COLORADO
Department of
Labor and Employment

Division of Workers' Compensation
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August Case Law Update

Presented by Judge Laura Broniak and Judge Marcus Zarlengo

This update covers COA and ICAO decisions issued from
July 11, 2020, to August 13, 2020

Court of Appeals

Industrial Claim Appeals Office

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COLORADO COURT OF APPEALS

DATE FILED: July 23, 2020
CASE NUMBER: 2019CA651

Court of Appeals No. 19CA0651
Industrial Claim Appeals Office of the State of Colorado
WC No. 505-39-06

Aaron Chaussignand,

Petitioner,

v.

Industrial Claim Appeals Office of the State of Colorado, West Lake Creek Co, LLC, and Pinnacol Assurance,

Respondents.

ORDER AFFIRMED

Division III
Opinion by CHIEF JUDGE BERNARD
Vogt* and Taubman* JJ., concur

NOT PUBLISHED PURSUANT TO C.A.R. 35(e)
Announced July 23, 2020

Cairns Associates, P.C., Gregory Cairns, Denver, Colorado, for Petitioner

No Appearance for Respondent Industrial Claim Appeals Office

Harvey D. Flewelling, Denver, Colorado, for Respondents West Lake Creek Co, LLC, and Pinnacol Assurance

*Sitting by assignment of the Chief Justice under provisions of Colo. Const. art. VI, § 5(3), and § 24-51-1105, C.R.S. 2019.

¶ 1 In this workers' compensation action, a claimant, Aaron Chaussignand, asks us to review a final order of a panel of the Industrial Claim Appeals Office. The order affirmed a decision of an administrative law judge that denied and dismissed his claim for benefits. We affirm.

I. Background

¶ 2 Claimant worked as a seasonal farm laborer for employer, West Lake Creek Company, in Eagle County during the summer of 2017; he had his fifteenth birthday during that time. In late June, he changed positions and began working "on the ranch side of the operations" on an as-needed basis.

¶ 3 At the end of July, the claimant and two coworkers were clearing branches, loading them onto a truck, moving them, and then unloading them into a pile to be burned. He later testified that, at one point, he "felt some pops" in his "upper, middle and lower" back when he was unloading branches from the truck. He told a supervisor about his injury and filled out an injury report later in the day. But the ranch's foreman said that claimant did not mention being injured and that he did not walk with a limp.

¶ 4 Immediately after receiving the injury report, employer sent claimant to a doctor. The doctor, whom we shall call "the original treating doctor," diagnosed him as suffering from sprains of the lumbar and thoracic ligaments and provided some treatment.

¶ 5 Claimant filed a claim for benefits, which employer contested on causality grounds. During the ensuing hearing, numerous discrepancies emerged between claimant's testimony and the testimony of other witnesses:

- Claimant testified that, on the day he was injured, he and his coworkers were "moving various objects going from trees, to stumps, to logs, to rocks, to various pieces of trash." Employer's director of administration disputed claimant's characterization, testifying that employer did not "move rocks . . . [or] lift logs. We do clean branches."
- Claimant said that some of the branches weighed over fifty pounds. He told one physician that the branches weighed up to seventy-five pounds. But the ranch's foreman, with whom claimant worked on the day of his putative injury, testified that the branches weighed "anywhere from 5 pounds to maybe

30 pounds." And the ranch's manager testified that the branches "would probably be half inch to an inch in diameter."

- The ranch's foreman testified that the bed of the flatbed truck was "around 3 feet" off the ground, referring to a photograph to illustrate the truck's design. For perspective, the ranch's manager said that the truck bed came up to his waist. But claimant denied that the truck's bed was only three feet high, repeatedly stating that he had to stand on his "tippy toes" to reach the bed to unload the branches.
- Claimant insisted that, when he quit working as a seasonal farm laborer and switched to the ranch side of the operations, the director of administration told him that he would be working full time. But she testified that, when she met with claimant and his mother about changing his duties, she emphasized that the new position with the ranch would *not* be full time; he would, instead, work on an as-needed basis.
- Claimant unequivocally stated that it "is very accurate" that he had "no prior back problem." But employer's medical expert testified that his review of claimant's prior medical records uncovered numerous prior complaints and medical visits for

back pain in 2016 and 2017, some related to claimant's competitive skiing.

- Claimant said that employer's expert became "really mad because I was filling out the [pain diagram] really slow, so he said my mom could help make it a little bit faster. So I told her what to put down." But employer's expert said that claimant's description of the incident was "not at all" accurate. According to employer's expert, "when [he] walked into the waiting room, [he] observed [claimant's] mother completing the pain diagram and the review of system checklist. So [he] asked [claimant] why, and [claimant's] mother responded that her son was dyslexic so she had to help . . . ." Employer's expert denied instructing claimant's mother to fill out the paperwork, adding that he had asked claimant to do it.

¶ 6 The administrative law judge expressly rejected claimant's testimony, finding it neither credible nor persuasive. Instead, the judge credited the testimony of the director of administration, the ranch's foreman, and the ranch's manager concerning the nature of claimant's employment "and the events of" the late July 2017 date when claimant claimed that he was injured.

¶ 7 The judge also credited the testimony and opinions of employer's expert, who expressed reservations that the mechanism of claimant's injury could cause enduring pain months later. He repeatedly said that claimant's injury made no sense to him. Elaborating on his opinions, he testified that

- the "mechanism of injury was minor";
- MRI findings showed no acute injury and there were "absolutely no objective findings of an acute injury";
- claimant's presentation at the examination was inconsistent with an eight-out-of-ten pain rating;
- claimant's complaints of hand and foot pain, without complaints of shooting pain down an arm or leg, were "not radicular" and could not be spinally-caused;
- he shared the original treating doctor's concerns that claimant had heightened pain complaints, that he had exerted "minimal effort" during muscle testing examinations, and that he had described pain and disability inconsistent with findings on examination; and
- any muscle strain claimant may have suffered on the day in question "should have been better within a week."

¶ 8 Distilling his observations, employer's expert decided that claimant's "current condition [was not] causally related to the alleged injury that occurred in July of 2017." He added that any injury claimant had sustained then had reached maximum medical improvement and that claimant had not suffered any permanent impairment as a result of the putative work-related injury.

¶ 9 Based on his credibility determinations, the judge determined that claimant had not sustained an injury on the day in question. Rather, the judge found, claimant's back pain and need for treatment were "related to his longstanding medical history." Because the judge decided that claimant had not shown that he had suffered a compensable injury in July 2017, the judge denied claimant's claim for benefits and then dismissed it.

¶ 10 The panel upheld the judge's decision on review because substantial evidence in the record supported it.

II. Analysis

¶ 11 On appeal, claimant contends that the evidence supports a finding that he suffered a compensable injury that necessitated medical treatment. He points out that employer's expert never said that he had not suffered an injury and, instead, had deferred to the

original treating doctor's diagnosis of a lumbar and thoracic muscle strain. As a result, he submits that employer's expert's testimony that the "mechanism of injury was minor" confirms that he had sustained an injury.

¶ 12 Claimant also highlights employer's expert's suggestion that treatment may be necessary "depend[ing] on who the patient is." He contends that this evidence supported an award of benefits and that it requires us to set aside the panel's decision.

¶ 13 Finally, he asserts that his "age at the time of the injury and testimony" should have been given greater consideration and weight.

¶ 14 We are not persuaded by any of these contentions.

A. Standard of Review

¶ 15 The Workers' Compensation Act expressly limits this court's review of a panel's decision. The Act states:

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

> supported by applicable law. If the findings of fact entered by the director or administrative law judge are supported by substantial evidence, they shall not be altered by the court of appeals.

§ 8-43-308, C.R.S. 2019.

¶ 16 This statute means that we cannot accept claim's invitation to grant him relief beyond its borders. Rather, we are bound by the well-settled standards of review applicable when a party seeks to set aside a finding that a claim is not compensable.

B. Law Governing Compensability

¶ 17 "Proof of causation is a threshold requirement which an injured employee must establish by a preponderance of the evidence before any compensation is awarded." *Faulkner v. Indus. Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000). The issue of causation "is generally one of fact for determination by the [administrative law judge]." *Id.*; *see also H&H Warehouse v. Vicory*, 805 P.2d 1167, 1170 (Colo. App. 1990)("The [judge] has great discretion in determining the facts and deciding ultimate medical issues.").

