COLORADO COURT OF APPEALS

DATE FILED: April 20, 2017
CASE NUMBER: 2016CA1684

Court of Appeals No. 16CA1684
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-947-730

Karen Adams,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado; Heart of the Rockies Regional Medical Center and CHA Trust,

Respondents.

ORDER AFFIRMED

Division VI
Opinion by JUDGE KAPELKE*
Loeb, C.J., and Vogt*, J., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced April 20, 2017

Karen Adams, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., Douglas L. Stratton, Fort Collins, Colorado, for Respondents Heart of the Rockies Regional Medical Center and CHA Trust

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2016.

¶ 1 In this workers' compensation proceeding, claimant, Karen Adams, seeks review of the final order of the Industrial Claim Appeals Office (Panel), which affirmed the order of the administrative law judge (ALJ). The Panel found that employer, Heart of the Rockies Regional Medical Center, and its insurer, Cha Trust, had overpaid benefits to claimant and were entitled to repayment in the amount of $16,326.77. We affirm.

I. Factual and Procedural Background

¶ 2 Claimant was injured in a work-related accident in March 2014. As a result of that injury, claimant began receiving temporary total disability (TTD) benefits.

¶ 3 In a subsequent motion to recover overpayment of those benefits, respondents stated that claimant had been placed at maximum medical improvement (MMI) on January 26, 2015, with a zero percent impairment rating. Claimant then requested a division-sponsored medical examination (DIME). The DIME physician also placed claimant at zero percent impairment rating, but determined that claimant had reached MMI on June 9, 2014, approximately thirty-three weeks earlier than the previously admitted MMI date.

¶ 4 Respondents then filed a final admission of liability, which admitted to the June 9, 2014, MMI date with a zero percent impairment rating. Respondents also asserted entitlement to refund of an overpayment in the amount of $16,326.77, based on TTD payments made to claimant after the MMI date determined by the DIME physician.

¶ 5 In response, claimant did not dispute the facts presented by respondents. Rather, she argued that respondents failed to comply with Department of Labor & Employment Rule 5-5(D)(1)(a), 7 Code Colo. Regs. 1101-3, which claimant alleged required respondents to send her to a level II accredited physician within forty days. Because respondents failed to do so, and she did not see a level II physician for seventy-two days, claimant asserts that respondents could not rely upon their own inaction to extend the amount of the overpayment. Consequently, claimant requested that the overpayment be reduced by the seventy-two days it took for her to see the level II physician. .

¶ 6 In reply, respondents alleged that the applicable rule, which followed section 8-42-107(8)(b.5)(II), C.R.S. 2016, required them only to refer, not send, claimant to a level II physician within forty

days after the MMI determination. Respondents attached correspondence which they claimed showed that the required referral had been made thirty-seven days after MMI.

¶ 7 The ALJ granted the respondents' motion and ordered claimant to pay respondents $16,326.77, the amount of the overpayment. Claimant appealed the ALJ's decision to the Panel and, after reiterating her medical history, requested that the Panel "forgive repayment."

¶ 8 The Panel noted that claimant did not dispute that respondents had overpaid TTD benefits beyond the date of the MMI in the amount of $16,326.77. The Panel also referenced prior decisions in which it had upheld the recovery of an overpayment when a DIME physician had determined that a claimant had reached MMI at an earlier date and the claimant had failed to overcome a zero percent impairment rating by the DIME physician. In addition, the Panel presumed that the ALJ was not persuaded by claimant's argument that respondents failed to comply with Rule 5-5(D)(1)(a) and that the overpayment should be reduced. The Panel therefore affirmed the ALJ's decision.

¶ 9 Claimant now brings this appeal.

II. Standard of Review

¶ 10 We may set aside the Panel's decision if (1) the findings of fact are not sufficient to permit appellate review; (2) conflicts in the evidence are not resolved in the record; (3) the findings of fact are not supported by the evidence; (4) the findings of fact do not support the order; or (5) the award or denial of benefits is not supported by applicable law. § 8-43-308, C.R.S. 2016.

III. Discussion

¶ 11 As she did before the Panel, claimant requests that the overpayment be forgiven based on medical documentation showing that she continues to have problems arising from her work injury. We are not persuaded.

¶ 12 Section 8-40-201(15.5), C.R.S. 2016, defines overpayment as follows:

> "Overpayment" means money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles. For an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles.

¶ 13 "Overpayment" includes sums that are erroneously paid by an employer. See Simpson v. Indus. Claim Appeals Office, 219 P.3d 354, 358 (Colo. App. 2009), rev'd in part on other grounds, vacated in part sub nom. Benchmark/Elite, Inc. v. Simpson, 232 P.3d 777 (Colo. 2010). Thus, respondents here were not precluded from seeking the recovery of TTD payments after discovering that claimant was not entitled to those payments. Id. at 361.

¶ 14 Claimant's brief on appeal does not make any specific legal argument for setting aside her repayment obligation. Rather, in her brief, she details her initial injury, and the medical treatment she has received, and then requests that we "forgive repayment" based on her continued medical problems. However, we may not consider claimant's statements regarding her current medical conditions as a basis for setting aside the repayment order because that evidence was not part of the record before the ALJ. *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."); *see also City of Durango v. Dunagan*, 939 P.2d 496, 500 (Colo. App. 1997) (failure to raise an issue before the ALJ precludes

consideration of it on review). As the Panel noted, claimant's continued medical problems might constitute a basis upon which she may file a petition to reopen. *See* § 8-43-303, C.R.S. 2016.

¶ 15 The only argument claimant presented to the ALJ was that the repayment amount should be reduced by the number of days it took her to see a level II physician. Respondents, however, presented evidence that they referred claimant to a level II physician within the time allowed by Rule 5.5(D)(1)(a).

¶ 16 Although the ALJ did not specifically rule on this issue, the Panel presumed that the ALJ was not persuaded that respondents' failure to comply with Rule 5-5(D)(1)(a) required that the overpayment should be reduced. Claimant does not argue on appeal that the Panel erred in failing to set aside the ALJ's implicit rejection of this argument. Moreover, the record indicates that respondents complied with Rule 5.5(D)(1)(a), which required them only to refer, not send, claimant to a level II physician within forty days after the MMI determination. Thus, even if a reduction were allowed on these grounds, we perceive no basis for it under the record before the ALJ.

¶ 17 Therefore, we conclude that the Panel did not err in upholding the ALJ's overpayment decision.

IV. Conclusion

¶ 18 The Panel's order is affirmed.

CHIEF JUDGE LOEB and JUDGE VOGT concur.

Court of Appeals

STATE OF COLORADO
2 East 14th Avenue
Denver, CO 80203
(720) 625-5150

CHRIS RYAN
CLERK OF THE COURT

PAULINE BROCK
CHIEF DEPUTY CLERK

NOTICE CONCERNING ISSUANCE OF THE MANDATE

Pursuant to C.A.R. 41(b), the mandate of the Court of Appeals may issue forty-three days after entry of the judgment. In worker's compensation and unemployment insurance cases, the mandate of the Court of Appeals may issue thirty-one days after entry of the judgment. Pursuant to C.A.R. 3.4(m), the mandate of the Court of Appeals may issue twenty-nine days after the entry of the judgment in appeals from proceedings in dependency or neglect.

Filing of a Petition for Rehearing, within the time permitted by C.A.R. 40, will stay the mandate until the court has ruled on the petition. Filing a Petition for Writ of Certiorari with the Supreme Court, within the time permitted by C.A.R. 52(b), will also stay the mandate until the Supreme Court has ruled on the Petition.

BY THE COURT: Alan M. Loeb
Chief Judge

DATED: September 22, 2016

Notice to self-represented parties: *The Colorado Bar Association provides free volunteer attorneys in a small number of appellate cases. If you are representing yourself and meet the CBA low income qualifications, you may apply to the CBA to see if your case may be chosen for a free lawyer. Self-represented parties who are interested should visit the Appellate Pro Bono Program page at http://www.cba.cobar.org/repository/Access%20to%20Justice/AppelateProBono/CBAAppProBonoProg_PublicInfoApp.pdf*

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-002-271-02

IN THE MATTER OF THE CLAIM OF:

TONJA M. GILBERT,

Claimant,

v.

SEARS OUTLET,

Employer,

and

ACE USA c/o ESIS,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Felter (ALJ) dated December 29, 2016, that denied and dismissed her claim for temporary disability benefits, and denied and dismissed her claim for surgery performed by Dr. Faulkner. We affirm.

This matter went to hearing on whether the claimant sustained a compensable aggravation and acceleration of her right knee condition, medical benefits, and temporary total disability (TTD) benefits. As pertinent here, the ALJ found that the paramount issue involved the compensability of a work-related event on November 27, 2015, and the primary issue concerned the causal relatedness of the need for surgery on April 28, 2016, to fix the claimant's patellar instability, or whether the need for the surgery was attributable to a pre-existing condition of the right knee.

After the hearing, the ALJ found that on November 27, 2015, the claimant was moving a washing machine with her hip and leg when she felt a burning sensation in her right knee. The claimant subsequently was seen at Concentra by Dr. Naidu. Dr. Naidu's report supports a temporary compensable event in the nature of a right knee strain. On December 3, 2015, the claimant returned to Concentra and was seen by Dr. Deonarain. The claimant reported that the burning sensation felt like the last time she tore her ligament. She also told Dr. Deonarain that after her last surgery, she had an occasional sensation of patellar slipping with certain activity. The claimant subsequently underwent

an MRI on her right knee, which showed no effusion and no hemarthrosis. The ALJ found the MRI supported a temporary right knee strain.

The claimant eventually was referred to Dr. Failinger, an orthopedic surgeon, for consultation. In his report dated December 17, 2015, Dr. Failinger noted the claimant's long history of similar problems. The claimant eventually underwent surgery with Dr. Faulkner on April 28, 2016, to fix her patellar instability.

The claimant underwent an independent medical examination with Dr. Healey on June 3, 2016. Dr. Healey opined that the claimant had a permanent, severe aggravation of a pre-existing chronic patellofemoral syndrome with intermittent subluxation as a result of the November 27, 2015, work incident.

On June 28, 2016, Dr. O'Brien performed an independent medical examination at the request of the respondents. Dr. O'Brien opined that the onset of the claimant's right knee pain on November 27, 2015, was a manifestation of the claimant's personal health and that there was no new tissue tearing or yielding and no evidence of bleeding on that date. He also stated that the claimant's reported mechanism and behavior after the alleged event was not consistent with an injury. Dr. O'Brien stated that the claimant's MRI showed no evidence of an acute injury, and that all evidence pointed to a pre-existing, longstanding condition.

The ALJ found that while the incident on November 27, 2015, was a compensable event, this event only amounted to a right knee sprain or strain, which necessitated some medical care and treatment prior to April 28, 2016. He instead found that the claimant's need for the surgery with Dr. Faulkner was based entirely on the claimant's pre-existing condition of patellar instability, which he found was not aggravated and/or accelerated by the November 27, 2015, work incident. The ALJ specifically credited Dr. O'Brien's opinion that the claimant's April 28, 2016, surgery was not causally related to the claim involving her right knee injury on November 27, 2015. The ALJ also credited Dr. Failinger's opinion as supporting a strain of the right knee resulting from the incident on November 27, 2015, which was temporary in nature. He further credited Dr. Healey's opinions as supporting a compensable right knee strain on November 27, 2015. The ALJ therefore ordered the respondents to pay for the costs of medical treatment from Dr. Naidu, Dr. Deonarian, and Dr. Failinger for treatment of the claimant's right knee strain. However, the ALJ denied and dismissed all claims for surgery performed by Dr. Faulkner. He also denied and dismissed the claimant's claim for temporary disability benefits.

On appeal, the claimant argues that the ALJ's findings of fact are insufficient to permit appellate review and are not supported by the evidence, and that the ALJ abused his discretion in determining the claimant suffered a compensable injury, but that the April 28, 2016, surgery was not causally related. In support of her argument, the claimant contends that the ALJ's conduct at the hearing prevented her from properly presenting testimony. She further argues that the ALJ's findings of fact are insufficient as they are based on a flawed and fundamentally confusing hearing. She explains that allowable testimony was prohibited without request, valid questions were dismissed, and several minutes were wasted on irrelevant questions from the ALJ. Moreover, the claimant contends that the ALJ erred in finding that causation and relatedness of the April 28, 2016, surgery were at issue in the hearing. She argues that at the commencement of the hearing, the respondents stipulated that if the ALJ found the claim compensable, then all the treatment post-injury was reasonable, necessary, and casually related. We are not persuaded there is reversible error.

To the extent the claimant argues that the ALJ's findings of fact are insufficient to permit appellate review, we disagree. An ALJ must make sufficient findings of fact to indicate the evidence which he considered to be determinative of the issues involved. *See Riddle v. Ampex Corp.*, 839 P.2d 489 (Colo. App. 1992). If the findings are insufficient to support appellate review of the basis for the order, we may set the order aside and remand for further findings of fact and conclusions of law. Section 8-43-301(8), C.R.S. However, we conclude that the ALJ's findings and conclusions here are sufficient to permit appellate review. The ALJ clearly found that the claimant sustained a temporarily exacerbating, compensable injury on November 27, 2015. He also found that the claimant's April 28, 2016, surgery was not causally related to the work incident on November 27, 2015. Instead, he found that the claimant's need for the surgery was the result of her pre-existing condition. In support of his determinations, the ALJ credited the opinions of Dr. O'Brien, part of the opinions of Dr. Failinger, and the opinion of Dr. Healey. Moreover, we reject the claimant's argument that the ALJ was confused in his order since certain findings he made were inconsistent with several other findings. We recognize inconsistencies in the ALJ's order. Order at 7-8 ¶28. However, an ALJ is not held to crystalline standard in articulating his 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*, 5 P.3d 385 (Colo. App. 2000). Since the ALJ here has thoroughly stated the basis for his order, despite the presence of some inconsistent findings, we will not disturb it.

Next, to the extent the claimant argues that the ALJ's conduct at the hearing prevented her from properly presenting testimony, we again are not persuaded there is reversible error. It is well settled that an ALJ has wide discretion to control the course of a hearing and make evidentiary rulings. Section 8-43-207(1)(c), (d), and (h), C.R.S.; *IPMC Transportation Co. v. Industrial Claim Appeals Office*, 753 P.2d 803 (Colo. App. 1988). However, fundamental due process requires that the parties be afforded notice and a reasonable opportunity to confront adverse witnesses, and present evidence and argument in support of their position. *Hendricks v. Industrial Claim Appeals Office*, 809 P.2d 1076 (Colo. App. 1990). We may not interfere with the ALJ's evidentiary rulings in the absence of an abuse of discretion. *Denver Symphony Ass'n v. Industrial Commission*, 34 Colo. App. 343, 526 P.2d 685 (1974). The appellate standard on review of an alleged abuse of discretion is whether the ALJ's order exceeds the bounds of reason, as where it is contrary to the applicable law or unsupported by the evidence. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993); *Rosenberg v. Board of Education of School District # 1*, 710 P.2d 1095 (Colo. 1985). Further, the party challenging the exclusion of evidence as an abuse of discretion must show sufficient prejudice before it is reversible error. CRE 103(a); *Williamson v. School District No. 2*, 695 P.2d 1173 (Colo. App. 1984).

While it is true, as the claimant argues, that the ALJ repeatedly interrupted both attorneys and the witnesses while providing testimony, there is no showing that the claimant's counsel was precluded from asking additional relevant questions she felt were necessary. *See also* CRE 611. Instead, the record demonstrates that the ALJ interrupted examination and cross-examination and interjected his questions primarily to gain clarity or additional information, to prevent redundant or repetitive examination, and to control the conduct of counsel during the hearing, all of which are expressly allowed under §8-43-207(1)(c), (d), and (h), C.R.S. Moreover, the claimant does not demonstrate how the outcome would have been any different had she asked additional questions or had the ALJ not interjected her questions or not interrupted. Therefore, we are not persuaded the claimant was denied due process of law. *See Williamson v. School District No. 2*, *supra* (party challenging order as abuse of discretion must show sufficient prejudice before it is reversible error).

Moreover, the claimant argues that the ALJ erred in finding that the April 28, 2016, surgery was not causally related. She reasons the respondents stipulated that if the ALJ found the claim compensable, then the claimant's April 28, 2016, surgery was causally related. We reject the claimant's argument.

