COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
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November Case Law Update

Presented by Judge Elsa Martinez Tenreiro and Judge David Gallivan

This update covers ICAO, COA, and Supreme Court decisions issued from October 11, 2018 to November 1, 2018

Industrial Claim Appeals Office

Court of Appeals

Colorado Supreme Court

*Included for informational purposes but not covered.

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INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-972-625-03

IN THE MATTER OF THE CLAIM OF:

JUNIOR LOY,

Claimant,

v.

FINAL ORDER

CITY MARKET,

Employer,

and

SELF INSURED,

Insurer,
Respondent.

The respondents seek review of an order of Administrative Law Judge Sidanycz (ALJ) dated April 16, 2018, that ordered the claim reopened and directed the respondents to pay for physical therapy as recommended by Dr. Price and a surgical consult with Dr. Hackett. We affirm.

The issues before the ALJ were whether the claimant demonstrated that the claim should be reopened based on a change of condition under § 8-43-303, C.R.S., and whether, upon reopening, recommended physical therapy and a surgical consultation is reasonable and necessary to cure and relieve the claimant from the effects of the admitted occupational disease.

The claimant worked as a grocery clerk and submitted a claim for an occupational disease to his right shoulder dating from October 20, 2014. A hearing on compensability of the occupational disease and authorized treating physician was conducted by ALJ Mottram on August 10, 2015. By order of September 23, 2015, ALJ Mottram determined that the claimant sustained a compensable occupational disease to the right shoulder. In addition, the authorized treating physician was designated to be Dr. Stagg.

The claimant received medical treatment for his right shoulder condition from Drs. Stagg and Huene. When seen by Dr. Huene on November 25, 2015, the doctor opined that the claimant's right shoulder pain was due to glenohumeral bone-on-bone arthritis

with biceps tendonitis. Dr. Huene discussed the possibility of a rotator cuff arthropathy and a partial or total shoulder replacement to address the bone-on-bone arthritis. The claimant indicated to Dr. Huene that he did not wish to pursue surgery.

On December 29, 2015, the claimant was seen by Dr. Stagg. The claimant confirmed that he was not interested in proceeding with the surgery to address the advanced degenerative arthritis and wanted to just use periodic injections to maintain his condition. Accordingly, Dr. Stagg placed the claimant at maximum medical improvement (MMI) on that date and assigned a 22% upper extremity impairment rating which converted to 13% whole person impairment. As part of the impairment rating, the doctor provided an assessment, which was limited to "right shoulder pain with degenerative arthritis." On the rating form, the doctor listed "right shoulder DJD" (degenerative joint disease) as the diagnosis. Six percent impairment was given for "crepitation" and 17% was assigned for loss of range of motion. Frozen shoulder and adhesive capsulitis (synonymous terms) were not mentioned in the doctor's assessment, diagnosis, or impairment rating. Resp. Exhibit T.

Dr. Stagg noted that the claimant would need maintenance medical treatment including three to four medical visits per year, up to three repeat injections per year, and "he will need a total shoulder arthroplasty in the future" and medications. The cause of claimant's need for a total shoulder arthroplasty was not specifically addressed by Dr. Stagg, but the doctor gave no indication that the recommendation was for anything other than the work-related condition for which the doctors were treating the claimant.

On May 23, 2016, the parties attended a second hearing before ALJ Mottram on the issue of conversion of the 22% scheduled impairment rating to whole person impairment. On June 22, 2016, ALJ Mottram issued an order converting the impairment to 13% whole person impairment.

The respondents filed a final admission of liability (FAL) on June 29, 2016 admitting for the MMI date of December 29, 2015; the 13% whole person impairment; and reasonable and necessary post-MMI medical maintenance treatment.

The claimant returned to Dr. Stagg on September 18, 2017, reporting significant pain in his right shoulder, with pain in his neck and bilateral numbness in his hands. The claimant also requested a referral to Dr. Hackett, for a second opinion regarding the right shoulder. Dr. Stagg referred the claimant for an orthopedic consultation. In addition, Dr. Stagg referred the claimant to Dr. Price for pain management. Dr. Price saw the claimant on September 21, 2017, and noted that the claimant had significant degenerative arthritis

and supraspinatus tendinopathy on MRI and was "still being considered for a total shoulder replacement and plans to see Dr. Hackett at Steadman Hawkins." Dr. Price provided acupuncture treatment and referred the claimant for pool-based physical therapy, and prescribed Lyrica.

On October 16, 2017, Dr. Polanco performed a medical records review and opined that pool therapy was not medically necessary because the claimant could perform land based rehabilitation activities or an independent exercise program. He further noted that the claimant was three years post injury with no significant change, flare up, or new injury. As a result, the doctor recommended denial of pool physical therapy for the right shoulder.

Dr. Burris also performed a medical records review on October 16, 2017 and opined that the current treatment was driven by the claimant's underlying arthritic condition and no further care would be warranted for his occupational disease. The doctor also noted that the claimant suffered from chronic pain related to numerous musculoskeletal issues that are unrelated to the current WC claim.

The Respondents denied authorization for additional physical therapy and the referral to Dr. Hackett. By December 2017, the claimant returned to Dr. Price who noted that the claimant failed to progress with five acupuncture sessions and indicated that the claimant needed to see Dr. Hackett for consideration of shoulder replacement. Dr. Price stated that "there is likely no other option."

On January 18, 2018, the claimant attended a medical examination at the referral of the respondents with Dr. Larson. In his report, Dr. Larson opined that the claimant does need a total right shoulder arthroplasty. However, with regard to causation, Dr. Larson stated that the need for the shoulder replacement is due to the preexisting osteoarthritis and not because of the work injury.

The hearing before ALJ Sidanycz followed on March 6, 2018 on the issues of reopening the claim and reasonable and necessary medical treatment. In ALJ Sidanycz's order, she credited the testimony of the claimant along with medical records entered into evidence. The judge noted that the physicians suggested shoulder surgery as a possibility at the time MMI was originally reached and that such was indicated in their recommendations for medical maintenance treatment. The ALJ found that the claimant established by a preponderance of the evidence that his condition worsened from its status on the date of MMI and that he is no longer at MMI. Further, the ALJ determined that physical therapy and a referral to Dr. Hackett were reasonable and necessary (and

inferentially causally related) medical care. The ALJ specifically credited the testimony of the claimant and the opinions of Drs. Stagg and Price, over the conflicting opinions of Drs. Larson, Burris, and Polanco. The ALJ reopened the claim and ordered the respondents to pay for the physical therapy recommended by Dr. Price and for a referral to Dr. Hackett for an orthopedic surgical consultation.

In their appeal to the panel, respondents argue that the findings of fact are insufficient to permit appellate review, including whether the ALJ made sufficient findings to support her determination that claimant has established a worsening of condition of his occupational disease and is no longer at MMI. The respondents also question whether substantial evidence supports the ALJ's findings of fact including 1) whether the ALJ erred in finding that the claimant demonstrated that his current right shoulder condition is related to his occupational disease; 2) whether the ALJ erred in failing to articulate what "condition" worsened such as to warrant a reopening of the claimant; 3) whether the ALJ erred in finding that consideration of a total shoulder arthroplasty related to the claimant's occupational disease; and 4) whether the ALJ erred in finding that claimant's need for treatment relates to a worsening of the occupational disease. Lastly, the respondents raise whether the ALJ erred as matter of fact and law in ordering the reopening of claimant's claim based upon a worsening of the occupational disease.

The respondents essentially contend that the occupational disease was limited to the development of adhesive capsulitis and frozen shoulder and did not include a diagnosis of arthritis. Consequently, the respondents argue that the arthritic condition was never deemed compensable by ALJ Mottram and was never admitted to by the respondents. Thus the respondents argue that the cause of the need for consideration of a total shoulder arthroplasty has not been adjudicated or admitted, and that there is insufficient evidence to establish causation of the arthritic condition.

The claimant counters that the ALJ's findings regarding reopening and medical benefits are supported by substantial evidence and should not be altered by the Panel. Secondly, the claimant contends that the respondents did not set forth the applicable standard of review, and failed to demonstrate fraud or abuse of discretion by the ALJ in their appeal, and thus the ALJ's decision to reopen the claim is binding.

Specifically, the claimant asserts that 1) the need for total shoulder arthroplasty surgery has not yet been presented as an issue, only a referral for an orthopedic opinion; 2) ALJ Mottram generally found an occupational disease to the right shoulder but did not limit the compensable disease to only a frozen shoulder; 3) that progression of a disease

over time is a ground for reopening; 4) the existence of a preexisting condition does not preclude a finding of a compensable injury where the industrial aggravation is the proximate cause of the disability and need for treatment; and 5) apportionment between occupational and non-occupational causes is not proper under § 8-42-104(3), C.R.S., because claimant has not suffered more than one permanent medical impairment to the same body part nor has he received a settlement or award from a prior injury.

The party attempting to reopen a claim "shall bear the burden of proof as to any issues sought to be reopened." Section 8-43-303(4), C.R.S. Thus, claimant bore the burden of demonstrating that a change of condition occurred. *See Jarosinski v. Indus. Claim Appeals Office*, 62 P.3d 1082, 1084 (Colo. App. 2002); *City & County of Denver v. Industrial Claim Appeals Office*, 58 P.3d 1162, 1164 (Colo. App. 2002).

An ALJ has broad discretionary authority to determine whether a claimant has met his burden of proof justifying reopening. *See Renz v. Larimer County School District, Poudre R-1*, 924 P.2d 1177, 1181 (Colo. App. 1996). Indeed, Section 8-43-303, C.R.S., states simply that an ALJ "may" reopen a claim if a change in condition or mistake is demonstrated. The statutory reopening authority granted ALJs is thus "permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the sound discretion of the ALJ." *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186, 189 (Colo. App. 2002). An ALJ's decision to grant or deny a petition to reopen may therefore be reversed only for fraud or clear abuse of discretion." *Kilpatrick v. Industrial Claim Appeals Office*, 356 P.3d 1008, (Colo App. 2015). *See also Wilson v. Jim Snyder Drilling*, 747 P.2d 647, 651 (Colo. 1987); *See also Heinicke v. Industrial Claim Appeals Office*, 197 P.3d 220, 222 (Colo. App. 2008)("In the absence of fraud or clear abuse of discretion, the ALJ's decision concerning reopening is binding on appeal.").

No fraud is charged in this case and we find no evidence of same in the record; neither do we find any abuse of discretion. Under such circumstances appellate courts are without authority to order a reopening or review of awards. *Kokel* , supra. at 260.

Respondents initially denied that the claimant's right shoulder condition was related to his work. As stated above, the claimant's right shoulder injuries were deemed compensable by ALJ Mottram. After the ALJ's determination, the claimant underwent an MRI on October 9, 2015, which discovered advanced humeral degenerative joint disease and also found an intact rotator cuff. The treating physicians thereafter focused their treatment on the degenerative joint disease and the symptoms that derived therefrom. Dr. Huene, an orthopedist, first saw the claimant on November 25, 2015. He confirmed the arthritis diagnosis and all of his treatment recommendations were centered

on such diagnosis. Dr. Huene discussed treatment options that included, "conservative modalities, physical therapy, NSAIDS, steroid injections, arthroscopic surgery, viscosupplementation, unicompartmental vs. TSA (total shoulder arthroplasty), and other options." Resp. Exhibit R at 103. By the time the claimant saw Dr. Stagg on December 29, 2015, the claimant's treatment options had effectively narrowed to either ongoing periodic injections and medications or total or partial shoulder replacement. The claimant opted for the former and the physician determined that MMI had been reached. Resp. Exhibit T at 111. On the date of maximum medical improvement (MMI), adhesive capsulitis was not mentioned as part of the differential diagnosis. Dr. Stagg indicated that MMI was found due to the claimant's deferral of the total shoulder replacement. Conversely, it is reasonable to infer that had the claimant accepted the total shoulder replacement, he would not have been placed at MMI status and his treatment would have continued.

Dr. Stagg's recommended medical maintenance treatments were "3 to 4 [physician] visits over one year with repeat injections, up to 3 a year. He will need a total shoulder arthroplasty in the future and medications." Resp. Exhibit T at 112. Respondents filed a Final Admission of Liability on June 29, 2016 admitting for 13% whole person impairment and for post-MMI medical maintenance treatment. In admitting to the maintenance treatment recommended by Dr. Stagg without challenging the recommended total shoulder replacement, respondents essentially conceded the recommended future treatment including the total shoulder replacement. In their admission of liability as to permanent medical impairment, the respondents essentially conceded causation for the degenerative arthritis.

The claimant testified that his pain has worsened to the point that it is unbearable. Hearing Tr. at 11. He further testified that "the pain had worsened to a point that I couldn't hardly take it, and I asked to be referred." Hearing Tr. at 13. Further, the claimant was asked about his current shoulder complaints and testified, "Just tremendous pain." Hearing Tr. at 15. Other than his complaints of more severe pain, the claimant did not describe how his condition has changed nor whether his physical abilities have changed. Likewise the medical reports submitted in favor of a reopening, do not describe how the claimant's condition changed. Such reports notate the claimant's ongoing complaints of pain. The medical reports describe a complaint of bilateral numbness in the claimant's hands which was not a complaint on the date of MMI. Compare Resp. Exhibits EE at 153 and T at 111. Dr. Price measured the claimant's range of motion on September 29, 2017. When compared with the range of motion studies taken on the date of MMI, as to flexion it was reduced from 90 degrees to 80 degrees; abduction was reduced from 90 degrees to 60 degrees; internal rotation was the same at 30 degrees; and

external rotation was improved from 30 degrees to 40 degrees. (Extension and adduction were not measured by Dr. Price.) Resp. Exhibit FF at 157. The respondents argue that with such limited testimony/evidence, the hearing officer's decision that the condition had worsened is not supported by sufficient evidence. We disagree.

In *Savio House v. Dennis, 665 P.2d 141,* (Colo. App. 1983), a claimant had sustained compression fractures of her vertebrae and was awarded a 5% medical impairment. Nearly three years later the claimant filed a petition to reopen accompanied by a medical letter stating that the claimant was suffering from severe osteoporosis, a degenerative bone condition. The claimant testified that her condition had gotten worse, she was less able to bend over, reach, or lift and was in constant pain. The claimant's doctor testified that the impairment for the compression fractures had not increased since the rating of impairment was measured. The doctor also stated that the subsequent disability was attributable to the extensive osteoporosis. The referee concluded that the claimant's condition had worsened. Respondents argued that the only medical evidence established that the deteriorated condition was the result of her osteoporosis, not the industrial accident. The respondents contended that the ALJ erred in reopening the claim because the claimant had failed to establish "by credible medical testimony," that her condition was caused by the industrial injury.

The *Savio House* court stated at 665 P.2d 142:

> Whether the claimant has established causation is a question of fact, the determination of which is within the determination of the fact finder. If the findings are supported by substantial evidence, they are binding upon appellate review.
>
> Contrary to the assertions of petitioners, substantial evidence of causation is not restricted to credible medical testimony.
>
> Claimant's testimony was sufficient to establish with reasonable probability that her condition had worsened, and that the worsening was attributable to the accident.
> (Internal citations omitted.)

In our view it was reasonable for the ALJ to infer—even if not iterated—that the claimant's complaints of greater pain, the reduction in range of motion, and new complaints of numbness in the hands demonstrated a worsening of the claimant's condition. Notwithstanding the respondents' contentions, substantial evidence supports

the ALJ's determination that the claimant's condition worsened after the date of MMI, thus justifying the reopening of the claim, and the recommended therapy and evaluation are reasonable, necessary, and related to the occupational disease.

We have considered all of the respondents' contentions of error and are not persuaded to disturb the hearing officer's order.

IT IS THEREFORE ORDERED that the ALJ's order issued April 16, 2018 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

David G. Kroll

CERTIFICATE OF MAILING

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

10/12/18 by TT .

WITHERS SEIDMAN RICE & MUELLER PC, Attn: SEAN EP GOODBODY ESQ, 101 S 3RD STREET STE 265, GRAND JUNCTION, CO, 81501 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: CAROL A FINLEY ESQ, 1700 LINCOLN STREET SUITE 4500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-924-715-03

IN THE MATTER OF THE CLAIM OF:

ROBERT MARTIN,

Claimant,

v.

FINAL ORDER

BLACK HILLS CORPORATION,

Employer,

and

LIBERTY MUTUAL INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Lamphere (ALJ) dated May 14, 2018, that ordered them to pay medical benefits, including but not limited to medial branch blocks, for the claimant's compensable low back injury. We affirm.

After a hearing, the ALJ issued his order, making the pertinent findings of fact summarized below.

The claimant was working for the respondent employer on July 24, 2013, as a journeyman lineman. The claimant responded to a power outage in the Flower service area of Pueblo County. Heavy storms passing through the area caused a high voltage transmission pole to break and fall into an adjacent pole triggering a cross-wire fire. The claimant and a co-worker were dispatched to extinguish the fire and repair the downed transmission lines. While working in a bucket lift approximately 40 feet off the ground, the claimant inadvertently came into contact with a live wire and was severely electrically shocked. The claimant felt an arc, saw a blue flame, and was snapped backwards.

The claimant was transported by Flight for Life to University of Colorado Hospital in Denver. The claimant reported tenderness to palpation "over the left scapula and pain

with provocative arm extension and supination against resistance." It was determined the claimant had injured his left shoulder in the industrial accident.

The respondents filed a General Admission of Liability admitting liability for the claimant's injuries on August 7, 2013.

The claimant eventually was discharged from the hospital on July 25, 2013. Upon discharge, the claimant was referred to Dr. Caughfield for follow-up care. The claimant complained of left subacromial shoulder pain. Dr. Caughfield noted the claimant sustained an injury to his left arm on July 24, 2013. He also stated the claimant had intense spasm with the high voltage and ended up with a rotator cuff tear. Given the claimant's confirmed rotator cuff tear and persistent left shoulder pain, Dr. Caughfield referred the claimant to an orthopedist for a surgical opinion.

On October 18, 2013, the claimant underwent left shoulder surgery, consisting of a subacromial decompression, arthroscopic rotator cuff repair, biceps tenodesis, and distal clavicle resection with Dr. Weinstein. While the condition of the claimant's shoulder improved, he continued to suffer from neck pain and debilitating headaches.

Dr. Caughfield instructed the claimant to pursue a home strengthening program to improve strength and range of motion in the left shoulder. The exercise program became unnecessary as of March 13, 2014, when Dr. Weinstein noted the claimant had reached maximum medical improvement for his left rotator cuff tear.

On May 18, 2015, the claimant completed a pain diagram depicting pain in his neck, upper left shoulder, and left wrist. He characterized the pain as aching, sharp, numbing, and tingling.

The claimant's headaches and neck pain persisted. Discography and MRI revealed disc pathology at the C5-6 level. Conservative treatment directed to the neck, including injections and ablation treatment, failed. Consequently, on May 4, 2017, Dr. Prusmack performed an anterior cervical discectomy with artificial disc replacement at C5-6.

The claimant subsequently was referred to post-surgical physical therapy to "restore functional movement, [decrease] neck pain and improve strength and function" for the following diagnoses: "Cervical disc disorder at C5-C6 level with radiculopathy" and "Spinal stenosis, cervical region."

During the hearing, the claimant testified that he had discussed with his medical providers returning to work and preparing for a functional capacity evaluation. However, he explained that due to the fact he had been inactive for over three years after his work injury, Dr. Prusmack and Physical Therapist Barry Brown (PT Brown) recommended he supplement his physical therapy with a workout routine at a gym. The claimant testified that Dr. Prusmack and PT Brown wrote out a list of strength and conditioning exercises for him to do at the gym and at home (outside of formal physical therapy) in order to get stronger and ready to go back to work.

The claimant then joined Planet Fitness on May 15 or 16, 2017. He testified that from either May 15 or 16 through July 18, 2017, he worked out at Planet Fitness three days per week for three to four hours at a time.

On June 14, 2017, a physical therapy assistant at the office of PT Brown, Melinda Velasquez, documented that the claimant was lacking an appropriate home exercise program. The claimant's physical therapy treatment remained focused on meeting treatment goals in connection with his neck and left shoulder/arm conditions and impairments. While the majority of exercises performed in physical therapy focused on the claimant's neck and upper extremities rather than his low back, the claimant nevertheless was performing seated rowing and upper body ergometer as part of an in clinic core exercise program. Moreover, the claimant was instructed in and performed exercise for stabilization including marching in place, pelvic tilts, and hands on knees-push/hold.

On July 6, 2017, approximately seven weeks after the claimant began working out at Planet Fitness, he was instructed in the independent performance of an exercise program that was designed to address the problems and achieve the goals outlined in the plan of care. The ALJ specifically found the plan of care focused on "improving cervical range of motion, decreasing cervical trigger points, improv[ing] grip and pinch strength, improv[ing] upper extremity strength, and increase[ing] independence with activities of daily living along with core strengthening given that the list of exercises included hands on knees-push/hold, marching in place, and pelvic tilts-knees flexed in addition to seated rowing."

Thereafter, on July 18, 2017, the claimant was at Planet Fitness following the written protocol recommended by Dr. Prusmack and PT Brown. While completing a sidesaddle exercise, which involved sitting with his legs to left and his arms to right and pulling 40-60 pounds to his left, as recommended by Dr. Prusmack and PT Brown, the claimant felt a pop in his back.

The claimant underwent a non-contrast CT-scan of the lumbar spine on August 14, 2017. The scan revealed "chronic bilateral well-corticated pars defects (fracture) at the L2-3 level" along with bilateral foraminal protrusions and osteophytes with moderate right and mild left foraminal stenosis. Dr. Prusmack subsequently referred the claimant to Dr. Bernardini. Dr. Bernardini recommended the claimant undergo a series of lumbar injections. However, the respondents denied the request.

The ALJ ultimately concluded the pars defect was related to the claimant's July 24, 2013, industrial injury. He specifically found that while the claimant was performing physical conditioning, including core-strengthening exercises at the gym at the direction of his authorized treating providers, Dr. Prusmack and PT Brown, he injured his lower back. The ALJ found the core-strengthening exercises were part of the claimant's formal PT protocol and were likely made part of his independent exercise program by his physical therapist no later than July 6, 2017, and probably by recommendation of Dr. Prusmack much earlier. Applying the quasi-course doctrine, the ALJ determined the claimant was participating in medical treatment related to his work injury when he injured his lower back. He expressly concluded that "[b]ut for Claimant's July 24, 2013 industrial injury, he probably would not have been in the gym on July 18, 2017, and would not have injured his lower back." The ALJ concluded the injections recommended by Dr. Bernardini were reasonable and necessary to cure the claimant of the ongoing effects of his persistent low back symptoms. He ordered the respondents to pay for all medical treatment to cure and relieve the claimant from the ongoing effects of his compensable low back injury, including the medial branch blocks recommended by Dr. Bernardini.

On appeal, the respondents argue that substantial evidence does not support the ALJ's determination that the claimant's lower back injury is a compensable part of his claim under the quasi-course of employment doctrine. Namely, they contend the ALJ erred in concluding the claimant was injured while receiving authorized medical treatment. We disagree.