¶ 18 We must uphold a judge's factual findings if they are supported by substantial evidence in the record. *See* § 8-43-308;

Leewaye v. Indus. Claim Appeals Office, 178 P.3d 1254, 1256 (Colo. App. 2007)("We are bound by the factual determinations of the [judge] if they are supported by substantial evidence in the record."); *Wal-Mart Stores, Inc. v. Indus. Claims Office*, 989 P.2d 251, 252 (Colo. App. 1999)("If substantial evidence supports the [judge's] conclusion that a claimant's condition is work-related, that determination may not be disturbed on review."). The reviewing court is bound by the judge's factual findings even if the evidence was conflicting and could have supported a contrary result. It is the judge's sole province, as the finder of fact, to weigh the evidence and to resolve contradictions in it. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 415 (Colo. App. 1995)(reviewing court must defer to the judge's credibility determinations and resolution of conflicts in the evidence and may not substitute its judgment for that of the judge).

C. Substantial Evidence Supports the Judge's Finding That Claimant Did Not Suffer a Compensable Injury

¶ 19 Claimant essentially asks us to reweigh the evidence to reach a finding contrary to the judge's conclusion, asserting that the evidence was not susceptible to the judge's interpretation. But we

may not reweigh the evidence, *see id.*, and "we may not interfere with the [judge'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.").

¶ 20 Claimant bore the burden of establishing his entitlement to benefits in this case. *See Faulkner*, 12 P.3d at 846. But the judge did not find him to be credible or persuasive.

¶ 21 As we have indicated above, employer's witnesses directly contradicted claimant's description of his working conditions, and their testimony supported the judge's finding that he was not credible. For example, their testimony differed from claimant's with respect to the weight and size of the branches, whether he also had to move rocks and logs, and the height of the truck's bed. For another example, claimant and the director of administration disagreed about the parameters of claimant's employment at the ranch: he insisted that he had been hired to work full time on the

ranch, while the director said that he only worked on an as-needed basis.

¶ 22 Because the law entrusts the judge with the authority to make credibility determinations — the judge has the benefit of personally seeing witnesses testify — we are prohibited from setting aside those credibility determinations unless there is "hard, certain evidence" to the contrary. *Arenas*, 8 P.3d at 561. Claimant has not pointed to any "hard, certain evidence" in the record contradicting the judge's credibility determinations. We therefore conclude that the record supports the judge's finding that claimant's testimony was not credible.

¶ 23 The judge's determination that claimant did not sustain a compensable work injury is further supported by the testimony and report of employer's expert, who said that the mechanism of claimant's injury was minor and that it should not have resulted in ongoing symptoms. He explained that claimant's pain profile was beyond the duration or severity expected for his injuries, noted that the original treating doctor shared these doubts, and emphasized that there were no objective findings establishing the cause of claimant's pain complaints. In addition, he pointed to medical

records establishing claimant's prior complaints of back pain, despite claimant's denial that he had previously experienced back problems. And, although employer's expert deferred to the original treating doctor's diagnosis that claimant had suffered a back sprain, this deference, contrary to claimant's assertion, does not outweigh employer's expert's other opinions.

¶ 24 Importantly for our review, the weight to be given expert medical testimony is within the judge's sound discretion. *See Rockwell Int'l v. Turnbull*, 802 P.2d 1182, 1183 (Colo. App. 1990). The judge consequently acted well within her discretion when she credited the opinion of employer's expert. We therefore will not disturb that credibility determination. *See Rockwell Int'l*, 802 P.2d at 1183.

¶ 25 To the extent that claimant suggests that he should have been treated differently because he was a minor at the time of his injury and at the time of the hearing, he offers no authority in support of this contention. And he was represented by counsel at the hearing, who protected his interests. *See, e.g.*, *In re Marriage of Barnthouse*, 765 P.2d 610, 612 (Colo. App. 1988)(Attorney representing child "must represent the children's interests alone. In so doing, the

attorney is not to take a passive role but should present all evidence available concerning the child's best interests. The attorney is not simply to parrot the child's expressed wishes.").

¶ 26 Accordingly, we conclude that the evidence amply supports the judge's factual findings and legal conclusions that claimant did not show that he had suffered a compensable injury while working on the ranch on the day in question. We will not, therefore, set aside the panel's or the judge's orders. *See* § 8-43-308; *Faulkner*, 12 P.3d at 846; *Metro Moving & Storage*, 914 P.2d at 415.

¶ 27 Having upheld the judge's finding that claimant did not sustain a compensable injury, we need not address claimant's assertions that his medical treatment was reasonable and necessary or that he was entitled to temporary total disability benefits.

¶ 28 The order is affirmed.

JUDGE VOGT and JUDGE TAUBMAN concur.

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-108-612-001

IN THE MATTER OF THE CLAIM OF:

ALEX MERCADO,

Claimant,

v.

STATE OF COLORADO
DEPARTMENT OF CORRECTIONS,

Self-Insured Employer,
Respondent.

FINAL ORDER

The respondent seeks review of an order of Administrative Law Judge Felter (ALJ) dated November 27, 2019, that ordered the respondent to pay temporary total disability benefits and medical benefits. We affirm.

The claimant was employed as a correctional officer at the Denver Women's Correctional Facility. While working the graveyard shift the evening of May 16 through May 17, 2019, the claimant reported he twisted and hurt his right ankle while descending a flight of stairs. The claimant indicated that when he stepped awkwardly on a step he felt a twinge of pain but did not think much of it. However, following the conclusion of his shift the pain and swelling in his ankle continued to increase.

The claimant reported the injury to his supervisor approximately ten hours after the end of his shift. The claimant visited the emergency room on May 20 where he was given a walking boot. An X-ray did not initially reveal any fracture. The claimant reported a history of an injury to his right ankle three years previously that included an avulsion fracture for which he did not complete treatment. The claimant followed up at the Concentra Clinic on May 24. There he was diagnosed with a chronic avulsion fracture of the medial malleolus. He was restricted to modified duty featuring sitting for 95% of his shift and no climbing of stairs. On August 1 the claimant was examined at the UC Health Foot and Ankle Center-Stapleton. The diagnosis of a chronic avulsion fracture was confirmed. There was no evidence of an acute osseous injury. An MRI was requested and a lace up ankle brace was prescribed as was as a course of physical therapy.

The respondent disputed the compensability of the injury relying upon security video of the claimant making his rounds during his shift the early morning of May 17. The video did not reveal a precipitous event or evidence of a limp or pain behavior on the part of the claimant. The respondent contended the claimant's injury either did not occur at work or was caused by a preexisting condition and was not affected by any circumstance that could be characterized as a 'hazard of employment.'

The ALJ seemingly ruled the claim compensable on two alternative grounds. Initially, the ALJ found the claimant twisted his right ankle while descending a flight of stairs within the course and scope of his employment. Alternatively, the ALJ discussed how the claimant's injury might have been caused by a preexisting condition that combined with a hazard of employment that led to the claimant's injuries. The hazard of employment was identified as the requirement that the claimant ascend and descend stairs routinely as part of his work duties.

The ALJ accepted the parties' stipulation of the average weekly wage as $949.38 and that the physicians at UC Foot and Ankle Center were authorized to treat the claimant. The ALJ found the claimant had last worked on May 17, 2019, and has been prevented by his injury restrictions from working since that date. The claimant was awarded temporary total disability benefits from the date of the injury through the date of the hearing on November 6, 2019. The respondent was also found liable for the costs of authorized medical care related to the right ankle injury.

On appeal, the respondent contends the evidence does not support a finding the claimant sustained an ankle injury on May 17. The respondent points to the security video and to the medical diagnosis of a 'chronic' avulsion fracture that predated the point of the alleged injury. The respondent also argues that when the cause of an injury is a preexisting condition the injury is not compensable unless a special hazard of employment combines with the preexisting condition to increase the degree of injury. Respondent asserts the ALJ's finding the claimant was required to constantly ascend and descend stairs as a function of his job made the stairs a hazard of employment is not supported by evidence in the record. The respondent makes a similar point in regard to the ALJ's finding the requirement the claimant had to go up and down stairs aggravated and accelerated the claimant's preexisting right ankle condition that had been asymptomatic. The respondent asserts the claimant is not making an occupational disease claim, but rather, a claim of a specific accidental injury occurring at a specific time while descending a flight of stairs.

While the ALJ's alternative finding of compensability involving a hazard of employment may be subject to objection as not consistent with the law concerning compensability, that is not the case with the ALJ's initial finding of compensability. The Supreme Court pointed out in *City of Brighton v. Rodriquez*, 2014 CO 7, 318 P.3d 496 (Colo. 2014), an injury "arises out of" employment when it has its "origin in" an employee's work-related functions and is "sufficiently related to" those functions so as to be considered part of employment. 2014 CO 7, ¶ 17. The Court categorized the risks of injury encountered by an employee as belonging to one of three descriptions. The first is 'employment' risks which are an inherent part of the occupation and are compensable. The second are 'personal' risks that are unique to the employee and are usually not compensable. The third are 'neutral' risks that are compensable if the risk that led to an injury would not have occurred 'but for' the employee's work obligations.