We recognize that during the hearing, there was confusion and the respondents were unclear regarding their stipulations:

> [RESPONDENTS' COUNSEL]: At this point Respondents are conceding if – if found compensable at a later point and date and – causation is not an issue, we're not disputing authorized provider or reasonable and necessary –
> THE COURT: Okay. Wait a minute, let's do this methodically. It's all if compensable, these are all contingent stipulations.
>
> [RESPONDENTS' COUNSEL]: Correct.
>
> THE COURT: One, all the medical providers are authorized; am I right?
>
> [RESPONDENTS' COUNSEL]: Yes, Your Honor.
>
> THE COURT: Okay. What else?
>
> [RESPONDENTS' COUNSEL]: That the – the actual knee surgery that was performed was reasonable and necessary.
>
> THE COURT: Surgery was – and causally related, if compensable?
>
> [RESPONDENTS' COUNSEL]: Correct.
>
> THE COURT: Okay.
>
> [RESPONDENTS' COUNSEL]: Actually all treatment up until this point is reasonable and necessary.
>
> THE COURT: Okay. All righty. . .
>
> * * *
>
> THE COURT: -- has recited them, so they're the Respondents' stips. So those stipulations are accepted and I find as fact that they are what they are, if the case is compensable. So really the only real issue is compensability here today.
>
> [RESPONDENTS' COUNSEL]: Correct, Judge. Tr. at 6-9.

Later on during the hearing, the respondents' counsel objected to a question posed to the claimant during direct examination regarding a position offered by the respondent employer. The respondents stated as follows regarding causation:

> Q (By claimant's counsel) Did you accept that position, Ms. Gilbert?
>
> A I could not accept that position. At the time I was primary caretaker at my house and I cannot go off of a commission spot, so I told them that I couldn't. So he offered me another position as a store manager in Grand Junction four hours away. I also had to deny that one, so they told me that they didn't have a spot for me, but I was willing to –
>
> [RESPONDENTS' COUNSEL]: Your Honor, at this point I'm going to object. I don't know what relevance this has. The only issues are compensability and causation. We've stipulated to TTD. Tr. at 24.

Then, after the hearing, the respondents provided their Position Statement to the ALJ. Throughout their Position Statement, the respondents contested compensability and argued that the work incident did not cause the need for medical care or the need for the April 28, 2016, surgery. Additionally, in his Order, the ALJ made contrary findings of fact regarding the respondents' position on causal relatedness. Order at 2 ¶¶2, 4. Although there were conflicting statements regarding the respondents' stipulation, the ALJ resolved the conflict and ultimately determined that the respondents did, in fact, dispute whether the April 28, 2016, surgery was causally related to the work incident of November 27, 2015. We conclude the ALJ made a reasonable inference from the record regarding the respondents' stipulation. Additionally, the claimant does not contend that the presentation of her case was compromised due to confusion surrounding the respondents' stipulation. Consequently, we will not disturb the ALJ's order in this regard. Section 8-43-301(8), C.R.S.

Last, the claimant's argument notwithstanding, the ALJ's findings are supported by the evidence and support his determinations that the claimant sustained a compensable right knee strain, but that the April 28, 2016, surgery was not causally related to the industrial incident on November 27, 2015. The reports of both Dr. Naidu and Dr. Deonarain support a compensable right knee strain as a result of the work incident on November 27, 2015. These reports indicate that the claimant suffered right knee pain due to pushing a washer with her right hip during the course and scope of her employment. Ex. 12 at 109-110, 114-115; Ex. D at 34. Similarly, Dr. Healey opined that the claimant aggravated her pre-existing chronic patellofemoral syndrome as a result of the industrial

incident on November 27, 2015. Ex. 20 at 231. Further, the ALJ credited the claimant's testimony regarding the mechanism of her industrial injury. The claimant testified that as she was resetting the floor at work and pushing a washing machine to a different pod, her knee popped and she felt sharp pain. Tr. at 12-15. Additionally, in his report dated July 7, 2016, Dr. O'Brien opined that the surgery Dr. Faulkner performed in April 2016 was not causally related to the November 27, 2015, work incident. He instead stated that the claimant's need for the knee surgery was the result of her longstanding and pre-existing patellofemoral instability condition. Ex. A at 12-15; Ex. O at 130-131. We must uphold the ALJ's determination of this issue if it is supported by substantial evidence in the record. Section 8-43-301(8), C.R.S.; *see Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). This standard of review requires us to defer to the ALJ's credibility determinations, resolution of conflicts in the evidence, and plausible inferences drawn from the record. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). The testimony and medical reports referenced by the ALJ represent substantial evidence to support the ALJ's finding there was an inadequate causal link between the claimant's November 27, 2015, accident at work and her April 28, 2016, knee surgery. Section 8-43-301(8), C.R.S. Consequently, we have no basis to disturb the ALJ's order.

IT IS THEREFORE ORDERED that the ALJ's order dated December 29, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

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Colorado Court of Appeals
2 East 14th Avenue
Denver, CO 80203

Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

______5/1/2017____________ ______ by _____ TT ________ .

MCDIVITT LAW FIRM, Attn: RACHEL E. BENTLEY, ESQ, 19 E. CIMARRON ST., COLORADO SPRINGS, CO, 80903 (For Claimant)
THOMAS POLLART & MILLER, LLC, Attn: ERIC J. POLLART, ESQ, 5700 S. QUEBEC STREET, SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-002-020-02

IN THE MATTER OF THE CLAIM OF

JAMES ECKE,

Claimant,

v.

CITY OF WALSENBURG,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

FINAL ORDER

The claimant seeks review of an order of Administrative Law Judge Spencer (ALJ) dated December 22, 2016, that denied the claimant's request for temporary total disability (TTD) benefits. We affirm the decision of the ALJ.

The claimant worked for the respondent employer as a mechanic until December 18, 2015. On October 18, 2015, the claimant submitted a letter of resignation announcing his decision to retire from the employer's job on December 18. The day before his retirement, on December 17, the claimant was rear ended in a traffic accident while transporting one of the employer's trucks to the shop.

The claimant sustained injuries to his shoulder and cervical spine. The claimant's treating doctor recommended work restrictions involving no lifting over 10 pounds. The claimant reached maximum medical improvement (MMI) on March 8, 2016. A Division sponsored Independent Medical Examiner assigned the claimant a 12% whole person permanent impairment. The respondents filed a Final Admission of Liability, which awarded permanent partial disability benefits based on this rating. However, the respondents denied liability for temporary disability benefits asserting the claimant was responsible for the termination of his employment when he retired and that any wage loss was not due to his work injury.

The claimant submitted an application for a hearing seeking TTD benefits between the date of the injury on December 17 and the date of MMI on March 8. The claimant asserted his work restrictions prevented him from performing his preinjury job and it was his injury, which accounted for his wage loss. The claimant also contended he lost concurrent employment from two part time jobs with the local fire department and with a water company. The ALJ did award the claimant temporary partial disability benefits due to his inability to perform his concurrent employment. The ALJ denied the request for TTD benefits premised on wage loss from the claimant's full time job with the respondent employer. The ALJ reasoned the claimant's retirement was a volitional act on the part of the claimant. The claimant was therefore deemed responsible for the loss of employment and the resulting wage loss could not be attributed to the effects of his injury pursuant to § 8-42-103(g) and § 8-42-105(4) (a) C.R.S

Both of these two statutory sections provide that when a temporarily disabled employee is responsible for the loss of employment, the "resulting wage loss shall not be attributable to the on-the-job injury." The claimant argues that because he was disabled the day prior to the effective date of his retirement, that retirement cannot be characterized as the cause of his wage loss. Instead, the claimant asserts the wage loss was "resulting" from his work injury. We do not find that sequence to represent an exception to the disqualification from TTD if the claimant is responsible for his termination.

The claimant's contention limits the application of these statutes to situations where the claimant is employed in a modified duty job, which he was then responsible for losing. Only then, pursuant to his theory, does wage loss actually result from actions for which he was 'responsible.' However, in *Gilmore v. Industrial Claim Appeals Office* 187 P.3d 1129 (Colo. App. 2008), the Court rejected such an argument. Instead, the decision ruled that where the claimant becomes responsible for his termination, even prior to an offer of modified work, the resulting wage loss is attributable to his termination. The reason being that the employer is precluded by the job termination from the opportunity to make an offer of modified duty.

In *Gilmore,* the claimant was injured and began receiving TTD benefits. However, when the results of a drug screen administered immediately after the work accident showed the claimant tested positive for marijuana consumption, the violation of the employer's drug free policy led to his discharge. The claimant admitted he had smoked marijuana several days prior to his work injury. The claimant's TTD benefits were terminated when he was released to modified employment. The ALJ denied the

claimant's request for additional TTD benefits and the Court affirmed. The decision reasoned:

> The ALJ awarded claimant TTD benefits for the period of time he was unable to work because of his injuries. Once claimant was released to modified work, the ALJ ordered that the disability benefits ceased. Had claimant not precipitated his termination by engaging in activities that violated employer's no-tolerance drug policy, he could have been offered modified work by employer. The fact that he was not offered modified employment because he had been terminated has no bearing on the critical fact that he was physically able to work. We therefore conclude that the ALJ properly applied the law when he discontinued claimant's TTD benefits. 187 P.3d at 1132.

We applied this reasoning in *Gutierrez-Delgado v. North Star Foods, LLC*, W.C. No. 4-857-384-03 (December 19, 2012). In that case, the claimant fell at work on March 17 and injured her wrist and back. She was provided light duty restrictions. The next day, March 18, the employer obtained information the claimant's Social Security number did not match her birthdate. The claimant was asked to get the matter straightened out with the Social Security office before she could return to work. When the claimant failed to do so, she was discharged. We affirmed the denial of TTD benefits by the ALJ on the basis the claimant was responsible for her termination.

> The same analysis [as in *Gilmore*] applies to the facts of the present case; had the claimant not precipitated her termination by failing to provide the correct social security number and birth date or having the discrepancy fixed at the Social Security Administration, the claimant could have been offered modified work by the employer.

The circumstances in *Gilmore* and in Gutierrez-*Delgado* are substantially similar to those in this matter. The claimant was injured and shortly thereafter engaged in a volitional act, his retirement, to end his employment. The claimant was provided work restrictions but the employer was prevented from offering modified work because the claimant had retired. Despite the preceding work injury, the claimant's responsibility for his termination renders his resulting wage loss not attributable to the work injury.

We have, in fact, applied the termination statutes, § 8-42-103(g) and § 8-42-105(4)(a), to the circumstance where the claimant was found responsible for his discharge from a modified duty job. We have ruled in those cases that when the claimant causes the loss of such a job, and the modified job was not paying him his full preinjury wage, the claimant only becomes disqualified from receiving temporary total benefits, but may continue to receive any temporary partial disability benefits he was receiving during the duration of the modified duty job. This is because the 'resulting wage loss' is limited to the loss of the modified duty wages. *Tarman v. US Transport*, W.C. No. 4-981-955-01 (June 2, 2016). However, where, as here, the claimant was not available to be offered modified duty, *Gilmore* requires that we assume the loss of the claimant's preinjury wage in its entirety is the result of the claimant's termination from employment for which he was responsible.

This is the case because responsibility for the termination of 'employment' refers either to part time modified 'employment' or 'employment' in the claimant's preinjury job. This inclusion of both types of jobs renders the claimant's argument that he must have first been offered modified duty to be inapplicable. In *Sharon George v. T & M, Inc*., W.C. No. 4-609-400 (July 20, 2006), *aff'd George v. Industrial Claim Appeals Office* No. 06CA1627 (Colo. App. October 25, 2007) (not selected for publication), the claimant was injured and disabled from her job and was not working when she was investigated for either embezzling or allowing money in her care to be stolen prior to her injury. She was discharged and the ALJ terminated her temporary benefits despite her continuing work restrictions. The Panel rejected her argument that her wage loss was due to her injury, not her discharge, and would therefore justify continued temporary benefits.

> The claimant asserts that the ALJ erred in terminating her TTD benefits. According to the claimant, the failure to return her to modified employment after her injury irrefutably results in her wage loss resulting from her disabling injury, rather than from her being terminated for cause. The claimant would essentially require that TTD benefits be continued in every case in which the affected employee remained off work at the time of termination from employment for cause.
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> We conclude that the ALJ properly applied the termination statutes. The claimant, citing language from *Anderson v. Longmont Toyota*, 102 P.3d 323 (Colo. 2004), contends that the termination statutes do not apply because the claimant was not returned to modified employment at the time she was

> terminated. However, *Anderson v. Longmont Toyota* interpreted the termination statutes as not repealing the authority to reopen workers' compensation awards in cases involving a worsened condition. The case in front of us does not involve such a claimed worsening of condition. Moreover, in *Colorado Springs Disposal,* 58 P.3d at 1063, the court noted that nothing in the context of the termination statutes mandates the restrictive view, as proposed by the claimant here, that "employment" means only "modified employment." The court concluded that the term "employment" as used in the termination statutes is not ambiguous and encompasses both modified and regular employment. We do not read *Anderson v. Longmont Toyota* as compelling a different result here.

The claimant makes the same argument here as did the claimant in *Sharon George*. As noted in that case, above, the reference in § 8-42-103(g) and § 8-42-105(4)(a) to an employee responsible for termination of 'employment' also refers to 'regular employment.' Here, the claimant was responsible for his termination from regular employment through his retirement. The resulting wage loss therefore, is measured by the entirety of his preinjury wage for that regular employment. Accordingly, the ALJ did not commit error when he disqualified the claimant from temporary benefits calculated through wage loss from his regular job with the respondent employer, but only ordered temporary partial benefits premised on the claimant's loss of wages from his concurrent employment. The claimant did not lose wages from those latter jobs due to his retirement, but rather, as a result of his work injury.

The claimant relies on *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995) to the extent that decision holds that if a work injury contributed "in some degree" to wage loss the claimant's responsibility for the loss of employment does not affect his eligibility for TTD benefits. The claimant also points to two cases in which he argues the claimant's voluntary retirement did not lead to a denial of TTD benefits due to the application of § 8-42-103(g) and § 8-42-105(4) (a), i.e. *El Paso County Department of Social Services v. Donn*, 865 P.2 877 (Colo. App. 1993), and *Grisbaum v. Industrial Claim Appeals Office*, 109 P.3d 1054 (Colo. App. 2005).

The claimant's reliance on these decisions is misplaced. The enactment in 1999 of § 8-42-103(g) and § 8-42-105(4) (a), was aimed at overruling the *PDM Molding* decision. See, *Colorado Springs Disposal v. Industrial Claims Appeals Office*, 58 P.3d 1061 (Colo.

App. 2002) Consequently, despite the continuing application of work restrictions, the finding that the claimant was responsible for the loss of his employment will render insignificant the vestiges of wage loss initiated by the work injury.

In both *Donn* and in *Grisbaum*, the claimant had resigned from employment following a work injury. In both matters it was determined those resignations were intervening causes of subsequent wage loss which served to bar awards of TTD benefits. In *Donn v. El Paso County*, W.C. No. 3-883-779 (May 3, 1990), *aff'd*, *Donn v Industrial Claim Appeals Office*, (Colo. App. No. 90CA0840, April 11, 1991) (NSFP), the ALJ found the claimant voluntarily retired from her job following her injury. The ALJ ruled the retirement constituted an intervening event, which severed the causal connection between the wage loss and the injury. Two years later the claimant asserted her disability had worsened. Finding the claimant's evidence of greater disability persuasive, the ALJ ruled the wage loss could, at that point, be seen as caused by the work injury and not the retirement. That finding was affirmed by the Panel and by the Court of Appeals. *El Paso County v. Donn*, *supra*. *Grisbaum* featured a similar history. The claimant resigned from employment following an injury in January 2002. However, the claimant's condition deteriorated such that by May 2002, the ALJ concluded he was more disabled than at the date of his resignation. TTD benefits were awarded beginning in May. The Court of Appeals affirmed applying both § 8-42-105(4) (a) and the decision in *Anderson v. Longmont Toyota, Inc*. 102 P.3d 323 (Colo. 2004). In this matter, the ALJ found the claimant's condition did not worsen during any portion of the period between the date of injury and the date of MMI. The claimant did not make that assertion either at the hearing or on appeal. Accordingly, the decisions in neither *Donn* nor in *Grisbaum* apply to this matter. The claimant's retirement from his job required the ALJ to conclude the claimant's wage loss was not attributable to the work injury.