Under the quasi-course of employment doctrine, injuries sustained during treatment of the industrial injury have been held compensable as a consequence of the industrial injury. *Excel Corp. v. Industrial Claim Appeals Office*, 860 P.2d 1393 (Colo. App. 1993). As argued by the respondents, the doctrine is restricted to injuries arising out of "authorized" treatment. *Schrieber v. Brown & Root, Inc*., 888 P.2d 274, 278(Colo. App. 1993). However, the doctrine is not limited to injuries sustained while actually engaged in a particular medical treatment explicitly "prescribed" by the authorized treatment physician. To the contrary, the quasi-course of employment doctrine applies to

post-injury activities undertaken by the employee which, although they take place outside the time and space limits of the employment, and would not be considered employment activities for usual purposes, are nevertheless related to the employment in the sense that they are necessary or reasonable activities that would not have been undertaken but for the compensable injury. *Excel Corp. v. Industrial Claim Appeals Office, supra*; *Travelers Insurance Co. v. Savio*, 706 P.2d 1258 (Colo. 1985). For instance, in *Excel Corp*., the Colorado Court of Appeals held that injuries sustained while leaving a physical therapy session for treatment of the industrial injury were compensable. The Court reasoned that because the employer is required to provide medical treatment, and the claimant is required to submit to medical treatment, the "trip to the doctor's office" becomes an "implied part of the employment contract." *Id.* at 1394-1395. Consequently, the Court concluded that when the injured employee suffered additional injuries "in the course of a journey to a doctor's office occasioned by" the industrial injury, the additional injuries were compensable. *Id.*

Additionally, a claimant is obligated to cooperate with reasonable medical treatment designed to cure and relieve the effects of the industrial injury. *See* §8-43-404(3), C.R.S. We explained in *Miller v. Progressive Driver Services, Inc*., W.C. No. 4-318-241 (April 22, 1998), *aff'd* 98CA0902 (Nov. 27, 1998)(NSOP), that "[a]s pointed out by Professor Larson, this includes treatment in the form of exercise. 1 Larson, Workers' Compensation Law § 13.22 & § 13.22(d)." Accordingly, the failure to compensate a claimant for the natural and proximate results of his unsupervised rehabilitation efforts which are consistent with the "prescribed" treatment for the industrial injury could undermine a claimant's prompt and complete recovery. *See Miller v. Progressive Driver Services, Inc., supra*.

The question of whether a particular injury falls within the quasi-course of employment doctrine is essentially one of fact for determination by the ALJ. *See City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). Accordingly, we must uphold the ALJ's determination if supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. Under this standard we must defer to the ALJ's resolution of conflicts in the evidence, his credibility determinations, and plausible inferences which he drew from the evidence. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In this regard, the ALJ's findings may be based upon inferences drawn from circumstantial evidence. *Ackerman v. Hilton's Mechanical Men, Inc*., 914 P.2d 524 (Colo. App. 1996).

In *Miller*, we previously addressed a similar situation to that presented here. In that case, the claimant suffered a work-related back injury. The respondents admitted

liability and referred the claimant to Dr. Lynch for treatment. Thereafter, the claimant injured his left knee while engaged in a "home therapy" walking program. The claimant argued that the left knee injury was compensable under the quasi-course of employment doctrine. The ALJ agreed and ordered the respondents to pay for treatment of the left knee. In support, the ALJ found that Dr. Lynch referred the claimant to physical therapy, which included stretching exercises, walking on a treadmill, and pool therapy. The ALJ found that when the claimant was released from formal physical therapy, he continued actively to participate in his rehabilitation by doing daily home therapy walks to strengthen his back. The ALJ determined that the walking therapy was countenanced by Dr. Lynch as reasonably necessary to cure and relieve the effects of the back injury. He concluded that the left knee injury occurred during authorized treatment of the back injury, and therefore, was a compensable consequence of the back injury.

On appeal, the respondents argued there was no credible or persuasive evidence that the claimant's knee injury occurred during treatment of the industrial back injury. Further, they argued the quasi-course of employment doctrine did not apply to circumstances where the injury occurred during a home therapy program not explicitly "prescribed" by the authorized treating physician.

The Panel disagreed with the respondents' arguments. The Panel held that the failure to compensate a claimant for the natural and proximate results of his unsupervised rehabilitation efforts which were consistent with the "prescribed" treatment for the industrial injury could undermine a claimant's prompt and complete recovery. Thus, the Panel rejected the respondents' argument that unless the claimant is engaged in an exercise or treatment "expressly prescribed" by the authorized treating physician the quasi-course of employment doctrine was inapplicable. Further, the Panel held that substantial evidence supported the ALJ's finding of a causal connection between the claimant's walking activities at home and treatment of the industrial back injury. They reasoned that Dr. Lynch prescribed physical therapy for treatment of the back injury, and the claimant testified that the physical therapy he previously received consisted of stretching exercises, walking on a treadmill, and walking exercises in a pool, but that it was easier to walk at home than on the treadmill because he could stop and rest. The claimant also testified that he had reported to Dr. Lynch that he was walking at home and this activity reduced his pain from the back injury. The Panel added that Dr. Lynch admitted he encouraged his patients to engage in walking therapy and stated that it was "entirely possible" that if the claimant asked him whether "walking would be good for his back, [he] probably said yes." Additionally, the physical therapist directed the claimant to continue a self-monitored home exercise program and pool therapy. Thus, the Panel

determined the ALJ could reasonably find that walking was part of the authorized treatment of the claimant's industrial back injury.

Here, substantial evidence supports the ALJ's determination that the claimant sustained a low back injury while receiving authorized medical treatment for the industrial injuries he sustained on July 24, 2013. As detailed above, after undergoing anterior cervical discectomy surgery with Dr. Prusmack on May 4, 2017, the claimant was referred to physical therapy. A physical therapy note authored by PT Brown and dated June 7, 2017, states that the reason for the referral was to "restore functional movement, [decrease] neck pain and improve strength and function." That note also provides that the claimant was "instructed in the independent performance of a home exercise program that addresses the problems and achieving the goals outlined in the plan of care." Ex. 14 at 225, 229. The respondents do not dispute that Dr. Prusmack and PT Brown were authorized treating providers. Brief In Support at 7. Additionally, as noted by the ALJ, in the June 14, 2017, note of the physical therapist assistant, Ms. Velasquez, it specifically provides "Rehab Program Components: Core Exercise Program:" "Seated-Rowing" and "Upper Body Ergometer." Ex. 14 at 231. The claimant testified that Dr. Prusmack gave him strength and conditioning exercises to do at the gym and at home, and PT Brown gave him a written list of exercises to do as well. The claimant testified that he was exercising on the sidesaddle machine to strengthen his core when he injured his low back. The claimant explained that Dr. Prusmack and PT Brown directed the claimant to perform the exercise he was doing when he injured his low back. Tr. at 25-27, 30-31. Merely because the claimant sustained his low back injury while performing core exercises at the gym as opposed to at home does not dictate a different result. Similar to *Miller*, the evidence demonstrates and the ALJ reasonably inferred that at the time the claimant suffered the low back injury, he was engaged in a sanctioned therapy program which he would not have been doing but for the July 24, 2013, industrial injury. Section 8-43-301(8), C.R.S.

The respondents further argue that the written instructions by Dr. Prusmack and PT Brown were not presented as evidence at hearing and have not been subsequently produced. However, this complaint does not lead to a different result. The ALJ relied upon the testimony of the claimant in support of his determination that he sustained a low back injury while performing physical conditioning, including core-strengthening exercises at the gym, at the direction of his authorized treating providers, Dr. Prusmack and PT Brown. It was the ALJ's prerogative to credit the claimant's testimony in this regard despite the fact that the written instructions were not presented at the hearing. *See Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997).

Moreover, throughout their brief in support, the respondents cite to evidence in support of their position, including the testimony of their medical expert, Dr. Fall. However, the existence of evidence which, if credited, might support a determination contrary to that reached by the ALJ does not afford us grounds to grant appellate relief. *See Mountain Meadows Nursing Center v. Industrial Claim Appeals Office*, 990 P.2d 1090 (Colo. App. 1999) (the existence of conflicting evidence does not lessen the import of substantial evidence in support of a finding). The ALJ is not required to cite or discuss every piece of evidence before crediting evidence to the contrary. *Crandall v. Watson-Wilson Transportation System, Inc.*, 171 Colo. 329, 467 P.2d 48 (1970). Rather, evidence not cited is implicitly rejected as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Thus, we have no basis to disturb the ALJ's order awarding medical benefits, including the medial branch blocks recommended by Dr. Bernardini, to the claimant for his compensable low back injury. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated May 14, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

CERTIFICATE OF MAILING

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

10/11/18 by TT .

BURG SIMPSON ELDREDGE HERSH & JARDINE PC, Attn: STEPHAN MARSH ESQ, 40 INVERNESS DRIVE EAST, ENGLEWOOD, CO, 80112 (For Claimant)
LEE & BROWN LLC, Attn: EVAN M THOMPSON ESQ, C/O: SHEILA TOBORG ESQ, 3801 E FLORIDA AVENUE SUITE 210, DENVER, CO, 80210 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-919-279-01

IN THE MATTER OF THE CLAIM OF:

CHAD HEBERT,

Claimant,

v.

FINAL ORDER

BLAC FRAC TANKS INC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Sidanycz (ALJ) dated March 20, 2018, that denied the claimant's request for temporary disability benefits. We set aside the order of the ALJ.

The claimant sustained an injury to his face and head on May 21, 2013, while working on a gas well. A pipe being removed was swung into his face. The impact caused numerous fractures to the structures in the claimant's face including bilateral nasal bone fractures, a septal fracture, a fracture of the left orbital bone and multiple maxillary bone fractures. A CT scan did not reveal any acute intracranial injuries.

The claimant was treated conservatively and was returned to light duty work on June 25, 2013. He was returned to full duty in August. On April 25, 2014, the claimant complained of headaches and nose bleeds brought on by exposure to dust. The claimant also described cognitive problems involving short term memory, focus, and concentration. A septoplasty surgery was performed on the claimant's deviated septum on June 9, 2014. Two days later the claimant reported to the emergency room due to a "jittery sensation", a "spacey feeling", heart palpitations and narrowed vision. It felt to the claimant as if he was experiencing a stroke. There was no clear diagnosis as to the cause of the symptoms.

The claimant was placed at maximum medical improvement (MMI) on January 7, 2015. He was assigned by his treating doctor a 3% permanent impairment rating for loss of olfactory sensation and 4% for a closed head injury. The respondents filed a Final Admission of Liability on January 16, 2015, admitting for the 7% impairment rating.

The claimant continued to work for the employer until laid off due to an economic slowdown in April 2015. The claimant worked for several other employers until April 2017, when he began driving a water truck for Gonzo, LLC, servicing oil and gas wells. Following his layoff from the employer the claimant noted the onset of panic attacks from time to time. He also reported anger fits and feeling particularly nervous. On June 30, 2017, while driving a truck with the windows down, the truck cab filled with dust. The claimant then panicked and became afflicted with chest pain and numbness in his arm. He felt he was experiencing a stroke or heart attack and had difficulty breathing through his nose and throat. He was diagnosed at the emergency room with a panic attack.

The claimant returned to his authorized treating doctors. Dr. Fay noted periodic panic attacks related to episodes of breathing difficulty. The doctor recommended the claimant observe a work restriction featuring no exposure to dust. The claimant was also referred to a psychologist. On August 29, a physician's assistant concluded the claimant was no longer at MMI due to complaints of panic attacks, memory and cognitive deficits. She suggested a neuropsychologic evaluation with Dr. Young. In addition, the claimant was referred to a psychiatrist, Dr. Good, for medication to control his anxiety. Dr. Good diagnosed depression, panic disorder, attention deficit disorder, and panic disorder. He prescribed Prozac and psychological therapy. The respondents obtained second opinion reports from Dr. Moe and Dr. Hammerberg. They agreed the claimant was no longer at MMI and required therapy for his work injury related anxiety and depression. The respondents denied authorization for the recommended neuropsychological testing and treatment with Dr. Young.

The claimant has been unable to work for Gonzo LLC as a driver due to his no dust work restriction. The claimant described how this job leads to dust exposure even in the event the claimant roles up the truck windows. Gonzo will not reemploy the claimant until his no dust restriction is lifted. The claimant explains that he desires to return to work with Gonzo and therefore has not sought other employment.

Following a hearing on February 7, 2018, the ALJ reopened the claim as of June 30, 2017, as the claimant's condition has worsened subsequent to his original date of MMI. The ALJ ruled the recommended treatment to address the claimant's anxiety,

depression and cognitive deficits are related to the claimant's original work injury, including neuropsychological testing and treatment with Dr. Young. The ALJ authorized the proposed treatments.

The respondents argued to the ALJ that the claimant was not entitled to an award of temporary benefits after the date of reopening. The respondents complained of an absent causal connection between the work injury and the claimant's wage loss. The respondents pointed out that disability "connotes medi[c]al incapacity evidenced by loss or restriction of bodily function" and "impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work." The respondents conclude the claimant has not "shown restrictions which impair his ability to effectively and properly perform his regular employment."

The ALJ denied the claimant's request for temporary disability benefits. The ALJ noted the claimant had work restrictions and they are limited to "no dust". The ALJ observed the claimant did not demonstrate "he was unable to work." The ALJ found the claimant had not sought employment elsewhere because he would like to return to work for Gonzo. The claimant's wage loss was deemed to be caused by "claimant's personal preference to not seek work elsewhere, and not due to a physical disability or medical condition."

The ALJ referenced the holding in *Culver v. Ace Electric*, 971 P2d 641 (Colo. 1999), that disability pursuant to the statute consists of two elements including evidence of a physical disability and "impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work." The ALJ observed, "The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment." The ALJ's order concluded by finding: "As found, claimant has failed to demonstrate by a preponderance of the evidence that he is entitled to TTD benefits. As found, the medical records and claimant's testimony are credible and persuasive on this issue."

On appeal, the claimant contends the undisputed evidence establishes the claimant did have a medical restriction and that restriction did preclude the claimant's ability to perform his regular work, i.e. driving a truck for Gonzo, LLC. The claimant characterizes the ALJ's finding that he could have possibly performed other types of work as a basis to deny temporary benefits, as the addition of a burden not required to justify an award. We find the argument of the claimant compelling.

In the case of a reopened claim due to a change of condition, a claimant may qualify for an award of temporary benefits if he establishes the worsened condition caused a "greater impact upon claimant's temporary work capability than he had originally sustained" when he reached MMI. *City of Colorado Springs v. Industrial Claim Appeals Office*, 954 P.2d 637, 640 (Colo. App. 1997). We have applied this standard to justify temporary benefits in the situation where the claimant was not actually working when initially placed at MMI. Noting that temporary benefits may be awarded where the claimant is able to "show the worsened condition resulted in increased physical restrictions (over those which existed on the original date of MMI), and that the increased restrictions caused a 'greater impact' on the claimant's temporary 'work capability' than existed at the time of MMI." *Friesz v. Wal-Mart Stores, Inc*., W.C. No. 4-823-944-01 (December 21, 2012).

Here, the ALJ found the claimant has an additional work restriction involving "no dust". The ALJ credited the claimant's testimony that he could not resume his truck driving job with Gonzo, LLC due to this new restriction. However, the ALJ concluded the claimant did not successfully prove he suffered a loss of wages because of the work injury. It was reasoned the work restriction was not germane to this case. The ALJ held the claimant did not show "he is unable to work". Rather, it was observed the claimant had not sought employment elsewhere because he would like to return to work for Gonzo. "The ALJ finds that claimant's wage loss is due to claimant's personal preference to not seek work elsewhere, and not due to a physical disability or medical condition." Finding of Fact ¶ 32.

The ALJ correctly noted the applicable standard to justify an award of temporary benefits referencing *Culver, supra*, as well as *PDM Molding v. Stanberg*, 898 P.2d 542 (Colo. 1995). The criteria for an award require:

> An award of temporary total disability benefits is mandatory pursuant to section 8-42-105 if the following conditions exist: (1) the injury or occupational disease causes disability, § 8-42-103(1), 3B C.R.S. (1994 Supp.), (2) the injured employee leaves work as a result of the injury, § 8-42-103(1)(a), (b), 3B C.R.S. (1994 Supp.), and (3) the temporary disability is total and lasts more than three regular workings days' duration, § 8-42-105(1), 3B C.R.S. (1994 Supp.). If these statutory criteria are met, temporary total disability benefits "shall

> continue until" one of the four events specified in section 8-42-105(3) occurs. *Id*. at 546.

The standard stipulates the claimant need only be required by the injury to "leave work". It does not impose upon the claimant an obligation to seek other work. *Gaitan v. Pita Subway*, W.C. No. 4-726-194 (August 26, 2009). Only in the event an employer takes the initiative to offer modified duty are any additional responsibilities imposed upon the claimant. § 8-42-105(3).

In *Schlage Lock v. Lahr*, 870 P.2d 615 (Colo. App. 1993), the Court ruled the claimant was not required as a condition for an award of temporary benefits to seek out other employment within his work restrictions:

> The Workers' Compensation Act is organic and is self-operational without the need for supplementation. *Bradley v. Industrial Claim Appeals Office*, 841 P.2d 1071 (Colo. App. 1992). It does not create an affirmative duty on the part of a temporarily disabled claimant to seek out work within his or her restrictions. Thus, a claimant's ability to perform post-injury employment or willingness to seek employment does not necessarily reflect the degree of physical impairment resulting from the change in physical condition. *Denny's Restaurant, Inc. v. Husson*, 746 P.2d 63 (Colo. App. 1987).
>
> Nor does a claimant's hypothetical ability to perform some employment within his or her temporary medical restrictions sever the causal connection between the injury and the temporary wage loss. *Id*. at 617.

Accordingly, we have held in *Bonney v. Pueblo Youth Service Bureau*, W.C. No. 4-485-720 (April 24, 2002), *Holsonback v. Brand Scaffold Builders*, W.C. No. 4-724-509 (June 12, 2008) and in *Hendricks v. Keebler Co*., W.C. No. 4-373-392 (June 11, 1999), that should the restrictions imposed as a result of the work injury lead to the loss of the claimant's preinjury job, the requirement that the claimant "leaves work as a result of the injury" has been satisfied.

Here, the claimant testified his job as a truck driver servicing oil and gas wells involved exposure to significant amounts of dust. When his physician restricted the

claimant from working while exposed to those conditions of dust, the claimant explained he could not perform the driving job. The ALJ found the "claimant's testimony credible and persuasive on this issue." Accordingly, the claimant has established eligibility for an award of temporary benefits after he left work. The ALJ's finding that the causal connection between the work injury and the claimant's wage loss was severed due to the claimant's preference 'to not seek work elsewhere' is notwithstanding and represents an additional qualification not recognized by the statute.

As noted, the findings of fact in this matter do not support the order and the denial of benefits is not supported by applicable law, § 8-43-301(8). Accordingly, we set aside that portion of the ALJ's order that denied the claimant temporary total disability benefits as of July 1, 2017.

IT IS THEREFORE ORDERED that the ALJ's order issued March 20, 2018, to the extent it denied the claimant an award of temporary disability benefits is reversed and set aside.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

John A. Steninger

CERTIFICATE OF MAILING

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

10/19/18 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BLVD, DENVER, CO, 80230 (Insurer)
WITHERS SEIDMAN RICE MUELLER GOODBODY PC, Attn: SEAN E P GOODBODY ESQ, 101 SOUTH THIRD STREET SUITE 265, GRAND JUNCTION, CO, 81501 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: CAROL A FINLEY ESQ, 1700 LINCOLN ST SUITE 4500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

FEIN No. 47-5390162

IN THE MATTER OF THE CLAIM OF:

FINAL ORDER

MMJ 95 LLC,

Employer,

and

NON INSURED,

Insurer,
Respondent.

The respondent seeks review of a supplemental order of the Director of the Division of Workers' Compensation (Director) dated July 2, 2018, that assessed and ordered the respondent to pay a fine totaling $39,950 for failing to meet its statutory obligation to maintain workers' compensation insurance. We affirm.

The respondent, MMJ 95, LLC, is a limited liability company and does business as TweedLeaf. The respondent has a license to operate a medical marijuana dispensary store at 5495 North Academy Blvd. in Colorado Springs.

On January 25, 2018, the Director sent a Notice to Show Compliance (Notice) to the respondent to provide proof of workers' compensation insurance coverage or proof that it was exempt from such coverage. The Notice also directed the respondent to return a completed Employer's Compliance Questionnaire (Questionnaire). The Director gave the respondent 20 days to respond to the Notice and Questionnaire. Additionally, the respondent also was advised of its opportunity to request a prehearing conference regarding the issue of default.

The respondent did not request a prehearing conference. However, it submitted its responses to the Director on February 22, 2018. The respondent stated that it began its business operation on October 21, 2015, its sole owner is John Kaweske, and it has no employees.

On February 27, 2018, an investigator for the Colorado Department of Labor and Employment, Troy Dumas, visited the Tweedleaf Medical Marijuana Dispensary on 5495 North Academy Blvd. in Colorado Springs. A worker there, who had a lanyard with an identification card attached, offered to help Mr. Dumas, and explained that there are no recreational sales in the Colorado Springs city limits. Rather, she explained the business was a medical marijuana dispensary. Another worker there, who also had a lanyard with an identification tag, informed Mr. Dumas that the prices for recreational marijuana were "pretty pricey." Then, on March 13, 2018, Mr. Dumas checked the National Council on Compensation Insurance (NCCI) database to determine if the respondent had obtained insurance. The NCCI database did not indicate a current policy of workers' compensation insurance in place for the respondent. Additionally, pursuant to §8-41-202, C.R.S., the Division of Workers' Compensation had not received any notice of election to reject coverage by a corporate officer or LLC member from anyone associated with the respondent, including Mr. Kaweske.

Thereafter, on March 14, 2018, the Director issued his Specific Findings of Fact, Conclusions and Order to Pay Fine. In his order, the Director found that during the period beginning three years prior to the date of the Notice, the respondent employed one or more persons, the respondent was not exempt from the provisions of Colorado's Workers' Compensation Act (Act), and the respondent did not have a policy of workers' compensation insurance in effect during the relevant times. Pursuant to §8-43-409, C.R.S., the Director imposed a daily fine for the period of October 21, 2015, through March 14, 2018, which totaled $12,090.00. The Director also stated that as part of the fines imposed, if the respondent's default continued beyond the date of the order, then fines would continue at a rate of $250.00 per day until the respondent obtained the required insurance.

The respondent then filed a petition to review. In its brief in support of its petition, the respondent argued that it did not have and never has had any employees. The respondent further included a copy of its workers' compensation insurance coverage dated April 1, 2017, for AJC Industries, LLC d/b/a Front Range Alternative Medicine. The respondent explained that all employees are currently employed through AJC Industries, LLC. The respondent further requested that the fine be vacated and stated that due to its current financial situation, it "would be devastating" to pay the fine. The brief is signed by Wendie Greeley, Bookkeeper.

The Director then issued a supplemental order on July 2, 2018, addressing the statements and arguments made in the respondent's brief. The Director found that the respondent filed Articles of Organization as a Limited Liability Company with the

Colorado Secretary of State on October 21, 2015, and has two trade names registered to it. Those trade names are MMJ 95 and TweedLeaf. He found that there also is an entity registered with the Colorado Secretary of State which filed Articles of Organization on April 28, 2009, by the name of AJC Industries, LLC and has four effective trade names associated with it, including Front Range Alternative Medicine and TweedLeaf. Mr. Kaweske is the registered agent of both entities. The Director found that Mr. Kaweske is the sole member of the respondent MMJ 95, LLC. The Director further found that Mr. Kaweske had not filed a statutory LLC member rejection of coverage for workers' compensation insurance, as required by §8-41-202(1), C.R.S. Thus, the Director determined that Mr. Kaweske was an employee of the respondent on and after October 21, 2015, and that no LLC member exemption applied to relieve the respondent from its obligation to have workers' compensation insurance coverage for all of its employees. The Director further found that pursuant to the Colorado Marijuana Enforcement Division's website, the respondent is the only entity licensed to sell medical marijuana at 5495 North Academy Blvd. in Colorado Springs. He therefore determined that the workers Mr. Dumas observed operating at that location were the respondent's employees. The Director also rejected the respondent's argument that it had fulfilled its workers' compensation obligation by a policy carried by a different entity, AJC Industries. He found AJC Industries was a separate entity, and the policy was written solely for AJC Industries and would not cover the respondent.

Based on the evidence, the Director concluded that the respondent employed one or more persons in the State of Colorado, including its principal, the respondent was not exempt from the provisions of the Act, and that it did not have a policy of workers' compensation insurance in effect during the period beginning three years prior to the date of the Notice to Show Compliance, or from October 21, 2015, through March 14, 2018. After considering the three factor test enunciated in Associated Business Products v. Industrial Claim Appeals Office, 126 P.3d 323 (Colo. App. 2005), the Director assessed the fine. The Director calculated the fine based on the formula adopted by the Division under §8-43-409(1)(b)(I), C.R.S. in Department of Labor & Employment Rule 3-6(B), 7 Code Colo. Regs. 1101-3 as follows: $5.00 per day from October 21, 2015, though January 25, 2018; $10.00 per day from January 26, 2018, through January 30, 2018; $30.00 per day from January 31, 2018, through February 4, 2018; $50.00 per day from February 5, 2018, through February 9, 2018; $100.00 per day from February 10, 2018, through February 14, 2018; and $250.00 per day from February 15, 2018, through July 2, 2018. The Director ordered the respondent to pay the total fine of $39,590.00. The Director further stated that if the respondent's default continued beyond the date of the Order, then beginning on July 2, 2018, the respondent was to pay $250.00 per day for each day until the required insurance was obtained.