The concept of a 'hazard of employment' is significant only in the context of the second category of a personal risk. *Id*. at 2014 CO 7, ¶ 22 note 3. When applied to an injury while negotiating stairs, this category necessarily features a fall that was caused by an idiopathic circumstance such as a preexisting injury or medical condition. In that case, the resulting injury is not compensable unless the injury was aggravated in its degree by an accompanying hazard of employment. For example, in *Randell v. Horn*, 781 P.2d 150, 152 (Colo. App. 1989), the claimant was injured when he suffered an epileptic seizure, an idiopathic condition, but the injury became compensable when the seizure caused him to fall twenty five feet from the scaffolding on which he was working.

However, contrary to the assertion of the respondent, the evidence in the record does not indicate the claimant's previous avulsion fracture played any role in his injury on the stairwell. The claimant testified: "I had stepped on the edge of one of the steps and I felt, like, a twinge in my right ankle. You know, as if your – twisted it." Tr. at 16. In the First Report of Injury he filled out, the claimant wrote "… as I was coming down the stairs I stepped on the edge of one of the steps with the bottom middle of my foot, I felt an immediate twinge of pain, I originally thought it was just a sprain …", Exhibit D at 10. There is no description of the injury, either by the claimant, a medical treater, or a witness, that a preexisting avulsion fracture of three years duration that featured no symptoms caused the twist of the claimant's ankle on May 17. In *City of Brighton* the Court viewed similar circumstances as adequate to exclude the claimant's fall on a stairway from the category of personal risks: "…Rodriguez's fall was not attributable to her preexisting brain aneurysms and that there was no other evidence to indicate that her fall was caused by an idiopathic condition." Id. at ¶ 22. Accordingly, the concept of a 'hazard of employment' has no applicability in this case.

Instead, the *City of Brighton* decision places this case in the category of a 'neutral' risk that is compensable due to the answer to the required 'but for' analysis.

> It is clear that Rodriguez's fall [on a stairway] was not the result of an occupational hazard or a personal risk. Because the precise mechanism of her unexplained fall was neither occupational nor personal, by definition, such a fall is fundamentally similar to other neutral risks -- like car thieves, lightning, murderous lunatics, and stray bullets -- because none of these risks has a connection with the employee's work or with the employee him- or herself. 2014 CO ¶ 24.
>
> ...
>
> Importantly, however, injuries stemming from neutral risks, whether such risks be an employer's dry and unobstructed stairs or stray bullets, "arise out of" employment because they would not have occurred but for employment. That is, the employment causally contributed to the injury because it obligated the employee to engage in employment-related functions, errands, or duties at the time of injury. See *Horodysky*, 32 P.3d at 477 ("[A]n injury is compensable under the Act as long as it is triggered by a neutral source that is not specifically targeted at a particular employee and would have occurred to any person who happened to be in the position of the injured employee at the time and place in question."); 2014 CO 7, ¶ 25.

Here, the ALJ found: "On May 17, 2019, at approximately 4:15 AM while in the course and scope of his employment descending stairs, the claimant twisted his right ankle (Respondent's Exhibit D). At the time of his injury, the claimant was working with Officer Linda Doeur and was performing rounds in Unit 3D while on the graveyard shift which commenced at 9:45 PM and ended at 6:15 AM." Findings of Fact ¶ 2. As noted above, this finding was supported by the claimant's testimony and the First Report of Injury cited by the ALJ. The finding indicates that 'but for' the requirement that the claimant climb down the stairs to perform a job function he would not have twisted and injured his ankle. There was no indication a three year old fracture of the ankle caused the claimant to twist his ankle on the stairs. Consistent with the analysis in *City of Brighton,* we find no error in the ALJ's finding of compensability.

The fact a preexisting condition did not contribute to the occurrence of the work injury is distinct from the situation where the presence of the preexisting condition

nonetheless contributed to the resulting disability of the claimant. "An employer takes an employee as he finds him, and if an injury is significant in that there is a direct causal relationship between the precipitating event and the resulting disability, an industrial injury is still compensable if it has caused a dormant pre-existing condition to become disabling." *Lindner Chevrolet v. Industrial Claim Appeals Office*, 914 P.2d 496, 499 Colo. App. (Colo. App. 1995). Insofar as a claimant establishes that his work-related injury contributed in some degree to a temporary wage loss, the claimant is eligible for temporary disability benefits. *PDM Molding v. Stanberg*, 898 P.2d 542 (Colo. 1995).

Here, the ALJ found the claimant's three year old avulsion fracture had healed by the time the claimant twisted his ankle on May 17. It was found to have presented the claimant with no restrictions as of May 17, 2019. Findings of Fact ¶ 17. The ALJ also determined the claimant's twisting of his ankle on May 17 "aggravated and accelerated" the preexisting condition of a right ankle avulsion fracture. Findings of Fact 20, 25. These findings indicate that while a portion of the claimant's disability may be related to his preexisting ankle fracture, at the same time the twisting injury occurring on May 17 did contribute to some degree to his wage loss. The award of temporary disability benefits and medical benefits are therefore supported by the findings of fact.

It is the prerogative 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). Despite the respondent's arguments, we perceive no extreme circumstances here.

The ALJ's discussion of a possible hazard of employment represented by the routine use of stairs at work notwithstanding, we conclude the ALJ's determination the claimant twisted his right ankle at work while descending stairs on his work rounds on May 17 to be supported by substantial evidence in the form of the claimant's testimony and written report of the injury. The security video that does not record a stumbling event does not necessarily require an opposite conclusion. It is not inconsistent with the claimant's testimony that his injury dramatically worsened in the hours after he finished his shift which would not have been captured on the video. There was little delay in the claimant's reporting of his injury. The ALJ's finding of a disabling injury on May 17 is supported by substantial evidence in the record.

IT IS THEREFORE ORDERED that the ALJ's order issued November 27, 2019, is affirmed.

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

7/23/2020 by TT .

LAW OFFICE OF OTOOLE & SBARBARO PC, Attn: NEIL D OTOOLE ESQ, 226 WEST 12TH AVENUE, DENVER, CO, 80204 (For Claimant)
OFFICE OF THE ATTORNEY GENERAL, Attn: HOLLY M BARRET ESQ, C/O: WORKERS COMPENSATION UNIT, 1300 BROADWAY 10TH FLOOR, DENVER, CO, 80203 (For Respondents)

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

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

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

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 4-797-901

IN THE MATTER OF THE CLAIM OF:

ROCKY TARAVELLA,

Claimant,

v.

US BANCORP,

Employer,

and

OLD REPUBLIC INSURANCE COMPANY,

Insurer,
Respondents,

v.

INJURED WORKERS PHARMACY,

Interested Party.

FINAL ORDER

The respondents seek review of an order of Administrative Law Judge Edie (ALJ) dated March 4, 2020, that ordered them to pay the Injured Workers Pharmacy (IWP) for several prescriptions it filled for the claimant. We affirm.

The Panel entered a procedural order on July 1, 2020, wherein we amended the caption to add IWP as a party in interest and provided the respondents and IWP with an opportunity to object to such designation within ten (10) calendar days. No objection was received from either the respondents or IWP. The claimant did not enter an appearance for this matter and is not considered an interested party.

At hearing, the respondents sought relief from paying certain prescriptions that were filled by IWP for the claimant. Accordingly, the ALJ held that IWP was a party in interest in lieu of the claimant. *See* W.C. Rule of Procedure 16-11(D)(6), 7 CCR 1101-3 ("In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts."); *see also* W.C. Rule of Procedure 16-1, 7 CCR 1101-3 ("This Rule defines …

dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule."); *see also* §8-43-207(1)(ALJs are empowered to determine any controversy concerning any issue arising under the Colorado Workers' Compensation Act). The respondents objected to paying the bills for the following prescriptions:

8/13/19	Gabapentin 300MG	$243.53
8/13/19	Tramadol	$153.92
8/13/19	Testosterone	$48.38
8/13/19	BD Needles	$4.16
8/13/19	BD Syringe	$4.21
8/13/19	Ibuprofen	$76.23
8/13/19	Fluoxetine	$80.39
8/13/19	Desvenlafaxine	$348.04
TOTAL		$958.86

In lieu of an in-person hearing, the respondents and IWP agreed to submit a stipulation of facts to the ALJ, and to then make their respective arguments in written position statements. The stipulation of facts was submitted by the parties and approved by the ALJ in an order dated February 13, 2020. The undisputed facts are as follows:

> 1. The prescriptions at issue were received by the claimant from the authorized treating provider, Dr. Timothy Hall. Dr. Hall has been claimant's authorized treating physician since at least 2010.
>
> 2. The prescriptions were filled by the IWP, a pharmacy licensed in Colorado, and the corresponding bills are in line with the Colorado fee schedule. IWP has filled the prescriptions since November of 2012.
>
> 3. The claimant is currently receiving his medications from IWP at his home through the mail.
>
> 4. The respondents previously had denied the payment of the pharmacy bills which resulted in the IWP seeking penalties and the payment of the bills in dispute. A stipulation ultimately was entered by the parties and approved by an ALJ which resolved those issues. However, there was no agreement in the stipulation as to how this issue would be handled in the future.