We find no compelling reason to find error in the ALJ's decision and therefore affirm his order.

IT IS THEREFORE ORDERED that the ALJ's order issued December 22, 2016, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Brandee DeFalco-Galvin

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

- A complete copy of this final order, including the mailing date shown, must be attached to the notice of appeal, and you must provide a copy of both the notice of appeal and the complete final order to the Colorado Court of Appeals.

- You must also provide copies of the complete notice of appeal package to the Industrial Claim Appeals Office, the Attorney General's Office (addresses shown below), and all other parties or their representative whose addresses are shown on the Certificate of Mailing on the next page.

- In addition, the notice of appeal must include a certificate of service, which is a statement certifying when and how you provided these copies, showing the names and addresses of these parties and the date you mailed or otherwise delivered these copies to them.

- An appeal to the Colorado Court of Appeals is based on the existing record before the Administrative Law Judge and the Industrial Claim Appeals Office, and the court will not consider documents and new factual statements that were not previously presented or new arguments that were not previously raised.

- Forms are available for you to use in filing a notice of appeal and the certificate of service. You may obtain these forms from the Colorado Court of Appeals online at its website, www.colorado.gov/cdle/CTAPPFORM or in person, or from the Industrial Claim Appeals Office. **Please note address changes as listed below.**

- The court encourages use of these forms. Proper use of the forms will satisfy the procedural requirements of the Colorado Appellate Rules for appeals to the Colorado Court of Appeals. **For more information regarding an appeal, you may contact the Court of Appeals directly at 720-625-5150.**

Colorado Court of Appeals
2 East 14th Avenue
Denver, CO 80203

Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

________5/5/2017_________ by _____TT________ .

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ, 7501 EAST LOWELL BLVD, DENVER, CO, 80230 (Insurer)
STRIEGEL LAW FIRM, LLC, Attn: MATTHEW J. STRIEGEL, ESQ, 332 BROADWAY AVENUE, PUEBLO, CO, 81004 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN, LLC, Attn: LORI R. MISKEL, ESQ, 1401 SEVENTEENTH STREET SUITE 900, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-942-783-01

IN THE MATTER OF THE CLAIM OF:

ROGER A. PORTILLO,

Claimant,

v.

FINAL ORDER

SHOCO OIL-SAMHILL-OIL, INC.,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated December 20, 2016, that ordered the respondents to pay for lumbar sympathetic block injections. We set aside the order of the ALJ.

The claimant was injured on February 11, 2014, while working as a laborer for the respondent employer. On February 11, the claimant fell and landed on his back. A day or two later he was a passenger in a company truck when the driver rear ended another vehicle. The claimant also sustained injuries to his low back in this accident.

The claimant initially treated with Dr. Drapeau. She noted the claimant complained of back pain from his lumbar spine to his thoracic region. The claimant also noted pain with numbness running into his right leg. An MRI study revealed a disc extrusion at the right S1 nerve root and a disc protrusion at the L4-5 level. Dr. Drapeau referred the claimant to Dr. Wakeshima for further treatment. Dr. Wakeshima suspected S1 radiculopathy and complex regional pain syndrome (CRPS) in the claimant's right leg. CRPS represents a nerve injury featuring burning pain and swelling. Dr. Wakeshima obtained a three-phase bone scan, interpreted as inconsistent with CRPS. The claimant underwent a QSART test that did indicate a diagnosis of CRPS. To treat the CRPS the claimant was administered four lumbar steroid neve block injections. The claimant's response was equivocal. Some of the blocks reduced the claimant's pain but others actually increased his pain.

Upon referral to Dr. Castro, the doctor recommended a discectomy surgery for the lumbar spine. Dr. Wakeshima suggested the claimant be provided lumbar sympathetic nerve block injections both prior to the surgery and following the procedure.

The claimant was evaluated at different points by Dr. Olsen, Dr. Ring and Dr. Schakaraschwili. These physicians reviewed the medical records and examined the claimant. They concluded the claimant did not have a diagnosis of CRPS and found lumbar sympathetic nerve blocks unnecessary. Dr. Wakeshima, Dr. Bernton and Dr. Castro came to the opposite conclusion and favored the lumbar sympathetic blocks.

The respondents denied authorization for the requested repeat sympathetic nerve blocks. Dr. Castro performed a laminectomy and a lumbar microdiskectomy at the L5-S1 level without the use of sympathetic blocks on April 12, 2016.

On February 4, 2016, Dr. Albert Hattem examined the claimant. The claims adjuster referred the claimant to Dr. Hattem and requested the doctor serve as a "designated provider." At the examination, the claimant signed a notice form pertinent to an independent medical examination required by W.C. Rule of Procedure 8-9 (A). Dr. Hattem had the claimant return for monthly evaluations on three subsequent occasions. The doctor scheduled an ultrasound to check for blood clots in the claimant's leg post back surgery, prescribed physical swim therapy, and provided work restrictions. The claimant participated in the ultrasound and the swim therapy and attended all scheduled appointments. Dr. Hattem concluded the claimant did not have CRPS. He relied on the bone scan reported as negative and on the claimant's inconsistent response to previous lumbar sympathetic blocks. Dr. Hattem saw the claimant on July 25, 2016, and determined the claimant was at maximum medical improvement (MMI). The claimant was assigned a 13% whole person permanent impairment rating. The doctor derived the rating from table 53 of the AMA Guides regarding permanent impairment of the lumbar spine, range of motion deficits, and for persistent radiculopathy. The doctor recommended permanent work restrictions, maintenance pool therapy and weaning from opioid analgesics. Exhibit J.

The respondents filed a Final Admission of Liability (FAL) on August 11, 2016. Exhibit 2. The FAL adopted the MMI date of July 25 and the 13% impairment rating. The claimant submitted a request to select a Division sponsored Independent Medical Exam (DIME). Exhibit 8. On that same day, August 11, the claimant filed an application for a hearing seeking authorization for the additional lumbar sympathetic blocks recommended by Dr. Wakeshima.

Prior to the December 6, 2016, hearing, the respondents moved to strike the application for hearing on the basis that an ALJ did not have jurisdiction to conduct a hearing pertinent to medical benefits when MMI had been announced but a DIME review of the MMI determination had not been completed. Prehearing ALJ Harr denied the motion. PALJ Harr reasoned the medical treatment at issue need not be characterized as a treatment to cure the claimant's injury but might also qualify as treatment to maintain his condition following MMI.

On December 6, the parties submitted numerous exhibits into the record without objection. The claimant testified briefly that the sympathetic blocks he had received sometimes improved his pain, sometimes did not, and sometimes made the pain worse. Tr. at 72, 74, 76, 80, 82, 84. The ALJ received the transcript of a November 14, 2016, deposition of Dr. Wakeshima. Dr. Wakeshima testified he did not believe the claimant would be at MMI until "after accomplishing a sympathetic block to see if this further improves or resolves his pain symptoms. And then at that point, further sympathetic blocks can be added under maintenance." Ex. 18, at 29-30.

At the hearing, the respondents asked that PALJ Harr's order be reversed and that the request to have a hearing on medical benefits prior to a DIME be denied. In response, the claimant argued that Dr. Hattem was not an authorized treating doctor. Therefore, the claimant contended the respondents' FAL was void and no DIME was necessary. The ALJ ruled the claimant successfully proved he suffered from a diagnosis of CRPS. The ALJ deemed the opinions of Dr. Wakeshima and Dr. Castro were more persuasive than those of Dr. Hattem, Dr. Olsen and Dr. Schakaraschwili. The ALJ found the prescription for lumbar sympathetic nerve block injections was a reasonable and necessary medical treatment "to cure and relieve the effects of the Claimant's admitted injury." The ALJ did not strike the respondents' FAL as void nor did he conclude a DIME review was unnecessary or not legally ripe. Instead, the ALJ noted the statement of claimant's counsel that the claimant could not afford to pay for a DIME review. For that reason, the claimant asserted he had not attended a DIME examination and would not be able to do so in the near future. In his order of December 20, 2016, the ALJ held:

> … the reasonable necessity of the lumbar sympathetic blocks are ripe for adjudication at the present time, regardless of the academic pendency of a DIME on January 7, 2017 (it is unlikely that it will occur because the Claimant cannot afford to pay for it and there is no indication that Dr. Dillon will perform the DIME pro bono). …medical care and treatment cannot be delayed until the Claimant can afford to pay for a

> DIME, or until the "twelfth of never," whichever comes first. [Ultimate Finding of Fact 52].
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> What is actually speculative is the Respondents' "Catch-22" argument that the pendency of the DIME, which could occur in the distant future, makes the issue of specific treatment recommended by the Claimant's ATPs months ago, and continuously recommended, unripe. The Workers' Compensation Act is not designed to allow a legal 'checkmate' on reasonably necessary medical care until a DIME occurs. [Conclusion of Law d].

On appeal, the respondents argue the ALJ did not have jurisdiction to enter orders in respect to future medical treatment once an authorized treating physician (ATP) has proclaimed MMI but before a requested DIME review has been completed. The claimant contends in his response that the ALJ either did find that Dr. Hattem was not an ATP or that he should have made that determination.

I.

The Workers' Compensation statute provides the finding of MMI by an ATP to be the event in a claim that will affect the nature of the benefits available to a claimant. The term is defined in § 8-40-201(11.5) to refer to the point when any "impairment as a result of injury, has become stable and when no further treatment is reasonably expected to improve the condition." Section 8-42-107(8) (b) (I) provides that "an authorized treating physician shall make a determination" of MMI and a dispute of that determination requires a request for a DIME, § 8-42-107(8) (b) (II). A hearing concerning MMI may not take place until the findings of the DIME physician have been filed with the Division, § 8-42-107(8) (b) (III). The payment of temporary disability benefits ceases as of the date of MMI, § 8-42-105(3)(a), and an ALJ lacks jurisdiction to hear a claimant's request for additional temporary benefits while a DIME application is pending in regard to MMI. *Chapman v. American Medical Response*, W.C. No. 4-600-029 (September 15, 2006). A hearing may not be conducted pertinent to permanent impairment benefits until a DIME determination has been concluded. *Egan v. Industrial Claim Appeals Office*, 971 P.2d 604 (Colo. App. 1998). The finding of MMI by an ATP ends the claimant's entitlement to further treatment to cure and relieve the effects of the claimant's injury. *Whiteside v. Smith*, 67 P.3d 1240, 1245 (Colo. 2003). Therefore, an ALJ lacks jurisdiction to hear a request for medical treatment when a DIME has not yet filed a report regarding MMI

with the Division. *Story v. Industrial Claim Appeals Office*, 910 P.2d 80 (Colo. App. 1995).

In this matter, the ALJ noted in his findings of fact that Dr. Wakeshima did not believe the claimant would be at MMI "until he had at least one more sympathetic block." Finding of Fact 47 (k). Accordingly, the ALJ characterized that treatment as designed to "cure and relieve" the effects of the injury. Findings of Fact 51, 52, and Conclusion of Law (c). However, the request for medical treatment designed to improve the claimant's condition represents a challenge to the finding of MMI by an ATP. As a result, the ALJ did not have jurisdiction to conduct a hearing about that issue or to award those medical benefits until a DIME report was filed. Until that time, the finding of MMI by an ATP ends the claimant's entitlement to further treatment to cure and relieve the effects of the claimant's injury. *Gonzales v. Industrial Claim Appeals Office*, 905 P.2d 16 (Colo. App. 1995); *Whiteside v. Smith*, *supra*.

The reference made by Dr. Wakeshima to his analysis that some of the lumbar sympathetic blocks following the initial injection may be characterized as maintenance does not help the claimant's argument here. The ALJ held the injection requested was to "cure" the claimant's condition. In *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988), the Court held that an award of ongoing medical benefits may be appropriate if there is substantial evidence the treatment is necessary to "relieve" the effects of the injury or to prevent a deterioration of the claimant's condition. Treatment necessary to "cure" the injury is, therefore, not available post MMI while treatment to "relieve" or prevent deterioration is. In *Karathanasis v. Chili's Grill & Bar*, W.C. No. 4-461-989 (August 8, 2003) we observed there is no bright line test to distinguish treatment designed to "cure" an injury from treatment which is designed to "relieve" the effects of the injury. In *Hayward v. Unisys Corp*. W.C. No. 4-230-686 (July 2, 2002) we identified as critical the reason for the treatment recommendation. "Further, the question of whether medical treatment is administered for the purpose of 'curing' or merely 'relieving' the claimant's condition does not depend on the type of treatment, but rather the reason for the treatment." *See Milco Construction v. Cowan*, 860 P.2d 539, 542 (Colo. App. 1992). Here, the request for the sympathetic blocks was specifically described by Dr. Wakeshima as necessary to "see if this further improves or resolves his pain symptoms." The ALJ accepted this reasoning, found it to be persuasive, and therefore ruled the sympathetic blocks were necessary to "cure" the effects of the claimant's injury. As noted above, a hearing concerning such treatment must await a DIME report, which finds the claimant is not at MMI. In the posture of this claim, the hearing was premature.

Even in the event some portion of the sympathetic blocks were for maintenance care, the hearing on December 6 was not a timely venue to consider their authorization. In *Hubbard v. University Park Care Center*, W.C. No. 4-907-314-02 (July 17, 2014) we noted that in *Grover v. Industrial Commission, supra*, the Court held that an order for liability for the costs of future medical care post MMI is to be considered "at the hearing on the final award of permanent disability." *See also Milco Construction v. Cowan, supra*. Because the issue of permanent disability cannot be considered until the issue of MMI has been resolved, medical benefits after MMI could not be considered by the ALJ in the December 6, 2016, hearing. *See also Murray v. Broadspire Services, Inc*. W.C. No. 4-921-576-02 (June 10, 2014); *Chism v. Walmart*, W.C. No. 4-809-103-3 (January 9, 2017).

II.

The claimant contends the ALJ did hold either that Dr. Hattem was not an ATP, or that he should have. The ALJ writes in Finding of Facts, ¶ 2, "The claimant disputes whether Dr. Hattem is an ATP. The ALJ infers that if it walks, talks and squawks like an Independent Medical Examination (IME), it probably is an IME." The ALJ nowhere else in the order suggests Dr. Hattem's placement of the claimant at MMI was insufficient to justify the respondents' filing of an FAL. At the conclusion of the December 6 hearing the ALJ stated from the bench: "I don't have to deal with the issue of who Hattem really is today other than, gosh, it seems like he was sent for an evaluation by Hattem but that just goes to the weight to be accorded his opinion. He didn't deal with claimant that much." Tr. at 95. In the claimant's brief in opposition to petition to review, filed with the ALJ, the claimant requests that the ALJ clarify his order to state: "Dr. Hattem was an independent medical examiner, not an authorized physician." However, the ALJ declined to submit a supplemental order. We conclude the ALJ did not make a finding that Dr. Hattem was other than an ATP and the respondents could legitimately file an FAL premised on the doctor's finding of MMI.

Claimants can, and do, often have multiple authorized treating physicians. In *Town of Ignacio v. Industrial Claim Appeals Office*, 70 P.3d 513 (Colo. App. 2002), the claimant was treated by a physician provided by the employer. This physician provided some treatment and then referred the claimant to a hand specialist to determine the possible need for surgery. The specialist saw the claimant on one occasion and rendered a differential opinion pertinent to surgery. Three months later the specialist filled out a form indicating the claimant was at MMI as of the previous date of his evaluation. The first physician disagreed with the declaration of MMI. The Court noted § 8-42-107(8) (b) (I) refers to "[a]n" authorized treating physician as an individual capable of designating

the status of MMI. Therefore, either the original physician or the specialist could make a finding of MMI. Concerning whether the specialist was a "treating" physician, the Court explained:

> The specialist was a 'treating' physician because he examined claimant not in anticipation of litigation or simply for purposes of providing a disability rating, but to determine whether additional surgery was needed to alleviate claimant's pain. *See Miller v. Lake Forest, Inc.,* 370 So.2d 647, 651 (La.Ct.App. 1979) (rejecting, in workers' compensation action, argument that bills should be disallowed because physicians did not treat claimant: 'While these specialists did not provide a course of treatment, they did examine plaintiff for purposes of medical assistance and not merely in preparation for the ... trial."; *see also Hester v. Ford,* 221 Ala. 592, 130 So. 203, 206 (1930) (medical malpractice action: "In common parlance and often in the law, 'treatment' is the broad term covering all the steps taken to effect a cure of the injury or disease; it includes examination and diagnosis as well as application of remedies."); *Robinson v. Howard Hall Co.,* 219 So.2d 688, 691 (Fla. 1969) (workers' compensation case: "The statute in requiring remedial treatment to be provided an employee contemplates that a preliminary medical examination may be necessary as an incident to such treatment."). 70 P.3d at 515.