The respondent has petitioned to review the Director's supplemental order. However, the respondent has not filed a brief in support of its petition to review or raised any contentions of error in the Director's supplemental order. Accordingly, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986).

Employers that are subject to the terms and provisions of Colorado's Workers' Compensation Act (Act), §§ 8-40-101 to 8-47-209, C.R.S., are required to have insurance in compliance with the Act. Section 8-43-409(1), C.R.S. Pursuant to § 8-43-409(1), C.R.S., an employer that "fails to insure or to keep the insurance required by such articles in force, allows the insurance to lapse, or fails to effect a renewal of the insurance shall not continue business operations while such default in effective insurance continues." Pursuant to §8-43-409(1)(b)(I), C.R.S., the Director may impose a fine of not more than $250 per day for every day that the employer fails to comply with its mandatory workers' compensation insurance requirements for an initial violation.

Additionally, §8-47-111, C.R.S. provides that it is the General Assembly's intent that Colorado employers that fall under the provisions of Articles 40 to 47 of Title 8 provide workers' compensation insurance coverage for their Colorado employees. Moreover, §8-44-101, C.R.S. provides that it is the responsibility of the employer to secure compensation for all employees. The employer is allowed under the Act to accomplish this in different ways, including securing an insurance policy. Section 8-44-101, C.R.S.

Here, based on our review of the record, the respondent's failure to request a prehearing conference, and the respondent's failure to raise any contentions of error, we have no grounds to disturb the Director's supplemental order. First, the Director found, with record support, that the respondent has employees. As detailed above, the investigator who visited the respondent's business location at 5495 North Academy Blvd. in Colorado Springs, spoke with two individuals who appeared to be working there. One of the workers offered to help Mr. Dumas. Tab 29 Affidavit of Troy Dumas 2/27/2018. Further, the City of Colorado Springs prohibits any Retail/Recreational Marijuana Establishments. Instead, only medical marijuana may be sold in the City. *See* City of Colorado Springs Ordinance Nos. 2.2.101(A) and (B), 2.2.104. The respondent is the only entity licensed to sell medical marijuana at 5495 North Academy Blvd. in Colorado Springs. https://www.colorado.gov/pacific/sites/default/files/Centers%2010012018.pdf. Also, the Director found, with record support, that Mr. Kaweske is an employee of the respondent, MMJ 95, LLC. The respondent's Questionnaire identifies Mr. Kaweske as having 100% ownership of the respondent. Tab 28. The Division has no records

indicating that there is no statutory LLC member coverage rejection for Mr. Kaweske, as required by §8-41-202(1), C.R.S. It has long been held that absent a rejection of coverage by corporate officers and members under §8-41-202, C.R.S., the members of a limited liability company are considered employees. *See generally Pulsifer v. Pueblo Professional Contractors, Inc*., 161 P.3d 656 (Colo.2007)(corporate officers or members of limited liability company who execute and file election to reject coverage under §8-41-202(1) cannot make workers' compensation claims); *see also Kelly v. Mile Hi Single Ply, Inc*., 890 P.2d 1161 (Colo. 1995)(although the Act is intended to provide exclusive remedies for all employees injured on the job, the General Assembly has authorized corporate officers the option to reject workers' compensation coverage). The Director further found, with record support, that for the period in question, or from October 21, 2015, through July 2, 2018, the respondent did not have a policy of workers' compensation insurance covering its employees. More specifically, the NCCI database does not list the respondent as having a policy of workers' compensation insurance. Tabs 27, 30. Thus, since the respondent employed one or more persons in the State of Colorado, including its principal, it was not exempt from the provisions of the Act, and it did not have a policy of workers' compensation insurance in effect during the period beginning three years prior to the date of the Notice, or from October 21, 2015, through July 2, 2018, the Director was allowed under §8-43-409, C.R.S. to impose a fine on the respondent.

Additionally, under either a de novo or an abuse of discretion standard of review, we similarly have no grounds to disturb the amount of the Director's fine. *See Dami Hospitality, LLC, v. Industrial Claim Appeals Office*, 2017COA21 (Feb. 23, 2017)(recognizing abuse of discretion and de novo standards of review), *cert. granted in part* (Sept. 11, 2017). As explained in his supplemental order, the Director considered the three factors enunciated in *Associated Business Products* when imposing the fine.

Regarding the first factor, or the degree of reprehensibility of the respondent's conduct, the Director found that since the respondent is a marijuana retailer, the risks associated with working in the marijuana industry involve biological, chemical, and physical hazards. As found by the Director, biological hazards include mold and allergic reactions, and chemical risks related to both the use of external chemical and chemical compounds produced by marijuana itself. The Director found that physical risks include the normal slips, trips, and falls and also workplace violence such as robbery and assault. He therefore determined the respondent's failure to provide workers' compensation insurance in such an environment was reprehensible. Regarding the second factor, or the disparity between the harm or potential harm suffered and the fine to be assessed, the Director found the harm was demonstrated in two ways. Initially, an employee working

for a non-insured employer must rely solely on limited financial resources of the employer for the payment of all costs associated with an injury, including lost wages. While the Director found there was no history of workers' compensation claims for the respondent, the potential nevertheless existed that the respondent may be unable to absorb such costs. Next, the respondent's failure to carry workers' compensation coverage harmed the competitive business environment by allowing the respondent to offer its goods and services at a lower cost than competitors. Accordingly, he concluded the respondent's failure to insure created potential and actual harm to the respondent's workers and competitors. Regarding the third factor, or the difference between the fine imposed and the penalties authorized or imposed in comparable cases, the Director imposed the respondent's fine at $5 per day until the initial notice was sent, as the Director stated he had done in other cases. Once the respondent was noticed and continued to operate without coverage, the Director escalated the fine through the range allotted for in §8-43-409, C.R.S., as he stated he had done with other employers. The Director specifically found that although the total amount of the fine can differ between employers, such difference is dependent on the length of time the employer fails to carry insurance. He further found that the respondent had not provided the Division with any financial documentation demonstrating it was unable to pay the fine. Since the inferences the Director made were reasonable, we have no basis to disturb the $39,590 fine the Director imposed in his supplemental order. Section 8-43-301(8), C.R.S.

Last, we note that the dissent has raised issues/arguments that never were raised before the Director below and have not been raised by the respondent to us on appeal. As we understand the dissent, these issues/arguments appear to include the following: (1) the Director erred in "more than doubl[ing] the daily fines" assessed against the respondent, MMJ 95, after AJC Industries purchased workers' compensation insurance; (2) AJC Industries is merely a staffing company or administrative employer for the respondent, MMJ 95, and its workers' compensation insurance policy covers the employees working for MMJ 95; and (3) AJC Industries' workers' compensation policy effective March 22, 2018, precluded the Director from imposing a fine on the respondent, MMJ 95, after that date. However, the Panel is not allowed to raise and address issues/arguments that were not raised below and never have been raised by the parties on appeal. To do so, as the dissent has done here, is acting in excess of the authority granted to us under our governing statutes. Sections 8-1-102, 8-43-301, C.R.S.

Additionally, to support the conclusions reached for the new arguments raised by the dissent, the dissent also engages in improper fact-finding. Once again, this exceeds the authority granted to us under our governing statutes. Sections 8-1-102, 8-43-301, C.R.S. Further, the findings of fact made by the dissent are contrary to the findings made

by the Director. For example, the dissent states that "once the employer secured workers' compensation insurance, the Supplemental Order more than doubled the daily fines assessed against the employer." However, the dissent is improperly finding that the respondent, MMJ 95, and AJC Industries are one-in-the-same "employer" or that AJC Industries is acting as a staffing company or administrative employer for the respondent. To the contrary, however, the Director found that the respondent, MMJ 95, and AJC Industries are distinct and separate business entities, they filed separate and distinct Articles of Organization with the Colorado Secretary of State, and the respondent, MMJ 95, is an uninsured employer. The mere fact that both companies are doing business under the same trade name "TweedLeaf" is inconsequential and does not demonstrate they are one-in-the-same business or that AJC Industries is acting as an administrative employer for the respondent, as is suggested by the dissent. As explained by the Colorado Secretary of State, "[a] trade name provides notice that you are using that trade name, but does not prevent anyone else from using the same name" and "[a]ny trade name may be registered, even if it is similar to or exactly the same as another name that is in the records." https://www.sos.state.co.us/pubs/business/FAQs/tradeNames.html. Similarly, the dissent finds that AJC Industries and the respondent, MMJ 95, had an arrangement for AJC Industries' employees to work for the respondent, MMJ 95, and that they agreed that AJC Industries would secure and maintain workers' compensation insurance that would cover those employees working for MMJ 95 at the 5495 North Academy Blvd. business location in Colorado Springs. However, in his supplemental order, the Director never made any such findings regarding this arrangement or alleged joint-employer relationship, and there is no evidence in the record demonstrating that AJC Industries is acting as a staffing company or administrative employer for the respondent.

IT IS THEREFORE ORDERED that the Director's supplemental order issued July 2, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

Brandee DeFalco Galvin

Examiner Kroll submits the following dissent:

I respectfully dissent from the decision in this matter. My concern stems from the peculiar circumstance that once the employer secured workers' compensation insurance, the Supplemental Order more than doubled the daily fines assessed against the employer. Such a result is contrary to the entire purpose of § 8-43-409.

In paragraph 5 of the Supplemental Order it is found that a single individual, John Kaweske owns three businesses, i.e. MMJ 95, TweedLeaf, and AJC Industries. It then states that the Secretary of State's office shows TweedLeaf is an effective trade name registered to MMJ 95. Paragraph 7 of the Order explains that ALJ Industries is also on file with the Secretary of State and it also has a TweedLeaf tradename registered to it. Mr. Kaweske is listed as the registered agent for both. Paragraph 11 then describes how the respondent provided the Division with a copy of a Pinnacol insurance policy effective March 22, 2018. The policy lists AJC Industries as the insured and its address is 5495 North Academy Blvd. This is the address of MMJ 95 and a TweedLeaf store. The policy states it is applicable to employees working in the categories of 'Florist-farm' and 'store-drug-retail'. The NCCI reports in exhibit tab 45 confirm that AJC Industries obtained a Pinnacol workers' compensation policy for its business at 5495 North Academy Blvd. on March 22, 2018. The type of workers covered include "Farm: Florists & Drivers" and "Store: Drug – Retail". It assures that the policy has not been cancelled.

The affidavit of investigator Dumas states that on February 27, 2018, he visited two locations identified as TweedLeaf Medical Marijuana Dispensaries. One was on the North Academy Blvd address, and the second was on West Colorado Blvd. The investigator then, confirmed the business being operated on 5495 North Academy was indeed a TweedLeaf store.

The result is a situation where the sole owner of MMJ 95 and AJC Industries, both doing business as TweedLeaf, their designated trade name, at 5495 North Academy Blvd., submitted to the Director proof of insurance for employees working at 5495 North Academy Blvd. in jobs characteristic of a medical marijuana dispensary, effective as of March 22, 2018. However, the Supplemental Order, paragraph 10, holds this coverage is not adequate to satisfy the obligation of MMJ 95 to obtain workers' compensation insurance coverage. The Order reasons this is because the policy states AJC is the insured and does not reference MMJ 95:

> Thus, an insurance policy that is written solely for AJC will not cover any other entity, just as a debt of AJC would not

extend to any other entity.

This reasoning ignores the long applicable legal arrangement in Colorado whereby an employer may arrange for another company to secure and maintain workers' compensation insurance to cover the employer's employees. Such an arrangement was described in *Staff Administrators Inc. v. Reynolds*, 977 P.2d 866, 867 (Colo. 1999). In *Reynolds* the claimant was employed by the Armendariz Construction Company and was traveling to their job site when he was injured. However, Armendariz was not a party to the claim because it had arranged for workers' compensation insurance, and its injury liability, to be provided by a separate company.

> Petitioner, Staff Administrators, Inc. (Staff Administrators), is an administrative employer that acts as the employer of record for its clients' employees. In this capacity, Staff Administrators pays the workers' compensation coverage for its clients' employees. At the time of Reynolds' accident, Armendariz Construction Company utilized the services of Staff Administrators, so Staff Administrators paid Reynolds' workers' compensation coverage. The petitioner, Liberty Mutual Insurance Company is Staff Administrators' insurer. *Id*. at 867.

The Court ruled the claim was compensable. Consequently, Staff Administrators and Liberty Mutual were ordered liable for the expenses of the claim. The business of providing personnel services to employers by separate companies, including workers' compensation insurance coverage, is long standing. *See*, *Human Resources Co. v. Industrial Claim Insurance Co*., 984 P.2d 1194 (Colo. App. 1999); *Gregory v. Special Counsel*, W.C. No 4-713-707 (January 6, 2008); *Robertson v. Vincam Staff Administrators*, W.C. No. 4-389-907 (January 10, 2007); *Lopez v. Accord Human Resources*, W.C. No. 4-551-435 (March 19, 2003); *Schutter v. Outsource International*, W.C. No. 4-520-338 (August 21, 2002); *Johnson v. Virtual Industires & Staff Administrators*, W.C. No 4-266-253 (February 23, 1999); *Westerkamp v. Get Auto Transportation d/b/a Staff Administrators*, W.C. No. 4-213-838 (May 21, 1996); *Gomez v. H & G Framing*, W.C. No. 4-447-171 (February 18, 2004); *Ritthaler v. Denver Jewish Day School*, W.C. No. 4-905-362-02 (May 7, 2014).

In *Gomez v. H & G Framing*, W.C. No. 4-447-171 (February 18, 2004), we concluded that the presence of an agreement to arrange workers' compensation insurance for an employer rendered both the employer and the administrative employer co-employers. It was ruled the insurance carrier for the administrative employer, Zurich, was liable for the costs of the claim. The decision noted: "As to whether Zurich is liable for the claimant's injuries, it well established that the insurance policy and the liability of the insured, that measures the liability of the insurer."

The record in this matter, in paragraph 10 of the Order, notes that MMJ 95 states it has satisfied its insurance obligation by way of the policy it obtained through AJC Industries. As noted above, that policy specifies the business at 5495 North Academy Blvd, and covers workers engaged in jobs required by a medical marijuana dispensary. The affidavit of the Division's investigator acknowledges that is precisely the business being carried on at that address. The analogy drawn by the Supplemental Order to a debt owed to one business as being unrelated to another is not an apt comparison. In this instance the Supplemental Order is legally in error.

The Supplemental Order rules that between February 15 and July 2, 2018, MMJ 95 should be assessed the maximum penalty allowed by § 8-43-409(1)(b)(I) of $250 per day. Due to the policy indicating MMJ 95 secured insurance coverage as of March 22, 2018, the assessment of fines should cease on that date, thereby reducing the penalties by $25,500. To hold otherwise would undermine the statute's goal of ensuring coverage for employees and instead lead to the arbitrary assessment of fines.[1]

David G. Kroll
Examiner

[1] I am also confused by the holding in the Supplemental Order that "members of a limited liability company are considered employees of the LLC under the Act," by virtue of § 8-41-202(1). That section provides that an individual who is an employee of an LLC, and is also a 'member', may elect to waive workers' compensation insurance coverage. However, § 7-80-404(6) specifies "A member is not entitled to remuneration for services performed for the limited liability company …" Since that member is allowed to transact business with the LLC, he may, in fact, be hired to be an employee. Status of an 'employer' is governed by § 8-40-203(1)(b). An employer is described there as "Every person, association of persons … who has one or more persons engaged in the same business or employment, … in service under any contract of hire, express or implied." Section 8-40-202(2)(a) provides an 'employee' is "an individual who performs services for pay for another …". There is no information in the record indicating Mr. Kaweske has a 'contract of hire' with MMJ 95 nor that he performs 'services for pay' for MMJ 95. That is the sole basis offered for finding MMJ 95 had employees as long ago as October, 2015. Accordingly, the ruling in the Supplemental Order that an LLC member is necessarily an employee appears incorrect. The noted cases of *Pulsifer* and *Kelly*, *supra*, do not deal with this issue.

CERTIFICATE OF MAILING

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

10/15/18 by TT .

MMJ 95 LLC, Attn: D/B/A TWEEDLEAF, C/O: D/B/A MMJ 95, 5495 N ACADEMY BLVD, COLORADO SPRINGS, CO, 80918 (Employer)
MMJ 95 LLC, Attn: D/B/A TWEEDLEAF, C/O: D/B/A MMJ 95, 330 EAST COSTILLA STREET #418, COLORADO SPRINGS, CO, 80904 (For Claimant)
TANNENBAUM TROST & BURK LLC, Attn: ROBERT E BURK ESQ, 4155 E JEWELL AVE STE 1018, DENVER, CO, 80222 (For Respondents)
MMJ 95 LLC, Attn: D/B/A TWEEDLEAF, C/O: D/B/A MMJ 95, 445 E CHEYENNE MTN BLVD SUITE C240, COLORADO SPRINGS, CO, 80904 (Other Party)
DIVISION OF WORKERS COMPENSATION, Attn: TROY DUMAS, C/O: COVERAGE ENFORCEMENT UNIT, 633 17TH STREET SUITE 400, DENVER, CO, 80202 (Other Party 2)

COLORADO COURT OF APPEALS

DATE FILED: October 25, 2018
CASE NUMBER: 2017CA2165

Court of Appeals No. 17CA2165
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-881-225

Salahaddin Amin,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Schneider National Carriers, and Liberty Mutual Insurance Company,

Respondents.

ORDER AFFIRMED

Division I
Opinion by JUDGE FOX
Taubman and Terry, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced October 25, 2018

Irwin Fraely PLLC, Roger Fraley Jr., for Petitioner Salahaddin Amin

No Appearance for Respondent Industrial Claim Appeals Office

Ruegsegger Simons Smith & Stern, LLC, Michele S. Carey, for Respondents Schneider National Carriers and Liberty Mutual Insurance Company

¶ 1 In this workers' compensation action, claimant, Salahaddin Amin, seeks review of a final order of the Industrial Claim Appeals Office (Panel) affirming summary judgment in favor of employer, Schneider National Carriers, and its insurer, Liberty Mutual Insurance Company (collectively employer). An administrative law judge (ALJ) ruled that claimant's claim for workers' compensation benefits automatically closed for failure to prosecute and could not be reopened based on a change in medical condition. The Panel held that because no admission of liability was entered and no finding of compensability was ever made, no base condition existed which could have worsened to warrant reopening the claim. We agree with the Panel's reasoning and affirm.

I. Background

¶ 2 Claimant allegedly sustained a work-related injury in January 2012. Employer contested the claim one month later. In September 2012, after claimant had taken no action to advance the claim, employer moved to dismiss it for failure to prosecute. On October 9, 2012, the Division of Workers' Compensation issued an order to show cause allowing claimant to provide "what recent effort

you have made or are making to pursue your claim." The Division explicitly warned claimant that *if* (1) he did not respond to the order to show cause "within thirty (30) days of the date of the Certificate of Mailing attached to this order, your claim will be automatically closed," and (2) his claim closed, he had "the right to petition to reopen [his] case as set forth in [section] 8-43-303, C.R.S. [2018]." Claimant did not respond to the order and his claim automatically closed.

¶ 3 Two years later, in December 2014, claimant obtained counsel who then applied for a hearing, endorsing the issues of compensability, medical benefits, authorized provider, average weekly wage, and temporary total and partial disability benefits. But no hearing was set. Over the next twenty-five months, claimant filed four more applications for hearing, and a petition to reopen. None of these applications proceeded to a hearing or an adjudication on the merits, however.

¶ 4 Finally, in April 2017, claimant filed a sixth application for hearing, endorsing only one issue – his petition to reopen. Before the scheduled hearing occurred, however, employer moved for

summary judgment, asserting that claimant's petition to reopen be denied and dismissed. Employer argued that claimant could not reopen his claim based on a change in condition because the claim "was never found or admitted to be compensable[.]" In other words, according to employer, there was no base condition against which to compare whether claimant's condition had changed or worsened. The ALJ agreed and granted employer's motion for summary judgment.

¶ 5 On review, the Panel affirmed, holding that reopening based on a change in condition requires "an original determination of compensability." This appeal followed.

II. Applicability of Reopening Statute

¶ 6 Claimant contends that the ALJ and the Panel misinterpreted the reopening statute, section 8-43-303, C.R.S. 2018. He argues that he should not have been barred from reopening his claim based on a change in medical condition simply because compensability had not been adjudicated. He suggests that if the legislature had intended to limit reopenings based on changes in condition "to admitted claims or claims adjudicated compensable,

then it could have plainly stated so," and that the Panel improperly inserted that requirement into the statute. We are not persuaded that the Panel erred.

A. Standard of Review for Summary Judgment

¶ 7 "[S]ummary judgment may be sought in a workers' compensation proceeding before the ALJ." *Fera v. Indus. Claim Appeals Office*, 169 P.3d 231, 232 (Colo. App. 2007). Under Office of Administrative Courts Rule of Procedure (OACRP) 17, a party may move "for summary judgment seeking resolution of any endorsed issue for hearing." Dep't of Pers. & Admin. Rule 17, 1 Code Colo. Regs. 104-3. Like a motion for summary judgment pursued under C.R.C.P. 56, summary judgment may be granted in a workers' compensation case if "there is no disputed issue of material fact and . . . the party is entitled to judgment as a matter of law." OACRP Rule 17; *see also Nova v. Indus. Claim Appeals Office*, 754 P.2d 800, 802 (Colo. App. 1988) (noting that the Colorado Rules of Civil Procedure apply to workers' compensation proceedings unless inconsistent or in conflict with the procedures and practices followed under the Workers' Compensation Act (Act)).

¶ 8 We review an ALJ's legal conclusions on summary judgment de novo. *See A.C. Excavating v. Yacht Club II Homeowners Ass'n*, 114 P.3d 862, 865 (Colo. 2005).

B. Governing Law and Review Standard

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

¶ 10 We review statutory construction de novo. *Ray v. Indus. Claim Appeals Office*, 124 P.3d 891, 893 (Colo. App. 2005), *aff'd*, 145 P.3d 661 (Colo. 2006). Although we give deference to the Panel's reasonable interpretations of the statute it administers, *Sanco Indus. v. Stefanski*, 147 P.3d 5, 8 (Colo. 2006), we are not bound by

the Panel's interpretation. *Olivas-Soto v. Indus. Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006). In general, though, "an administrative agency's interpretation of its own regulations is . . . entitled to great weight and should not be disturbed on review unless plainly erroneous or inconsistent with such regulations." *Jiminez v. Indus. Claim Appeals Office*, 51 P.3d 1090, 1093 (Colo. App. 2002).

C. Reopening Cannot Be Based on Change of Condition Absent a Finding or Admission of Compensability

¶ 11 The Act permits reopening a claim in the following circumstances: "At any time within six years after the date of injury, the director or an [ALJ] may, after notice to all parties, review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition." § 8-43-303. Claimant correctly points out that no language in the statute expressly limits reopenings based on a changed condition to claims already found to be compensable.

¶ 12 But, an express statement by the legislature is not necessary here because the construction claimant advances would produce an illogical result. *See People v. Cross*, 127 P.3d 71, 74 (Colo. 2006)

Reopening based on a change in condition "does not permit relitigation of every potential issue because the question is restricted to the 'extent of improvement or worsening of the injury on which the original award was based'; 'neither party can raise original issues such as work-connection, employee or employer status, occurrence of a compensable accident, and degree of disability at the time of the first award.'" *City & Cty. of Denver v. Indus. Claim Appeals Office*, 58 P.3d 1162, 1164 (Colo. App. 2002) (quoting 8 *Larson's Workers' Compensation Law* § 131.03(2)(a) (2001)). Rather, causation here is "limited to whether there is a change in the claimant's physical or mental condition that can be causally connected to the original compensable injury." *Id.* Thus, in order for an ALJ to assess whether a claimant's condition has *changed*, one must start with a compensable condition.