5. To pursue this issue moving forward, the respondents disputed the limited bills on August 13, 2019, but have paid all the other bills. Specifically, the respondents have voluntarily paid the pharmacy bills before and after the bills from August 13, 2019, which are in dispute. The reason the respondents did this was to have this issue decided by an ALJ without discontinuance of the medications to the claimant or IWP not receiving further significant payments in the interim while the issue was litigated.

6. The nature of this dispute involves a CorVel pharmacy payment card. Specifically, the respondents sent a CorVel pharmacy payment card to the claimant in the past on numerous occasions between 2013 and 2018. The claimant was specifically instructed in writing on numerous occasions during this time frame to use the CorVel pharmacy payment card when filling the prescriptions provided by Dr. Hall.

7. The claimant also was instructed in writing on numerous occasions (including in March of 2018) that the respondents would not pay for the ongoing prescriptions provided by Dr. Hall and filled at IWP if the CorVel pharmacy payment card was not used.

8. The CorVel pharmacy payment card can be used at most pharmacies (including national chains such as Walgreens, CVS, Safeway, Sam's Club and many smaller pharmacies) and/or the claimant can have the prescriptions delivered by mail to his home for convenience. Use of the CorVel pharmacy card does not change the prescriptions or medications provided by Dr. Hall (or the choice of delivery by mail). Specifically, the claimant would obtain the precise same prescriptions and medications if the CorVel pharmacy payment card was used or not.

9. The CorVel pharmacy payment card provides a further discount on the payment of the medications. As a result, the CorVel pharmacy payment card is intended by respondents as a cost savings payment measure for the prescriptions.

> 10. The claimant has failed to use the CorVel pharmacy payment card and IWP is still filling the prescriptions. As a result, the dispute was presented to the ALJ for consideration.

The ALJ ultimately ordered the respondents to pay the costs of the prescriptions filled by IWP for the claimant. The ALJ held that while the Workers' Compensation Act (Act) and the Workers' Compensation Rules of Procedure are silent on whether a claimant can be required to use a cost containment measure, the apparent intent of W.C. Rule of Procedure 18-6(C)(2)(c), 7 CCR 1101-3, nevertheless is to ensure prescription medications are provided to injured workers in a way that provides the intended medical benefit but it also provides reasonable cost containment. Regardless, the ALJ held that the Office of Administrative Courts does not have courts of equity and, therefore, he was not in a position to impose a new requirement upon the parties where one does not otherwise exist. As pertinent here, the ALJ compared the respondents' attempt to require the claimant to use the CorVel pharmacy payment card to their attempt to substitute an ATP for simply ordering treatment with which they did not agree. He specifically held that he could not identify a legal mechanism to provide the relief sought by the respondents, no matter how reasonable their arguments might be. The ALJ further held that he could not "conclude that it is not reasonably medically necessary to continue to allow Claimant to use the pharmacy of his choice." Order at 6 ¶F.

On appeal, the respondents argue that the ALJ erred in finding it was reasonably medically necessary to continue allowing IWP to fill the claimant's prescriptions without requiring the claimant to use the CorVel pharmacy payment card. Relying on Rule 18-6(C)(2)(c), the respondents contend that it is not reasonably necessary for the claimant to continue filling his prescriptions without utilizing the CorVel payment card. They contend that this is because the claimant's failure to use this payment card unreasonably increases the price they have to pay to provide him with the medications prescribed by Dr. Hall. The respondents also argue that the ALJ erred in equating their requirement for the claimant to use the CorVel pharmacy payment card to their seeking to change an ATP because they do not like the prescribed medical treatment. The respondents argue that the ALJ's analogy is misplaced and the circumstances are factually distinguishable. The respondents explain that the claimant would obtain the precise same prescriptions and medications, including maintaining the convenience of mail delivery, if the CorVel pharmacy card is used, and that the only difference that results from the card being used is the respondents receive a discounted cost for the medications. As a result, they argue that use of the CorVel card is simply a cost containment measure that does not alter the nature of the medical treatment provided in any fashion. We are not persuaded the ALJ erred.

The respondents do not dispute that under §8-42-101(1)(a), C.R.S., they are required to provide reasonable and necessary medical treatment to cure and relieve the effects of the industrial injury. *See Grover v. Industrial Commission*, 759 P.2d 705, 711 (Colo. 1988)("legislative intent in section 8-49-101(1)(a) to make medical benefits available to a disabled worker without regard to any time limitation measured from the date of the injury as long as further treatment is reasonably necessary to relieve the worker from the effects of the industrial injury or occupational disease."). The respondents explain that given their responsibility under §8-42-101(1)(a), C.R.S., they have been paying for the claimant's prescription medications filled by IWP since November 2012. However, relying on Rule 18-6(C)(2)(c), the respondents contend that it is not reasonably necessary for the claimant to continue filling his prescriptions without utilizing the CorVel payment card.

While the respondents appear to contend that the claimant has an affirmative duty to use the CorVel payment card to obtain his prescriptions, we do not understand the Act or the Workers' Compensation Rules of Procedure to impose such a duty. *See Kraus v. Artcraft Sign Co*., 710 P.2d 480, 482 (Colo. 1985)(court has uniformly held that non-existent provisions should not be read into the Workers' Compensation Act). In interpreting Rule 18-6(C)(2)(c), the ordinary rules of statutory construction are applicable. Consequently, the words and phrases in the regulation should be given their plain and ordinary meaning. Further, Rule 18-6(C)(2)(c) should be read in connection with other provisions so that the rules may be interpreted as a whole. *Williams v. Colorado Department of Corrections*, 926 P.2d 110 (Colo. App. 1996). The Rule also should be interpreted, to the extent possible, to effect a purpose which is consistent with the authorizing statute. *See Riley Family Trust v. Hood*, 874 P.2d 503 (Colo. App. 1994).

Here, the respondents' argument notwithstanding, we do not read Rule 18-6(C)(2)(c) as requiring the claimant to use the CorVel payment card to obtain the medications prescribed by Dr. Hall. Rule 18-6(C)(2)(c) provides as follows:

> All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the Rule 16 requirements, providers prescribing a brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.

It is true, as argued by the respondents, that Rule 18-6(C)(2)(c) calls for generic drugs to be provided in place of brand name drugs unless there is a medical justification for the more expensive brand name, and this is to ensure that prescription medications are provided to injured workers to achieve the intended medical benefit in a financially reasonable way. Regardless, we do not and cannot view this Rule as allowing the respondents to require the claimant to use the CorVel pharmacy payment card to fill the prescriptions provided by Dr. Hall. If we were to read Rule 18-6(C)(2)(c) in the manner suggested by the respondents, then we would be adding non-existent provisions into the Rule, an approach that is prohibited. *Cf. Kraus v. Artcraft Sign Co., supra*. Additionally, as stipulated by the respondents, the corresponding bills for the claimant's prescriptions are in line with the Colorado medical fee schedule. *See* W.C. Rule of Procedure 18, 7 Code Colo. Reg. 1101-3; *see also* W.C. Rule of Procedure 16-8(A), 7 Code Colo. Reg. 1101-3 ("All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure" unless an exception applies.); *see also* §8-42-101(3)(a)(I), C.R.S.

The respondents further argue that the ALJ erred in concluding that "it is not reasonably medically necessary to continue to allow Claimant to use the pharmacy of his choice." According to the respondents, in reaching this conclusion, the ALJ constructed and resolved a conflict that was not at issue. They specifically contend that they have not challenged claimant's choice of pharmacy and the stipulated findings of fact are devoid of any indication claimant is not being permitted to use the pharmacy of his choice. Rather, the respondents argue that they instead have challenged the claimant's decision not to use the CorVel pharmacy payment card. However, we are not persuaded the ALJ erred in inferring from the evidence that by using the CorVel pharmacy payment card, that the claimant would have to change pharmacies to fill the prescriptions at issue. The respondents' argument notwithstanding, the ALJ's finding in this regard is a plausible inference from the dispute at issue and the evidence in the record. As such, the ALJ's inference in this regard must be upheld. *See Ackerman v. Hilton's Mechanical Men, Inc.*, 914 P.2d 524 (Colo. App. 1996)(ALJ findings may be based on reasonable inferences from circumstantial evidence).