Here, Dr. Hattem's initial report of February 3, 2016, states the claimant is there to see him because the insurer's claims adjuster requested he assume the role of "designated provider." Ex. J. pg. 150. As noted above, Dr. Hattem proceeded to schedule three subsequent monthly appointments with the claimant. He arranged for an ultrasound test and prescribed pool therapy. Ex. J., pg. 188. There was no litigation pending at any time through Dr. Hattem's dealings with the claimant. Pursuant to the standard applied in *Town of Ignacio*, Dr. Hattem would fit the category of a "treating" physician.

The claimant argues the claims adjuster may not unilaterally authorize a treating physician. The fear appears to be that the respondents could use such a tactic to undermine plans of treatment pursued by other ATP's through which the claimant is achieving recovery. The statute however, contemplates disruption of a claimant's

treatment when a therapy is recommended but there is no designation of a provider or when an authorized provider closes its practice without referral to another doctor. In those circumstances, among others, the employer is allowed to provide an additional treater. Section 8-42-101(1) (a) specifies that every employer shall furnish such medical treatment as may reasonably be needed at the time of the injury "and thereafter during the disability" to cure and relieve the employee from the effects of the injury. W.C. Rule of Procedure 16-2 (B) (6) also allows the payer insurance company to designate an ATP through agreement with the injured worker. There is no provision for the form of the agreement. The actions of an injured worker in appearing for subsequent appointments and participating in treatments recommended or prescribed by the designated ATP would indicate agreement to the services of the ATP.

In his report of May 17, 2016, Dr. Hattem had prescribed an ultrasound for the claimant post-surgery to ensure he did not develop clots in his veins. Ex. J, pg. 191. The doctor phoned the claimant to provide him the number for the technician administering the ultrasound. Ex. J, pg. 188. The claimant then scheduled the ultrasound and Dr. Hattem was able to consult with the technician as to the results. Ex. J, pg. 189. In his July 25 report, Dr. Hattem notes the claimant is continuing the recommended pool therapy, which the claimant says, is beneficial. Ex J, pg. 193. These activities represent treatment and agreement. The authorization of Dr. Hattem by the claims adjuster was appropriate pursuant to both § 8-42-101(1) (a) and Rule 16-2 (B).

Given this record, the determination of the ALJ that the method by which the claimant was referred to Dr. Hattem would only go to the weight the ALJ put on an opinion of the doctor, rather than disqualify him entirely as an ATP, is a reasonable conclusion to reach.

III.

The ALJ concluded that the equities of the claim justified the authorization of additional treatment to cure the effects of the injury regardless of the absence of a DIME report. The ALJ observed that the claimant was unable to pay for a DIME review. This circumstance, he reasoned, frustrated the goal of the workers' compensation statute and required an exception to the DIME review process. The only information in the record concerning this claim is comprised of statements by the claimant's counsel made during legal argument at the hearing. The claimant did not testify in this regard and no admitted exhibit discusses those details. Counsel stated the claimant does not know that he will ever get a DIME exam because he does not have adequate funds. Tr. at 27. Counsel explained that the DIME costs $675 and the physician designated to perform the DIME

requested an additional $650 due to the large amount of medical records necessary for review. Tr. at 29.

Assuming the accuracy of these assertions, the record does not support the ALJ's conclusion claimant is unable to secure a DIME review based on his lack of money. Section 8-42-107.2 (5) (b) provides that a claimant able to establish he is indigent may have a DIME without the necessity of advancing the cost to the DIME physician. W.C. Rule of Procedure 11-11 (B) (2) specifies that once an ALJ determines the claimant is indigent the insurer will be obligated to advance the cost of the DIME review. Neither the claimant nor his counsel was queried nor did they offer any information as to whether the claimant was ever found to be indigent, or whether he even applied for such relief.

It was not clear as to whether the claimant could afford the initial $675 fee but not the additional $650 requested to review the extraordinary amount of records. W.C. Rule of Procedure 11-4 (A) allows a DIME physician to request additional payment in the situation where record review is unusually extensive. However, the Division is to pass on this plea for more money to the party requesting the DIME and that requesting party may decline to pay the additional money. The DIME physician is directed to then complete the DIME process "to the best of his/her ability". Again, the record in this matter contains no information as to why the claimant did not refuse to pay the additional $650 and complete the DIME review.

Finally, § 4-42-107(8)((d) and W.C. Rule of Procedure 5-10 (A) allows a claimant to request payment of any permanent partial disability award up to the amount of $10,000 to be paid immediately in a lump sum. The request does not prejudice the ability to contest the impairment rating. This payment may be applied to the cost of a DIME. Here, the respondents admitted in their FAL to a permanent disability award for $5,644.51. The record reflects no information regarding the status of any lump sum request.

The record in this matter does not support the ALJ's determination that "medical care and treatment cannot be delayed until the Claimant can afford to pay for a DIME, or until the 'twelfth of never,' whichever comes first." The statute does provide for prerequisite conditions to exist before an ALJ has jurisdiction to award certain types of medical benefits. § 8-42-107 (8) (b)(III) and (c). Here, the prerequisite is a DIME report filed with the Division. The statute and rules allow a DIME review to be secured within a matter of weeks. They also anticipate the circumstance wherein a party has limited funds to pay for the DIME and operate to prevent that condition from delaying the process. § 8-42-107.2 (5) (b); W.C. Rule of Procedure 11-11 (B) and 11-4 (A).

Because the ALJ did not have jurisdiction to hold a hearing regarding a request for medical benefits following an ATP's determination of MMI but prior to the completion of a DIME review, we set aside the December 20, 2016, order of the ALJ. *Story v. Industrial Claim Appeals Office, supra; Chapman v. American Medical Response, supra.*

IT IS THEREFORE ORDERED that the ALJ's order issued December 20, 2016, is set aside.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

NOTICE

- This order is **FINAL** unless you appeal it to the **COLORADO COURT OF APPEALS**. To do so, you must file a notice of appeal in that court, either by mail or in person, but it must be **RECEIVED BY** the court at the address shown below within twenty-one (21) calendar days of the mailing date of this order, as shown below.

- A complete copy of this final order, including the mailing date shown, must be attached to the notice of appeal, and you must provide a copy of both the notice of appeal and the complete final order to the Colorado Court of Appeals.

- You must also provide copies of the complete notice of appeal package to the Industrial Claim Appeals Office, the Attorney General's Office (addresses shown below), and all other parties or their representative whose addresses are shown on the Certificate of Mailing on the next page.

- In addition, the notice of appeal must include a certificate of service, which is a statement certifying when and how you provided these copies, showing the names and addresses of these parties and the date you mailed or otherwise delivered these copies to them.

- An appeal to the Colorado Court of Appeals is based on the existing record before the Administrative Law Judge and the Industrial Claim Appeals Office, and the court will not consider documents and new factual statements that were not previously presented or new arguments that were not previously raised.

- Forms are available for you to use in filing a notice of appeal and the certificate of service. You may obtain these forms from the Colorado Court of Appeals online at its website, www.colorado.gov/cdle/CTAPPFORM or in person, or from the Industrial Claim Appeals Office. **Please note address changes as listed below.**

- The court encourages use of these forms. Proper use of the forms will satisfy the procedural requirements of the Colorado Appellate Rules for appeals to the Colorado Court of Appeals. **For more information regarding an appeal, you may contact the Court of Appeals directly at 720-625-5150.**

Colorado Court of Appeals
2 East 14th Avenue
Denver, CO 80203

Industrial Claim Appeals Office
633 17th Street, Suite 200
Denver, CO 80202

Office of the Attorney General
State Services Section
Ralph L. Carr Colorado Judicial Center
1300 Broadway 6th Floor
Denver, CO 80203

CERTIFICATE OF MAILING

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

5/1/17 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D. FLEWELLING, ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Insurer)
MARTINEZ TENREIRO & LAFORETT, LLC, Attn: ELSA MARTINEZ TENREIRO, ESQ, 6000 E. EVANS AVE SUITE 3-400, DENVER, CO, 80222 (For Claimant)
RUEGESSGER SIMONS SMITH & STERN, Attn: KEVIN M. CARLOCK, ESQ, 1401 17TH ST STE 900, DENVER, CO, 80202 (For Respondents)

First Regular Session
Seventy-first General Assembly
STATE OF COLORADO

REREVISED

This Version Includes All Amendments Adopted in the Second House

LLS NO. 17-0143.01 Kristen Forrestal x4217

HOUSE BILL 17-1119

HOUSE SPONSORSHIP

Kraft-Tharp, Singer

SENATE SPONSORSHIP

Jahn and Tate,

House Committees
Business Affairs and Labor
Finance
Appropriations

Senate Committees
State, Veterans, & Military Affairs
Finance
Appropriations

SENATE
3rd Reading Unamended
May 10, 2017

SENATE
Amended 2nd Reading
May 9, 2017

HOUSE
3rd Reading Unamended
May 1, 2017

HOUSE
Amended 2nd Reading
April 28, 2017

A BILL FOR AN ACT

101 CONCERNING THE PAYMENT OF WORKERS' COMPENSATION BENEFITS
102 TO INJURED EMPLOYEES OF UNINSURED EMPLOYERS, AND, IN
103 CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill creates the "Colorado Uninsured Employer Act" to create a new mechanism for the payment of covered claims to workers who are injured while employed by employers who do not carry workers' compensation insurance. The bill creates the Colorado uninsured employer fund, which consists of penalties from employers who do not

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

carry workers' compensation insurance.

The bill creates the uninsured employer board to establish the criteria for the payment of benefits, to set rates, to adjust claims, and to adopt rules. The board is required to adopt, by rule, a plan of operation to administer the fund and to institute procedures to collect money due to the fund.

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1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** In Colorado Revised Statutes, **add** article 67 to title
3 8 as follows:

4 **ARTICLE 67**

5 **Colorado Uninsured Employer Act**

6 **8-67-101. Short title.** THE SHORT TITLE OF THIS ARTICLE 67 IS
7 THE "COLORADO UNINSURED EMPLOYER ACT".

8 **8-67-102. Legislative declaration.** (1) THE GENERAL ASSEMBLY
9 HEREBY FINDS AND DECLARES THAT THE PURPOSE OF THIS ARTICLE 67 IS
10 TO PROVIDE A MECHANISM FOR THE PAYMENT OF COVERED CLAIMS TO
11 WORKERS INJURED WHILE EMPLOYED BY EMPLOYERS WHO HAVE FAILED
12 TO OBTAIN AND MAINTAIN THE REQUIRED WORKERS' COMPENSATION
13 INSURANCE AND TO AVOID EXCESSIVE DELAY IN PAYMENT AND FINANCIAL
14 LOSS TO INJURED WORKERS.

15 (2) THEREFORE, IT IS THE INTENT OF THE GENERAL ASSEMBLY TO
16 REQUIRE EMPLOYERS TO MAINTAIN WORKERS' COMPENSATION INSURANCE
17 AND THAT THE REQUIREMENT BE VIGOROUSLY ENFORCED IN ORDER TO
18 PROTECT COMPLIANT EMPLOYERS FROM THOSE WHO WOULD GAIN A
19 COMPETITIVE ADVANTAGE AT THE EXPENSE OF THE SAFETY AND
20 WELL-BEING OF EMPLOYEES.

21 **8-67-103. Definitions.** AS USED IN THIS ARTICLE 67, UNLESS THE
22 CONTEXT OTHERWISE REQUIRES:

1 (1) "BOARD" MEANS THE UNINSURED EMPLOYER BOARD CREATED
2 IN SECTION 8-67-106.
3 (2) "COVERED CLAIM" MEANS A CLAIM FOR BENEFITS RESULTING
4 FROM AN INJURY OCCURRING ON OR AFTER JANUARY 1, 2020, THAT HAS
5 BEEN ADJUDICATED TO BE COMPENSABLE, FOR WHICH THE EMPLOYER HAS
6 BEEN DETERMINED TO BE UNINSURED, AND FOR WHICH THE EMPLOYER HAS
7 FAILED TO PAY THE FULL AMOUNT OF BENEFITS AS ORDERED.
8 (3) "DEPARTMENT" MEANS THE DEPARTMENT OF LABOR AND
9 EMPLOYMENT.
10 (4) "DIRECTOR" MEANS THE DIRECTOR OF THE DIVISION OF
11 WORKERS' COMPENSATION.
12 (5) "DIVISION" MEANS THE DIVISION OF WORKERS' COMPENSATION
13 IN THE DEPARTMENT OF LABOR AND EMPLOYMENT.
14 (6) "FUND" MEANS THE COLORADO UNINSURED EMPLOYER FUND.
15 **8-67-104. Exclusions.** (1) THE FOLLOWING PERSONS MAY NOT
16 RECOVER COMPENSATION OR OTHER BENEFITS FROM THE FUND:
17 (a) A PARTNER IN A PARTNERSHIP OR AN OWNER OF A SOLE
18 PROPRIETORSHIP;
19 (b) A DIRECTOR OR OFFICER OF A CORPORATION;
20 (c) A MEMBER OR MANAGER OF A LIMITED LIABILITY COMPANY;
21 (d) AN INDIVIDUAL WHO WAS RESPONSIBLE FOR OBTAINING AND
22 MAINTAINING THE EMPLOYER'S WORKERS' COMPENSATION INSURANCE
23 COVERAGE AND WHO FAILED TO DO SO;
24 (e) AN INDIVIDUAL WHO WAS ELIGIBLE TO BE COVERED UNDER A
25 WORKERS' COMPENSATION INSURANCE POLICY AND VOLUNTARILY
26 REJECTED THE COVERAGE UNDER SECTION 8-41-202, 8-41-404 (4)(a)(V),
27 OR 8-41-404 (4)(a)(VI);

1 (f) AN INDIVIDUAL WHO IS NOT AN "EMPLOYEE" AS DEFINED IN
2 SECTIONS 8-40-202 AND 8-40-301 OR WHO IS OTHERWISE INELIGIBLE TO
3 RECEIVE BENEFITS UNDER ARTICLES 40 TO 47 OF THIS TITLE 8.
4 **8-67-105. Colorado uninsured employer fund.** (1) THE
5 COLORADO UNINSURED EMPLOYER FUND IS HEREBY CREATED IN THE
6 STATE TREASURY. A BOARD OF DIRECTORS ESTABLISHED UNDER SECTION
7 8-67-106 SHALL ADMINISTER THE FUND UNDER A PLAN OF OPERATION
8 ESTABLISHED UNDER SECTION 8-67-108.
9 (2) (a) THE MONEY COLLECTED FOR THE FUND PURSUANT TO
10 ARTICLES 40 TO 47 OF THIS TITLE 8 SHALL BE TRANSMITTED TO THE STATE
11 TREASURER, WHO SHALL CREDIT THE MONEY TO THE FUND. THE MONEY
12 CREDITED TO THE FUND AND ALL INTEREST EARNED THEREON ARE HEREBY
13 CONTINUOUSLY APPROPRIATED FOR THE PAYMENT OF THE DIRECT COSTS
14 OF ADMINISTERING THE PROGRAM, INCLUDING BENEFITS PAID PURSUANT
15 TO THIS ARTICLE 67 AND PAYMENTS TO THIRD PARTIES RETAINED
16 PURSUANT TO THIS ARTICLE 67.
17 (b) THE INTERNAL STAFFING COSTS, NOT INCLUDING PAYMENTS TO
18 THIRD PARTIES CONTRACTED BY THE BOARD, ASSOCIATED WITH
19 UNINSURED EMPLOYER PROGRAMS SHALL BE PAID OUT OF THE WORKERS'
20 COMPENSATION CASH FUND IN ACCORDANCE WITH APPROPRIATIONS MADE
21 PURSUANT TO SECTION 8-44-112 (7).
22 (c) THE FUND CONSISTS OF:
23 (I) CIVIL PENALTIES, FINES, AND OTHER REVENUE COLLECTED BY
24 THE DIVISION AND SPECIFICALLY ALLOCATED TO THE FUND PURSUANT TO
25 ARTICLES 40 TO 47 OF THIS TITLE 8;
26 (II) ANY PUBLIC OR PRIVATE GIFTS, GRANTS, OR DONATIONS TO
27 THE FUND RECEIVED BY THE DEPARTMENT;