¶ 13 Relying on *City & County of Denver* and discerning the legislature's intent, the Panel concluded that a claimant whose claim had not been adjudicated compensable cannot seek to reopen based on a change in condition. Because this interpretation is neither plainly erroneous nor inconsistent with the legislature's

intent, we perceive no reason to reject it. *See Jiminez*, 51 P.3d at 1093; *Support, Inc.*, 968 P.2d at 175.

¶ 14 Here, the record shows employer never admitted compensability and no order ever found claimant's claim compensable. Rather, employer contested the relatedness of claimant's injury and the claim was later closed because of claimant's failure to prosecute it. An admission or finding of compensability is generally a prerequisite for continued receipt of benefits. *See, e.g., Snyder v. Indus. Claim Appeals Office*, 942 P.2d 1337, 1340 (Colo. App. 1997) (where the employer filed admission of liability, it could not unilaterally stop benefits payments unless and until ALJ issued order finding claim non-compensable). Because there is no compensability finding here, claimant would have to establish threshold causality before he could receive any benefits. *See Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000). But, as noted above, claimant cannot "raise original issues such as work-connection" on reopening. *City & Cty. of Denver*, 58 P.3d at 1164.

¶ 15 Accordingly, we conclude that the Panel did not err in holding that claimant could not reopen his claim based on a change in condition. *Id.*

III. Constitutional Claims

¶ 16 Claimant next contends that his rights to equal protection and due process under the law were violated when he was barred from reopening based on a change in medical condition. Specifically, he argues that he is being treated differently from litigants seeking to reopen workers' compensation claims based on mistake or fraud. As we understand his argument, claimant contends that other claimants whose claims have not been admitted or adjudicated compensable may seek to reopen based on mistake or fraud, but he — who seeks to reopen such a claim for a change in condition — is prohibited from reopening. We conclude that no equal protection or due process violation occurred.

A. Governing Law and Review Standard

¶ 17 Colorado courts have repeatedly held that workers' compensation claimants are not a suspect class and that workers' compensation benefits are not a fundamental right. *See Dillard v.*

Indus. Claim Appeals Office, 134 P.3d 407, 413 (Colo. 2006). "The rational basis test therefore applies to equal protection challenges in the workers' compensation context, and claimant's constitutional challenge should be assessed under that standard." *Sanchez v. Indus. Claim Appeals Office*, 2017 COA 71, ¶ 20; *see also Mathews v. Eldridge*, 424 U.S. 319 (1976).

¶ 18 "[B]ecause neither an ALJ nor the Panel is authorized to address constitutional challenges to the Act, such challenges can be raised for the first time on appeal." *United Airlines v. Indus. Claim Appeals Office*, 2013 COA 48, ¶ 27. "This court has initial jurisdiction to address constitutional challenges to the [Act]." *Zerba v. Dillon Cos.*, 2012 COA 78, ¶ 8. Our review of these contentions is, therefore, also de novo. *See, e.g.*, *People v. Lovato*, 2014 COA 113, ¶ 12 ("We review the constitutionality of a statute, both facially and as applied, de novo.").

B. No Equal Protection or Due Process Violation

¶ 19 Claimant's equal protection challenge rests on the presumption that he is similarly situated to all other claimants seeking to reopen a claim that was never found to be compensable.

He is not. "The threshold question in an equal protection challenge is whether the legislation results in dissimilar treatment of similarly situated individuals. To violate equal protection provisions, the classification must arbitrarily single out a group of persons for disparate treatment from that of other persons who are similarly situated." *Pepper*, 131 P.3d at 1140. Claimant seeks to create a broad category of all litigants seeking to reopen claims that were never adjudicated compensable. However, he is not similarly situated to litigants seeking to reopen based on fraud or mistake. These grounds for reopening are separate and distinct from a change in condition, which claimant alleged. Because claimant cannot establish that he is similarly situated to these other litigants, he cannot meet the threshold burden of an equal protection claim. *Id.*

¶ 20 To the extent claimant also asserts that his procedural due process rights were violated, we also reject that contention. "The fundamental requisites of due process are notice and the opportunity to be heard by an impartial tribunal." *Wecker v. TBL Excavating, Inc.*, 908 P.2d 1186, 1188 (Colo. App. 1995). "The

essence of procedural due process is fundamental fairness." *Avalanche Indus., Inc. v. Indus. Claim Appeals Office*, 166 P.3d 147, 150 (Colo. App. 2007), *aff'd sub nom. Avalanche Indus., Inc. v. Clark*, 198 P.3d 589 (Colo. 2008); *see also Kuhndog, Inc. v. Indus. Claim Appeals Office*, 207 P.3d 949, 950 (Colo. App. 2009).

¶ 21 The record establishes that the ALJ and the Division complied with the fundamental requisites of procedural due process: (1) claimant was notified that a hearing had been scheduled on his sixth application for hearing; (2) claimant received employer's pre-hearing motion for summary judgment; and, (3) the ALJ received and considered claimant's response to the motion. The fact that the ALJ granted employer's motion for summary judgment and vacated the hearing does not establish, or even suggest, that claimant was denied any of the requisites of procedural due process.

¶ 22 Accordingly, we conclude that neither claimant's right to equal protection nor his right to due process was violated here. *See Wecker*, 908 P.2d at 1188.

IV. Conclusion

¶ 23 The order is affirmed.

JUDGE TAUBMAN AND JUDGE TERRY concur.

ADVANCE SHEET HEADNOTE
November 5, 2018

2018 CO 87

No. 18SA135, Schultz v. GEICO Casualty Company – Insurance – Bad Faith – § 10-3-1115, C.R.S. (2018) – Fair Debatability – C.R.C.P. 35 – Independent Medical Exams.

In this original proceeding pursuant to C.A.R. 21, the supreme court reviews the district court's order requiring the plaintiff-petitioner to undergo an independent medical examination ("IME"), pursuant to C.R.C.P. 35, at the request of the defendant-respondent. The court issued a rule to show cause and now makes the rule absolute.

In this case, the plaintiff, who was insured by the defendant, alleged that the defendant insurance company breached its duty of good faith and fair dealing and violated its statutory obligation to evaluate and pay her insurance claim without unreasonable delay. The defendant denied liability, asserting that because the question of medical causation was "fairly debatable" at the time it made its coverage decision, it did not act unreasonably or in bad faith. To establish these defenses, the defendant sought an IME of the plaintiff, and over the plaintiff's objection, the district court granted that request.

The court now concludes that the defendant's conduct must be evaluated based on the evidence before it when it made its coverage decision and that, therefore, the defendant is not entitled to create new evidence in order to try to support its earlier coverage decision. Accordingly, the court further concludes that the district court abused its discretion when it ordered the plaintiff to undergo an IME over three years after the original accident that precipitated this case and a year and a half after the defendant had made the coverage decision at issue.

The court therefore makes the rule to show cause absolute.

The Supreme Court of the State of Colorado
2 East 14th Avenue • Denver, Colorado 80203

2018 CO 87

Supreme Court Case No. 18SA135
Original Proceeding Pursuant to C.A.R. 21
Weld County District Court Case No. 17CV30881
Honorable Marcelo Kopcow, Judge

In Re
Plaintiff:
Charissa Schultz

v.

Defendant:
GEICO Casualty Company.

Rule Made Absolute
en banc
November 5, 2018

Attorneys for Plaintiff:
Speights & Worrich, LLC
David Roth
Jennifer A. Milne
Denver, Colorado

Attorneys for Defendant:
Deisch, Marion & Klaus, P.C.
Gregory K. Falls
Denver, Colorado

JUSTICE GABRIEL delivered the Opinion of the Court.

¶1 In this original proceeding pursuant to C.A.R. 21, we review the district court's order requiring the plaintiff-petitioner, Charissa Schultz, to undergo an independent medical examination ("IME"), pursuant to C.R.C.P. 35, at the request of the defendant-respondent GEICO Casualty Company. We issued a rule to show cause and now make the rule absolute.

¶2 In this action, Schultz alleges that GEICO breached its duty of good faith and fair dealing and violated its statutory obligation to evaluate and pay her insurance claim without unreasonable delay. GEICO denies liability, asserting that because the question of medical causation was "fairly debatable" at the time it made its coverage decision, it did not act unreasonably or in bad faith. To establish these defenses, GEICO sought an IME of Schultz, and over Schultz's objection, the district court granted that request.

¶3 We now conclude that GEICO's conduct must be evaluated based on the evidence before it when it made its coverage decision and that, therefore, GEICO is not entitled to create new evidence in order to try to support its earlier coverage decision. Accordingly, we further conclude that the district court abused its discretion when it ordered Schultz to undergo an IME over three years after the original accident that precipitated this case and a year and a half after GEICO had made the coverage decision at issue.

I. Facts and Procedural Background

¶4 In February 2015, Schultz and another driver collided when the other driver failed to stop at a stop sign. Thereafter, Schultz underwent multiple knee replacement surgeries.

¶5 The other driver's insurance company settled with Schultz for its $25,000 policy limit, and Schultz then made a demand for uninsured/underinsured motorist ("UM/UIM") benefits under her GEICO policy, which also had a $25,000 policy limit. In connection with this demand, Schultz provided GEICO with medical authorizations to allow it to obtain the medical records associated with her claim.

¶6 In April 2017, after months of correspondence and apparent review of an MRI performed on Schultz in April 2015, GEICO offered Schultz its full policy limit, and it did so without requesting that she undergo an IME. Indeed, GEICO's claim logs reveal that at the time GEICO decided to offer Schultz its policy limits, it "concede[d] peer review wouldn't be necessary," indicating an affirmative decision not to request an IME.

¶7 A few months later, Schultz filed the present lawsuit asserting claims for bad faith breach of an insurance contract and, pursuant to sections 10-3-1115 and 10-3-1116, C.R.S. (2018), unreasonable delay in the payment of covered benefits. GEICO denied liability, disputing the extent and cause of Schultz's claimed injuries and asserting that causation surrounding the knee replacement surgeries was "fairly debatable" because Schultz had preexisting arthritis, which GEICO claimed may independently have necessitated her surgeries.

¶8 As part of its effort to support these defenses, GEICO requested that Schultz undergo a medical examination pursuant to C.R.C.P. 35. Schultz objected, arguing that C.R.C.P. 35 was inapplicable because her physical condition was no longer in controversy. The parties attended a hearing before the district court to resolve this question.

¶9 At the hearing, GEICO contended that it had decided to pay Schultz's UM/UIM claim even though it had recognized that the question of causation was unresolved. In light of Schultz's current claims, however, GEICO argued that causation was again a live issue because "[y]ou can't delay a benefit that was never owed." GEICO thus asserted that it was entitled to explore the causation issue through, among other means, an IME of Schultz. Schultz disagreed, asserting that the reasonableness of GEICO's conduct had to be evaluated based on the information that GEICO had at the time it evaluated her claim. The district court ultimately agreed with GEICO and ordered Schultz to undergo the C.R.C.P. 35 examination.

¶10 Schultz then filed a petition for a rule to show cause pursuant to C.A.R. 21, which we granted.

II. Analysis

¶11 We begin by discussing our jurisdiction to hear this matter. We then address the legal framework for claims that an insurer has unreasonably and in bad faith delayed payment to a policy holder. Finally, we consider whether GEICO is entitled to obtain an IME of Schultz long after it made its coverage decision.

A. Jurisdiction

¶12 Although discovery issues generally fall within the discretion of the district court and the appropriate mechanism for reviewing such decisions is by appeal rather than by original proceeding,

> [w]hen . . . a procedural ruling may significantly affect a party's ability to litigate the merits of a case and may cause damage to a party that cannot be

> cured on appeal, it is appropriate to challenge a trial court's order relating to matters of pretrial discovery by way of an original proceeding.

Belle Bonfils Mem'l Blood Ctr. v. Dist. Court, 763 P.2d 1003, 1013 (Colo. 1988). In addition, we may exercise our discretion under C.A.R. 21 to consider "issues of significant public importance that we have not yet considered." *Wesp v. Everson*, 33 P.3d 191, 194 (Colo. 2001).

¶13 Here, the district court ordered Schultz to undergo a medical examination against her will, and this decision implicates her privacy interests in her body and her health. *See Doe v. High-Tech Inst., Inc.*, 972 P.2d 1060, 1068 (Colo. App. 1998) (noting "a generally recognized privacy interest in a person's body," as well as a "generally recognized privacy interest in information concerning one's health"). Because a violation of these interests could not adequately be remedied on appeal, we invoke our original jurisdiction pursuant to C.A.R. 21 to review the trial court's order. *See Ortega v. Colo. Permanente Med. Group, P.C.*, 265 P.3d 444, 447 (Colo. 2011) (invoking our C.A.R. 21 jurisdiction when the enforcement of the order at issue would have resulted in the disclosure of a party's medical records and such disclosure, if erroneous, could not properly have been remedied on appeal).

B. Claims for the Unreasonable Delay or Denial of Benefits

¶14 Due to the significant disparity in bargaining power between an insurer and its insured, we have recognized the special nature of insurance contracts and of the relationship between an insurer and its insured, and we have concluded that in addition to liability for breach of contract, an insurer's bad faith breach of an insurance contract

also gives rise to tort liability. *See Nunn v. Mid-Century Ins. Co.*, 244 P.3d 116, 119 (Colo. 2010). Thus, an insured may bring a claim asserting that its insurer, acting in bad faith, has unreasonably refused or delayed payment on a claim. *Goodson v. Am. Standard Ins. Co.*, 89 P.3d 409, 414 (Colo. 2004).

¶15 To prevail on such a claim, the insured "must establish that the insurer acted unreasonably and with knowledge of or reckless disregard for the fact that no reasonable basis existed for denying the claim." *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1274 (Colo. 1985). The reasonableness of the insurer's conduct is determined objectively and is "based on proof of industry standards." *Goodson*, 89 P.3d at 415. Moreover, we have observed that "[a]n insurer's decision to deny benefits to its insured must be evaluated based on the information before the insurer at the time of that decision." *State Farm Mut. Auto. Ins. Co. v. Reyher*, 266 P.3d 383, 390 (Colo. 2011) (quoting *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 970 (Colo. App. 1996), *aff'd*, 955 P.2d 1008 (Colo. 1998)). Thus, in defending against a bad faith claim by attempting to show that it acted reasonably, an insurer may present all of the information that it considered at the time it made the decision to delay or deny the claim. *Id.*

¶16 In addition to the above-described common law bad faith claim, the Colorado General Assembly has provided a statutory remedy against insurance companies that unreasonably delay or deny benefits owed.

¶17 Section 10-3-1115 provides, in pertinent part:

> (1)(a) A person engaged in the business of insurance shall not unreasonably delay or deny payment of a claim for benefits owed to or on behalf of any first-party claimant.

. . . .

> (2) . . . for the purposes of an action brought pursuant to this section and section 10-3-1116, an insurer's delay or denial was unreasonable if the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action.

¶18 Section 10-3-1116(1), in turn, provides that a first-party claimant whose claim for benefits has been unreasonably delayed or denied may bring an action "to recover reasonable attorney fees and court costs and two times the covered benefit" from an insurance company responsible for the unreasonable delay or denial.

¶19 Although this court does not appear to have addressed the issue, decisions of both the Colorado Court of Appeals and federal courts interpreting Colorado law have consistently recognized that proof of a statutory claim differs from proof of a common law claim. Specifically, these courts have noted that whereas a common law claim requires proof that the insurer acted unreasonably and that it knew or recklessly disregarded the fact that its conduct was unreasonable, "the only element at issue in the statutory claim is whether an insurer denied benefits without a reasonable basis." *Vaccaro v. Am. Family Ins. Grp.*, 2012 COA 9M, ¶¶ 21, 44, 275 P.3d 750, 756, 760; *accord Baker v. Allied Prop. & Cas. Ins. Co.*, 939 F. Supp. 2d 1091, 1107 (D. Colo. 2013); *see also Kisselman v. Am. Family Mut. Ins. Co.*, 292 P.3d 964, 975 (Colo. App. 2011) (noting that the insured's burden of proving a statutory claim is "less onerous" than his or her burden of proving a common law claim).

¶20 In this case, GEICO denies that it acted in bad faith and asserts that it acted reasonably because the issue of coverage was "fairly debatable," given that the adjuster

had identified questions about the cause of Schultz's knee replacements from the outset of the evaluation of her claim. "Fair debatability" is a factor in determining whether an insurer acted reasonably. *Sanderson v. Am. Family Mut. Ins. Co.*, 251 P.3d 1213, 1217 (Colo. App. 2010). "[I]f a reasonable person would find that the insurer's justification for denying or delaying payment of a claim was 'fairly debatable,' this weighs against a finding that the insurer acted unreasonably." *Vaccaro*, ¶ 42, 275 P.3d at 759. Fair debatability, however, "is not a threshold inquiry that is outcome determinative as a matter of law, nor is it both the beginning and the end of the analysis in a bad faith case." *Sanderson*, 251 P.3d at 1218.

¶21 Having described the elements of the claims at issue, as well as GEICO's pertinent defense thereto, we turn to the question of whether the district court erred in ordering Schultz to undergo the IME that GEICO had requested.

C. The Requested IME

¶22 In *Reyher*, 266 P.3d at 390, we observed that the reasonableness of an insurance company's decision to deny benefits is to be evaluated based on the information before the insurer at the time it made its decision. Divisions of our court of appeals and of other federal and state courts appear to have consistently reached the same conclusion. *See, e.g., Fireman's Fund Ins. Cos. v. Alaskan Pride P'ship*, 106 F.3d 1465, 1470 (9th Cir. 1997) ("The bad faith claim required the jury to determine whether Insurer's denial of coverage was unreasonable when it occurred, not whether later developments could have vindicated the Insurer's decision."); *Austero v. Nat'l Cas. Co.*, 148 Cal. Rptr. 653, 673 (Cal. Ct. App. 1978) ("In evaluating the evidence to see if there was any unreasonable conduct

by the Company, it is essential that no hindsight test be applied. The reasonable or unreasonable action by the Company must be measured as of the time it was confronted with a factual situation to which it was called upon to respond."), *disapproved on other grounds by Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 149 n.7 (Cal. 1979); *Peiffer*, 940 P.2d at 970 ("An insurer's decision to deny benefits to its insured must be evaluated based on the information before the insurer at the time of that decision."); *Southgate Bank v. Fid. & Deposit Co.*, 794 P.2d 310, 316 (Kan. Ct. App. 1990) ("Whether just cause exists is to be determined by the circumstances facing the insurer when payment is denied, judged as they would appear to a reasonably prudent person having a duty to investigate in good faith."); *Buzzard v. Farmers Ins. Co.*, 824 P.2d 1105, 1109, 1114 (Okla. 1991) (noting that "[t]he knowledge and belief of the insurer during the time period the claim is being reviewed is the focus of a bad-faith claim" and that therefore, the insurer-defendant could not rely on information that it obtained after it denied the claim).

¶23 We perceive no basis to depart from this well-established principle, and, thus, we reaffirm that the reasonableness of an insurer's decision to deny or delay benefits to its insured must be evaluated based on the information that was before the insurer at the time it made its coverage decision. The question thus becomes whether GEICO's requested IME could provide information that is somehow relevant to the decision that it made over a year ago to pay Schultz the limits of her UM/UIM coverage. For two reasons, we conclude that it cannot.

¶24 First, GEICO has not shown, and we perceive no basis on which to conclude, that newly developed medical evidence would be pertinent to the question of what GEICO

knew when it made its coverage decision in this case. As the Ninth Circuit observed in *Fireman's Fund*, 106 F.3d at 1470, a bad faith claim requires an assessment of whether the insurer's coverage decision was unreasonable when it occurred, "not whether later developments could have vindicated the Insurer's decision." *See also Buzzard*, 824 P.2d at 1114 (noting that an insurer could not defend against a bad faith claim by relying on information that it obtained after it denied that claim).

¶25 Second, GEICO has not explained, nor can we discern from the record before us, how the state of Schultz's medical condition today would be relevant to her medical condition over a year ago, when GEICO made its coverage decision.

¶26 Accordingly, on the record facts now before us, we conclude that the district court abused its discretion in ordering Schultz to undergo the IME that GEICO had requested.

¶27 In so concluding, we are not persuaded by GEICO's reliance on *Peiffer*, 940 P.2d at 969–71. Like this case, *Peiffer* involved a car accident and a subsequent first-party dispute between an insurance company and its insured. *Id.* at 969. There, the insurer paid its insured for various treatments and therapies, as well as for wage loss and services, before requesting a series of IMEs of the insured. *Id.* Based on the results of these IMEs, the insurer advised its insured that except for one type of therapy, it would no longer pay for any of the insured's treatments. *Id.* The insured then sued for breach of contract and bad faith breach of an insurance policy. *Id.* The case proceeded to trial, where the insurer attempted to introduce testimony from the doctors who performed the IMEs, as well as from a neuropsychologist who had examined the insured's medical records *after* the litigation had commenced. *Id.* at 970. The trial court excluded this proffered evidence as

irrelevant, but a division of the court of appeals reversed, concluding that such evidence was relevant to the reasonableness of the denial of the insured's claim. *Id.* at 970–71.

¶28 GEICO relies heavily on the *Peiffer* division's decision to admit the testimony of the neuropsychologist even though he had not reviewed the pertinent records until after the insurer had made its coverage decision. The circumstances there, however, are different from those now before us. In *Peiffer*, the insurer sought to introduce testimony from an expert witness who had evaluated the medical records that the insurer had obtained *before* it made its coverage decision. *Id.* at 970. Thus, the insurer was not seeking to create new evidence to justify a previous benefits decision. *Id.* Rather, it was seeking to introduce an expert's opinion on evidence that existed *before* the insurer made its decision. *Id.* Here, in contrast, GEICO seeks a *new* medical examination, with the apparent intention of introducing such post-coverage-decision evidence to establish the reasonableness of its earlier coverage decision. For the reasons set forth above, we conclude that it cannot do so.

III. Conclusion

¶29 For these reasons, we conclude that GEICO's conduct must be evaluated based on the evidence before it when it made its coverage decision in Schultz's case and that, therefore, GEICO is not entitled to create new evidence in order to try to support its earlier coverage decision. Accordingly, we further conclude that the district court abused its discretion when it ordered Schultz to undergo the C.R.C.P. 35 examination that GEICO had requested.

¶30 We thus make the rule to show cause absolute.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-044-948-01

IN THE MATTER OF THE CLAIM OF:

KAREN BELL,

Claimant,

v.

FINAL ORDER

CHRISTIANSON CELLARS LLC
d/b/a CANYON WIND CELLARS,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Sidanycz (ALJ) dated May 1, 2018, that ordered the Respondents to reimburse the claimant for out of pocket payment for physical therapy; out of pocket payment for dental treatment; and temporary total disability (TTD) from August 1, 2016 through November 1, 2017. We affirm the order of the ALJ.

The claimant was employed on a part-time basis as an in-house accountant. In addition, the claimant also assisted with pouring wine in the employer's tasting room and at special events.

On June 6, 2016, the claimant was involved in a motor vehicle accident (MVA) while returning from the bank for the employer. The respondents admitted liability for the injuries sustained in the accident. The claimant believed that her neck and low back were injured. Initial diagnostic tests of the cervical and lumbar spines showed no acute changes or fractures. However, there was evidence of arthritic changes and narrowing of the neural canal at the lower four lumbar levels.

Throughout this claim, the designated medical provider (ATP) has been Work Partners. At Work Partners, the claimant was primarily seen by Ms. Herrera, a physician's assistant (PA), and on one occasion was seen by Dr. Marbas. During the course of active treatment, PA Herrera referred the clamant for exercise treatment,

massage therapy at Work Partners as well as physical therapy (PT) with Sean Richardson at Fyzical Therapy. The physical therapy began with Mr. Richardson on August 18, 2016.

The claimant continued to work following the MVA although her pain made it necessary to get up and walk or stretch every 30 minutes while at work. The employer accommodated the claimant in doing so.