Last, the respondents argue the ALJ erred in equating their requirement for the claimant to use the CorVel pharmacy payment card to fill the prescriptions at issue to the respondents' attempt to seek a change of an ATP because they did not like the prescribed medical treatment. However, we need not reach this issue because the ALJ's use of this analogy was, at most, harmless error. Section 8-43-310 C.R.S.; *A & R Concrete Construction v. Lightner*, 759 P.2d 831 (Colo. App. 1988)(error which is not prejudicial

will be disregarded). Instead, we agree with the ALJ's ultimate determination that neither the Act nor the Workers' Compensation Rules of Procedure impose a duty on the claimant to use the CorVel pharmacy payment card to fill his prescriptions from Dr. Hall. Consequently, we have no basis to disturb the ALJ's order. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated March 4, 2020, 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

7/15/2020 by TT .

KAPLAN MORRELL, Attn: BRITTON J MORRELL ESQ, 6801 WEST 20TH STREET SUITE 201, GREELEY, CO, 80634 (For Claimant)
POLLART MILLER LLC, Attn: BRAD J MILLER ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

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

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

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

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-066-685-001

IN THE MATTER OF THE CLAIM OF:

LEON MEDINA,

Claimant,

v.

FINAL ORDER

QWEST CORPORATION,

Employer,

and

XL SPECIALTY INSURANCE COMPANY,

Insurer,
Respondents.

The respondents seek review of an order of Administrative Law Judge Mottram (ALJ) dated April 13, 2020, that determined the claimant's complex regional pain syndrome (CRPS) is causally related to the September 20, 2017, work injury and ordered the respondents liable for reasonable and necessary medical benefits related to this condition. We affirm.

This matter went to hearing on the issue of whether the claimant's CRPS diagnosis is causally related to his admitted work injury. After hearing, the ALJ entered factual findings that for purposes of review can be summarized as follows. The claimant sustained an admitted injury to his right shoulder on September 20, 2017, when he pulled equipment weighing 150-200 lbs. out of his truck. The claimant's authorized treating physician, Dr. Butzen, performed a right shoulder arthroscopy with SLAP repair, biceps tenodesis and arthroscopic limited debridement. The claimant's right arm was then placed in a sling for six weeks with sling immobilization instruction. This caused inflammation, cramping and pain. On January 7, 2019, the claimant reported that his right shoulder was worsening, which was confirmed by MRI. On February 12, 2019, Dr. Butzen performed a repeat right shoulder arthroscopy with SLAP repair, rotator cuff repair, partial synovectomy and subacromial decompression.

The claimant was diagnosed with Shingles on February 18, 2019, after he reported to his primary care physician with complaints of burning pain to his right forearm and a rash on his right hand. The claimant reported to his physician that his wife had contracted Shingles two to three weeks prior. The claimant testified at hearing that his wife was diagnosed with Shingles in December of 2018 and not 2-3 weeks prior to his outbreak.

Following the development of Shingles, the claimant continued to complain of worse pain with attempts to raise and lower his arm. Medical notes from April 15, 2019, noted that the claimant had painful skin in the right hand, cracking skin and malformed fingernails that began seven to 10 days after his shoulder surgery and Shingles outbreak. The presentation was noted to be consistent with CRPS.

Dr. McCranie performed an independent medical examination (IME) at the respondents' request. Dr. McCranie confirmed a clinical diagnosis of CRPS in the right upper extremity. In Dr. McCranie's opinion, however, the claimant's CPRS was not related to the work injury. Dr. McCranie stated that the claimant's CRPS was related to the development of Shingles, which was not related to the surgery.

Dr. Butzen testified at hearing as an expert in orthopedic surgery. The ALJ's order noted that Dr. Butzen testified that he was not an expert in the transmission of Shingles. Dr. Butzen, however, went on to state that the claimant's Shingles outbreak was related to the shoulder surgery based on the fact that the claimant's immune system would have been lowered because of the surgery. Dr. Butzen explained that the latent virus may become active when there is a stressor and because the virus is living in the spinal column, it will travel along the spinal nerves and affects the skin where those nerves go. Thus, according to Dr. Butzen, the CRPS was related to the Shingles outbreak. The Shingles outbreak was related to the surgery based on the timing of the outbreak and the fact that the stress from the surgery could decrease the function of the claimant's immune system. Dr. Butzen further testified that the claimant would not have contracted the Shingles from his wife because the transmittable form of the virus is chicken pox.

The ALJ found Dr. Butzen's testimony credible and persuasive. Based on that testimony, the ALJ concluded that the claimant's Shingles outbreak was related to the claimant's second shoulder surgery and, therefore, the CRPS caused by the Shingles was related to the September 20, 2017, work injury. The ALJ ordered the respondents liable for reasonable and necessary medical benefits attributable to the CRPS condition.

On appeal the respondents contend that the ALJ abused his discretion by relying on Dr. Butzen's testimony after the ALJ "specifically found that Dr. Butzen was not an expert in the area of Shingles transmission." The respondents also contend that the ALJ's findings are not supported by substantial evidence. We are not persuaded the ALJ committed reversible error.

I.

We find no error in the ALJ's reliance on Dr. Butzen's testimony and opinions. The respondents do not dispute that Dr. Butzen is an expert in orthopedic surgery. Dr. Butzen testified that although he does not consider himself an "expert" in viruses, he also testified that he has a general understanding of virology from medical school training that is expert compared to a lay witness. Dr. Butzen depo. at 9-10. This is consistent with the ALJ's finding in paragraph 15 at page four.

The ALJ has broad discretion to determine whether a particular witness is qualified to express opinions as an expert, and whether the evidentiary requirements governing admission of such opinions have been satisfied. *People v. Williams*, 790 P.2d 796 (Colo. 1990); *Dow Chemical Co. v. Industrial Claim Appeals Office,* 843 P.2d 122 (Colo. App. 1992). Where, as here, medical experts proffer opinions based on their experience and knowledge, the ALJ must determine whether the experts possess specialized information which will assist him in resolving a relevant issue. Under C.R.E. 702, a witness may be qualified as an expert if he has "scientific, technical, or other specialized knowledge" which "will assist the trier of fact to understand the evidence or determine a fact in issue."

We may not interfere with the ALJ's exercise of discretion unless a clear abuse of discretion is shown. *Hall v. Home Furniture Co*., 724 P.2d 94 (Colo. App. 1986). An abuse of discretion is shown only if the ALJ's determination is beyond the bounds of reason as where it is not supported by the evidence or the applicable law. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). Here, substantial evidence supports the ALJ's decision to credit Dr. Butzen as a medical expert despite the fact that Dr. Butzen qualified his limited expertise with regard to the transmission of Shingles. Although Dr. Butzen is not a virologist, this fact does not necessarily disqualify him from expressing an opinion on the issue of medical causation. Such issues are not the unique province of a virologist. Rather, Dr. Butzen's qualifications in this regard merely go to the probative weight of his opinions and the weight the ALJ chose to give them. *Rockwell International v. Turnbull,* 802 P.2d 1182 (Colo. App. 1990). Under these circumstances, we cannot say the ALJ abused his discretion.

II.

We are also not persuaded by the respondents' argument that the ALJ's findings are not supported by substantial evidence. The claimant has the burden to prove a causal relationship between the work-related injury and the condition for which benefits or compensation is sought. *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997). Whether the claimant sustained his burden of proof is a factual question for resolution by the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). We are, therefore, bound by the ALJ's determinations in this regard if they are supported by substantial evidence in the record. Section 8-43-304(8), C.R.S. 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). The substantial evidence standard requires that we view evidence in the light most favorable to the prevailing party, and defer to the ALJ's assessment of the sufficiency and probative weight of the evidence. Thus, the scope of our review is "exceedingly narrow." *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 2003). This narrow standard of review also requires that we 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).

A claimant is not required to present medical evidence to prove the cause of an injury. *See Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). Similarly, the claimant is not required to prove the cause of his injuries by medical certainty. *Industrial Commission v. Riley*, 165 Colo. 586, 441 P.2d 3 (1968). To the contrary, the claimant's testimony may be sufficient to establish the requisite nexus between an industrial injury and the disability for which benefits are sought. *Savio House v. Dennis*, 665 P.2d 141 (Colo. App. 1983). To the extent expert medical testimony is presented, as it was done here, it is the ALJ's sole prerogative to assess its weight and sufficiency. *Rockwell International v. Turnbull, supra.* As explained above, the ALJ here was more persuaded by the opinions and testimony of Dr. Butzen over that of the respondents' expert. We are unable to say that Dr. Butzen's opinion is rebutted by such hard, certain evidence that it was error as a matter of law for the ALJ to credit it. *Halliburton Services v. Miller,* 720 P.2d 571 (Colo. 1986). Contrary to the respondents' arguments, there is ample evidence supporting the ALJ's determination that the claimant sustained his burden to prove that his CRPS is related to the September 2017 work injury. Consequently, we have no basis to disturb the ALJ's order on any of the foregoing grounds. Section 8-43-301(8), C.R.S.