1 (III) ANY APPROPRIATIONS MADE TO THE FUND; AND
2 (IV) EARNED INTEREST, WHICH THE STATE TREASURER SHALL
3 DEPOSIT IN THE FUND.
4 (d) THE DEPARTMENT MAY USE REVENUES IN THE FUND FOR
5 BENEFITS TO BE PAID OUT OF THE FUND PURSUANT TO THIS ARTICLE 67 AS
6 WELL AS ADMINISTRATIVE COSTS OF THE BOARD.
7 (e) THE MONEY IN THE FUND:
8 (I) SHALL REMAIN IN THE FUND AND NOT BE CREDITED OR
9 TRANSFERRED TO THE GENERAL FUND AT THE END OF ANY FISCAL YEAR;
10 (II) IS EXEMPT FROM SECTION 24-75-402; AND
11 (III) IS NOT SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL
12 ASSEMBLY.
13 (3) NO LATER THAN JUNE 1, 2022, THE STATE AUDITOR SHALL
14 CONDUCT OR CAUSE TO BE CONDUCTED A PERFORMANCE AUDIT OF THE
15 COLORADO UNINSURED EMPLOYER FUND.
16 **8-67-106. Creation of board.** (1) THERE IS HEREBY CREATED IN
17 THE DIVISION THE UNINSURED EMPLOYER BOARD, CONSISTING OF THE
18 DIRECTOR OF THE DIVISION OR THE DIRECTOR'S REPRESENTATIVE AND
19 FOUR MEMBERS APPOINTED BY THE GOVERNOR AND CONFIRMED BY THE
20 SENATE. APPOINTED MEMBERS OF THE BOARD MUST INCLUDE AT LEAST
21 ONE INDIVIDUAL TO REPRESENT EACH OF THE FOLLOWING:
22 (a) EMPLOYERS;
23 (b) LABOR ORGANIZATIONS;
24 (c) INSURERS; AND
25 (d) ATTORNEY REPRESENTATIVES OF INJURED WORKERS.
26 (2) THE BOARD SHALL EXERCISE ITS POWERS AND PERFORM ITS
27 FUNCTIONS UNDER THE DEPARTMENT AND THE DIRECTOR AS IF THE BOARD

1 WERE TRANSFERRED TO THE DEPARTMENT BY A **TYPE 2** TRANSFER, AS
2 SUCH TRANSFER IS DEFINED IN THE "ADMINISTRATIVE ORGANIZATION ACT
3 OF 1968", ARTICLE 1 OF TITLE 24.

4 (3) THE APPOINTED MEMBERS OF THE BOARD SHALL SERVE FOR
5 TERMS OF THREE YEARS AND MAY BE REAPPOINTED; EXCEPT THAT, OF THE
6 MEMBERS FIRST APPOINTED, ONE SHALL SERVE FOR AN INITIAL TERM OF
7 THREE YEARS, TWO SHALL SERVE FOR INITIAL TERMS OF TWO YEARS, AND
8 ONE SHALL SERVE FOR AN INITIAL TERM OF ONE YEAR. A MEMBER MAY
9 SERVE NO MORE THAN THREE CONSECUTIVE TERMS.

10 (4) MEMBERS OF THE BOARD ARE NOT ENTITLED TO
11 COMPENSATION FOR THEIR SERVICES BUT SHALL BE REIMBURSED FOR
12 ACTUAL AND NECESSARY TRAVELING AND EXPENSES INCURRED IN THE
13 PERFORMANCE OF THEIR OFFICIAL DUTIES AS MEMBERS OF THE BOARD.

14 **8-67-107. Powers of the board.** (1) THE BOARD HAS THE
15 FOLLOWING POWERS AND DUTIES:

16 (a) TO ESTABLISH STANDARDS AND CRITERIA FOR PAYMENT OF
17 BENEFITS FROM THE FUND;

18 (b) TO SET MINIMUM AND MAXIMUM BENEFIT RATES; EXCEPT THAT
19 BENEFITS PAID BY THE FUND SHALL NOT EXCEED THE MAXIMUM ALLOWED
20 UNDER ARTICLES 40 TO 47 OF THIS TITLE 8 OR SET FORTH BY ORDER OF THE
21 DIRECTOR. MINIMUM BENEFIT RATES SHALL BE AT THE LEVEL REQUIRED
22 BY ARTICLES 40 TO 47 OF THIS TITLE 8 UNLESS THE FUND LACKS
23 SUFFICIENT MONEY AS DETERMINED BY THE BOARD. IF BENEFITS ARE PAID
24 BELOW THE AMOUNT MANDATED BY ARTICLES 40 TO 47 OF THIS TITLE 8,
25 BENEFITS SHALL BE PRIORITIZED AND PAID AS FOLLOWS:

26 (I) MEDICAL BENEFITS;

27 (II) FUNERAL BENEFITS;

1 (III) TEMPORARY DISABILITY;
2 (IV) DEATH BENEFITS;
3 (V) PERMANENT TOTAL DISABILITY;
4 (VI) PERMANENT PARTIAL DISABILITY;
5 (VII) DISFIGUREMENT.
6 (c) TO ADJUST CLAIMS, WHICH MAY BE PERFORMED BY
7 CONTRACTING WITH ANY APPROPRIATE ENTITIES DESIGNATED AS
8 THIRD-PARTY ADMINISTRATORS. DESIGNATION OF A THIRD-PARTY
9 ADMINISTRATOR IS SUBJECT TO THE APPROVAL OF THE DIRECTOR.
10 (d) TO PAY THE EXPENSES OF THE BOARD AS AUTHORIZED BY THIS
11 SECTION;
12 (e) TO DISSEMINATE INFORMATION REGARDING THE FUND;
13 (f) TO ADOPT RULES AS NECESSARY TO CARRY OUT THE PURPOSES
14 OF THIS ARTICLE 67, INCLUDING RULES REGARDING ADMISSION TO THE
15 FUND AND PAYMENT OF BENEFITS IN ORDER TO ENSURE THE FINANCIAL
16 STABILITY OF THE FUND;
17 (g) TO INVESTIGATE CLAIMS BROUGHT FOR BENEFITS AND TO
18 ADJUST, COMPROMISE, SETTLE, AND PAY COVERED CLAIMS TO THE EXTENT
19 PERMITTED BY STATUTE AND RULE; TO DENY PAYMENT OF BENEFITS FROM
20 THE FUND OF ALL OTHER CLAIMS AND TO REVIEW SETTLEMENTS,
21 RELEASES, AND FINAL ORDERS TO WHICH THE UNINSURED EMPLOYER AND
22 INJURED WORKER WERE PARTIES; AND TO DETERMINE THE EXTENT TO
23 WHICH SUCH SETTLEMENTS, RELEASES, AND ORDERS MAY EFFECT
24 ELIGIBILITY FOR BENEFITS.
25 (2) THE BOARD MAY:
26 (a) EMPLOY OR RETAIN PERSONS AS NECESSARY TO HANDLE
27 CLAIMS AND PERFORM OTHER DUTIES OF THE BOARD;

1 (b) INTERVENE AS A PARTY BEFORE ANY COURT OR
2 ADMINISTRATIVE TRIBUNAL IN THIS STATE THAT HAS JURISDICTION OVER
3 AN UNINSURED EMPLOYER OR OTHER PARTY POTENTIALLY RESPONSIBLE
4 FOR PAYMENT OF BENEFITS;
5 (c) NEGOTIATE AND BECOME A PARTY TO CONTRACTS AS
6 NECESSARY TO CARRY OUT THE PURPOSES OF THIS ARTICLE 67;
7 (d) PERFORM OTHER ACTS NECESSARY OR PROPER TO EFFECTUATE
8 THE PURPOSES OF THIS ARTICLE 67;
9 (e) PURCHASE OR OTHERWISE OBTAIN INSURANCE AND
10 REINSURANCE POLICIES TO LIMIT THE LIABILITY OF THE FUND FOR
11 PAYMENT OF BENEFITS UNDER THIS ARTICLE 67; AND
12 (f) DENY ENTRY TO THE FUND OR PAYMENT OF BENEFITS IF THE
13 UNDERLYING CLAIM APPEARS TO BE PREMISED ON FRAUDULENT ACTIVITY.
14 **8-67-108. Plan of operation.** (1) THE BOARD SHALL, BY RULE,
15 ADOPT A PLAN OF OPERATION AND ANY AMENDMENTS NECESSARY OR
16 SUITABLE TO ASSURE THE FAIR, REASONABLE, AND EQUITABLE
17 ADMINISTRATION OF THE FUND.
18 (2) IF THE BOARD FAILS TO ADOPT A PLAN OF OPERATION ON OR
19 BEFORE SEPTEMBER 1, 2018, THE DIRECTOR SHALL, AFTER NOTICE AND
20 HEARING, ADOPT AND PROMULGATE REASONABLE RULES AS NECESSARY
21 OR ADVISABLE TO EFFECTUATE THIS ARTICLE 67. THE RULES SHALL
22 CONTINUE IN FORCE UNTIL MODIFIED OR SUPERSEDED BY THE BOARD.
23 (3) THE PLAN OF OPERATION SHALL:
24 (a) ESTABLISH THE PROCEDURES BY WHICH ALL THE POWERS AND
25 DUTIES OF THE BOARD UNDER SECTION 8-67-107 WILL BE PERFORMED;
26 (b) ESTABLISH THE AMOUNT AND METHOD OF REIMBURSING
27 MEMBERS OF THE BOARD UNDER SECTION 8-67-106 (4);

1 (c) ESTABLISH PROCEDURES BY WHICH CLAIMS MAY BE FILED WITH
2 THE BOARD, INCLUDING ESTABLISHING ACCEPTABLE FORMS OF PROOF OF
3 COVERED CLAIMS;
4 (d) ESTABLISH PROCEDURES FOR PURSUING ACTIONS AGAINST
5 UNINSURED EMPLOYERS PURSUANT TO SECTION 8-67-110;
6 (e) ESTABLISH REGULAR PLACES AND TIMES FOR MEETINGS OF THE
7 BOARD;
8 (f) ESTABLISH PROCEDURES FOR MAINTAINING RECORDS OF ALL
9 FINANCIAL TRANSACTIONS OF THE BOARD;
10 (g) CONTAIN ADDITIONAL PROVISIONS NECESSARY OR PROPER FOR
11 THE EXECUTION OF THE POWERS AND DUTIES OF THE BOARD; AND
12 (h) ESTABLISH PROCEDURES FOR CONTRACTING WITH THIRD-PARTY
13 ADMINISTRATORS TO ADMINISTER CLAIMS PAID BY THE FUND.
14 **8-67-109. Effect of benefits.** (1) NOTWITHSTANDING THIS
15 SECTION OR ARTICLES 40 TO 47 OF THIS TITLE 8, A PERSON SEEKING
16 BENEFITS UNDER THIS ARTICLE 67 FROM THE FUND IS DEEMED TO HAVE
17 ASSIGNED HIS OR HER RIGHTS UNDER ARTICLES 40 TO 47 OF THIS TITLE 8
18 TO THE BOARD TO THE EXTENT OF THE BENEFITS PAID BY THE FUND.
19 EVERY INJURED WORKER SEEKING THE PROTECTION OF THIS ARTICLE 67
20 SHALL COOPERATE WITH THE BOARD TO THE SAME EXTENT AS HE OR SHE
21 WOULD HAVE BEEN REQUIRED TO COOPERATE WITH THE EMPLOYER.
22 (2) IF AN EMPLOYER HAS NO INSURANCE AND FAILS TO PAY THE
23 FULL AMOUNT OF BENEFITS AS REQUIRED BY ARTICLES 40 TO 47 OF THIS
24 TITLE 8, THE INJURED WORKER MAY APPLY TO THE BOARD FOR PAYMENT
25 OF THE COMPENSATION BENEFITS, INCLUDING MEDICAL BENEFITS, TO
26 WHICH THE INJURED WORKER IS ENTITLED, TO BE PAID FROM THE FUND.
27 BENEFITS TO WHICH THE INJURED WORKER IS ENTITLED FROM THE FUND

1 DO NOT INCLUDE ANY PENALTIES ASSESSED AGAINST THE EMPLOYER.
2 (3) THE BOARD HAS THE RIGHT TO APPEAR AS A CREDITOR IN A
3 BANKRUPTCY PROCEEDING INVOLVING AN UNINSURED EMPLOYER WHO
4 HAS BEEN FOUND LIABLE TO AN INJURED WORKER ADMITTED TO THE FUND.
5 (4) THE RECEIVER, LIQUIDATOR, OR STATUTORY SUCCESSOR OF AN
6 UNINSURED EMPLOYER IS BOUND BY SETTLEMENTS OF COVERED CLAIMS
7 WITH THE BOARD. THE COURT HAVING JURISDICTION SHALL GRANT SUCH
8 CLAIMS PRIORITY EQUAL TO THAT WHICH THE INJURED WORKER WOULD
9 HAVE BEEN ENTITLED IN THE ABSENCE OF THIS ARTICLE 67 AGAINST THE
10 ASSETS OF THE EMPLOYER. THE EXPENSES OF THE BOARD SHALL BE
11 ACCORDED THE SAME PRIORITY AS THE LIQUIDATOR'S EXPENSES.
12 (5) UPON THE ACCEPTANCE OF A CLAIM INTO THE FUND, THE
13 BOARD SHALL RECORD, AS PROVIDED BY SUBSECTION (6) OF THIS SECTION,
14 A CERTIFICATE PREPARED AND FURNISHED BY THE DIVISION SHOWING THE
15 DATE ON WHICH THE CLAIM WAS FILED, THE DATE OF THE INJURY, THE
16 NAME AND LAST KNOWN ADDRESS OF THE EMPLOYER AGAINST WHOM IT
17 WAS FILED, THE NAMES AND LAST KNOWN ADDRESSES OF THE EMPLOYER'S
18 PRINCIPALS, AND THE FACT THAT THE EMPLOYER HAS NOT SECURED THE
19 PAYMENT OF COMPENSATION AS REQUIRED. UPON RECORDING, THE
20 CERTIFICATE CONSTITUTES A VALID LIEN AGAINST THE ASSETS OF THE
21 EMPLOYER AND ITS PRINCIPALS IN FAVOR OF THE FUND FOR THE WHOLE
22 AMOUNT THAT MAY BE DUE AS COMPENSATION. ANY LIEN SECURED
23 PURSUANT TO THIS ARTICLE 67 HAS PRIORITY IN THE ORDER FILED. THE
24 BOARD SHALL SERVE A COPY OF THE CERTIFICATE UPON THE EMPLOYER
25 AND ITS PRINCIPALS.
26 (6) THE CERTIFICATE CONSTITUTING A LIEN IN FAVOR OF THE FUND
27 MUST BE FILED IN THE FOLLOWING OFFICES:

1 (a) THE OFFICES OF THE COUNTY CLERKS OF THE COUNTIES IN
2 WHICH THE PRINCIPALS OF THE DEFENDANT EMPLOYER RESIDE;
3 (b) THE OFFICE OF THE COUNTY CLERK OF THE COUNTY IN WHICH
4 THE DEFENDANT EMPLOYER HAS ITS PRINCIPAL PLACE OF BUSINESS; AND
5 (c) THE OFFICES OF THE COUNTY CLERKS IN THE COUNTIES WHERE
6 THE EMPLOYER'S PROPERTY IS LOCATED.
7 (7) IF AN UNINSURED EMPLOYER BECOMES INSOLVENT, THE BOARD
8 MAY CONVERT ALL FUTURE PAYMENTS OF WORKERS' COMPENSATION
9 WEEKLY BENEFITS, MEDICAL EXPENSES, OR OTHER PAYMENTS PURSUANT
10 TO ARTICLES 40 TO 47 OF THIS TITLE 8 TO A PRESENT LUMP SUM. THE
11 BOARD SHALL FIX THE LUMP SUM OF PROBABLE FUTURE MEDICAL EXPENSES
12 AND WEEKLY COMPENSATION BENEFITS, OR OTHER BENEFITS PAYABLE
13 PURSUANT TO ARTICLES 40 TO 47 OF THIS TITLE 8, CAPITALIZED AT THEIR
14 PRESENT VALUE UPON THE BASIS OF INTEREST AT THE RATE OF FOUR
15 PERCENT PER ANNUM. THE BOARD SHALL THEN FILE WITH THE RECEIVER OR
16 LIQUIDATOR OF AN INSOLVENT EMPLOYER THE STATEMENT OF THE LUMP
17 SUM, WHICH SHALL PRESERVE THE RIGHTS OF THE BOARD AGAINST THE
18 ASSETS OF THE INSOLVENT EMPLOYER. THE EMPLOYER IS DISCHARGED
19 FROM ALL FURTHER LIABILITY FOR THE COMMUTED WORKERS'
20 COMPENSATION CLAIM UPON PAYMENT OF THE PRESENT LUMP SUM TO
21 EITHER THE INJURED WORKER OR, SUBJECT TO APPROVAL BY THE BOARD,
22 TO A LICENSED INSURER FOR PURCHASE OF AN ANNUITY OR OTHER
23 PERIODIC PAYMENT PLAN FOR THE BENEFIT OF THE INJURED WORKER.
24 (8) PAYMENT FROM THE FUND DOES NOT RELIEVE THE OBLIGATION
25 OF THE EMPLOYER TO PAY BENEFITS AS REQUIRED BY ARTICLES 40 TO 47
26 OF THIS TITLE 8 TO THE INJURED WORKER; EXCEPT THAT ANY BENEFITS DUE
27 TO THE INJURED WORKER WILL BE REDUCED BY THE AMOUNT OF THE

1 BENEFITS PAID BY THE FUND TO THE INJURED WORKER. ALL BENEFITS
2 REQUIRED PURSUANT TO ARTICLES 40 TO 47 OF THIS TITLE 8 REMAIN THE
3 LIABILITY OF THE EMPLOYER.
4 **8-67-110. Collection of benefit reimbursements.** (1) THE BOARD
5 SHALL INSTITUTE PRACTICES AND PROCEDURES AS IT DEEMS NECESSARY TO
6 COLLECT ANY MONEY DUE THE FUND IN THE FORM OF REIMBURSEMENT FOR
7 BENEFITS PAID FROM THE FUND TO AN INJURED WORKER.
8 (2) THE BOARD, IN ITS ROLE AS GUARDIAN OF FUND DOLLARS, IS
9 EXEMPT FROM SECTION 24-30-202.4. IF THE BOARD DETERMINES AN
10 ACCOUNT TO BE UNCOLLECTIBLE, THE ACCOUNT MAY BE REFERRED TO THE
11 CONTROLLER FOR COLLECTION. REASONABLE FEES FOR COLLECTION, AS
12 DETERMINED BY THE BOARD AND THE CONTROLLER, SHALL BE ADDED TO
13 THE AMOUNT OF DEBT. THE DEBTOR IS LIABLE FOR REPAYMENT OF THE
14 TOTAL OF THE AMOUNT OF OUTSTANDING DEBT PLUS THE COLLECTION FEE.
15 ALL MONEY COLLECTED BY THE CONTROLLER SHALL BE RETURNED TO THE
16 FUND; EXCEPT THAT ALL FEES COLLECTED SHALL BE RETAINED BY THE
17 CONTROLLER. IF LESS THAN THE FULL AMOUNT IS COLLECTED, THE
18 CONTROLLER SHALL RETAIN ONLY A PROPORTIONATE SHARE OF THE
19 COLLECTION FEE.
20 (3) IF, AFTER DUE NOTICE, AN EMPLOYER DEFAULTS IN THE
21 REPAYMENT OF ANY BENEFITS PAID BY THE FUND TO AN INJURED WORKER
22 ON THAT EMPLOYER'S BEHALF, THE BOARD MAY SEEK COLLECTION FROM
23 THE EMPLOYER BY INSTITUTING A CIVIL ACTION, WHICH SHALL INCLUDE
24 THE RIGHT OF ATTACHMENT IN THE NAME OF THE FUND. COURT COSTS
25 SHALL NOT BE CHARGED TO THE BOARD, BUT ANY EMPLOYER AGAINST
26 WHOM JUDGMENT IS TAKEN SHALL BE CHARGED WITH ALL COSTS OF THE
27 ACTION. ALL COSTS COLLECTED BY THE FUND SHALL BE PAID INTO THE

REGISTRY OF THE COURT.

(4) THE BOARD MAY EMPLOY COUNSEL AND OTHER PERSONNEL NECESSARY TO COLLECT REIMBURSEMENTS AS DESCRIBED IN THIS SECTION.

8-67-111. Payment of benefits. (1) BENEFITS PAID UNDER THIS ARTICLE 67 ARE TREATED AS BENEFITS PAID BY AN INSURER OR SELF-INSURED EMPLOYER UNDER ARTICLES 40 TO 47 OF THIS TITLE 8.

(2) A PERSON HAVING A SINGLE CLAIM AGAINST MULTIPLE EMPLOYERS IS NOT ENTITLED TO RECEIVE BENEFITS UNLESS EACH OF THE LIABLE EMPLOYERS IS UNINSURED.

(3) WHEN PAYING BENEFITS, THE BOARD IS ENTITLED TO CLAIM ANY REDUCTION OF BENEFITS, TO CLAIM OVERPAYMENTS, OR TO MAKE ANY OTHER ADJUSTMENTS ALLOWED UNDER ARTICLES 40 TO 47 OF THIS TITLE 8.

(4) BENEFITS AWARDED UNDER THIS ARTICLE 67 MUST BE REDUCED BY ANY BENEFITS PAID BY THE UNINSURED EMPLOYER.

8-67-112. Medical benefits. (1) MEDICAL BENEFITS PAID UNDER THIS ARTICLE 67 ARE TREATED AS BENEFITS PAID BY AN INSURER OR SELF-INSURED EMPLOYER UNDER ARTICLES 40 TO 47 OF THIS TITLE 8.

(2) UPON ACCEPTANCE OF A CLAIM FOR BENEFITS FROM THE FUND, THE BOARD MAY DESIGNATE A NEW AUTHORIZED TREATING PHYSICIAN. APPLICATION TO THE FUND SHALL BE DEEMED AS ACCEPTANCE BY THE INJURED WORKER OF THE NEW DESIGNATED PHYSICIAN IF THE DESIGNATION IS MADE. THE PREVIOUSLY AUTHORIZED TREATING PHYSICIAN PROVIDING PRIMARY CARE SHALL CONTINUE AS THE AUTHORIZED TREATING PHYSICIAN PROVIDING PRIMARY CARE FOR THE INJURED EMPLOYEE UNTIL THE INJURED EMPLOYEE'S INITIAL VISIT WITH THE NEWLY AUTHORIZED TREATING PHYSICIAN, AT WHICH TIME THE TREATMENT RELATIONSHIP WITH THE

PREVIOUSLY AUTHORIZED TREATING PHYSICIAN PROVIDING PRIMARY CARE IS TERMINATED.

(3) NOTWITHSTANDING ARTICLES 40 TO 47 OF THIS TITLE 8, THE BOARD IS PERMITTED TO NEGOTIATE RATES OF REIMBURSEMENT FOR MEDICAL PROVIDERS.

8-67-113. Procedure. (1) A CONTROVERSY CONCERNING ANY ISSUE ARISING UNDER THIS SECTION SHALL BE RESOLVED THROUGH HEARINGS IN ACCORDANCE WITH SECTIONS 8-43-207 AND 8-43-207.5. IN ANY SUCH HEARING, A DECISION OF THE BOARD TO DENY BENEFITS MAY ONLY BE SET ASIDE UPON A SHOWING OF ABUSE OF DISCRETION.

(2) THE DIVISION SHALL NOTIFY THE BOARD OF ANY CLAIM DETERMINED OR SUSPECTED TO BE UNINSURED, EITHER AT THE TIME OF FILING OR OTHERWISE. UPON THE NOTIFICATION, THE BOARD IS PERMITTED TO JOIN THE CLAIM AS A PARTY UPON WRITTEN NOTICE TO ALL OTHER PARTIES.

(3) A HEARING MUST NOT PROCEED ON THE ISSUE OF LACK OF COVERAGE WITHOUT THE BOARD HAVING BEEN NOTIFIED AND PROVIDED AN OPPORTUNITY TO JOIN THE CLAIM AS A PARTY.

(4) THE BOARD, ITS AGENTS, OR EMPLOYEES HAVE NO LIABILITY FOR ANY ACTION TAKEN AGAINST THEM FOR THE PERFORMANCE OF THEIR DUTIES UNDER THIS ARTICLE 67.

SECTION 2. In Colorado Revised Statutes, 8-40-301, **amend** (1); and **add** (10) as follows:

8-40-301. Scope of term "employee" - definition. (1) (a) "Employee" excludes any person employed by a passenger tramway area operator, as defined in section 25-5-702 (1), ~~C.R.S.,~~ or other employer, while participating in recreational activity, who at such time is

1 relieved of and is not performing any duties of employment, regardless of
2 whether such person is utilizing, by discount or otherwise, a pass, ticket,
3 license, permit, or other device as an emolument of employment.
4 (b) (I) "EMPLOYEE" EXCLUDES ANY PERSON EMPLOYED BY AN
5 OUT-OF-STATE EMPLOYER PERFORMING INCIDENTAL WORK IN COLORADO
6 WHERE THE EMPLOYEE IS COVERED AT THE TIME OF INJURY UNDER THE
7 WORKERS' COMPENSATION ACT OF ANOTHER STATE REGARDLESS OF WHERE
8 THE CONTRACT FOR EMPLOYMENT WAS CREATED.
9 (II) FOR PURPOSES OF THIS SECTION, "INCIDENTAL WORK" MEANS
10 WORK THAT IS RANDOMLY OR FORTUITOUSLY IN COLORADO.
11 (III) THIS SECTION ONLY APPLIES TO A WORKERS' COMPENSATION
12 ACT OF ANOTHER STATE THAT INCLUDES A RECIPROCAL PROVISION
13 EXEMPTING COLORADO EMPLOYERS FROM LIABILITY UNDER THE OTHER
14 STATE'S ACT FOR INCIDENTAL WORK.
15 **SECTION 3.** In Colorado Revised Statutes, 8-41-404, **amend** (3)
16 as follows:
17 **8-41-404. Construction work - proof of coverage required -**
18 **violation - penalty - definitions.** (3) A violation of subsection (1) of this
19 section is punishable by an administrative fine imposed pursuant to
20 section 8-43-409 (1)(b). The division shall transmit revenues collected
21 through the imposition of fines pursuant to this section to the state
22 treasurer, who shall credit them to the ~~workers' compensation cash fund~~
23 ~~created in section 8-44-112 (7). Such revenues shall be appropriated to the~~
24 ~~division for the purpose of enforcing this section~~ COLORADO UNINSURED
25 EMPLOYER FUND CREATED IN SECTION 8-67-105.
26 **SECTION 4.** In Colorado Revised Statutes, 8-43-304, **amend** (1)
27 and (1.5)(b) as follows:

1 **8-43-304. Violations - penalty - offset for benefits obtained**
2 **through fraud - rules.** (1) Any employer or insurer, or any officer or
3 agent of either, or any employee, or any other person who violates ~~any~~
4 ~~provision of~~ articles 40 to 47 of this ~~title~~ TITLE 8, or does any act
5 prohibited thereby, or fails or refuses to perform any duty lawfully
6 enjoined within the time prescribed by the director or panel, for which no
7 penalty has been specifically provided, or fails, neglects, or refuses to
8 obey any lawful order made by the director or panel or any judgment or
9 decree made by any court as provided by ~~said~~ THE articles shall be subject
10 to such order being reduced to judgment by a court of competent
11 jurisdiction and shall also be punished by a fine of not more than one
12 thousand dollars per day for each ~~such~~ offense, to be apportioned, in
13 whole or part, at the discretion of the director or administrative law judge,
14 between the aggrieved party and the ~~workers' compensation cash fund~~
15 ~~created in section 8-44-112 (7)(a)~~ COLORADO UNINSURED EMPLOYER FUND
16 CREATED IN SECTION 8-67-105; except that the amount apportioned to the
17 aggrieved party shall be a minimum of ~~fifty~~ TWENTY-FIVE percent of any
18 penalty assessed.
19 (1.5) (b) Fines imposed pursuant to this subsection (1.5) ON OR
20 AFTER JULY 1, 2018, shall be transmitted to the state treasurer, who shall
21 credit ~~seventy-five percent of such~~ THE fines to the ~~general fund and~~
22 ~~twenty-five percent to the workers' compensation cash fund, created in~~
23 ~~section 8-44-112~~ COLORADO UNINSURED EMPLOYER FUND CREATED IN
24 SECTION 8-67-105.
25 **SECTION 5.** In Colorado Revised Statutes, 8-43-306, **amend** (2)
26 as follows:
27 **8-43-306. Collection of fines, penalties, and overpayments.**

1 (2) All ~~such~~ penalties, when collected, ~~shall be~~ ARE payable to the
2 division and transmitted through the state treasurer for credit to the
3 ~~subsequent injury fund, created in section 8-46-101~~ COLORADO
4 UNINSURED EMPLOYER FUND CREATED IN SECTION 8-67-105.
5 **SECTION <u>6.</u>** In Colorado Revised Statutes, 8-43-401, **amend**
6 (2)(b) as follows:
7 **8-43-401. District attorney or attorney of division to act for**
8 **director or office - penalties for failure of insurer to pay benefits.**
9 (2) (b) All ~~moneys~~ MONEY collected as penalties by the division pursuant
10 to this subsection (2) shall be transmitted to the state treasurer, who shall
11 credit ~~the same~~ IT to the ~~workers' compensation cash fund created in~~
12 ~~section 8-44-112~~ COLORADO UNINSURED EMPLOYER FUND CREATED IN
13 SECTION 8-67-105.
14 **SECTION <u>7.</u>** In Colorado Revised Statutes, 8-43-408, **amend** (1);
15 and **add** (5) and (6) as follows:
16 **8-43-408. Default of employer - additional liability.** (1) ~~In any~~
17 ~~case where the~~ IF AN employer is subject to ~~the provisions of~~ articles 40
18 to 47 of this ~~title~~ TITLE 8 and, at the time of an injury, has not complied
19 with the insurance provisions of ~~said~~ THOSE articles or has allowed the
20 required insurance to terminate, or has not effected a renewal thereof, the
21 employee, if injured, or, if killed, the employee's dependents may claim
22 the compensation and benefits provided in ~~said~~ THOSE articles. ~~and in any~~
23 ~~such case the amounts of compensation or benefits provided in said~~
24 ~~articles shall be increased fifty percent.~~
25 (5) IN ADDITION TO ANY COMPENSATION PAID OR ORDERED IN
26 ACCORDANCE WITH THIS SECTION OR ARTICLES 40 TO 47 OF THIS TITLE 8,
27 AN EMPLOYER WHO IS NOT IN COMPLIANCE WITH THE INSURANCE

PROVISIONS OF THOSE ARTICLES AT THE TIME AN EMPLOYEE SUFFERS A COMPENSABLE INJURY OR OCCUPATIONAL DISEASE SHALL PAY AN AMOUNT EQUAL TO TWENTY-FIVE PERCENT OF THE COMPENSATION OR BENEFITS TO WHICH THE EMPLOYEE IS ENTITLED TO THE COLORADO UNINSURED EMPLOYER FUND CREATED IN SECTION 8-67-105.

(6) AN EMPLOYER WHO FAILS TO COMPLY WITH A LAWFUL ORDER OR JUDGMENT ISSUED PURSUANT TO SUBSECTION (2) OR (3) OF THIS SECTION SHALL BE ORDERED TO PAY AN AMOUNT EQUAL TO TWENTY-FIVE PERCENT OF THE COMPENSATION OR BENEFITS TO WHICH THE EMPLOYEE IS ENTITLED TO THE COLORADO UNINSURED EMPLOYER FUND CREATED IN SECTION 8-67-105 IN ADDITION TO ANY OTHER AMOUNT ORDERED PURSUANT TO THIS SECTION OR ARTICLES 40 TO 47 OF THIS TITLE 8.