PA Herrera (with the agreement of Dr. Marbas) placed the claimant at maximum medical improvement (MMI) on November 8, 2016 with a finding of no permanent medical impairment and no work restrictions. Maintenance medical treatment was recommended of six additional PT visits with Mr. Richardson over the following six months.

The claimant testified that soon after the finding of MMI, a piece of one of her teeth "came off." Coincidentally, the claimant was already scheduled for a normal dental check-up with her dentist, Dr. Stein, on November 15, 2016. The claimant waited for the appointment to have Dr. Stein address the broken tooth. Upon dental evaluation, x-rays showed fractures in the claimant's #5 and #20 teeth. Dr. Stein opined that the MVA caused these fractures. Dr. Stein noted that shortly before the MVA, the claimant had been seen by the dentist and at that time the two teeth in question were not fractured. Further, Dr. Stein opined that for these fractures to occur the teeth would have to sustain a "sharp trauma." The claimant thereafter underwent dental treatment that included a crown restoration and dental implants for the damaged teeth. The claimant paid out of pocket for this dental treatment.

On May 1, 2017, the respondents filed a final admission of liability (FAL) admitting for the MMI date of November 8, 2016, with no impairment rating, and admitting for reasonable and necessary post-MMI medical treatment and/or medication. The claimant contested the FAL and requested a Division-sponsored independent medical examination (DIME). The DIME took place on July 25, 2017 with Dr. McLaughlin. The DIME physician opined that the MVA aggravated the claimant's preexisting back condition and such condition was not at MMI. Dr. McLaughlin also opined that the dental fractures were likely caused by the MVA. The respondents filed a general admission of liability (GAL) on September 15, 2017 acknowledging that the claimant was not at MMI and admitting for additional medical benefits.

The claimant was returned to Work Partners for further treatment and was seen by a new physician, Dr. Fay, on November 2, 2017. Dr. Fay agreed with the DIME

physician that the claimant was not at MMI and that the dental issues were related to the injury. Dr. Fay assigned work restrictions that included working no more than four hours per day, sitting and standing as tolerated, and no lifting, carrying, pushing, or pulling over 15 pounds. An MRI was ordered for the lumbar spine and the claimant was referred back to Mr. Richardson for PT. Dr. Fay also referred the claimant to Dr. Stein for treatment of her fractured teeth.

Following Dr. Fay's evaluation, the respondents filed an amended GAL on November 14, 2017 admitting for TTD benefits beginning on November 2, 2017.

The claimant returned to Dr. Fay on November 27, 2017, and reported aching, sharp, and stabbing pain in her low back that was aggravated by sitting, standing, and riding in a car. The claimant reported that her pain level was getting worse. Dr. Fay referred the claimant to Dr. Clifford for an orthopedic consultation.

Dr. Clifford evaluated the claimant on December 27, 2017 and noted that despite PT, the claimant had significant debilitating symptoms with pain radiating down the right thigh into the lateral calf and foot. Dr. Clifford diagnosed grade 1 spondylolisthesis at L4-5 and grade 2 spondylolisthesis at L5-S1 as well as L4-5 stenosis. Transforaminal epidural steroid injections were performed on January 11, 2018.

The ALJ noted that between the original date of MMI, November 8, 2016, and returning to Work Partners on November 2, 2017, Work Partners refused to schedule any appointment because the claim was "closed." As a result, the claimant was unable to obtain a referral for additional PT. Nonetheless, the claimant continued PT with Mr. Richardson and self-paid for the treatment. The claimant testified that she continued PT because her back pain was increasing. In addition to the recommended maintenance treatment of six post-MMI sessions of PT, the claimant was also seen at Fyzical Therapy between April 25, 2017 and October 31, 2017. As these visits were self-paid, the claimant requested reimbursement for these visits at the hearing.

At the request of the respondents the claimant underwent a medical examination (IME) with Dr. Hattem on February 21, 2018. In his report, Dr. Hattem concluded that the claimant had again reached MMI on February 21, 2018 and that the cervical spine injury was a sprain that had resolved by August 4, 2016. Dr. Hattem only assessed the lumbar spine for a permanent impairment rating and assigned a 15% whole person impairment. He also recommended permanent work restrictions of "light level of work" with the ability to sit, stand, and stretch for five minutes every hour, and to avoid

repetitive bending or twisting at the waist. Dr. Hattem did not address the causation of the claimant's dental issues.

In August 2016, the employer sold the business and the claimant's employment ended. She has not returned to work since that time and believes she is unable to work because of the effects of the MVA. Specifically, she asserts that she is unable to sit for more than 20 or 30 minutes and unable to stand for more than 20 to 30 minutes. She relates that her injuries have negatively impacted her daily living. For example, she contends that she is unable to cook like she did previously, an activity she enjoyed. Similarly she testified that she is unable to complete housekeeping tasks. She also has lost the ability to perform former hobbies such as kayaking and off-road 4-wheeling.

The ALJ credited the testimony of the claimant, the medical records, and the opinion of Dr. Fay and found that the claimant showed that it is more likely than not that the PT that the claimant received between April 25, 2017 and October 31, 2017 was reasonable medical treatment necessary to cure and relieve the claimant from the effects of the work injury. Further the ALJ credited the claimant's testimony, the dental records, and the opinions of Drs. Stein, McLaughlin, and Fay and found that the claimant showed that it is more likely than not that the claimant's #5 and #20 teeth were fractured in the MVA. The ALJ found that the dental treatment performed by Dr. Stein was reasonable medical treatment necessary to cure and relieve the claimant from the effects of the work injury. The ALJ found that the claimant has demonstrated that the dental treatment is authorized medical care.

The ALJ also credited the claimant's testimony and the medical records and found that the claimant has demonstrated that she suffered a wage loss from August 1, 2016 (when her employment ended) through November 1, 2017 (the date the respondents voluntarily instituted TTD benefits). The ALJ held that although PA Herrera released the claimant to "full duty," it was undisputed that the claimant's work for the employer was sedentary and the claimant was able to make accommodations to continue her employment with the employer following the MVA.

The ALJ ordered the respondents to reimburse the claimant for her out-of-pocket payment for physical therapy between April 25 and October 31, 2017; for her out-of-pocket payment for dental treatment with Dr. Stein; and TTD benefits from August 1, 2016 and November 1, 2017.

On appeal, the respondents do not challenge the ALJ's order regarding the payment of TTD benefits as described above. The respondents challenge whether the

ALJ made sufficient findings to support her determination that the PT the claimant received between April 25, 2017 and October 31, 2017 was authorized and whether the ALJ made sufficient findings to support her determination that Dr. Stein's treatment prior to November 2, 2017, was authorized. Secondly, the respondents challenge whether substantial evidence in the record supports the ALJ's findings of fact regarding the same PT and dental authorizations. Thirdly, the respondents challenge whether the findings of fact support the order regarding the PT and dental authorizations. Lastly, the respondents challenge whether the award of benefits is supported by the applicable law, again limiting their objections to the PT and dental authorizations only.

I. Authorization of physical therapy with Mr. Richardson

The respondents primarily contend that the ALJ's order does not comport with § 8-43-404(10), C.R.S., which states, in pertinent part:

> (a) If an authorized physician refuses to provide medical treatment to an injured employee or discharges an injured employee from medical care for nonmedical reasons when the injured employee requires medical treatment to cure or relieve the effects of the work injury, then the physician shall, within three business days from the refusal or discharge, provide written notice of the refusal or discharge by certified mail, return receipt requested, to the injured employee and the insurer or self-insured or self-insured employer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured employee's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured employee. The director or any administrative law judge of the office of administrative courts has jurisdiction to resolve disputes regarding whether a refusal to provide medical treatment or a discharge from medical care was for medical or nonmedical reasons.
>
> (b) If the insurer or self-insured employer receives written notice pursuant to paragraph (a) of this subsection (10), or if the insurer or self-insured employer and the authorized treating physician receive written notice by certified mail, return receipt requested, from the injured employee or the injured employee's legal representative that an authorized

> physician refused to provide medical treatment to the injured employee or discharged the injured employee from medical care for nonmedical reasons when such injured employee requires medical treatment to cure or relieve the effects of the work injury, and there is no other authorized physician willing to provide medical treatment, then the insurer or self-insured employer shall, within fifteen calendar days from the receiving the written notice, designate a new authorized physician willing to provide medical treatment. If the insurer or self-insured employer fails to designate a new physician pursuant to this paragraph (b), then the injured employee may select the physician who attends to the injured employee.

The respondents contend that they were not notified of Work Partners refusal to treat "for non-medical reasons" and thus were not afforded an opportunity to select a replacement physician; correspondingly the claimant was not entitled to change physicians without procuring authorization of the respondents or an ALJ. Respondents state that without notice of the refusal to treat, "it is error to conclude that the right of selection passed to the claimant." The argument is inapposite to the circumstances here. The claimant did not seek to obtain PT services from an unauthorized provider; she rather sought to continue with treatment from her authorized PT provider but such was denied by Work Partners due to their discharge from treatment. We agree with the claimant that with Mr. Richardson's authorized status, the only question remaining is whether the treatment that was afforded to the claimant from April 25, 2017 through October 31, 2017, was reasonable, necessary, and related to the injury.

We do not view the issue as a right of selection issue. Subsection 8-43-404(9), C.R.S., states: "A claimant shall not be liable for payment for treatment by the [authorized] provider under this subsection (9) if the treatment is reasonably needed and related to the injury." (Unstated word added.) Respondents do not contest that Mr. Richardson at Fyzical Therapy was an authorized provider of physical therapy. Nor has the respondents challenged the reasonableness, necessity, or relatedness of the physical therapy. An unchallenged DIME opinion indicated that the claimant had not reached MMI when Work Partners discharged her from further treatment with their facility. The DIME physician also extolled the physical therapy provided by Mr. Richardson during the time that the MMI finding was in dispute, as improving the claimant's range of motion. Dr. McLaughlin stated, "I attribute this to her independent exercise program and the continued physical therapy with Sean Richardson." Clt.'s Exhibit 4 at 9. It is a reasonable inference—even if not iterated by the ALJ—to conclude that the physical

therapy provided by Mr. Richardson after the prescribed maintenance visits were exhausted was reasonable, necessary, and related to the injury in that it actually had measurable benefit to the claimant's condition.

The respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of the industrial injury. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). "Authorization" refers to the provider's legal status to treat the injury at the respondents' expense. *Popke v. Industrial Claim Appeals Office*, 944 P.2d 677 (Colo. App. 1997). Whether or not a provider is an authorized treating provider is generally a question of fact for the ALJ which must be upheld if supported by substantial evidence in the record. *See Blue Mesa Forest v. Lopez*, 928 P.2d 831 (Colo. App. 1996); *Popke v. Industrial Claim Appeals Office, supra*. Substantial evidence is probative evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory testimony or contrary inferences. *See F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

Thus, contrary to the respondents' arguments, the ALJ did not hold that the right of provider selection passed to the claimant as it regards physical therapy. Rather, it was found that the physical therapy provided by the *authorized* provider was reasonable, necessary, and related to the injury and was approved, in retrospect, by the DIME physician. The ALJ is not held to a crystalline standard in articulating her findings of fact and we may consider findings that are necessarily implied by the ALJ's order. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). We perceive no error in the ALJ's determination.

II. Authorization of dental treatment with Dr. Stein

The claimant only became aware of her cracked teeth when one of her teeth "slabbed off on the crown," a short time after being placed at MMI. Soon thereafter, she saw her dentist, Dr. Stein, for a regularly scheduled dental checkup and was informed that she had two fractured teeth and that the fractures were caused by the work related MVA. Hearing Tr. at 11, 12. After the dispute regarding MMI was resolved by the DIME physician, the new authorized treating physician at Work Partners, Dr. Fay, referred the claimant to Dr. Stein for dental care. However, by the time of the referral, most if not all of the dental treatment had been performed and paid for by the claimant.

When the claimant became aware of the compensable nature of the teeth fractures, she attempted to make an appointment with PA Herrera to discuss what her dentist said but was told the PA would not see her. The claimant also called the Pinnacol claims adjuster, Scott Guthrie, to report the dental findings. The claimant testified that "he [Guthrie] asked that the dentist send all the records to him and they would look at them. And then a few days later … he called me back to tell me that they were not going to cover my dental." Hearing Tr. at 17, 18. This testimony was unrebutted and was credited by the ALJ.

Respondents again argue that the authorized provider did not provide notice that they were refusing to treat the claimant's dental condition, thus precluding the claimant from selecting the dentist to treat her. However, in this instance, the claimant provided actual notice to the insurer of her dental injuries and the relatedness of the injuries to the MVA. Human experience suggests that the breakage and sloughing of teeth is an emergent dental situation requiring immediate remediation. The ATP refused to meet with or talk to the claimant about the dental condition. The ATP failed to notify the insurer that they were refusing to provide the claimant with dental treatment or a referral for treatment. The insurer was provided actual notice of the above. The claimant requested dental care directly from the claims adjuster, but such was refused. Upon notice that the claimant was claiming a dental injury, the claims adjuster had an opportunity to direct the claimant to a dentist as an authorized provider. Whether or not the dental condition was emergent or not, the claims adjuster instead denied the dental claim and any referral to a dentist.

Rule 8-3, W.C. Rules of Procedure (WCRP), 7 Code Colo. Reg. 1101-3, makes specific provision for emergency situations. Rule 8-3 provides that in an emergency situation the injured worker shall be taken to any physician or medical facility that is able to provide the necessary care. Rule 8-3 further provides that when emergency care is no longer required the usual provisions relating to the employer's right in the first instance to select the medical care provider apply. In *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990), the court held that in cases of medical emergency the claimant need not seek authorization from the employer or insurer before obtaining medical treatment from an unauthorized provider. The question of whether a bona fide emergency exists is one of fact and is dependent on the circumstances of the particular case. *Timko v. Cub Foods* W. C. No. 3-969-031 (June 29, 2005). Therefore, as with all factual questions, we must uphold the ALJ's resolution of this issue if it is supported by substantial evidence. § 8-43-301(8), C.R.S. 2006.

Claimant argues that § 8-42-101(6)(a), C.R.S, applies in the alternative. This statute states:

> If an employer receives notice of injury and the employer or, if insured, the employer's insurance carrier, after notice of the injury, fails to furnish reasonable and necessary medical treatment to the injured worker for a claim that is admitted or found to be compensable, the employer or carrier shall reimburse the claimant … for the costs of reasonable and necessary treatment that was provided.

The ALJ made no finding that the dental condition and the treatment therefore was an emergent necessity, nor did the ALJ make a specific finding regarding the respondent's failure to provide a referral upon notice of an injury. However, from the ALJ's finding "that the dental treatment performed by Dr. Stein is reasonable and authorized medical treatment necessary to cure and relieve the effects of the work injury," a reasonable inference can be made that such treatment was authorized either under the emergent care standard (WCRP 8-3 and *Sims v. Industrial Claim Appeals Office, supra*) or under the failure to provide medical treatment upon notice of an injury standard (§ 8-42-101(6)(a), C.R.S). Respondents' contention that they are excused from reimbursing the claimant for her dental care because the ATP failed to notify them that were refusing to provide dental care, we find to be inapplicable to the circumstances before us.

IT IS THEREFORE ORDERED that the ALJ's order issued May 1, 2018 is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

10/16/18 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BLVD, DENVER, CO, 80230 (Insurer)
KILLIAN DAVIS RICHTER & MAYLE PC, Attn: CHRISTOPHER H RICHTER ESQ, 202 NORTH SEVENTH STREET, GRAND JUNCTION, CO, 81502 (For Claimant)
RUEGSEGGER SIMONS SMITH & STERN LLC, Attn: CAROL A FINLEY ESQ, 1700 LINCOLN ST SUITE 4500, DENVER, CO, 80203 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-043-459-02

IN THE MATTER OF THE CLAIM OF:

MARIA ZAGAL VALENCIA,

Claimant,

v.

FINAL ORDER

OLSONS GREENHOUSE OF COLORADO,

Employer,

and

ZURICH AMERICAN INSURANCE COMPANY,

Insurer,
Respondents.

The *pro se* claimant[1] seeks review of an order of Administrative Law Judge Goldman (ALJ) dated May 29, 2018, that denied and dismissed the claimant's claim for compensation. We affirm the ALJ's order.

After an evidentiary hearing on January 18, 2018, and multiple post-hearing depositions, the ALJ established findings of fact which are summarized below.

The claimant was employed as a production worker in the employer's greenhouse. The claimant worked on an assembly line, planting plants into containers and moving them from the assembly line onto carts. While standing next to a waist high conveyor belt on the assembly line, the claimant was struck from behind by the corner of a metal cart. She was struck in the left shoulder. She was knocked forward by the cart and caught herself by placing her hand or hands on the conveyor belt.

Conflicting evidence was presented as to whether the claimant reported the incident to her supervisor, Mr. Zavala, on the same day. Although the claimant testified that she reported the injury immediately, the ALJ found that Mr. Zavala's testimony that she did not so report the injury, was credible and persuasive.

[1] The claimant was represented by legal counsel throughout the claim and hearing process. After filing a Petition to Review on behalf of the claimant for the specified purpose of preserving the claimant's right to appeal, counsel withdrew as attorney of record and did not participate further in the appellate process.

The claimant presented to the Salud Family Health Center on July 1, 2016, and was evaluated for stomach pain, diabetes, shoulder pain, and depression. There was no mention of the cause of the shoulder pain. There was no mention of the shoulder being injured at work.

On July 19, 2016, the claimant was advised she was being laid off due to the end of season. She became upset and angry. She claimed that her termination was unfair due to the fact that she worked at the greenhouse longer than other employees; worked harder than others; felt that the supervisors played favorites; and alleged that she was being laid off due to her work injury. Because the claimant raised the allegation that she was being laid off partially due to a work injury, the issue was brought to the attention of Ms. Powell in Human Resources. The claimant met with Ms. Powell on July 20 to discuss the alleged injury. The claimant was referred to an urgent care facility which refused to see the claimant.

The claimant returned to Salud on July 21 and complained of left sided neck and shoulder pain and alleged it was caused by an accident at work approximately two months ago. The claimant filed a claim for unemployment benefits on July 22. The claimant's treating physician at Salud completed a form that took the claimant off work due to left shoulder pain on July 29. On August 11, the Division of Unemployment Insurance issued a decision that the claimant was ineligible for unemployment benefits due to her medical inability to work. The Division of Unemployment Insurance issued a subsequent decision on September 6 that approved unemployment benefits when additional medical information was received that approved the claimant for work. The claimant received unemployment benefits thereafter until such ended on March 4, 2017. On March 6, 2017, the claimant filed a workers' claim for compensation. As part of her claim, the claimant requested temporary total disability benefits from July 19, 2016, and continuing.

An MRI on February 28, 2017, showed a high-grade, near full-thickness bursal tearing of the supraspinatus; moderate tendinosis; and moderate infraspinatus tendinosis with local interstitial split tear.

The claimant obtained an independent medical examination (IME) with Dr. Mason on June 15, 2017. Dr. Mason did not address causation in her report but recommended a psychologist for the depression and an orthopedist for a surgical evaluation of the left shoulder. After issuing the report, Dr. Mason testified via deposition. Dr. Mason opined that the pain generator is the near full-thickness tear of the supraspinatus tendon. She also opined that the tear occurred when the cart struck the claimant and she braced herself

from falling with her left hand. The doctor testified that the mechanism of injury was the same mechanism commonly referred to as FOOSH, or a fall on outstretched hand, which is the most common mechanism for injury to the rotator cuff.

During her testimony Dr. Mason qualified her opinions as to causation in this case by stating, "certainly *could* cause the tearing." (ALJ's emphasis.) Whether the findings on the MRI were caused by the alleged incident, Dr. Mason stated that, "We know that some of the things on her MRI are things that develop over time. And then other things on her MRI, particularly the tearing, are, you know, more likely to *potentially* be something that in the context of a trauma." (ALJ's emphasis.) When asked whether she had an opinion, within a reasonable degree of medical probability, whether the shoulder problems are related to the accident on May 2, 2016, the doctor indicated, "the mechanism related to me is *plausible* as far as causing a tear to the supraspinatus tendon." (ALJ's emphasis.) The doctor also testified that the physical examination and physical findings correlated "reasonably well." The ALJ found that Dr. Mason's use of various qualifiers when rendering opinions about causation such as "could" – "plausible" – and "potentially" rendered her opinions regarding causation unpersuasive. To the extent that Dr. Mason testified that there is no way to determine whether a rotator cuff tear shown on an MRI was caused by degeneration or an acute injury, the ALJ found that portion of the testimony to be credible.

The respondents referred the claimant for an IME with Dr. Roth on August 10, 2017. The claimant did not provide Dr. Roth with a history that she was injured when she braced herself after being hit by the cart. Dr. Roth opined that the claimant did not sustain an injury to her left shoulder when she was hit by a cart. Dr. Roth testified that the mechanism of injury did not cause internal derangement in the shoulder. He further testified that the shoulder pathology is degenerative change and the described "bracing" component would not have torn the rotator cuff. Part of the basis for that opinion is that the claimant continued with her work activities for six weeks and had there been an acute injury, there would have been swelling, immediate pain, such to have precluded continuing normal activities of daily living, especially the work. Thus, Dr. Roth opined that it was "not medically likely that the event was associated with a significant anatomic change." Dr. Roth also testified that the incident did not aggravate, accelerate, or exacerbate the claimant's pathology documented on the MRI. Lastly, Dr. Roth opined that the left shoulder condition was not due to an occupational disease.

The ALJ found Dr. Roth's medical opinions to be "credible and extremely persuasive." The ALJ found Dr. Roth's medical opinions regarding causation to be more credible and persuasive than those of Dr. Mason.

The ALJ referenced a preexisting component to the claimant's left shoulder, identified from the Salud medical records that demonstrated shoulder pain as early as February 2011 and again in February 2014 with pain in the neck radiating to the left arm.

The employer's human resources manager, Ms. Powell, testified that the claimant did not report any injury to the employer until she had been laid off. She noted that the claimant worked her regular hours through the date of the lay-off. The ALJ found this testimony to be credible and persuasive.

The ALJ found that the claimant never claimed that her job duties caused problems requiring health care or was disabling and interfered or prevented her from working until she had been laid off. After the alleged injury, the clamant did not see any medical provider until visiting Salud on July 1, 2016. As part of the history given to Salud, it was stated, "also L shoulder pain had x-ray done in Feb but never got results." The ALJ determined that the Salud records do not support an alleged industrial injury in May 2016, or an occupational disease dating from July 1, 2016.

The ALJ specifically enumerated five reasons for discrediting the claimant's testimony regarding the alleged injury:

- The claimant testified that she went to her personal physician in May 2016 due to the on-the-job injury. However, the claimant did not see her personal physician until July 1, 2016, and during that appointment did not mention a work injury.
- The employer conceded that the claimant was struck in the back with a cart, but the claimant stated she was okay and did not need to see a doctor. The claimant said nothing more about the injury until after she was laid off.
- Salud records document that the claimant had been the victim of domestic violence. The claimant had been severely depressed for about a year as a result of that violence and was prescribed an antidepressant. During her testimony, the claimant denied any domestic violence. (The ALJ stated that he was mindful that such violence is particularly personal and extremely difficult for most victims to discuss, but found that the failure to honestly answer questions about the matter decreases the claimant's overall credibility.)
- The testimony and evidence of Dr. Roth was credible and persuasive. As a result, the ALJ found that the claimant's actions are inconsistent with suffering a rotator cuff tear when the cart hit her.
- The claimant's testimony regarding her fall on an outstretched hand did not comport with the job site and thus the ALJ did not find the claimant's described mechanism of injury to be credible.

The ALJ ultimately concluded that the claimant did not meet her burden of proof to establish either a compensable injury or a compensable occupational disease. The ALJ denied and dismissed the claim.

The claimant filed a Petition to Review and asserted generally that the ALJ acted without or in excess of his powers; that the ALJ misapplied the law or used the wrong legal standard; and that the findings of fact and conclusions of law do not support the order. The claimant did not file a brief in support of her petition to review and thus has failed to raise any allegations of specific error. Accordingly, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986).