IT IS THEREFORE ORDERED that the ALJ's order dated April 13, 2020, is affirmed.

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

7/20/2020 by TT .

ADAN CERDA & ASSOCIATES LLC, Attn: LENNEE N MOZIA ESQ, 6000 E EVANS AVE SUITE 3-400, DENVER, CO, 80222 (For Claimant)
POLLART MILLER LLC, Attn: JESSICA L GRIMES ESQ, 5700 S QUEBEC STREET SUITE 200, GREENWOOD VILLAGE, CO, 80111 (For Respondents)

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-034-884-001

IN THE MATTER OF THE CLAIM OF:

TIMOTHY BROWNE,

Claimant,

v.

FINAL ORDER

CITY OF COLORADO SPRINGS,

Employer,

and

SELF INSURED,

Insurer,
Respondent.

The claimant seeks review of an order of Administrative Law Judge Spencer (ALJ) dated March 6, 2020, that denied the claimant's request for additional permanent partial disability (PPD) benefits beyond the statutory cap in §8-42-107.5, C.R.S. (statutory cap). We affirm the ALJ's order.

The issue before us on appeal is whether §8-42-104(5), C.R.S. (the apportionment statute) or the statutory cap is applied first. This issue does not appear to previously have been addressed by the panel or the courts.

The apportionment statute addresses the effect of a previous injury or compensation. This statute provides, in pertinent part:

> (5) In cases of permanent medical impairment, the employee's award or settlement shall be reduced:
>
> (a) When an employee has suffered more than one permanent medical impairment to the same body part and has received an award or settlement under the "Workers' Compensation Act of Colorado" or a similar act from another state. ***The permanent medical impairment rating applicable to the previous injury to the same body part, established by award or settlement, shall be deducted***

> ***from the permanent medical impairment rating for the subsequent injury to the same body part.***

Section 8-42-104(5)(a), C.R.S. (emphasis added).

The statutory cap places limits on temporary and permanent partial disability payments depending on the claimant's impairment rating. Section 8-42-107.5, C.R.S., ("No claimant whose ***impairment rating*** is twenty-five percent or less may receive…)(emphasis added). As pertinent here for the claimant's date of injury, no claimant whose impairment rating is twenty-five percent or less may receive more than $86,697.04 from combined temporary disability and permanent partial disability benefits. No claimant whose impairment rating is greater than twenty-five percent may receive more than $173,391.90 from combined temporary disability and permanent partial disability payments.

The essential facts of the case are not disputed by the parties. The claimant had a prior work-related neck injury in October 2007 while working for this employer. The claimant was placed at maximum medical improvement (MMI) for this injury in December of 2009 and given a six percent whole person rating for the cervical spine. The respondent admitted for the six percent rating and paid $28,930.94 in PPD benefits.

The claimant then sustained an admitted injury to his cervical spine on July 11, 2016, which is the subject of the present claim. The claimant was placed at MMI for this injury on April 9, 2019, and given a 26 percent whole person rating for the cervical spine by a DIME physician. The DIME physician determined that apportionment was warranted but could not determine the apportionment because the DIME physician did not have the necessary information from the previous impairment rating.

The respondent filed a final admission of liability dated January 27, 2020[1], admitting for a 20 percent rating after subtracting the six percent for the prior injury. The respondent applied the lower benefit cap under §8-42-107.5, C.R.S., limiting the claimant to a combined total of $86,697.04, in temporary and permanent disability benefits. The claimant had already been paid $55,933.57 in temporary disability benefits. Therefore, his PPD was capped at $30,763.47.

The ALJ noted that neither party disputes the overall 26 percent rating. The claimant also concedes that apportionment is required under the apportionment statute

[1] At hearing the parties agreed that the respondent would file the final admission of liability based on the 20 percent rating to allow the ALJ to address the issue. Tr. at 22-23

because he received an "award or settlement" for his prior six percent rating from the 2007 injury. The ALJ, therefore, only addressed the dispute over which indemnity cap applies under statutory cap. The ALJ relied on the plain language of the apportionment statute to conclude that the impairment rating from the prior claim "shall be deducted from the…impairment rating for the subsequent injury." The ALJ determined that under apportionment statute, apportionment is part of the process used to determine the claimant's compensable rating and reduces the rating ultimately used to calculate to PPD award. Once that rating is established, the value of that rating is determined by the other sections of the Workers' Compensation Act. One of those sections is the statutory cap which limits the benefits that would otherwise be payable for the rating based on the statutory formula. The ALJ, therefore, concluded that the respondent correctly admitted for PPD in the January 27, 2020, final admission and the claimant is not entitled to additional PPD benefits.

On appeal the claimant continues to assert that the higher cap should apply. The claimant contends that because his overall rating for the current injury is 26 percent before apportionment, the PPD award should be calculated based on the 26 percent under the higher cap and then the prior six percent rating paid out by the respondent becomes a credit against the resulting award. The respondent, in contrast, contends that the ALJ correctly concluded that the plain language of the statute mandates that determination of the applicable statutory cap occurs after apportionment and not before. We are not persuaded the ALJ erred in his conclusion.

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). Our primary task in construing the relevant statutes is to give effect to the legislative intent. *Snyder Oil Co. v. Embree*, 862 P.2d 259 (Colo. 1993). To discern the intent of the General Assembly, we must first examine the language of the statute. If clear and unambiguous, the words and phrases of the statute should be given their plain and ordinary meaning, and the statute must be applied as written unless the result is absurd. *Weld County School District RE-12 v. Bymer,* 955 P.2d 550 (Colo. 1998); *Spracklin v. Industrial Claim Appeals Office*, 66 P.3d 176 (Colo. App. 2002).

The respondent asserts, and the ALJ concluded, that the apportionment statute is first used to determine the claimant's impairment rating and then the statutory cap is applied to that apportioned rating. The result is that the claimant's 26 percent rating is first reduced by the prior six percent rating to get a net 20 percent rating. When the statutory cap is applied, the lower cap limits the claimant's PPD benefit to $30,763.47.

Under the claimant's interpretation of the relevant statutes, the claimant's PPD benefits are calculated using the unapportioned 26 percent rating. The higher cap is then applied under the statutory cap. The claimant asserts that the apportionment statute is then applied to reduce the award as a credit against the award. In this case, that would result in the application of the higher cap of $173,391.90, which would allow the claimant to receive the full value of the 26 percent impairment rating, $117,458.33 less the value of the prior six percent award, and admitted PPD for additional payout of $55,116.91, in PPD benefits.

We conclude that under the plain language of the both the apportionment statute and the statutory cap, apportionment of the impairment rating must be done first before the applicable benefit cap can be determined. We agree with the ALJ that apportionment is part of the process to determine the claimant's impairment rating used to calculate the PPD award.

The apportionment statute specifically states that the previous ***impairment rating*** is deducted from the subsequent ***impairment rating***. Section 8-42-104(5)(a), C.R.S., (The permanent medical impairment rating applicable to the previous injury to the same body part…shall be deducted from the permanent medical impairment rating for the subsequent injury to the same body part.) Thus, the apportionment statute is part of the process to determine the impairment rating attributable to an injury and is not merely to reduce the amount of money the claimant is entitled to receive. *See Colo. Fuel & Iron Corp. v. Rhodes*, 166 Colo. 82, 441 P.2d 652 (1968)(This section spells out just how the percentage of disability for the subsequent injury shall be determined, namely, by computing the percentage of entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury). The apportionment statute does not say, as the claimant contends, that the award or settlement shall be deducted from the award or settlement for the subsequent injury. Rather, the apportionment statute establishes the permanent impairment rating for the subsequent injury that is used for purposes of determining which benefit cap applies under the statutory cap.

To the extent that the language of the apportionment statute is ambiguous when read in conjunction with the statutory cap, the statute must be construed in light of the apparent legislative intent and purpose. *Henderson v. RSI, Inc.*, 824 P.2d 91 (Colo. App. 1991). We may also consider administrative construction of the statute, the legislative history, and other provisions of the Act on the same or similar subjects. Section 2-4-203, C.R.S. Furthermore, where, as here, the statute is part of a comprehensive statutory scheme, the statute must be construed in a manner which gives consistent, harmonious, and sensible effect to all related provisions. *Gonzales v. Advanced Components*, 949 P.2d 569 (Colo.