SECTION 8. In Colorado Revised Statutes, 8-43-409, **amend** (7); and **add** (1.5) as follows:

8-43-409. Defaulting employers - penalties - enjoined from continuing business - fines - procedure - definition - repeal. (1.5) (a) A VIOLATION THAT OCCURS MORE THAN SEVEN YEARS AFTER THE DATE THE PRECEDING VIOLATION ENDED IS SUBJECT TO A FINE UP TO THE MAXIMUM AMOUNT PERMITTED PURSUANT TO SUBSECTION (1)(b)(I) OF THIS SECTION.

(b) AFTER ANY FINES HAVE BEEN IMPOSED PURSUANT TO SUBSECTION (1)(b)(I) OR (1)(b)(II) OF THIS SECTION, THE DIRECTOR HAS THE DISCRETION TO ENTER INTO A SETTLEMENT AGREEMENT AND ACCEPT AS CONSIDERATION AN AMOUNT LESS THAN THE MINIMUM FINE ALLOWED BY SUBSECTION (1)(b)(II) OF THIS SECTION.

(c) NOTWITHSTANDING ARTICLES 40 TO 47 OF THIS TITLE 8, FINES

1 PURSUANT TO THIS SECTION MAY BE IMPOSED ONLY FOR PERIODS THAT
2 TAKE PLACE NO MORE THAN THREE YEARS PRIOR TO THE DATE AN
3 EMPLOYER IS NOTIFIED BY THE DIVISION OF A POTENTIAL VIOLATION OF
4 THE REQUIREMENTS OF ARTICLES 40 TO 47 OF THIS TITLE 8.
5 (d) THIS SUBSECTION (1.5) IS REPEALED, EFFECTIVE JULY 1, 2022.
6 BEFORE ITS REPEAL, THIS SUBSECTION (1.5) IS SCHEDULED FOR REVIEW IN
7 ACCORDANCE WITH SECTION 24-34-104.
8 (7) Fines collected pursuant to this section ON OR AFTER JULY 1,
9 2018, shall be transmitted to the state treasurer, who shall credit
10 ~~twenty-five percent of such~~ THE TOTAL AMOUNT OF THE fine to the
11 ~~workers' compensation cash~~ COLORADO UNINSURED EMPLOYER fund,
12 created in section ~~8-44-112, which shall be used to offset the premium~~
13 ~~surcharge. The state treasurer shall credit the remainder of the fine to the~~
14 ~~general fund~~ 8-67-105.
15 **SECTION 9.** In Colorado Revised Statutes, 8-46-102, **amend**
16 (1)(a); and **add** (1)(c) as follows:
17 **8-46-102. Funding for subsequent injury fund and major**
18 **medical insurance fund.** (1) (a) For every compensable injury resulting
19 in death wherein there are no persons either wholly or partially dependent
20 upon the deceased, the employer or the employer's insurance carrier, if
21 any, shall pay to the division the sum of ~~fifteen~~ TWENTY thousand dollars,
22 not to exceed one hundred percent of the death benefit, to be transmitted
23 to the state treasurer, as custodian, and credited by the state treasurer to the
24 ~~subsequent injury~~ COLORADO UNINSURED EMPLOYER fund CREATED IN
25 SECTION 8-67-105. In the event that there are only partially dependent
26 persons dependent upon the deceased, the employer or the employer's
27 insurance carrier, if any, shall first pay such benefits to such partial

1 dependents and shall transmit the balance of the sum of ~~fifteen~~ TWENTY
2 thousand dollars to the state treasurer, as custodian, who shall credit the
3 same to the ~~subsequent injury~~ COLORADO UNINSURED EMPLOYER fund.
4 (c) FOR INJURIES SUSTAINED ON OR AFTER JULY 1, 2018, AND ON
5 EACH JULY 1 THEREAFTER, THE DIRECTOR SHALL ADJUST THE AMOUNT
6 PAID TO THE COLORADO UNINSURED EMPLOYER FUND IN THIS SUBSECTION
7 (1) BY THE PERCENTAGE OF THE ADJUSTMENT MADE BY THE DIRECTOR TO
8 THE STATE WEEKLY WAGE PURSUANT TO SECTION 8-47-106.
9 **SECTION 10.** In Colorado Revised Statutes, 8-47-203, **add**
10 (1)(c)(III) as follows:
11 **8-47-203. Access to files, records, and orders.**
12 (1) Notwithstanding the provisions of section 8-47-202, the filing of a
13 claim for compensation is deemed to be a limited waiver of the
14 doctor-patient privilege to persons who are necessary to resolve the claim.
15 Access to claim files maintained by the division will be permitted only as
16 follows:
17 (c) (III) NOTWITHSTANDING ARTICLES 40 TO 47 OF THIS TITLE 8,
18 THE DIRECTOR MAY PROVIDE INFORMATION TO THE COLORADO UNINSURED
19 EMPLOYER BOARD CREATED IN SECTION 8-67-106, AS NECESSARY, TO
20 EXERCISE ITS POWERS AND DUTIES.
21 **SECTION 11.** In Colorado Revised Statutes, 24-34-104, **amend**
22 (22)(a) introductory portion; and **add** (22)(a)(II) as follows:
23 **24-34-104. General assembly review of regulatory agencies and**
24 **functions for repeal, continuation, or reestablishment - legislative**
25 **declaration - repeal.** (22) (a) The following agencies, functions, or both,
26 ~~will~~ ARE SCHEDULED FOR repeal on July 1, 2022:
27 (II) THE LIMITATIONS ON IMPOSITION OF FINES FOR FAILURE TO

1 CARRY WORKERS' COMPENSATION INSURANCE PURSUANT TO SECTION
2 8-43-409 (1.5).
3 **SECTION 12. Appropriation.** For the 2017-18 state fiscal year,
4 $6,000 is appropriated to the department of labor and employment for use
5 by the division of workers' compensation. This appropriation is from the
6 workers' compensation cash fund created in section 8-44-112 (7)(a),
7 C.R.S. To implement this act, the division may use this appropriation for
8 operating expenses.
9 **SECTION 13. Effective date.** This act takes effect July 1, 2017.
10 **SECTION 14. Safety clause.** The general assembly hereby finds,
11 determines, and declares that this act is necessary for the immediate
12 preservation of the public peace, health, and safety.

An Act

SENATE BILL 17-214

BY SENATOR(S) Smallwood and Garcia, Aguilar, Crowder, Donovan, Fenberg, Gardner, Guzman, Jones, Kagan, Kefalas, Kerr, Martinez Humenik, Merrifield, Moreno, Scott, Tate, Todd, Williams A., Zenzinger, Grantham;
also REPRESENTATIVE(S) Exum and Pettersen, Esgar, Pabon, Arndt, Becker K., Benavidez, Bridges, Buck, Buckner, Carver, Catlin, Coleman, Covarrubias, Danielson, Foote, Garnett, Ginal, Gray, Hamner, Hansen, Herod, Hooton, Humphrey, Jackson, Kennedy, Kraft-Tharp, Landgraf, Lawrence, Lebsock, Lee, Lewis, Lontine, McLachlan, Melton, Michaelson Jenet, Mitsch Bush, Navarro, Nordberg, Rankin, Ransom, Rosenthal, Saine, Salazar, Sias, Singer, Valdez, Van Winkle, Weissman, Williams D., Wilson, Winter, Wist, Young, Duran.

CONCERNING THE CREATION OF THE VOLUNTARY FIREFIGHTER CANCER BENEFITS PROGRAM.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** part 4 to article 5 of title 29 as follows:

PART 4
VOLUNTARY FIREFIGHTER CANCER

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

BENEFITS PROGRAM

29-5-401. Legislative declaration. (1) HOUSE BILL 07-1008, ENACTED IN 2007, ESTABLISHED A REBUTTABLE PRESUMPTION IN THE STATE WORKERS' COMPENSATION SYSTEM THAT CERTAIN TYPES OF CANCER, WHEN CONTRACTED BY FIREFIGHTERS, ARE OCCUPATIONAL DISEASES CAUSED BY EMPLOYMENT AS A FIREFIGHTER.

(2) NINE YEARS OF EXPERIENCE HAS SHOWN THAT THE REBUTTABLE PRESUMPTION ESTABLISHED BY HOUSE BILL 07-1008 HAS PRODUCED NO DEMONSTRABLE BENEFIT TO FIREFIGHTERS BUT HAS LED TO SIGNIFICANTLY GREATER COSTS TO EMPLOYERS OF FIREFIGHTERS.

(3) THE PURPOSE OF THIS PART 4 IS TO PROVIDE SUPPLEMENTAL INCOME AND REIMBURSEMENT FOR OUT-OF-POCKET COSTS NOT OTHERWISE PAID FOR BY INSURANCE COVERAGE TO FIREFIGHTERS WHO CONTRACT COVERED CANCERS AND TO REDUCE THE COST OF WORKERS' COMPENSATION INSURANCE FOR EMPLOYERS OF FIREFIGHTERS. THIS PART 4 IS NOT A REPLACEMENT FOR WORKERS' COMPENSATION COVERAGE OR ANY OTHER KIND OF MEDICAL INSURANCE.

(4) THIS PART 4 DOES NOT ELIMINATE OR CURTAIL THE OBLIGATION OF AN EMPLOYER OF FIREFIGHTERS TO PARTICIPATE IN THE STATE WORKERS' COMPENSATION SYSTEM, NOR DOES IT ELIMINATE OR CURTAIL THE RIGHT OF A FIREFIGHTER TO PURSUE BENEFITS UNDER THE STATE WORKERS' COMPENSATION SYSTEM. RATHER, IT PROVIDES A PRACTICAL ALTERNATIVE FOR FIREFIGHTERS TO PURSUE IN DEALING WITH THE COSTS AND BURDENS OF COVERED CANCERS WITHOUT BEING FORCED TO RELY ON RECOVERING COMPENSATION UNDER THE REBUTTABLE PRESUMPTION CREATED BY HOUSE BILL 07-1008.

29-5-402. Definitions. AS USED IN THIS PART 4, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "CANCER" MEANS CANCER THAT ORIGINATES AS A CANCER OF THE BRAIN, SKIN, DIGESTIVE SYSTEM, HEMATOLOGICAL SYSTEM, OR GENITOURINARY SYSTEM OR AS DEFINED BY THE TRUST.

(2) "COVERED INDIVIDUAL" MEANS A FIREFIGHTER, PART-TIME FIREFIGHTER, OR VOLUNTEER FIREFIGHTER WHO MEETS THE COVERAGE

REQUIREMENTS IN SECTION 29-5-403 (12).

(3) "EMPLOYER" MEANS A MUNICIPALITY, SPECIAL DISTRICT, FIRE AUTHORITY, OR COUNTY IMPROVEMENT DISTRICT THAT EMPLOYS ONE OR MORE FIREFIGHTERS, PART-TIME FIREFIGHTERS, OR VOLUNTEER FIREFIGHTERS. "EMPLOYER" DOES NOT INCLUDE A POWER AUTHORITY CREATED PURSUANT TO SECTION 29-1-204 OR A MUNICIPALLY OWNED UTILITY.

(4) "FIREFIGHTER" MEANS A FULL-TIME, ACTIVE EMPLOYEE OF AN EMPLOYER WHO REGULARLY WORKS AT LEAST ONE THOUSAND SIX HUNDRED HOURS IN ANY CALENDAR YEAR AND WHOSE DUTIES ARE DIRECTLY INVOLVED WITH THE PROVISION OF FIRE PROTECTION SERVICES, AND WHO IS NOT A VOLUNTEER FIREFIGHTER.

(5) "PART-TIME FIREFIGHTER" MEANS AN ACTIVE EMPLOYEE OF AN EMPLOYER WHO REGULARLY WORKS LESS THAN ONE THOUSAND SIX HUNDRED HOURS IN ANY CALENDAR YEAR, WHOSE DUTIES ARE DIRECTLY INVOLVED WITH THE PROVISION OF FIRE PROTECTION SERVICES, AND WHO IS NOT A VOLUNTEER FIREFIGHTER.

(6) "TRUST" MEANS A MULTIPLE EMPLOYER HEALTH TRUST DESCRIBED IN SECTION 10-3-903.5 (7)(b)(I), ESTABLISHED FOR THE PURPOSES OF THIS PART 4.

(7) "VOLUNTEER FIREFIGHTER" MEANS A VOLUNTEER FIREFIGHTER AS DEFINED IN SECTION 31-30-1102, INCLUDING A PERSON MEETING THIS DEFINITION WHO PROVIDES VOLUNTEER SERVICES TO A FIRE AUTHORITY CREATED BY AN INTERGOVERNMENTAL AGREEMENT PROVIDING FIRE PROTECTION.

29-5-403. Required benefits - conditions of receiving benefits. (1) AN EMPLOYER MAY PARTICIPATE IN THE VOLUNTARY FIREFIGHTER CANCER BENEFITS PROGRAM BY PAYING CONTRIBUTIONS INTO A MULTIPLE EMPLOYER HEALTH TRUST AS SET FORTH IN SECTION 10-3-903.5 (7)(b)(I), ESTABLISHED FOR THE PURPOSES OF THIS PART 4. THE CONTRIBUTION LEVELS AND AWARD LEVEL DEFINITIONS WILL BE SET BY THE TRUST.

(2) FOR AN EMPLOYER CHOOSING TO PARTICIPATE IN THE VOLUNTARY FIREFIGHTER CANCER BENEFITS PROGRAM, THE TRUST SHALL

PROVIDE THE MINIMUM BENEFITS SPECIFIED IN SUBSECTION (3) OF THIS SECTION TO COVERED INDIVIDUALS DIAGNOSED WITH CANCER, BASED ON THE AWARD LEVEL OF THE CANCER AT THE TIME OF DIAGNOSIS, AFTER THE EMPLOYER BECOMES A PARTICIPANT.

(3) AWARD LEVELS WILL BE ESTABLISHED BY THE TRUST BASED ON THE CATEGORY AND STAGE OF THE CANCER AS FOLLOWS:

(a) AWARD LEVEL ZERO, ONE HUNDRED DOLLARS UP TO TWO THOUSAND DOLLARS;

(b) AWARD LEVEL ONE, FOUR THOUSAND DOLLARS, WHICH SHALL BE PAID IN ADDITION TO THE AMOUNTS PAID FOR AN AWARD LEVEL TWO OR HIGHER DIAGNOSIS;

(c) AWARD LEVEL TWO, FIVE THOUSAND DOLLARS;

(d) AWARD LEVEL THREE, FIFTEEN THOUSAND DOLLARS;

(e) AWARD LEVEL FOUR, TWENTY-TWO THOUSAND FIVE HUNDRED DOLLARS;

(f) AWARD LEVEL FIVE, TWENTY-EIGHT THOUSAND ONE HUNDRED TWENTY-FIVE DOLLARS;

(g) AWARD LEVEL SIX, THIRTY-SEVEN THOUSAND FIVE HUNDRED DOLLARS;

(h) AWARD LEVEL SEVEN, SIXTY-FIVE THOUSAND SIX HUNDRED TWENTY-FIVE DOLLARS;

(i) AWARD LEVEL EIGHT, EIGHTY-FOUR THOUSAND THREE HUNDRED SEVENTY-FIVE DOLLARS;

(j) AWARD LEVEL NINE, ONE HUNDRED SIXTY-EIGHT THOUSAND SEVEN HUNDRED FIFTY DOLLARS; OR

(k) AWARD LEVEL TEN, TWO HUNDRED TWENTY-FIVE THOUSAND DOLLARS.

(4) IN ADDITION TO AN AWARD PURSUANT TO SUBSECTION (3) OF THIS SECTION:

(a) A PAYMENT IS MADE TO THE COVERED INDIVIDUAL FOR THE ACTUAL COST, UP TO TWENTY-FIVE THOUSAND DOLLARS, FOR REHABILITATIVE OR VOCATIONAL TRAINING EMPLOYMENT SERVICES AND EDUCATIONAL TRAINING RELATING TO THE CANCER DIAGNOSIS;

(b) A PAYMENT IS MADE TO THE COVERED INDIVIDUAL OF UP TO TEN THOUSAND DOLLARS IF A COVERED INDIVIDUAL INCURS COSMETIC DISFIGUREMENT COSTS RESULTING FROM CANCER.

(5) IF THE CANCER IS DIAGNOSED AS TERMINAL CANCER, THE COVERED INDIVIDUAL WILL RECEIVE A LUMP-SUM PAYMENT OF TWENTY-FIVE THOUSAND DOLLARS AS AN ACCELERATED PAYMENT TOWARD THE BENEFITS DUE IN SUBSECTION (3) OF THIS SECTION.