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

Because the question of whether the claimant met her burden to prove compensability is factual in nature, we are bound by the ALJ's factual determinations if they are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to consider the evidence in a light most favorable to the prevailing party, and defer to the ALJ's resolution of conflicts in the evidence, credibility determinations, and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office,* 81 P.3d 1117 (Colo. App. 2003).

We perceive no error in the ALJ's order. We find no evidence that the ALJ acted without or in excess of his powers; that the ALJ misapplied the law or used the wrong legal standard; or that the findings of fact and conclusions of law do not support the order. The ALJ credited Dr. Roth's testimony that the claimant did not sustain an injury or occupational disease to the left shoulder. While crediting Dr. Roth's testimony, the ALJ found the claimant to not be credible and further found that the opinions of Dr. Mason were not persuasive. Thus, since the ALJ's denial and dismissal of the claimant's

claim is supported by substantial evidence in the record, 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 issued May 29, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

John A. Steninger

Brandee DeFalco-Galvin

CERTIFICATE OF MAILING

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

10/26/18 by TT .

MARIA ZAGAL VALENCIA, 69 S 8TH AVE, BRIGHTON, CO, 80601 (Claimant)
RITSEMA & LYON PC, Attn: RICHARD A BOVARNICK ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-061-749-01

IN THE MATTER OF THE CLAIM OF:

JOHN TRELOAR,

Claimant,

v.

FINAL ORDER

CONDUENT BUSINESS SERVICES,
XEROX BUSINESS SERVICES, LLC

Employer,

and

INDEMNITY INSURANCE COMPANY
OF NORTH AMERICAN,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Lamphere (ALJ) dated May 30, 2018, that denied and dismissed his claim for workers' compensation benefits. We affirm.

This matter went to hearing on whether the claimant suffered a compensable injury to his right shoulder on October 4, 2017, and medical benefits. After the hearing, the ALJ entered the following pertinent findings of fact.

The claimant worked for the respondent employer as a customer service representative. He worked at a call center answering calls for the employer's clients. On October 4, 2017, the claimant claimed he went to the bathroom and upon attempting to exit while opening the door inward with his right hand/arm, he heard or felt his shoulder "pop." According to the claimant, the door would stick making it difficult to pull open.

The claimant did not think much of the popping. He thought he had pulled a muscle. After the incident, the claimant went into a coaching meeting with his supervisor, Brian Roe. After the meeting, the claimant asked Mr. Roe if he had any Tylenol for his pain, but Mr. Roe had none.

The claimant claimed he went to the same bathroom and had a similar experience on October 6, 2017. He told Melissa Hicks about the door sticking and asked her to have maintenance adjust it, but he did not claim he had injured his shoulder. Rather, Ms. Hicks said the claimant only reported his shoulder was sore.

Mr. Roe and the claimant had a regular weekly coaching meeting on October 4, 2017. Mr. Roe explained that during this meeting, the claimant did not notify him of a work-related injury to his shoulder. However, Mr. Roe does recall the claimant asking him if he had any Tylenol because his shoulder hurt.

On October 16, 2017, the claimant sent Mr. Roe a text stating he had hurt his shoulder on October 4, 2017, while exiting the bathroom as he was pulling on the door. The claimant indicated that because he thought he simply pulled a muscle he did not report it earlier. However, because his shoulder had not improved by October 16, 2017, the claimant felt there was something more going on. He requested that Mr. Roe begin the process of starting a workers' compensation claim. Mr. Roe informed the claimant that since he did not timely provide a written report of the injury, i.e. four days, that the claimant was not covered by workers' compensation and he should seek treatment with his personal physician. Mr. Roe testified he was not aware of the medical provider designation form providing the claimant a choice of medical provider with whom he could treat for work related injuries. Consequently, the claimant was not provided with a designated provider list. Mr. Roe admitted to his erroneous understanding of the reporting rules.

The claimant's primary care physician works at DaVita Medical Group (DaVita). Review of the claimant's records from DaVita establish that after his alleged injury, he was seen on a number of occasions without ever mentioning his alleged shoulder injury occurring on October 4 or 6, 2017. In particular, the DaVita report from October 12, 2017, shows the claimant was evaluated for osteoarthritis of the hand and gastritis. The report is devoid of any reference to shoulder pain or any injury occurring October 4 or 6, 2017. The claimant's physical examination established his neck was supple, and his musculoskeletal examination showed degenerative changes unchanged from previous.

The claimant returned to DaVita on October 16, 2017. This is the same day the claimant reported he suffered a work related shoulder injury to Mr. Roe. The DaVita medical report is devoid of any reference to a shoulder injury. Rather the report indicates the claimant was seen for acute otitis media, fever, and nasal congestion. The claimant's physical examination indicated his neck was supple and the appearance of the neck was normal. The claimant returned to DaVita on October 27, 2017. The claimant was seen

for "cramp and spasm." Under "Active Problems" the report shows nine problems listed, none of which revealed a right shoulder problem. Under "Review of Systems," the report states as follows: "Musculoskeletal: no joint pain and no joint swelling. Cramps." Motor strength was noted to be "normal" in both upper and lower extremities and no neurologic deficits were documented. The claimant returned to DaVita on November 16, 2017, with a continued complaint of "cramp and spasm." Under "Active Problems," the report lists ten problems, none of which include a shoulder problem. Although "limb pain" is noted, the ALJ found this likely was leg pain based upon the claimant's chief complaint of leg cramping.

The first medical notation in the DaVita records of the alleged incident is contained in a note from December 4, 2017. In this note, Dr. Rudderow reports that the claimant "injured his shoulder when he pulled on a 'stubborn bathroom door'" on October 4, 2017, and "reinjured it on the 6th of October when he pulled on the same door." This report also states that the claimant felt as though his shoulder was coming out of the socket and that he had two months right shoulder pain. The claimant further reported that it "took this long to get OK from work comp to be seen."

The claimant admitted he saw his primary care physician for other non-work related conditions during October and November 2017. According to the claimant, he did not tell these physicians about his shoulder pain because it was his understanding they were not workers' compensation doctors.

At the request of the respondents, the claimant underwent an independent medical examination (IME) with Dr. Ridings. Dr. Ridings opined that the claimant's presentation was "most similar to that of someone with a severe . . . massive rotator cuff tear, with secondary right upper quadrant myofascial pain." According to Dr. Ridings, the described mechanism of injury was unlikely to cause a rotator cuff tear because the movement associated with pulling on the door would not be "expected to cause any abnormality of the glenohumeral joint itself." Thus, Dr. Ridings concluded the claimant may have a rotator cuff tear but that the tear did not occur as a consequence of pulling the door as the claimant alleged.

Dr. Hall performed an IME at the request of the claimant. Dr. Hall's examination of the claimant was very limited due to complaints of extreme pain. He was unable to make a diagnosis based on his examination without an MRI of the joint. He did note that when he saw the claimant, his pain encompassed the entire shoulder girdle, which according to Dr. Hall could have changed in nature and location since the original injury in October 2017. Dr. Hall testified that the act of pulling open the door and then stepping

around the door would cause the shoulder joint to be in some abduction heading toward external rotation. Dr. Hall opined that the maneuver of pulling the door towards the claimant could have led to subluxation of the humeral head which could, in turn, lead to tendon tears. He explained that pulling weight toward oneself can stress the rotator cuff, can cause impingement, and could cause ligament strain. He explained, however, that there is really no way to know for sure what was going on with the claimant's shoulder because an MRI had not been completed. While Dr. Hall opined that the claimant's mechanism of injury was not common, considering that the claimant was using his non-dominant extremity in a position that compromises the shoulder joint, he felt the right shoulder pain was related to the October 4 and 6, 2017, bathroom door incidents. Dr. Hall further explained that the claimant being left handed and injuring his non-dominant right shoulder is relevant because non-dominant extremities tend to be weaker, less coordinated, and more vulnerable to injury.

The ALJ ultimately determined that the claimant failed to meet his burden of demonstrating he sustained a right shoulder injury arising out of and in the course of his employment. Crediting the opinions of Dr. Ridings, the ALJ found that the claimant's described mechanism of injury probably did not cause his right shoulder complaints. The ALJ also found relevant the lack of shoulder complaints during the claimant's visits to his primary care physician in the months of October and November 2017 coupled with normal upper extremity examination findings. Further, the ALJ was not persuaded by the claimant's explanation that he did not tell his DaVita personal physician about his shoulder pain because it was his understanding that they were not workers' compensation doctors. The ALJ denied and dismissed the claimant's claim for workers' compensation benefits.

The claimant has petitioned to review the ALJ's order but has failed to raise any allegations of error. Accordingly, the effectiveness of our review is limited. *Ortiz v. Industrial Commission*, 734 P.2d 642 (Colo. App. 1986). Instead, the claimant reiterates the incidents on October 4 and 6, 2017, and explains how he was turned away from the workers' compensation doctor since there was no claim number. The claimant contends that without an MRI of his shoulder, he is unable to show the details of his injury. We perceive no error in the ALJ's order.

In order to prove a compensable injury, the claimant bears the burden to establish that the injury arose out of and in the course of employment. Section 8-41-301(1), C.R.S.; *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). The ALJ is charged with making pertinent factual determinations, including those concerning liability for benefits, under a preponderance of the evidence standard. Section 8-43-201, C.R.S.

Proof by a preponderance of the evidence requires the proponent to establish that the existence of a contested fact is more probable than its nonexistence. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). Under this standard, the ALJ assesses the credibility of the witnesses, the weight of the evidence, and determines whether the burden of proof has been satisfied. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). It is solely for the trier of fact to determine the persuasive effect of the evidence and whether the burden of proof has been satisfied. *Id*.

Because the question of whether the claimant met his burden to prove compensability is factual in nature, we are bound by the ALJ's determinations in this regard if they are supported by substantial evidence in the record. Section 8-43-301(8), C.R.S. This standard of review requires us to consider the evidence in a light most favorable to the prevailing party, and defer to the ALJ's resolution of conflicts in the evidence, credibility determinations, and plausible inferences drawn from the record. *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo. App. 2003).

Here, we perceive no error in the ALJ's order. During the hearing, Dr. Ridings testified that during his examination of the claimant, the claimant pointed to where he felt or heard the pop and felt the pain on October 4. Dr. Ridings explained that this area had "nothing to do with the muscles that [the claimant] would be using to open the door. . . ." Tr. at 85-86. Further, Dr. Ridings opined that the mechanism of injury that the claimant described would not cause the injury he claims he had where he cannot use his shoulder at all. Tr. at 89-90. Also, Dr. Ridings testified that it is significant that from October 4 through November 16, 2017, the claimant went to his primary care physician on four different occasions and at no point in time did he complain about or did the physician find any problems with his right shoulder. Dr. Ridings testified that the claimant's right shoulder was not listed in his active problems, and it was not mentioned at all as a problem. Tr. at 91-92. Further, as found by the ALJ, the DaVita medical records from October 12, 2017, through November 16, 2017, show that the claimant did not complain about his right shoulder. In fact, as noted above, the DaVita medical report dated November 16, 2017 specifically states that "motor strength was normal in both upper and lower extremities." Ex. 7 15-31; Ex. 7 at 30. Thus, since the ALJ's denial and dismissal of the claimant's claim is supported by substantial evidence in the record, 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 May 30, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Kris Sanko

John A. Steninger

CERTIFICATE OF MAILING

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

10/22/18 by TT .

JOHN TRELOAR, 7608 BARN OWL DR, FOUNTAIN, CO, 80817 (Claimant)
RITSEMA & LYON PC, Attn: RICHARD A BOVARNICK ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-004-079-05

IN THE MATTER OF THE CLAIM OF:

TOM DELGESSO,

Claimant,

v.

ORDER

LITTLETON FIRE RESCUE,

Employer,

and

CCMSI,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Felter (ALJ) dated March 23, 2018, that determined the respondents failed to overcome the Division Independent Medical Examination (DIME) physician's finding that the claimant's left upper extremity condition is causally related to the admitted right shoulder injury of November 4, 2015, and that the claimant is not at maximum medical improvement (MMI). We dismiss the respondents' petition to review without prejudice for lack of a final order.

The matter went to hearing on the issue of the respondents overcoming the DIME physician's MMI determination and relatedness of the claimant's left upper extremity. Although other issues were listed on the application for hearing, the parties limited the issue before the ALJ to overcoming the DIME physician's findings on MMI and the relatedness of the left upper extremity. Tr. at 8-9, 108-109. The ALJ found that the claimant, a firefighter paramedic captain, suffered an admitted injury to his right shoulder on November 4, 2015. The claimant underwent right shoulder surgery on January 12, 2016. In May 2016, the claimant sought treatment for his left elbow. The claimant testified that his left elbow pain began when he was on light duty and due to the right shoulder surgery he was unable to use his right upper extremity to perform the essential functions of his job, which at the time was light duty and involved 16-20 safety fire inspections per day using various tools. The claimant received medical treatment for his

left elbow during the summer of 2016 and was provided home exercise and an elbow strap for his left elbow.

The claimant's authorized treating physician diagnosed the claimant with lateral epicondylitis on September 15, 2016. The claimant returned to full duty on September 15, 2016, and subsequently began performing his regular job which requires physical work in the heavy category. After being released to full duty, the claimant began lifting patients, trams, and extraction equipment, as well as engaging in fire suppression, training and overhaul. This activity caused the claimant's condition to worsen. An MRI showed findings consistent with chronic medial epicondylitis with a partial thickness tear of the central fibers of the common flexor tendon. The claimant received two injections for the elbow. Additional treatment was denied by the respondents.

The claimant was placed at MMI on May 17, 2017, by his authorized treating physician, without any permanent impairment for the left elbow. The claimant requested a DIME which was performed by Dr. Henke. The DIME physician determined that the claimant was not at MMI for the right shoulder or the left elbow and recommended that the claimant undergo follow-up treatment for the left elbow. The DIME physician stated that the claimant's "left elbow pain that developed from overuse when he was rehabilitating from right shoulder surgery," and that he had some occupational therapy visits with some improvement, but pronation and flexion still causes discomfort. Claimant's Exhibit 2, at 17.

At the respondents' request, the claimant underwent an independent medical examination (IME) with Dr. Cebrian. In Dr. Cebrian's opinion it was not medically probable that the claimant's left medial epicondylitis, with a partial tear, is causally related to the November 4, 2015, injury. The ALJ rejected Dr. Cebrian's opinion determining that Dr. Cebrian inadequately explained his opinion on causation. The ALJ was more persuaded by the claimant's expert, Dr. Swarsen, who testified that the DIME had adequately provided causation analysis under the AMA Guides and the Medical Treatment Guidelines and that there was adequate evidence to support the DIME physician's causation determination.

The ALJ found the opinion from Dr. Swarsen, the claimant's testimony and medical records to be highly persuasive and credible and supportive of the DIME physician's opinion that the claimant sustained a work-related left elbow injury and is not at MMI. The ALJ, therefore, concluded that the respondents failed to overcome the DIME physician's opinion by clear and convincing evidence. The ALJ further reserved all other issues for future determination.

The respondents have petitioned to review the ALJ's order, asserting that the order is not supported by substantial evidence in the record. Section 8-43-301(2), C.R.S., provides that a party may petition to review any order which "requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty." Orders which do not award or deny benefits or penalties are interlocutory and not subject to immediate review. *Ortiz v. Industrial Claim Appeals Office*, 81 P.3d 1110 (Colo. App. 2003). Further, an order must determine the amount of benefits to be awarded before it is considered final and appealable. *United Parcel Service, Inc. v. Industrial Claim Appeals Office*, 988 P.2d 1146 (Colo. App. 1999). In light of these principles, the panel repeatedly has held that orders containing a general determination of liability without awarding specific medical treatment are interlocutory. *Shapiro v. Aspen Ski Company*, W.C. No. 4-820-840 (September 30, 2013); *Adams v. Manpower*, W.C. No. 4-389-466 (August 2, 2005); *see Cheney v. Coca Cola*, W.C. Nos. 4-854-583, 4-873-873, (July 9, 2012); *Mallow v. Catholic Health Initiatives*, W. C. No. 4-776-395 (November 25, 2011). This is true because respondents may contest liability for a specific treatment on grounds of reasonableness and necessity for the treatment, or the authorization for such treatment.

The ALJ here addressed the limited issue of whether the respondents were able to overcome the DIME physician's determination that the claimant was not at MMI because of the claimant's left upper extremity. Although the ALJ concluded that the respondents did not overcome the DIME physician's finding that the claimant is not at MMI, the order does not require the respondents to pay any particular medical or temporary benefits as a result of that determination. Under these circumstances, the ALJ's order is not final and reviewable, and the respondents' petition to review must be dismissed without prejudice. *McNeley v. AMS Staffing*, W.C. No. 4-511-838 (October 14, 2004); *Thomas v. Four Corners Health*, W.C. No. 4-484-220 (December 17, 2002); *Canales v. City and County of Denver*, W.C. No. W. C. Nos. 4-476-907, 4-476-906 & 4-356-910 (July 10, 2002).

IT IS THEREFORE ORDERED that the respondents' petition to review the ALJ's order dated March 23, 2018, is dismissed without prejudice.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

John A. Steninger

CERTIFICATE OF MAILING

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

10/26/18 by TT .

LAW OFFICE OF OTOOLE AND SBARBARO PC, Attn: NEIL D OTOOLE ESQ, 226 WEST 12TH AVE, DENVER, CO, 80204-3625 (For Claimant)
NATHAN DUMM & MAYER PC, Attn: BERNARD WOESSNER ESQ, C/O: KAITLIN AKERS ESQ, 7900 EAST UNION AVE SUITE 600, DENVER, CO, 80237-2776 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-819-262-13

IN THE MATTER OF THE CLAIM OF:

CAROLD PEOPLES,

Claimant,

v.

FINAL ORDER

STATE OF COLORADO-DEPT OF TRANSPORTATION,

Self-Insured Employer,

and

SELF INSURED,

Insurer,
Respondent.

The claimant seeks review of an order of Administrative Law Judge (ALJ) Nemechek dated June 6, 2018, that ordered the claimant to repay an overpayment at the rate of $50 per week and allowed the respondent to take credit for currently owed disfigurement benefits against an existing overpayment. We affirm the ALJ's order.

This matter came to hearing on the issue of an overpayment and whether the respondent's collection of the overpayment was barred by the statute of limitations in §8-42-113.5(1)(b.5)(I), C.R.S. After hearing the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury on February 5, 2010. A Notice of an Award from the Social Security Administration dated May 21, 2012, was admitted into evidence. According to the notice, the claimant became disabled on March 10, 2010, and was awarded a lump sum and monthly payments in the amount of $921.30 per month. The claimant gave the respondent timely notice of receipt of the SSDI award. The respondent filed a general admission of liability dated July 17, 2012, admitting for temporary total disability benefits beginning March 11, 2010, and continuing and referencing an overpayment of $15,519.93, to be recouped from future benefits owed.

The respondent subsequently filed a final admission of liability on April 16, 2013, admitting for a 10 percent scheduled rating. Permanent disability benefits were not paid because the claimant reached the statutory cap on indemnity benefits in §8-42-107.5, C.R.S., by receiving a total of $83,569.36 in temporary disability benefits. The respondent stated on the final admission of liability that there was now a total overpayment of $17,632.79. The claimant filed an application for hearing on the issues of overcoming a Division Independent Medical Examination, disfigurement and permanent partial disability benefits. Neither party raised overpayment as an issue for hearing.

The respondent filed another final admission of liability on November 10, 2017, this time admitting for an additional three percent scheduled impairment rating. The final admission again referenced that the claimant had exceeded the statutory cap and reserved the right to recover the overpayment of $17,632.79.

The claimant argued that the respondent's failure to file an application for hearing to recover the overpayment within the one year statute of limitation in §8-42-113, bars the respondent from recovering the overpayment. The respondent, in contrast, asserted that filing the final admission of liability was sufficient to comply with the statute of limitations. Relying on a prior panel order, *Maez v. Adelphia Communications Corp.* W.C. No. 4-609-810 (January 25, 2011), the ALJ agreed with the respondent and held that filing the final admission of liability preserved the respondent's right to recover the overpayment. The ALJ ordered that the respondent was entitled to a credit in the amount of $2,175 in disfigurement benefits currently owed by a June 6, 2018 disfigurement order against the overpayment. The ALJ further ordered the claimant to repay the remaining overpayment of $15,257.79, at the rate of $50 per week.

On appeal the claimant argues that the ALJ erred in ordering the claimant to repay the overpayment amount at the rate of $50 per week because the issue was not an issue for hearing. The claimant also contends that the ALJ erred in his conclusion that the filing a final admission of liability listing the amount of the overpayment was enough to preserve the respondent's right to recover the overpayment and, consequently, the ALJ erred in allowing the respondent to take credit for disfigurement benefits owed against the overpayment amount. We disagree that the ALJ committed reversible error.

I.

We are not persuaded by the claimant's assertion that the ALJ erred in addressing the recovery of the overpayment. We note initially that the claimant did not request a

transcript of the hearing. Where, as here, the appealing party fails to procure transcripts of the relevant hearing, we must presume the pertinent findings of fact are supported by substantial evidence. *Nova v. Industrial Claim Appeals Office*, 754 P.2d 800 (Colo. App. 1988). Thus, based on our review of the limited record provided, we conclude that the issue of the employer's recovery of the claimed overpayment was before the ALJ.

Although due process requires that the parties are given notice and opportunity to be heard, without a transcript of the hearing we are unable to corroborate the claimant's assertion that the recovery of the overpayment was not properly before the ALJ. The record before us indicates the contrary. The claimant's January 9, 2018, application for hearing lists the issues for hearing as "Disfigurement," and in other issues states,

> Respondents have alleged a right to recover the $17,632.79 overpayment, thay (sic) claim exists. They might have a right to claim overpayment but they do not have a right to recover it as the exact same amount of claimed overpayment was on the 4/16/13 FAL and Sec. 8-42-113.5(1)(b.5)(I) sets a one year limit on recovering such overpayments which SOL lapsed over three years ago.

In response to the claimant's application for hearing, the respondent listed the issues of disfigurement and "whether contesting overpayment is ripe since claimant did not dispute overpayment in prior final admission of liability, credit for any disfigurement award against overpayment, credit for previously paid disfigurement, attorney fees." The respondent's CIS contained the same language. The claimant's CIS stated in issues remaining for determination, "Claimant seeks to block any attempt to recover overpayment because statute of limitation bars it now." The respondent filed a position statement after hearing contending that the claimant should be ordered to repay the overpayment in the about of $500 per month. The ALJ, however, ordered the claimant to repay the overpayment at $50 per week. Without a transcript, the claimant's assertion that the amount of recovery was not an issue for hearing is merely a factual assertion on appeal and cannot provide a basis for any relief on appeal.

II.

Nor are we persuaded that the ALJ erred in his interpretation of §8-42-113.5 (1)(b.5)(I), C.R.S., to conclude that the respondent's act of reserving the right to recoup the overpayment amount in the final admission of liability preserved the right to seek collection of the overpayment.

Section 8-42-113.5, (1)(b.5)(I), C.R.S., provides, in pertinent part; "…except in cases of fraud, any *attempt to recover* an overpayment shall be asserted within one year after the time the requester knew of the existence of the overpayment." (*emphasis added).*

Statutes should be interpreted to give effect to the legislative intent. The initial step is to examine the language of the statute, and give the words and phrases their plain and ordinary meaning, unless the result is absurd. Where the statutory language is clear and unambiguous, it is unnecessary to resort to rules of statutory interpretation. *Snyder Oil Co. v. Embree*, 862 P.2d 259 (Colo. 1993).

In *Maez v. Adelphia Communications, supra,* the panel recognized that an "attempt to recover" an overpayment is satisfied by either filing a final admission of liability asserting the overpayment or filing an application for hearing. There is nothing in the plain language of the statute that limits the attempt to recover to only filing an application for hearing as argued by the claimant. The phrase at issue is "*any* attempt to recover" which includes filing a final admission of liability. The plain meaning of "any" is unlimited in amount. *See Merriam Webster Dictionary.* Consequently, in *Maez*, the panel held that the determination that the statute at issue requires the requesting party to either file a final admission or seek an order to recover the overpayment is a reasonable construction of the provision. Moreover, as the claimant recognizes in his brief, filing a final admission of liability and asserting the right to recoup the overpayment against future benefits is the preferable method, rather than forcing the issue into litigation.

Here, the respondent was notified of the SSDI award on May 30, 2012. The respondent first filed a general admission of liability on July 17, 2012, asserting an overpayment and the right to recoup the overpayment from future benefits owed. The respondent also filed a final admission of liability on April 6, 2013, asserting an overpayment in the amount of $17,632.79 and the right to recoup the overpayment against future benefits owed. Thus, we agree with the ALJ that the respondents made a timely "attempt to recover" the overpayment. The claimant has not persuaded us to depart from the reasoning in *Maez* and we see no reason to disturb the ALJ's determination.

III.

For similar reasons we perceive no error in the ALJ's determination to credit the overpayment against the disfigurement benefits owed in the amount of $2,175. As noted above, the final admission of liability satisfied the statutory requirement to "attempt to

recover the overpayment." As such, the respondent may offset their liability for the disfigurement award in the amount of $2,175, against the existing overpayment. *See generally Donald B. Murphy Contractors v. Industrial Claim Appeals Office*, 916 P.2d 611 (Colo. App. 1995)(petitioners entitled to offset permanent partial benefits paid against temporary total disability benefits); *Danks v. Rayburn Enterprises*, W.C. No. 4-770-978 (September 10, 2014).

IT IS THEREFORE ORDERED that the ALJ's order dated June 6, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

Brandee DeFalco-Galvin

David G. Kroll

CERTIFICATE OF MAILING

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

10/24/18 by TT .

IRWIN FRALEY PLLC, Attn: ROGER FRALEY JR ESQ, 6377 S REVERE PARKWAY SUITE 400, CENTENNIAL, CO, 80111 (For Claimant)
RITSEMA & LYON PC, Attn: NANCY C HUMMEL ESQ, 999 18TH STREET SUITE 3100, DENVER, CO, 80202 (For Respondents)

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-033-529-01

IN THE MATTER OF THE CLAIM OF:

LAVERNE MATTHEW,

Claimant,

v.

FINAL ORDER

STATE OF COLORADO,

Employer,

and

SELF INSURED,

Insurer,
Respondent.

The claimant seeks review of an order of Administrative Law Judge Michelle Jones (ALJ) dated April 4, 2018, that denied the claimant's request for medical benefits and found her claim to be not compensable. We affirm the decision of the ALJ.

The claimant reported an injury in December 2016 involving insect bites she received while working for the Colorado Department of Local Affairs in its office at 1313 Sherman Street in Denver. The claimant stated the problem began on September 8, 2016, when she first moved into her office at that address. She complained of many sharp and prickly bites. She soon after reported also incurring insect bites while at her home. The claimant believed her office was infested with biting insects that the respondent had refused to acknowledge or control.

The claimant was first evaluated at the Kaiser Permanente clinic by Physician Assistant Cramer on November 30, 2016. PA Cramer was unable to confirm evidence of any bites. She observed the claimant pointed to several moles and pigment lesions but PA Cramer could locate no insects, insect parts or foreign bodies in or under the claimant's skin. The claimant was referred to dermatologist Dr. Weber. The doctor examined the claimant's skin and the sites of suspected bites on December 7. Dr. Weber found no lesions consistent with insect bites and confirmed the locations the claimant feared were bites were moles or freckles characteristic of a regular pigment network. The doctor assured the claimant she had not sustained insect bites. The claimant was

diagnosed with delusions of parasitosis and was recommended to seek counseling through psychiatry should her fears continue.

On January 4, 2017, the claimant was examined by Dr. Silverman for complaints of particular insect bites, and insects imbedded in her upper lip and on her clavicle. Laboratory exams of excised flesh from these areas revealed an enlarged pore on the clavicle and a large freckle on the lip. Biopsies uncovered no sign of bug bites or insect body parts.

The respondent maintains an arrangement for regular pest control with Terminix Company. Terminix employee, Mr. Ceas, performed several inspections of the building at 1313 Sherman and of the claimant's office in October, November and December 2016. Mr. Ceas testified he set traps to collect specimens of any bugs or insects present. He also applied extermination treatments and checked for the presence of expired insects. Mr. Ceas explained he responded to the individual complaints of the claimant at that location in one office and then again, when she was moved to a second office. He reported that only on one occasion were there indications of the presence of an insect. In October, a trap contained a sawtooth grain beetle. He confirmed that beetle is not known for biting humans. Mr. Ceas obtained no other evidence that insects were present in the claimant's offices.

The claimant testified at a March 8, 2018, hearing that she has been bitten and bothered by bugs in her work place for the last 18 months. She routinely applies Off and Raid repellants and insecticides. She described how these steps have not led to any abatement of the problem. The claimant stated she believes the infestation may be engineered by someone who seeks to compel her to quit her job. The claimant noted she has incurred medical expenses for which she seeks reimbursement. She submitted receipts for $503 in related medical copays and expenses.

The ALJ concluded the claimant failed to demonstrate she had sustained a compensable injury involving insect bites at work. The ALJ recounted that the claimant had been examined by three medical professionals. PA Cramer was unable to find any evidence of insect bites. Dr. Weber arrived at the same conclusion and identified the status of scars and blemishes the claimant suspected to be bug bites were actually moles, freckles, pores, papules or other normal lesions of the body. The ALJ observed that Dr. Silverman went so far as to secure biopsies of suspicious skin areas. These were shown to contain no evidence of the presence of insects or other bug activity. The ALJ found persuasive the testimony of Mr. Ceas that his investigations of the claimant's work site did not disclose signs consistent with insect habitation. The ALJ found the claimant's

testimony relating to bug bites insufficient to overcome this medical and professional evidence indicating an absence of insect and pest infestation by a preponderance of the evidence. The ALJ ruled the claim not compensable and denied the claimant's request for medical benefits.

On appeal, the claimant reiterates her assertion that she is the victim of insect bites. She argues the medical records have been completed by medical staff untrained in the investigation of the bites of microscopic sized insects. The claimant compares a patient's knowledge that they have been bitten by insects to the sensation of being hot or cold, hungry or full. She argues the opinion of a medical expert holding that the patient is mistaken when they experience any of those conditions is necessarily incorrect in the face of the patient's contention otherwise. The claimant asserts the failure of the respondent to relieve her suffering represents possible discrimination as a motivation for the respondent's inaction. Additional witness statements, emails, photos and other documents accompanied the claimant's Brief in Support of her Petition to Review.

The respondent points out the evidence in the record is substantial and adequate to support the conclusions of the ALJ that no work related injury has been established. The respondent contends that simply because the claimant asserts she experienced symptoms of insect bites at work does not compel the ALJ to conclude there is a sufficient connection between the work place and the claimant's complaints. The respondent objects to the submission by the claimant of evidence attached to her brief which was not submitted to the ALJ at the hearing.

Upon an appeal to the Industrial Claims Appeals Office (ICAO), § 8-43-301(8), C.R.S. limits the ICAO panel to a review of the ALJ's order, and does not grant the panel the authority to receive and evaluate new evidence. The panel is to determine whether the ALJ's determinations are supported by substantial evidence in the hearing record. Therefore, to the extent the claimant has presented exhibits and documents that were not submitted at the hearing, we have no authority to consider them and we decline to do so.

Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove a causal relationship between a work-related injury and the condition for which benefits or compensation are sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997).

Pursuant to §8-41-301(1) (c), C.R.S., a disability is compensable if it is shown that it was "proximately caused by an injury . . . arising out of and in the course of the employee's employment." To establish that an injury arose out of an employee's

employment, there must be a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). In reaching a conclusion concerning causation, the ALJ may make reasonable inferences from the circumstantial evidence presented. See *Electric Mutual Liability Insurance Co. v. Industrial Commission*, 154 Colo. 491, 391 P.2d 677 (1964). Furthermore, it is the sole province of the ALJ to resolve conflicts in the evidence and determine the credibility of witnesses and the probative value of the evidence. *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). So long as such determination is supported by substantial evidence in the record, it is binding on review. *See May D & F v. Industrial Claim Appeals Office*, 752 P.2d 589 (Colo. App. 1988). Substantial evidence is probative evidence, which would warrant a reasonable belief in the existence of facts supporting a particular finding, without regard to the existence of contradictory or contrary inferences. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985). *Ackerman v. Hilton's Mech. Men*, 914 P.2d 524, 527-28 (Colo. App. 1996).

Under this standard, we must defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo. App. 1990). Further, we may not interfere with the ALJ's credibility determinations except in the extreme circumstance where the evidence credited is so overwhelmingly rebutted by hard, certain evidence that the ALJ would err as a matter of law in crediting it. *Halliburton Services v. Miller*, 720 P.2d 571 (Colo. 1986); *Johnson v. Industrial Claim Appeals Office*, 973 P.2d 624 (Colo. App. 1997). The claimant's arguments notwithstanding, we perceive no extreme circumstances here.

The ALJ found persuasive the medical records of PA Cramer, Dr. Weber, and Dr. Silverman. The ALJ also relied on the testimony of Mr. Ceas. The medical opinions reflected personal examinations and histories obtained by each of the three providers. None of the three was able to confirm the claimant's assertion of insect bites. The examinations were accompanied by laboratory analysis of skin specimens including a biopsy. The ALJ noted those tests confirmed the medical opinions provided by each of the three that the claimant was not afflicted with insect bites. Mr. Ceas testified to his several visits to the claimant's work place and the steps he took as a professional pest control technician to identify the presence of any biting insects and to apply the appropriate treatment. The ALJ found credible Mr. Ceas' conclusion that the claimant's work office did not have present any biting insects and was not the source of any bites the claimant may have encountered. Relying on these records and this testimony, the ALJ

ruled the claimant failed to meet her burden of proof that her perception of insect bites was related to any condition or circumstance associated with her work for the respondent.

We have reviewed the order and the record and we do not perceive reversible error. To the extent the ALJ relied on the evidence provided by the records of PA Cramer, Dr. Weber, and Dr. Silverman, as well as the testimony of Mr. Ceas that the claimant's complaints of insect bites were not caused by the conditions of her employment, the ALJ's decision is supported by substantial evidence and is a reasonable conclusion for the ALJ to draw. Section 8-43-301(8), C.R.S.

The credibility attributed to expert medical opinion on the issue of causation is within the ALJ's province as fact-finder. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). Here, the ALJ credited the respondent's experts and resolved the conflicts in the evidence in favor of the respondent and we perceive no basis on which to disturb her resolution. Section 8-43-301(8), C.R.S. We may not interfere with the ALJ's assessment of the probative value of the evidence. *See Eisnach v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Further, the claimant's argument notwithstanding, the ALJ need not address every piece of evidence if the basis of the order is clear from the findings, as they are here, and evidence not addressed was presumably rejected as not persuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). Consequently, we perceive no error in the ALJ's decision to find the claim for the treatment of insect bites not compensable and to deny the request for benefits.

IT IS THEREFORE ORDERED that the ALJ's order issued April 4, 2018, is affirmed.

INDUSTRIAL CLAIM APPEALS PANEL

David G. Kroll

Kris Sanko

CERTIFICATE OF MAILING

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

10/29/18 by TT .

LAVERNE MATTHEW, 2525 E 104TH ST APT 938, THORNTON, CO, 80233 (Claimant)
ATTORNEY GENERALS OFFICE, Attn: D CLAY THORNTON ESQ, C/O: WORKERS COMPENSATION UNIT, 1300 BROADWAY 10TH FLOOR, DENVER, CO, 80203 (For Respondents)

COLORADO COURT OF APPEALS

DATE FILED: October 25, 2018
CASE NUMBER: 2017CA2020

Court of Appeals No. 17CA2020
Industrial Claim Appeals Office of the State of Colorado
WC No. 5-013-335

Linda Dizmang,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, Axis Financial Management, and Norguard Insurance,

Respondents.

ORDER AFFIRMED

Division I
Opinion by JUDGE TERRY
Taubman and Fox, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced October 25, 2018

Linda Dizmang, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Hall & Evans, LLC, Matthew J. Hegarty, Evan M. Blonigen, for Respondents Axis Financial Management and Norguard Insurance

¶ 1 Claimant, Linda Dizmang, appearing pro se, seeks review of a final order of the Industrial Claim Appeals Office (Panel) which affirmed the denial and dismissal of her claim for worker's compensation benefits. We affirm.

I. Background

¶ 2 Claimant worked as a caregiver for her husband, Kevin Dizmang, under the auspices of a Colorado program, Consumer/Client Directed Attendant/Employee Support Services (CDASS), which assists individuals "with their caregiving for a family member to be able to take care of them at home." She testified that her husband was "disabled" and had "numerous disabilities . . . not only physical but mental and emotional." She began caring for him under the program in February 2015, after he underwent spinal fusion surgery. Although her husband was identified as her employer, Access Financial Management Services managed her employment.

¶ 3 Claimant testified that on March 1, 2015, a few weeks after she started caring for her husband, she was helping him "out of bed and our hands slipped apart and he fell back on the bed and I fell backwards into the entertainment center." She told her husband

about her injury, but the workers' compensation carrier, insurer Norguard Insurance, was not informed until October 6, 2015.

¶ 4 Claimant initially testified that she "sought medical treatment . . . within a couple of days" with her primary care physician, Dr. Charles Johnson. However, the record is devoid of any contemporaneous medical report drafted by Dr. Johnson. To the contrary, the record shows a gap in claimant's treatment with Dr. Johnson from December 4, 2014, until March 29, 2016, more than a year after her alleged injury. Under cross-examination, claimant admitted that the first physician she saw after the injury was Dr. John Pak, whom she saw on October 19, 2015, "seven and a half months following [her] injury."

¶ 5 When claimant first saw Dr. Pak, she complained of right shoulder pain. A month later, in November 2015, she complained to Dr. Pak about pain in both her right and left shoulders. Although Dr. Pak prescribed physical therapy and gave claimant a cortisone shot to alleviate her shoulder pain, she told him that neither helped her. By February 2016, Dr. Pak also identified cervical spondylosis and spinal stenosis among claimant's complaints.

¶ 6 In May 2016, Norguard filed a notice contesting the claim. Norguard retained the services of Dr. Robert Messenbaugh to independently examine claimant and determine the relatedness of her claim. He concluded claimant had not sustained a compensable injury on March 1, 2015. He made the following observations:

> Ms. Dizmang did not report having experienced any accident/injuries occurring on March 1, 2015 to any medical personnel until months and months after that date.
>
> * * * * *
>
> It is my opinion that a person that sustains an injury, especially during their employment, reasonably would be expected to report such injuries to the appropriate personnel and seek medical attention promptly for an evaluation of those injuries and treatment for those injuries.
>
> * * * * *
>
> Under the circumstances, I find no clear documentation that Ms. Dizmang sustained any accident or injuries on March 1, 2015.

Dr. Messenbaugh also noted that claimant's "symptoms seem to be ever expanding, changing, going from — Dr. Pak says from shoulder and then to neck. . . . It just all seems to be highly inconsistent." For example, claimant reported to Dr. Messenbaugh "that she had

injured her low back on March 1, 2015, yet in her medical records I do not find objective evidence or for that matter subjective indications that she had injured her lower back on March 1, 2015." He observed that claimant's medical records "failed to report her experiencing low back issues resulting from" the alleged injury. And, he testified, imaging studies showed some degenerative changes, but were otherwise normal and revealed no acute injury.

¶ 7 The administrative law judge (ALJ) found Dr. Messenbaugh's opinions persuasive and credible. Conversely, the ALJ found claimant's credibility "compromised." Factors the ALJ cited to support his finding that claimant lacked credibility included that she waited seven and a half months before seeking treatment, that she regularly sought a "variety of benefits" such as unemployment compensation and Social Security disability benefits, and that she continued to receive "income as her husband's paid caretaker with no apparent supervision or oversight." Based on these findings, the ALJ concluded that claimant "failed to sustain her burden of proving, by a preponderance of the evidence, that she sustained a compensable work injury."

¶ 8 The Panel affirmed on review, holding that the ALJ's order was supported by substantial evidence in the record and was based on the ALJ's credibility determinations, which it could not reweigh. The Panel rejected claimant's other asserted bases for setting aside the ALJ's order — (a) that her counsel was ineffective; and, (b) that pre-existing conditions should not disqualify her from receiving benefits — as not offering grounds upon which the Panel could set aside the ALJ's decision.

II. Analysis

¶ 9 Claimant contends that the Panel erred in affirming the ALJ's order. She argues that the evidence upon which the ALJ relied was "not true" and justifies this court's review of the transcript. In particular, she alleges that Dr. Messenbaugh's testimony was biased and "false." She also argues that she was "misguided by ineffective counsel," and suggests she would have offered more detail and explanation during her testimony had she not been advised by her counsel to respond "yes or no" to questions posed at the hearing. Finally, she accuses Norguard of inadequately investigating her claim, and argues that her claim could not be

barred because of a preexisting condition. However, none of these contentions provides a basis for setting aside the Panel's decision.

A. Governing Law and Standard of Review

¶ 10 To be compensable, an injury must be "proximately caused by an injury . . . arising out of and in the course of the employee's employment and is not intentionally self-inflicted." § 8-41-301(1)(c), C.R.S. 2018. "Proof of causation is a threshold requirement which an injured employee must establish by a preponderance of the evidence before any compensation is awarded. The question of causation is generally one of fact for determination by the ALJ." *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000).

¶ 11 A reviewing court must uphold the factual determinations of the ALJ if the decision is supported by substantial evidence in the record. § 8-43-308, C.R.S. 2018; *Leewaye v. Indus. Claim Appeals Office*, 178 P.3d 1254, 1256 (Colo. App. 2007). "Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App.

1995). "The reviewing court is bound by the ALJ's factual determinations even if the evidence was conflicting and could have supported a contrary result." *Gilmore v. Indus. Claim Appeals Office*, 187 P.3d 1129, 1133 (Colo. App. 2008).

¶ 12 Because it is the sole province of the fact finder to weigh the evidence and resolve contradictions in the evidence, a reviewing court may not substitute its judgment for that of the ALJ. *See Metro Moving & Storage*, 914 P.2d at 415 (reviewing court must defer to the ALJ's credibility determinations and resolution of conflicts in the evidence and may not substitute its judgment for that of the ALJ). Claimant asks us to reweigh the evidence to reach a finding contrary to the ALJ's conclusion, arguing that the ALJ's decision was based on false information. However, we may not do so. *See id.*

B. Substantial Evidence Supports the ALJ's Findings

¶ 13 Dr. Messenbaugh testified that claimant did not suffer a work-related injury on March 1, 2015. He questioned the lengthy gap of seven and half months between claimant's allegedly sustaining an injury and seeking any treatment. He also noted inconsistencies in the extent of claimant's self-reported injuries, commenting that her

symptoms seemed to be "ever expanding." Finally, he pointed out that there were no objective findings — i.e. no test results or images — substantiating claimant's symptoms. His opinions are corroborated by the medical records evidence, which confirms that, after her March 1, 2015 accident, claimant did not visit any health care provider until October 2015.

¶ 14 The ALJ found Dr. Messenbaugh's testimony credible and persuasive. Because the weight to be given expert medical testimony is within the sound discretion of the ALJ, the ALJ acted well within his authority in crediting Dr. Messenbaugh's testimony. *See Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990).

¶ 15 In contrast, the ALJ found claimant's failure to seek contemporaneous treatment "unreasonable and inconsistent with an acute injury." The ALJ concluded that these inconsistencies compromised claimant's credibility and led him to find claimant less persuasive than Dr. Messenbaugh and the "contemporaneous medical records." "[W]e may not interfere with the ALJ's credibility determinations" unless the evidence is "overwhelmingly rebutted by hard, certain evidence" to the contrary. *Arenas v. Indus. Claim*

Appeals Office, 8 P.3d 558, 561 (Colo. App. 2000); *see also Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46 ("Nor may we set aside a ruling dependent on witness credibility where the testimony has not been rebutted by other evidence.").

¶ 16 Although claimant asserts that Dr. Messenbaugh's testimony and opinions were "not true," she points to no evidence in the record nor identifies any contrary evidence to support her contention beyond her conclusory statement questioning Dr. Messenbaugh's veracity. But, in the absence of overwhelming evidence rebutting Dr. Messenbaugh's opinions, we may not disturb the ALJ's determination that Dr. Messenbaugh's conclusions were credible and persuasive. *See Youngs*, ¶ 46; *Arenas*, 8 P.3d at 561; *Rockwell Int'l*, 802 P.2d at 1183. We therefore conclude that substantial evidence amply supports the ALJ's finding that claimant did not sustain a compensable work-related injury.

C. Remaining Claims

¶ 17 None of claimant's remaining assertions provide a basis for setting aside the Panel's decision. With respect to claimant's contention that her presentation was hampered by ineffective counsel at the hearing, we note that no such claim has been

recognized in the workers' compensation arena, and claimant has not cited any authority supporting such a claim. In making her argument, claimant appears to conflate two different areas of the law. "An accused in a criminal prosecution is guaranteed the right to effective assistance of counsel by the United States and Colorado Constitutions." *Armstrong v. People*, 701 P.2d 17, 19 (Colo. 1985). The right stems from the Sixth Amendment's guarantee of representation for criminal defendants. *See People v. Corson*, 2016 CO 33, ¶ 32 ("Criminal defendants have a right to counsel . . . and 'the right to counsel is the right to the effective assistance of counsel.'" (quoting *McMann v. Richardson*, 397 U.S. 759, 771 n.14 (1970))).

¶ 18 Claims of ineffective assistance of counsel have also been recognized in termination of parental rights cases, in which a right to counsel has been guaranteed because of the gravity of the rights at stake. *See People in Interest of C.H.*, 166 P.3d 288, 290-91 (Colo. App. 2007) ("When evaluating a claim of ineffective assistance of counsel in termination proceedings, Colorado courts employ the same test that governs claims of ineffective assistance of counsel in criminal cases."). But, we know of no case applying a guarantee of

counsel, and, by extension, a right to *effective* assistance of counsel, in a workers' compensation case.

¶ 19 Claimant also implies that the decision should be set aside because Norguard failed to thoroughly investigate her claim. However, the Workers' Compensation Act imposes upon an injured worker — not the insurer or the employer — the threshold burden of establishing a compensable claim. *See* § 8-41-301(1)(c), C.R.S. 2018; *Faulkner*, 12 P.3d at 846. Thus, claimant, not insurer, bore the burden of establishing her entitlement to benefits; insurer owed claimant no duty to "investigate" the claim.

¶ 20 Last, to the extent claimant asserts that she could not be barred from receiving benefits based on a pre-existing condition, we agree that this is an accurate statement of the law. "A preexisting condition does not disqualify a claimant from receiving workers' compensation benefits. Rather, where the industrial injury aggravates, accelerates, or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury." *Duncan v. Indus. Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004).

¶ 21 However, the ALJ did *not* deny and dismiss claimant's claim for benefits because she may have had a preexisting condition. Rather, the ALJ was simply not persuaded that claimant had sustained any injury on March 1, 2015. He therefore concluded that claimant "failed to sustain her burden of proving, by a preponderance of the evidence, that she sustained a compensable work injury." Accordingly, this contention, too, does not provide a basis for setting aside the Panel's decision.

III. Conclusion

¶ 22 The order is affirmed.

JUDGE TAUBMAN and JUDGE FOX concur.

COLORADO COURT OF APPEALS

DATE FILED: October 25, 2018
CASE NUMBER: 2018CA273

Court of Appeals No. 18CA0273
Industrial Claim Appeals Office of the State of Colorado
WC No. 5-013-170

Velma R. Brooks,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and Aurora Public School District,

Respondents.

ORDER AFFIRMED

Division III
Opinion by JUDGE MÁRQUEZ*
Loeb, C.J., and Kapelke*, J., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced October 25, 2018

Velma R. Brooks, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema & Lyon, P.C., T. Paul Krueger, David R. Bennett, Denver, Colorado, for Respondent Aurora Public School District

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

¶ 1 In this workers' compensation action, claimant, Velma R. Brooks, appearing pro se, seeks review of a final order of the Industrial Claim Appeals Office (Panel), which affirmed the decision of an administrative law judge (ALJ) finding claimant did not overcome the division-sponsored independent medical examination (DIME). Because we agree with the Panel that substantial evidence supports the ALJ's decision, we affirm.

I. Background

¶ 2 Claimant works as a substitute teacher for employer, Aurora Public Schools. In January 2016, she sustained admitted work-related injuries when she slipped and fell on ice in the parking lot. She reported her fall and indicated that she injured her right knee, left leg, both shoulders, and left lower back side. Aurora Public Schools referred her to Health One Occupational Medicine and Rehabilitation for treatment, where she saw Dr. Matthew Lugliani.

¶ 3 In March 2016, claimant told Dr. Lugliani that she was still experiencing pain in her shoulders. Her complaints continued in May 2016, when she reported "diffuse body pain involving her bilateral shoulders" and requested "impairment ratings for back, shoulder, and knee." But, contemporaneous chiropractic notes did

not indicate significant deficits in claimant's shoulder range of motion. Dr. Lugliani concluded that, with respect to claimant's back and shoulder complaints, "the majority of her symptoms are osteoarthritic in nature and long standing." He therefore concluded she had reached maximum medical improvement (MMI) as of May 26, 2016, with a permanent impairment rating of 14% for the right lower extremity. He assigned no impairment ratings for claimant's shoulders.

¶ 4 Dr. Lugliani's assessment was echoed by Dr. Scott Primack, a specialist in physical medicine and rehabilitation, to whom Dr. Lugliani had referred claimant for pain management. Dr. Primack reported that claimant had "no complaints of any shoulder pain" at her May 4, 2016, visit with him.

¶ 5 Shortly thereafter, though, an MRI of claimant's left shoulder showed she had a "full-thickness partial width tear . . . of the distal supraspinatus." The MRI findings prompted Dr. Lugliani to retract his MMI determination.

¶ 6 In November 2016, Dr. Primack thoroughly reviewed claimant's medical records. Based on his medical records review,

Dr. Primack opined that claimant's shoulder injury was unrelated to her workplace fall. He wrote:

> After reviewing all of the medical records and specifically the clinical examinations done by Dr. Lugliani as well as myself, I do not believe that she requires intervention to the left shoulder. Although she may have fallen, the functional impairment at least by May 2016 was not at the shoulders. It was at the level of the right knee, and she had a history of chronic pain. She had also maximized her function. Therefore, if she necessitates care at the shoulders, it would not be considered work related. Clearly, shoulder surgery would not be work-related in this case, given the medical records and her inconsistency of progressive pain. I can state my opinions as to within a reasonable degree of medical probability.

¶ 7 Upon receiving Dr. Primack's opinion, Dr. Lugliani again placed claimant at MMI, and agreed she did "not require an impairment rating in relation to the left shoulder" and that any future treatment "to the left shoulder is not work related."

¶ 8 Claimant then requested a DIME. The DIME physician, Dr. Allison Fall, examined claimant and concurred with Dr. Lugliani's original assessment that claimant reached MMI on May 26, 2016. Dr. Fall also concluded that claimant sustained a permanent impairment to her right knee as a result of the fall and gave

claimant an impairment rating of 20% of the right lower extremity. However, like Drs. Primack and Lugliani, Dr. Fall determined that claimant's shoulder complaints were unrelated to the workplace injury. She opined:

> I find no work-related relatable impairment to the cervical, thoracic, or lumbar spine, bilateral shoulders, or psychological issues. She has complained of shoulder pain; however, her examinations were inconsistent with, at times, showing full range of motion. Her shoulders had been evaluated numerous times. Now, her shoulder range of motion is quite different than what was depicted in the medical records. Therefore, at this time, I am unable to state that her current right shoulder complaints are directly related to the work-related injury. The MRI findings are most likely chronic, given that she did not have acute pain associated with acute tearing at the moment her hands hit the ground.

¶ 9 The opinions of Drs. Fall, Primack, and Lugliani were not shared by all physicians who examined claimant. Dr. Benjamin Sears, a private physician claimant saw outside of the workers' compensation system, eventually performed two arthroscopic surgeries to repair claimant's rotator cuff tears. He contradicted Dr. Fall's causality conclusion, opining instead that claimant's shoulder injury was likely work-related:

> This is . . . regarding my patient, Velma Brooks, who is status post a fall that occurred while she was substitute teaching approximately a year prior. Then she was found to have bilateral rotator cuff tears. She reports that she had no shoulder pain or problems prior to this fall and that she has had pain since that time. I recently fixed her left shoulder, which demonstrated a full-thickness cuff lesion. We know she has right shoulder rotator cuff disease as well.
>
> This is in regard to her Work Comp case. It does seem that this injury occurred during this fall which was sustained while the patient was at work.

¶ 10 Supported by Dr. Sears' opinion, claimant applied for a hearing to overcome Dr. Fall's DIME report. The dispute proceeded to hearing, although a transcript of that hearing is not included in the record before us or the Panel. After listening to claimant's testimony and reviewing the admitted evidence, the ALJ concluded that claimant had not overcome the DIME's opinions. Noting that Dr. Fall's DIME opinion was corroborated by the opinions of Drs. Primack and Lugliani, and that contemporaneous chiropractic notes "failed to demonstrate any significant shoulder pathology," the ALJ found that Dr. Sears' contrary opinion did "not rise to the level of it being 'highly probable' that the DIME physician erred."

Thus, although claimant received a permanent partial impairment rating of 20% for her right lower extremity, her shoulder injury was found to be unrelated to her work injury.

¶ 11 On review, the Panel affirmed, holding that substantial evidence supported the ALJ's findings and decision.

II. Analysis

¶ 12 Claimant now challenges the ALJ's adoption of the DIME determination that her bilateral shoulder injuries were not related to her work injury. She contends that Dr. Fall based her opinion on false information contained in Dr. Primack's report. She also criticizes Dr. Lugliani's decision to discharge her from treatment "without further evaluation of my shoulder issues." In support of her position, she asserts that she experienced pain in her shoulders so severe that she "could not sleep at night," and implies that treatment for her shoulder pain, including the surgeries Dr. Sears performed, should have been compensable. None of these arguments, however, merits setting aside the Panel's order.

A. Governing Law and Standard of Review

¶ 13 A DIME physician's opinions concerning MMI and impairment of the whole person are binding unless overcome by clear and

convincing evidence. § 8-42-107(8)(b)(III), C.R.S. 2018; *Meza v. Indus. Claim Appeals Office*, 2013 COA 71, ¶ 15. "Clear and convincing evidence means evidence which is stronger than a mere 'preponderance'; it is evidence that is highly probable and free from serious or substantial doubt." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995).

¶ 14 Whether a party has overcome the DIME physician's opinion is a question of fact to be resolved by the ALJ. *Id.* We may not set aside the ALJ's determination that a party has or has not overcome the DIME if the finding is supported by substantial evidence in the record. *See* § 8-43-308, C.R.S. 2018; *Benuishis v. Indus. Claim Appeals Office*, 195 P.3d 1142, 1144-45 (Colo. App. 2008). "Substantial evidence is that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage*, 914 P.2d at 414.

¶ 15 We note that claimant should only have had to show that her shoulder injury was related to her workplace fall by a preponderance of the evidence. Although DIME opinions regarding MMI and impairment of the whole person must be overcome by

clear and convincing evidence, a DIME's opinions concerning threshold causation — like the question of the causality of claimant's shoulder injuries — carries no presumptive weight. *See Leprino Foods Co. v. Indus. Claim Appeals Office*, 134 P.3d 475, 483 (Colo. App. 2005) ("[T]he threshold question of whether the claimant has sustained a compensable injury in the first instance is one of fact that the ALJ must determine, if contested, under the preponderance of the evidence standard. Consequently, the DIME physician's opinion on this issue is not entitled to special or presumptive weight."). However, because claimant does not challenge the application of the burden on proof,, we do not address it..

B. Substantial Evidence Supports the ALJ's Findings

¶ 16 Claimant essentially asks us to reweigh the evidence to reach a finding contrary to the ALJ's conclusion, arguing that the evidence is not susceptible to the ALJ's interpretation. But, we may not reweigh the evidence. *See Metro Moving & Storage*, 914 P.2d at 415. Likewise, "we may not interfere with the ALJ's credibility determinations" unless the evidence is "overwhelmingly rebutted by hard, certain evidence" to the contrary. *Arenas v. Indus. Claim*

Appeals Office, 8 P.3d 558, 561 (Colo. App. 2000); *see also Youngs v. Indus. Claim Appeals Office*, 2012 COA 85M, ¶ 46 ("Nor may we set aside a ruling dependent on witness credibility where the testimony has not been rebutted by other evidence."). The weight to be given expert medical testimony is within the ALJ's sound discretion. *See Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990).

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

¶ 18 Nevertheless, even if we exclude hearing testimony from our analysis, medical reports and written opinions that are contained in the record amply support the ALJ's decision. As described above, both Drs. Primack and Lugliani corroborated Dr. Fall's conclusion that no causal relationship existed between claimant's workplace fall and her ongoing complaints of bilateral shoulder pain. Drs. Fall and Primack both commented that claimant's shoulder pain

complaints were "inconsistent," and, "at times, showed full range of motion."

¶ 19 Although claimant suggests that Dr. Sears' opinions are more trustworthy and should be given greater weight than the opinions of Drs. Fall, Primack, and Lugliani, such credibility determinations are soundly within the ALJ's discretion and claimant has offered no basis to challenge the ALJ's finding that their opinions were credible and persuasive and that Dr. Sears' opinion was insufficient to overcome them. *See Youngs*, ¶ 46; *Arenas*, 8 P.3d at 561; *Rockwell Int'l*, 802 P.2d at 1183. Because Dr. Fall's opinions are corroborated by those of Drs. Primack and Lugliani, the ALJ's conclusion that "at best" Dr. Sears' contrary opinion "shows only a disagreement among physicians," is supported by the record. *See Youngs*, ¶ 46; *Arenas*, 8 P.3d at 561.

¶ 20 Accordingly, we conclude that the evidence amply supports the ALJ's factual findings and legal conclusions. We therefore perceive no basis for setting aside the Panel's or the ALJ's orders. *See* § 8-43-308; *Wal-Mart Stores, Inc. v. Indus. Claim Appeals Office,* 989 P.2d 251, 252 (Colo. App. 1999); *Metro Moving & Storage*, 914 P.2d at 415.

III. Conclusion

¶ 21 The order is affirmed.

CHIEF JUDGE LOEB and JUDGE KAPELKE concur.

COLORADO COURT OF APPEALS

DATE FILED: November 1, 2018
CASE NUMBER: 2017CA1998

Court of Appeals No. 17CA1998
Industrial Claim Appeals Office of the State of Colorado
WC No. 4-975-232

Daniela Gosselova,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado and Vail Resorts,

Respondents.

ORDER AFFIRMED

Division IV
Opinion by JUDGE HAWTHORNE
Bernard and Tow, JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced November 1, 2018

Daniela Gosselova, Pro Se

No Appearance for Respondent Industrial Claim Appeals Office

Ritsema Lyon P.C., Paul Krueger, David R. Bennett, Denver, Colorado, for Respondent Vail Resorts

¶ 1 In this workers' compensation action, claimant, Daniela Gosselova, seeks review of a final order of the Industrial Claim Appeals Office (Panel), which affirmed the order of an administrative law judge (ALJ) denying claimant's request for a change in or deauthorization of a physician. We affirm.

I. Background

¶ 2 Claimant worked for employer, Vail Resorts, Inc., as an outdoor emergency medical technician with Vail's ski patrol. She is also a level-3 ski instructor. On February 4, 2015, claimant injured her knee skiing off duty at Beaver Creek. A few days later, on February 9, 2015, while "unloading fencing supplies from the basket" of a snow cat at Vail, claimant further injured her meniscus and anterior cruciate ligament (ACL).

¶ 3 Claimant reported her injury to her supervisor. Vail instructed her to seek treatment at Avon Occupational Health. However, it failed to provide her with the names of any other providers in violation of section 8-43-404(5)(a)(I)(A), C.R.S. 2018, which requires employers to provide injured workers with a list of four physicians or treatment facilities from which to choose. Claimant complied with Vail's instructions by attending

appointments at Avon Occupational Health. She saw a physician on staff, Dr. Frederick Scherr, numerous times between February 2015 and February 2017. However, after learning that Avon Occupational Health did not have on-site orthopedic facilities, claimant sought treatment at Vail Summit Orthopedics. Vail conceded its error in providing only one medical treatment option and agreed that Vail Summit Orthopedics and the physicians there, particularly Dr. Peter Janes, should become claimant's authorized treating physicians (ATPs) along with Dr. Scherr.

¶ 4 In March and June of 2015, Dr. Janes performed surgery on claimant's knee. Six months later, Dr. Janes suggested another scope of claimant's knee because her knee pain persisted. Reluctant to undergo another surgery, claimant asked Dr. Scherr to refer her to another physician for a second opinion. However, the physician to whom Dr. Scherr referred claimant, Dr. Robert LaPrade, seconded Dr. Janes' opinion that another scope was necessary because "her ACL graft has failed."

¶ 5 A month later, on April 26, 2016, claimant told Dr. Scherr that although Drs. Janes and LaPrade recommended additional surgery, she was unwilling to undergo another procedure. She asked Dr.

Scherr to refer her for another medical opinion, but Dr. Scherr declined because he felt that a fourth opinion was "not warranted." Instead, Dr. Scherr placed claimant at maximum medical improvement (MMI) with no permanent restrictions because, without surgery, additional treatment was unlikely to improve her condition.

¶ 6 Claimant requested a division-sponsored independent medical examination (DIME) to challenge Dr. Scherr's MMI finding. The DIME physician agreed with Dr. Scherr that claimant reached MMI in April 2016, and assigned her an impairment rating of nineteen percent of the lower extremity.

¶ 7 Claimant then applied for a hearing to challenge the DIME's MMI finding. In addition to challenging the DIME, she endorsed the issues of reasonably necessary medical treatment, permanent partial disability, and designated medical providers.

¶ 8 Before the DIME was completed, claimant independently sought treatment outside the workers' compensation system from another orthopedist, Dr. Charles Gottlob. In November 2016, Dr. Gottlob performed an arthroscopic partial medial meniscectomy, chondroplasty of the patella and medial femoral condyle, and

removal of the deep bone staple that had been implanted during a previous surgery. Claimant testified that her knee subsequently improved. She told Dr. Scherr about the post-surgery improvement to her knee, but he declined to change her MMI date.

¶ 9 At the hearing in April 2017, claimant testified that although she attended all her scheduled appointments with Dr. Scherr in order to fulfill her workers' compensation obligations, she was unhappy with his care and sought an order deauthorizing his ATP status. But, the ALJ was not persuaded that claimant "only continued going to Vail Valley Medical Center [where Dr. Scherr practices] because of workers' compensation bureaucracy." Rather, the ALJ concluded, claimant "signified through her conduct of continuing to treat extensively with Vail Valley Medical Center for over one year that she had chosen them." Based on this conclusion, the ALJ denied claimant's request to deauthorize Dr. Scherr, finding instead that "[t]he authorized providers include Dr. Scherr, Dr. Janes, Dr. St[e]rett [also of Vail Valley Medical Center], and Dr. La[P]rade." The ALJ interpreted claimant's treatment with Dr. Gottlob outside the workers' compensation system as a request to name him as an ATP, even though claimant never asked to have

Dr. Gottlob authorized. Finding that claimant exercised her right to select an authorized treating provider when she chose Dr. Janes, the ALJ ruled that Dr. Gottlob was not one of claimant's authorized treating providers and that his treatment of claimant was consequently not compensable.

¶ 10 On review, the Panel affirmed the ALJ's order. The Panel noted that "whether the claimant has made a proper showing to authorize a change of physician . . . is a discretionary determination for the ALJ." Because the evidence established that Dr. Scherr treated claimant's injury for many months, prescribed dozens of physical therapy sessions, and referred claimant to at least three orthopedic specialists for additional treatment, the Panel held that the record amply supported the ALJ's finding that a change of physician from Dr. Scherr was not warranted.

II. Analysis

¶ 11 Claimant challenges the Panel's affirmance of the ALJ's denial of her request to deauthorize Dr. Scherr. She argues that the decision should be set aside as being beyond the bounds of reason because, contrary to the ALJ's interpretation, she never requested a change to Dr. Gottlob. As we understand claimant's argument, she

contends that the ALJ's alleged misunderstanding of the framed issue — presuming claimant sought a change in physician to Dr. Gottlob when, if fact, she only sought to deauthorize Dr. Scherr — suggests the ALJ "may have selected different pieces of evidence and/or assessed findings from different point of view than she would have done if she ruled on issues that were originally presented." This alleged misframing of the issues, claimant argues, warrants setting aside the decision. We disagree.

A. Standard of Review and Governing Law

¶ 12 The Workers' Compensation Act (Act) provides that "[u]pon the proper showing to the division, the employee may procure the division's permission at any time to have a physician of the employee's selection treat the employee. . . ." § 8-43-404(5)(a)(VI)(A). A claimant is entitled to request a change of physician even "after having reached MMI to the extent that that change was for purposes of obtaining future medical treatment to relieve the effects of her industrial injury or to prevent future deterioration of her work-related condition." *Story v. Indus. Claim Appeals Office*, 910 P.2d 80, 81 (Colo. App. 1995).

¶ 13 Whether a claimant has made a "proper showing" that a change in physician is warranted is a question of fact within the ALJ's discretion. *See, e.g.*, *Kilwein v. Indus. Claim Appeals Office*, 198 P.3d 1274, 1276 (Colo. App. 2008) ("Whether a referral is made as part of the normal progression of authorized treatment is a question of fact for the ALJ to determine."); *see also Villalobos v. Spring Air Mattress Co.*, W.C. No. 4-662-825, 2007 WL 1875245, at *2 (Colo. I.C.A.O. June 22, 2007) ("The question of whether the claimant has made a proper showing to authorize a change of physician pursuant to section 8-43-404(5)(a) . . . is a discretionary determination for the ALJ."). Because the decision is discretionary, we may not set it aside unless the decision is beyond the bounds of reason. *See Coates, Reid & Waldron v. Vigil*, 856 P.2d 850, 856 (Colo. 1993) (Abuse of discretion standard "requires a showing that the alleged abuse 'exceeds the bounds of reason,' and in resolving whether an ALJ has in fact 'exceeded the bounds of reason,' courts may specifically consider whether an award is supported by the applicable law." (quoting *Rosenberg v. Bd. of Educ. of Sch. Dist. #1*, 710 P.2d 1095, 1098-99 (Colo. 1985))); *Pizza Hut v. Indus. Claim Appeals Office*, 18 P.3d 867, 869 (Colo. App. 2001) (When decision

"is discretionary, we may not interfere with the ALJ's order unless it is beyond the bounds of reason, that is, where it is unsupported by the evidence or contrary to law.").

B. Substantial Evidence Supports ALJ's Decision Not to Deauthorize Dr. Scherr

¶ 14 Claimant maintains that she did not request a change to a new physician. As we understand her position, she sought Dr. Scherr's deauthorization without naming a desired replacement, instead suggesting that Vail could provide a list of physicians. The Act does not specify a procedure for the exclusive deauthorization of a physician without the naming of a replacement, but the procedures for changing a physician under section 8-43-404(5)(a)(VI)(A) are relevant. The ALJ was not wrong to proceed under this provision. And, because the ALJ has discretion to determine whether a claimant has made a proper showing warranting a change in physician, we must uphold the ALJ's decision if it is supported by substantial evidence. *See Pizza Hut*, 18 P.3d at 869.

¶ 15 The undisputed evidence establishes and supports the ALJ's finding that claimant saw Dr. Scherr or treaters in his practice at

least a dozen times between February 2015 and February 2017. Similarly, it confirms that Dr. Scherr referred claimant to specialists, prescribed multiple physical therapy sessions and medications, and evaluated claimant's overall treatment. The ALJ was not persuaded by claimant's explanation that she "only continued" seeing Dr. Scherr to comply with applicable workers' compensation requirements. Rather, the ALJ concluded that by her "words and conduct" claimant selected Dr. Scherr as an authorized treating provider for her work-related injury.

¶ 16 Because this evidence supports both the ALJ's determination that Dr. Scherr was claimant's authorized treating physician and that deauthorizing him was not warranted, we must uphold these findings and cannot set them aside.

¶ 17 We are not persuaded to reach a different conclusion by claimant's concern that treatment with Dr. Scherr could be duplicative. First, we know of no currently pending treatment.

¶ 18 Second, and perhaps more importantly, claimant's future need to treat with Dr. Scherr is speculative. She has reached MMI, a finding which is now final because she did not seek review of the ALJ's MMI determination. She could seek post-MMI medical

benefits, but only if she shows such treatment is "reasonably necessary to relieve [her] from the effects of the industrial injury." *Grover v. Indus. Comm'n*, 759 P.2d 705, 710 (Colo. 1988). Dr. Scherr opined that the "only maintenance [claimant would require] would be for the hardware removal. . . . There is no further maintenance or care warranted at this time." No order in the record awards her maintenance medical benefits. If such an order were to be issued or claimant actively sought post-MMI treatment, other specialists she trusts — including Drs. Janes, Sterett, and LaPrade, all of whom the ALJ also named as ATPs — could potentially provide the needed care. And, if either party were to contest the reasonableness or necessity of any future recommended treatment, that party may challenge the treatment at that time. *See Hanna v. Print Expediters Inc.*, 77 P.3d 863, 866 (Colo. App. 2003) ("Once the claimant establishes the probability of a need for future treatment, the claimant is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity."). Consequently, any suggestion that future treatment may be duplicative is purely speculative.

C. Remaining Contentions

¶ 19 Claimant next suggests that the Panel erred in applying "the procedure listed in 8-43-404(5)[(a)](VI)(B)" because a) section 8-43-404(5)(a)(VI)(B) cannot be applied retroactively; and, b) she was seeking a change in physician under section 8-43-404(5)(a)(III). Neither of these arguments persuades us to reach a different outcome.

¶ 20 Section 8-43-404(5)(a)(VI)(B) provides for the automatic deauthorization of a physician when a claimant is granted a request for a newly-authorized physician. The legislature added sub-subparagraph (B) in 2016, effective July 1 of that year. We agree that section 8-43-404(5)(a)(VI)(B) does not apply retroactively and that it did not apply to this case. *See Berthold v. Indus. Claim Appeals Office*, 2017 COA 145, ¶ 20.

¶ 21 Contrary to claimant's contention, though, section 8-43-404(5)(a)(III) does not apply, either. Changes in physician under that provision are limited to requests made "within ninety days after the date of injury." § 8-43-404(5)(a)(III)(A). As claimant acknowledges, she did not make such a request within the first ninety days of her injury. Rather, she requested Dr. Scherr's

deauthorization nearly two years after her injury, and almost eighteen months after he first personally examined her. She could not, then, seek a change of physician deauthorizing him under section 8-43-404(5)(a)(III)(A).

¶ 22 Her request for a change of physician was properly addressed under section 8-43-404(5)(a)(VI)(A), which permits a claimant to request a change in physician at any time. As we have already discussed claimant's request to deauthorize Dr. Scherr under section 8-43-404(5)(a)(VI)(A), we need not address it further.

¶ 23 Last, to the extent claimant asks us to set aside the Panel's and ALJ's orders because they are "unfair," we cannot do so. Our review of any Panel decision is limited to the bases set forth in the Act. We may set aside a Panel's decision

> only upon the following grounds: That the findings of fact are not sufficient to permit appellate review; that conflicts in the evidence are not resolved in the record; that the findings of fact are not supported by the evidence; that the findings of fact do not support the order; or that the award or denial of benefits is not supported by applicable law. If the findings of fact entered by the director or administrative law judge are supported by substantial evidence, they shall not be altered by the court of appeals.

§ 8-43-308, C.R.S. 2018. "Unfairness" is not a ground upon which we can set an order aside. Accordingly, this contention does not articulate a basis upon which we can set aside the Panel's order affirming the ALJ's decision.

III. Conclusion

¶ 24 The order is affirmed.

JUDGE BERNARD and JUDGE TOW concur.