1997). Finally, interpretation of the statute should yield a reasonable result. *Humane Society of the Pikes Peak Region v. Industrial Claim Appeals Office,* 26 P.3d 546 (Colo. App. 2001)(statutory construction producing absurd results must be avoided).

Applying the apportionment statute to determine the percentage of disability before applying the statutory cap is consistent with the Division of Workers' Compensation apportionment rule that provides guidelines to physicians to determine permanent impairment. Worker's Compensation Rule of Procedure (WCRP) 12-3(B), provides, "apportionment shall be made by subtracting from the injured worker's impairment from the preexisting impairment as it existed at the time of the subsequent injury or occupational disease." The rule, like the statute, discusses subtracting the prior impairment rating from the subsequent impairment rating to reach the rating used to calculate permanent disability benefits. Additionally, WCRP 5-11 (2), discusses the adjusting requirements and sets forth the documentation required in a final admission of liability to reducing a claimant's permanent *impairment rating* for apportionment. The rule states, "If a permanent impairment rating is reduced on an admission…" The Rule does not discuss reducing the monetary award on the final admission.

The Division of Workers' Compensation's Impairment Rating Tips for physicians similarly discusses apportionment in the context of determining the actual impairment rating, rather than as a mechanism to offset the prior monetary award. The language used in the Impairment Rating Tips tracks the language used in the apportionment statute. "Impairment ratings" are calculated by reference to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* ("AMA Guides"), (3d ed. rev. 1990). *See* § 8-42-101(3.7), C.R.S. ("[A]ll physical impairment ratings used under Articles 40 to 47 of this title shall be based on the revised third edition" of the *AMA Guides*).

Moreover, this construction achieves the intended purposes of both the apportionment statute and the statutory cap the statute to lower costs in the workers' compensation system. *Dillard v. Indus. Claim Appeals Office*, 134 P.3d 407, 413 (Colo. 2006). This has been determined to be a legitimate governmental purpose. *Culver*, 971 P.2d at 652 (listing "maintaining the fiscal integrity of the workers' compensation system; allocating the fiscal burden equitably among funding sources, and controlling costs to employers while providing legislatively-intended benefits to injured workers" as possible legitimate government purposes).

Here, the claimant had both injuries while working for the same employer. Under the claimant's interpretation, however, in cases where there are two different employers, it

would be contrary to the intent of the statutory cap to have the subsequent employer pay benefits based on the higher cap, even though the subsequent injury did not cause impairment greater than 25 percent.

We agree with the ALJ's conclusion that the apportionment statute must be applied first in order to calculate the claimant's impairment rating. Once the impairment rating is established, the applicable statutory cap can then be determined. We therefore agree with the ALJ's application of the relevant statutes and affirm the order.

IT IS THEREFORE ORDERED that the ALJ's order dated March 6, 2020, 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

8/7/2020 by TT .

FRANKLIN D AZAR & ASSOCIATES PC, Attn: ROBERT W TURNER ESQ, 1259 LAKE PLAZA DRIVE SUITE 260, COLORADO SPRINGS, CO, 80906 (For Claimant)
DWORKIN CHAMBERS WILLIAMS YORK BENSON & EVANS PC, Attn: GREGORY K CHAMBERS ESQ, 3900 E MEXICO AVENUE SUITE 1300, DENVER, CO, 80210 (For Respondents)

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

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

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

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

INDUSTRIAL CLAIM APPEALS OFFICE

W.C. No. 5-115-369

IN THE MATTER OF THE CLAIM OF:

YVONNE TINER,

Claimant,

v.

FINAL ORDER

PEOPLECARE LLC,

Employer,

and

PINNACOL ASSURANCE,

Insurer,
Respondents.

The claimant seeks review of an order of Administrative Law Judge Sidanycz (ALJ) dated March 17, 2020, that determined her claim was not compensable and denied her request for temporary total disability benefits and medical benefits. We affirm.

The claimant worked as a Certified Nursing Assistant. She provided in home services to patients including assistance with medications, cleaning and other aspects of their living situations. On August 18, 2019, the claimant tripped over a patient's kitten in the patient's home and caused her right ankle to roll. She complained of pain and swelling in her ankle and reported the injury to the employer.

The claimant was referred to Colo. Mesa University and Community Care. An X-ray on August 18 was negative for fractures. The claimant was advised to use a walking boot and to follow up with her provider. The claimant was examined by Dr. Stagg at St. Mary's Medical Group on August 21. The doctor noted the claimant's report to him that she had sustained a prior right ankle injury on April 21, 2019, while fishing, and had obtained an MRI study of the ankle on July 15, 2019. Dr. Stagg deferred an opinion regarding the cause of the claimant's ankle symptoms until he could review her previous records. He recommended use of a Cam boot while walking.

The claimant was referred to Dr. Copeland, an orthopedist. Dr. Copeland read the claimant's MRI from July as revealing degenerative joint disease, tendinopathy and a

partial tear of the posterior tibial tendon. He suggested treatment that included a fitted Cam boot, physical therapy and a surgical stage two flat foot reconstruction.

Nurse Practitioner Harkreader at St. Mary's Medical Group obtained and reviewed prior medical records pertinent to treatment of the claimant's right ankle. The claimant had sought medical care in January, 2019, due to an ankle twist occurring in September, 2018. X-rays indicated swelling and degenerative changes. On April 21, 2019, the claimant twisted the right ankle again while fishing. An X-ray at that time again demonstrated soft tissue swelling. On July 10, when ankle braces did not help, the clamant requested an MRI of her ankle and a referral to an orthopedic physician. The MRI was completed on July 15, 2019, which showed a partial tear of the tibial tendon. The claimant returned to the Marillac Clinic on August 12, complaining of persistent right ankle pain. Nurse Harkreader concluded the August 18 twisting incident at work did not represent an aggravation of a preexisting injury, but rather the continuation of a preexisting unstable ankle condition stemming from a September, 2018 injury.

The respondents contested the compensability of the injury claim. The claimant requested a hearing seeking medical treatment and temporary total disability benefits. A hearing was conducted on February 13, 2020. The claimant testified and medical records relating to the past and present treatment of the claimant's ankle were submitted.

The claimant indicated in her testimony that whereas she did reinjure her ankle in April, 2019, while fishing, that injury largely had resolved by the time she tripped over her client's kitten on August 18. The claimant stated that following that last incident she could not walk well enough to perform her job and that she had developed pain on a different side of her ankle. She testified that prior to August 18 she had only been experiencing some soreness, no swelling in her ankle and that it hardly hurt at all. She later admitted she did inform her treater at the Marillac Clinic she was having problems with her ankle in July and August. Tr. at 40. She then informed the insurance carrier's claims adjuster that prior to August 18 her ankle was just fine. Tr. at 42. On cross examination she acknowledged that she had requested from her treater at the Marillac clinic on July 10 to be referred to an orthopedist and on that same date she requested an MRI exam. She explained she made these requests because her ankle did not "feel right" and something could be wrong with it. Tr. at 31, 32. The claimant a few moments later testified she had not requested an orthopedic referral or an MRI and that was the doctor's idea. Tr. at 38. She asserted she would not agree to either because she had no medical insurance to pay for them. Tr. at 39, 40. Nonetheless the MRI occurred on July 15. On August 12 she was scheduled for an injection into her ankle on August 26. The claimant also disagreed with several statements attributed to her in medical records. She stated she

misspoke to Dr. Stagg when she told him her ankle did not bother her prior to August 18. Tr. at 36. Nurse Harkreader wrote on October 2 the claimant informed him her ankle had improved to its condition prior to August 18. He then released her to regular work and placed her at maximum medical improvement. The claimant testified she did not state her ankle had returned to that base line. Tr. at 43. She then acknowledged she did tell him she felt she could do her regular work because she needed a pay check. Tr. at 54.

The ALJ determined she did not find the claimant's testimony that her ankle presented no disability prior to August 18 "to be credible or persuasive". The ALJ found compelling the conclusion of nurse Harkreader that the claimant's ankle symptoms and the recommendations for medical treatment were related to the claimant's prior and longstanding right ankle condition. The August 18 incident involving the kitten was ruled to not have aggravated or accelerated the preexisting condition so as to require treatment. The conditions involving the partial tear of the tibial tendon was noted to have been documented on the July, 2019 MRI preceding the August 18 trip at work. The need for medical treatment was deemed to be required by injuries occurring prior to August 18. The ALJ ruled the claimant had not sustained her burden of proof to establish she suffered an injury as a result of the August 18, 2019, incident that arose out of and in the course of her employment. Her claim for benefits was denied.

On appeal the claimant contends she necessarily sustained some type of injury on August 18 when she tripped over the kitten. Because this accident occurred while the claimant was working, and it would not have occurred 'but for' the work, the injury was asserted to be compensable as a matter of law. When the ALJ did not rule the claim was compensable the claimant argues she was therefore imposing additional burdens of proof on the claimant not justified by the statute. We do not find this analysis compelling.

I.

The claimant maintains the evidence shows that following the claimant's fall on August 18, she received medical treatment and displayed symptoms of pain. The claimant then missed more than three days of work subsequent to August 18. The claimant points out that an injury is compensable in the event either that medical treatment is required or more than three work shifts are missed. Because these circumstances would not have occurred 'but for' her job, she maintains her claim is compensable as a matter of law. The claimant asserts she would not have sought medical care or suffered wage loss if an injurious event had not occurred. The filing of a first report of injury by the respondents is said to be objective evidence of an injury.

The difficulty with the claimant's reasoning is that she may also have sought medical care and missed work after August 18 due to the injury to her ankle in September, 2018, and while fishing in April, 2019. That was, in fact, the conclusion of the ALJ. Merely because the claimant required medical treatment or sustained wage loss does not automatically dictate the conclusion that her injury is work-related. *Nielson v. Tri-State Generation*, W.C. No. 5-103-366-001 (April 1, 2020). *Cf. Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337, 1339 (Colo. App. 1997)("right to workers' compensation benefits, including medical payments, arises only when an injured employee initially establishes, by a preponderance of the evidence, that the need for medical treatment was proximately caused by an injury arising out of and in the course of the employment").

In addition, while the statute, § 8-43-103(1), requires the employer to give notice to the Division of an injury reported to the employer as specified by § 8-43-102(1.5), § 8-43-203(1)(a) allows an employer or insurance carrier to state the claim is not compensable within twenty days after the report of injury was filed. Here, the respondents did file a notice of contest within twenty days. Accordingly, simply the filing of a first report of injury cannot be seen as objective evidence that the claimant sustained an injury within the course and scope of employment.

Section 8-43-201(1) provides "A claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence." 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 prerogative 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).

Here, the ALJ determined the claimant did not demonstrate by a preponderance of the evidence that the August 18 tripping incident at work was the proximate cause of the need for benefits, either medical or for wage loss. The respondents referenced the circumstances that prior to August 18, the claimant had been prescribed Percocet for pain, she had been fitted and wore a boot on her right ankle, and she had paid for an MRI a few weeks prior to August 18. She was also given an orthopedic referral and an appointment for an ankle injection previous to August 18. The recommendation for ankle surgery was premised on a review of the July 15 MRI. These all support the inference and conclusion of the ALJ that the medical treatment and disability subsequent to August 18 was little more than a progression of the claimant's preexisting injuries to her ankle. They also indicate a basis for the ALJ to decide the claimant had not demonstrated by a preponderance that she reinjured her ankle within the course of employment on August 18. The ALJ was not necessarily required to assume an injurious event has occurred on August 18.

The reliance of the claimant on the decision in *City of Brighton v. Rodriquez*, 214 CO 7, 318 P.3d 496 (Colo. 2014), and its explanation of 'but for' causation is misplaced. The Supreme Court pointed out in *City of Brighton* an injury "arises out of" employment when it has its "origin in" an employee's work-related functions and is "sufficiently related to" those functions so as to be considered part of employment. 2014 CO 7, ¶ 17. The Court categorized the risks of injury encountered by an employee as belonging to one of three descriptions. The first is 'employment' risks which are an inherent part of the occupation and are compensable. The second are 'personal' risks that are unique to the employee and are usually not compensable. The third are 'neutral' risks that are compensable if the risk that led to an injury would not have occurred 'but for' the employee's work obligations.

The claimant argues her August 18 fall is either due to an inherent part of her occupation or a neutral circumstance that would not have occurred but for her work obligations. However, in *City of Brighton* the ALJ had found the claimant "… injured herself after falling down a flight of stairs at work." 2014 COA 7, ¶ 2. The Court applied the neutral risk test which held: "but for the fact that the conditions and obligations of employment placed the employee in the position where he or she was injured" a claim is compensable. However, as stated, the test requires it be established the claimant was 'injured' by the event. Accordingly, before even discussing the three categories of risk the decision noted: "The determination of whether an employee's injuries arose out of employment is a question of fact for resolution by the ALJ." 2014 7, ¶ 11. Because the claimant failed to carry her burden to demonstrate her injuries occurred when she tripped

over a kitten at work, the discussion of risks in *City of Brighton* has no application to the claimant.

II.

The claimant complains the ALJ imposed upon her additional burdens of proof not required by the statute or case law. It is argued the ALJ required her to establish a relationship between her disability and need for treatment through "definitive proof". The ALJ is also asserted to have erred by insisting the claimant demonstrate her alleged injury "objectively caused" an "identifiable structural change to their underlying anatomy" in order that it be compensable. The claimant maintains that she need show nothing more precise than a nexus between her injury and the conditions of employment. She contends that instead of showing a structural change or a mechanism of injury, it is sufficient for her to prove no more than a symptomatic aggravation of her condition.

A review of the ALJ's order does not indicate the ALJ required any of these auxiliary standards described by the claimant. The ALJ did not extensively discuss the reasons she did not find the claimant persuasive other than to observe the claimant did not achieve her threshold by a preponderance of evidence by showing the August 18 fall aggravated, accelerated or combined with her preexisting right ankle condition to necessitate treatment or cause disability. The ALJ specified she found instead, the medical records and the opinion of nurse Harkreader to be credible and persuasive. The ALJ's ruling need only be supported by substantial evidence to be entitled to credit on appeal.

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).

Claimant's arguments notwithstanding, we perceive no extreme circumstances here. Nurse Harkreader's report of September 19, 2019, reviewed past medical records

of the claimant that revealed medical care in January, 2019, related to a twisting injury to the right ankle in September, 2018 including an X-ray substantiating swelling and degenerative changes. The records further showed the claimant underwent additional treatment for her ankle following an April 21, 2019, injury while fishing. In the short interval of time between April and August 18, the claimant was fitted for a brace, underwent an MRI and was scheduled for an injection and an orthopedic evaluation. The MRI confirmed a torn tendon five weeks prior to the claimant's fall at work. We conclude the ALJ's skepticism of the claimant's testimony and her reliance on nurse Harkreader's opinion there was no new injury on August 18 is supported by substantial evidence in the record.

III.

The claimant's assertion that "under the Act, the generally neutral rules applicable to the adjudicative process are shifted subtly in favor of solicitude for the rights of the injured worker" is not supported by the statute or the case law. The claimant cites as authority cases that are resolving conflicting interpretations of the statutory provisions of the Act. i.e. *Specialty Restaurants v. Nelson*, 231 P.3d 393, 398 (Colo. 2010) (statutory provisions regarding lump sum applications), *Williams v. Kunau*, 147 P.3d 33, 38 (Colo. 2006)(the DIME procedures), *England v. Amerigas*, 395 P.3d 766 (Colo. 2017)(the reopening section), *City of Brighton v. Rodriquez*, 318 P. 3d 496, 506 (Colo. 2017)(the course and scope concept). Here, the ALJ was not construing conflicting readings of the Act. The ALJ was weighing the evidence presented to determine if the claimant sustained her burden of proof by a preponderance of the evidence. In that instance the Act itself is explicit that "… the facts in a workers' compensation case shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer:…" §8-43-201(1). The ALJ ruled consistently with this requirement and to decide "subtly in favor of solicitude for the rights of the injured worker," as the claimant proposes, would be contrary to this statutory standard.

We have reviewed the order and the record provided and we do not perceive reversible error. To the extent the ALJ relied on the evidence provided by the medical records and found they established the claimant's request for benefits was caused by a preexisting injury not sustained within the course and scope of her employment is a reasonable conclusion for the ALJ to draw.

IT IS THEREFORE ORDERED that the ALJ's order issued March 17, 2020, that denied the claim for benefits 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

8/7/2020 by TT .

PINNACOL ASSURANCE, Attn: HARVEY D FLEWELLING ESQ, 7501 EAST LOWRY BOULEVARD, DENVER, CO, 80230 (Insurer)
WITHERS SEIDMAN RICE MUELLER GOODBODY PC, Attn: SEAN GOODBODY ESQ, 101 SOUTH THIRD STREET SUITE 265, GRAND JUNCTION, CO, 81501 (For Claimant)
RUEGSEGGER SIMONS & STERN LLC, Attn: KEVIN M CARLOCK ESQ, 1700 LINCOLN STREET SUITE 4500, DENVER, CO, 80202 (For Respondents)

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