(6) THE COVERED INDIVIDUAL IS ENTITLED TO ADDITIONAL AWARDS IF THE CANCER INCREASES IN AWARD LEVEL, BUT THE AMOUNT OF ANY AWARD PAID EARLIER FOR THE SAME CANCER WILL BE SUBTRACTED FROM THE NEW AWARD.

(7) IF A COVERED INDIVIDUAL DIES WHILE OWED BENEFITS PURSUANT TO THIS SECTION, THE BENEFITS WILL BE PAID TO THE SURVIVING SPOUSE OR DOMESTIC PARTNER, IF ANY, AT THE TIME OF DEATH, AND IF THERE IS NO SURVIVING SPOUSE OR DOMESTIC PARTNER, ANY SURVIVING CHILDREN EQUALLY. IF THERE IS NO SURVIVING SPOUSE, DOMESTIC PARTNER, OR CHILD, THE OBLIGATION OF THE TRUST TO PAY BENEFITS WILL CEASE.

(8) IF A COVERED INDIVIDUAL RETURNS TO THE SAME POSITION OF EMPLOYMENT AFTER A CANCER DIAGNOSIS, THE COVERED INDIVIDUAL IS ENTITLED TO THE BENEFITS IN THIS SECTION FOR ANY SUBSEQUENT NEW TYPE OF COVERED CANCER DIAGNOSIS.

(9) THE MAXIMUM AMOUNT THAT MAY BE PAID TO A COVERED INDIVIDUAL FOR EACH CANCER DIAGNOSIS IS TWO HUNDRED FORTY-NINE THOUSAND DOLLARS.

(10) UNLESS THE OFFSET PROVISIONS OF SECTION 8-42-103 (1)(h)

HAVE ALREADY BEEN TAKEN, THE BENEFITS PAID PURSUANT TO THIS SECTION MUST BE OFFSET BY ANY PAYMENTS MADE UNDER THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO 47 OF TITLE 8, REGARDLESS OF WHEN THE PAYMENTS ARE MADE. THE TRUST MAY DETERMINE HOW AND WHEN THE OFFSETS ARE IMPLEMENTED.

(11) THE BENEFITS IN THIS SECTION ARE REDUCED BY TWENTY-FIVE PERCENT IF A COVERED INDIVIDUAL USED A TOBACCO PRODUCT WITHIN THE FIVE YEARS IMMEDIATELY PRECEDING THE CANCER DIAGNOSIS.

(12) (a) IN ORDER FOR A COVERED INDIVIDUAL TO BE ELIGIBLE FOR THE BENEFITS IN THIS SECTION, PRIOR TO THE DIAGNOSIS OF CANCER AND NO MORE THAN FIVE YEARS FOR A FIREFIGHTER OR NO MORE THAN TEN YEARS FOR A VOLUNTEER FIREFIGHTER OR PART-TIME FIREFIGHTER AFTER THE FIREFIGHTER, VOLUNTEER FIREFIGHTER, OR PART-TIME FIREFIGHTER BECAME EMPLOYED BY AN EMPLOYER, THE FIREFIGHTER, VOLUNTEER FIREFIGHTER, OR PART-TIME FIREFIGHTER MUST HAVE HAD A MEDICAL EXAMINATION THAT WOULD REASONABLY HAVE FOUND AN ILLNESS OR INJURY THAT COULD HAVE CAUSED THE CANCER AND NO ILLNESS OR INJURY WAS FOUND.

(b) IN ADDITION TO SUBSECTION (12)(a) OF THIS SECTION, IN ORDER FOR A COVERED INDIVIDUAL TO BE ELIGIBLE FOR THE BENEFITS IN THIS SECTION, THE FOLLOWING CONDITIONS MUST BE MET:

(I) THE FIREFIGHTER:

(A) HAS AT LEAST FIVE YEARS OF CONTINUOUS, FULL-TIME EMPLOYMENT WITH AN EMPLOYER; AND

(B) IS DIAGNOSED WITH CANCER WITHIN TEN YEARS AFTER CEASING EMPLOYMENT AS A FIREFIGHTER; OR

(II) THE VOLUNTEER FIREFIGHTER:

(A) HAS AT LEAST TEN YEARS OF ACTIVE SERVICE, AS USED IN SECTION 31-30-1122, AND HAS MAINTAINED A MINIMUM TRAINING PARTICIPATION IN THE FIRE DEPARTMENT OF THIRTY-SIX HOURS EACH YEAR; AND

(B) IS DIAGNOSED WITH CANCER WITHIN TEN YEARS AFTER CEASING EMPLOYMENT AS A VOLUNTEER FIREFIGHTER; OR

(III) THE PART-TIME FIREFIGHTER:

(A) HAS AT LEAST TEN YEARS OF ACTIVE SERVICE; AND

(B) IS DIAGNOSED WITH CANCER WITHIN TEN YEARS AFTER CEASING EMPLOYMENT AS A PART-TIME FIREFIGHTER.

(c) THE TRUST SHALL DEVELOP A FORMULA TO ALLOW THE COMBINING OF VOLUNTEER, PART-TIME, AND FULL-TIME FIREFIGHTER SERVICE TO ESTABLISH ELIGIBILITY.

(d) THE CLAIM FOR BENEFITS MUST BE FILED NO LATER THAN TWO YEARS AFTER THE DIAGNOSIS OF THE CANCER. THE CLAIM FOR EACH TYPE OF CANCER NEEDS TO BE FILED ONLY ONCE TO ALLOW THE TRUST TO INCREASE THE AWARD LEVEL PURSUANT TO SUBSECTION (3) OF THIS SECTION.

(13) FOR THE PURPOSE OF EMPLOYER POLICIES AND BENEFITS, A CANCER DIAGNOSIS IS TREATED AS AN ON-THE-JOB INJURY OR ILLNESS. THIS SUBSECTION (13) DOES NOT AFFECT ANY DETERMINATION AS TO WHETHER THE CANCER IS COVERED UNDER THE "WORKERS' COMPENSATION ACT OF COLORADO", ARTICLES 40 TO 47 OF TITLE 8.

29-5-404. Authority of the trust - rules. (1) IN ADDITION TO ANY AUTHORITY GIVEN TO THE TRUST, THE TRUST HAS THE AUTHORITY TO:

(a) CREATE A PROGRAM DESCRIPTION TO FURTHER DEFINE OR MODIFY, BUT NOT DECREASE, THE BENEFITS OF THIS PART 4;

(b) MODIFY THE CONTRIBUTION RATES, BENEFIT LEVELS, INCLUDING THE MAXIMUM AMOUNT, CONSISTENT WITH SUBSECTION (1)(a) OF THIS SECTION, AND STRUCTURE OF THE BENEFITS BASED ON ACTUARIAL RECOMMENDATIONS AND WITH INPUT FROM A COMMITTEE OF THE TRUST CONSISTING OF REPRESENTATIVES FROM LABOR, MANAGEMENT, VOLUNTEER, AND TRUST ADMINISTRATION; AND

(c) ADOPT RULES AND PROCEDURES FOR THE ADMINISTRATION OF

THE TRUST.

29-5-405. Exclusion from coverage. AN EMPLOYER WHO PARTICIPATES IN THE VOLUNTARY FIREFIGHTER CANCER BENEFITS PROGRAM CREATED IN THIS PART 4 IS NOT SUBJECT TO SECTION 8-41-209 (1) AND (2) UNLESS THE EMPLOYER ENDS PARTICIPATION IN THE PROGRAM.

SECTION 2. In Colorado Revised Statutes, 8-41-209, **add** (4) as follows:

8-41-209. Coverage for occupational diseases contracted by firefighters. (4) AN EMPLOYER WHO PARTICIPATES IN THE VOLUNTARY FIREFIGHTER CANCER BENEFITS PROGRAM CREATED IN PART 4 OF ARTICLE 5 OF TITLE 29 IS NOT SUBJECT TO THIS SECTION UNLESS THE EMPLOYER ENDS PARTICIPATION IN THAT PROGRAM.

SECTION 3. In Colorado Revised Statutes, 8-42-103, **add** (1)(h) as follows:

8-42-103. Disability indemnity payable as wages - period of disability. (1) If the injury or occupational disease causes disability, a disability indemnity shall be payable as wages pursuant to section 8-42-105 (2)(a) subject to the following limitations:

(h) UNLESS THE OFFSET PROVISIONS OF SECTION 29-5-403 (10) HAVE ALREADY BEEN TAKEN, IN CASES WHERE IT IS DETERMINED THAT A FIREFIGHTER HAS RECEIVED AN AWARD OF BENEFITS FOR A CANCER DIAGNOSIS PURSUANT TO SECTION 29-5-403 (3)(b) TO (3)(k), THE AGGREGATE BENEFITS PAYABLE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY, PERMANENT PARTIAL DISABILITY, AND PERMANENT TOTAL DISABILITY SHALL BE REDUCED, BUT NOT BELOW ZERO, BY AN AMOUNT EQUAL TO THE TOTAL AMOUNT OF SUCH CANCER DIAGNOSIS BENEFITS. IN CASES WHERE IT IS DETERMINED THAT A COVERED INDIVIDUAL HAS RECEIVED COSMETIC DISFIGUREMENT BENEFITS PURSUANT TO SECTION 29-5-403 (4)(b), BENEFITS FOR DISFIGUREMENT PAYABLE PURSUANT TO SECTION 8-42-108 SHALL BE REDUCED, BUT NOT BELOW ZERO, BY AN AMOUNT EQUAL TO SUCH COSMETIC DISFIGUREMENT BENEFITS.

SECTION 4. In Colorado Revised Statutes, 10-3-903.5, **amend** (7)(b)(I) as follows:

10-3-903.5. Jurisdiction over providers of health care benefits. (7) (b) A multiple employer health trust is any trust that is:

(I) Sponsored, maintained, and funded by one or more entities of state government or political subdivisions of the state organized pursuant to state law and is for the benefit of the entity's employees, including a multiple employer health trust established for the purposes of ~~part 3~~ PART 3 OR 4 of article 5 of title 29; ~~C.R.S.;~~ or

SECTION 5. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

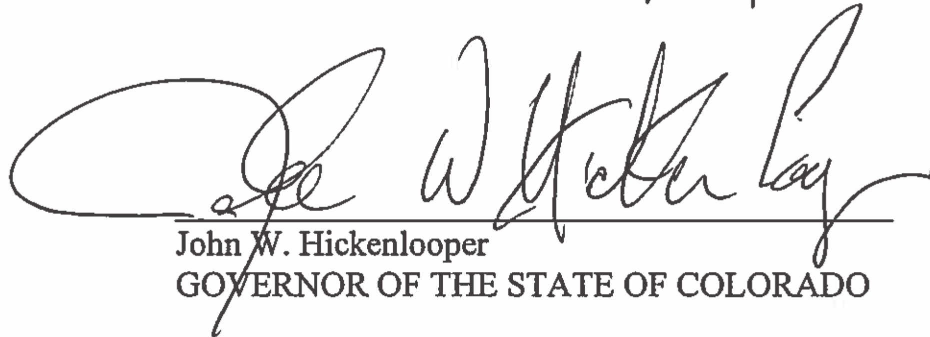
Kevin J. Grantham
PRESIDENT OF
THE SENATE

Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Effie Ameen
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED 2:18 pm 5/03/17



John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

NOTE: This bill has been prepared for the signatures of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

HOUSE BILL 17-1229

BY REPRESENTATIVE(S) Singer and Becker J., Ginal, Arndt, Liston, Lawrence, Coleman, Exum, Herod, Hooton, Kennedy, Kraft-Tharp, Landgraf, Lebsock, Lontine, Melton, Michaelson Jenet, Mitsch Bush, Pettersen, Rosenthal, Salazar, Van Winkle, Weissman, Young, Duran;
also SENATOR(S) Cooke and Todd, Aguilar, Court, Donovan, Fenberg, Fields, Garcia, Guzman, Hill, Jahn, Jones, Kagan, Kefalas, Kerr, Martinez Humenik, Merrifield, Moreno, Tate, Zenzinger.

CONCERNING A CLARIFICATION OF WHEN A WORKER MAY BE COMPENSATED FOR A CLAIM OF MENTAL IMPAIRMENT FOR A PSYCHOLOGICALLY TRAUMATIC EVENT UNDER WORKERS' COMPENSATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 8-41-301, **amend** (2)(a); **repeal** (2)(a.5); and **add** (3) as follows:

8-41-301. Conditions of recovery - definitions. (2) (a) A claim of mental impairment must be proven by evidence supported by the testimony of a licensed ~~physician~~ PSYCHIATRIST or psychologist. ~~For purposes of this subsection (2), "mental impairment" means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and~~

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

~~consists of a psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances.~~ A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, lay-off, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. The mental impairment that is the basis of the claim ~~shall~~ MUST have arisen primarily from the claimant's then occupation and place of employment in order to be compensable.

(a.5) ~~For purposes of this subsection (2), "mental impairment" also includes a disability arising from an accidental physical injury that leads to a recognized permanent psychological disability.~~

(3) FOR THE PURPOSES OF THIS SECTION:

(a) "MENTAL IMPAIRMENT" MEANS A RECOGNIZED, PERMANENT DISABILITY ARISING FROM AN ACCIDENTAL INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT WHEN THE ACCIDENTAL INJURY INVOLVES NO PHYSICAL INJURY AND CONSISTS OF A PSYCHOLOGICALLY TRAUMATIC EVENT. "MENTAL IMPAIRMENT" ALSO INCLUDES A DISABILITY ARISING FROM AN ACCIDENTAL PHYSICAL INJURY THAT LEADS TO A RECOGNIZED PERMANENT PSYCHOLOGICAL DISABILITY.

(b) (I) "PSYCHOLOGICALLY TRAUMATIC EVENT" MEANS AN EVENT THAT IS GENERALLY OUTSIDE OF A WORKER'S USUAL EXPERIENCE AND WOULD EVOKE SIGNIFICANT SYMPTOMS OF DISTRESS IN A WORKER IN SIMILAR CIRCUMSTANCES.

(II) "PSYCHOLOGICALLY TRAUMATIC EVENT" ALSO INCLUDES AN EVENT THAT IS WITHIN A WORKER'S USUAL EXPERIENCE ONLY WHEN THE WORKER IS DIAGNOSED WITH POST-TRAUMATIC STRESS DISORDER BY A LICENSED PSYCHIATRIST OR PSYCHOLOGIST AFTER THE WORKER EXPERIENCED EXPOSURE TO ONE OR MORE OF THE FOLLOWING EVENTS:

(A) THE WORKER IS THE SUBJECT OF AN ATTEMPT BY ANOTHER PERSON TO CAUSE THE WORKER SERIOUS BODILY INJURY OR DEATH THROUGH THE USE OF DEADLY FORCE, AND THE WORKER REASONABLY BELIEVES THE WORKER IS THE SUBJECT OF THE ATTEMPT;

(B) THE WORKER VISUALLY WITNESSES A DEATH, OR THE IMMEDIATE AFTERMATH OF THE DEATH, OF ONE OR MORE PEOPLE AS THE RESULT OF A VIOLENT EVENT; OR

(C) THE WORKER REPEATEDLY VISUALLY WITNESSES THE SERIOUS BODILY INJURY, OR THE IMMEDIATE AFTERMATH OF THE SERIOUS BODILY INJURY, OF ONE OR MORE PEOPLE AS THE RESULT OF INTENTIONAL ACT OF ANOTHER PERSON OR AN ACCIDENT.

(c) "SERIOUS BODILY INJURY" MEANS BODILY INJURY THAT, EITHER AT THE TIME OF THE ACTUAL INJURY OR A LATER TIME, INVOLVES A SUBSTANTIAL RISK OF DEATH, A SUBSTANTIAL RISK OF SERIOUS PERMANENT DISFIGUREMENT, OR A SUBSTANTIAL RISK OF PROTRACTED LOSS OR IMPAIRMENT OF THE FUNCTION OF ANY PART OR ORGAN OF THE BODY.

SECTION 2. Act subject to petition - effective date - applicability. (1) This act takes effect July 1, 2018; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

(2) This act applies to injuries sustained on or after the applicable effective date of this act.

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Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Kevin J. Grantham
PRESIDENT OF
THE SENATE

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Marilyn Eddins
CHIEF CLERK OF THE HOUSE
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APPROVED____

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John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO