State of Colorado **Office of Administrative Courts** 1330 Inverness Drive, Ste. 330, Colorado Springs, CO 80910	
In the Matter of the Workers' Compensation Claim of: [redacted] [redacted] Claimant, vs. **Capella Pueblo West LLC,** Employer, and **Pinnacol Assurance,** Insurer, Respondents.	▲ **COURT USE ONLY** ▲ **Case Number:** **WC 5-298-875-001**

Summary Order

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A hearing in this matter was held on July 22, 2025, before Administrative Law Judge Patrick C.H. Spencer II. Claimant was represented by Lawrence D. Saunders, Esq. Respondents were represented by Craig R. Anderson, Esq. The hearing was conducted in Pueblo, Colorado, commencing at 9:02 AM.

The following exhibits were admitted into evidence: Claimant's Exhibits 1-15 and Respondents' Exhibits A-I. Claimant testified at the hearing with the assistance of a neutral interpreter provided by the OAC. Dr. Albert Hattem testified via deposition on August 1, 2025

In this order, [redacted] [redacted] will be referred to as "Claimant," Capella Pueblo West LLC will be referred to as "Employer," Pinnacol Assurance will be referred to as "Insurer," and Employer and Insurer collectively will be referred to as "Respondents."

Based on the evidence presented at hearing, **IT IS HEREBY ORDERED**:

1. Claimant proved she suffered a compensable injury on January 14, 2025. Claimant's testimony is credible. Claimant's treating providers at Concentra uniformly agree that the bilateral Achilles and posterior tibial tendinopathy are work-related. Dr. Simpson's opinions and conclusions are credible and persuasive. Claimant either suffered an acute injury, an occupational disease, or some combination thereof. Claimant proved the development of symptoms on January 14, 2025 was proximately caused by her work activities. It is immaterial whether those symptoms reflect the occurrence of an acute injury or the "onset of disability" from an occupational disease, because there is no persuasive evidence that Claimant's condition resulted from a hazard to which she was equally exposed outside of work. The symptoms prompted Claimant to seek treatment and caused a disability. Therefore, she proved a compensable injury.

2. Claimant's average weekly wage is $530.32, with a corresponding TTD rate of $353.55. This determination is based on 16 weeks of earnings from September 1, 2024, through December 21, 2024. This

3. Insurer shall pay Claimant TTD benefits at the rate of $353.55 per week, commencing February 6, 2025, and continuing until terminated by law.

4. Insurer shall pay Claimant statutory interest of 8% per annum on all compensation not paid when due.

5. All issues not decided herein are reserved for future determination.

DATED: October 1, 2025

DIGITAL SIGNATURE
Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

This decision is final and not subject to appeal unless a full order is requested. The request shall be made at the Office of Administrative Courts, 1330 Inverness Drive, Suite 330, Colorado Springs, CO 80906 within ten working days of the date of service of this

Summary Order. Section 8-43-215(1), C.R.S. Such a request is a prerequisite to review under § 8-43-301, C.R.S.

Pursuant to OACRP 26(B), if either party requests a full order, both parties shall submit a proposed order containing specific findings of fact and conclusions of law within seven days from the date of the request. The proposed full order must be submitted by e-mail in Word format to oac-csp@state.co.us The proposed order shall also be submitted to opposing counsel and unrepresented parties by e-mail, facsimile, or same day or next day delivery.

Issues

► Whether Claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer?

► If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that the C5-C6 discectomy performed by Dr. Gill was reasonable medical treatment necessary to cure and relieve the Claimant from the effects of his industrial injury?

Findings of Fact

1. Claimant was employed with Employer as a Transportation Maintenance Worker I. Claimant testified at hearing that on April 4, 2025 he arrived at work at 7;00 a.m. and proceeded to the snow plows as it had snowed the previous night. Claimant testified that in anticipation of performing his duties operating the snow plow, he walked around the truck to perform his inspection of the vehicle.

2. Claimant testified that the snow plow truck is 13 feet tall and Claimant that in order to check the oil level on the truck, he needed to squeeze into the wheel well of the truck and reach into the engine area to access the oil dipstick. Claimant testified he needed to contort his body to reach the dipstick. Claimant testified that while performing this task, he experienced a lightning like pain through his left arm.

3. Claimant testified he had a prior injury when he was 19 years old which resulted in medical treatment to his mid-back and thoracic spine area. Claimant

testified he had a prior injury to his neck area from a work injury in Arizona that resulted in medical treatment including spinal injections.

4. The medical records document Claimant reporting an injury to his neck in February 2024 while working in Arizona. Claimant's February 2024 injury resulted from Claimant hitting his head on a hydrovac boom resulting in a concussion and two chipped teeth. Claimant sought physical therapy on February 19, 2024 at which time he reported developing severe neck pain over the weekend. By March 6, 2024, Claimant began reporting additional symptoms including numbness and tingling into his fingers and hands.

5. Claimant underwent a magnetic resonance image ("MRI") of his cervical spine on March 8, 2025 that was reported to have shown a disc bulge at C5-6 causing severe left and moderate right foraminal stenosis; a C6-C7 disc bulge with severe left and moderate right foraminal stenosis; a C7-T1 disc bulge with right foraminal stenosis; and a C4-C5 disc bulge with moderate bilateral foraminal stenosis. No cord signal change was noted.

6. Claimant was referred for an electromyelogram ("EMG") on March 14, 2024 based on a diagnosis of probable C6 cervical radiculopathy by Dr. Singh. Claimant subsequently underwent bilateral C6 transforaminal epidural steroid injections on April 8, 2024 with Dr. Rowley.

7. Claimant was examined by Dr. Gause with the Spine Institute of Arizona on April 25, 2024. Dr. Gause noted Claimant reported significant improvement in his symptoms after the bilateral transforaminal injections. Dr. Gause diagnosed Claimant with C5-6 disc bulge causing severe left and moderate right foraminal stenosis; C6-7 disc bulge with severe left and moderate right foraminal stenosis; C7-T1 disc bulge with right foraminal stenosis; and C4-5 disc bulge with moderate bilateral forminal stenosis.

8. Dr. Gause noted Claimant had significant improvement with medication, physical therapy and the epidural steroid injections. Dr. Gause recommended

Claimant return in four (4) weeks for a repeat evaluation at which time they would discuss maximum medical improvement ("MMI").

9. The medical records do not document any additional medical treatment related to Claimant's Arizona work related injury.

10. On April 4, 2025, after Claimant experienced the symptoms into his left upper extremity, Claimant was taken by Employer to Colorado Mountain Medical after he reported the incident to his employer. Claimant was examined by Physicians' Assistant ("PA") Philmus. Claimant reported to PA Philmus that he was checking the oil on his snow plow when he felt a sharp pain behind his left scapula. Claimant reported this pain radiated through his shoulder and down his right arm with some tingling in his hand. Claimant reported some of the pain had resolved, but he still noted pain behind the scapula that radiated into his left upper trapezius. Claimant was diagnosed with a thoracic muscle strain and prescribed cyclobenzaprine along with recommended over the counter medications in addition to physical therapy. Claimant was provided with work restrictions of no lifting over ten (10) pounds and instructed to follow up if there was no improvement or his symptoms worsened.

11. Claimant initiated physical therapy with Howards Head Sports Medicine on April 5, 2025. The physical therapist noted Claimant reported left shoulder soreness over the last sever weeks with a sharp, shooting pain down his whole arm when changing oil the previous day.

12. Claimant returned to PA Geller on April 11, 2025. Claimant reported an onset of pain when leaning forward under the hood of his truck to lift the oil dipstick, when he felt a pop and sharp pain involving his left shoulder. PA Geller noted Claimant reported a history of having cervical thoracic compression fractures 20 years ago with intermittent bilateral upper extremity pain and paresthesia following additional work comp injuries resulting in spinal injections both in Arizona as well as locally. Claimant reported that while his initial symptoms involved only his left side, he had developed some tingling in his right fingers over the past two (2) days. Claimant reported his left scapular pain was different from the symptoms he had previously

experienced and complained of left upper extremity weakness that was not present in the months prior to April 4, 2025. Claimant was diagnosed with left subscapular pain, but PA Geller noted she could not exclude cervical radiculopathy. PA Geller prescribed Claimant a Medrol dosepak and recommended Claimant continue physical therapy.

13. Claimant returned to PA Geller on April 21, 2025 for a telemedicine appointment after complaining of worsening symptoms to his physical therapist. PA Geller noted Claimant was complaining of significant myotome weakness of C6 and C7 and noted that the worsening of symptoms suggested an immediate referral was necessary. Claimant was then referred for and MRI of the cervical spine and a surgical consultation.

14. The MRI was performed on April 23, 2025 and demonstrated congenital and/or degenerative narrowing of the cervical spine, with superimposed degenerative changes. Neural foraminal narrowing was most pronounced from C4-5 through C6-7, left more than right; and also on the left at C7-T1. Mild contouring of the ventral cord due to canal narrowing was also noted with mild fluid in the C5-6 disc and mild edema in the subchondral marrow beneath the flanking endplates.

15. PA Geller noted on April 28, 2025 after reviewing the MRI results from April 23, 2025 that Claimant's findings on MRI are degenerative which were similar to the MRI from August 2024. PA Geller noted that because the flare up of Claimant's symptoms resulted from pulling a dipstick out of the engine and no specific trauma, in conjunction with what PA Geller opined were no new findings on his MRI scan, it points to Claimant's condition not be work related. PA Geller closed Claimant's case and instructed Claimant to pursue treatment on his private insurance.

16. Claimant was examined by Dr. Gill with the Steadman Clinic on May 6, 2025. Claimant reported a history of his prior injury in Arizona in February 2024 along with his report that his symptoms being managed well conservatively after the cervical spine injection until on April 4, 2025 when he was leaning forward to lift the oil dipstick when he experienced pain in his left upper extremity. Claimant reported to Dr. Gill that

he significantly aggravated his symptoms while working on April 4, 2025. Dr. Gill recommended a left transforaminal epidural steroid injection at the C5-C6 and C6-C7 levels. This was performed on May 8, 2025 under the auspices of Dr. Evans.

17. Claimant returned to Dr. Gill on May 14, 2025. Claimant reported no significant improvement following the transforaminal epidural steroid injection and Dr. Gill recommended Claimant proceed with a C5-C6 total disc arthroplasty.

18. A computed tomography ("CT") scan of the cervical spine was performed on May 15, 2025 that revealed mild to moderate spinal canal stenosis, moderate right neuroforaminal stenosis and severe left neuroforaminal stenosis at the C4-C5 level; mild spinal canal stenosis, moderate to severe right neuroforaminal stenosis and severe left neuroforaminal stenosis at the C5-6 level; mild spinal canal stenosis, moderate to severe right neuroforaminal stenosis and severe left neuroforaminal stenosis at the C6-C7 level.

19. Claimant underwent surgery on his cervical spine on May 20, 2025 with Dr. Gill. Claimant testified that after the surgery, he continues to have neck pain and weakness, but does not have tingling down his left arm. Claimant testified that after the surgery, he was off of work for approximately three (3) months, but has returned to work without restrictions.

20. Respondents obtained an independent medical examination ("IME") of Claimant with Dr. Chen on August 26, 2025. Dr. Chen reviewed Claimant's medical records, obtained a medical history and performed a physical examination in connection with his IME. Dr. Chen noted Claimant's history of a pre-existing condition involving his cervical spine resulting in medical treatment that Dr. Chen chronicled as chronic neck pain since age 19. Dr. Chen noted Claimant has had prior injections into his cervical spine, including injections in 2015, 2016 and February, 2024. Dr. Chen described Claimant's mechanism of injury as performing a maneuver with his left arm and feeling pain going from the neck down his arm. Dr. Chen opined this was a benign mechanism of injury, with no real trauma. Dr. Chen opined this was a physiologic motion that a "normal" body should be able to handle. Dr. Chen went on

to opine that Claimant's condition was a natural progression of Claimant's underlying disease process with no evidence of aggravation from the 2025 clinical work injury.

21. Dr. Chen noted that Claimant had an injection in 2024 for his cervical spine, which relieved the majority of his pain. Dr. Chen further noted, however, that injections are never meant to last forever and not meant to be curative. And therefore, it was a foregone conclusion that Claimant's symptoms would return, which they eventually did. Dr. Chen further opined that Claimant's surgery was reasonable and necessary, but not related to the April 4, 2025 work injury.

22. The ALJ credits Claimant's testimony at hearing along with the medical records entered into evidence and finds that Claimant has established that it is more probable than not that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer on April 4, 2025 when he contorted his body under the hood of the snow plow to check the dipstick for the oil. While Claimant did suffer from a pre-existing condition involving his cervical spine, the medical records document that Claimant had last received medical treatment for that condition in April 2024. Claimant's testimony that his symptoms significantly resolved after the cervical spine injection in 2024 is found to be credible and persuasive.

23. The ALJ notes that the opinion of PA Geller that Claimant's onset of symptoms resulted from pulling out the dipstick involving no specific trauma does not appear to take into consideration the fact that Claimant needed to contort his body while on the wheel well of the plow in order to reach the dipstick on a vehicle that is 13 feet in height.

24. Likewise, the opinion of Dr. Chen that the surgery was the natural progression of Claimant's pre-existing condition is not credited by the ALJ. While Dr. Chen opines that injections are not intended to be permanent, Claimant's medical records document a history of cervical issues in 2015 and 2016 that resolved after a cervical injection with no credible evidence of ongoing active medical treatment until Claimant's injury in February 2024. Claimant then received medical treatment and his symptoms largely resolved after an injection in April 2024 until his new injury on April

4, 2025, resulting in disability and the need for additional medical treatment and surgery.

25. Because the case law relevant to Colorado workers' compensation injuries establishes that a work injury is compensable if the work injury aggravates, accelerates or combines with a pre-existing condition to cause the need for medical treatment, Claimant's case is compensable because the injury on April 4, 2025 when Claimant contorted his body to attempt to reach the oil dipstick, Claimant's actions aggravated, accelerated or combined with his pre-existing condition to cause the need for medical treatment. In this case, Claimant was working without restrictions and not under any active medical treatment at the time of the April 4, 2025 work injury. As a result of the Claimant contorting his body while trying to check the oil, the Claimant aggravated his underlying condition that resulted in the need for medical treatment and disability as evidenced by the work restrictions set for the PA Philbus and PA Geller.

26. The ALJ further credits the medical records entered into evidence in this case and finds that Claimant has established that it is more probable than not that the surgery performed by Dr. Gill was reasonable medical treatment necessary to cure and relieve Claimant from the effects of his injury.

27. The ALJ notes that Claimant's testimony that the tingling down his arm resolved following the surgery performed by Dr. Gill is credible and supported by the medial records entered into evidence at hearing. The ALJ notes that they symptoms were present from the onset of Claimant's injury and finds that Claimant has established that they symptoms and resulting medical treatment were causally related to his April **4,** 2025 work injury.

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-

102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2016.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance* Co. *v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson,* 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, the ALJ credits the medial records entered into evidence along with Claimant's testimony at hearing and finds that Claimant has established that the April 4, 2025 incident in which he contorted his body to attempt to reach the oil dipstick,

represents actions that aggravated, accelerated or combined with his pre-existing condition to cause the need for medical treatment. Notably, Claimant developed symptoms immediately and was taken immediately by his employer for medical treatment related to the symptoms down his left arm. The ALJ determines that Claimant has established by a preponderance of the evidence that this incident represents a work related injury in that Claimant's actions in the course and scope of his employment with Employer aggravated, accelerated or combined with Claimant's pre-existing condition to cause the disability and need for medical treatment.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990).

6. As found, the ALJ credits the testimony of Claimant at hearing along with the medical records entered into evidence in this case and finds that the surgery performed by Dr. Gill on May 20, 2025 was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the industrial injury.

Order

It is therefore ordered that:

1. Respondents shall pay for the surgery performed by Dr. Gill on May 20, 2025 pursuant to the medical fee schedule.

2. All issues not herein decided are reserved for future determination.

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts,** 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed

within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts.** For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts.

Dated: 10/28/2025

/s/ Keith E. Mottram

Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 5-162-970-001

ISSUE

I. Did Claimant prove by a preponderance of the evidence that the peripheral nerve stimulator is reasonable and necessary maintenance treatment?

FINDINGS OF FACT

Based on the evidence received at hearing, and the evidentiary deposition of Dr. Primack, the ALJ makes the following Findings of Fact:

1. Claimant's authorized treating provider is Dr. Daniel Peterson. After a significant amount of treatment and several surgeries, Dr. Peterson placed claimant at MMI on April 4, 2025. Claimant had a spinal cord stimulator placed by Dr. Barolat October 14, 2024. Dr. Peterson provided an impairment rating, which was admitted by respondents in a final admission of liability dated April 29, 2025. The FAL included an admission for maintenance benefits. Claimant objected to the FAL and filed an application for hearing.

2. Dr. Barolat's notes dated March 13, 2025, indicate that claimant had come in and worked with the Medtronic representative for over an hour in reference to his spinal cord stimulator. When they were done, "We were able to achieve both improved coverages in the arm, shoulder, lateral elbow as well as without increasing his headaches with the programming. The patient was extremely pleased by the results."

3. Dr. Peterson's maintenance recommendation on April 4, 2025, included a DME referral for an elbow brace. Also recommended were a psychology referral, medication and maintenance by Dr. Barolat and Dr.

Malinky.

4. On April 14, 2025, claimant reported that he was having improvement but his evaluator Justin Call said "we are still having difficulty covering a focal area in his right lateral elbow." It is the right lateral elbow symptoms that have prompted the request for the additional stimulator. Dr. Barolat's assistant Justin Call said, "his nervous system and pain in his right lateral arm are not cooperating the way we would like." He guesses that this may be due to prior infection in the area and multiple surgeries. "[W]e feel that there is a distinct possibility that we cannot cover this from his epidural electrode location." This, despite also saying that "certainly" the paddle placement that had been done by that office was a location that is "perfect" for what claimant needs. Without more explanation, a request for an additional stimulator trial for an *additional* stimulator to be placed in the right forearm was made, post MMI.

5. At the request of Respondents, Dr. McCranie reviewed the request and opined that the second stimulator should be denied as not reasonable or necessary. She noted that an additional stimulator was not consistent with the Chronic Pain Medical Treatment Guidelines.

6. Dr. Scott J. Primack testified via deposition as an expert. He is a physiatrist with experience in peripheral nerve procedures. He is trained in electrophysiology and had an understanding of nerve injury and the treatment of nerve injuries. He evaluated the claimant twice and reviewed medical records for a records review on the instant issues. *Ex. A.* His expert conclusion is that it is not reasonable and necessary to place an additional right forearm peripheral nerve stimulator as maintenance treatment for claimant. Dr. Primack noted that claimant's function increased with his initial spinal cord stimulator and "he has achieved reasonable expectations with the technology". He pointed to the example of claimant traveling to Europe after the stimulator was placed. An additional stimulator is not going to change his function. His initial stimulator was successful, and there is no justification for an additional stimulator. "Just because someone says I've got pain in my forearm doesn't

mean that that necessitates another stimulator because of what you've been able to demonstrate functionally. Because the entire system is based upon and about function.... "

CONCLUSIONS OF LAW

Generally

A. The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

B. Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or

none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 441 P.2d 21 (Colo. 1968).

C. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

D. Where the relatedness, reasonableness, or necessity of medical treatment is disputed, the Claimant has the burden to prove that the disputed treatment is causally related to the injury, and reasonably necessary to cure or relieve the effects of the injury. *Ciesiolka v. Allright Colorado, Inc*., W.C. No. 4-117-758 (ICAO April 7, 2003). The question of whether a particular medical treatment is reasonably necessary to cure and relieve a claimant from the effects of the injury is a question of fact. *City & County of Denver v. Industrial Commission*, 682 P.2d 513 (Colo. App. 1984). I conclude that the recommendation for a peripheral nerve stimulator is not reasonable or necessary. I am persuaded by the opinions of Dr. McCranie and Dr. Primack that this proposed treatment is not consistent with the MTG and will not improve his function.

ORDER

Based on the forgoing findings of fact, it is ORDERED:

1. Claimant’s request for a peripheral nerve stimulator is denied.
2. Any issue not resolved herein is reserved for future determination.

Dated: October 21, 2025

Michael A. Perales

Administrative Law Judge

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after

mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 27(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts. For statutory reference, see Section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://www.colorado.gov/dpa/oac/forms-WC.htm.

ISSUES

1. Whether Claimant proved by a preponderance of the evidence that he sustained a compensable injury on September 4, 2024.

2. Whether Claimant proved by a preponderance of the evidence that he is entitled to medical benefits reasonably necessary to cure and relieve Claimant of the effects of his work injury.

3. Whether Claimant has proved by a preponderance of the evidence that he is entitled to temporary partial and temporary total disability benefits.

STIPULATIONS

1. Claimant's average weekly wage is $968.98.

FINDINGS OF FACT

1. On September 4, 2024, Claimant was employed by Respondent Employer as an installer of metal and insulation, working at a high-rise residential construction site. His duties that day required him to work from a suspended platform—referred to as a "swing stage" or "basket"—on the exterior of the building. Claimant was accompanied in the basket by a co-worker, Jose Emiliano Fuentes Hernandez.

2. During the afternoon, at approximately 3:45 p.m., a gust of wind struck the basket, causing it to swing outward from the side of the building and then back against it. He struck the left side of his head on a metal part of the basket's motor, struck his

left ribs on the basket's top rail, twisted his body causing low back pain, and experiencing whiplash. A ground laborer, Ms. Blanca Diaz, witnessed the incident and observed that some of the ropes or cables beneath the basket became entangled. She untangled the ropes within roughly half a minute. Following the gust and the brief entanglement, Claimant and Mr. Fuentes lowered the basket to the ground. Once on the ground, they secured the equipment, gathered their tools, and concluded their work for the day. Rain began to fall shortly thereafter. Claimant departed the job site with assistance from a co-worker rather than driving himself.

3. When Claimant arrived home around 5:30 P.M., he had some water and went to bed until about 9:00 P.M., when he woke up in increased pain and difficulty sleeping.

4. First thing in the morning on September 5, 2024, Claimant reported his injury from the day before. He completed an Employee Accident Report in which he indicated that his injury occurred at the end of the workday the day before. He wrote that a gust of wind came and that his safety rope got entangled with the cable of another swing stage and yanked his body. Claimant reported that the left parts of his neck, spine, and ribs were hurting him. Claimant did not report a head injury at that time.

5. Respondent-Employer provided Claimant with a designated provider list and Claimant selected Midtown Occupational Health Services where he was attended by Carissa Sales, PA-C, under the supervision of Dr. Lori Rossi that same day. Claimant reported that his injury occurred when his harness got stuck on a cable causing him to swing to the left, putting pressure on his left side of his body and hitting the left side of his body and head on the metal enclosure. Claimant complained of back pain, left rib pain, neck pain, headache, dizziness, vision changes, numbness to the left side of the face, numbness of the left hand, numbness into the left heel, joint pain at the left shoulder, left elbow symptoms, and left fingers symptoms. Specifically, Claimant reported that he experienced low back pain that would radiate down into his lower extremities. Claimant reported

that his neck pain radiated down his left upper extremity into his hand. As for his left-sided rib pain, Claimant reported that he felt the pain when breathing deeply. Claimant also described his head pain as being posterior with a 7.5/10 headache, numbness on the left side of his face, and dizziness.

6. Claimant underwent a CT scan of his head which showed no acute findings within the brain and no evidence for acute hemorrhage or infarction. Claimant also underwent an MRI of the lumbar spine which showed mild multilevel facet hypertrophic changes of the lumbar spine but no evidence of focal disc herniation, spinal stenosis, or neural foraminal narrowing at any level. Claimant's cervical spine MRI was unremarkable as was his left rib X-ray.

7. Dr. Rossi's diagnoses of Claimant included head contusion (with severe headache, dizziness, and vision changes), left cervical strain (with left upper extremity complaints), left lumbar strain (with left lower extremity paresthesias, pain radiation, bladder incontinence, and saddle anesthesia), and left rib contusion/intercostal muscle strain. Dr. Rossi released Claimant to full duty with no recommendations for medication or physical therapy. Claimant was to return the next day.

8. Claimant returned to Midtown on September 10, 2024, where he was attended by Dr. Cedillo. Claimant reported to Dr. Cedillo that he had not been working due to feeling unsafe to drive, despite having been released to full duty, and despite Claimant normally obtaining a ride from coworkers. Claimant reported that his rib pain had improved but that he was having new blurred vision when standing too quickly and was experiencing photophobia and dizziness. Dr. Cedillo opined that Claimant had experienced a left rib cage contusion, a cervical strain, left-sided head contusion or concussion, a left hip contusion, and a lumbar strain. With regard to Claimant's lower extremity symptoms, Dr. Cedillo noted that there were no neurologically significant findings on the MRI. Physical examination of the chest wall found "no swelling, bruising, deformity, tenderness to palpation in the rib cage

bilaterally." Dr. Cedillo recommended that Claimant continue with massage therapy, NSAIDs, and a follow-up visit.

9. On September 13, Claimant returned to Midtown where he was attended by PA Sales. PA Sales documented, "For the first time, today patient tells me that possibly some part of his exposed head without the hard hat may have hit that metal wall. He shows me a picture of this metal bar/wall he is referring to." Claimant was continued at full duty and prescribed ibuprofen.

10. When Claimant returned to Midtown on October 3, 2024, he reported dysuria since several days after his injury, though the attending clinician noted that Claimant had previously denied experiencing dysuria. Claimant also reported that he had been wearing a hard hat at the time of his injury which saved his life. Claimant reported that his head complaints continued without improvement, including headache and vision changes. PA Sales referred Claimant to Dr. Lesnak as well as for physical therapy and chiropractic care in addition to the massage therapy Claimant had been undergoing. PA Sales assigned temporary work restrictions of "Maximum. lifting 15 pounds. Repetitive lifting 5- 10 pounds. No crawling. No repetitive bending or twisting at the waist. Change positions as needed for comfort. Avoid screen/computers."

11. Claimant returned to Midtown on October 18, 2024, reporting inability to sleep due to increased pain. Claimant also reported feeling depressed. PA Sales kept Claimant on his existing temporary work restrictions but excused him from work for that day due to Claimant not yet having received his pain medication in the mail.

12. On October 20, 2024, Claimant saw Dr. Maria Jimenez, PsyD, for a psychological evaluation. Dr. Jimenez concluded that Claimant had anxiety and depression secondary to a diagnosis of PTSD. She recommended a referral to a psychiatrist.

13. Claimant was terminated from his employment on October 21, 2024, due to the company no longer having light-duty tasks available.

14. On October 23, 2024, Claimant underwent a CT scan of his left rib cage which showed a partially healed left lateral tenth rib fracture.

15. At some point, Claimant reported to Midtown that he was experiencing suicidal ideation for which Midtown referred Claimant to Dr. Stephen Moe, MD, for a psychiatric evaluation. Dr. Moe felt that Claimant's current symptoms did not reflect the residual effects of a concussion based on normative outcomes. Dr. Moe's assessment of Claimant was that of "Probable Adjustment Disorder with Depression and Anxiety" and a possibility of PTSD. Dr. Moe recommended Claimant continue taking fluoxetine (antidepressant) and begin trazadone for insomnia.

16. On February 4, 2025, Claimant saw Dr. David Mirich, Ph.D, a neuropsychologist. Claimant informed Dr. Mirich that he lost consciousness when his head hit the motor. This is the first time that Claimant alleged that he lost consciousness after denying it multiple times. Dr. Mirich's diagnostic impressions were mild neurocognitive disorder due to TBI and adjustment disorder with depression.

17. Dr. Mirich noted that Claimant presented consistently with the DSM-5 criteria for Mild Neurocognitive Disorder due to Traumatic Brain Injury, with impairments in attention, memory, executive function, and social cognition. Dr. Mirich opined that Claimant would likely benefit from neurocognitive rehabilitation and psychotherapy and medication evaluation.

18. On February 19, 2025, Claimant underwent C2-3 and C3-4 medial branch blocks and a left occipital nerve block. Claimant reported about a week later that he had complete pain relief in the neck and resolution of his headache pain. Dr. Kawasaki opined that the results were diagnostic.

19. Claimant underwent an IME with Dr. Mark Paz on April 3, 2025. Dr. Paz concluded that Claimant did not have any diagnosis causally related to Claimant's September 4, 2024 accident. Specifically, he noted no objective medical findings to support the subjective symptoms reported. Despite diagnoses of concussion, post-concussion syndrome, PTSD, and various musculoskeletal complaints, he observed that none were corroborated by physical examination or imaging consistent with acute trauma. The later-discovered rib fracture was in his opinion unrelated to the incident, as records from shortly after the accident did not document objective findings on physical examination consistent with a rib fracture. Additionally, he felt that the reported head, neck, and back symptoms lacked objective evidence of injury. He opined that the cervical MRI findings reflected degenerative, not traumatic, changes, and diagnostic procedures failed to confirm a pain generator. Dr. Paz emphasized that without correlating objective findings or a medically supported diagnosis, the causation criteria could not be satisfied.

20. On April 17, 2025, Claimant saw Dr. Kawasaki for pain management. Claimant underwent an EMG of the lumbar spine and left lower extremity. The EMG of the lumbar spine was within normal limits and that of the lower extremity showed no evidence of lumbar radiculopathy, lumbar plexopathy, or peripheral neuropathy. Claimant also underwent left C2-3 and left C3-4 medial branch blocks and experienced 100% relief. Claimant was scheduled for a May 14, 2025 rhizotomy.

21. On April 23, 2025, Claimant underwent an IME with Dr. Miguel Castrejon. Claimant reported the injury in a manner mostly consistent with prior descriptions. He reported that he had no loss of consciousness. Claimant also reported to Dr. Castrejon that he had improvement in his range of motion in his neck and reduction in headaches following the second set of injections with Dr. Kawasaki and that his left chest symptoms had since resolved. Claimant's present complaints at the time of the IME included headaches and low back pain with symptoms extending to his left lower extremity. He reported no difficulty with memory or speech and reported

that his insomnia, nightmares, depression, and anxiety had all improved with medication. Claimant exhibited tenderness on examination from his head down to his trapezius and exhibited mildly positive facet loading on the left side.

22. Dr. Castrejon opined that Claimant's experience on the date of injury met the criteria for PTSD and that Claimant's presentation was consistent with PTSD arising out of the accident. Additionally, he felt that Claimant had sustained a mild traumatic brain injury arising out of his accident. However, he noted that the effects of the traumatic brain injury had resolved and that there was insufficient documentation to support the development of post-concussive syndrome.

23. Regarding Claimant's neck symptoms, Dr. Castrejon noted that Claimant described an incident consistent with whiplash and that patients who experience whiplash often experience injuries to the facet joints. Dr. Castrejon clarified that Claimant's response to the injections was diagnostic as Claimant reported being pain free for at least eight hours after the injections and had increased range of motion in the neck and elimination of headaches, allowing him to feel normal again. Dr. Castrejon concluded that Claimant sustained a cervical spine strain and injury to the facet joints with development of both facet-mediated pain and myofascial pain. He felt that a cervical rhizotomy would be reasonable.

24. Dr. Castrejon noted that Claimant had findings of stable mild sacroiliac joint dysfunction. Dr. Castrejon offered no opinion as to whether that condition was caused or aggravated by the work accident. Similarly, with regard to Claimant's rib fracture, Dr. Castrejon declined to address causation as Claimant was asymptomatic and the point was then, in Dr. Castrejon's opinion, moot.

25. Dr. Castrejon later credibly testified at hearing consistently with the above. Furthermore, he credibly testified that he himself had suffered post-traumatic stress and experienced parasympathetic responses that manifested in physical pain. Therefore, he testified, he understood why Claimant could have extremity

pain resulting from the stress even in the absence of a physical etiology to explain the pain.

26. The Court finds Dr. Castrejon's testimony credible and his opinions persuasive.

27. On June 4, 2025, Dr. Paz issued a supplemental report after having reviewed Dr. Kawasaki's April 17, 2025 report. Dr. Paz felt that the medial branch blocks performed by Dr. Kawasaki were non-diagnostic pursuant to the Medical Treatment Guidelines. He explained that a diagnostic response required improvement in three functional measures and at least 80% reduction in pain. Dr. Paz explained that Claimant's response did not meet the 80% reduction in pain criterion for a diagnostic response.

28. Claimant testified at hearing on his own behalf. Claimant testified that when the gust of wind hit the basket, his personal fall-protection line that was attached to his harness became entangled with a cable from another basket and that he struck the left side of his head on a metal part of the basket's motor, struck his left ribs on the basket's top rail, and twisted his body causing low back pain. Claimant attributed neck pain to the basket's movement.

29. Claimant testified that he was working with Mr. Fuentes in the basket at the time of the injury, and Blanca Diaz, Mr. Fuentes's partner, was working from the ground. Mr. Fuentes stopped the machine and Ms. Diaz helped free the lines by pulling a master rope. Claimant testified that upon reaching the ground, he told Mr. Fuentes that he felt unwell, that Mr. Fuentes remarked that they had almost died, and that Ms. Diaz remarked that it was a close call.

30. Claimant testified that coworker Jose Salazar gave him a ride home, that he tried to rest, and that he woke up around 9:00 P.M. with increased pain, headache, dizziness, and inability to sleep. Claimant testified that the following morning Jose

Salazar drove him to work again and he reported the accident to his foreman who in turn reported it to the safety manager, Edson Coronado.

31. Claimant testified that Edson Coronado advised him to go home to rest and, if needed, to see a doctor. Claimant testified that he insisted to Edson Coronado that he was in pain and needed immediate medical care. Edson Coronado provided Claimant with a designated provider list, from which Claimant chose Midtown Occupational Health. Claimant testified that he has treated exclusively with Midtown since first receiving treatment there and that all his treatment was covered until it was suspended by Respondents a month and a half prior to hearing.

32. Claimant testified that he returned to work on September 6, 2024, with temporary work restrictions to avoid screens, lifting no more than five pounds, and limitations on duration of standing and sitting. Claimant testified that Respondent-Employer partially accommodated his restrictions. Claimant testified that he continued working for Respondent-Employer through October 20, 2024, as he was terminated on October 21 due to unavailability of light-duty work.

33. Claimant testified that after his termination he began working full-time at All American Seasonings on March 3, 2025 for $800 per week with accommodations, but stopped working there in May 2025. Claimant began a new job on May 16, 2025 working full-time for QED/Sonepar, though he had not yet received a paycheck as of the time of the hearing.

34. The Court finds Claimant's testimony credible, except for his testimony about the statements that he, Mr. Fuentes, and Ms. Diaz made upon Claimant and Mr. Fuentes reaching the ground after the accident and except for Claimant's testimony that he was given temporary work restrictions on September 6, 2024.

35. Jose Emiliano Fuentes Hernandez also testified at hearing. Mr. Fuentes testified that he was indeed working with Claimant in the basket on the date of the accident when a gust of wind struck the basket. Mr. Fuentes testified that the gust of wind caused the basket to move away from the building by one or two feet before swinging back to the wall and that he and Claimant decided to descend immediately for safety reasons. Mr. Fuentes testified that the basket did not throw or strike him and that he did not see Claimant thrown, injured, or tangled in any rope. He noted that the rope below the basket became twisted but did not involve either worker. In his opinion, the movement of the basket was unusual and unsafe but not extreme and that he did not personally feel frightened or endangered. Mr. Fuentes testified that Claimant did not mention any injury or distress to him upon reaching the ground.

36. The Court finds Mr. Fuentes' testimony credible, except insofar as it conflicts with that of Claimant.

37. Blanca Diaz testified as well. Ms. Diaz testified that she was cleaning on the ground while Mr. Fuentes and Claimant were working in a suspended basket several stories above. She noticed cords became tangled when she felt a gust of wind and saw that a rope had wrapped around the basket's cords. Ms. Diaz quickly untangled them, estimating it took about thirty seconds. Afterward, Ms. Diaz testified, the basket was lowered to the ground, and both men exited, secured the ropes, gathered their belongings, and left without incident or conversation.

38. Ms. Diaz testified that she did not observe any injuries and did not hear screams or any indication of distress from the basket. She confirmed that she and Mr. Fuentes went home together afterward but did not discuss the event. On cross-examination, Diaz clarified that although she was positioned beneath the basket, she was focused on cleaning and could not see inside it. She acknowledged she was not a medical professional and did not evaluate anyone's condition.

39. The Court finds Ms. Diaz's testimony credible.

40. José Luis Limas Ramirez testified at hearing as well. He testified that he is a supervisor for Respondent-Employer and directly supervised Claimant on September 2024. Mr. Limas testified that he first learned that Claimant alleged an injury the day after it occurred, when Claimant personally reported it to him in the morning. Mr. Limas instructed Claimant to complete an incident report and assisted him in doing so with the help of a translator.

41. Mr. Limas testified that Claimant stated he was injured after becoming tangled in a rope but did not mention hitting his head. Mr. Limas recalled Claimant indicating pain in either his shoulder or back, though he was uncertain which. Mr. Limas testified that Claimant did not initially request medical attention but later spoke by phone with Edson Coronado, after which Mr. Limas drove him to a clinic approximately thirty minutes away. Mr. Limas noted that Claimant showed no visible difficulty entering or exiting the vehicle and did not complain of pain during the drive. He did not see Claimant again until later at the office, where Claimant was performing cleaning work.

42. The Court finds Mr. Limas's testimony credible.

43. Edson Coronado also testified at hearing. He testified that he first learned of Claimant's reported injury on the morning of September 5, 2024, via a phone call from Claimant himself. During that call, Claimant reported pain in his low back, ribcage, and neck but made no mention of any head injury or fear of returning to work.

44. Mr. Coronado testified that Claimant explained the injury occurred when he was pressed against the guardrails of a basket and became tangled in a rope. Following the call, Mr. Coronado arranged for Claimant to be examined by a medical professional at Midtown Health, instructing José Limas to transport him. Mr.

Coronado noted that Claimant initially seemed reluctant to seek medical care but denied ever advising him to delay treatment or wait fifteen days before seeing a doctor. He further testified that Claimant did not threaten to seek medical attention independently.

45. The Court finds Mr. Coronado's testimony credible.

46. Respondents also called Dr. Paz to testify at hearing.

47. Dr. Paz generally testified consistently with his IME report. He testified that Claimant's early medical records documented multiple subjective complaints with no objective findings on examination. He noted that the September 10, 2024 examination by Dr. Cedillo included a detailed chest-wall examination that documented no bruising, swelling, crepitus, observed pain response, or other objective finding. He also noted that a rib X-ray on the day after Claimant's injury showed no fracture. Regarding the October 2024 CT scan of Claimant's abdomen showing a partially healed rib fracture, Dr. Paz opined that it was an incidental radiographic finding and felt that the absence of objective findings on examination shortly after the accident was determinative.

48. Regarding Claimant's cognitive complaints, Dr. Paz testified that the absence of a loss of consciousness or visible head injury made a traumatic brain injury unlikely. Dr. Paz agreed with Dr. Moe that there was no traumatic brain injury or post-concussive syndrome.

49. In his testimony, Dr. Paz questioned Dr. Moe's opinion as to adjustment disorder and PTSD, noting Claimant's inconsistencies with reporting loss of consciousness and expressing some doubt as to whether the incident would be sufficient to cause PTSD.

50. The Court finds Dr. Paz credible. However, the Court finds Dr. Castrejon's and Dr. Moe's opinions more persuasive. The Court finds persuasive Dr. Castrejon's explanation that Claimant's positive diagnostic response to the medial branch blocks confirmed the presence of cervical facet-mediated pain, consistent with the whiplash-type mechanism described by Claimant. The Court further credits Dr. Castrejon's testimony that Claimant's neck and upper extremity symptoms were plausibly explained by cervical facet injury and myofascial pain arising from the incident, rather than from degenerative processes.

51. The Court additionally credits Dr. Castrejon's opinion that Claimant experienced psychological sequelae, including PTSD, causally related to the September 4, 2024 work incident. Dr. Castrejon's testimony reflected careful clinical reasoning and was supported by consistency between Claimant's psychological presentation, contemporaneous documentation, and later evaluation by Dr. Moe. His testimony demonstrated both professional insight and credibility, including candid acknowledgment of the interplay between physiological and psychological manifestations of trauma. Accordingly, the Court accords greater weight to Dr. Castrejon's opinions regarding the causal relationship between the work incident and Claimant's cervical and psychological conditions.

52. The Court finds that Claimant has proved by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment on September 4, 2024, while working for Respondent-Employer. Although the contemporaneous medical records do not contain objective findings of acute trauma, the totality of the evidence establishes that Claimant experienced a compensable injury. The mechanism of injury described by Claimant—a sudden gust of wind causing the suspended basket to swing and impact the building—was corroborated by coworker testimony and is consistent with the onset of the physical complaints Claimant reported the following day. Claimant's reports of neck, rib, and back pain were prompt, consistent, and plausible in light of the incident's dynamics.

53. The credible medical evidence supports that Claimant's subsequent diagnostic medial branch blocks yielded a diagnostic response. Additionally, Claimant's psychological symptoms, including anxiety and PTSD, were credibly linked to the workplace event and further corroborate that the incident was traumatic and injurious in nature.

54. Taken together, the credible lay and medical evidence established that it is more likely than not that at least some of Claimant's physical and psychological conditions were causally connected to the September 4, 2024 incident. The Court therefore finds that Claimant met his burden to prove, by a preponderance of the evidence, that he sustained an injury arising out of and in the course of his employment.

55. Furthermore, Claimant has proved that he is entitled to medical benefits reasonably necessary to cure and relieve him of the effects of his September 4, 2024 injury.

56. The parties stipulated, and the Court accepts, that Claimant's average weekly wage is $968.98.

57. The Court finds that Claimant has proved by a preponderance of the evidence that he is entitled to temporary total disability benefits from October 21, 2024, through March 2, 2025. During that period, Claimant was not working due to Respondent-Employer's inability to accommodate Claimant's temporary work restrictions. Claimant returned to lesser wages of $800 per week when he began working full time for All American Seasonings on March 3, 2025, and Claimant has proved that he is entitled to temporary partial disability from March 3, 2025 onward at varying rates.

CONCLUSIONS OF LAW

Generally

1. The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

2. Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is the exclusive domain of the administrative law judge. *University Park Care Center v. Industrial Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to

conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

3. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Compensability

1. An injury must "arise out of and occur in the course of" employment to be compensable, and it is the claimant's burden to prove these requirements by a preponderance of evidence. Section 8-41-301, C.R.S.; *see also Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). An injury "arises out of" the employment when it is sufficiently related to the conditions and circumstances under which the employee usually performs his or her job functions to be considered part of the service provided to the employer. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207 (Colo. 1996); *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). An injury is said to have arisen in the course of employment if the injury occurred while the employee was acting within the time, place, and circumstances of the employment. *Id*.

2. As found, Claimant has proved by a preponderance of the evidence that he sustained an injury arising out of and in the course of his employment on September 4, 2024, while working for Respondent-Employer. Although the contemporaneous medical records do not contain objective findings of acute trauma, the totality of the evidence establishes that Claimant experienced a compensable injury. The mechanism of injury described by Claimant—a sudden

gust of wind causing the suspended basket to swing and impact the building—was corroborated by coworker testimony and is consistent with the onset of the physical complaints Claimant reported the following day. Claimant's reports of neck, rib, and back pain were prompt, consistent, and plausible in light of the incident's dynamics. The credible medical evidence supports that Claimant's subsequent diagnostic medial branch blocks yielded a diagnostic response. Additionally, Claimant's psychological symptoms, including anxiety and PTSD, were credibly linked to the workplace event and further corroborate that the incident was traumatic and injurious in nature.

3. Taken together, the credible lay and medical evidence established that it is more likely than not that at least some of Claimant's physical and psychological conditions were causally connected to the September 4, 2024 incident. As found, Claimant met his burden to prove, by a preponderance of the evidence, that he sustained an injury arising out of and in the course of his employment

Medical Benefits

1. The Colorado Workers' Compensation Act ("the Act") provides that an employer must provide medical care "as may reasonably be needed . . . to cure and relieve the employee from the effects of the injury." Section 8-42-101(1)(a), C.R.S.

2. "An employer who has admitted liability for medical benefits can dispute a claimant's need for continued medical benefits." *Bolton v. Industrial Claim Appeals Office*, 487 P.3d 999 (2019). Where the claimant's entitlement to benefits is disputed, the claimant has the burden to prove that the requested medical treatment is reasonable, necessary, and related. *Tafoya v. Associations, Inc.*, W.C. No. 4-931-088-03 (Jan. 13, 2017). Whether the claimant sustained this burden of proof is a factual question for resolution by the ALJ. *Id*.

3. As found, Claimant has proved that he is entitled to medical benefits reasonably necessary to cure and relieve him of the effects of his September 4, 2024 injury.

TTD and TPD

4. If the injury or occupational disease causes temporary total disability, a disability indemnity shall be payable as wages at a rate of 66 2/3% of the claimant's average weekly wage. Sections 8-42-103(1) and 8-42-105(1), C.R.S.

5. TTD benefits are designed to compensate an injured worker for wage loss while the injured worker recovers from a work-related injury. *Pace Membership Warehouse, Div. of K-Mart Corp. v. Axelson,* 938 P.2d 504 (Colo. 1997). Claimant bears the burden of establishing three conditions before qualifying for TTD benefits: (1) that the industrial injury caused the disability; (2) that Claimant left work because of the injury; and (3) that the disability is total and last more than three working days. *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo.App.1997).

6. As found, Claimant has proved by a preponderance of the evidence that he is entitled to temporary total disability benefits from October 21, 2024, through March 2, 2025. During that period, Claimant was not working due to Respondent-Employer's inability to accommodate Claimant's temporary work restrictions. Claimant returned to lesser wages of $800 per week when he began working full time for All American Seasonings on March 3, 2025, and Claimant has proved that he is entitled to temporary partial disability from March 3, 2025 onward at varying rates.

ORDER

It is therefore ordered that:

1. Claimant has proved that he sustained a compensable injury on September 4, 2024.
2. Claimant has proved that he is entitled to reasonably necessary medical benefits to cure and relieve him of the effects of his September 4, 2024 injury.
3. Claimant has proved that he is entitled to TTD benefits from October 21, 2024, through March 2, 2025.
4. Claimant has proved that he is entitled to TPD benefits from March 3, 2025, through ongoing.
5. All matters not determined herein are reserved for future determination.

DATED: October 22, 2025

Stephen J. Abbott
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, Colorado 80203

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, *see* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Office of Administrative Courts

State of Colorado

Workers' Compensation No. 4-348-842-002

Issues

- Did Claimant prove his claim should be reopened for additional medical treatment based on a change of condition?
- Did Respondents prove that reopening is barred by the statute of limitations?

Findings of Fact

1. Claimant suffered admitted injuries on July 7, 1997, when a chain broke and struck him in the mouth. The impact damaged Claimant's teeth and jaw. He underwent dental work, including implants.

2. Claimant was put at MMI with no impairment in 1998. Insurer filed a Final Admission of Liability on May 26, 1998. Claimant did not object to the FAL, and the claim closed.

3. Claimant agreed at hearing that his claim is closed. He did not object to the FAL in 1998 because he understood there was no further injury-related treatment recommended at that time.

4. Respondents paid no further benefits after the claim closed.

5. Claimant started seeing Andre Shook, DDS in October 2023. Dr. Shook noted a history of trauma to the anterior maxillary teeth, resulting in progressive mobility and fremitus (sensation of vibration) on teeth #7 to #10. The implant was also loose. X-rays showed severe bone loss and resorption with minimal crown to root ratio. Dr. Shook fashioned a split to "buy some time," and referred Claimant to Dr. Audrey Wang, a periodontist.

6. Claimant saw Dr. Wang on November 4, 2024. Dr. Wang determined that the existing implant was hopeless and recommended new implants for teeth 7-9. The pathology and associated treatment described by Dr. Wang are consistent with the natural progression of Claimant's 1997 dental injury.

7. Claimant was not referred to Dr. Shook or Dr. Wang by Respondents or any authorized provider. Therefore, neither Dr. Shook nor Dr. Wang are authorized treating physicians.

8. Respondents proved reopening is barred by the statute of limitations. It has been more than six years since the injury, and more than two years since the last medical benefits became due and payable.

Conclusions of Law

Section 8-43-303 allows an ALJ to reopen any award on the grounds of error, mistake, or a change in condition. However, any request to reopen a claim must be made within six years after the date of injury, or two years after the last medical benefits became due and payable, whichever is later. Section 8-43-303(2)(a) and (b). The time limits set forth in § 8-43-303 operate as a statute of limitations. *Calvert v. Industrial Claim Appeals Office*, 155 P.3d 474 (Colo. App. 2006). The statute of limitations on reopening is an affirmative defense, which Respondents must prove by a preponderance of the evidence. *Kersting v. Industrial Commission*, 567 P.2d 394 (Colo. 1977).

Claimant's injury occurred in 1997, and it has been more than six years from the date of injury. Furthermore, it has been more than two years since the last medical benefits became due and payable. Insurer paid no medical benefits since 1998. Even though Claimant has received injury-related treatment within the past two years, the treatment was not authorized. No benefits have been "due and payable" within two years before Claimant requested to reopen the claim.

Order

It is therefore ordered that:

1. Claimant's request to reopen his claim for additional medical benefits is denied and dismissed.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or

service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 16, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

Issues

- Did Respondent prove that the issue of disfigurement was closed by the June 24, 2025 Final Admission of Liability?
- Disfigurement.

Findings of Fact

1. Claimant suffered admitted injuries to both ankles on May 10, 2023. She underwent right ankle surgery on May 24, 2023, followed by hardware removal on December 6, 2023. She received extensive rehabilitative treatment and eventually put at MMI on May 28, 2025.

2. Respondent filed a Final Admission of Liability ("FAL") on June 24, 2025, admitting for the ATP's impairment rating and medical benefits after MMI. No disfigurement benefits were admitted. The FAL stated, "All benefits not admitted on this claim are hereby specifically denied."

3. On July 3, 2025, Claimant filed an Objection to Final Admission of Liability form with the Division and sent a copy to Respondent.

4. Also on July 3, 2025, Claimant attempted to file an Application for Hearing – Disfigurement Only ("AFH") with the OAC. However, because of a typo in the email address, the OAC did not receive the AFH. The AFH was addressed to "cap-oac@state.co.us," but the OAC's correct email address is "csp-oac@state.co.us."

5. Respondent received a copy of the AFH via email on July 3.

6. Claimant sent a follow-up email to the OAC on July 8, 2025, inquiring about the status of the AFH. The July 8 email used the same incorrect email address, and therefore was not received.

7. On July 17, 2025, Claimant discovered the typo and forwarded a copy of the July 3 email to the OAC's correct email address, with the original AFH attached. Claimant copied Respondent's counsel on the July 17 email.

8. Shortly thereafter, the OAC acknowledged receipt of Claimant's filing. The acknowledgement gave no indication of any problem with the AFH.

9. In reliance on the July 17 confirmation email from the OAC, Claimant took no further action but waited for the OAC to set the hearing in accordance with standard procedures.

10. The 30-day deadline for Claimant to object to the FAL expired on July 24, 2025.

11. On July 25, 2025, the OAC clerk emailed the parties that "the application [filed on July 17] will need to be refiled, with an updated Certificate of Service. This is necessary to ensure the record is complete and that all applicable deadlines can be properly calculated."

12. Claimant promptly resubmitted the AFH with a corrected certificate of service, and a disfigurement hearing was set for October 7, 2025.

13. Respondent failed to prove the issue of disfigurement is closed. Claimant timely objected to the June 24, 2025 FAL and requested a hearing. Claimant's AFH was received and acknowledged by the OAC on July 17, 2025, within the 30-day objection window. The incorrect date on the Certificate of Service is a mere procedural error and not a jurisdictional defect. At a minimum, Claimant substantially complied with the statutory requirement to request a hearing within 30 days, notwithstanding the technical issue with the Certificate of Service. The OAC did not "reject" Claimant's AFH filed on July 17 but merely instructed her to "re-file" the AFH with a corrected certificate of service for administrative purposes. Furthermore, even if the July 17 filing had been formally rejected, the rejection would be "without prejudice" under OACRP 10(A)(4). Therefore, the July 25, 2025 amended AFH would relate back to July 17, when the original AFH was received by the OAC.

14. As a result of the May 10, 2023 work accident, Claimant has visible disfigurement to areas of the body normally exposed to public view, consisting of: (1) two ¾-inch diameter areas of irregularly shaped, discolored, partially raised, partially indented scarring on the anterior aspect of the lower right ankle, (2) a 1 ½ inch by ¾-inch irregularly shaped, discolored, partially raised, partially indented scar on the lateral right ankle, above the malleolus, (3) a ½-inch diameter scar on the right Achilles area, (4) swelling

and discoloration around the right lateral malleolus, (5) an area of splotchy discoloration on the top of the right foot, (6) a large area of discoloration around the right medial malleolus, (7) a protrusion on the lateral ankle, and (8) a limp favoring the injured right leg.

Conclusions of Law

A. Claim closure

Section 8-43-203(2)(b)(II)(A) provides that claim will be "automatically closed" by a FAL if the claimant does not request a hearing on ripe and disputed issues within 30 days of the FAL. Once a claim is closed by an FAL, no additional benefits can be awarded unless the claim is reopened. Section 8-43-203(2)(d). The argument that a claim is "closed" is an affirmative defense that the respondents must establish by a preponderance of the evidence. *Roddam v. Rocky Mountain Recycling*, W.C. No. 4-367-003 (ICAO, January 24, 2005).

As found, Respondent failed to prove that the issue of disfigurement is closed. The FAL provisions are part of a "statutory scheme designed to promote, encourage, and ensure the prompt payment of compensation without the necessity of a formal administrative determination in cases not presenting a legitimate controversy." *Drykopp v. Industrial Claim Appeals Office*, 30 P.3d 821, 822 (Colo. App. 2001). The requirement to request a hearing on any disputed issues within 30 days of the FAL was intended to facilitate "prompt adjudication of disputed issues 'admitted' in the FAL, and to close claims where no dispute exists." *Chavez v. Cargill, Inc*., W.C. No. 4-421-748 (ICAO, November 1, 2002). Claimant satisfied these purposes by notifying the Division and Respondents within 30 days that she objected to the FAL and filing an AFH that was actually received by Respondent and the OAC within 30 days of the FAL (on July 17, 2025).

Accepting Claimant's AFH as timely filed is consistent with OAC Rule of Procedure 4(E), which provides that, "The date of filing shall be the date indicated on the certificate of service on the filing. If no certificate of service is included, the date of filing shall be the date received by the OAC." Had Claimant simply omitted the certificate of service, the AFH would have been deemed "filed" when the OAC received it on July 17. It would be nonsensical for a mis-dated certificate of service to put Claimant in a worse position than if she had omitted the certificate entirely. Nothing in OACRP 4 indicates that a pleading

with an incorrect certificate of service is invalid or will otherwise be treated as though it were never filed.

Additionally, OACRP 10(A)(4) states that the OAC "may reject any Disfigurement Application that is not complete. *The rejection of a Disfigurement Application shall be without prejudice*." (Emphasis added). The July 25 email from the OAC clerk did not state that the AFH was "rejected." Rather, it simply advised Claimant to file a new AFH to facilitate calculation of dates and other administrative details. In any event, because the Rule states that rejection of a Disfigurement Application is "without prejudice," the most reasonable interpretation is that an amended AFH relates back to the filing date of the original AFH when necessary to preserve a jurisdictional time limit. *See* CRCP 15(a) (leave to amend a pleading "shall be freely given when justice so requires"); *see also* CRCP 15(c). To the extent that Claimant's July 25 filing constitutes a request to amend the certificate of service on the AFH she filed on July 17, such request is Granted.

Relation back is particularly appropriate here, because the amended AFH added no new issues beyond those addressed in the first AFH. It was simply intended to correct the certificate of service. *Compare, e.g.*, *Ignacio Olivas-Soto v. Genesis Consolidated Services*, W.C. No. 4-518-876 (ICAO, November 2, 2005) (issue of PTD endorsed on supplemental AFH was closed because it was not endorsed on the initial AFH within 30 days of the FAL).

At a minimum, Claimant substantially complied with the statutory requirement to "request a hearing" on the issue of disfigurement within 30 days of the FAL. The doctrine of substantial compliance has been applied in workers' compensation claims to excuse minor procedural deficiencies where a party made a good faith or colorable effort to comply with the statutory requirements. *E.g.*, *EZ Building Components Mfg., LLC v. Industrial Claim Appeals Office*, 74 P.3d 516 (Colo. App. 2003); *Gomez v. Kangaroo Express of Southern Colorado*, W.C. No. 4-680-295 (ICAO, January 4, 2012).

Respondent relies on an unpublished Court of Appeals decision, *Russell v. Industrial Claim Appeals Office*, No. 23CA0471 (Colo. App. Jan. 11, 2024), for the proposition that the issue of disfigurement is closed. In *Russell*, the claimant had applied for a hearing within 30 days of an FAL but failed to set the hearing. As a result, the application for hearing was stricken without prejudice. The court equated striking the application with

"dismissing" the application and determined that the claim was closed pursuant to § 8-43-203(2)(b)(II)(A).

Russell is inconsistent with a line of ICAO decisions holding that timely filing of an application for hearing is the only "jurisdictional" requirement to prevent a claim from closing. *E.g.*, *Gerchman v. Wal-Mart Stores, Inc.*, W.C. No. 4-525-960 (ICAO, July 23, 2004); *Del Ramirez v. Con Agra Beef Co.*, W.C. No. 4-478-614 (ICAO, April 12, 2004); *Poyner v. Philip Services South Central, Inc.*, W.C. No. 4-425-162 (ICAO, March 31, 2004).

Russell is an unpublished case and therefore is not binding authority. Admittedly, ICAO cases are not binding either. However, the ICAO cases on this point are well-reasoned and persuasive. Therefore, to the extent there is a conflict of authority, I agree with the ICAO's previous determinations.

B. Disfigurement

Section 8-42-108(1) provides that a claimant is entitled to additional compensation if she is "seriously, permanently disfigured about the head, face, or parts of the body normally exposed to public view." As found, Claimant has sustained noticeable disfigurement as a direct and proximate result of the industrial injury. Claimant shall be awarded $4,000 for disfigurement.

Order

It is therefore ordered that:

1. Respondent shall pay Claimant $4,000 for disfigurement.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email

address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 24, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

Office of Administrative Courts

State of Colorado

Workers' Compensation No. 5-267-029-001

Issues

- Did Claimant prove entitlement to an impairment rating based on loss of strength?

Findings of Fact

1. Claimant works for Employer as an art teacher. He suffered an admitted injury on September 5, 2023, when shelves collapsed on his right hand.

2. Claimant saw Dr. Gayle Long at Medicine for Business and Industry (MBI), which has been the primary ATP. Dr. Long diagnosed a right thumb crush injury.

3. An X-ray of the right thumb on October 12, 2023, revealed a small abnormality that could be a small avulsion fracture or degenerative calcification. Dr. Williams, an orthopedic surgeon, reviewed the case on October 17, 2023, and opined that the symptoms were more likely due to a nerve crush injury rather than an acute fracture. Dr. Williams opined that Claimant did not need surgery.

4. Claimant started physical therapy (PT) on November 17, 2023. A PT re-evaluation on January 12, 2024, showed improvement in some areas, such as right key pinch strength, but grip strength remained limited. The plan was to continue PT for two more weeks.

5. Claimant followed up with Dr. Long on January 12, 2024. Claimant's condition was improving, although he noted increased aching at the base of his thumb, which began around the time PT stopped massage and dry needling. Dr. Long ordered three sessions of massage therapy.

6. On June 19, 2024, Claimant reported that increased pain and stiffness in his thumb over the past couple of months. More massage therapy was ordered. Claimant continued to work full duty but was off for the summer.

7. At a follow up with Dr. Long on August 15, 20254, Claimant said his right thumb was still sore and had worsened since returning to work. He was referred for a second opinion with a different orthopedic surgeon, Dr. Davis, as Dr. Williams had left the practice.

8. Dr. Davis evaluated Claimant on September 19, 2024, and ordered an MRI of the right hand due to the uncertain cause of the persistent pain. The MRI was performed on October 1, 2024, and was "essentially negative." On October 11, 2024, Dr. Davis administered a steroid injection to the thumb IP and middle finger PIP joints.

9. At a follow-up with Dr. Davis on February 4, 2025, Claimant said that the steroid injection helped, but tenderness had returned. Dr. Davis administered a second steroid injection and discussed the possible future removal of scar tissue.

10. Claimant's final appointment with Dr. Long took place on March 20, 2025. He described pain across his hand, and occasional numbness in his right thumb and middle finger that required him to stop his activity. Dr. Long determined that Claimant was at MMI. She assigned a 6% upper extremity rating, based on range of motion deficits and loss of sensation related to a peripheral nerve injury. Dr. Long also noted, "There was a discrepancy between the two hands in strength, but I cannot confidently say this is due to the [ ] injury, so I am not going to include this in the rating." Dr. Long recommended maintenance care, including up to three visits with Dr. Davis in the next year for evaluation or injections. Claimant was released to regular duty with no restrictions.

11. Respondent filed a Final Admission of Liability on March 26, 2025, admitting for Dr. Long's rating and medical benefits after MMI.

12. No formal measurements are documented in Dr. Long's MMI report. Claimant made several attempts to obtain the documentation from MBI before the hearing, without success. A motion to compel MBI to produce the measurements was denied by Judge Kayce on June 16, 2025, as beyond the scope of the OAC's authority regarding discovery with a non-party. Claimant obtained a subpoena for the records, but the records were not produced, for unknown reasons. There is no persuasive evidence that Claimant attempted to have the district court to enforce the subpoenas. Nor is it clear that actual documented measurements even exist. Regardless, because the documentation was not offered at hearing, it cannot be determined what the specific measurements were, or what techniques were used to obtain the measurements.

13. No Level II accredited physician has opined that Dr. Long's rating is deficient or inaccurate.

14. Claimant failed to prove Dr. Long's rating is deficient or incorrect. Claimant failed to prove entitlement to an additional rating beyond that admitted by Respondent.

Conclusions of Law

The Workers' Compensation Act sets forth different standards for determining permanent impairment, depending on the body part(s) involved. See § 8-42-107(2) and (8). Where, as here, the functional impairment is limited to parts of the body listed on the schedule in § 8-42-107(2), the claimant must prove entitlement to a rating by a preponderance of the evidence. *Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000); *Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998).

Impairment ratings in Colorado workers' compensation claims must be based on the *AMA Guides to the Evaluation of Permanent Impairment, Third Edition (Revised) ("AMA Guides")*. Sections 8-42-101(3)(a)(I), 8-42-101(3.7); *Fisher v. Industrial Claim Appeals Office*, 484 P.3d 816 (Colo. App. 2021). Because Claimant is alleging a purely scheduled impairment, the ALJ must "independently determine the correct rating," based on the preponderance of evidence presented. *E.g., Trujillo v. Nestle USA Holdco, Inc.*, W.C. No. 5-225-262-001 (ICAO, September 12, 2024); *Deleon v. Whole Foods Market, Inc.*, W.C. No. 4-600-477 (ICAO, November 16, 2006).

As found, Claimant failed to prove that Dr. Long's rating is incorrect and should have included a rating for loss of strength. No Level II physician has offered a critique of Dr. Long's rating or proposed an alternate rating. Although a claimant is not required to present expert opinion evidence to support a rating, *e.g., Savio House v. Dennis*, 665 P.2d 141 (Colo. App. 1983), the presence or absence of such evidence is a legitimate factor to consider when determining if a party carried their burden of proof. Indeed, a competing rating from a Level II physician is particularly important evidence in a case such as this, which involves a potential peripheral nerve impairment rating under Table 14. Whereas some ratings are obvious (e.g., 20% for a knee replacement under Table 40), peripheral nerve ratings are more nuanced and typically involve an exercise of medical judgement with respect to selecting the appropriate nerve level(s) and grading the severity of the impairment. Dr. Long did not specify which nerve or nerve branch she considered when calculating the rating for sensory deficits, although she was probably

considering the median nerve. But the impairment percentages for loss of strength or power related to the median nerve under Table 14 are 0%, and therefore would not have changed the overall rating.

GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

Table 14. Specific Unilateral Spinal Nerve Impairment Affecting the Upper Extremity

Nerve	Maximum % Loss of Function Due to Sensory Deficit, or Pain,	Maximum % Loss of Function Due to Motor Deficit or Loss of Power
Anterior thoracic (pectoral)	0	5
Axillary (circumflex)	5	35
Dorsal scapular	0	5
Long thoracic (posterior thoracic n., external respiratory n. of Bell, n. to serratus anterior)	0	15
Medial antebrachial cutaneous	5	0
Medial brachial cutaneous	5	0
Median (above midforearm)	40	55
Median (below midforearm)	40	35
Branch to radial side of thumb	7	0
Branch to ulnar side of thumb	11	0
Branch to radial side of index finger	5	0
Branch to ulnar side of index finger	4	0
Branch to radial side of middle finger	5	0
Branch to ulnar side of middle finger	4	0
Branch to radial side of ring finger	3	0

Claimant's argument that he should receive a rating under the Loss of Strength sections set forth on pages 52 to 54 of the *AMA Guides* is unpersuasive. The *AMA Guides* state, "*It must be stressed that, in general, grip and pinch measurements are functional tests and are not to be used for evaluating impairment*." (Emphasis in original). However, the *Guides* do contain an exception, providing that loss of strength "may" be rated in appropriate cases if it represents "an additional impairing factor *not already taken into account*." (Emphasis added). Consistent with these provisions, the Division of Workers' Compensation advises physicians that "grip and lateral pinch strength is rarely used for impairment ratings." (*See* Level II Accreditation curriculum, April 2024, p. 111). The

Division also cautions physicians to avoid “double dipping” by rating both range of motion loss and weakness. Here, Claimant received a rating for range of motion deficits and sensory deficits and presented no persuasive basis for a separate grip strength rating in addition to the other ratings Dr. Long assigned.

Furthermore, even if a grip or pinch strength rating were otherwise appropriate, Claimant failed to present persuasive data upon which such a rating could be calculated. The *AMA Guides* require at least three measurements of grip and pinch strength during an impairment evaluation, with less than 20% variation to establish reliability. No such measurements were produced at hearing, and it is questionable whether such documentation even exists. Because Dr. Long did not believe Claimant qualified for an additional rating based on loss of strength, she had no reason to record or keep formal measurements consistent with the *AMA Guides* protocols. Claimant’s suggestion that he could submit appropriate evidence later is misplaced. The presentation of evidence in this matter is complete, and the record is closed. Parties are expected to submit their evidence at the time of the hearing. *Frank v. Industrial Commission*, 43 P.2d 158 (Colo. 1935). The decision whether to reopen the record for additional evidence lies within the ALJ’s discretion, and is based on factors such as whether the party could have produced the evidence at the first hearing, whether the evidence is material to the issues, and whether it is likely to change the result. *Green v. Colorow Health care Center*, W.C. No. 4-791-626 (August 3, 2011). Claimant has failed to demonstrate circumstances sufficient to warrant reopening the record.

Order

It is therefore ordered that:

1. Claimant’s claim for additional permanent partial disability benefits beyond those already admitted by Respondent is denied and dismissed.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address

for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 10, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

Office of Administrative Courts
State of Colorado
Workers' Compensation Number 5-272-506-001

Issues

Has Claimant overcome, by clear and convincing evidence, the opinions of the Division sponsored independent medical examination (DIME) physician on the issues of permanent impairment and maximum medical improvement (MMI)?

Findings of Fact

1. This matter involves an admitted claim with a date of injury of May 9, 2024.

2. The medical records[1] admitted into evidence indicate that Claimant injured his lumbar spine when he fell approximately ten feet from a ladder.

3. Claimant testified that his treatment has included physical therapy, pool therapy, and injections. With regard to the injections, Claimant testified that injections he received in approximately September 2024 caused his symptoms to worsen. Claimant also testified that since his work injury, he has been unable to work.

4. During this claim, Claimant's authorized treating provider (ATP) has been Dr. Debra Drengenberg. On May 12, 2024, Dr. Drengenberg referred Claimant for an orthopedic consultation. Claimant was seen by Dr. Tyson Sloan for that orthopedic consultation on May 16, 2024. At that time Dr. Sloan diagnosed Claimant with lumbar radiculopathy, myelopathy, and lumbar spondylolisthesis. Dr. Slone recommended a transforaminal epidural injection, which Claimant declined.

5. On June 10, 2025, Claimant was seen by orthopedic spine surgeon, Dr. Alex Sielatycki. At that time, Dr. Sielatycki recommended physical therapy and an epidural injection.

[1] The medical record information is primarily from the reports of Drs. Sasha and Messenbaugh. The ALJ has extrapolated her findings regarding the medical records from these reports.

Claimant returned to Dr. Sielatycki on July 29, 2024, who specifically recommended bilateral transforaminal injections at the L5 level.

6. The recommended injections were performed by Dr. Sloan on August 20, 2024. Claimant reported short term relief, with the pain returning after 30 minutes.

7. On November 15, 2024, Dr. Drengenberg recorded that Claimant continued to experience low back and leg pain, with numbness and tingling.

8. On November 19, 2024, Dr. Sielatycki recommended surgery, which Claimant declined. Claimant testified that it was his understanding that the recommended surgery was "risky" and was not guaranteed to improve his condition.

9. On December 16, 2024, Claimant was seen in Dr. Drengenberg's practice by Dr. Akers. At that time, Dr. Akers noted that Claimant had reached maximum medical improvement (MMI) and would undergo an impairment rating with Spine West, as well as a functional capacity evaluation (FCE).

10. On December 19, 2024, Dr. Bradley Gale determined that Claimant had reached MMI as of November 18, 2024. Dr. Gale also assessed a total permanent impairment rating of 34 percent whole person. Dr. Gale reached this total by assessing 24 percent impairment for range of motion; a Table 53 impairment of eight percent; and 13 percent for lower extremity neurologic impairment.

11. Claimant testified that in February 2025 he underwent an FCE at The Steadman Clinic. Claimant further testified that following the FCE he learned that he was not able to work as he had prior to his injury. The records admitted into evidence show that the FCE took place on February 3, 2025, with lifting of up to 10 pounds, and push/pull up to 25 pounds.

12. On March 20, 2025, Claimant was seen at The Steadman Clinic by Dr. Stuart Kinsella. At that time, Dr. Kinsella identified Claimant's diagnoses as lumbar radiculopathy and degenerative spondylolisthesis. Dr. Kinsella recommended conservative treatment that would include NSAIDs[2], physical therapy, and activity modification.

[2] Non-Steroidal Anti-Inflammatory Drugs.

13. Claimant testified that he understands that it is Dr. Kinsella's recommendation for one year of physical therapy. Claimant also testified that it is his further understanding that continuation of physical therapy will allow him to avoid surgery.

14. On April 22, 2025, Claimant attended a Division sponsored independent medical examination (DIME) with Dr. John Sasha. In connection with the DIME, Dr. Sasha reviewed Claimant's medical records, obtained a history from Claimant, and performed a physical examination. In his DIME report, Dr. Sasha agreed that Claimant reached MMI as of November 18, 2024. With regard to permanent impairment, Dr. Sasha opined that only Claimant's lumbar spine condition necessitated a rating. Dr. Sasha assessed a rating of seven percent whole person. This was calculated as seven percent for a Table 53 rating, and zero percent for range of motion. In his report, Dr. Sasha described Claimant's effort during the range of motion measurements to be "extremely poor effort", "invalid", and "inconsistent".

15. Relying upon Dr. Sasha's report, on May 19, 2025, Respondents filed a Final Admission of Liability admitting for the MMI date of November 18, 2024, and a whole person impairment rating of seven percent.

16. On August 11, 2025, Claimant attended an independent medical examination (IME) with Dr. Robert Messenbaugh. In connection with the IME, Dr. Messenbaugh reviewed Claimant's medical records, obtained a history from Claimant, and performed a physical examination. In his IME report, Dr. Messenbaugh opined that Claimant has chronic lumbar spine pathology that was present prior to the work injury. Dr. Messenbaugh further identified that chronic condition as "extensive L5-S1 disc degeneration with bilateral pars defects and spondylolisthesis of L5 upon S1." Dr. Messenbaugh further opined that Claimant's "symptoms are magnified, and his pain behaviors are extreme".

17. Claimant asserts that the impairment rating of 34 percent, as assessed by Dr. Gale in December 2024, is a more accurate reflection of his impairment. It is Claimant's belief that Dr. Sasha erred when the range of motion measurements taken at the DIME were performed while Claimant was seated and not while standing. Claimant testified that he also believes that seven percent is too low because prior to his injury he was working three different jobs, and now he is unable to work.

18. Claimant also asserts that Dr. Sasha erred in determining that Claimant reached MMI as of November 18, 2024. In support of this assertion, Claimant testified that he continues to be unable to work.

19. The ALJ credits the medical records and the opinions of Dr. Sasha. The ALJ specifically credits the opinion of Dr. Sasha that only Claimant's lumbar spine condition warranted a permanent impairment rating. The ALJ finds that Claimant has failed to overcome the opinions of Dr. Sasha that Claimant has permanent impairment of seven percent, and that he reached MMI on November 18, 2024. Contrary medical opinions and Claimant's testimony are not sufficient to demonstrate that it is highly probable that Dr. Sasha's opinions are incorrect.

Conclusions of Law

1. The purpose of the Workers' Compensation Act of Colorado is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S.

2. The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16.

4. The ALJ's factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

5. Under the Workers' Compensation Act of Colorado, opinions of a DIME physician are given great deference Section 8-42-107(8)(b)(III) and (c), C.R.S. provides that the DIME physician's finding of MMI and permanent medical impairment is binding unless overcome by

clear and convincing evidence. Clear and convincing evidence is highly probable and free from substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it is highly probable that the DIME physician is incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

6. A fact or proposition has been proved by clear and convincing evidence if, considering all of the evidence, the trier-of-fact finds it to be highly probable and free from substantial doubt. *Metro Moving & Storage, supra.* A mere difference of opinion between physicians fails to constitute error. See *Gonzales v. Browning Ferris Industries of Colorado*, W.C. No. 4-350-356 (March 22, 2000). The ALJ may consider a variety of factors in determining whether a DIME physician erred in their opinions including whether the DIME appropriately utilized the Medical Treatment Guidelines and the AMA Guides in their opinions.

7. As found, Claimant has failed to prove by clear and convincing evidence that Dr. Sasha's opinions regarding permanent impairment and MMI were incorrect. Claimant has failed to establish anything other than a difference of opinion between medical providers. As found, the medical records and the opinions of Dr. Sasha are credible and persuasive.

Order

It is therefore ordered that Claimant has failed to overcome the DIME physician's opinions on the issues of permanent impairment and MMI. All matters not determined here are reserved for future determination.

Dated October 10, 2025.

Cassandra M. Sidanycz
Administrative Law Judge
Office of Administrative Courts

If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after service of the order,

as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. Section 8-43-301(2), C.R.S. and OACRP 27. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms.

You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review via email to either **oac-ptr@state.co.us** or to **oac-dvr@state.co.us**. If the Petition to Review is emailed to either of the aforementioned email addresses, the Petition to Review is deemed filed in Denver pursuant to OACRP 27(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts. **It is also recommended that you provide a courtesy copy of your Petition to Review to the Grand Junction OAC via email at oac-gjt@state.co.us.**

Office of Administrative Courts

State of Colorado

Workers' Compensation Nos. 5-286-346-001 & 5-270-772

Issues

- Did Claimant prove he suffered a compensable low back injury on April 22, 2024 (W.C. No. 5-270-772), and/or September 13, 2024 (W.C. No. 5-286-346)?
- Did Claimant prove entitlement to TTD benefits from April 23, 2024 through July 18, 2024, and September 13, 2024 through November 18, 2024?
- What is Claimant's average weekly wage (AWW)?

Findings of Fact

1. Claimant works for Employer as an Overnight Stocker. The work is physically demanding, requiring him to unload trucks, move pallets, stock shelves, and lift and carry up to 50 pounds.

2. Claimant has filed two separate workers' compensation claims pending for alleged low back injuries occurring on April 22, 2024 and September 13, 2024. These claims have been assigned W.C. No. 5-270-772 and W.C. No. 5-286-346, respectively.

3. Claimant has experienced chronic low back problems since January 26, 2022. On that date, he slipped on an icy ramp while exiting a truck stop, falling backward and striking his tailbone, upper back, and head. The impact caused him to lose consciousness for several minutes. Medical records from February 7, 2022, document ongoing muscle spasms in his lower back that interfered with sleep.

4. Thereafter, Claimant suffered multiple aggravations from work activities.

5. On August 8, 2022, Claimant reported an injury when he lifted a 40-pound case at work and felt a pop in his back. When Claimant was asked about his back pain, he responded that he is always in pain and, "His body is old."

6. Claimant reinjured his back on March 22, 2023 while pulling an empty pallet. He described the symptoms as shooting pain and spasms. Claimant was given a Toradol injection and prescribed muscle relaxers. He was put at MMI from the March 22, 2023, accident on April 10, 2023.

7. Claimant reported another work injury on February 12, 2024, when he lifted a heavy tote and felt a painful pop in his low back. Claimant was given sedentary work restrictions and worked modified duty for a few days. He was released to regular duty on February 15, 2024.

8. On April 22, 2024, Claimant developed back pain while stocking bags of weed killer on a high shelf in the garden department. This incident is the basis for the claim in W.C. No. 5-270-772.

9. Employer referred Claimant to Concentra, where he saw Brendon Madrid, NP. The examination showed bilateral muscle spasms and limited lumbar ROM. Straight leg raise test was positive bilaterally. Lumbar x-rays showed multilevel degenerative changes but no fracture or other acute pathology. Mr. Madrid diagnosed a low back "sprain" and lumbar radiculopathy, and restricted Claimant to sedentary work duties with the ability to sit or stand as needed. Employer accommodated these restrictions.

10. A lumbar MRI was performed on May 1, 2024. It showed multilevel degenerative change with osteophytes, and a right-sided disc protrusion at L3-4. There was no sign of any acute soft tissue abnormality.

11. Claimant returned to Concentra on May 8, 2024 and saw Dr. Kathryn Murray. The physical exam showed minimal muscle spasms or tenderness to palpation. Motor strength was 5/5 and SLR testing was negative bilaterally. Claimant's restrictions remained unchanged. Dr. Murray noted Claimant was, "working with restrictions, but wants to sit at home instead." Claimant testified he "was forced to take a LOA" in May 2024 because he could not tolerate the modified work. This testimony is not credible, considering the largely benign physical exam, Employer's willingness to accommodate Claimant's work restrictions, and the lack of corroborating contemporaneous documentation in the medical records or Employer's records.

12. Dr. Murray concurred with Mr. Madrid that Claimant's condition was causally related to the April 22, 2024 work accident.

13. Claimant was referred to Dr. Scott Primack for a physical medicine evaluation. Dr. Primack first evaluated Claimant on May 29, 2024, and diagnosed "joint pain/arthritis and back pain." Dr. Primack recommended an epidural steroid injection, which was performed on June 7, 2024.

14. At a July 8, 2024 follow-up with Dr. Primack, Claimant reported he was "doing great" with only 2/10 pain. Dr. Primack noted the significant improvements and opined that Claimant was probably back to his pre-accident "baseline." Dr. Primack stated that Claimant had reached a "stable and stationary level of functioning where no further treatment will significantly affect his outcome." However, Dr. Primack also opined there was a "high probability of recurrent back pain."

15. On July 18, 2024, Dr. Daniel Peterson at Concentra agreed that Claimant was at MMI with no impairment and no restrictions.

16. Claimant testified he still had low back pain after being put at MMI in July 2024. But he acknowledged these ongoing issues were the same problems he experienced from prior injuries, before April 2024.

17. On September 13, 2024, Claimant experienced an acute exacerbation of his back condition while pulling totes at work that were "quite heavy." He felt a pop in his low back.

18. Claimant returned to Concentra on September 17, 2024 and reported that he had "aggravated [the] injury all over again." Examination showed bilateral muscle spasms and limited lumbar ROM. Mr. Madrid opined the symptoms and limitations were consistent with a work-related mechanism of injury. Dr. Marcie Wilde reviewed the chart and concurred with Mr. Madrid's assessment. Claimant was given a 10-pound lifting restriction and referred back to Dr. Primack.

19. Claimant saw Dr. Primack on September 23, 2024. Dr. Primack reminded Claimant that his history of back pain was a predictor for future pain, and further stated that, "ultimately, the essential functions of the job may be too much for his age and physical stature." Dr. Primack advised Claimant that "he will need to make a new claim" for the September 2024 incident and recommended a repeat lumbar ESI.

20. On October 3, 2024, Mr. Madrid documented that Claimant was having difficulty standing for long periods of time due to back and leg pain. He was on a leave of absence at work because Employer could not find work within his restrictions.

21. Dr. Primack performed a second ESI on November 1, 2024, opining it was necessary due to "another injury."

22. On November 11, 2024, Claimant reported to Dr. Tanya Hrabal at Concentra that his back was “much better” after the injection, and he felt he would “work and stand much better.” His lifting restriction was increased to 15 pounds.

23. Employer offered Claimant a modified position with a start date of November 16, 2024, which he accepted.

24. Dr. Qing-Min Chen performed an IME for Respondents on June 30, 2025. Claimant explicitly denied any low back injuries before April 2024, which Dr. Chen noted was inconsistent with the pre-injury medical records he reviewed. Claimant mixed up the mechanism of his April 22, 2024 injury (stocking shelves) with the March 2023 incident (pulling a pallet). He also gave a confusing history regarding the September 2024 injury. Because of these significant discrepancies, Dr. Chen considered Claimant an unreliable historian.

25. Dr. Chen’s physical examination was essentially normal, with no tenderness to palpation over the lumbar spine, negative SLR test, and no sensory or motor deficits in the lower extremities. Dr. Chen reviewed the May 1, 2024 MRI and found no evidence of acute traumatic injury. In his opinion, “everything on that MRI appears to be age-related chronic and degenerative in nature.” He diagnosed pre-existing chronic low back pain and multilevel lumbar spine degenerative disc disease.

26. Dr. Chen opined the April 2024 incident was merely a temporary “lumbar strain,” for which Claimant reached MMI by May 1, 2024 (the date of the MRI). He conceded the strain was work related but opined that all treatment after May 1, 2024 date “should be 100% apportioned to those pre-existing conditions.”

27. Regarding the September 2024 incident, Dr. Chen opined there was “no objective evidence that a new injury occurred.” He characterized the event as a “waxing and waning course of his degenerative changes” rather than a new, discrete injury.

28. Claimant proved he suffered a compensable injury on April 22, 2024. Claimant’s ATPs concluded the injury was work-related, and even Dr. Chen agreed he suffered a work-related lumbar “strain.” The injury caused Claimant to seek treatment and impaired his ability to perform his regular job.

29. Claimant proved he suffered a second compensable injury on September 13, 2024. The opinions and conclusions of his ATPs, including Dr. Primack, are more

persuasive than the contrary opinions of Dr. Chen. The preponderance of persuasive evidence shows that moving heavy totes at work on September 13 caused another lumbar strain and a temporary aggravation of his pre-existing condition.

30. Claimant was paid $20.23 per hour at the time of the April 2024 injury and typically worked 40 hours per week.

31. The only pre-injury pay period documented at hearing ended on April 21, 2024, and shows $1,625.89 for 80.17 hours. There is no persuasive evidence regarding the regularity of any overtime. Claimant's proposal to calculate the AWW using 40 hours at his regular hourly rate is reasonable. Claimant's AWW is $809.20 ($20.23 x 40 hours = $809.20).

32. As there is no persuasive evidence of any substantial change in the terms of Claimant's employment between April 2024 and September 2024, the AWW of $809.20 applies to both claims.

33. Claimant's request for TTD commencing April 23, 2024 is contradicted by wage records showing he worked modified duty until mid-May 2024. The payroll records reflect 67.73 hours in the pay period ending May 5, and 45.75 hours in the period ending May 19.

34. Claimant failed to prove he left work in May 2024 because of the injury or that the injury proximately caused his wage loss. Claimant conceded that Employer accommodated his restrictions, yet Dr. Murray noted he would "rather sit at home." Neither the medical records nor Employer's records persuasively support Claimant's allegation that he could not perform sedentary modified duty.

35. Claimant's wage records reflect decreased earnings after the September 13, 2024 accident. The payroll records show the following:

Payroll date	Hours	Gross wages
9/8/2024	78.62	$1,625.89
9/22/2024	60.16	$1,399.11
10/6/2024	0	$0.00
10/20/2024	0.25	$5.06
11/3/2024	0	$0.00
11/17/2024	7.95	$160.83

36. Claimant acknowledged he did not miss the entire period from September 13 to November 18, 2024, although he did not specify exact dates. Claimant accepted a modified job offer with a start date of November 16, 2024, and I infer that he returned to work on that date. Based on the wage records, Claimant is entitled to:

- **TTD benefits** from September 23 through October 6, 2024 and October 21 through November 15, 2024, and
- **TPD benefits** from October 7 through October 20, 2024, totaling $1,075.56. Claimant's AWW for that two-week period is $1,618.40 ($809.20 x 2), but he only earned $5.06. This results in a wage loss of $1,613.34. He is therefore eligible for TPD benefits for this period in the amount of $1,075.56.

Conclusions of Law

A. Compensability

To receive compensation or medical benefits, a claimant must prove they are a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000). Even a "minor strain" can be a sufficient basis for a compensable claim if it was caused by a claimant's work activities and caused her to seek medical treatment. *E.g.*, *Garcia v. Express Personnel*, W.C. No. 4-587-458 (ICAO, August 24, 2004); *Conry v. City of Aurora*, W.C. No. 4-195-130 (ICAO, April 17, 1996). The existence of a pre-existing condition does not preclude a finding of compensability if an industrial injury aggravated, accelerated, or combined with the pre-existing condition to produce the need for medical treatment. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). The ultimate question is whether the disability or need for treatment is proximately caused by an industrial aggravation or is merely the direct and natural consequence of the pre-existing condition. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Carlson v. Joslins Dry Goods Company*, W.C. No. 4-177-843 (ICAO, March 31, 2000).

As found, Claimant proved a compensable back injury on April 22, 2024. Multiple ATPs diagnosed a work-related injury, and even Dr. Chen acknowledged that Claimant suffered a work-related lumbar strain. The injury caused Claimant to seek treatment and impaired his ability to perform his regular job. Although Dr. Chen opined that Claimant reached MMI for the injury on May 1, 2024, that opinion is moot, because the ALJ lacks

authority to determine MMI in the first instance. *E.g., Brown v. Ace Hardware Corporation*, W.C. No. 4-791-494 (ICAO, October 22, 2010).

Claimant also proved a compensable injury on September 13, 2024. The opinions of Claimant's ATPs, particularly Dr. Primack, are credible and more persuasive than Dr. Chen's contrary assessment. The problem with Dr. Chen's argument about "natural waxing and waning" is that the "waxing" of Claimant's symptoms has primarily been associated with work activities. In that regard, Dr. Primack's view is more accurate; Claimant's back seems ill suited to a physically demanding job and will likely continue to experience periodic exacerbations if he stays in the position.

B. Average weekly wage

Section 8-42-102(2) requires that compensation be based on the employee's average weekly earnings "at the time of the injury." The statute provides various computational methods for workers paid hourly, weekly, salary, or per diem basis. But § 8-42-102(3) gives the ALJ wide discretion to "fairly" calculate the employee's AWW in any manner that seems most appropriate under the circumstances. The entire objective of AWW calculation is to arrive at a "fair approximation" of the claimant's actual wage loss and diminished earning capacity because of the industrial injury. *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993).

As found, Claimant's AWW is $809.20, for both claims. At the time of the April 2024 injury, Claimant was paid $20.23 per hour and typically worked 40 hours per week. The sole pre-injury pay period in evidence (end date April 21, 2024) shows $1,625.89 for 80.17 hours over two weeks. There is no persuasive evidence regarding the regularity of any overtime, and Claimant's proposal to calculate the AWW using 40 times the hourly rate is reasonable.

C. TTD from April 23, 2024 through July 18, 2024

A claimant is entitled to TTD benefits if the injury causes a disability, the disability causes the claimant to leave work, and the claimant suffers a wage loss proximately caused by the injury. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *Montoya v. Industrial Claim Appeals Office*, 488 P.3d 314 (Colo. App. 2018).

Claimant seeks TTD benefits from April 23, 2024 through July 18, 2024. But Claimant's wage records show he worked modified duty until approximately mid-May

2024. The exact date he stopped work is unclear, but the payroll records show 45.75 hours in the pay period ending May 19, 2024.

Claimant did not prove he stopped working in May 2024 because of the injury or that the injury proximately caused a wage loss. The persuasive evidence shows Employer accommodated his restrictions, and Dr. Murray noted on May 8 that he would rather "sit at home." Neither the contemporaneous medical records nor Employer's documentation corroborate Claimant's allegation that he could not perform the available sedentary modified duty. Accordingly, Claimant has not met his burden of proving entitlement to TTD benefits for this period.

D. TTD from September 13, 2024 through November 18, 2024

Claimant failed to prove eligibility for TTD benefits commencing September 13, 2024. Wage records show that he continued to earn wages through the pay period ending September 22, 2024. Claimant was off work commencing September 23, 2024, except for 0.25 hours in the pay period ending October 20, 2024. While the evidence does not explain the brief return to work, a return to work in any capacity terminates TTD benefits under § 8-42-105(3)(b). Consequently, Claimant is eligible for TTD benefits from September 23 through October 6, 2024, and October 21 through November 15, 2024.

E. TPD from October 7, 2024 through October 20, 2024

Claimant earned $5.06 in the pay period ending October 20, 2024. This equates to total TPD from October 7 through October 20, 2024, in the amount of $1,075.56 ($809.20 x 2 = $1,618.40 - $5.06 = $1,613.34 wage loss x 2/3 = $1,075.56).

Order

It is therefore ordered that:

1. Claimant's claims in W.C. No. 5-270-772 and W.C. No. 5-286-346, for injuries occurring on April 22, 2024, and September 13, 2024, respectively, are compensable.

2. Claimant's average weekly wage is $809.20 for both claims, with a corresponding TTD rate of $539.47.

3. Claimant's claim for TTD benefits from April 23, 2024 through July 18, 2024 is denied and dismissed.

4. Insurer shall pay Claimant TTD benefits in claim W.C. No. 5-286-346, at the rate of $539.47 per week, from September 23, 2024 through October 6, 2024, and October 21, 2024 through November 15, 2024.

5. Insurer shall pay Claimant TPD benefits in claim W.C. No. 5-286-346, for the period of October 7, 2024 through October 20, 2024, in the amount of $1,075.56.

6. Insurer shall pay Claimant statutory interest of 8% per annum on all compensation not paid when due.

7. All issues not decided herein are reserved for future determination.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 20, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

ISSUES

1. Whether Claimant proved by a preponderance of the evidence that he sustained a compensable injury on October 27, 2024, arising out of and in the course of his employment with Respondent-Employer.

2. Whether Claimant has proved by a preponderance of the evidence that he is entitled to temporary total disability (TTD) benefits.

3. Whether Claimant has proved by a preponderance of the evidence that he is entitled to medical benefits reasonably necessary to cure and relieve him of the effects of his work injury.

4. What is Claimant's average weekly wage (AWW).

STIPULATIONS

1. Claimant's average weekly wage is $1,871.63.

2. If the claim is compensable, Claimant would be entitled to TTD benefits from October 28, 2024 to February 28, 2025.

FINDINGS OF FACT

1. Claimant is a delivery driver and hostler operator who worked for Respondent-Employer for approximately seven years. As a delivery driver, Claimant transported loaded trailers to King Soopers locations for delivery. As a hostler operator, he was responsible for moving trailers around the yard to prepare them for loading. He typically worked the evening shift, from 6:00 P.M. to 4:00 A.M. The hostler vehicle itself would operate as a sort of tug for cargo trailers, capable of moving cargo trailers about a yard but not designed for over-the-road operation.

2. On October 27, 2024, at around 10:00 P.M., while attempting to connect a hostler truck to a trailer, he experienced a sudden jolt that caused immediate pain in his lower left back. The trailer he was coupling to was set lower than normal, which required him to back up using additional speed and momentum to wedge the hostler underneath the trailer. When the fifth-wheel pin engaged, the truck came to an abrupt stop, producing a jerking motion. Claimant later testified that he was seated facing forward but looking over his right shoulder to align the connection when he felt the pain.

3. Later that night, after completing his shift, Claimant began experiencing sharp pain radiating from his low back down his left leg to his foot. Despite the pain, he completed his shift. Afterward, he reported the incident to Anthony Stasse, the union steward, and Madeline, the dispatcher on duty, while dropping off his paperwork in the dispatch office. He also filled out a Driver Vehicle Inspection Report (DVIR) noting, “New Seat IMMEDIATELY!!!”, referencing the poor condition of the hostler seat, which had rips, tears, and missing padding.

4. Claimant completed a written statement the following day regarding his injury. In that statement, he wrote, “Doing my shift in the hostler, I felt pain in my back (like a backache). So continuing with the shift, the pain started to move down my left leg, (through my thigh [and] into my calf area). No ‘specific’ incident caused this. (to my knowledge)” Claimant later testified that Sometime after writing his report of injury, he determined that there had been a “specific incident.” Claimant also later testified that his written statement that there had been “no specific incident” meant that there was no crash or misconduct, not that the injury lacked a specific mechanism.

5. Claimant sought medical treatment at Concentra on December 29, 2024, where he was attended by Brittany Lain, NP, under the supervision of Dr. Darla Draper. According to the record, Claimant reported to NP Lain that he was driving at the time of his injury and parking a trailer in his work lot when he felt a sharp pain in

his left low back that began mild at first and gradually worsened throughout the shift, radiating into his left lower extremity. Claimant reported that his pain at the time of the visit was five out of ten. On physical examination, Claimant exhibited left-sided lumbar dysfunction with pain and tenderness near the left sacroiliac joint, mild weakness and reduced reflex on the left, limited flexion, and a positive left straight leg raise—consistent with possible left-sided nerve root irritation or SI joint involvement. Claimant was diagnosed with left lumbar radiculopathy and acute low back pain prescribed corticosteroids and physical therapy. Claimant was also given temporary work restrictions of no prolonged sitting, no prolonged standing, and no forward bending.

6. Claimant continued with treatment over the next several months, including physical therapy.

7. On December 12, 2024, Claimant underwent a lumbar MRI. The MRI showed spondylosis at L5-S1 resulting in moderate left lateral recess stenosis with encroachment on the traversing left S1 nerve root secondary to a disc extrusion, mild spinal canal stenosis with mild to moderate bilateral neuroforaminal stenosis, and mild right-sided neuroforaminal stenosis at L4-5.

8. Claimant underwent an IME with Dr. Mark Paz on April 1, 2025. Dr. Paz reviewed Claimant's medical history, took Claimant's subjective history, and performed a physical examination of Claimant. Ultimately, Dr. Paz opined that it was not medically probable that the degenerative changes shown on Claimant's lumbar MRI were causally related to Claimant's work injury. He explained that "the mechanism of injury reported by [redacted] during this IME and as documented in the medical record is inconsistent with a mechanism of injury causing or contributing to a lumbar disc extrusion." He stated that based on the Colorado Department of Workers' Compensation, Level II Accreditation curriculum regarding the Causation Analysis method, "the mechanism of injury, the diagnosis/diagnoses, and the need for treatment, in this specific claim, are

incongruent, and based on reasonable medical probability, it is not medically probable that the condition is causally related." He did not elaborate further.

Claimant's Testimony

9. Claimant testified at hearing consistently with the above findings.

10. Furthermore, Claimant testified that he had no prior history of low back problems and had experienced no difficulties performing his job duties before the date of injury. He stated that he had been performing this work for roughly six years and had successfully passed his regular DOT physicals, the most recent of which occurred in July 2024 at Employer's request. That examination revealed no abnormalities or restrictions concerning his back or mobility. Claimant did acknowledge that he had a prior gunshot wound to his left leg in 2015, which required surgery to repair fractures to his femur. However, he testified that he had no ongoing symptoms or limitations from that injury and had no treatment for back pain between that time and his work injury.

11. Claimant testified that he was given work restrictions on October 29, 2024, and did not return to work for the next four months.

12. The Court finds Claimant's testimony credible. His demeanor at hearing was forthright. His testimony that he felt immediate pain while coupling the hostler to a trailer, followed by radiating pain down his left leg, is consistent with the medical findings of left-sided lumbar dysfunction and radiculopathy. Moreover, Claimant's prompt report of the injury to both the dispatcher and union steward, as well as his written statement the following day, supports his assertion that the incident occurred in the course of employment. While the written report initially stated that there was "no specific incident," Claimant credibly explained that he meant only that there was no crash or misconduct, not that no injury occurred. Finally, the absence of any prior back complaints or medical treatment for low back pain before the date of injury further supports the veracity of his account.

Anthony Stasse Testimony

13. Anthony Stasse also testified at hearing. Mr. Stasse testified that he had been employed by Respondent-Employer for just under twelve years and currently worked as a local teamster driver delivering groceries for King Soopers/Kroger. Prior to obtaining delivery routes, Mr. Stasse performed hostler duties for approximately five and one-half years, during which time he became very familiar with the nature of that work. Mr. Stasse testified that he was Claimant's union representative.

14. Mr. Stasse explained that a hostler, also known as a "yard dog" or "yard pup," is a heavy truck used to move trailers around Employer's yard. The work would involve maneuvering in tight spaces and repositioning trailers that are often at varying heights and angles. He testified that hostlers are equipped with leaf-spring suspension systems, which would make the ride rough and bumpy. While some hostlers would have air-ride suspension systems, the ride could still be jarring, particularly when the trailer was not perfectly aligned. The seats in the hostlers were adjustable, moving up and down through a combination of shock absorbers and air cushions, but their condition would vary depending on the age and maintenance of the individual unit. According to Mr. Stasse, the back of the hostler frame is sloped, allowing the driver to push the vehicle under the trailer, though trailer heights could differ by as much as six to eight inches, and the ground surface was uneven, with many potholes, cracks, and crevices. He described the condition of the yard as poorly maintained, comparing it to "Vietnam after Nixon bombed it."

15. Mr. Stasse testified that he was working the night of Claimant's injury, beginning his shift at 4:00 A.M., which coincided with the end of Claimant's shift. He observed Claimant at the dispatch window, where Claimant was "hobbling in." Mr. Stasse asked what was wrong, and Claimant responded that he was "all messed up from the seat in the hostler."

16. The Court finds Mr. Stasse's testimony credible.

Dr. Paz Testimony

17. Dr. Paz testified at hearing as well.

18. Dr. Paz testified that Claimant's lumbar MRI showed pre-existing advanced degenerative disc disease and was consistent with a herniated disc and lumbar radiculopathy. He also testified that Claimant's symptoms were consistent with a herniated disc. He noted that Claimant's complaints of radiculopathy were consistent through his course of care, though there was some migration between the right and left lower extremities.

19. Dr. Paz also testified that he believed the mechanism of injury was inconsistent with the diagnosis. He testified that direct trauma to the lumbar spine is not an etiology for a herniated lumbar disc but that a forward-flexion incident would be. He explained that the purpose of lumbar discs is to absorb pressure in the spine and that a traumatic forward flexion of the spine would transfer forces primarily to the last disc causing a herniation resulting in contact with spinal nerves and causing pain and discomfort in the extremities or the low back. He explained that the typical mechanism involved flexion with a load such as bending over to lift a box, standing up, and twisting. In his opinion, low-speed motor vehicle accidents less than thirty miles per hour would not cause a herniated disc.

20. Dr. Paz acknowledged that there was no evidence of a pre-existing condition. Though, the Court infers that Dr. Paz meant that Claimant did not have any clinical presentation for lumbar degenerative disc disease prior to his date of injury, notwithstanding the degenerated condition of his spine. Dr. Paz testified that it is not uncommon for degenerative low back pain to become suddenly worse due to exacerbation and that such an exacerbation or aggravation would not require a profound mechanism. When asked whether the mechanism could have aggravated Claimant's degenerative lumbar spine, Dr. Paz testified that assuming

an aggravation of a pre-existing condition would be presumptive as there was no historical documentation of Claimant's prior condition.

21. The Court finds that Dr. Paz's opinions that the mechanism of injury was insufficient to cause an injury to Claimant's degenerative lumbar spine to be insufficiently developed. While he testified that backing up the hostler to the trailer would not cause an aggravation or injury to Claimant's lumbar spine, presumably because it would not cause in his opinion forward flexion of the spine, he did not develop his rationale further. Given the absence of credible evidence that the accident did not cause compressive forces on Claimant's lumbar spine, the Court finds Dr. Paz's opinion in this regard unpersuasive and affords it little credit.

22. To the extent that Dr. Paz opined that Claimant's onset of low back pain while at work was purely idiopathic and did not arise from Claimant's work in the hostler truck that day, the Court finds such an explanation unlikely.

Ultimate Findings

23. The Court finds that Claimant has proved by a preponderance of the evidence that he sustained a compensable work injury arising out of and in the course of his employment with Respondent-Employer on October 27, 2024, and that he is entitled to medical benefits reasonably necessary to cure and relieve him of the effects of his October 27, 2024 injury.

24. The Court finds, based on the parties' stipulations, that Claimant's average weekly wage is $1,871.63 and that Claimant is entitled to temporary total disability benefits from October 28, 2024, to February 28, 2025.

CONCLUSIONS OF LAW

Generally

1. The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical

benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

2. Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is the exclusive domain of the administrative law judge. *University Park Care Center v. Industrial Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

3. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of

evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Compensability

3. An injury must "arise out of and occur in the course of" employment to be compensable, and it is the claimant's burden to prove these requirements by a preponderance of evidence. Section 8-41-301, C.R.S.; *see also Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). An injury "arises out of" the employment when it is sufficiently related to the conditions and circumstances under which the employee usually performs his or her job functions to be considered part of the service provided to the employer. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207 (Colo. 1996); *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). An injury is said to have arisen in the course of employment if the injury occurred while the employee was acting within the time, place, and circumstances of the employment. *Id*.
4. An incident which merely elicits pain symptoms caused by a pre-existing condition does not compel a finding that the claimant sustained a compensable aggravation. F. R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985); Barba v. RE 1J School District, W.C. No. 3-038-941 (June 28, 1991); Hoffman v. Climax Molybdenum Company, W.C. No. 3-850-024 (December 14, 1989). Rather, a claimant must establish to a reasonable degree of probability that the need for additional medical treatment is proximately caused by the aggravation, and is not simply a direct and natural consequence of the pre-existing condition. Merriman v. Indus. Comm'n, 210 P.2d 448 (Colo.1949); Rockwell International v. Turnbull, 802 P.2d 1182 (Colo.App.1990) cf. Valdez v. United Parcel Service, 728 P.2d 340 (Colo.App.1986).

5. As found, Claimant credibly testified that he experienced immediate low back pain while coupling the hostler to a trailer on October 27, 2024, followed by progressive symptoms of radiating pain into his left lower extremity. The incident occurred as

a result of the performance of his work duties and within the course of his employment. Claimant's injury on October 27, 2024, caused of his need for medical treatment and resulting disability. Accordingly, the Court concludes that Claimant has established by a preponderance of the evidence that his injury arose out of and in the course of his employment and is compensable under § 8-41-301, C.R.S.

Medical Benefits

6. The Colorado Workers' Compensation Act ("the Act") provides that an employer must provide medical care "as may reasonably be needed . . . to cure and relieve the employee from the effects of the injury." Section 8-42-101(1)(a), C.R.S.

7. As found, Claimant has proved that he is entitled to medical benefits reasonably necessary to cure and relieve him of the effects of his October 27, 2024 injury.

AWW and TTD

8. If the injury or occupational disease causes temporary total disability, a disability indemnity shall be payable as wages at a rate of 66 2/3% of the claimant's average weekly wage. Sections 8-42-103(1) and 8-42-105(1), C.R.S.

9. As found based on the parties' stipulations, Claimant's average weekly wage is $1,871.63 and Claimant is entitled to temporary total disability benefits from October 28, 2024, to February 28, 2025.

ORDER

It is therefore ordered that:

1. Claimant has proved that he sustained a compensable injury on October 27, 2024.
2. Claimant has proved that he is entitled to reasonably necessary medical benefits to cure and relieve him of the effects of his October 27, 2024 injury.

3. Claimant's average weekly wage is $1,871.63.

4. Claimant is entitled to TTD benefits from October 28, 2024, to February 28, 2025.

5. All matters not determined herein are reserved for future determination.

DATED: October 29, 2025.

Stephen J. Abbott
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, Colorado 80203

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, *see* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Issues

1. Whether Claimant established by a preponderance of the evidence that Kathleen Connell, M.D., at UC Health Urogynecology Clinic is an authorized treating physician.

2. Whether Claimant established by a preponderance of the evidence that the sacrocolpopexy and sutured rectopexy recommended by Dr. Connell is reasonable, necessary, and related to Claimant's admitted industrial injury.

Summary Order

Based on the evidence presented at hearing, the ALJ finds and concludes as follows:

1. Claimant suffered a work-related industrial injury on October 8, 2024, when she helped a coworker move a heavy pallet of ice and felt pain in her lower abdomen. Claimant was initially diagnosed with right lower quadrant pain and was later diagnosed with genital prolapse on December 11, 2024. Respondents filed a general admission of liability admitting for medical benefits on December 20, 2024. Ex. 1.

Authorized Provider

2. Claimant began treating with an authorized treating physician at HealthOne CareNow Urgent Care on October 13, 2024. Ex. 6. The results of a physical exam showed abnormal uterus, vagina, vaginal wall, and cervix. Ex. 6 p. 34. On November 21, 2024, Claimant was diagnosed with genital prolapse. Ex. 6 p. 35.

3. On December 11, 2025, Claimant was referred by Travis Bellville, M.D., of HealthOne CareNow Urgent Care, to UC Health Urogynecology Clinic. Ex. 6 p. 38; Ex. 6 p. 40.

4. Claimant saw Kelsey Linda Pfau, PA-C at UC Health Urogynecology Clinic on December 31, 2024. Ex. 8. PA Pfau diagnosed Claimant with stress incontinence, midline cystocele, rectocele, and vaginal vault prolapse. *Id.* PA Pauf referred Claimant to UC Health's Women's Pelvic Health and Surgery Center for a pessary fitting. Ex. B p. 22.

5. On March 24, 2025, Claimant saw Kathleen Connell, M.D., and Amber Moyer, M.D., at UC Health Urogynecology Clinic. Ex. B p. 28 ("Pt was seen and examined by me with resident physician and Dr. Moyer in our multi-D clinic."); Tr. p. 23 ln. 5-19.

6. Drs. Connell and Moyer recommended Claimant undergo a combined sacrocolpopexy and sutured rectopexy. Ex. B p. 26 (Dr. Moyer); Ex. B p. 28 (Dr. Connell).

7. "Under the Act, treatment is compensable where it is provided by an 'authorized treating physician.'" *Kilwein v. Indus. Claim Appeals Off.*, 198 P.3d 1274, 1276 (Colo. App. 2008); *see* § 8-42-107(8)(b)(I), C.R.S.; § 8-43-404(7), C.R.S. "A physician may become authorized to treat a claimant's industrial injury as a result of a referral from an authorized treating physician where the referral is made in the normal progression of authorized treatment." *Kilwein*, 198 P.3d at 1276. "Whether a referral is made as part of the normal progression of authorized treatment is a question of fact for the ALJ to determine." *Id.*

8. Claimant proved by a preponderance of the evidence that Dr. Connell is an authorized treating physician as she practices at UC Health Urogynecology Clinic where Claimant was referred by Dr. Bellville in the normal progression of authorized treatment.

Reasonable, Necessary, and Related Medical Care

9. As is the case here, once a claimant has established the compensable nature of her work injury, she is entitled to a general award of medical benefits and respondents are liable to provide all reasonable, necessary, and related medical care to cure and relieve the effects of the work injury. § 8-42-101, C.R.S.; *see Grover v. Indus. Comm'n*, 759 P.2d 705, 709 (Colo. 1988); *see generally Urban v. City of Colo. Springs*, W.C. No. 5-180-359 (Jan. 2, 2024). However, a claimant is only entitled to such benefits if the care is reasonable, necessary, and the industrial injury is the proximate cause of her need for medical treatment. § 8-41-301(1)(c), C.R.S.; *Standard Metals Corp. v. Ball*, 172 Colo. 510, 515, 474 P.2d 622, 625 (1970). Ongoing benefits may be denied if the current and ongoing need for medical treatment is not proximately caused by the injury arising out of and in the course of the injured worker's employment. *Snyder v. Indus. Claim Appeals Off.*, 942 P.2d 1337, 1339 (Colo. App. 1997).

10. The question of whether medical treatment is reasonable and necessary to cure and relieve the effects of an industrial injury is one of fact. *Kroupa v. Indus. Claim Appeals Off.*, 53 P.3d 1192, 1197 (Colo. App. 2002). Similarly, the question of whether the need for treatment is causally related to the industrial injury is also one of fact. *Walmart Stores, Inc. v. Indus. Claim Appeals Off.*, 989 P.2d 251, 252 (Colo. App. 1999). Where the

relatedness, reasonableness, or necessity of medical treatment is disputed, the claimant has the burden to prove that the disputed treatment is casually related to the injury, and reasonably necessary to cure or relieve the effects of the injury. *Ciesiolka v. Allright Colo. Inc.*, W.C. No. 4-117-758 (ICAO, Apr. 7, 2003). In this case, there was no genuine dispute that the sacrocolpopexy and sutured rectopexy recommended by Dr. Connell is reasonable and necessary to relieve Claimant from the effects of her genital prolapse. Respondents' retained expert Dr. Fall testified at hearing that the sacrocolpopexy and sutured rectopexy are reasonable and necessary. Tr. p. 52 ln. 4-15 ("Q: Now, in this situation, you would agree with me that the course of treatment that the [claimant] has undergone so far is reasonable and necessary, correct? A: Reasonable and necessary for her condition, yes, not related to work. Q: I'm just talking about reasonable and necessary for right now. A: Yeah. Q: And you agree that the surgeries that are recommended are reasonable and necessary as well, correct? A: Yes."); *but see* Ex. C p. 35 ("In my opinion within a reasonable degree of medical probability, the proposed sacrocolpopexy and sutured rectopexy were not medically reasonable, necessary, and related to a work-related incident."). Instead, the question is whether Claimant's need for the recommended surgery is casually related to her October 8, 2024 work injury.

11. Here, the totality of the evidence presented, including Claimant's testimony, the content of the medical records, and the opinions and recommendations of Drs. Bellville, Connell, and Moyer persuade the ALJ that Claimant's October 8, 2024 work injury probably resulted in an acute pelvic/bladder prolapse or, alternatively, in an aggravation of preexisting, yet asymptomatic, pelvic floor issue giving rise to Claimant's symptoms and need for the recommended sacrocolpopexy and sutured rectopexy. *See* Ex. 6 p. 38 (Dr. Bellville: "After past medical records review, review of her employment history, job description and the described circumstances of this injury I do believe it is reasonable to consider the acute pelvic/bladder prolapse to be work related."); Ex. 6 p. 44 (Ashley Nichols, PA: "No improvement with use of pessary device- failure of conservation treatment, would recommend surgery at this time if also recommended by urogyn to move patient towards MMI."); Ex. B p. 26 (Dr. Moyer: "Given stage 3 prolapse with bowel symptoms, recommend combined procedure."); Ex. B p. 28 (Dr. Connell: "surgical case

request: perineoplasty, coloporrhaphy, combined anteroposterior, sacrocolpopexy, abdominal cystoscopy, rectopexy, using suture").

12. Taken in its entirety, the ALJ finds the evidentiary record to contain substantial evidence to support a conclusion that Claimant's October 8, 2024 work injury is responsible for her current diagnoses and symptoms and that the recommended sacrocolpopexy and suture rectopexy will cure and relieve the effects of that work injury. In so concluding, the undersigned ALJ rejects Dr. Fall's contrary opinions, to find and conclude that Claimant has established the requisite casual connection between her work-related injury and her need for the recommended sacrocolpopexy and sutured rectopexy.

It is therefore ordered that:

1. Claimant has established that Dr. Kathleen Connell is an authorized treating physician.
2. Respondents shall authorize and pay for all expenses associated with completion of the sacrocolpopexy and sutured rectopexy recommended by Dr. Connell. Payment shall be in accordance with the Colorado workers' compensation medical benefits fee schedule.
3. All matters not determined herein are reserved for future determination.

Signed: October 15, 2025.

Robin E. Hoogerhyde
Administrative Law Judge

This decision is final and not subject to appeal unless a full order is requested. The request shall be made at the Office of Administrative Courts, 1525 Sherman Street, Floor 4, Denver, Colorado 80203 within ten working days of the date of service of this Summary Order. § 8-43-215(1), C.R.S. Such a request is a prerequisite to review under section 8-43-301, C.R.S.

Pursuant to OACRP 26(B), if either party requests a full order, both parties shall submit a proposed order containing specific findings of fact and conclusions of law within seven days from the date of the request. The proposed full order must be submitted by e-mail in Word format to oac-dvr@state.co.us. The proposed order shall also be submitted to opposing counsel and unrepresented parties by e-mail, facsimile, or same day or next day delivery.

Office of Administrative Courts

State of Colorado

Workers' Compensation No. 5-298-875-001

Issues

- Did Claimant prove she suffered a compensable injury on January 14, 2025?
- What is Claimant's average weekly wage ("AWW")?
- If the claim is compensable, Respondents stipulated that Claimant is entitled to TTD benefits from February 6, 2025 until terminated by law.

Findings of Fact

1. Claimant worked as a personal care provider at Employer's nursing home. She worked three 8-hour shifts per week, typically on Monday, Tuesday, and Wednesday. She assisted residents with basic tasks such as transfers, grooming, meals, and other routine activities. In January 2025, there were approximately 48 residents on her floor, about one-third of whom used wheelchairs. Claimant pushed wheelchair-bound residents to and from the dining room twice per shift. She also pushed residents in wheelchairs to and from other activities, if needed. The nature of the work required Claimant to be on her most of the day.

2. The week before January 14, 2025, was particularly busy, and Claimant's feet felt tired and sore at the end of her shifts. Claimant credibly testified her feet occasionally felt tired or sore because of all the standing and walking associated with her job, but the symptoms were worse in the several days before January 14. Claimant took ibuprofen and her husband bought her a new pair of shoes he hoped would be more comfortable.

3. On January 14, 2025, Claimant was taking a wheelchair-bound resident to breakfast. The resident was overweight and Claimant pushed the wheelchair with extra force to start moving forward. When she pushed the wheelchair, Claimant felt sharp pain in her right lower leg, and lesser pain in her left leg. The pain was primarily in the back of her ankles near the Achilles tendons. Claimant had difficulty walking after the incident and could not put as much weight on her right foot. She reported the injury to a supervisor but finished her shift.

4. Claimant told her husband about the symptoms, and he urged her to see a doctor. Claimant went to the Southern Colorado Clinic on January 14, 2025. The record contains a January 15, 2025, a Return to Work / School form stating Claimant saw Danielle Kizzie, N.P. on January 14, 2025, and was "diagnosed with bilateral Achilles tendonitis." Claimant subsequently contracted the flu then Covid, which kept her off work for a couple of weeks.

5. Claimant saw Lyric Jones, NP at Concentra on February 6, 2025. Claimant reported she, ""[W]as pushing heavy residents repeatedly and has pain in both feet/back of ankle at tendons, pt has pain when walking a lot." Claimant's right and left Achilles tendons were tender to palpation. Nurse Jones diagnosed bilateral Achilles tendonitis. She prescribed ibuprofen and a Medrol Dosepak, and referred Claimant to PT. She also put Claimant on work restrictions. Ms. Jones opined that Claimant's symptoms and history are consistent with a work-related mechanism of injury. Dr. Peterson reviewed the chart and concurred that the condition was work-related.

6. Claimant attended three PT sessions in February 2025. The therapist documented that the injury was cased by repeatedly pushing heavy residents. Claimant said the activity caused pain in both feet and the back of her ankles and tendons. The therapist performed manual therapy and dry needling. On February 19, 2025, PT was put on hold pending an MRI.

7. MRIs of both ankles on March 6, 2025, showed bilateral mild Achilles and posterior tibialis tendinopathy.

8. Claimant started seeing Dr. Kathryn Murray at Concentra on March 12, 2025. Her left leg had improved significantly but the right leg was not getting better. Descending stairs and squatting were particularly bothersome. Dr. Murray documented the mechanism of injury as, "pushing heavy residents in wheelchairs. Was pushing heavier patients and more of them than she normally does." Dr. Murray reviewed the MRIs and referred Claimant to Dr. Michael Simpson for an orthopedic evaluation. Dr. Murray opined that the condition was caused by Claimant's work.

9. Claimant saw Dr. Simpson on April 1, 2025. She reported the onset of bilateral foot pain while doing "a lot of walking" and "pushing heavy wheelchairs" at work. Physical examination showed a bilateral pes planus (flatfoot) deformity, tenderness in the

posterior tibial and Achilles tendons bilaterally (worse on the right), and a painful toe raise test. Dr. Simpson diagnosed bilateral Achilles and bilateral posterior tibial tendinitis. He recommended immobilizing the right foot in a short-leg walker for 3 to 4 weeks. Regarding causation, Dr. Simpson opined that Claimant did not have a "discrete injury," but thought the condition represented "an overuse injury." He further opined that the preexisting flatfoot deformity was "likely contributing in some way."

10. Claimant returned to Dr. Simpson on May 6, 2025. She had no pain while wearing the boot, but the pain immediately recurred when she came out of the boot. Dr. Simpson recommended injections of the Achilles and posterior tibial tendons.

11. Before the onset of symptoms in January 2025, Claimant's typical activities outside of work involved no significant walking, our pushing heavy objects. Claimant perceived that the foot and leg symptoms were triggered by her work activities as opposed to any nonwork-related activity.

12. As of the date of the hearing, Claimant's left leg pain had resolved but her right leg symptoms persisted.

13. Dr. Albert Hattem performed a record review for Respondents in March 2025. Dr. Hattem concluded that the Claimant's bilateral lower extremity complaints are not work-related. He noted that pushing heavy loads is not a recognized mechanism for Achilles tendonitis under the Lower Extremity MTGs. Rather, the condition is associated with activities like falling, twisting, or jumping. Dr. Hattem also cited the *AMA Guides to the Evaluation of Disease and Injury Causation*, which states there is, "insignificant evidence for any association of occupation with Achilles tendinopathy."

14. Dr. Hattem expressed similar opinions in his deposition testimony. Additionally, upon learning that Claimant experienced heel pain and bought special shoes the week before January 14, Dr. Hattem testified that the symptoms represented a "pre-existing" condition and therefore could not be related to any injury on January 14, 2025. Dr. Hattem opined that an overuse injury was unlikely given Claimant's part-time work schedule of 24 hours per week. He further opined that standing for lengthy periods would not likely cause her foot conditions.

15. The opinions of Dr. Simpson and Claimant's other treating providers are credible and more persuasive than the contrary opinions offered by Dr. Hattem.

16. Claimant's testimony is credible.

17. There is no persuasive evidence that Claimant's bilateral foot and leg symptoms were proximately caused by a hazard to which she was equally exposed outside of her work.

18. Claimant proved she suffered a compensable injury on January 14, 2025.

19. Claimant earned $8,485.09 in the 16 weeks from September 1, 2024, through December 21, 2024. This period provides a representative sample of Claimant's typical wages, unaffected by irregular factors such as the unexplained "PTO Cash in" during the pay period ending January 4, 2025. Claimant's AWW is $530.32, with a corresponding TTD rate of $353.55.

20. Claimant has been continuously under work restrictions since the February 6, 2025. Employer could not accommodate those restrictions, and Respondents stipulated that Claimant is entitled to TTD benefits from February 6, 2025, until terminated by law, if the claim is compensable.

Conclusions of Law

A. Compensability

To receive compensation or medical benefits, a claimant must prove they are a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, *33 P.3d 1230* (Colo. App. 2001). The mere fact that an employee experiences symptoms while working does not compel an inference the work caused the condition. *Scully v. Hooters of Colorado Springs*, W.C. No. 4-745-712 (October 27, 2008). There is no presumption that a condition which manifests at work arose out of the employment. Rather, the Claimant must prove a direct causal relationship between the employment and the injury. Section 8-43-201; *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989).

The Act imposes additional requirements for liability of an occupational disease beyond the "arising out of" and "course and scope" requirements. A compensable occupational disease must meet each element of the four-part test mandated by § 8-40-201(14), which defines an occupational disease as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

The equal exposure element effectuates the "peculiar risk" test and requires that the injurious hazards associated with the employment be more prevalent in the workplace than in everyday life or other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The claimant "must be exposed by his or her employment to the risk causing the disease in a measurably greater degree and in a substantially different manner than are persons in employment generally." *Id.* at 824. The hazard of employment need not be the sole cause of the disease, but must cause, intensify, or aggravate the condition "to some reasonable degree." *Id*.

The Division has adopted Medical Treatment Guidelines (MTGs) to advance the statutory mandate to assure quick and efficient delivery of medical benefits to injured workers at a reasonable cost to employers. Under § 8-42-101(3)(b) and WCRP 17-2(A), medical providers must use the MTGs when furnishing medical treatment. The ALJ may consider the MTGs as an evidentiary tool but is not bound by the MTGs when determining if a condition is work-related. Section 8-43-201(3); *Logiudice v. Siemans Westinghouse*, W.C. No. 4-665-873 (January 25, 2011). The MTGs are primarily intended to facilitate quick determinations by insurers regarding requests for pre-authorization. They are not binding rules and not intended to supplant a case-by-case evaluation of individual circumstances. *See* § 8-43-201(3).

As found, Claimant proved she suffered a compensable injury on January 14, 2025. Claimant has consistently attributed her foot and leg symptoms to work activity in January 2025. Although Claimant is not a medical expert, she is competent to describe her perception of the impact the work activities had on her own body. Furthermore, Claimant's treating providers at Concentra uniformly agree that the diagnoses of bilateral Achilles and posterior tibial tendinopathy are work-related. Dr. Simpson's opinions and

conclusions are credible and persuasive. Dr. Hattem's opinion that Claimant suffered from a nonwork-related "pre-existing condition" is not credible. Claimant had no significant problems with her legs or feet before January 2025, and the symptoms she experienced the week before January 14 probably reflected the initial manifestations of the work-related overuse condition, rather than any independent condition. Claimant proved the development of symptoms on January 14, 2025 was proximately caused by her work. She either suffered an acute injury, an occupational disease, or some combination thereof. There is no persuasive evidence the condition resulted from a hazard to which Claimant was equally exposed outside of work. As a result, it is immaterial whether her symptoms reflect either an accidental injury or the "onset of disability" from an occupational disease.

B. Average weekly wage

Section 8-42-102(2) provides that compensation is payable based on the employee's average weekly earnings "at the time of the injury." The statute sets forth various computational methods for workers paid on an hourly, salary, per diem basis, etc. But § 8-42-102(3) gives the ALJ wide discretion to "fairly" calculate the employee's AWW in any manner that seems most appropriate under the circumstances. The entire objective of AWW calculation is to arrive at a "fair approximation" of the claimant's actual wage loss and diminished earning capacity because of the industrial injury. *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993).

As found, Claimant's AWW is $530.32, with a corresponding TTD rate of $353.55. Claimant earned $8,485.09 in the 16 weeks from September 1, 2024, through December 21, 2024. This period provides a representative sample of Claimant's typical wages, unaffected by irregular factors such as the unexplained "PTO Cash in" during the pay period ending January 4, 2025.

Order

It is therefore ordered that:

1. Claimant's claim is compensable.

2. Claimant's average weekly wage is $530.32, with a corresponding TTD rate of $353.55.

3. Insurer shall pay Claimant TTD benefits at the rate of $353.55 per week, commencing February 6, 2025, and continuing until terminated by law.

4. Insurer shall pay Claimant statutory interest of 8% per annum on all compensation not paid when due.

5. All issues not decided herein are reserved for future determination.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 15, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 5-128-511-003

ISSUES

- Are Respondents entitled to an order of repayment?
- What are the appropriate repayment terms?

FINDINGS OF FACT

1. Claimant sustained an admitted injury to his low back on October 15, 2019, while working as a physical therapist.

2. A prior order issued by Judge Kabler determined that Claimant was overpaid by Respondents in the amount of $71,731.90 based on a Division Sponsored Independent Medical Examination (DIME) determination that Claimant reached MMI on November 4, 2019, and an impairment rating of 0%.

3. Claimant appealed that order and it was affirmed by both ICAO and the Colorado Court of Appeals.

4. Although the prior order determined that an overpayment of $71,731.90 existed, it did not address the repayment of the overpayment.

5. As a result of the DIME determinations that Claimant sustained no impairment, the previous PPD benefits paid to Claimant became an overpayment. In addition, since the MMI date was determined to have occurred shortly after the work injury, a majority of the TTD benefits paid were also an overpayment.

6. There is no persuasive evidence Claimant withheld information from Respondents or otherwise contributed to creation of the overpayment.

7. Claimant's household consists of three members: Claimant, his spouse, and his 20-year-old daughter. The Claimant's wife owns the shared home, which is valued by the Claimant as worth $800,000. There is no mortgage on the home. Claimant and his wife are also paying for their daughter's college expenses which total approximately $55,000 per year.

8. Claimant is the only household member employed at present. The Claimant's wife is retired. Although Claimant testified that his wife does consulting work Claimant did not know how much she earns for such work. Claimant's hourly wage is $51 per hour, and he works 40 hours per week. Alternatively, Claimant testified that he earns approximately $104,000 per year. This equals $8666.67 per month.

9. Claimant credibly testified to recurring household expenses of approximately $3,500 to $4,000 per month.

10. Three hundred dollars ($300) per month is an appropriate repayment rate considering Claimant's financial circumstances and lack of culpability in contributing to the overpayment.

CONCLUSIONS OF LAW

A. Repayment terms

Where, as here, an overpayment cannot be collected from ongoing benefits, the respondents may seek an order of repayment. Section 8-42-113.5(1)(c). The statute prescribes no specific recovery rate or period, and repayment terms are left to the ALJ's discretion. *Louisiana Pacific Corp. v. Smith*, 881 P.2d 456 (Colo. App. 1994).

As found, $300 per month is an appropriate repayment rate. At present, it is also significant that Claimant did not contribute to the creation of the overpayment.

ORDER

It is therefore ordered that:

1. Claimant shall repay $71,731.90 to Respondents, in monthly installments of $300. The first payment shall be due thirty (30) days after this Order becomes final, with payments continuing thereafter on a monthly basis due on the 5th day of each month until the overpayment is repaid in full.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 2, 2025

Michael A. Perales
Michael A. Perales
Administrative Law Judge
Office of Administrative Courts

Office of Administrative Courts

State of Colorado

Workers' Compensation No. WC 5-176-695-008

Stipulations

At the outset of the hearing, the parties agreed to reserve litigation concerning Claimant's entitlement to disfigurement. The parties' agreement/stipulation was accepted and approved.

Remaining Issues

- Whether Respondents produced clear and convincing evidence to overcome the Division Independent Medical Examination (DIME) opinions of Dr. Jack Rook regarding maximum medical improvement (MMI).

- If Respondents established that Dr. Rook's DIME determination concerning MMI is erroneous, whether Respondents also established, by clear and convincing evidence, that Dr. Rook's whole person impairment rating opinion is highly probably incorrect.

- Whether Claimant proved by a preponderance of the evidence that additional medical care for his July 14, 2024, work injury is reasonable, necessary, and related.

Findings of Fact

Based upon the evidence presented at hearing along with the evidentiary deposition testimony of Dr. Chen, the ALJ enters the following findings of fact:

Claimants' July 14, 2024, Injury and Medical Treatment

1. Claimant works as a part time "Lot Associate" for Employer. (RHEs A, p. 5 &

G, p. 50). On July 14, 2024, Claimant was in the parking lot "standing still and talking to a customer in their car . . . when a parked car in a parking spot behind him started to back up and hit him in the back." Id. According to Claimant, the driver who hit him was not "going super fast." Id. Claimant reported being "thrown a little" but did not fall to the ground. Id.

2. The incident was captured on closed-circuit footage. (RHE J). The video demonstrates Claimant walking through a parking lot when the driver of a white sedan pulls alongside him and stops. Id. Claimant's attention is directed to the driver of this vehicle, and he stops walking and turns towards the car to speak to the driver. Id. Almost immediately after he turns towards the while sedan, the driver of a second SUV style vehicle, who had started reversing out of a parking space behind Claimant, backs into Claimant from behind. Id. Claimant is hit in the low back near the waistline. Id. The impact causes him to arch backward abruptly and then lurch forward towards the car in front of him. Id. Claimant maintains his footing as the force of the impact pushes him into the car in front of him. Id. He does not fall to the ground. Id. Immediately after the incident, Claimant walks, without apparent limitation, to the window of the driver who struck him. Id. After walking to and briefly standing by the driver's window, Claimant begins walking back toward the center of the parking lot to resume speaking with the other driver, who remained positioned behind the responsible vehicle. *Id*. As Claimant walks back into the parking lot, the driver who hit him pulls forward and disappears from view. Id. Claimant then stands, while shifting and moving his feet in front of the white sedan momentarily before the video stops. Id.

3. Claimant reported the incident immediately and an Employer's First Report of Injury (FROI) was completed. (RHE A, p. 5). According to Claimant, Employer indicated they would file a claim within 48 hours, but since that time had elapsed and he had not heard anything, Claimant elected to proceed to "CareNow Urgent Care" (CareNow) for medical attention on July 16, 2024. (RHE G, p. 50; CHE 11, p. 61).

4. During his July 16, 2024, encounter at CareNow, Claimant reported 5/10,

intermittent dull, aching and throbbing central mid-back pain. (RHE G, p. 50). Physical examination was “abnormal” and revealed right and left paraspinal spasm of the thoracic musculature. Id. at 51. Claimant was assessed with a “[s]prain of unspecified parts of thorax” and “other muscle spasm.” Id. Claimant was prescribed cyclobenzaprine and instructed to return to the clinic in 3 days if he had not improved. Id. at 52. Imaging was not felt to be necessary. Id.

5. Claimant presented to Concentra Medical Centers (Concentra) on July 30, 2024, where he reported low-mid back pain while pushing carts and standing for “a time.” (RHE H, p. 56). Claimant described bilateral, mild, non-radiating low back pain which was dull and aching in nature. Id. at 57. He estimated that he had been hit by a vehicle traveling 5-10 MPH and reported that his pain had returned when he attempted to return to work. Id. at 57-58. Accordingly, he presented to Concentra for further evaluation. Id. at 58. Physician Assistant (PA) Amanda Ying diagnosed Claimant with a lumbar contusion, ordered x-rays, and referred him for physical therapy. Id. at 59-60. Claimant was returned to work with restrictions of lifting, carrying, pushing, and pulling no more than 20 pounds and alternating between sitting and standing as needed. Id. at 63, 71.

6. Claimant’s 7/30/2024, lumbar x-rays revealed no acute fractures, a Grade 1 anterolisthesis at L5 over S1 with narrowing of the L5-S1 disc space, and probable L5-S1 pars defects. (RHE H, p. 72).

7. Claimant began a course of physical therapy through Concentra on July 30, 2024. (RHE H, p. 73).

8. Claimant returned to Concentra on August 1, 2024, with reports of feeling “about the same.” (RHE H, p. 86). After discussion with John Sacha, M.D., PA Ying referred Claimant for flexion and extension x-rays and an MRI “given [that] pars defect can make further injury easier to obtain with even minor back trauma.” (RHE H, p. 89). Claimant’s flexion and extension x-rays were compared with his imaging done July 30,

2024, and revealed a “Grade 1 anterolisthesis L5 over S1 without instability, degenerative disc disease at L5-S1 and a high degree of suspicion for L5-S1 pars defects.” Id. at 81.

9. Claimant returned to Concentra on August 13, 2024. (RHE H, p. 109). During this encounter, Claimant reported continued pain when pushing, pulling or twisting when trying to push carts in the parking lot at work. Id. Claimant’s MRI was noted to be set for August 16, 2024. Id.

10. Claimant completed his August 16, 2024, lumbar MRI as scheduled. The MRI demonstrated no acute compression fractures along with “mild degenerative changes of the lumbar spine including L5 pars defects with grade 1 anterolisthesis of L5 upon S1.” (RHE I, p. 151). There was also a minimal disc bulge at L1-L2 and L4-L5 with mild facet hypertrophy. Id. At L3-L4 there was minimal disc bulging with mild facet hypertrophy and “minimal left foraminal narrowing with slight contact on the exiting left L3 nerve root in the foramen.” Id.

11. Claimant was evaluated by Carol Dombro, M.D., on August 23, 2024. (RHE H, p. 127). Claimant reported improvement with physical therapy and Dr. Dombro indicated he was ready for a full duty trial. Id. at 130. Dr. Dombro agreed with the physical therapist that Claimant was ready for release. Id. at 134. Dr. Dombro was unable to reproduce musculoskeletal pain upon exam and there was no loss of range of motion. Id.

12. Dr. Dombro placed Claimant at maximum medical improvement (MMI) on August 30, 2024. (RHE H, p. 138; 142). Claimant reported doing well overall, except for struggling at work with heavy lifting. Id. at 139. There were no ongoing symptoms of concern and Claimant was released to full duty without restrictions. Id. at 140. PA Ying discussed follow-up with primary care for the underlying pars defect, which was deemed unrelated to the work injury. Id. No permanent impairment was assigned. Id. at 142.

13. Respondents filed a Final Admission of Liability (FAL) on September 19, 2024.

(RHE B, p. 7). Consistent with Dr. Dombro's opinion, no impairment was reflected on the FAL. Id. Additionally, maintenance care was denied. Id.

14. Claimant requested a Division Independent Medical Evaluation (DIME). Dr. Jack Rook was selected to perform the evaluation and completed the same on March 10, 2025. (RHE D). Dr. Rook issued a report outlining his opinions regarding MMI and impairment on March 30, 2025. Id. In his report, Dr. Rook noted that during his treatment at Concentra, Claimant was not referred for a surgical spine evaluation despite his imaging findings of spondylolysis, spondylolisthesis and facet arthropathy. Indeed, Dr. Rook noted, "No specific recommendations were made regarding the abnormal MRI." Id. at 20, 22. Dr. Rook also noted that Claimant did not undergo any spinal injections. Id.

15. Claimant reported to Dr. Rook that, in the months leading up to his DIME, he had increasing low back pain with some radiation into the left hip. (RHE D, p. 20). At the time of the DIME, Claimant reported constant low back pain extending across his low back. Id. He reported 3/10 level back pain at rest which increased to 8/10 level pain with activity, including prolonged standing, lying on his back, bending, twisting, lifting more than 40 pounds, and pushing multiple shopping carts while at work. Id. There was a pinching sensation associated with his pain during certain movements and Claimant could feel a "popping" in his low back when twisting or bending forward. Id. Claimant denied any history of prior low back problems. Id.

16. Following a review of Claimant's pertinent medical records and diagnostic imaging, Dr. Rook completed a physical examination. (RHE D, p. 23). As part of his examination, Dr. Rook documented complaints of spinal and muscular tenderness along with impaired lumbar range of motion (ROM). Id. Dr. Rook then provided the following clinical diagnoses:

1. Chronic low back pain:
   - Probable discogenic pain associated with lumbar degeneration, particularly at L5-S1.

- Rule out pain associated with spondylolysis and spondylolisthesis at the L5-S1 level.
- Myofascial pain component.
- Facet mediated pain.

(RHE D, p. 24).

17. Dr. Rook opined that Claimant was not at MMI, noting that he continued to have "fairly significant" low back pain which he did not feel had been adequately worked up based upon the objective abnormalities revealed at the L5-S1 spinal level on imaging, including MRI. (RHE D, p. 24). In support of his conclusion, Dr. Rook noted the following regarding the cause of Claimant's symptoms/condition: "At the very least, there has been a permanent aggravation of what was previously an asymptomatic condition. It is also possible that the SL/SLTH[1] at the L5-S1 level resulted from the forces to his back caused by this accident. (RHE D, p. 25). Concerning MMI, Dr. Rook noted, "Additionally, the patient was placed at maximum medical improvement within six weeks of first being seen at Concentra despite the findings on his MRI scan. I believe that further diagnostic workup to determine if there is instability at the L5-S1 level is indicated as well as spinal injection therapy per the treatment guidelines which could include lumbar epidural injections, facet injections, diagnostic anesthetic injections into the spondylolysis, and perhaps even a left L3 selective nerve root block to determine if his left hip pain is coming from irritation of that nerve root (based upon his MRI report). I also believe that a consultation with an orthopedic spine surgeon or a neurosurgeon is indicated." Id.

18. Dr. Rook assigned an advisory impairment rating of 15% of the whole person for combined ROM loss and specific disorders of the spine. (RHE D, pp. 24-25). Eight percent of this overall rating was based on Table 53(III)(A) of the *AMA Guides, 3rd ed., rev.*, for grade 1 spondylolisthesis and the remaining impairment was assigned for measured ROM loss.

[1] Spondylolysis and Spondylolisthesis.

19. Dr. Qing-Min Chen, M.D., examined Claimant at Respondents request on April 16, 2025. During this independent medical examination (IME), Claimant complained of "low back pain and back pain." (RHE E, p. 28). Claimant specified that he had 8/10 low back pain "midline to the left across L4-S1." Id. at 29. He also reported 5/10 mid-back pain around T10-12. Id. There were no complaints of numbness or tingling. Id.

20. Dr. Chen noted that Claimant usually worked 30 hours per week but was presently working 20 hours per week, still at full duty without restrictions. (RHE E, p. 29). Claimant denied prior injuries, illnesses, surgeries, hospitalizations or allergies and reported working out for fitness and playing basketball two to three times per week. Id. During the examination, Claimant displayed no overt pain behavior, symptom magnification or other inappropriate responses. Id. Physical examination revealed tenderness to palpation of the paraspinal musculature across the low back in the L4-S1 spinal area. Id. The remainder of Claimant's examination was unremarkable. Diagnoses included: preexisting, multilevel degenerative disc disease and facet arthritis; preexisting and chronic L5 pars defect with degenerative anterolisthesis at L5 on S1; and lumbar contusion/strain (related). Id. at 32.

21. Dr. Chen indicated that there was no objective evidence, including on MRI, to support a contusion/strain but gave this diagnosis based on the mechanism of injury and initial complaints. (RHE E, p. 32). Dr. Chen noted that the objective findings on diagnostics, including the degenerative disc disease, arthritis, and spondylolisthesis with pars defect verified by MRI were not caused or aggravated by Claimant's parking lot accident from an objective standpoint. Id. Dr. Chen noted that Claimant's subjective complaints (symptoms) could be proportional to the objective imaging findings apart from his reports of midback pain, although Dr. Chen noted a lack of imaging for this area. Id. at 33.

22. Dr. Chen opined that Claimant's diagnosis of soft tissue strain/contusion of the lumbar and possibly the thoracis spine was work related. (RHE E, p. 33). However, he opined that neither the pars defect nor the degenerative changes in the spine were related

to the injury as there was no evidence of aggravation based on the MRI findings. Id. Indeed, Dr. Chen noted that there was no edema in the pars region, and it was specifically noted by the radiologist that the pars defect and anterolisthesis were degenerative in nature suggesting that these were pre-existing conditions. Id. at 34. Dr. Chen opined that Claimant did not qualify for an impairment rating given the minimum criteria under Table 53 of the *AMA Guides* for six months of documented treatment. (RHE E, p. 35).

23. Dr. Chen reviewed the DIME report of Dr. Rook and specifically disagreed with the conclusions reached by Dr. Rook. Indeed, Dr. Chen noted:

> As an addendum, I have reviewed Dr. Rook's DIME report and respectfully disagree. There is no evidence that the pars defect or spondylolisthesis occurred from this accident. In fact, the radiologist himself reported that this was a degenerative spondylolisthesis (as opposed to an acute fracture). Again, medical literature has shown that pars defects usually occur in adolescence. Had this claimant truly had an acute pars fracture from a traumatic injury he would have been in an emergency room and not be able to go back to work that day. MRI again does not mention any sort of increased edema in that area that would be suggestive of an acute injury. The claimant also does not qualify for a table 53 impairment based on what I discussed above, so he should not really be awarded any impairment with respect to this claim.

(RHE E, p. 35).

24. Claimant requested an independent medical evaluation from Dr. Miguel Castrejon, M.D. Dr. Castrejon evaluated Claimant on May 19, 2025. (CHE 15). Claimant reported to Dr. Castrejon he had no benefit from physical therapy or chiropractic care. Id. at 189. At the time of exam, Claimant reported a present complaint of non-radiating constant sharp low back pain when sitting/standing for prolonged periods and sharp pain

when bending at a certain angle forward. Claimant rated his pain at 7/10 and reported increased discomfort with prolonged sitting, standing, repetitive bending, and stooping. Id. at 192. Lying down and resting helped lessen Claimant's pain. Id. Physical examination revealed hypertonicity of the paralumbar musculature. Id. at 193. There was mildly decreased lumbar with painful extension and a positive facet loading maneuver on left side. Id. Based upon Claimant's history, the content of his medical records and his physical examination, Dr. Castrejon provided the following diagnosis: "Lumbar musculoligamentous strain/sprain, aggravation of pre-existing lumbar spondylosis/spondylolisthesis, and chronic pain." Id.

25. Following his examination, Dr. Castrejon opined that the mechanism of injury was considered significant in an individual with preexisting anatomical abnormality, stating that "literature" notes that even minor low speed rear-end collisions can exacerbate preexisting spondylolisthesis. (CHE 15, p. 194). He added that "impact of the vehicle against claimant's lumbar region resulted in a hyperextension moment thereby aggravating a pre-existing spondylolisthesis and possibly contributing to instability that would necessitate surgical intervention. Id. Prior to considering MMI, Dr. Castrejon noted that claimant "should undergo flexion-extension lumbar films, followed by a spine surgery consultation."[2] Id. He did not feel that spinal injections were appropriate as there were "no further hip-referred issues on a consistent basis." Id. He added that Claimant may well "benefit from medial branch blocks." Id. Nonetheless, he noted, "I would wait until completion of a spine surgical consultation and additional radiological studies to proceed with medial branch blocks." Id.

26. Dr. Chen submitted an addendum report on July 15, 2025. As part of an addendum report, Dr. Chen noted that he reviewed video tape of the incident along with the IME report of Dr. Castrejon. (RHE F, pp. 45-46). Dr. Chen noted that both Drs. Rook and Castrejon had missed the August 1, 2024, flexion-extension x-ray that showed no

[2] While Dr. Castrejon included a summary of the August 1, 2024, flexion and extension x-rays showing no spinal instability, he stated that "There is no indication that the claimant had undergone flexion-extension x-rays to assess for instability" in his conclusions as part of his reasoning that Claimant was not at MMI. (CHE 15, p. 190, 194).

spinal instability. Id. at 46-47. Dr. Chen then reiterated, "At this point, I do not have any objective evidence of aggravation here." Id. at 47. Dr. Chen disagreed with the conclusion of Drs. Rook and Castrejon that Claimant aggravated a pre-existing spondylolisthesis giving rise to his symptoms. Indeed, Dr. Chen noted, "If there was truly an aggravation of the pars defects and listhesis as claimed by Dr. Castrejon, an MRI August 16, 2024, would have picked up some sort of inflammation in that area; some evidence of pathologic worsening, which was not the case. For these reasons, my original opinion remains unchanged." Id.

The Hearing Testimony of Dr. Castrejon

27. Dr. Castrejon testified as a Level II accredited expert in Physical Medicine and Rehabilitation (PM&R). Dr. Castrejon reiterated his diagnoses for Claimant as documented in his written report, i.e. musculoligamentous strain-sprain; aggravation of preexisting lumbar spondylosis/spondylolisthesis; and chronic pain and testified that in his professional opinion, Claimant was not at MMI. According to Dr. Castrejon, suddenly being pushed forward by a vehicle fulfilled the criteria for Claimant having experienced a hyperextension motion to the lumbar spine that aggravated Claimant's underlying spondylosis and spondylolisthesis[3]. (Hrg. Tr. p. 21, ll. 6-10). Dr. Castrejon testified that he could not "define" whether Claimant's spondylolisthesis was preexisting or caused by the motor vehicle hitting Claimant, but he noted specifically that there was an aggravation. Id. at ll. 12-14.

28. Dr. Castrejon testified that the aggravation in this case was defined as "prior to this event, this gentleman was asymptomatic, had been working for Home Depot, I assume had participated in the activities of a young individual, and had not sought medical care; never had he been limited in any fashion." (Hrg. Tr. p. 21, ll. 14-18). Whereas

[3] Dr. Castrejon defined a spondylolisthesis as a slip in the vertebra. (Hrg. Tr. p. 21, l. 11). He also testified that he considered the impact a "significant trauma" because Claimant's underlying pre-existing spondylosis and spondylolisthesis set him up for requiring less force to result in an injury when compared to an individual who does not have those anatomical problems. (Hrg. Tr. p. 44, ll. 21-25, p. 45, ll. 1-3). See also, Id. at p. 46, ll. 16-23.

"[a]fter the event, he has been experiencing symptoms since then and remains symptomatic at the time that I saw him, with findings on examination that supported pain emanating from the facet joints, and at the level of the spondylolisthesis that's in the lumbar spine. Id. at ll. 19-23.

29. Dr. Castrejon explained that he could not determine the "exact origin" of Claimant's spondylolisthesis, which is the actual slipping of the vertebral body on one another, the top body slipping on the body below, which in the case of a grade I slippage means that the top body slips forward on the lower vertebra by approximately 25%. (Hrg. Tr. p. 22, ll. 3-8). According to Dr. Castrejon the spondylolisthesis could have been caused by a number of mechanisms, including degeneration, chronic or repetitive stress, or sudden impact and/or force applied to the back. Id. at ll. 9-17. In the absence of a pre-injury imaging study documenting its presence, Dr. Castrejon was unable to discern whether the slippage that was evident on Claimant's post-accident imaging was a direct result of the car accident or not. Id. at ll. 17-21. Nonetheless, assuming that Claimant's spondylolisthesis and pars defects were pre-existing, Dr. Castrejon testified that an aggravation of Claimant's pre-existing congenital condition was manifested by the objective (physical examination findings) functional and subjective residuals that had been documented through the medical file. Id. at ll. 22-25, p. 23, l. 1

30. Duringn his testimony, Dr. Castrejon acknowledged, contrary to his IME report, that flexion/extension x-rays had obtained and that they were read as demonstrating "no instability." (Hrg. Tr. p. 27, ll. 21-25, p. 28, ll. 1-6). Dr. Castrejon surmised that when the DIME occurred, Dr. Rook did not have access to the x-ray report which then resulted in the recommendation that such x-rays be obtained in part to "formulate" a treatment plan for Claimant. Id. at 28, ll. 7-11).

31. Dr. Castrejon testified that it was important to know if the spine was stable because the treatment for a stable versus an unstable spondylolisthesis was different. (Hrg. Tr. p. 26, ll. 20-21). If the spine was unstable, then the only treatment would be surgical fixation in the form of a spinal fusion. (Hrg. Tr. p. 27, ll. 4-11). If the

spondylolisthesis was stable, more conservative methods, such as local injections could be used to treat. Id. at ll. 12-20. Dr. Castrejon suggested facet joint injections and a potential rhizotomy to address pain. Id. Dr. Castrejon testified that he felt Claimant should have a repeat set of flexion/extension x-rays because Claimant remained symptomatic and the preceding flexion/extension study was done 10 months prior to his (Dr. Castrejon's) IME. Id. at p. 28, ll. 15-22. Even if Claimant's spondylolisthesis was determined to be stable on repeat x-ray, Dr. Castrejon still recommended surgical consultation for provision of other treatment recommendations from a spinal surgeon. Id. at p. 28, ll. 23-25, p. 29, ll. 1-2.

32. Dr. Castrejon reviewed Dr. Chen's IME report testifying that he agreed with part of his conclusions and disagreed with other parts of his analysis. Indeed, Dr. Castrejon testified:

> Do you agree or disagree with Dr. Chen's conclusion? Well, I disagree with his -- pardon me -- I agree with his conclusion, in the fact that this condition, the spondylolysis, was a preexisting condition that was asymptomatic and not causing any functional deficits. I am not in agreement with the incorporation of a spondylolisthesis because, as I indicated previously, I don't think he or I really knew or know what the pre-injury status of that slip was. Was it already there or was it somehow augmented? My suspicions, though, just based upon once -- one X-ray that says it was stability, it's probable that -- or it's likely that that spondylolisthesis was probably already there and that became symptomatic and was aggravated. So, if we look at it in that manner, then the preexisting items that were present before this accident would consist of the -- the L4 -- pardon me -- the spondylosis, (sic), L5-S1, and probably spondylolisthesis, and any degenerative changes that were there. However, I would like to add that the patient is a young individual and was a symptomatic as far as I know and as far as the record tells us. He was working,

> functional, doing the things that a 20-year-old gentlemen or young man does. There was no indication that he was being limited in -- in any compacity (sic) in carrying out those activities. It was not until this event occurred that, in my mind, resulted in an aggravation of a preexisting and asymptomatic condition. And that's the point that Dr. Chen did not focus on. He -- his argument primarily focused on what was preexisting rather than looking at what we're taught, in terms of analyzing cases. Okay; it was preexisting, but was it aggravated or exacerbated or not? Then you can make an argument and explain your point. In this particular case, he never acknowledged that type of -- of -- of a question nor answer. In fact, I found it interesting when he -- on page 6 of his report where he was asked were the objective findings consistent with and proportional to the subjective complaints, Dr. Chen, as part of his response stated, and quote, "At this 21 point, I am uncertain if he had a recurrence of pain or what is going on and why he has not gotten treated since August of 23 2024." Well, that pretty much tells me, okay, do you really know what's going on? But you certainly feel that he hasn't had any care, so expand on that, that he did not.

(Hrg. Tr. p. 29, ll.9-25; p. 30-31, ll. 1).

33. Dr. Castrejon testified that he relied upon his file review, his professional experience treating patient and literature research he completed from *PubMed* and *Medline* in support of his opinion that Claimant aggravated an underlying asymptomatic low back condition as a result of getting struck from behind by a motor vehicle. (Hrg. Tr. p, 31, ll. 2-25, pp. 32-33, ll. 1-7). Indeed, Dr. Castrejon testified that his opinions were based not only on the literature he examined, but also on his examination of the Claimant, his knowledge of the pathology surrounding spondylosis and pars defects, how such conditions arise and how they are diagnosed and treated. Id. at p. 47, ll. 13-19.

34. During cross-examination, Dr. Castrejon testified that he agreed Dr. Rook removed Claimant from MMI specifically for workup and treatment for spondylolysis and spondylolisthesis. (Hrg. Tr. p. 39, ll. 3-16). Dr. Castrejon testified that Dr. Rook was in error in his report in stating the study for instability for the spine was not done. Id. at p. 42, ll. 14-25, p. 43, ll. 1-16. Nevertheless, Dr. Castrejon testified that the fact that there is no instability simply means that Claimant would not be considered a surgical candidate, and not that additional treatment is not warranted or that Claimant symptoms may not be emanating from at the level of the facet joints. Id. at p. 44, ll. 9-16. Dr. Castrejon admitted there was no evidence of acute trauma on any of the diagnostics, no edema, soft tissue injury, fractures, or lesions. Id. at p. 45, ll. 7-16. Dr. Castrejon testified that high energy trauma is necessary to cause a traumatic spondylolisthesis. Id. at p. 53, ll. 11-14. While he agreed that high-energy trauma is necessary to cause a traumatic spondylolisthesis, Dr. Castrejon clarified that Claimant's spondylolisthesis was probably pre-existing and asymptomatic prior to being hit from behind by a vehicle and this mechanism of injury gave rise to Claimant's symptoms. Id. at p. 55, ll. 5-13. Indeed, Dr. Castrejon made it clear that he was not contending that being hit in the back from behind did not cause Claimant to suffer a traumatic spondylolisthesis. Id. at ll. 13-14. Dr. Castrejon disagreed with Respondent's suggestion that an aggravation of a pre-existing spondylolisthesis would involve a "significant disruption in the musculature and ligaments around the spine" and that the individual would be in "pretty severe" pain at the time of the impact. Id. at p. 55, ll. 19-25, p. 56, ll. 1-15. Dr. Castrejon viewed the CCTV video and testified that Claimant was standing approximately four to five feet behind the stationary vehicle, which was likely traveling below five (5) mph at the time of impact, around walking speed. Id. at p. 64, ll. 18-24.

The Deposition Testimony of Dr. Chen

35. Dr. Chen testified by deposition as a board-certified, Level II accredited Orthopedic surgeon. (Depo. Tr. Dr. Chen, p. 8). Dr. Chen presently practices in a Level I trauma center ER at Denver Health and has extensive experience treating patients who have high acuity trauma, including injuries sustains in high-speed automobile accidents

resulting in trauma to the spine. Id. at p. 6, ll. 13-25, p. 7, 3-18. Dr. Chen testified that he performed an IME on Claimant on April 16, 2025. Id. at p. 8, ll. 20-24. As part of his IME, Dr. Chen took a history from Claimant, watched the video footage of the incident, and reviewed Claimant's medical records, including the imaging studies and the DIME report of Dr. Rook. Id. at p. 9, ll. 2-17.

36. Concerning Claimant's imaging, Dr. Chen testified that the primary concern was a possible pars defect at L5. (Depo. Tr. Dr. Chen, p. 9, ll. 22-24). He noted that there was no evidence of spinal instability, which was important because instability can cause pain. Id. at p. 10, ll. 1-2. Dr. Chen also noted that the MRI demonstrated minimal to mild finding which were consistent with a 20-year-old male. According to Dr. Chen, the "biggest" thing was the lack of any sort of acute findings on imaging, including bruising, swelling or inflammation to suggest that there was an "objective or pathologic aggravation of the chronic findings revealed on Claimant's imaging. Id. at p. 11, ll. 2-7. Dr. Chen disagreed with Dr. Castrejon's opinion that Claimant's pre-existing lumbar spine condition was aggravated by the mechanism of injury in this case. Indeed, Dr. Chen testified:

> So, Dr. Castrejon testified that his diagnosis was that the spondylolisthesis, this was preexisting, but it was also aggravated by this July 14th injury. Do you agree with that? No. And I -- I think -- you know, reading through his testimony -- again, I can't speak for him -- but it seems like he was going off the word that, you know, this claimant was made worse. And so that's kind of where he based his opinion off of. So, when I do my exams and I read the records, you know, I take the claimant's subjective complaints as one data point. But it should be backed up, in my mind, at least -- in my opinion, at least, it should be backed up with something objective. And so, if there is truly an "aggravation" -- and that word means it was made worse, right? If there is truly worsening, I need to see that, you know? And he is a young guy, you know, the claimant. His body would react to a change in his anatomy. You are essentially telling me that this

> action rearranged and worsened his anatomy. And so, it would be odd that the body does nothing, the body doesn't respond at all, doesn't bring in the white blood cells, doesn't bring in blood products, doesn't try and clean up the mess, right? And so, in my mind, on this MRI, which, again, is done in a decent timeframe, I don't see any evidence of the aggravation that Dr. Castrejon is speaking of.

(Depo. Tr. Dr. Chen, p. 12, ll. 9-25, p. 13, ll. 1-10).

37. Dr. Chen testified that if there was an aggravation of a preexisting condition, this would have been evidenced in the diagnostics, particularly the MRI, which was done "in a decent timeframe" from the injury. (Depo. Tr. Dr. Chen, p. 13, ll. 7-13). Dr. Chen testified the MRI would have shown effusion or edema if there was an injury to the pars, or language reflecting a traumatic condition (e.g. disc herniation, annular tear, facet injury, etc.) that is absent on the MRI. Id. at pp. 13-14. Indeed, Dr. Chen testified that there was nothing on the MRI to suggest there was any evidence of ligamentous damage or blunt force trauma to correspond with any injury seen on the video. Id. at pp. 14-15.

38. Based upon his testimony the ALJ infers that Dr. Chen believes that there must be some objective evidence of pathology and/or trauma, i.e. anatomic structural disruption, bruising, swelling (effusion) or inflammation on imaging and this must be correlated with any subjective complaints in order to conclude that there was an aggravation of a pre-existing condition.

39. While he testified that he was not a biomechanical expert, Dr. Chen opined that the mechanism of injury (MOI) in this case was not "gentle." (Depo. Tr. Dr. Chen, p. 18, ll. 9-11). He characterized the MOI as the equivalent to getting tackled. Id. at p. 18, ll. 11-12. In being advised that Dr. Castrejon felt that the MOI involved forces sufficient to aggravate Claimant's pre-existing low back condition, Dr. Chen testified that if a disc were compromised sufficiently, a sneeze could cause a herniation. Id. at p. 18, ll. 18-23. In keeping with this concept, Dr. Chen testified that the force associated with the MOI in this

case was “certainly enough, I think, just like the sneeze, to . . . cause that aggravation, for sure. Id. at p. 18, l. 25, p. 19, ll. 1-3. Nonetheless, Dr. Chen testified that he just didn’t see it in this case. Id. at p. 19, l.13.

40. Dr. Chen testified that there are three types of listhesis, including degenerative, traumatic, and congenital. (Depo. Tr. Dr. Chen, p. 20, ll. 19-24). Dr. Chen testified that, unlike traumatic listhesis, which disrupts multiple structures in the back, a degenerative listhesis is something people can live with and not even know that they have it. Id. at p. 20, l. 25, p. 21-22, ll. 1-22. Indeed, Dr. Chen testified that a lot of degenerative listhesis are asymptomatic. Id. at p. 22, l. 22. Based upon the evidence presented, the ALJ finds that Claimant probably had a congenital (developmental) pars defect, which probably caused a pre-existing, stable and asymptomatic listhesis at the time of the July 14, 2024, parking lot incident where he was hit in the back by a SUV backing out of a parking space. The ALJ is also convinced that Claimant had other asymptomatic degenerative conditions throughout the lumbar spine which pre-dated the July 14, 20-24 incident. See generally, RHE I; Depo. Tr. Dr. Chen, p. 36, l. 25, p. 37, ll. 1-19).

41. Dr. Chen testified that Dr. Rook was clearly in error in stating that flexion/extension x-rays had not been done. (Depo. Tr. Dr. Chen, p. 24, ll. 17-20). Nonetheless, Dr. Chen added: “. . . I don’t know if he missed it or if he just didn’t get it. Sometimes you are only as good as the information you have. And maybe he didn’t have all of the information. So . . . he misstated or – I don’t know if he misstated, but he – he didn’t realize, for whatever reason, that that study was already done. Id. at p. 24, ll. 20-25, p. 25, ll. 1-2. Regarding Claimant’s need for additional diagnostic workup and treatment, Dr. Chen deferred to the treating physician given the familiarity with the patient history in treatment recommendations, including referral for specialist evaluation. Id. at p. 25, ll. 17-25, pp. 26-27, ll. 1-3. Dr. Chen agreed there was no need for further treatment or diagnostics. Id. at p. 27, ll. 4-25, p. 28, ll. 1-22. Accordingly, Dr. Chen opined that Dr. Rook erred in not finding Claimant at MMI. Id. at p. 28, ll. 23-25.

42. Dr. Chen opined that Claimant did not qualify for a rating because the

spondylolisthesis that served as a basis for the DIME rating was unrelated to the claim. (Depo. Tr. Dr. Chen, p. 30, ll. 23-25, p. 31, l. 1).

Conclusions of Law

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

Generally

A. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. 2007, et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

B. In accordance with §8-43-215 C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. See *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Overcoming Dr. Rook's MMI and Impairment Rating Determinations Generally

C. Pursuant to § 8-42-107(8), C.R.S., a DIME physician's opinions concerning MMI and permanent medical impairment are binding unless overcome by clear and convincing evidence. Clear and convincing" evidence has been defined as evidence

which demonstrates that it is “highly probable” the DIME physician’s rating is incorrect. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In other words, to overcome a DIME physician's opinion regarding permanent medical impairment, the party challenging the DIME must demonstrate that the physician’s determinations in this regard is highly probably incorrect and this evidence must be “unmistakable and free from serious or substantial doubt.” *Leming v. Industrial Claim Appeals Office,* 62 P.3d 1015, 1019 (Colo. App. 2002). *Adams v. Sealy, Inc.*, W.C. No. 4-476-254 (ICAP, Oct. 4, 2001). The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appears Office,* 961 P.2d 590 (Colo. App. 1998). Further, C.R.S. § 8-42-107(8)(c) *presumes* the physician followed his/her directive to assign an impairment rating in accordance with the *AMA Guides*, thereby making their rating correct. *Rodriguez v. Domino’s Pizza Inc. and Am. Home Assurance*, W.C. No. 4-467-433 at 3 (ICAO, Aug. 30, 2002).

Causation- Applicable Burden of Proof Regarding the Cause of Claimant’s Low Back Symptoms

D. The determination of permanent impairment requires the DIME physician to assess, as a matter of diagnosis, whether the various components of the claimant's medical condition are causally related to the alleged industrial injury. See *Qual-Med, Inc. v. Industrial Claim Appeals Office*, supra; *Mosley v. Industrial Claim Appeals Office,* 78 P.3d 1150 (Colo. App. 2003). The rating physician’s determination concerning the cause or causes of impairment should include an assessment of data collected during a clinical evaluation and the mere existence of impairment does not create a presumption of contribution by a factor with which impairment is often associated. *Wackenhut Corp. v. Industrial Claim Appeals Office,* 17 P.3d 202 (Colo. App. 2000). Consequently, when a party challenges the DIME physician’s determination of MMI or permanent impairment, the Colorado Court of Appeals has recognized that a DIME physician’s determination on causation is also entitled to presumptive weight. *See*, *e.g.*: *Qual-Med*, 961 P.2d at 592 (1998); *Egan v. Indus. Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998); *Cordova*,

55 P.3d at 190 (2002); *Leprino Foods*, 134 P.3d at 482-83 (2005); *Denham v. L & L Disposal*, W.C. No. 4-891-278-04 at 5 (ICAO, June 18, 2015). However, in recent years, an apparent split of authority has emerged regarding the burden of proof necessary to overcome a DIME physician's opinion concerning what medical conditions(s) are causally related to a claimant's industrial injury. Indeed, a few appellate court panels have held that a DIME physician's opinion on causation is *not* entitled to presumptive weight and, therefore, only needs to be overcome by clearing the lower hurdle of "a preponderance of the evidence." *See*, *e.g.*: *Yeutter v. Indus. Claim Appeals Office*, 487 P.3d 1007, 1012 (Colo. App. 2019); *Peitz v. Bd. of Water Works of Pueblo and Travelers Casualty & Surety Co.*, W.C. No. 5-142-174 (ICAO, Jan. 22, 2024), *rev'd sub nom. on other grounds*, *Peitz v. Indus. Claim Appeals Office*, 560 P.3d 982 (Colo. App. 2024).

E. This ALJ has reviewed, analyzed, and considered this apparent split of authority. The *Yeutter* court appears to indicate that a DIME physician's opinion on causation should receive presumptive weight in *some* cases, but not others. *See Yeutter*, 487 P.3d at 1013 (holding that *Leprino Foods, supra* "does not stand for the proposition that a DIME's opinion on causation *always* carries presumptive weight). For example, it noted that the *Leprino Foods* court *did* give presumptive weight to a DIME physician's opinion that a claimant's shoulder injury was causally related to his elbow injury, because the issue was not whether the claimant had sustained an injury *at all*, but the *extent* of his admitted injury, and whether he had reached MMI for *all* related injuries. *See Yeutter*, 487 P.3d at 1012-13; *Leprino Foods*, 134 P.3d at 482-83. As another example, it noted that the *Cordova* court decided *against* giving presumptive weight to a post-FAL, post-claim closure DIME physician's opinion that the claimant's post-MMI surgery and complications were causally related to his back injury, because the issue was not whether the claimant had reached MMI, but whether his condition had *worsened*, which would justify reopening for further benefits. *See Yeutter*, 487 P.3d at 1013; *Cordova*, 55 P.3d at 190.

F. Upon careful review, the ALJ is convinced that the *Yeutter* court distinguished the claim claims presented from those raised in *Cordova* and *Leprino Foods* based on the issues involved. Based on that analysis, the *Yeutter* court applied the *lower* burden of

proof to the DIME physician's opinion that the claimant's narcolepsy was causally related to his head injury because it reasoned that the issues for hearing were permanent total disability and maintenance medical benefits, and neither required "examining" the physician's MMI or impairment rating opinions. *Yeutter*, 487 P.3d at 1013-14. Based upon these factors, this ALJ concludes that the *Yeutter* court might have ruled differently if MMI and/or permanent impairment were at issue, as they are in the instant claim.

G. After careful consideration, this ALJ does not interpret *Yeutter*, *Pietz*, and similar cases as representing a split in authority from *Cordova, Leprino Foods*, and their progeny. Rather, the ALJ interprets those cases, i.e. *Cordova, Leprino Foods* as being consistent in holding that a DIME physician's opinion on causation *is* entitled presumptive weight, *if* the causation opinion is "inextricably tied" to MMI or impairment. *See Yeutter*, 487 P.3d at 1012. The issue with regard to overcoming the DIME in this case is whether Dr. Rook erred in opining that Claimant is not at MMI on the basis that the July 14, 2024 accident aggravated a pre-existing spondylosis and spondylolisthesis, causing his persistent symptoms, which Dr. Rook concluded required additional workup and treatment before placing Claimant at MMI. Here, Dr. Rook's opinion regarding MMI and impairment is "inextricably tied" to his opinion concerning the cause of Claimant's persistent low back pain and need for additional treatment. Therefore, the ALJ concludes, in keeping with the principles announced in *Leprino,* that Respondents must present evidence demonstrating that Dr. Rook's opinion regarding the cause of Claimant's low back symptoms/condition is highly probably incorrect to overcome his opinions regarding MMI and impairment.

Factual Considerations in Overcoming Dr. Rook's MMI Determination

H. The question of whether the Claimant has overcome the DIME physician's findings regarding causality, MMI and impairment is one of fact for the ALJ's determination. *See Metro Moving and Storage Co. v Gussert,* 914 P.2d 411 (Colo. App. 1995). In deciding whether Claimant has met his burden of proof, the ALJ is empowered, "[t]o resolve conflicts in the evidence, make credibility determinations, determine the

weight to be accorded to testimony, and draw plausible inferences from the evidence." *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). Moreover, the ALJ may consider a variety of factors including whether the DIME physician properly applied the AMA Guides and other rating protocols. *See Metro Moving and Storage Co. v Gussert,* 914 P.2d 411 (Colo. App. 1995); *Wackenhut Corp. v. Indus. Claim Appeals Office*, 17 P.3d 2002 (Colo. App. 2000); *Aldabbas v. Ultramar Diamond Shamrock*, W.C. No. 4-574-397 (ICAO August 18, 2004). The ALJ should also consider all of the DIME physician's written and oral testimony. *Lambert and Sons, Inc. v. Industrial Claim Appeals Office,* 984 P.2d 656, 659 (Colo. App. 1998).

I. MMI is defined as the "the point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." Section 8-40-201(11.5), C.R.S. In this case, Respondents contend that Dr. Rook erred in concluding that Claimant had not reached MMI when he concluded that Claimant needed further diagnostic workup and treatment to assess "objective abnormalities at the L5-S1 level where there was a spondylolysis associated with grade 1 spondylolisthesis. Dr. Rook considered the need for additional work-up and treatment, at the very least, to be causally related to the July 14, 2024, incident by means of an aggravation of a pre-existing, yet asymptomatic condition, i.e. the aforementioned spondylosis and spondylolisthesis. The ALJ is not persuaded that Dr. Rook erred.

J. Based upon the evidence presented, the ALJ concludes that there is a general consensus among the medical professionals who have evaluated or treated the Claimant that he suffers from a pars defect and a spondylolisthesis. Nonetheless, there is a considerable dispute as to whether the July 14, 2024, incident aggravated Claimant's underlying condition resulting in the need for additional diagnostic work-up and treatment to cure and relieve Claimant of his persistent low back symptoms and dysfunction. On one hand, Drs. Rook and Castrejon contend that the MOI in this case was sufficient to

aggravate Claimant's underlying low back condition that was previously asymptomatic.[4] Because Claimant was asymptomatic prior to July 14, 2024, and remained symptomatic at their respective IMEs, both Dr. Rook and Dr. Castrejon relate Claimant current need for additional work-up and treatment to the parking lot incident. On Respondents' side, Dr. Chen argues that the July 14, 2024, incident did not cause or aggravate Claimant's underlying spondylosis and spondylolisthesis. In essence, Dr. Chen contends that Claimant did not suffer an injury beyond a lumbar contusion and strain and even that diagnosis was not really supported by objective findings. (RHE E, p. 32). Regarding the condition of Claimant's lumbar spine, Dr. Chen noted: "The diagnoses of degenerative disc disease, facet arthritis as well as degenerative spondylolisthesis with a pars defect was what was seen on MRI; these were certainly verified by objective findings." Id. Although Dr. Chen agrees that Claimant has a "decent" amount of degeneration in his lumbar spine", he asserts that the MOI in this case did not aggravate Claimant's underlying spinal condition.

K. In support of his argument that Claimant did not aggravate the pre-existing degeneration, including the spondylolisthesis in his lumbar spine, Dr. Chen points to Claimant MRI, which he asserts fails to demonstrate any objective evidence of a traumatic aggravation, including anatomic structural disruption, bruising, swelling (effusion) or inflammation, which would have been evident had there been any aggravation of the spondylolisthesis. Because there was no objective evidence of such aggravation, Respondents contend that Drs. Rook and Castrejon erred in concluding that the MOI in this case aggravated a previously asymptomatic condition in this case. Indeed, Respondents assert that both Drs. Rook and Castrejon speculated that there was an aggravation when the same was not supported by the diagnostic imaging.

L. Respondents also maintain that Dr. Rook erred the DIME erred in omitting review of the lumbar flexion-extension x-ray showing no instability, which was performed just over two weeks after the injury. Dr. Rook included review of the August 1, 2024,

[4] A contention that is supported by the paucity of evidence establishing that Claimant was treated for low back pain/complaints in the weeks or months prior to being struck from behind on July 14, 2024.

Concentra report in his summary but omitted review of the x-ray findings on that date. Dr. Rook likewise included the August 13, 2024, record in his summary, which recited the August 1st x-ray findings, but omitted these specific findings from his review. Respondents assert that the primary basis that Dr. Rook concluded that Claimant was not at MMI was because he needed further assessment of the spondylolisthesis, specifically to test for instability with flexion and extension x-rays. Because this study had been performed and demonstrated the spine to be stable, Respondents argue that Dr. Rook erred and his MMI determination should be set aside. While the ALJ agrees that Dr. Rook erred in concluding that Claimant required further diagnostic work-up to assess the stability of the lumbar spine, the ALJ reads Dr. Rook's DIME report to indicate a second basis for his conclusion that that Claimant was not at MMI, namely because Claimant remained symptomatic and was released at MMI without first undergoing spinal injection therapy, including facet injections, diagnostic injections into the spondylosis and a left L3 nerve root block. The ALJ infers from Dr. Rook's DIME report and the testimony of Dr. Chen that questions remain as to Claimant's pain generator. Indeed, Dr. Chen testified in response to whether Claimant's pain generator could be something beside the pars defect, that it (Claimant's pain) could be all the things that are degenerative in the spine, which is why it is so hard to treat back pain. (Depo. Tr. Dr. Chen, p. 37, ll. 15-25, p. 38, ll. 1-9).

M. As presented, the evidence persuades the ALJ that Claimant probably suffered from a latent pre-existing condition which became symptomatic after being hit by a car in Employer's parking lot on July 14, 2024. Such injuries constitute compensable aggravations of pre-existing conditions. See, *Subsequent Injury Fund v. Devore*, 780 P.2d 39 (Colo. App. 1989); *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986). While Dr. Chen suggests that there must be some quantum of objective evidence such as effusion, bruising, anatomic structural disruption or inflammation on imaging to support a conclusion that there has been an aggravation of a pre-existing condition, this ALJ is unaware of any such requirement and Respondents cited no legal authority for this proposition. To the contrary, it is well established that a trigger of symptoms from a dormant condition will qualify as a compensable aggravation. See e.g., *Industrial*

Commission v. Pacific Employer's Insurance Company, 128 Colo. 411, 262 P.2d 926 (1953).

N. Recommendations for future treatment have been discussed by the courts in the context of whether a Claimant is at MMI. "A recommendation for therapies which present a reasonable prospect for improving physical function may be viewed as evidence that the claimant's condition is not stable, and the resulting impairment is not measurable. Therefore, such treatment recommendations are inconsistent with MMI…." *Gebert v. Nordstrom, Inc.*, W.C. No. 4-428-645 (ICAO, June 20, 2003). In this case, the ALJ is convinced that Claimant's need for additional lumbar spine treatment is directly related to an aggravation of a pre-existing condition resulting from Claimant being struck in the back by a moving vehicle on July 14, 2024. Because this treatment has not been afforded and it presents a reasonable prospect for curing and relieving Claimant of the ongoing effects caused by the aggravation of his pre-existing degenerative spinal condition, the ALJ agrees that Claimant is not at MMI. See *Eby v. Wal-Mart Stores, Inc.*, W.C. No. 4-350-176 (February 14, 2001), *aff'd. Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, (Colo. App. No. 01CA0401, February 14, 2002)(*not selected for publication)* (citing *PDM Molding v. Stanberg,* 898 P.2d 542 (Colo. App. 1995*)* and *Colorado AFL-CIO v. Donlon*, 914 P.2d 396 (Colo. App. 1995)]; *Hatch v. John H. Harland Co.,* W.C. No. 4-368-712 (August 11, 2000).

O. To the extent that Dr. Chen's opinions concerning causality, and therefore MMI, diverge from those expressed by Dr. Rook and Dr. Castrejon, the ALJ concludes those discrepancies constitute a professional difference of opinion. Differences of opinion between physicians is common and does not rise to the level of clear and convincing evidence that is required to overcome Dr. Rook's opinion concerning MMI. *See generally, Gonzales v. Browning Farris Indust. of Colorado, W.C. No. 4-350-356 (ICAO March 22, 2000)* fails to constitute error pursuant to well-settled case law. See, *Gonzales v. Browning Farris Indust. of Colorado*, W.C. No. 4-350-356 (ICAO March 22, 2000). After considering the totality of the evidence presented, the ALJ concludes that Respondents have failed to produce unmistakable evidence establishing that the DIME physician's

determination regarding causation and MMI is highly probably incorrect. Consequently, Respondents request to set aside Dr. Rook's MMI determination must be denied and dismissed. Because Respondents have failed to meet the required legal burden to set Dr. Rook's opinion regarding MMI aside, the determination regarding Claimant's degree of permanent impairment is premature and need not be addressed further.

Medical Benefits

P. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. Because MMI is largely a medical determination heavily dependent on the opinions of medical experts, the ALJ concludes that it is necessary to return Claimant to his authorized providers for referral to the appropriate provider(s) for completion of the necessary injection therapy to bring Claimant to MMI.

Order

It is therefore ordered that:

1. Respondents request to set aside the DIME opinions of Dr. Rook regarding causation and MMI is denied and dismissed. Claimant is not at MMI. Respondents shall return Claimant to Dr. Dombro for referral to the appropriate provider(s) for provision of the additional injection therapy recommended by Dr. Rook so that Claimant may appropriately achieve MMI.

2. All matters not determined herein are reserved for future determination.

Dated: October 22, 2025

/s/ Richard M. Lamphere_____

Richard M. Lamphere
Administrative Law Judge

NOTE: If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not be mailed to the Denver Office of Administrative Courts. For statutory reference, see Section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

Office of Administrative Courts

State of Colorado

Workers' Compensation No. WC 5-176-695-008

Issues

- Whether Claimant established, by a preponderance of the evidence, that his need for a right thumb ulnar collateral ligament repair surgery was reasonable, necessary and related to his February 13, 2024, work-related slip and fall.

- Whether Claimant proved, by a preponderance of the evidence, that he is entitled to temporary total disability (TTD) benefits from September 16, 2024 – November 13, 2024.

- Whether Claimant established, by a preponderance of the evidence, that he is entitled to permanent partial disability (PPD) consistent with a report of maximum medical improvement (MMI) and impairment completed by Dr. Thomas Centi on December 9, 2024.

Although disfigurement was endorsed as an issue for hearing, Claimant did not ask the ALJ to view any scarring associated with his right hand/thumb surgery. Consequently, no evidence concerning disfigurement was presented to the ALJ and this order does not address that issue.

Findings of Fact

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

Background and Claimant's February 13, 2024, Work Injury

1. Claimant works for Employer as an Assembler I. He cuts and bends copper pipe as part of Employer's cooling tower manufacturing process. Claimant testified that he made $17.00 or $18.00 an hour and worked 40 – 50 plus hours per week.

2. On February 13, 2024, Claimant was returning to work from his lunch break, which he took while sitting in his car in the employer's parking lot. Claimant testified that he was short on time in returning to work from his car and while rushing back into the plant, he tripped on the sidewalk and fell forward onto his hands and knees.

3. Claimant testified that he fell hard, landing mostly on his extended right hand.

4. Claimant reported the incident to his supervisor and was directed to see Employer's onsite nurse. According to Claimant, the nurse provided him with an Ace wrap and biofreeze and referred him to Employer's designated provider at the Southern Colorado Clinic.

5. Claimant was first evaluated by Nurse Practitioner (NP) Edith Reichert at the Southern Colorado Clinic on February 13, 2024, at 3:14 p.m. (CHE 6, p. 21). Physical examination of the right hand/digits revealed, "tenderness of the soft tissue dorsal aspect, the soft tissue of the palmer prominence, and the soft tissue palmer aspect. *Id*. at 24. The right thumb was tender at the first metacarpal, the MCP joint and proximal phalanx. *Id.* X-rays of the right hand were ordered with specific instructions to include the thumb. *Id*. at 25. The results of Claimant's x-rays from this visit were not included in the documentation from this visit. Nonetheless, a separate report outlining the results of Claimant's February 13, 2024, right hand x-ray was admitted into evidence. This report reveals that Claimant's x-ray findings were consistent with a "[p]robable old DRUJ injury with dorsal subluxation of the distal ulna" and "[d]egenerative change of the base of the thumb." (CHE 7, p. 129).

6. Claimant returned to the clinic on February 15, 2024, where he was

evaluated by Dr. Thomas Centi. (CHE 6, p. 30). Dr. Centi noted that Claimant's x-rays were negative and that he was feeling better overall, but that his right hand and wrist were hurting, especially when "grabbing, lifting or pushing." Examination of the right hand revealed "mild" edema and tenderness at the base of the thumb and wrist. *Id*. Dr. Centi referred Claimant to occupational therapy, applied a thumb spica splint and returned Claimant to modified duty work. *Id*.

7. An MRI of the right hand/thumb was ordered and completed on March 7, 2024. (CHE 7, p. 133). This imaging revealed mild joint space narrowing and hypertrophy in the distal interphalangeal joints (finger joints) of the right hand. There was also erosion of the second and third metacarpal heads and similar smaller erosions of the triquetrum, lunate, capitate and hamate bones with diffuse synovitis of the right wrist. Regarding the thumb, there was joint space narrowing, joint effusion and subchondral cysts versus erosions in the first carpometacarpal (CMC) joint at the base of the thumb along with subluxation of the first CMC joint suggesting a torn collateral ligament. Based upon these findings, Dr. Charles Domson opined that Claimant had: "Moderate to severe degenerative osteoarthritis in the first carpometacarpal joint at the base of the thumb with subchondral cysts, edema and possible erosions." (CHE 7, p. 133). He also concluded that there was "mild subluxation with [a] torn medial collateral ligament, which [was] likely chronic." *Id.* However, Dr. Domson specifically noted that the age of this tear was "indeterminate." *Id.* Finally, this MRI demonstrated, "Erosions in the second and third metacarpal heads and in the wrist with synovitis suggesting rheumatoid arthritis." *Id.*

8. On March 8, 2024, Dr. Centi noted that Claimant's MRI revealed "moderate DJD (degenerative joint disease), medial collateral ligament subluxation, possible chronic. (CHE 6, p. 45). He referred Claimant to orthopedics for evaluation. *Id.*

9. Claimant was evaluated by Dr. Dale Cassidy at Colorado Springs Orthopedic Group on April 16, 2024. (CHE 9, p. 146). During this evaluation, Claimant reported 5/10, constant, dull, aching and throbbing hand pain, which was waking him from sleep and worse with thumb flexion. *Id.* Claimant reported no history of prior thumb

injuries. *Id*. Dr. Cassidy noted that Claimant's MRI revealed a "tear in the ligament and arthritis. Id. He also noted that "[d]espite immobilization of the thumb for a period of 2 months, the pain persists." *Id.* Finally, Dr. Cassidy noted that Claimant was aware of "some thumb arthritis for some time." *Id.*

10. Physical examination of the right thumb revealed swelling (edema) over the ulnar aspect of the thumb at the MP joint" along with "signs of basilar joint enlargement", which Dr. Cassidy noted was "consistent with osteoarthritis." (CHE 9, p. 147). Claimant was tender at the basilar joint and reported pain with grind test and circumduction. *Id.* He also reported pain with stress of the ulnar collateral ligament and there was laxiety in both full and 30 degrees of flexion of the thumb suggesting a complete tear of the ligament. *Id*. Based upon his records review and examination findings, Dr. Cassidy concluded that Claimant was suffering from "CMC arthritis of the thumb" and "Right thumb UCL tear/complete. *Id*. at 148. Dr. Cassidy noted that while Claimant's MRI was rather inconclusive due to motion artifact, his clinical examination (supporting the diagnostic impression of a complete UCL tear) was quite clear. *Id.*

11. Dr. Cassidy informed Claimant that the arthritis at the base of his thumb was not directly related to the injury. (CHE 9, p. 148). While he noted that a steroid injection could be considered to treat Claimant's arthritis, Dr. Cassidy opined that Claimant's young age was a contraindication to surgical intervention for his arthritis. *Id.* Although surgical intervention for Claimant's arthritis was not advisable, Dr. Cassidy recommended surgical intervention for Claimant's right thumb. *Id*. He then requested pre-authorization to proceed with a right thumb UCL repair. *Id.* at 148-150.

12. Following Dr. Cassidy's request for pre-authorization, Insurer sought an independent radiology review of Claimant's right-hand MRI obtained March 7, 2024. (RHE F). The review was completed by Dr. Sheldon Feit, a Board-Certified Radiologist on May 1, 2024. (See RHE F). In his May 1, 2024, report, Dr. Feit noted that Claimant's March 7, 2024, right hand MRI demonstrated "extensive marrow edema within the first metacarpal bone of the right hand, which he concluded was "compatible with bone

contusion." *Id*. at 43. Cystic changes were also observed at the base of the first metacarpal as well as the trapezium. *Id.* No evidence of tendinitis, tenosynovitis or other form of tendinopathy was visualized and the visualized collateral ligaments and musculature were deemed intact. Id. Dr. Feit reached the following impression upon completion of his MRI review: 1. No evidence of fracture. 2. Bone contusion within the first metacarpal. 3. Degenerative Change. In conclusion, Dr. Feit noted:

> Review of the MRI of the right hand obtained just over three weeks following the date of injury demonstrates some underlying degenerative osteoarthritis. There is marrow edema within the first metacarpal shaft compatible with bone contusion without fracture. Assuming appropriate clinical symptomology, the finding would be posttraumatic and related to the injury on 2/13/2024.

Id. at 44.

13. On May 2, 2024, Dr. Qing-Min Chen conducted a review of Claimant's medical records at Respondents' request. (RHE G). Respondents forwarded specific questions to Dr. Chen in a cover letter that he answered as part of his May 2, 2024, report. *Id*. at 47-48. According to Dr. Chen, Claimant's "current condition is 100 percent chronic and preexisting in nature." Dr. Chen opined that the MRI read by Dr. Domson revealed that "everything on that MRI is chronic and degenerative or due to rheumatoid arthritis, given the erosions and synovitis across the second and third metacarpal head." *Id.* at 47. There is no indication that Dr. Chen reviewed the film from Claimant's March 7, 2024, MRI. To the contrary, it appears that Dr. Chen simply reviewed Dr. Domson's March 7, 2024, MRI report to reach his conclusions. Regardless, Dr. Chen opined that he did not see an indication for the requested right thumb UCL repair, noting instead that in this particular case, Claimant's "ligament injury across the CMC is due to a chronically torn MCL, but it is also due to his severe osteoarthritis." *Id.* Dr. Chen explained:

> As the joint space collapses, it causes laxity. There is no evidence that this MCL tear is acute. This is also the conclusion by Dr. Domson, which he mentions in the [MRI] report.[1] There is no indication for this procedure. This procedure is not medically reasonable or necessary. We do not perform ligament repair for the CMC in the setting of severe arthritis; we have to do something for the arthritis, which is the main issue here. The need for that particular procedure (UCL repair) is not related, as it is 100 percent due to preexisting conditions.

Id. at 47.

14. Dr. Chen also opined that Claimant's February 13, 2024, fall did not exacerbate or aggravate any pre-existing condition in Claimant's right hand/wrist. (RHE G, p. 47). In support of his opinion, Dr. Chen noted that there was no fracture, acute ligament tear or any evidence of subchondral injury to the cartilaginous surfaces in the right hand. *Id.* According to Dr. Chen, the findings on imaging are 100 percent due to the natural progression of Claimant's underlying disease process. *Id*. at 48. As such, Dr. Chen concluded that Claimant's hand/thumb pain (symptoms) are likely due to the natural progression of his pre-existing arthritis with no evidence of aggravation from his February 13, 2024, trip and fall.

15. Because there was no indication that Dr. Chen had reviewed Dr. Feit's independent radiological review dated May 1, 2024, the report was sent directly to Dr. Chen for comment by Melissa Conover, Insurers Claim Representative. Dr. Chen

[1] While Dr. Chen believes that the MCL tear was not acute, the ALJ notes that the MRI was not obtained for approximately 3 weeks post injury. Moreover, careful review of the MRI report of Dr. Domson does not actually indicate that the tear was not acute. Rather, Dr. Domson simply noted that there was some subluxation with in the first carpometacarpal joint suggesting a torn medial collateral ligament which was "likely" chronic. Nonetheless, he was unable to determine the age of the tear. Accordingly, the ALJ finds that Dr. Chen has mischaracterized the opinion of Dr. Domson regarding the age of Claimant's ligament tear. Because there was no imaging establishing the presence of this tear pre-injury, the ALJ finds the opinion of Dr. Domson that the age of the tear was indeterminate more persuasive than the conclusion of Dr. Chen that the tear was not acute.

commented by way of a report dated May 13, 2024. (RHE G, p. 50). In his May 13, 2024, report, Dr. Chen noted that because Dr. Feit concluded that the March 7, 2024, MRI did not demonstrate any injury to the ligaments, there was "definitely no indication for ligament repair." *Id.* Regarding Dr. Feit's conclusion that Claimant's MRI findings were consistent with a traumatic bone bruise, Dr. Chen noted:

> I have already opined that the claimant sustained a right hand and wrist contusion. I would then further clarify and state that after Dr. Feit's analysis, the claimant has a right thumb metacarpal contusion that is related that should have healed within 3 months of the injury; so, May 13, 2024.

Id.

16. As noted, Dr. Chen opined that there was no evidence in Dr. Feit's report that Claimant's pre-existing conditions were aggravated. (RHE G, p. 50). Accordingly, beyond acknowledging that Claimant may have sustained a right thumb bone contusion in the fall, Dr. Chen noted the "rest of [his] opinions [were] unchanged. *Id.*

17. Claimant was reevaluated by Dr. Centi on May 31, 2024. (CHE 6, p. 77). Dr. Centi noted that Claimant had been seen by orthopedics who had recommended a surgical repair and that Claimant was still waiting for a scheduled date to proceed as the requested surgery was "currently being denied by insurance carrier." *Id.*

18. On June 26, 2024, Claimant reported to Employer's onsite nurse (Bonnie Gandy-Roman) that he did not feel his hand would heal without surgery. He then asked Ms. Gandy-Roman how to use his private insurance for coverage. (RHE A, p. 10). Ms. Gandy-Roman referred Claimant to HR (Human Resources) for assistance. *Id*.

19. During a follow-up appointment on July 26, 2024, Dr. Centi noted that

Claimant was scheduled for surgery on "8/6/2024" (CHE 6, p. 89). Dr. Centi did not identify who was to perform the surgery or whether it was scheduled through workers' compensation. *Id*. Nonetheless, Dr. Centi indicated Claimant would be taken off work on 8/6/2024. *Id*.

20. On August 1, 2024, Claimant presented to Ms. Gandy-Roman for "first aid" (RHE A, p. 11). During this encounter, Claimant reported no improvement since his last visit to the RN. *Id.* While Claimant reported no improvement in his symptoms/condition, there is no indication that he advised Ms. Gandy-Roman that he was scheduled to proceed with surgery on 8/6/2024. *Id.*

21. On August 5, 2024, Insurer filed a General Admission of Liability (GAL) admitting liability for a right-hand contusion, bilateral knee contusion and lumbar strain. (CHE 2, p. 4). The GAL was filed as a "Medical only Claim" as Claimant had lost no time from work by this date. *Id.*

22. On August 6, 2024, Ms. Gandy-Roman noted that Claimant was "off work due to an upcoming surgery on his right hand." (RHE A, p. 11). Ms. Gandy-Roman noted that Claimant had "chosen to utilize private insurance for the surgery."[2] *Id*. No employment records were submitted to establish that Claimant left work on August 6, 2024. Instead, Claimant simply testified that he left work and tried to secure FMLI benefits. Based upon the evidence presented, the ALJ is convinced that Claimant did not undergo surgery on August 6, 2024. Indeed, the record evidence supports a finding that Claimant's surgery was rescheduled for 8/30/2024. (CHE 6, p. 94).

23. On August 29, 2024, Ms. Gandy-Roman noted that Claimant's supervisor had stopped by the first aid office to inquire if she had heard from Claimant. (RHE A, p. 11). Ms. Gandy-Roman reported that she had not heard from Claimant since 8/1/2024,

[2] Based upon the evidence presented, the ALJ is convinced that Claimant self-referred to Dr. Chance Henderson at the Orthopedic Centers of Colorado for surgery.

and reminded the supervisor that Claimant had to provide a return-to-work form in order to resume work following surgery. *Id.*

24. While the medical records indicate that surgery was scheduled for August 30, 2024, Claimant testified that he underwent a bone fusion procedure at the base of his right thumb on September 16, 2024. No surgical report was submitted for review. Consequently, the date of Claimant's right thumb surgery cannot be independently verified. However, the ALJ credits Claimant's testimony to find that he probably underwent surgery directed to the right thumb on September 16, 2024, as performed by Dr. Chance Henderson at the Orthopedic Centers of Colorado. The ALJ credits Claimant's testimony and the medical report from Dr. Cassidy to find that the surgery performed by Dr. Henderson was reasonable and necessary to cure and relieve Claimant's from the effects of his persistent hand/thumb pain and dysfunction.

25. Claimant testified that he underwent surgery with Dr. Henderson because his symptoms were not improving with conservative care. He testified that he felt compelled to seek the surgery through his health insurance because he was in pain and couldn't work. Contrary to Claimant's testimony, the record evidence supports a finding that Claimant has working modified duty and did not miss any work due to the effects of his work injury until his 9/16/2024 surgery. Claimant did not present any attendance or wage records as evidence in support of any claim for lost wages prior to September 16, 2024.

26. Based upon the evidence presented, the ALJ is not convinced that Claimant was experiencing lost time from work due to the effects of the injuries he sustained in association with his February 13, 2024, trip and fall prior to September 16, 2024. Indeed, the ALJ credits the medical records and Claimant's testimony to find that Employer had been and was consistently accommodating Claimant's work restrictions, and he was working modified duty until he decided to volitionally leave work in an attempt to secure FMLI benefits, probably around August 6, 2024. While the medical records substantiate that Dr. Centi removed Claimant from work on August 6, 2024, the ALJ finds this removal

from work based upon Dr. Centi's understanding that Claimant was to have surgery on this date. As presented, the evidence persuades the ALJ that Claimant did not experience a wage loss associated with his February 13, 2024, work injury until he underwent surgery on September 16, 2024.

27. Dr. Henderson authored a letter dated September 18, 2024, noting that Claimant was a patient in their office, that he had recently undergone surgery and was being seen under his personal insurance (Blue-Cross/Blue Shield) because his treatment was not due to a workers' compensation injury. (RHE E, p. 42). Claimant testified that the Orthopedic Centers of Colorado (Dr. Henderson) did not treat workers' compensation patients and that their office prepared the above referenced letter to submit to Bule Cross and Blude Shield in order to be reimbursed for their services to Claimant. Claimant added that Blue Cross and Blue Shield pay part of the billing for his 9/16/2024 surgery and that his mother paid around $6,000.00 exclusive of the anesthesiologists billing. As noted, Claimant did not present any records regarding his surgery, nor did he submit any surgical bills or payments made in conjunction with his surgical treatment.

28. Claimant testified that the surgery improved the strength and mobility in his right hand/thumb and that he did not participate in formal post-surgical therapy because all treatment had been denied and he could not afford to pay for treatment out of pocket.

29. Dr. Centi placed Clamant at MMI as of November 14, 2024. He returned Claimant to "regular" duty work and released him from care on this date.[3] (CHE 6, p. 110). Dr. Centi then referred Claimant to physical therapy for active range of motion testing of the right hand in advance of preparing an impairment rating report. *Id.*

30. Claimant's active range of motion (AROM) was tested by Physical Therapist (PT) Kelli Jakubowicz on December 2, 2024. (CHE 6, p. 119). The range of motion readings were recorded and given to Dr. Centi. *Id.* at 120; 122. Dr. Centi then prepared

[3] Claimant testified that he was released from care by Dr. Henderson and returned to full duty work on November 31, 2024.

a report of MMI and Impairment dated December 19, 2024, wherein he assigned 4% upper extremity impairment associated with Claimant February 13, 2024, slip and fall injury. *Id.* at 123-124.

Claimant's Remaining Testimony

31. Claimant testified that he had no prior treatment directed to his right hand/thumb and no functional limitations regarding the right hand/thumb prior to his trip and fall on February 13, 2024. Claimant suggested that the passage in Dr. Cassidy's April 16, 2024, report that he (Claimant) had known about some thumb arthritis for some time was inaccurate. On cross examination, Claimant admitted he had moved from his girlfriend's mother's house to an apartment about two weeks after the fall. He testified he did little actual moving, other than handling some clothes and dishes as there wasn't much to move. He did not lift or move any boxes or furniture, testifying that these things were left to family to move.

The Testimony of Bonnie Gandy-Roman

32. Ms. Gandy-Roman testified as Employer's onsite occupational health nurse. She has a bachelor's degree in nursing and is a registered nurse (RN). Nurse Gandy-Roman testified that she saw Claimant many times for first aid treatment post fall. She testified that her chart notes reflect that at Claimant's first visit he was there to follow up for ongoing wrist injury. She testified that it was documented in this fashion because the report that she received noted that Claimant suffered a wrist injury on February 13, 2024. (See RHE A, p. 1). As of Claimant's 2/20/2024 visit, Nurse Gandy-Roman was aware that Claimant had been provided with a brace. *Id*. Indeed, during his 2/20/2024 visit, Claimant inquired about taking FMLA because the brace made it difficult for him to work. *Id.* Claimant described the brace as covering (immobilizing) his thumb and locking his wrist in place but allowing for movement of his fingers. During cross-examination, Nurse Gandy-Roman agreed that such braces were uncomfortable, and it would be proper to remove them occasionally for some period of time. Significant issues arose

surrounding Claimant's use of the splint at work prompting Nurse Gandy-Roman to offer to wrap Claimant's wrist/hand with and ACE bandage if Claimant was not wearing his brace/splint at work. She also testified that she offered Claimant a simple thumb immobilizer when he was not using his brace.

33. Nurse Gandy-Roman testified that had Claimant specifically noted that he had pain in his knee, back, neck or thumb she would have documented that in his chart. Careful review of Nurse Gandy-Roman's chart notes do not reflect reports of knee, back or neck complaints. She documented right hand pain during Claimant's 3/14/2024 follow up appointment and right thumb complaints during his March 26, 2024, visit. (See RHE A, pp. 6, 8). Respondents suggest that Claimant only began complaining to Nurse Gandy-Roman of pain and dysfunction in his right and thumb after he moved. While Nurse Gandy-Roman did not document right hand and thumb pain until March 14, 2024, the medical records from the Southern Colorado Clinic (NP Reichert and Dr. Centi) clearly reference complaints of pain/tenderness in the right hand/thumb as of Claimant's first appointment on February 13, 2024. (CHE 6, p. 24). Moreover, Nurse Gandy-Roman was undoubtedly aware that Claimant was using a splint that immobilized his right thumb and wrist as of her 2/20/2024 visit with Claimant. Indeed, she spoke in length to NP Reichert about use of the splint at work. Accordingly, the ALJ finds any suggestion that Nurse Gandy-Roman was not aware that Claimant's injury involved his right hand and thumb is unpersuasive, even if Claimant did not report specific symptoms involving the right thumb to her. Based upon the evidence presented, the ALJ is not convinced that Claimant's need for treatment, i.e. surgical intervention was proximately caused by an injury or aggravation of a pre-existing condition he suffered during the move from his girlfriend's mother's house at the end of February and beginning or March 2024. Nor is the ALJ persuaded that Claimant's symptoms and need for treatment are due to the natural and probable progression of Claimant's underlying right hand/thumb arthritis as suggested by Dr. Chen.

Conclusions of Law

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

Generally

A. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S. 2007, et seq., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

B. In accordance with §8-43-215 C.R.S., this decision contains specific Findings of Fact, Conclusions of Law and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. See *Davison v. Industrial Claim Appeals Office*, 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Claimant's Request for Medical Benefits

C. Under the Workers' Compensation Act, Respondents are liable for medical treatment that is reasonably necessary to cure or relieve injured workers from the effects of injuries occurring in the course and scope of employment. § 8-42-101, C.R.S.; *Grover v. Industrial Commission,* 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Indus. Claim Appeals Office*, 916 P.2d 609, 611 (Colo.App.1995). However, the right to workers' compensation benefits, including medical care, arises only when the injured worker 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. C.R.S. § 8-41-301(1)(c); *Faulkner v. Indus. Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000).

D. Where the reasonableness, necessity or relatedness of medical treatment is disputed, Claimant has the burden to prove that the disputed treatment is reasonably necessary to cure or relieve the effects of the injury and causally related to the injury, *Ciesiolka v. Allright Colorado, Inc*., W.C. No. 4-117-758 (ICAO April 7, 2003). The question of whether medical treatment is necessitated by a compensable aggravation or a worsening of a claimant's pre-existing condition is one of fact for resolution by the ALJ based upon the evidentiary record. *See University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001); *Standard Metals Corp. v. Ball*, 172 Colo. 510, 474 P.2d 622 (1970); *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985).

E. To prove causation, it is not necessary to establish that the industrial injury was the sole cause of the need for treatment. Rather, it is sufficient if the injury is a "significant" cause of the need for treatment in the sense that there is a direct relationship between the precipitating event, i.e. Claimant's trip and fall and the need for treatment. A pre-existing condition does not disqualify a claimant from receiving workers' compensation benefits. *Duncan v. Indus. Claims Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). Thus, if the industrial injury aggravates, accelerates, or "combines with" a pre-existing infirmity or disease "to produce disability and/or cause a need for treatment, the treatment is compensable. *H & H Warehouse v. Vicory, 805 P.2d 1167 (Colo. App. 1990).* A claimant need not show that his/her injury objectively caused an identifiable structural change to their underlying anatomy to prove an aggravation. Rather, a purely symptomatic aggravation is a sufficient basis for an award of medical benefits if it causes the claimant to need treatment that he/she would not otherwise have required but for the accident. *Merriman v. Industrial Comm'n*, 210 P.2d 448 (Colo. 1949); *Dietrich v. Estes Express Lines*, W.C. No. 4-921-616-03 (ICAO, September 9, 2016). See also, *Industrial Commission v. Pacific Employers Insurance Co*., 128 Colo. 411, 262 P.2d 926 (1953) (trigger of symptoms from Claimant's dormant hemorrhoids from working in

cramped conditions determined to constitute compensable aggravation of a pre-existing condition).

F. Even temporary aggravations of pre-existing conditions may be compensable. *Eisnack v. Industrial Commission*, 633 P.2d 502 (Colo. App. 1981). Pain is a typical symptom from the aggravation of a pre-existing condition. Thus, a claimant is entitled to medical benefits for treatment of pain, so long as the pain is proximately caused by the claimant's employment–related activities and not his/her underlying pre-existing condition. *See Merriman v. Industrial Commission*, 120 Colo. 400, 210 P.2d 488 (1940).

G. While pain may represent a symptom from the aggravation of a pre-existing condition, the fact that Claimant may have experienced an onset of hand/thumb pain after falling while rushing into the plant following his lunch hour does not compel the ALJ to conclude that the duties of employment caused his symptoms, or that his employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may, as noted by Dr. Chen, represent the natural progression of Claimant's pre-existing disease process that is unrelated to the employment. *See F.R. Orr Construction v. Rinta,* supra; *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005).

H. In this case, the totality of the evidence presented persuades the ALJ that while Claimant undoubtedly had pre-existing degenerative arthritis and possibly a chronic MCL tear in the right hand, he was asymptomatic, was working without limitation and had not been treated for hand/thumb pain prior to his February 13, 2024, trip and fall. The evidence persuades the ALJ that Claimant's 2/13/2024, fall probably caused significant trauma to the right hand/thumb giving rise to his symptoms and need for treatment. Indeed, the independent radiological opinion of Dr. Feit notes that the findings on Claimant's 3/7/2024 MRI are "compatible with bone contusion without fracture." (RHE F, p. 44). Because the ALJ is convinced that Claimant's clinical symptomatology and physical examination are consistent with the findings revealed on the 3/7/2024 MRI, the

ALJ is persuaded that those findings are probably posttraumatic and related to the Claimant's 2/13/2024 fall as opined by Dr. Feit. *Id.*

I. In this case, there is simply no persuasive evidence to establish that Claimant was symptomatic or receiving active treatment for right hand/thumb pain prior to his 2/13/2024 fall. Nonetheless, Respondents seemingly contest the relatedness of Claimant's right hand/thumb symptoms and need for surgery on Dr. Chen's opinion that none of the findings on Claimant's 3/7/2024 MRI are acute and there is "no evidence of an exacerbation or aggravation" of a pre-existing condition in this case.

J. Taken in its entirety, the ALJ finds the evidentiary record to contain substantial evidence to support the conclusion that Claimant probably had a latent pre-existing, yet asymptomatic condition, including degenerative osteoarthritis and an asymptomatic ligament tear in the right hand/thumb, which became symptomatic after tripping and falling to the ground while returning to work on February 13, 2024. Such injuries constitute compensable aggravations of pre-existing conditions. See, *Subsequent Injury Fund v. Devore*, 780 P.2d 39 (Colo. App. 1989); *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986). While Dr. Chen suggests that there must be some quantum of objective evidence such as "some sort of fracture, some sort of acute ligament tear, or some sort of subchondral injury to the cartilage surface" to support a conclusion that there has been an aggravation of a pre-existing condition, this ALJ is unaware of any such requirement and Respondents cited no legal authority for this proposition. To the contrary, it is well established, as noted above, that a purely symptomatic aggravation is a sufficient basis to award medical benefits if it causes, as is the case here, Claimant's need for treatment. Because the ALJ finds/concludes that Claimant's 2/13/2024, trip and fall aggravated his underlying osteoarthritis/MCL tear and hastened his need for surgery, Claimant has established the requisite causal connection between his work-related fall and his need for the 9/16/2024 right hand/thumb surgery performed by Dr. Henderson. The contrary opinions of Dr. Chen have been considered and are rejected as unpersuasive.

K. Although the ALJ is convinced that Claimant's symptoms and need for treatment, including right hand/thumb surgery are related to his February 13, 2024, trip and fall, the record evidence persuades the ALJ that the September 16, 2024, surgical procedure performed by Dr. Henderson was unauthorized. Authorization to provide medical treatment refers to a provider's legal authority to deliver medical care to the injured worker with the expectation that the provider will be compensated by the workers' compensation insurer for such treatment. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006); *One Hour Cleaners v. Industrial Claim Appeals Office,* 914 P.2d 501 (Colo. App. 1995); *In re Bell*, W.C. No. 5-044-948-01 (ICAO, Oct. 16, 2018). Authorized providers include those medical providers to whom the claimant is directly referred to by the employer, as well as providers to whom an already authorized provider refers the claimant in the normal progression of treatment. *Town of Ignacio v. Industrial Claim Appeals Office,* 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997).

L. Under § 8-43-404(5) (a) (I) (A), C.R.S., the employer has the right in the first instance to designate the authorized provider to treat the claimant's compensable condition(s). The rationale for this principle is that the respondents may ultimately be liable for the claimant's medical bills and, therefore, have an interest in knowing what treatment is being provided. *Andrade v. Industrial Claim Appeals Office*, 121 P.3d 328 (Colo. App. 2005). Section 8-43-404(7)(a), C.R.S. provides that "an employer or insurer shall not be liable for treatment provided pursuant to article 41 of Title 12, C.R.S. unless such treatment has been prescribed by an authorized treating physician." If the claimant obtains unauthorized care, the respondents are not required to pay for it. *In Re Patton*, W.C. Nos. 4-793-307 and 4-794-075 (ICAO, June 18, 2010); see also, *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999); *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). In this case, the evidence supports a conclusion that Claimant self-referred to Dr. Henderson for treatment. Moreover, the record is devoid of any persuasive evidence establishing that Dr. Henderson requested pre-authorization from Respondent-Employer or Insurer to proceed with the surgery directed to Claimant's right hand/thumb. Accordingly, the ALJ is convinced that Claimant elected to proceed

with care outside of the Workers' Compensation system. Because Respondents properly designated Dr. Centi as Claimant's authorized treating provider (ATP) and because the evidence presented fails to establish that neither Dr. Centi nor Dr. Cassidy referred Claimant Dr. Henderson, the ALJ concludes that Dr. Henderson was not authorized to treat Claimant for the effects of his February 13, 2024, work injury. Thus, while the ALJ finds/concludes that Dr. Henderson's treatment, including the September 16, 2024, surgery was reasonable, necessary and related to Claimant's February 13, 2024, trip and fall, his care is unauthorized. As such, Respondents are not obliged to pay for this care. *Yeck v. Industrial Claim Appeals Office, supra.*

Claimant's Entitlement to Temporary Total and Permanent Partial Disability

M. To establish entitlement to temporary disability (TTD) benefits, Claimant must prove that the industrial injury caused a disability lasting more than three work shifts; that he left work as a result of the disability, and the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires Claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage-earning capacity as demonstrated by Claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of the earning capacity element may be evidenced by a complete inability to work, or by restrictions, which impair the Claimant's ability to effectively, and properly perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998). In this case, the evidence presented establishes that on July 26, 2024, Dr. Centi anticipated that Claimant was to undergo surgery to the right hand/thumb on August 6, 2024. Consequently, he took Claimant off work beginning this date. (CHE 6, p. 89). As noted, Claimant probably left work on or before this date, but he did not undergo surgery as scheduled. Instead, the ALJ is convinced that Claimant elected to leave work on or around August 6, 2024, and

apply for family leave after his August 6, 2024, surgery was denied and cancelled. Because employer had been accommodating Claimant's restrictions and he was only taken off work by Dr. Centi to have surgery and Claimant chose not to return to work after the cancellation of his surgery on 8/6/2024 and 8/30/2024, the ALJ is not convinced that Claimant left work and sustained a wage loss associated with his 2/13/2024 injury during the time between August 6, 2024 and September 15, 2024. Nonetheless, Claimant did proceed with surgery on September 16, 2024, for a condition that the ALJ has determined is related to Claimant's February 13, 2024, trip and fall, namely the compensable aggravation of his underlying osteoarthritis and chronic ligament tear.

N. Claimant's testimony combined with the content of his medical records persuades the ALJ that Claimant's right hand/thumb injury resulted in medical incapacity as evidenced by a loss/restriction in bodily function, which restriction reduced his wage-earning capacity as demonstrated by his inability to return to full duty employment based on the July 27, 2024, report of Dr. Centi. Because Dr. Centi had concluded that Claimant would be unable to work following surgery as referenced in his July 26, 2024 report (CHE 6, p. 89) and because the evidence supports a finding that Claimant underwent surgery for the compensable aggravation of his pre-existing osteoarthritis/chronic ligament tear, the ALJ is convinced that Claimant was completely unable to effectively and properly work in any capacity and began experiencing an actual wage loss due to a condition related to his 2/13/2024, trip and fall on September 16, 2024. Simply put, the ALJ concludes that Claimant was "disabled" within the meaning of section 8-42-105, C.R.S. beginning September 16, 2024. Once the claimant has established a "disability" and a resulting wage loss, the entitlement to temporary disability benefits continues until terminated in accordance with § 8-42-105(3)(a) - (d), C.R.S. 2024.

O. C.R.S. § 8-42-105(3) provides in pertinent part: Temporary total disability benefits shall continue until the first occurrence of any one of the following:

(a) The employee reaches maximum medical improvement;

(b) The employee returns to regular or modified employment;

(c) The attending physician gives the employee a written release to return to regular employment; or

(d)(I) The attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.

P. In this case, the evidence presented supports a finding/conclusion that Employer did not seek to return Claimant to modified duty at any time following his 9/16/2024 surgery. While he may have been capable for performing modified duty, there is no persuasive evidence establishing that Dr. Centi gave Claimant a written release to return to modified duty following his surgery or that a written offer of modified duty was extended to Claimant. Indeed, Respondents did not return Claimant to Dr. Centi to comment on MMI, work status and impairment until November 14, 2024 (CHE 6, pp. 121). In the absence of MMI or his return to modified or full duty work, Claimant's entitlement to temporary disability benefits continued until November 14, 2024, when Dr. Centi placed him at MMI and released him to "regular duty". *Id*. Based upon the evidence presented, the ALJ concludes that Claimant is entitled to TTD benefits from September 16, 2024, through November 13, 2024. Because Claimant's period of disability lasted longer than two weeks from the day he left work as a consequence of his right hand/thumb injury, he is entitled to recover disability benefits from the day he left work in this case, i.e. September 16, 2024. Section 8-42-103(1)(b), C.R.S. Based upon the evidence presented and this ALJ's conclusion that Claimant's right hand/thumb surgery is related to his February 13, 2024, trip and fall, the ALJ is also convinced that Claimant is entitled to permanent partial disability (PPD) benefits based on the scheduled rating calculated by Dr. Centi as referenced in his December 9, 2024, report of MMI and impairment. (CHE 6, p. 124).

Order

It is therefore ordered that:

1. Claimant has proven, by a preponderance of the evidence, that the September 16, 2024, surgery directed to his right hand/thumb was reasonable, necessary and related to his February 13, 2024, work-related fall. However, because the care Claimant obtained through Dr. Henderson was unauthorized, any request for reimbursement of his out-of-pocket expenses and payment by Respondent for remaining balances connected to this treatment is denied and dismissed.

2. Claimant has proven his entitlement to temporary total disability benefits beginning September 16, 2024, and running through November 13, 2024. Respondents shall pay Claimant TTD benefits commencing September 16, 2024, at the appropriate TTD rate associated with Claimant's average weekly wage (AWW). Because AWW was not endorsed for hearing, the parties shall determine Claimant's AWW and the amount of the applicable offsets to which Respondents are entitled. If the parties are unable to reach an agreement regarding the amount of Claimant's AWW or offset, either may apply for a hearing to determine the same.

3. Claimant has established, by a preponderance of the evidence, that he is entitled to permanent partial disability benefits as calculated by Dr. Centi in his December 9, 2024, report of MMI and Impairment.

4. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

Dated: October 29, 2025

/s/ Richard M. Lamphere_____

Richard M. Lamphere

Administrative Law Judge

NOTE: If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not be mailed to the Denver Office of Administrative Courts. For statutory reference, see Section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

Office of Administrative Courts
State of Colorado
Workers' Compensation WC 5-179-963-001

Issues

I. Whether Respondent established that the overpayment, TTD offset/reduction, and overpayment recovery issues are ripe for adjudication.

II. Whether Respondent established by a preponderance of the evidence that Claimant has been overpaid.

III. Whether Respondent established by a preponderance of the evidence that Respondent is entitled to offset/reduce ongoing TTD benefits and reduce/cease future financial payments to recover the overpayment.

Stipulation

- Claimant's Counsel stipulated to the admission, accuracy and validity of the claim adjuster's payment logs, which are found at Exhibits H, I, and J.

Proposed Orders

At the conclusion of the hearing, the ALJ directed the parties to submit proposed orders to clarify their respective positions, set forth proposed findings of fact, and apply the relevant legal standards in support of their positions.

Respondent submitted a detailed proposed order that included specific findings of fact, supported by the evidentiary record, establishing its overpayment calculation of $36,156.70, and setting forth the legal authority underlying its claim for recovery.

Claimant, in response to the claimed overpayment, argued only that the issue of recovery was not ripe for adjudication, contending that, because Claimant had not yet reached maximum medical improvement following the reopening of the case, any determination as to overpayment remained premature. Claimant presented no other argument in defense of the overpayment claim, nor did Claimant dispute the accuracy of

Respondent's calculation or challenge the reasonableness of the proposed recovery rate of $100.00 per week.

Having thoroughly reviewed the record and applicable law, the Court finds the issue is ripe and identifies no credible dispute regarding the amount of the overpayment, nor any persuasive argument that the proposed recovery rate of $100.00 per week is unreasonable. Furthermore, the Court finds Respondent's argument persuasive and well supported by the totality of the evidence. Accordingly, the Court adopts Respondent's proposed findings and analysis as set forth below in this opinion.

Findings of Fact

1. Claimant sustained an admitted industrial injury on July 9, 2021.
2. Claimant was 42 years-old at the time of the industrial injury. Claimant's date of birth is March 2, 1979. (Ex. C, p. 14.)
3. Respondent filed a medical only General Admission of Liability (GAL) on September 3, 2021. (Exhibit A)
4. Respondent filed a GAL on March 30, 2022, admitting to ongoing temporary total disability benefits (TTD) beginning March 17, 2022. (Exhibit B)
5. Respondent's March 30, 2022, GAL admitted to an average weekly wage (AWW) of $1,936.14 and to a TTD rate of $1,158.92.
6. Eric Chau, MD found Claimant reached maximum medical improvement (MMI) on September 1, 2022. (Ex. C, p. 19, 21.)
7. Respondent filed a Final Admission of Liability (FAL) on September 22, 2022, relying on Dr. Chau's September 1, 2022, medical report. (Exhibit C)
8. The FAL admitted to an 11% whole person impairment rating and a 5% scheduled impairment rating. (Id.)
9. The Benefit History in the FAL admitted to TTD benefits from March 17, 2022, through August 31, 2022, for a total of $27,814.08. (Id.)

10. The Benefit History in the FAL admitted for a combined Permanent Partial Disability Benefits (PPD) of $68,329.92 retroactive to September 1, 2022. (Id.)
11. The FAL did not list an overpayment. (See Id.)
12. David W. Yamamoto, MD saw Claimant on April 7, 2023, for a Division Independent Medical Examination (DIME) requested by Claimant. (See Ex. F, p. 50, last paragraph.)
13. Dr. Yamamoto opined that Claimant was not at MMI. (Ex. F, p. 52, last paragraph.)
14. On June 13, 2023, Respondent filed a GAL in light of Dr. Yamamoto's report. (Exhibit D)
15. The GAL admitted to TTD for a closed period of time. (Id.)
16. On July 5, 2023, Respondent filed an amended GAL. (Exhibit E)
17. The GAL admitted to TTD benefits beginning March 17, 2022, and ongoing at $1,158.92 per week. (Id.)
18. The GAL noted a credit will be taken for PPD previously paid. (Id.)
19. On March 28, 2024, Dr. Chau opined Claimant had reached MMI on Mach 22, 2024. (Ex. F, p. 57.)
20. On May 31, 2024, Dr. Yamamoto performed a follow-up DIME and opined Claimant was at MMI as of May 31, 2024. (Ex. F, p. 50 - 65)
21. Dr. Yamamoto assigned Claimant three permanent impairment ratings: a 17% whole person lumbar spine impairment rating, a 7% right ankle lower extremity scheduled impairment rating, and a 5% whole person psychiatric impairment rating (for which he used the impairment rating assigned by Dr. Gary Gutterman). (Ex. F, p. 59)
22. On July 12, 2024, Respondent filed a FAL pursuant to Dr. Yamamoto's May 31, 2024, DIME report. (Ex. F, p. 38 – 70)
23. The FAL admitted to TTD from March 17, 2022, through May 30, 2024, for $133,441.36. (Ex. F, p. 38)

24. At the time this FAL was filed, Respondent had paid $139,070.40 in TTD benefits.[1]

25. The FAL noted an overpayment of $36,156.70. (Ex. F, p. 38.)

26. The record contains no evidence or indication that Respondent has recovered any of the asserted overpayments.

27. $5,629.04[2] in TTD was paid from the MMI date of May 31, 2024, through July, 3, 2024. The TTD was paid for 4 6/7 weeks (May 31, 2024 through July 3, 2024) at $1,158.92 per week. (See Ex. F, p. 68, lines 8 – 10 and Ex. I, p. 79, lines 27 – 30.)

28. At the time the July 12, 2024, FAL was filed, Respondent had paid PPD in the amount of $30,527.66 for dates September 1, 2022 through June 21, 2023. (See highlighted PPD payments at Ex. J, p. 79 – 80.)

29. $5,629.04 (TTD after MMI) + $30,527.66 (PPD paid) = $36,156.70, which is the overpayment amount listed on the July 12, 2024, FAL. (See Ex. F, p. 38.)

30. At the time the July 12, 2024 FAL was filed, Respondent had paid $48,674.64[3] in TTD benefits for the same dates of September 1, 2022, through June 21, 2023, for which Respondent paid PPD. (See Ex. F, p. 68 and 70 (salary continuation).)

31. The FAL noted the indemnity cap for this claim was $106,911.08. (Id.)

32. Respondent is not seeking an overpayment for all TTD paid beyond the cap, just the TTD paid from the May 31, 2024, MMI date.

33. On January 27, 2025, Respondent filed a GAL, as Claimant was no longer at MMI as of January 2, 2025. (See Ex. G, p. 71.)

34. The GAL admitted to ongoing TTD benefits beginning from January 2, 2025 and continuing through the hearing date, at the rate of $1,158.92 per week. (See Id.)

35. On March 21, 2025, Respondent filed the Application for Hearing (APH) now before the Court.

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[1] $126,840.40 (Ex. F, p. 68 – 69) + $13,907.04 (salary continuation) (Ex. F, p. 70) = $140,747.44. $140,747.44 - $1,677.04 (interest)(Ex. F, p. 38) = $139,070.40.

[2] 4 6/7 weeks x $1,158.92 = $5,629.04.

[3] 42 weeks x $1,158.92 = $48,674.64.

Conclusions of Law

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *University Park Care Center v. Indus. Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Indus. Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Indus. Comm'n*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or

every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

I. Whether Respondent established that the overpayment, TTD offset/reduction, and overpayment recovery issues are ripe for adjudication.

Ripeness

"An issue is ripe for hearing when it 'is real, immediate, and fit for adjudication."' *Youngs v. Industrial Claim Appeals Office*, 297 P.3d 964, 969 (Colo. App. 2012) (quoting *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178, 1180 (Colo. App. 2006)). The term "fit for adjudication" refers to a disputed issue concerning which there is no legal impediment to immediate adjudication. *See Maestas v. Wal Mart Stores, Inc.*, W.C. 4-717-132 (Jan. 22, 2009)(quoting *Olivas-Soto v. Genesis Consolidated Services*, W. C. No. 4-518-876 (November 02, 2005), *off d Olivas-Soto v. Industrial Claim Appeals Office, supra))*.

TTD Overpayment

With respect to the issue of TTD overpayment, these criteria have been met. The legal prerequisites to determination also have been satisfied. Specifically, Claimant's right to TTD benefits ended pursuant to § 8-42-105 (3)(a), C.R.S., when Claimant reached MMI on May 31, 2024. Respondent filed an FAL, and Claimant did not challenge the FAL with respect to MMI, permanent impairment or overpayment.

Based on the Statement of Facts, the ALJ specifically concludes that the record here is devoid of any credible evidence demonstrating that there is any legal impediment to the immediate adjudication of the issues of overpayment, TTD offset/reduction and recovery of overpayment.

PPD Overpayment

With respect to the issue of PPD overpayment, these criteria have been met. Respondent identified an alleged overpayment in the July 12, 2024, FAL, and have

calculated the PPD overpayment based on the PPD benefits and TTD benefits being paid for the same dates. The legal prerequisites to determination also have been satisfied. Specifically, the PPD benefits exceeded the amount that should have been paid, and Claimant was not ultimately entitled to receive PPD benefits after Claimant was found to have not reached MMI. See below, 8-40-201(15.5), C.R.S. (2021) version in effect the time of Claimant's date of injury.

II. **Whether Respondent proved by a preponderance of the evidence that Claimant has been overpaid.**

III. **Whether Respondent proved by a preponderance of the evidence that Respondent is entitled to offset/reduce ongoing TTD benefits and reduce/cease future financial payments to recover the overpayment.**

TTD Offset/Reduction and Overpayment Recovery

With respect to the issues of TTD offset/reduction and overpayment recovery, these criteria have been met. The legal prerequisites to determination have also been satisfied.

That Respondent has not sought repayment of the TTD and PPD overpayments until now "[does] not render the issue premature for resolution at a hearing or otherwise not ripe." See *Tully v. Southwest Health Systems, Inc*., W.C. No. 5-062-753-001 (ICAO Feb. 9, 2021)

Section 8-42-113.5(1)(b.5)(I),C.R.S. expressly addresses recovery of an overpayment. "After the filing of a final admission of liability, 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." To recoup an overpayment, the statute requires that after the filing of a final admission of liability, the party file an application for hearing within one year of knowing about the existence of the overpayment. § 8-42-113.5(1)(b.5)(I).

A plain reading of the statute does not reflect an exception to this one-year statute of limitations. Had Respondent not filed the APH within the one-year SOL, Respondent would have been barred from recovering the TTD and PPD overpayments if contested by Claimant. See *Barnes*.[4]

In *Peoples*,[5] the Court of Appeals held that after an employer files an FAL and learns of an overpayment, § 8-42-113.5(1)(b.5)(I), C.R.S. requires the employer to ""attempt to recover" that overpayment from a claimant within one year of learning of its existence. The Court held that merely listing the overpayment on the FAL did not satisfy the employer's burden to "attempt to recover" the overpayment under § 8-42-113.5(1)(b.5)(I), C.R.S. when a claimant's indemnity benefits exceed the statutory cap in § 8-42-107.5, C.R.S. The term "attempt" in section 8-42-113.5(1)(b.5)(I) cannot be a mere assertion of an overpayment; it must include some effort to regain the overpayment. *Peoples*, supra, at p. 148. If recouping an overpayment by deducting from future benefits is not "practicable," an employer or insurer "is authorized to seek an order for repayment." § 8-42-113.5(1)(c). *Peoples*, supra at p. 147.

Barnes[6] is a prime example of a respondent's claim for repayment of an overpayment being barred by the one-year statute of limitations enunciated in 8-42-113.5(1)(b.5)(I), C.R.S. The ALJ found the respondent's claim for repayment of the overpayment was not barred by the one-year statute of limitations and ordered the claimant to repay the overpayment. However, the Panel concluded that the ALJ's order which ruled the respondent had timely sought to recover its overpayment was contrary to applicable law, including that of 8-42-113.5(1)(b.5)(I).

In *Barnes*, the Panel concluded that the respondent should have filed its application for hearing to "attempt to recover [the] overpayment" within one year of learning of it. The Panel further determined that the General Assembly intended to limit the employers' right to collect repayment of an overpayment to within one year of learning of the overpayment delineated in § 8-42-113.5(1)(b.5)(I), C.R.S.

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[4] *Barnes v. City and County of Denver*, W.C. No. 5-063-493 (ICAO March 27, 2023).
[5] *Peoples v. Indus. Claim Appeals Office,* 457 P.3d 143, 148 (Colo. App. 2019).
[6] *Barnes v. City and County of Denver*, W.C. No. 5-063-493 (ICAO March 27, 2023).

When Respondent here filed its July 12, 2024, FAL that noted there was a $36,156.70 overpayment, Respondent had no immediate means of recovering any overpayment from Claimant's PPD benefits because Claimant was to receive no such benefits. Claimant's TTD benefits exceeded the statutory cap, foreclosing Claimant's entitlement to PPD benefits. Thus, it was not practicable for Respondent to follow the PPD offset procedure contemplated by section 8-42-113.5(1)(a).

In connection with hearings, the director and administrative law judges are empowered to … "Require repayment of overpayments." 8-43-207(1)(q), C.R.S. (authorizing judges to order repayment of overpayments).

Based on the Findings of Fact and the law, the ALJ specifically concludes that by filing an application for hearing to recover the overpayments within one year of the July 12, 2024 Final Admission of Liability, the ALJ has jurisdiction to hear the overpayment, TTD offset/reduction, and overpayment recovery issues, and to order the recovery of any overpayments. *See* § 8-43-207(1)(q)

Allowing an employer to extend the deadline to seek recovery of overpayments solely by listing the overpayment in a FAL with no means to deduct installments, thwarts the goal of closure. See *Peoples* supra, noting, *Olivas-Soto*, 143 P.3d at 1179. The court in *Peoples* concluded that, where, as here, an employer cannot offset its overpayment by deducting from ongoing [permanent] disability payments, an employer must seek an ALJ's order of repayment within one year of learning of its entitlement to an overpayment. § 8-42-113.5(1)(b.5). *Peoples*, supra at p. 148.

Based on the Findings of Fact and law, the ALJ specifically concludes that the overpayment, TTD offset/reduction, and recovery of overpayment issues are ripe for hearing. Based on the Findings of Fact and law, the ALJ specifically concludes these issues are real, immediate, and fit for adjudication, and there is no legal impediment to immediate adjudication.

Furthermore, the ALJ specifically concludes that if Respondent had not filed the current Application for Hearing within one year of the July 12, 2024, FAL, and gone foreward with a hearing, Respondent could have been barred from recovering these overpayments. See also *Barnes* and *Peoples*, supra. Section 8-42-113.5, C.R.S. does

not provide Respondent a mechanism or legal avenue to delay filing an APH and litigating the overpayment, TTD offset/reduction, and recovery issues until a new FAL is filed.

Furthermore, it is speculative that Claimant's combined future impairment ratings would increase to 26% whole person or greater and permit Respondent full recovery of its overpayments by increasing the statutory cap. Whether a respondent is entitled to immediate or present recovery of an overpayment should not be based on speculation of a claimant's ultimate impairment nor dependent upon whether there is evidence to suggest that a claimant's impairment is likely to be above or below the lower indemnity cap, or increase or decrease after reopening.

Overpayment

The definition of "overpayment" in § 8-40-201(15.5), C.R.S. (2021)[7], that was in effect at the time of Claimant's injury (July 9, 2021), provided as follows:

> (15.5) "Overpayment" means money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles.
>
> For an overpayment to result, it is not necessary that the overpayment exist at the time the claimant received disability or death benefits under said articles.

Thus, there are three categories of possible overpayment pursuant to §8-40-201(15.5). *In Re Grandestaff*, No. 4-717-644 (ICAP, Mar. 11, 2013). An overpayment may occur even if it did not exist at the time a claimant received disability or death benefits. *Simpson v. ICAO*, 219 P.3d 354, 358 (Colo. App. 2009). Therefore, retroactive recovery for an overpayment is permitted. *In Re Haney*, W.C. No. 4-796-763 (ICAP, July 28, 2011).

[7] This version of § 8-40-201(15.5)(a), C.R.S. was amended effective January 1, 2022. However, the amended statute does not apply to injuries or causes of action occurring before January 1, 2022, and the amended statute is not applicable to Claimant's claim. *See Barnes v. City and Cty. of Denver*, W.C. No. 5-063-493 (ICAO Mar. 27, 2023).

The overpayment statute does not mandate that a claimant be at MMI for an overpayment to exist or to determine if an overpayment exists. Nor does the overpayment statute mandate a specific method to recover overpaid workers' compensation indemnity benefits. The legislature could have easily included in the statute that an ALJ could only find an overpayment when a claimant is at MMI – but they did not. The legislature could have included in the statute that an order of offset/reduction or repayment of overpayments could only be made from PPD. However, the legislature chose not to limit repayments to PPD or to after MMI.

TTD Overpayment for Benefits Paid at and

After MMI: May 31, 2024 – July 3, 2024 ($5,629.04)

Respondent is not seeking an overpayment for all TTD paid beyond the cap, just the TTD paid from the May 31, 2024 MMI date.[8]

TTD benefits paid from the May 31, 2024, MMI date[9] to July 3, 2024, are included in the definition and calculation of the overpayment. Claimant was paid TTD benefits for dates that included the MMI date and thereafter for 4 weeks and 6 days. Based on the Findings of Fact and applicable law, the ALJ specifically concludes that this TTD exceeded the amount Claimant should have been paid and for which Claimant was not entitled to receive, as TTD is to cease at MMI. Claimant was paid TTD for dates May 31, 2024, through July 3, 2024, at the TTD rate of $1,158.92 for a total of $5,629.04 (4 6/7 weeks x $1,158.92 = $5,629.04). (See Ex. F, p. 68, lines 8 – 10[10] and Ex. I, p. 79, lines 27 – 30.)

There is no credible evidence to indicate Respondent has recovered this $5,629.04 overpayment. Claimant has not asserted that Respondent recovered this overpayment.

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[8] TTD paid beyond the cap is $32,911.08. ($139,070.40 - $106,911.08). TTD paid from MMI is $5,629.04.

[9] DIME physician Dr. Yamamoto opined Claimant reached MMI on May 31, 2024. See Ex. F, p. 59. The July 12, 2024 FAL incorrectly noted the MMI date as "09/01/22". See Ex. F, p. 38.

[10] The payout log at Bates p. 68 and 69 show TTD payments made for dates 7/4/2024 – 7/17/24 (p. 68, line 6) and 7/18/2024 – 7/31/2024 (p. 69, line 4). But both payments were cancelled as noted at p. 68, lines 22 and 23.

Based on the Findings of Fact and applicable law, the ALJ specifically finds and concludes that Respondent has proven by the preponderance of the evidence that it has overpaid Claimant TTD benefits of $5,629.04.

Overpayment – Benefits Claimant Received That Exceeded Amount He Should Have Been Paid PPD and TTD Paid for the Same Dates: September 1, 2022 – June 21, 2023 ($30,527.66)

On September 22, 2022, Respondent filed a FAL admitting to multiple impairment ratings. (Ex. C, p. 7 – 32) Claimant reached MMI on September 1, 2022, per the ATP Dr. Chau. (See Ex. C, p. 19 and 21.) Respondent began paying PPD benefits.

Respondent paid $30,527.66 in PPD benefits before PPD was stopped when the Division IME physician, Dr. Yamamoto, opined that Claimant had not reached MMI. (See Ex. F, p. 52, last paragraph) Respondent had paid PPD for dates September 1, 2022, through June 21, 2023. (See highlighted PPD payments at Ex. J, p. 79 – 80.)

Since Claimant had now essentially not reached MMI, Claimant was not entitled PPD benefits. Once Respondent admitted to Dr. Yamamoto's opinion that Claimant had not reached MMI, Claimant was entitled to TTD benefits for September 1, 2022, through June 21, 2023, and not PPD benefits, for which Respondent paid Claimant paid Claimant a lump sum of $52,669.52 for TTD benefits covering September 1, 2022, through July 5, 2023, and interest on the TTD. ($50,992.48 TTD + $1,677.04 interest = $52,669.52) (See Ex. F, p. 68.) Respondent paid Claimant PPD benefits and TTD benefits for the same dates of September 1, 2022, through June 21, 2023. (See Ex. J, p. 79 – 80 (PPD) and Ex. F, p. 68 (TTD))

Since Respondent paid Claimant full TTD benefits for September 1, 2022, through June 21, 2023, the PPD paid for the same dates exceeded the amount that should have been paid. The PPD benefits of $30,527.66 amounted to an overpayment.

Later, when Dr. Yamamoto opined Claimant had reached MMI on May 31, 2024, with impairment, Respondent filed a corresponding FAL on July 12, 2024. At the time of the FAL, Claimant had been paid TTD benefits of $126,840.40, which exceeded the

$106,911.08 indemnity cap for Claimant's date of injury. Therefore, Claimant was not entitled to PPD benefits.

Dr. Yamamoto had assigned a 17% whole person IR for the lumbar spine, 7% scheduled IR for the right ankle, and 5% whole person IR for psychiatric impairment. [11] Claimant's three impairment ratings combined to a 23% whole person IR.[12]

For Claimant's date of injury, the lower cap applies to combined whole person impairment rating of 25% or less. The higher indemnity cap does not apply unless a claimant has a combined whole person impairment rating of 26% or higher. See 8-42-107.5, C.R.S. The whole person impairment rating 19% for the lower cap became effective for dates of injury beginning September 7, 2021, about 2 months after Claimant's date of injury in the present case.

For the Claimant's date of injury, the lower indemnity cap is $106,911.08.[13]

Based on the Findings of Fact and applicable law, the ALJ finds and concludes that Respondent has proven by the preponderance of the evidence that it has overpaid Claimant $30,527.66 in PPD benefits.

Overpayment Recovery

In *Garrett*[14], the ALJ permitted a reduction in the claimant's ongoing TTD payments so the respondents could begin recouping the overpayment that resulted from a child support order against the claimant. The Panel affirmed. Recovery was not dependent on the claimant's ultimate impairment rating nor was it dependent upon whether there was

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[11] PPD for the three IRs totaled $137,875.92. (17% x 1.30 x 400 x $1,158.92 = $102,448.53; 5% x 1.30 x 400 x $1,158.92 = $30,131.92; 7% x 208 x $363.70 = $5,295.47)

[12] When a claimant sustains both a scheduled and whole person rating, the ratings should be converted and combined to determine the applicable cap in § 8-42-107.5. See *Marquez v. Brigade Energy Holdings*, W.C. No. 5-076-766, p. 8 (Sept. 20, 2022). Claimant's 7% lower extremity scheduled IR converts to a 3% whole person IR. *Guides to the Evaluation of Permanent Impairment*, Third Edition (Revised), Table 46, p. 72. Claimant's 17% WP, 3% WP and 5% WP impairment ratings combine to 23% WP. See the Combined Value Charts at Id, p. 254.

[13] The dollar amounts contained in the benefits cap provision, § 8-42-107.5 CRS, is adjusted each year by the percentage of the adjustment made by the director to the state average weekly wage pursuant to § 8-47-106. See 8-42-107.5 C.R.S (2020) and the Director's 2021 Order regarding the benefit rates as of July 1, 2021. Based on Claimant's date of injury, the first benefit cap is $106,911.08.

[14] *Garrett v. Trinidad Drilling U.S.A.*, Inc., WC No. 4-704-929 (Jan. 16, 2008).

evidence to suggest that the claimant's impairment was likely to be above or below the lower indemnity cap.

Claimant argued that the respondent cannot avoid paying the TTD benefits that they admitted pursuant to a GAL. The Claimant contended *HLJ Management Group, Inc*. prevents a reopening from affecting an earlier award as to "moneys already paid." But the ALJ allowed the respondents an offset, which does not require the claimant to pay back moneys previously paid to him but instead results in a reduction in the claimant's future workers compensation TTD benefits. The Panel agreed with the ALJ's reasoning and that it was consistent with the purposes of the Act. The Panel also noted that the overpayment "statute contemplates that in the case of an overpayment the ALJ has the authority to fashion a remedy." Citing *Stroman v. Southway Services, Inc.,* W.C. No. 4-366-989 (August 31, 1999).

The Panel noted that the court of appeals held that in cases of reopening, recoupment of overpayments can be accomplished by reducing future benefits. *Citing Cody v. Industrial Claim Appeals Office*, 940 P.2d 1042 (Colo. App. 1996). The Panel further noted that this conclusion is consistent with the statutory objective of reopening to permit equitable adjustments in a previous award of benefits. *Referencing Kuziel v. Pet Fair, Inc*., 931 P2d 521 (Colo. App. 1996).

Furthermore, in *Cerda*, the Panel determined that if a claimant has received TTD benefits or PPD benefits in excess of the amount that should have been paid, the employer or insurer may seek to cease benefit payments.

> "While the statute in § 8-42-113.5(1) does discuss overpayments stemming from the receipt of Social Security or retirement benefits, § 8-42-113.5(1)(b) provides that if the claimant was "receiving benefits in excess of the amount that should have been paid under articles 40 to 47 of this title" the employer or insurer may seek to cease benefit payments "until the overpayments have been recovered in full." Articles 40 to 47 would include temporary and permanent disability benefits. Subparagraph (c) then states that "If for any reason recovery of overpayments as contemplated in

> paragraph (a) or (b) of this subsection (1) is not practicable, the employer or insurer is authorized to seek an order for repayment." The reference is to benefits discussed in either subparagraph. Accordingly, subparagraph (b) is not limited to overpayments that result from an award of Social Security or retirement benefits."

Cerda v. Safeway Inc., W.C. No. 5-213-316 (ICAO Apr. 1, 2024).

In *Powers*, the Panel affirmed an ALJ's order permitting the respondent to reduce a claimant's ongoing TTD benefits by five percent to recoup an overpayment.[15] Recovery was not dependent on the claimant's ultimate impairment rating nor was it dependent upon whether there was evidence to suggest that the claimant's impairment was likely to be above or below the lower indemnity cap.

In *Yates*, the ALJ found claimant was overpaid as he was receiving TTD benefits while working and being paid wages from a subsequent employer. The ALJ ordered that respondents "recoup" the overpayment by reducing the claimant's TTD benefits by 50 percent until the overpayment was recovered and if not fully recovered from TTD benefits the overpayment could be taken from PPD and disfigurement. Respondents requested the right to terminate TTD benefits pursuant to 8-42-113.5(1) C.R.S. (2004). On appeal, the Panel modified the order to reflect that all disability benefits shall cease until such time as the overpayment is fully recovered.

In *Danks*[16], the ALJ ordered that the respondent could credit the overpayment against the disfigurement benefits owed. The Panel affirmed.

Based on the findings of fact and applicable law, the ALJ specifically finds and concludes that Respondent has proven by the preponderance of the evidence that it is

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[15] *Powers v Temp Force Employer*, WC No. 3-880-251 (Jan. 12, 1994). In this 1987 claim, the respondent filed a GAL and paid ongoing TTD. Later, while TTD continued to be paid, the respondent learned that claimant was receiving social security disability benefits simultaneous to the TTD benefits. The ALJ found an overpayment due to the social security benefits and ordered a five percent reduction in the ongoing TTD benefits to assist respondents in recouping the overpayment. Respondents appealed requesting a more expeditious overpayment recovery. The Panel found that the remedy for the overpayment of benefits rests in the ALJ's inherent discretionary power to fashion an appropriate remedy based upon the particular circumstances of the claim. Citing *Johnson v. Industrial Commission*, 761 P.2d 1140 (Colo. 1988)

[16] *Danks v. Rayburn Enterprises*, W.C. No. 4-770-978 (ICAO Sept. 10, 2014).

entitled to recovery of TTD and PPD overpayments noted above, from Claimant's ongoing TTD payments. Thus, the ALJ specifically concludes that TTD/TPD can be offset/reduced for Respondent to recover the overpayments.

Donald B. Murphy – Recovery of PPD Payments

Based on the law and findings of fact, the ALJ specifically finds and concludes that the present case is analogous to *Donald B. Murphy*. Here, Respondent paid PPD benefits then the claim was reopened for TTD benefits due to Claimant's worsened condition. Respondent has paid indemnity benefits is excess of the cap limit in 8-42-107.5, C.R.S. for the Claimant's date of injury. Respondent was paying ongoing TTD benefits.

A case may be reopened to award additional temporary disability even after the award for permanent disability benefits has been paid so long as the worsened condition causes an additional temporary loss of wages. If the temporary and permanent disability cap has been reached, the respondent may offset the previously paid PPD benefits against the ongoing TTD benefits. See *Donald B. Murphy Contractors, Inc. v. Industrial Claims Appeals Office*, 916 P.2d 611 (Colo. App. 1995).

The *Donald B. Murphy* analysis is well described in subsequent ICAO claims.[17]

In *Donald B. Murphy Contractors, Inc. v. Industrial Claim Appeals Office*, the claimant suffered an admitted work-related injury in 1991 for which he received TTD benefits. The claimant reached MMI in 1993, and the respondents filed a final admission. The respondents paid PPD benefits to reach the applicable $60,000 limit at that time set forth in § 8-42-107.5, C.R.S. for medical impairment ratings of twenty-five percent or less. The claimant's condition then worsened and his authorized treating physician determined that another surgery was appropriate. The claimant sought TTD benefits in addition to medical benefits. The respondents objected, arguing, in part, that they already had paid the limit of available temporary and permanent benefits. While the court of appeals recognized that the impairment rating could not be determined while the claimant still was undergoing medical treatment, it nevertheless concluded that no further payment was required. As recognized by the ALJ, the court held that "when further benefits are sought after the

[17] *Petschl v. City of Montrose*, WC No. 4-735-853 (ICAO Jan. 15, 2015).

twenty-five percent or less limit of § 8-42-107.5, C.R.S. has been applied, the [respondents] are entitled to offset any permanent partial benefits paid against [TTD] benefits." *Id.* at 614. The court explained that allowing an offset requires the claimant to allocate the PPD benefits already paid toward his current inability to earn wages until such time as permanent medical impairment can be calculated. Once MMI is established, then the claimant may obtain additional benefits under the limits of § 8-42-107.5, C.R.S.

The panel has repeatedly recognized that the court's holding in *Donald B. Murphy Contractors*, which awarded a credit to the respondents, was not based on speculation of the claimant's ultimate impairment and thus, is not dependent upon whether there is evidence to suggest that the claimant's impairment is likely to increase or decrease after reopening. Rather, the court in *Donald B. Murphy Contractors* merely held that when further benefits are sought after the twenty-five percent or less limit of § 8-42-107.5, C.R.S. has been applied, the respondents are entitled to offset any PPD benefits paid against TTD benefits. *Rogan v. Industrial Claim Appeals Office*, 91 P.3d 414 (Colo. App. 2003); *See also Reynal v. Home Depot, Inc.*, W.C. No. 4-585-674 (January 17, 2012); *Addington v. United Airlines*, W.C. No. 4-732-201 (November 9, 2010) (while it was possible that claimant might be declared permanently and totally disabled, the panel was not persuaded that *Donald B. Murphy Contractors* could be distinguished on that ground; probability of whether a claimant's ultimate impairment will exceed twenty-five percent does not appear to be determinative in any role in court's reasons for fashioning the credit given to respondents).

As found in the findings of fact, *Donald B. Murphy* supports an order permitting Respondent here to cease all TTD payments. However, on the record at hearing, Respondent sought only to offset the PPD and TTD overpayments by reducing ongoing TTD benefits by $100.00 per week. Thus, the ALJ finds and concludes that Respondent is permitted to offset/reduce Claimant's ongoing TTD benefits by $100.00 per week, to be credited toward the PPD and TTD overpayments, not to exceed the total $36,156.70 in overpayments. Should Respondent not fully recover the $36,156.70 in overpayments from the $100.00 per week TTD offset/reduction, Respondent may recover the remaining overpayments from Claimant's future PPD benefits, should there be any.

Order

It is therefore ordered that:

1. Respondent has proven by a preponderance of the evidence that the overpayment, TTD offset/reduction, overpayment recovery issues are ripe for adjudication.
2. Respondent has proven by a preponderance of the evidence that there is $36,156.70 in overpayments; $5,629.04 in TTD and $30,527.66 in PPD.
3. Respondent has proven by a preponderance of the evidence that it is entitled to immediate relief regarding the overpayments.
4. Respondent is permitted to reduce Claimant's ongoing TTD benefits by $100.00 per week to recover the overpayments to the extent possible.
5. If the TTD offset/reduction does not result in full recovery of the $36,156.70 in overpayments before Claimant is found to be at MMI, Respondent may recover the remaining $36,156.70 overpayments from Claimant's future PPD benefits, should there be any.
6. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Dated: October 10, 2025

/s/ Glen Goldman
Glen B. Goldman
Administrative Law Judge

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-223-958-003

Issues

- Whether Claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer?

- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that the treatment he received was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the injury?

Findings of Fact

1. Claimant was employed by Employer working maintenance at an Extended Stay American motel. Claimant testified that on September 29, 2022, he went to the hospital after he lost control of his bowels and defecated in his pants. Claimant testified he initially believed that his issue with his bowels was related to the Covid-19 virus. Claimant testified when he was in the hospital he was advised that they needed to do emergency surgery on his back. Claimant testified he did not know the physician that was going to perform the surgery, so he declined the surgical recommendation.

2. Claimant testified he was subsequently advised that the surgery recommendation was related to a cauda equina syndrome involving his low back. Claimant testified that his employment with Employer required him to move heavy objects, including refrigerators, and therefore, believed that his condition was related to his employment with Employer. Claimant testified he eventually underwent low back surgery consisting of an L4-L5 laminectomy with Dr. Chow on October 12, 2022.

3. Claimant testified he had a prior low back injury involving his L4-L5 spine in Illinois for which he had received treatment.

4. Respondents obtained an independent medical examination ("IME") with Dr. Raschbacher on October 10, 2023. Dr. Raschbacher reviewed Claimant's medical records, obtained a medical history and performed a physical examination in connection with his IME. Dr. Raschbacher noted in his medical report Claimant's prior low back injury dating back to 1989 when he was operating a jack hammer at work which resulted in a laminectomy at the L5-S1 level. Dr. Raschbacher noted that Claimant had previously been diagnosed with spinal stenosis (narrowing of the spinal canal) and denied that Claimant had been diagnosed with cauda equina syndrome.

5. Dr. Raschbacher opined in his IME report that there did not appear to be any clear injury that led to Claimant's physical complaints for which he sought medical treatment in September 2022. Dr. Raschbacher opined there was no clear objective basis attributable to an injury leading to Claimant seeking medical treatment.

6. Dr. Raschbacher testified by deposition in this matter consistent with his IME report.

7. At hearing, Claimant failed to testify to any specific incident that led to his onset of symptoms that required him to seek medical attention. Claimant testified that initially, he attributed his loss of bowel control to be related to Covid as opposed to any incident occurring at work. Claimant failed to present credible testimony as to a specific event occurring in the course and scope of his employment with Employer that would result in Claimant's need for medical treatment. While Claimant testified that he was required to move objects at work, including refrigerators, Claimant failed to establish where or when or specifically what he was doing related to his employment with Employer that would explain the basis for his onset of symptoms.

8. Therefore, the ALJ finds that Claimant has failed to establish that it is more probable than not that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer.

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2016.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with "a preexisting

disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, the ALJ credits the testimony of the Claimant along with the medical records entered into evidence at hearing and finds that Claimant has failed to establish by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer on or about September 29, 2022. As found, Claimant has failed to present credible evidence as to the events that occurred at work on or about September 29, 2022 that would result in Claimant sustaining an injury resulting in the need for medical treatment.

Order

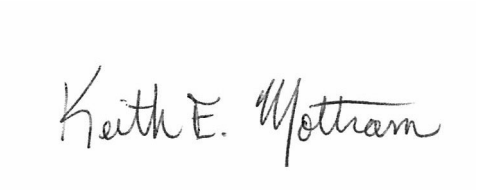
It is therefore ordered that:

1. Claimant's claim for benefits is hereby denied and dismissed.

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is

filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts.

DATED: October 23, 2025



Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-245-681-002

Issues

1. Whether Claimant overcame Dr. Parsons' true DIME opinion on maximum medical improvement (MMI) and permanent impairment by clear and convincing evidence.

2. Whether Respondents proved by a preponderance of the evidence that further medical maintenance treatment is not reasonable, necessary and causally related.

3. Whether Respondents established by a preponderance of the evidence that Claimant received an overpayment of permanent partial disability (PPD) benefits in the amount of $49,795.20 to which Respondents are entitled to recover.

4. If Respondents proved Claimant received an overpayment of benefits, determination of a repayment schedule.

Findings of Fact

1. Claimant is 49-year-old. Claimant worked for Employer as a construction worker.

2. Claimant sustained an admitted industrial injury during the course and scope of his employment for Employer on May 19, 2023. Claimant lifted a metal door weighing between 50-100 pounds and felt sudden pain in his low back. Claimant completed his work day. Claimant purports that he notified Employer soon thereafter but was not sent for evaluation until approximately two months later. Claimant continued to work full duty for Employer throughout this time period.

3. Claimant first presented for treatment at Midtown Occupational Health Services on July 17, 2023. Claimant saw Carissa Sales, PA-C under authorized treating physician

(ATP) Lori Rossi, M.D. Claimant complained of severe low back pain radiating down his legs. Claimant reported feeling as though his legs were “asleep” and that his feet were cold, with “knots” in the bottom of his feet, left greater than right. Claimant denied any history of back injury and paresthesias prior to the work injury. Lumbar spine x-rays demonstrated degenerative changes appearing moderate in severity with no acute abnormalities. PA Sales diagnosed Claimant with an acute lumbar strain from lifting with radiculopathy and radiating pain. She prescribed Claimant Celebrex, Cyclobenzaprine, physical therapy, massage therapy, and chiropractic treatment, ordered a lumbar MRI, and referred Claimant to Levi Karl Miller, D.O. for evaluation. PA Sales released Claimant to modified work duty.

4. Claimant underwent a lumbar spine MRI on July 19, 2023. The radiologist documented the following impression, in relevant part:

> 1. Unfortunately, evaluation is sub optimal given the extent of motion artifact on all sequences, particularly the axial images.
>
> 2. A right foraminal to extraforaminal disc protrusion, at L1-L2 contributes to mild to moderate right-sided L1-L2 neural foraminal narrowing and could affect the exiting right L1 nerve root if symptomatic.
>
> 3. Suspected disc herniations at L4-L5 with moderate bilateral L4-L5 neural foraminal narrowing and suspected subarticular recess stenosis, difficult to further assess. No high-grade lumbar spinal stenosis is suggested.
>
> 4. Mild bilateral foraminal narrowing at L3-L4.

(Cl. Ex. PDF p. 50).

5. Dr. Rossi evaluated Claimant on July 24, 2023. Claimant complained of sharp, poking low back pain radiating down his legs. He denied right lower extremity peripheral numbness, tingling or weakness. Dr. Rossi noted Claimant was currently undergoing chiropractic treatment, physical therapy and massage therapy with benefit.

6. Claimant returned to PA Sales on August 1, 2023, reporting that most of his back pain was left-sided. He reported tingling and weakness down his left and right legs with no improvement in his symptoms. PA Sales dispensed a cane for Claimant's use.

7. Claimant presented to ATP Miller on August 1, 2023. Dr. Miller noted that the majority of Claimant's pain was in his low back with intermittent numbness and tingling down his posterior thighs to his feet and toes. Claimant denied experiencing similar symptoms in the past requiring medical treatment. Dr. Miller assessed Claimant with lumbosacral radiculopathy, myofascial pain and paresthesias. He noted that, on examination, Claimant exhibited some mild to moderate pain behaviors with some positive Waddell signs. He further noted that Claimant scored in the "distressed somatic" psychosocial category functioning as per the DRAM. Dr. Miller prescribed medication and ordered an EMG of the lower extremities as well as a repeat lumbar MRI.

8. Claimant underwent a repeat lumbar MRI on August 17, 2023, which was compared to the 7/19/2023 lumbar MRI. The radiologist's impression was:

> 1 . Some straightening of the typical lordosis of the lumbar spine can be seen with injury.
>
> 2. Multilevel disc herniations, disc bulges and protrusions seen throughout the lumbar spine with areas of posterior annular fissures. Resultant multilevel thecal sac, neuroforaminal and lateral recess narrowing identified, overall unchanged from previous study. Possible irritation of the exiting right L1 nerve root at L1-2 and the exiting left L3 nerve root at L3-4 and the exiting bilateral L4 nerve roots at L4-5.
>
> 3. Additional lateral recess narrowing seen with possible irritation of the traversing left L4 nerve root at L3-4 and the traversing bilateral L5 nerve roots at L4-5.

(R. Ex. N, p. 660).

9. On September 1, 2023, Dr. Miller reevaluated Claimant and performed an EMG of his bilateral lower extremities. Claimant reported ongoing low back pain and bilateral leg pain left greater than right. Dr. Miller documented the impression from the repeat lumbar MRI. The EMG of Claimant's bilateral lower extremities was normal with no electrodiagnostic evidence of a left or right focal nerve entrapment, lumbosacral radiculopathy or plexopathy, myopathy, or polyneuropathy. Dr. Miller included lumbar disc herniation in his assessment and scheduled Claimant for a L4-L5 transforaminal epidural steroid injection (TFESI).

10. At a follow-up evaluation with PA Sales on September 6, 2023, Claimant reported improvement with physical therapy and chiropractic treatment. PA Sales remarked that some of Claimant's MRI findings may have been old, however, they were not bothering him until this injury, as the injury caused inflammation/flared issues in his back.

11. Claimant returned to PA Sales on September 29, 2023. Claimant reported that, since his last visit, he had sought treatment at the emergency department with an anxiety attack due to his job situation and getting injured. Claimant complained of several issues with Employer. Claimant reported experiencing short-term relief from physical therapy and chiropractic treatment. PA Sales referred Claimant to Guadalupe Ledezma, Ph.D. for psychological evaluation and treatment.

12. On October 2, 2023, Claimant underwent bilateral L4-L5 TFESI performed by Dr. Miller. On October 5, 2023, Claimant complained of multiple side effects from the injection, including nausea, headaches, anxiety, sleeping issues and acid reflux. Claimant reported that his pain increased from 4/10 to 6/10 after the injection, with no change in his bilateral leg nerve pain.

13. On October 11, 2023, Dr. Miller noted that Claimant had approximately 50% anesthetic phase relief from the TFESI. Claimant reported that, for 30 minutes following the TFESI, his pain decreased to 2/10; however, over the next several hours and next 10 days his back pain returned to 5-6/10, with muscle spasms and radiating numbness and tingling into his neck and upper extremities. Claimant continued to report numbness and tingling in the left lower extremity. Claimant reported that his symptoms were 90%

attributable to the low back and 10% to his legs. Dr. Miller added lumbar facet joint syndrome in his assessment. He recommended that Claimant undergo bilateral L3, L4 and L5 medial branch blocks (MBB).

14. At a follow-up evaluation with PA Sales on October 13, 2023, Claimant reported no improvement in his symptoms. Claimant reported experiencing the same amount of numbness and tingling in his lower extremity, now more so on the right side. Claimant reported experiencing no relief from the TFESI.

15. Claimant first presented to Dr. Ledezma on October 23, 2023. Dr. Ledezma diagnosed Claimant with moderate major depressive disorder and generalized anxiety disorder. She recommended that Claimant participate in psychotherapy.

16. On October 30, 2023, Claimant underwent bilateral L3, L4, and L5 MBB performed by Dr. Miller.

17. On November 2, 2023, Claimant reported to PA Sales worsening back pain radiating into his right leg since undergoing the MBB. Claimant also complained of left thigh cramping and neck pain that he purported began after the TFESI. PA Sales noted that Dr. Miller's questionnaire scored Claimant in the distressed somatic category and that Dr. Miller documented positive Waddell signs in the past. She wrote, "It remains apparent that patient may not improve with any further conservative interventions or injections…According to the patient, all treatments tried thus far have worsened sx or has not improved his sx…No improvement with therapies." (R. Ex. K, p. 481).

18. On November 2, 2023, Dr. Miller noted that Claimant appeared to have had a positive diagnostic response from the MBB as he had essentially no pain in the evening of the procedure, but developed a flare in back symptoms, which is common after an injection.

19. At a follow-up evaluation with PA Sales on November 6, 2023, patient disagreed with Dr. Miller that he had 66% relief following the MBB. Claimant reported that he was in more pain than before the MBB. Claimant reported experiencing anxiety attacks every

three days. PA Sales noted that it did not seem that any more treatment would help at this point.

20. Dr. Miller reevaluated Claimant on November 21, 2023. Claimant reported 7/10 pain, weakness associated with pain, and poor tolerance of lifting and bending. Dr. Miller noted 50% anesthetic phase relief from the TFESI with no enduring steroid phase relief. He further noted 66-100% anesthetic phase relief from the MBB with a flare in back pain three days later. Dr. Miller opined that Claimant was likely at MMI, stating:

> The patient has undergone extensive conservative and interventional treatment for his back condition. He has no focal neurologic deficits. Electrodiagnostic study was unremarkable of his bilateral lower extremities. MRI of his lumbar spine demonstrates multilevel degenerative changes. There is no surgically correctable lesion in the lumbar spine consistent with the patient's condition.
>
> The patient remains with persistent back and lower extremity pain which has not improved despite the extensive diagnostic workup and treatments. The patient's ATP, PA Carissa sales has ordered aquatic therapy period once this therapy has been completed, in my opinion, the patient will be at maximum medical improvement, this was discussed at length with the patient today."

(R. Ex. O, p. 729).

21. PA Sales reevaluated Claimant on November 21, 2023, noting Dr. Miller opined that Claimant was likely at MMI. Claimant continued to complain of back pain radiating down his right posterior leg into the popliteal area and the sole of the foot. PA Sales noted that Claimant declined having more injections with Dr. Miller but that he raised the idea of surgery. She referred Claimant for aquatic therapy and to Ezra Levy, D.O. for a surgical evaluation. PA Sales wrote,

> According to the patient, all treatments tried thus far have worsened sx or has not improved his sx. As per the patient…IFC increases swelling. ESI

> caused acid reflux and neck pain. MBB caused increased pain, tingling and nausea and dry mouth. No improvement with therapies. Is not hopeful about aquatic therapy. We discussed his negative mindset going into this therapy. I will send the referral but it is up to him if he would like to schedule this water based therapy.

(R. Ex. K, p. 496).

22. On December 4, 2023, Dr. Ledezma noted that, in Claimant's assessment, he had not responded to the treatment and at times felt the providers did not want to help him.

23. Claimant presented to Dr. Levy on December 6, 2023 with complaints of low back pain with bilateral lower extremity radicular symptoms. Claimant reported that physical therapy did not significantly improve his symptoms and that his pain had worsened. Dr. Levy noted that lumbar spine x-rays demonstrated mild to moderate spondylosis most notable at L4-5 with associated facet arthrosis and a lumbar demonstrated disc desiccation at L4-5 with posterior disc herniation causing moderate foraminal stenosis bilaterally, no significant central stenosis. Dr. Levy's assessment was low back pain with bilateral lower extremity radiculopathy. He recommended that Claimant undergo a L4-L5 bilateral TFESI and a repeat EMG of the lower extremities.

24. On December 19, 2023, Dr. Ledezma noted that Claimant believed there was some confusion about his assessment of the benefits of physical therapy. Claimant reported that he experienced temporary benefit from physical therapy and wanted more. Dr. Ledezma noted that Claimant was angry that his symptoms were being attributed to degeneration and felt that the other findings were being discounted. She further noted that Claimant was frustrated that his treatment was being suspended "too soon" and felt that his providers were not being clear with him about the real source of his pain and limitations.

25. On December 27, 2023, Claimant reported to PA Sales that the aquatic therapy was more beneficial than physical therapy, with five to six hours of temporary relief after each session. Claimant continued to report anxiety.

26. On January 15, 2024, Claimant underwent a repeat EMG of the bilateral lower extremities, performed by George Leimbach, M.D. The EMG demonstrated findings most consistent with bilateral L4 radiculopathy.

27. On February 8, 2024, Claimant reported to Dr. Levy that initially his back and lower extremity radiculopathy was on the left side but, as of late, he experienced a new onset right lower extremity radiculopathy and pain. Dr. Levy noted that the EMG showed bilateral L4 radiculopathy which he remarked corroborated Claimant's MRI findings. He again recommended that Claimant undergo bilateral L4-L5 TFESI.

28. On February 26, 2024, Claimant reported to PA Sales that his back pain remained the same. Claimant reported that he did not experience any long-term benefit from aquatic therapy. Claimant further reported bilateral knee pain.

29. Claimant underwent a Functional Capacity Evaluation (FCE) on March 5, 2024, conducted by occupational therapist Kristine M. Couch. Ms. Couch noted that Claimant's overall scores ranked in the below sedentary and severe disability categories.

30. PA Sales/Dr. Rossi reevaluated Claimant on March 11, 2024 and placed him at MMI. PA Sales noted that no further treatments were recommended given Claimant's lack of improvement, denial of the TFESI, absence of any surgically correctable lesion, and completion of aquatic therapy without any functional gains. The diagnosis was acute lumber strain from lifting with radiculopathy and radiating pain. PA Sales recommended the following permanent work restrictions: no crawling, kneeling, squatting, or climbing; maximum 15 pounds lifting waist to above; no lifting floor to waist or repetitive lifting; maximum carrying 15 pounds; maximum pushing 38 pounds; maximum pulling 20 pounds; no repetitive bending at the waist; and sitting, walking and stretching as needed. As maintenance treatment, PA Sales recommended that Claimant complete the remaining three to four sessions already scheduled with Dr. Ledezma. She noted that, according to Dr. Ledezma's notes, Claimant was becoming less anxious and improved symptoms.

31. Dr. Miller performed an impairment rating evaluation on March 26, 2024, agreeing with an MMI date of March 11, 2024. Claimant reported 7/10 pain with poor tolerance of bending, lifting and twisting. Dr. Miller noted that Claimant did not have focal neurologic deficits in his lower extremities. He noted,

> Plain radiographs of the lumbar spine demonstrated extensive degenerative changes throughout the lumbar spine without evidence of acute abnormality; initial MRI was of poor quality due to motion artifact. He received physical therapy, aquatic therapy, and massage therapy without benefit. Electrodiagnostic study was performed of his low back and bilateral lower extremities which was unremarkable for abnormality. MRI was repeated which showed multilevel degenerative changes, disc bulges and protrusions with L4-5 far left lateral disc protrusion and annular fissure that was most pronounced, multilevel facet arthropathy including facet effusions most pronounced at L4-5. The patient underwent lumbar epidural steroid injections as well as medial branch blocks without benefit.

(R. Ex. O, p. 731).

32. Using the AMA Guides, Dr. Miller assigned a combined total 13% whole person impairment rating, consisting of 7% whole person impairment under Table 53 II(C) and 6% whole person impairment for lumbar range of motion deficits. He recommended the permanent work restrictions assigned by PA Sales/Dr. Rossi and that, as maintenance care, Claimant complete the remaining authorized pain psychology treatment with Dr. Ledezma.

33. On April 15, 2024, Dr. Ledezma noted Claimant's understanding that he was put at MMI, and that the situation was upsetting to him because he did not yet feel well enough to return to regular work duties and wanted more treatment.

34. Respondents filed a Final Admission of Liability (FAL) on April 22, 2024, admitting for an MMI date of 3/11/2024, 13% whole person impairment equaling $49,795.20 in PPD benefits, and reasonable, necessary and related post-MMI treatment.

35. Respondents paid Claimant $49,795.20 in PPD benefits pursuant to the FAL.

36. Claimant filed an objection to the FAL and applied for a DIME.

37. On May 9, 2024, Claimant presented to the emergency department at Denver Health for a chief complaint of back pain. Claimant presented with midline lumbar spinal pain, right greater than left lower extremity paresthesias with bilateral foot numbness on the plantar aspect. Lumbar x-rays demonstrated degenerative changes. A lumbar MRI was performed that demonstrated: lower lumbar predominant degenerative changes, superimposed on moderate congenital narrowing of the lumbar spinal canal, most pronounced at L4-5 where there is moderate flattening of the thecal sac with narrowing of lateral recesses and mild-moderate bilateral neural foraminal narrowing. Visit diagnoses included chronic midline low back pain with bilateral sciatica and lumbar disc herniation. Claimant was discharged with instructions to follow up with outpatient neurosurgery.

38. Claimant underwent another lumbar spine MRI on May 14, 2024 that was compared to his 8/17/2023 lumbar MRI. The radiologist's impression was:

> 1. Straightening typical lordosis lumbar spine again seen, that can be seen with injury or spasm.
>
> 2. Multilevel disc herniations again seen with disc bulges and protrusions. Multiple sites of thecal sac, neural foraminal and lateral recess narrowing also again seen, overall unchanged. Possible irritation of the exiting right L1 nerve root, the exiting left L3 nerve root and the exiting bilateral L4 nerve roots.
>
> 3. L4-5 lateral recess narrowing may also compress and irritate the traversing bilateral L5 nerve roots and could irritate the traversing left L4 nerve root.

(R. Ex. N, p. 664).

39. On May 17, 2024, Employer put Claimant on unpaid administrative leave, stating there was no position available that coincided with Claimant's restrictions. No temporary disability benefits were paid on this claim, as Claimant continued to work and earn full wages up to being placed at MMI on March 11, 2024.

40. Dr. Miller reevaluated Claimant on May 28, 2024, noting there had been no significant change in Claimant's symptoms from August 2023. Dr. Miller noted that Claimant was frustrated, wanted his case reopened, and wanted to obtain an opinion from a surgeon. Dr. Miller again noted that physical therapy had limited benefit and the TFESI and MBB were without benefit. Nonetheless, he referred Claimant to Gary Ghiselli, M.D. for a surgical evaluation. Dr. Miller remarked, "Note the patient has scored 'distressed somatic' psychosocial functioning as per the DRAM, he has had substantial pain behaviors during his treatment course and has had subjective symptoms that do not match with objective findings and as such I would recommend strong caution before advancing to surgical intervention." (R. Ex. O, p. 741).

41. Lumbar x-rays taken on July 1, 2024 demonstrated normal alignment and normal lordosis. There was decreased disc height at L5-S1 and very mild decreased disc height at L4-L5. On flexion-extension views there was a very slight anterolisthesis at L4-5 and flexion that reduced back to neutral on extension. No other gross motion or instability was seen.

42. Claimant completed his last psychotherapy session with Dr. Ledezma on August 6, 2024. She remarked, "Given the stability in his psychological state for now, he is a good surgical candidate from a psychological perspective." (Cl. Ex. 4, PDF pp. 72-73). Dr. Ledezma recommended that Claimant undergo additional session to assist with the rehabilitation process in the event Claimant did undergo surgery.

43. On August 27, 2024, Dr. Ghiselli recommended that Claimant undergo a L4-L5 anterior-posterior fusion.

44. On August 29, 2024, PA Sales recommended that Claimant's case be re-opened due to Dr. Ghiselli's recommendation for lumbar spine surgery.

45. On September 12, 2024, Physician Advisor Marjorie Eskay-Auerbach, M.D. performed a review of the request for the L4-L5 lumbar fusion. Dr. Eskay-Auerbach opined that the requested surgery was not reasonable, necessary or related to Claimant's work injury. She explained that Claimant's MRI findings were degenerative in nature with no evidence they became symptomatic as a result of the work injury. Dr. Eskay-Auerbach noted that Claimant reported predominantly low back pain at 90% with 10% leg pain, with inconsistent complaints, non-physiologic findings, and no focal neurologic findings on examination. She further noted that there were no findings on MRI of nerve root compression, and that there were significant psychological factors and failed conservative treatment.

46. On September 17, 2024, Claimant saw PA Sales with continued complaints. He declined wanting to see Dr. Ledezma for further psychiatry treatment.

47. On October 22, 2024, Dr. Miller noted Claimant was awaiting a DIME. Dr. Miller deferred repeat lumbar minimally-invasive spine procedures, noting Claimant had poor outcomes from prior procedures.

48. Ryan Parsons, M.D. performed the DIME on November 4, 2024. Dr. Parsons performed a comprehensive review of medical records, physical examination, history from Claimant, and issued a thorough report explaining his findings and conclusions. Claimant presented wearing a velcro back brace and using a cane. Claimant denied a history of prior low back or bilateral hip issues. Claimant reported that he had been using a cane for about 8 months which Claimant purported helped him not to fall. On examination, Dr. Parsons noted, in relevant part, a mild-to-severe antalgic gait with a cane used on the right side. Dr. Parsons noted that there was non-focal and inconsistent tenderness out of proportion to the degree of pressure applied, along with pain behaviors. Dr. Parsons administered the DRAM psychological assessment, noting Claimant scored in the distressed depressive category with a high risk of somatization. Claimant also scored 66% on the Oswestry Low Back Disability Questionnaire, which Dr. Parsons noted indicated a crippling disability. He remarked,

> Claimant's objective findings on physical exam today are consistent with a level of physical function that is higher than what is reflected by the above physical scores. This, coupled with the significantly elevated psychological scores, make it likely that there are non-physiological factors that are contributing to an elevated level of perceived physical disability.

(R. Ex. E, p. 069).

49. Dr. Parsons opined that Claimant suffered a lumbar strain as a result of the work injury and concurred with an MMI date of March 11, 2024. He explained,

> The medical record is most consistent with the claimant sustaining a lumbar sprain on the DOI. Of note, the described mechanism becomes more dramatic with further reports of the injury, including in the claimant's report today. This shows a lack of consistency, as does the medical record in showing that his radicular type symptoms were initially more left sided and then became more right sided after the initial MRI had been performed.
>
> Additionally, there is no evidence in the medical record of an acute disc injury. His back pain and lower extremity symptoms are documented to worsen with time in the available records. This is NOT consistent with the typical natural course of acute disc herniations. Acute disc herniations are likely to gradually improve over time as they heal and are absorbed by the body over a period of weeks to months [1]. His MRI does show some mild to moderate degenerative changes, however these are relatively common, even in persons without symptoms. The CO DoWC Low Back Medical Treatment Guidelines, Rule 17, Exhibit 1 indicates in Table 8 that these degenerative changes are relatively common in the asymptomatic population and are present in the majority of asymptomatic persons over 40 years of age [2].

(Id. at 071).

50. Dr. Parsons noted that Dr. Miller also documented non-physiologic findings on his examination. He further noted that Claimant's records showed a lack of consistent or definitively radicular pattern to his paresthesias and an EMG on 9/1/2023 did not show any electrodiagnostic evidence of radiculopathy and was normal overall. Dr. Parsons noted that his examination of Claimant continued to show inconsistencies in Claimant's areas of paresthesias and did not correlate with any particular radiculopathy. Dr. Parsons acknowledged that the 2/8/2024 EMG showed evidence of a bilateral lower extremity L4 radiculopathy, but that this still did not correlate well with Claimant's overall symptoms.

51. Dr. Parsons noted that Claimant did not experience any meaningful improvement from the bilateral L4-L5 TFESI, the MBB, or the physical therapy, aquatic therapy, massage therapy and chiropractic treatment. Dr. Parsons explained that the lack of improvement from the TFESI further supported the non-physiologic nature of Claimant's ongoing low back pain.

52. Using the AMA Guides, Dr. Parsons assigned a total combined 16% whole person impairment of the lumbar spine. He assigned 5% whole person impairment under Table 53 II(B) for a lumbar strain and12% whole person impairment for lumbar range of motion deficits under Tables 60 and 61. Dr. Parsons disagreed with Dr. Miller's impairment rating under Table 53 II(C) as opposed to Table 53 II(B), opining that the primary proximate occupational cause of Claimant's low back pain was a lumbar strain rather than any underlying disc pathology. He explained that the Colorado Division of Workers' Compensation Desk Aid #11 Impairment Rating Tips,

> [s]tates under the Spinal Rating section #9 that 'The physician should not rate findings by diagnostic imaging if they have not been clearly defined as contributing significantly to the patient's condition.' I am of the medical opinion that the lumbar degenerative changes do NOT clearly contribute to the claimant's symptoms due to the reasons outline in the discussion above. Therefore, a IIB rating for the occupationally related lumbar strain that was treated for greater than 6 months is most appropriate.

(Id. at 075).

53. Dr. Parsons further noted that there were some differences in his and Dr. Miller's impairment ratings due to differences in range of motion on examinations. He noted that range of motion differences were most likely due to the fact that there are some muscular and soft tissue components to active range of motion restrictions that are likely to be altered from one time of measurement to the next. He opined that his impairment rating best reflected Claimant's current status related to the work injury.

54. Dr. Parsons opined that it was not medically probable the work injury caused, exacerbated or significantly affected any underlying degenerative change of Claimant's lumbar spine. He further opined that, despite subjective sensory changes in Claimant's bilateral lower extremities, there was no indication of any nerve root impairment related to the work injury. He explained that there was a lack of physiologic correlation, the radicular symptoms did not follow any particular dermatomal or nerve root distribution, the initial EMG did not show any evidence of radiculopathy, and the bilateral L4 TFESI did not result in any improvement. He further opined that it was not medically probable the mechanism of injury would cause, exacerbate or otherwise alter the natural history of Claimant's degenerative disc disease. He concluded that Claimant's chronic pain and the recommended lumbar fusion were also not to the work injury. Dr. Parsons noted there was no evidence of injury to either hip related to the work injury and no treatment provided to the hips during the claim.

55. Dr. Parsons further opined that the work injury did not cause, exacerbate or otherwise significantly affect Claimant's diagnoses of anxiety and depression. He noted that Dr. Ledezma identified anxiety and major depression as diagnoses but did not provide any specific statement of causality as related to the work injury. He noted that Claimant reported that his treatment with Dr. Ledezma did not result in any significant improvement in his symptoms. Dr. Parsons concluded that it was most medically probable that Claimant's ongoing mood symptoms were related to underlying biopsychological factors unrelated to the work injury. He opined that Claimant's psychological issues therefore did not meet the standards to be occupationally related and thus did not assign a corresponding impairment rating. Dr. Parsons nonetheless calculated a provisional 5%

whole person impairment rating as Claimant did undergo psychological treatment during his claim.

56. Dr. Parsons opined that the permanent work restrictions assigned by Dr. Rossi and PA Sales were "excessively restrictive given [Claimant's] overall presentation and exam," but nonetheless agreed with the permanent restrictions as Claimant felt they were necessary and they were supported by the FCE. (Id. at 076). He opined that no further maintenance care was indicated.

57. On February 5, 2025, Scott Primack, D.O. performed in Independent Medical Examination (IME) at the request of Respondents. In addition to taking Claimant's history, reviewing the medical records, and performing a physical examination, Dr. Primack reviewed video surveillance of Claimant obtained on October 22, 24, 30 and November 4, 2024.[1] He noted that Claimant appeared in the video with no pain behavior and was observed ambulating with good pace, performing quick moves with ambulation, lifting material, pushing items without difficulty, bending forward easily, walking with no limp, carrying a garbage can, fully flexing, and lifting a child into his truck without difficulty. Dr. Primack remarked, "Never once was there a 'limp' in the videos during a non-medical office day" yet, at his IME and on the day Claimant presented to Dr. Parsons for the DIME, Claimant was observed with a limp and cane. (R. Ex. G, p. 100).

58. Dr. Primack noted that Claimant's psychological screening scores indicated a physical manifestation secondary to underlying duress, a strong level of perceived disability, moderate anxiety, very high somatic complaints, high pain complaints, extremely high functional complaints and a perception of being totally disabled. Claimant reported that he must use a cane all of the time because of his equilibrium. On examination, Dr. Primack noted, in relevant part, that Claimant walked very slowly with a very antalgic gait pattern. He further noted a "bizarre" level of motion in flexion, extension, right lateral side bending, and left lateral side bending. Dr. Primack noted positive Waddell

[1] In his report Dr. Primack refers to surveillance video taken 10/22/2024, 10/24/2022, 10/30/2024, and 11/24/2024. Based on the totality of the evidence, the ALJ infers that the reference to 10/24/2022 and 11/24/2024 are typographical errors. The correct dates as reflected on the surveillance video are 10/22/2024, 10/24/2024, 10/30/2024, and 11/4/2024.

signs and stated, “One could not even come close with consistent measurements.” (Id. at 101).

59. Dr. Primack opined that Claimant did not sustain any permanent impairment related to the work injury. He wrote,

> After reviewing all the medical records, the imaging studies, the electrophysiologic data, the patient's BHI, outcome assessment, and the surveillance videos, the patient does have a consciousness misrepresentation of his physical activity. He is malingering. In fact, given how he scored in the BHI, as well as the outcomes analysis, I do believe the patient purposely intended to alter the clinician's judgment and perceptions of his impairment and disability. The BHI data is significantly magnified to present oneself as completely disabled without sufficient correlative pathology. His entire FCE was symptom limited and therefore has no merit. The surveillance demonstrated two extremely different behavior patterns. When he is not reporting to a medical evaluation, in the community, when one looks at the video, he moves quite easily and there are no issues with balance or limping with pain behavior. Therefore, although Dr. Parsons did an excellent job in the DIME with the data that he had given their surveillance video, his work capacity in almost two months, and the behavior in the clinic, the DIME is erroneous. I am sure that Dr. Parsons, after reviewing all the available data, would come to the same conclusion.
>
> . . .
>
> In reference to the impairment rating, given the extreme polarity of gait and movement when seen not going to the doctor’s office, or in the clinic area versus ‘in the office/parking lot,’ his clinical examination, his outcomes data, and his BHI, there is 0% impairment of whole person.

(Id. at 102).

60. On February 19, 2025, Claimant again sought treatment for his low back pain at the emergency department of Denver Health. Claimant was noted to be ambulating with a cane at baseline. Claimant reported that his pain acutely worsened last night with the cold weather. Physical exam was concerning for cord compression with bilateral lower extremity paresthesias and saddle anesthesia. Claimant underwent a lumbar MRI, which was compared to his 5/9/2024 MRI. The physician noted the following on MRI:

> 1. Unchanged multilevel lumbar spondylosis superimposed on congenital narrowing of the lumbar spinal canal resulting in moderate spinal canal narrowing at L4-L5 with unchanged subarticular effacement and crowding of cauda equina nerve roots at this level. Unchanged mild to moderate left greater than right foraminal narrowing at L4-L5.
>
> 2. Redemonstrated unchanged findings relating to partial sacralization of the L5 segment with left greater than right large transverse processes pseudoarticulating with the adjacent sacral ala without marrow edema, a finding that can be seen with Bertolotti syndrome.

(Cl. Ex. 3, PDF p. 60).

61. Dr. Miller reevaluated Claimant on March 18, 2025, noting Claimant reported being seen at Denver Health with an order for an EMG. Claimant requested that he be sent back to pain psychology for ongoing depression and pain management. Claimant reported bilateral hip pain. Dr. Miller ordered x-rays of Claimant's bilateral hips and referred Claimant back to Dr. Ledezma.

62. On April 2, 2025, David Yamamoto, M.D. performed an IME at the request of Claimant. As part of his record review, Dr. Yamamoto reviewed Dr. Parsons' DIME report and Dr. Primack's IME report. Claimant reported 6-8/10 pain in his lower back and numbness in both feet and hands, with symptoms worse on the right. Claimant further reported depression and anxiety. On examination, Dr. Yamamoto noted Claimant presented with a cane and had a slow, deliberate and antalgic gait. Dr. Yamamoto's assessment was a lumbar strain, pre-existing lumbar degenerative disease, and mild

depression. He noted that his findings, contrary to Dr. Primack's, were that Claimant had consistent range of motion with his measurements similar to those of Dr. Parsons'. Dr. Yamamoto also reviewed surveillance video in which he noted "[Claimant] was in general able to lift, carry, and bend without issues and only used a cane on the date of the surveillance video." (Cl. Ex. 2, PDF p. 29).

63. Dr. Yamamoto agreed with Dr. Parsons' MMI date of 3/11/2024. Dr. Yamamoto assigned 5% whole person impairment rating under Table 53 II(B). He explained that he did not assign any impairment for range of motion because the measurements he took were, "not consistent at all with the review of the surveillance videos." (Id.). Dr. Yamamoto also assigned 3% whole person impairment for depression, for a total combined 8% whole person impairment. He agreed with the permanent restrictions outlined by Dr. Parsons. Dr. Yamamoto opined Claimant did not require any maintenance care. With respect to Dr. Primack's opinion that Claimant was malingering, Dr. Yamamoto stated, "Upon review of the surveillance video, it is my opinion that [Claimant], while not malingering, is exaggerating his physical condition, especially on the mechanism of the injury and his lack of response to treatment." (Id. at PDF p. 30).

64. On April 10, 2025, Dr. Parsons testified under oath at a pre-hearing evidentiary deposition. Dr. Parsons testified on behalf of Respondents as a Level II accredited expert in occupational medicine and family medicine. Dr. Parsons testified that, since issuing his DIME report, he reviewed Dr. Primack's IME report and surveillance video of Claimant consisting of approximately ½ hour of edited footage and 1 ½ hours or more of continuous footage. Dr. Parsons testified that his opinion had since changed with respect to Claimant's MMI date and permanent impairment. Dr. Parsons opined that Claimant reached MMI as of Dr. Miller's November 21, 2023 evaluation. He explained:

> Q. Okay. Can you tell us why you changed the MMI date to 11/21/23?
>
> A. Well, the video that I've seen since my IME makes it pretty clear that when the claimant is not being seen for medical appointments that they move and present themselves in a much different fashion than when they are being observed for medical appointments.

Q. Okay. And then how was it – how was the presentation different, in your – in your view, by the claimant?

A: When I saw [Claimant] for the DIME appointment, he was very slow, hesitant in his movements, had a significantly antalgic gait required a cane to move.

The surveillance video that I've seen since is quite different than that.

(R. Ex. F, p. 086, Parsons Dep. Tr. 11:3-18).

65. Dr. Parsons further testified that his original opinion that Claimant sustained 16% whole person impairment had also changed:

Q: Okay. And do you – is that still your opinion, sitting here today, with respect to permanent impairment?

A: No. That has changed as a result of the new information as well.

Q: Okay. Can you tell us how it changed?

A: I would now assign a zero percent impairment because I do not believe the claimant's issues are physiologically based.

(Id., Parsons Dep. Tr. 12:5-18).

66. Dr. Parsons testified that the surveillance video significantly affected Claimant's credibility and reliability. He testified that at the time of the DIME, he did have concerns that Claimant's findings and symptoms were not physiologically based and that the objective findings did not correlate with all of Claimant's subjective underlying complaints. He further testified that he, however, is a "very empathetic provider overall" and that he believed Claimant was highly somatically focused and Dr. Ledezma was of the opinion that Claimant was being forthright. Thus, at the time, based on the "whole combination of [Claimant's] underlying biopsychological makeup," he felt there was some level of impairment. (Id. at 089, Parsons Dep. Tr. 23-24). Dr. Parsons testified:

> However, the – primarily the surveillance video that I've seen since that time leads me to a much different opinion. If [Claimant], you know, was indeed that person described by the medical records at the time of my DIME and in Dr. Ledezma's report, he would be continuing to move at all times in his life in a similar fashion.
>
> And that is clearly not the case. And there is a very dramatic discrepancy from how things are presented in the medical record and at the time of the DIME compared to what I see in that surveillance video.
>
> In my DIME report, you can tell I already had significant concerns that his symptoms were not physiologically based.
>
> And that – the information I've received since that time causes me to really feel even more strongly about that and to be of the professional medical opinion that this has not been presented accurately by the claimant throughout the medical record.

(Id. at 089-90, 24:25, 25:1-20).

67. Dr. Parsons testified that Claimant's movement on the surveillance video was completely inconsistent with how Claimant moved at the DIME evaluation and as documented throughout the medical records. He explained that, at the DIME, Claimant presented with marked gait abnormalities and pain behaviors/expressions that were not present on the surveillance video. He testified, "The surveillance video makes it very clear to me, combined with the rest of the nonphysiologic things that I already noted in my report, that his -- physical condition is not accurately represented by himself at the time of my exam." (Id. at 091, Parsons Dep. Tr. 32:5-8).

68. Dr. Parsons continued to opine that Claimant did not need any medical maintenance care as related to the work injury.

69. On May 6, 2025, Dr. Miller noted that Claimant's bilateral hip x-rays were unremarkable. He further noted that Claimant underwent an EMG through Denver Health on 4/30/2025 that described chronic right L5 radiculopathy.

70. On May 22, 2025, Dr. Primack issued a supplemental IME report after reviewing additional records including a Denver Health medical record dated 11/12/2021 which noted problems with chronic low back pain and right-sided sciatica. He also reviewed a 7/5/2022 Denver Health medical record where Claimant was seen for acute low back pain without sciatica. The record documents symptoms going into Claimant's arms and left leg and problems walking clinically. There was a question of possible kidney stones. Dr. Primack noted that the most common predictor for someone who has a back problem is essentially a history of spine pain. He opined that the fact Claimant did not discuss with his providers any previous history of low back pain and/or sciatica prior to his work injury added more data that Claimant is profoundly misrepresenting his injury and his level of impairment.

71. On August 13, 2025, Dr. Miller responded to a July 21, 2025, letter from Respondents' counsel in which she enclosed for review Dr. Parsons' DIME report, a transcript of Dr. Parson's deposition testimony, Dr. Primack's IME report, and surveillance video. Dr. Miller agreed with Dr. Parsons and Dr. Primack that Claimant has no permanent impairment as a result of the work injury and that Claimant consciously misrepresented his condition during his evaluation for a permanent impairment rating.

72. Claimant testified at hearing. Claimant testified that Dr. Parsons and others did not completely review his medical records from Denver Health. Claimant testified that he has good days and other days that his condition and symptoms are worse. He testified that his back hurts and that he does not think there is a picture or video that reflects what he feels. Claimant testified that his MRIs document findings. Claimant testified that PA Sales gave him a cane to use because of right knee symptoms, not because of issues with his back, and that he has never used the cane because of his back. Claimant testified that his son is six-years-old and has autism and ADHD, which requires Claimant to provide

him additional care and attention. Claimant testified that the weight of the items he is observed carrying or moving on surveillance video do not exceed his weight restrictions.

73. Claimant did not testify to, nor offer any other evidence, regarding any alleged overpayment, ability to pay any alleged overpayment, or request any particular schedule for repayment if ordered.

74. Dr. Primack credibly testified at hearing on behalf of Respondents as a Level II accredited expert in physical medicine and rehabilitation. Dr. Primack testified consistent with his IME reports and continued to opine that Claimant did not sustain any permanent impairment as a result of the work injury. Dr. Primack testified that Claimant has a significant history pre-existing multilevel lumbar degenerative disc disease and did not disclose any pre-existing lumbar spine conditions to his providers. Dr. Primack testified that Claimant presented dramatically different on surveillance video versus how he presented to providers and that, on clinical examination, there were several nonphysiologic findings. Dr. Primack opined that no further maintenance care is reasonable, necessary or causally related to the work injury.

75. The ALJ reviewed surveillance video of Claimant taken on October 22, 24, 30 and November 4, 2024, included in Respondents' Exhibit Q. Claimant is observed on October 22 and 24 doing the following without difficulty or pain behaviors: lifting his son into his truck; leaning into his truck; entering into his truck; ambulating at a normal-to-brisk pace without any altered gait or use of a cane; carrying items; putting items in a large trash bin; leaning over at the waist to move items in the trash bin; and moving the trash bin. On October 30, Claimant is observed walking at normal pace with no altered gait or pain behaviors and no use of a cane. Claimant is later seen holding a cane in his right hand and presents with significant pain behaviors and difficulty getting into his truck. On November 4, 2024, the date of his DIME evaluation with Dr. Parsons, Claimant is observed walking to the entrance of a building at a considerably slower pace with a significantly altered gait and using a cane. Claimant's presentation is markedly different in the November 4, 2024 video compared to the other videos.

76. At one point, Claimant became aware that he was being surveilled. (*See* Cl. Ex. 6, PDF p. 126) ("Once my wife and I realized we were being followed, we felt harassed…").

Ultimate Findings

77. The ALJ finds the opinions of Drs. Parsons, Miller, Primack and Eskay-Auerbach, as supported by the record, more credible and persuasive than Claimant's testimony and the contrary opinions of Drs. Rossi, Levy and Yamamoto.

78. Dr. Parsons changed his DIME opinion originally expressed in his November 4, 2024 DIME report. Per his deposition testimony under oath on April 10, 2025, Dr. Parsons changed his opinion as to Claimant's MMI date and impairment rating. Dr. Parsons' revised opinions as expressed in his deposition testimony are unambiguous. Dr. Parsons' true and correct DIME opinion is that Claimant reached MMI as of November 21, 2023 with no permanent impairment.

79. Claimant failed to overcome Dr. Parsons' DIME opinion that Claimant reached MMI on November 21, 2023 with no permanent impairment by clear and convincing evidence.

80. Respondents proved by a preponderance of the evidence further medical maintenance care is not reasonable, necessary or causally related to Claimant's work injury.

81. Respondents proved by a preponderance of the evidence Claimant knowingly and intentionally made false material misrepresentations regarding his condition, abilities and level of function to obtain additional treatment and benefits under the workers' compensation system. The ATPs, IME physicians, and Respondents were unaware of Claimant's true ability and level of function until surveillance video was obtained. As a result of Claimant's misrepresentations, Respondents paid Claimant PPD benefits to which he was not entitled.

82. Respondents proved by a preponderance of the evidence Claimant received an overpayment of $49,795.20 due to fraud. Respondents are entitled to recover the overpaid amount.

83. No evidence was offered upon which the ALJ can reasonably determine a payment schedule or terms of repayment. Accordingly, such issue is reserved for future determination.

84. Evidence and inferences contrary to these findings were not credible or persuasive.

Conclusions of Law

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *University Park Care Center v. Indus. Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Indus. Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d

186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Indus. Comm'n*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

The True Opinion of the DIME Physician

The DIME physician's findings include his or her subsequent opinions, as well as his or her initial report. *Andrade v. Industrial Claim Appeals Office,* 121 P.3d 328, 330 (Colo. App. 2005). If a DIME physician issues conflicting or ambiguous opinions concerning MMI or impairment, it is the ALJ's province to determine the Division IME's true opinion as a matter of fact. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000); *Rainwater v. Sutphin*, WC 4-815 042-04 (ICAO September 9, 2014).

In his initial DIME report dated November 4, 2024, Dr. Parsons opined that Claimant reached MMI on March 11, 2024 and assigned a total combined 16% whole person impairment, consisting of 12% whole person impairment for lumbar range of motion deficits and 5% whole person impairment for a lumbar sprain under Table 53 II(B). Upon reviewing surveillance video of Claimant and Dr. Primack's February 5, 2025 IME report, Dr. Parsons subsequently changed his DIME opinion regarding MMI and permanent impairment, as expressed in his deposition testimony given under oath on April 10, 2025. Dr. Parsons clearly states that he changed his opinions and ultimately opined that Claimant reached MMI on November 21, 2023 with no permanent impairment. As found, Dr. Parsons' revised opinions as expressed in his deposition testimony are unambiguous and represent Dr. Parsons' true and correct DIME opinion regarding MMI and permanent impairment. Accordingly, Dr. Parsons' true and correct DIME opinion is that Claimant reached MMI as of November 21, 2023 with no permanent impairment.

Overcoming the DIME Opinion

A DIME's findings of MMI, causation, and non-scheduled impairment are binding on the parties unless overcome by clear and convincing evidence. § 8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Indus. Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). "Clear and convincing evidence" is evidence that demonstrates it is "highly probable" that the DIME's findings are incorrect. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998). To overcome a DIME's opinion, "there must be evidence that the DIME physician's determination is incorrect and this evidence must be unmistakable and free from serious or substantial doubt." *Adams v. Sealy, Inc.*, W.C. No. 4-476-254 (ICAO, Oct. 4, 2001). A mere difference of opinion between physicians does not necessarily rise to the level of clear and convincing evidence. *See Gonzales v. Browning Ferris Industries of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

As found, the DIME physician's true opinion is that Claimant reached MMI as of November 21, 2023 with no permanent impairment. Accordingly, Claimant has the burden of proof to overcome Dr. Parsons' opinions by clear and convincing evidence.

MMI

MMI exists at the point in time when "any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." § 8-40-201(11.5), C.R.S. Under the statute, MMI is primarily a medical determination involving diagnosis of the claimant's condition. *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Monforte Transportation v. Industrial Claim Appeals Office,* 942 P.2d 1358 (Colo. App. 1997). A DIME physician's findings concerning the diagnosis of a medical condition, the cause of that condition, and the need for specific treatments or diagnostic procedures to evaluate the condition are inherent elements of determining MMI. *Mosley v. Industrial Claim Appeals Office,* 78 P.3d 1150 (Colo. App. 2003); *Quall-Med, Inc. v. Industrial Claim Appeals Office,* 961 P.2d 590 (Colo. App. 1998).

A finding that the claimant needs additional medical treatment (including surgery) to improve his condition by reducing pain or improving function is inconsistent with a finding of MMI. *MGM Supply Co. v. Industrial Claim Appeals Office,* 62 P.3d 1001 (Colo. App. 2002); *Reynolds v. Industrial Claim Appeals Office,* 794 P.2d 1080 (Colo. App.

1990); *Sotelo v. National By-Products, Inc.,* W.C. No. 4-320-606 (ICAO, March 2, 2000). Similarly, a finding that additional diagnostic procedures which offer a reasonable prospect for defining the claimant's condition or suggesting further treatment are warranted would be consistent with a finding that a Claimant was not at MMI. *Hatch v. John H. Harland Co.,* W.C. No. 4-368-712 (ICAO, August 11, 2000). However, the requirement for future medical maintenance which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of MMI per Section 8-40-201(11.5), C.R.S. nor does the need for recommended diagnostic testing solely to assist in the maintenance of a claimant's condition. *Brownson-Rausin v. Industrial Claim Appeals Office*, 131 P.3d 1172 (Colo. App. 2005).

Claimant failed to establish that it is highly probable Dr. Parsons' opinion Claimant reached MMI on November 21, 2023 is incorrect. The record demonstrates that, by November 21, 2023, Claimant underwent multiple diagnostic procedures and extensive conservative treatment including x-rays, an MRI, an EMG, a TFESI, MBB, physical therapy, chiropractic treatment, massage therapy and some aquatic therapy, without any significant improvement. At his November 21, 2023 evaluation, Dr. Miller opined that Claimant was likely at MMI, noting Claimant's persistent pain complaints despite extensive conservative and interventional treatment. Dr. Miller noted that there were no focal neurologic deficits, an unremarkable EMG, degenerative changes on the MRI and no surgically correctable lesion. Claimant was to complete aquatic therapy, which he did, and which ultimately did not result in any significant improvement.

It appears Claimant's providers continued to refer Claimant for additional evaluation and treatment based in large part on Claimant's continued complaints and misrepresentations regarding his condition and abilities. Despite Claimant undergoing additional diagnostic procedures and treatment after November 21, 2023 including, among other things, an evaluation by Dr. Levy and a repeat EMG, there remained no significant improvement or change in Claimant's condition and function as compared to his condition on November 21, 2023. Although a repeat EMG demonstrated bilateral L4 radiculopathy, Drs. Parsons and Eskay-Auerbach credibly opined that these findings did not correlate with Claimant's symptoms. While Dr. Ghiselli recommended lumbar surgery,

Drs. Parsons and Eskay-Auerbach credibly opined that such surgery was not reasonable, necessary or causally related to the work injury. The record demonstrates that evaluation and treatment after November 21, 2023 did not significantly improve Claimant's condition or function, nor further define Claimant's condition as related to the work injury.

The totality of the evidence supports Dr. Parsons' ultimate DIME opinion that, as of November 21, 2023, Claimant's impairment as a result of his work injury had become stable, with no further treatment reasonably expected to improve his condition. Although Drs. Rossi and Yamamoto opined that Claimant reached MMI on March 11, 2024, their opinions represent mere differences of opinion with the DIME physician that do not rise to the level of clear and convincing evidence.

In the alternative, even assuming, arguendo, Dr. Parsons' opinion that Claimant reached MMI on November 21, 2023 instead of March 11, 2024 is incorrect, there is no clear and convincing evidence demonstrating that Dr. Parsons' opinion that Claimant has reached MMI is incorrect. Drs. Rossi, Miller, Primack and Yamamoto have also all opined that Claimant has reached MMI for his work injury, with record support.

Permanent Impairment

The finding of a DIME physician concerning the claimant's non-scheduled medical impairment rating shall be overcome only by clear and convincing evidence. As a matter of diagnosis the assessment of permanent medical impairment inherently requires the DIME physician to identify and evaluate all losses that result from the injury. *Mosley v. Industrial Claim Appeals Office*, 78 P.3d 1150 (Colo. App. 2003); *Sharpton v. Prospect Airport Services* W.C. No. 4-941-721-03 (ICAO, Nov. 29, 2016). The rating physician's determination concerning the cause or causes of impairment should include an assessment of data collected during a clinical evaluation and the mere existence of impairment does not create a presumption of contribution by a factor with which the impairment is often associated. *Wackenhut Corp. v. Industrial Claim Appeals Office*, 17 P.3d 202 (Colo. App. 2000).

A DIME physician is required to rate a claimant's impairment in accordance with the AMA Guides. § 8-42-107(8)(c), C.R.S.; *Wilson v. Industrial Claim Appeals Office,* 81 P.3d 1117, 1118 (Colo. App. 2003). However, deviations from the AMA Guides do not

mandate that the DIME physician's impairment rating was incorrect. *In Re Gurrola,* W.C. No. 4-631-447 (ICAO, Nov. 13, 2006). Instead, the ALJ may consider a technical deviation from the AMA Guides in determining the weight to be accorded the DIME physician's findings. Rather, deviation from the AMA Guides constitutes evidence that the ALJ may consider in determining whether the DIME physician's rating has been overcome. *See Wilson v. Industrial Claim Appeals Office, supra*; *Logan v. Durango Mountain Resort,* W.C. No. 4-679-289 (ICAO, April 3, 2009); *Linda Vuksic v. Lockheed Martin Corporation* W.C. No. 4-956-741-02 (ICAO, Aug. 4, 2016). Whether the DIME physician properly applied the AMA Guides to determine an impairment rating is generally a question of fact for the ALJ. *In re Goffinett,* W.C. No. 4-677-750 (ICAO, Apr. 16, 2008).

The Colorado General Assembly, in the Act, has instructed the Director of the Division to promulgate rules establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines for impairment ratings. §§ 8-42-101(3)(a)(I), 8-42-101(3.7), C.R.S. The Division has created Desk Aid #11 - Impairment Rating Tips to provide guidance to Level II providers conducting impairment ratings in Colorado. "The Impairment Rating tips, and other rating protocols, have been rendered by the General Assembly as part of a judge's inherent duty and power to find and apply the law." *Serena v. SSC Pueblo Belmont Op Co., LLC*, W.C. No. 4-922-344-01 (ICAO, Dec. 1, 2015), aff'd, *Serena v. Industrial Claim Appeals Office*, (Colo. App. No. 15CA2095, November 3, 2016) (not selected for publication). "We extend deference to the Workers' Compensation Division's interpretation of the AMA Guides as set forth in the Impairment Rating Tips. These Tips were written at the direction of the statute, § 8-42-101(3.5) (a) (II)." *Serena v. SSC Pueblo Belmont Op Co., LLC, supra*; *see also In re Claim of Freeman,* W.C. No. 4-942-096-01 (ICAO, May 4, 2016). While the Impairment Rating Tips are not part of the AMA Guides, they may be relevant to the assignment of an impairment rating. Therefore, a physician's application of those tips goes to the weight the ALJ gives to an impairment rating. *In re Claim of Gallegos*, W.C. No. 5-054-538-002 (ICAO, Feb. 11, 2020); *Serena v. SSC Pueblo Belmont, supra.*

As found, Claimant failed to prove that it is highly probable Dr. Parsons' DIME opinion on permanent impairment is incorrect. Dr. Parsons conducted a thorough evaluation and records review and provided a detailed and comprehensive analysis in his

DIME report applying the AMA Guides. As Claimant had undergone more than six months of treatment for the lumbar strain, Dr. Parsons elected at the time to assign 5% whole person impairment for a lumbar strain under Table 53(II)(B) and 12% whole person impairment for lumbar range of motion deficits. Dr. Parsons explained the basis for his opinion, applying the AMA Guides and Impairment Rating Tips. Dr. Parsons also thoroughly explained in his DIME report why he did not assign any permanent psychological impairment or any other impairment related to the work injury.

Table 53(II)(B) provides for 5% whole person impairment of the lumbar spine in cases of unoperated intervertebral disc or other soft-tissue lesions with medically documented injury and a minimum of six months of medically documented pain and rigidity with or without muscle spasm, associated with none-to-minimal degenerative changes on structural tests.

The Spinal Rating section of the Impairment Rating Tips provides, in relevant part:

1. **Table 53 and Application of Spinal Range of Motion:** In order to be assigned a spinal rating, the patient must have objective pathology and impairment that qualifies for a numerical impairment rating of greater than zero under Table 53. Spinal range of motion impairment must be completed and applied to the impairment rating only when a corresponding Table 53 diagnosis has been established…
2. **Table 53 and 0% Impairment Rating with Six Months or More Treatment:** Whenever 6 months of treatment of the spine has occurred and a Table 53 zero percent rating is assigned, the physician must provide justification for the zero percent rating, based on the lack of physiologic findings. The rating physician shall be aware that a zero percent rating in this circumstance implies that treatment was performed in the absence of medically documented pain and rigidity.

. . .

9. **Using Table 53 to differentiate between II (B), (C) and (F) regarding x-ray findings:** The mere presence of findings by diagnostic imaging is not a sufficient justification to rate a nonspecific spinal complaint. This

> applies to the use of II (C) and II (F). The physician should not rate findings by diagnostic imaging *if they have not been clearly defined as contributing significantly to the patient's condition*…

Upon his review of additional information and surveillance video of Claimant, Dr. Parsons ultimately opined that Claimant did not sustain any permanent impairment as a result of the work injury. Dr. Parsons provided justification in his deposition testimony for the zero percent impairment rating. He credibly testified that, at the time of his DIME evaluation, he had significant concerns that Claimant's symptoms were not physiologically based and that Claimant was highly somatically focused, but believed Claimant was being forthright and that some impairment existed. This is reflected in Dr. Parsons' DIME report. Claimant's dramatically different presentation on surveillance video confirmed Dr. Parsons' initial concerns, resulting in his ultimate opinion that Claimant did not sustain any permanent impairment based on a lack of physiologic findings and objective findings correlating with Claimant's subjective symptoms.

Dr. Parsons' ultimate opinion is supported by the record and the opinions of Drs. Miller, Eskay-Auerbach and Primack. Dr. Eskay-Auerbach credibly noted inconsistent complaints, non-physiologic and non-correlative findings, a lack of neurologic findings on examination, and lack of MRI findings of nerve root compression. Rating ATP Miller previously noted that Claimant's subjective symptoms did not match the objective findings. While he initially assigned 13% total combined whole person impairment under Table 53(II)(C) and for lumbar range of motion deficits, subsequent to reviewing additional information and surveillance video, Dr. Miller credibly opined that Claimant did not sustain any permanent impairment and that Claimant had consciously misrepresented his condition. Dr. Primack also credibly opined there were non-physiologic findings, insufficient correlative pathology, Claimant was consciously mispresenting his physical activity and abilities, and that Claimant did not sustain any permanent impairment. Even Claimant's own IME physician, Dr. Yamamoto, opined that Claimant was exaggerating his physical condition and lack of response to treatment, and did not assign any permanent impairment for lumbar range of motion due to his measurements being wholly inconsistent with Claimant's presentation on the surveillance video.

Thus, despite Claimant undergoing more than six months of treatment for a lumbar strain, Dr. Parsons' zero percent impairment rating is justified based on the lack of physiologic and correlative findings. In the context of consistently documented non-physiologic findings, objective findings that do not correlate with Claimant's symptoms, and Claimant's conscious misrepresentations regarding his condition and abilities, the fact that Claimant underwent more than six months of treatment does not, by itself, establish he sustained any permanent physical impairment as a result of the work injury.

With respect to any mental impairment, Dr. Parsons has consistently opined that Claimant did not sustain any mental impairment as a result of the work injury. In his DIME report, he opined that Claimant's ongoing mood symptoms were more likely not causally related to the work injury and thus did not assign a corresponding impairment rating. He further explained that Dr. Ledezma did not provide any specific statement of causality as related to the work injury, and that Claimant reported no significant improvement from his treatment with Dr. Ledezma. Dr. Parsons' opinion that Claimant did not sustain any mental impairment is supported by the record and the opinions of ATP Miller and Dr. Primack, who also did not assign any permanent mental impairment rating.

Here, the totality of the credible and persuasive evidence demonstrates that Dr. Parsons considered and properly applied the AMA Guides in reaching his ultimate DIME opinion that Claimant did not sustain any permanent impairment. Although Dr. Yamamoto assigned 5% whole person lumbar impairment and 3% whole person impairment for depression, his opinion represents a mere difference of opinion with the DIME physician that does not rise to the level of clear and convincing evidence to overcome the DIME opinion.

Medical Maintenance Benefits

Section 8-42-101(1), C.R.S. requires the employer to provide medical benefits to cure or relieve the effects of the industrial injury, subject to the right to contest the reasonableness or necessity of any specific treatment. *See Snyder v. Indus. Claim Appeals Off.,* 942 P.2d 1337 (Colo. App. 1997). The need for medical treatment may extend beyond the point of MMI where the claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury

or prevent further deterioration of his condition. *Grover v. Indus. Comm'n*, 759 P.2d 705 (Colo. 1988); *Hanna v. Print Expediters Inc.*, 77 P.3d 863, 865 (Colo. App. 2003). An award of *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that the claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Indus. Claim Appeals Off.,* 992 P.2d 701 (Colo. App. 1999); *Hastings v. Excel Electric*, WC 4-471-818 (ICAO, May 16, 2002).

When the respondents challenge the claimant's request for specific medical treatment the claimant bears the burden of proof to establish entitlement to the benefits. *Martin v. El Paso School Dist. No.11*, WC 3-979-487 (ICAO, Jan. 11, 2012). Once a claimant establishes the probable need for future medical treatment he "is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); *see Karathanasis v. Chilis Grill & Bar,* WC 4-461-989 (ICAO, Aug. 8, 2003). When respondents seek to terminate all medical maintenance benefits they have the burden to prove that medical maintenance benefits are no longer reasonable, necessary or related to the industrial injury. *See Romey v. Golden Corral Littleton Englewood, Inc.*, W.C. No. 4-962-098-002 (ICAO, Dec. 19, 2022) (determining that the issue of maintenance medical benefits remained open once admitted in a FAL and thus did not require reopening pursuant to §8-43-303, C.R.S.); § 8-43-201(1), C.R.S.

As Respondents seek to terminate a general award of maintenance medical benefits admitted to in a FAL, it is Respondents' burden to prove that no further maintenance medical treatment is reasonable, necessary or causally related to the work injury. As found, Respondents met their burden.

When placing Claimant at MMI, the only form of medical maintenance treatment recommended by ATPs Rossi and Miller was the completion of three to four remaining sessions of psychotherapy with Dr. Ledezma. Claimant completed such treatment. Dr. Parsons, Primack and Yamamoto have all credibly opined that Claimant does not require any medical maintenance treatment related to the work injury. Additionally, Drs. Miller, Parsons and Primack have all credibly opined that Claimant's findings are non-physiologic and that Claimant consciously misrepresented his condition and physical

abilities and did not sustain any permanent impairment. The totality of the credible and persuasive evidence demonstrates that it is more probably true than not no further medical maintenance treatment is reasonable, necessary or causally related to the work injury.

Fraud

Respondents contend that Claimant received an overpayment of PPD benefits as the result of fraud.

> To establish fraud or material misrepresentation a party must prove the following: (1) A false representation of a material existing fact, or a representation as to a material fact with reckless disregard of its truth; or concealment of a material existing fact; (2) Knowledge on the part of one making the representation that it is false; (3) Ignorance on the part of the one to whom the representation is made, or the fact concealed, of the falsity of the representation or the existence of the fact; (4) Making of the representation or concealment of the fact with the intent that it be acted upon; [and] (5) Action based on the representation or concealment resulting in damage.

See In re Arczynski, W.C. No. 4-156-147 (ICAO, Dec. 15, 2005); *see also Morrison v. Goodspeed*, 68 P.2d 458 (Colo. 1937). Where the evidence is subject to more than one interpretation, the existence of fraud is a factual determination for the ALJ. *In re Arczynski,* W.C. No. 4-156-147 (ICAO, Dec. 15, 2005).

As found, Respondents proved it is more probably true than not Claimant received an overpayment of PPD benefits due to fraud.

Claimant is observed on surveillance video around the time of the DIME evaluation exhibiting a considerably different and higher level of function and ability than Claimant represented to his ATPs and the IME physicians. As credibly testified to by Drs. Parsons and Primack, and documented in the medical records, Claimant presented at evaluations, in part, with a deliberately slow and significantly antalgic gait with the use of a cane. Claimant reported that he must use a cane to assist with his equilibrium and to prevent falls. Claimant consistently reported 5-7/10 pain, including 7/10 pain at Dr. Miller's

November 21, 2023 and March 26, 2024 evaluations, and no significant, sustained improvement. Claimant further reported poor tolerance with lifting, bending, and twisting.

Claimant is observed on surveillance video ambulating at a normal-to-brisk pace without any antalgic gait or use of a cane, moving trash bins, carrying items, leaning over at the waist, and lifting his son, all without any apparent difficulty or pain behaviors. As one of Claimant's ATPs, Dr. Miller evaluated Claimant on multiple occasions and was familiar with Claimant's presentation. Upon review of the surveillance video, Dr. Miller, who previously assigned 13% whole person lumbar spine impairment, credibly opined that Claimant consciously misrepresented his condition at his impairment evaluation and concluded that Claimant sustained no permanent impairment.

Dr. Parsons credibly testified that there were dramatic discrepancies and inconsistencies in Claimant's presentation at his DIME evaluation and in the medical records as compared to surveillance video. The discrepancies were so dramatic that Dr. Parsons also retracted his permanent impairment rating, concluding that Claimant was not accurately representing his physical condition and abilities. Dr. Primack also credibly opined that Claimant consciously misrepresented his condition and physical abilities, noting two "extremely different" behavior patterns while in the community versus when attending medical appointments. Claimant was clearly able to function at a much higher level than he represented to his ATPs and the IME physicians and falsely represented his physical condition and true level of function. Claimant's misrepresentations about his condition and abilities were material to the ATPs' and IME physicians' assessment of Claimant's condition and impairment. Additionally, Claimant concealed a prior history of acute and chronic low back pain with lower extremity symptoms, for which Claimant sought treatment in November 2021 and July 2022.

The preponderant evidence demonstrates that Claimant knew his representations were false and that he made such false representations with the intention they be acted upon. As discussed, Drs. Miller, Parsons and Primack all credibly and persuasively opined that Claimant's presentation on surveillance video is dramatically different than at their evaluations and as reflected in the medical records. Even in the surveillance video,

Claimant's presentation is markedly different on the day he is heading into his DIME evaluation as opposed to other days. The evidence demonstrates that, at some point, Claimant became aware that he was being surveilled. The ALJ is persuaded this is likely why, on October 30, Claimant is first observed walking at a completely normal pace with no altered gait, no use of a cane and no pain behaviors, but later that same day he is seen with a markedly different presentation, holding a cane and exhibiting significant pain behaviors.

Claimant argues, in part, that he has "good" and "bad" days and that the surveillance video does not fully capture his condition and abilities. Claimant further contends that the items he is seen moving or carrying in the surveillance video do not exceed his permanent work restrictions. He also notes that, his son requires additional care due to having ADHD. The issue here is not that Claimant is seen exceeding his work restrictions, or that, on one occasion, he is observed lifting his son into a vehicle. The issue is Claimant's extremely different presentations on surveillance video than at his medical evaluations. Claimant represented to his providers and IME physicians a significantly lower level of ability and function than Claimant demonstrated on surveillance video. While It is true that an individual may have "good" and "bad" days such that their presentation and function reasonably varies, the difference in Claimant's presentations, as observed by the ALJ on the surveillance video, and as credibly opined by Drs. Miller, Parsons and Primack, is so disparate that it cannot be reasonably attributed to a "good" or "bad" day.

Moreover, it follows that, if such marked differences were merely the result of a "good" or "bad" day, at least some of the "good" days would coincide with Claimant's medical appointments, and his improved function would be accurately reflected in Claimant's medical records. Claimant underwent extensive evaluation and treatment yet consistently reported to his providers and IME physicians no significant, sustained improvement in his symptoms or function. As credibly testified to by Dr. Parsons, if Claimant's condition and true level of function was as Claimant presented at his DIME evaluation and documented in the medical records, Claimant would be expected to move at all times in his life in a similar fashion. Based on the dramatic and extreme differences

in Claimant's presentation at his medical appointments versus on surveillance video, it is clear Claimant knowingly and intentionally misrepresented his condition and abilities/level of function to his ATPs and the IME physicians.

While Claimant's ATPs and Dr. Parsons documented high somatic scores, pain behaviors, and psychological factors contributing to Claimant's perceived level of disability, there is no indication, prior to reviewing surveillance video, the ATPs or Dr. Parsons believed that Claimant was consciously mispresenting his condition and abilities. Claimant's presentation on surveillance video was so dramatically different that it led Drs. Miller, Parsons and Primack to conclude that Claimant inaccurately and *consciously* mispresented his condition and abilities. Claimant's providers and Respondents were unaware of Claimant's false representations regarding his ability and true level of function until surveillance video was obtained. The ALJ is persuaded that Claimant knowingly misrepresented his true level of function and abilities to the ATPs and the IME physicians with the intention that he receive additional treatment and benefits under the workers' compensation system. Claimant was aware that his abilities and level of function were considerably higher than he represented to the ATPs and the IME physicians, as he is seen on surveillance on multiple occasions with a dramatically different and wholly inconsistent presentation than at his medical appointments. The ATPs and IME physicians relied on Claimant to truly and accurately represent his condition, abilities and level of function. As a result of Claimant's intentional false material misrepresentations, Respondents paid Claimant $49,795.20 in PPD benefits to which he was not entitled.

Overpayment

An overpayment includes money received by a claimant that is the result of fraud. § 8-40-201(15.5)(a)(I), C.R.S. Pursuant to § 8–43–303(1) C.R.S., upon a prima facie showing that the claimant received an overpayment in benefits, the award shall be reopened solely as to overpayments and repayment shall be ordered. No such reopening shall affect the earlier award as to money already paid except in cases of fraud or overpayment. An overpayment may occur even if it did not exist at the time the claimant received disability or death benefits. *Simpson v. ICAO, 219 P.3d 354 (Colo. App. 2009)*

rev'd on other grounds, Benchmark/Elite, Inc. v. Simpson, 232 P.3d 777 (Colo. 2010). Therefore, retroactive recovery for an overpayment is permitted. *In Re Haney,* W.C. No. 4-796-763 (ICAO, July 28, 2011).

An ALJ in a workers' compensation claim has authority to order repayment of an overpayment and fashion a remedy with regard to overpayments. § 8-43-207(1)(q), C.R.S.; *Simpson v. ICAO, supra.* The ALJ has the authority to determine the terms of repayment and the recoupment schedule determined by the ALJ will not be disturbed absent an abuse of discretion. *Louisiana Pacific Corp. v. Smith*, 881 P.2d 456 (Colo. App. 1994).

As found, Respondents proved by a preponderance of the evidence Claimant was overpaid $49,795.20 in PPD benefits due to fraud. Respondents are entitled to recover the overpaid amount. No evidence exists in record upon which the ALJ can reasonably determine a payment schedule or the terms of repayment. Accordingly, such issue is reserved for future determination. If the parties are unable to agree upon a repayment schedule, Respondents may file an Application for Hearing on such issue.

Order

It is therefore ordered that:

1. Claimant failed to overcome Dr. Parsons' true DIME opinion on MMI and permanent impairment by clear and convincing evidence. Claimant reached MMI on November 21, 2023 with zero percent permanent impairment, as determined by Dr. Parsons.
2. No further medical maintenance treatment is not reasonable, necessary and causally related.
3. Claimant shall repay $49,795.20 in overpaid benefits to Respondents.
4. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after

mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Dated: October 31, 2025

Kara R. Cayce

Administrative Law Judge

Issues

1. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for Respondent's alleged failure to timely file a Final Admission of Liability (FAL) under WCRP 5-5(E).

2. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for an alleged failure to timely file a First Report of Injury (FROI) under WCRP 5-2.

3. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for an alleged failure to file a General Admission of Liability (GAL) under WCRP 5-2.

4. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for an alleged violation of Section 8-43-402, C.R.S.

5. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for alleged bad faith under Section 10-3-1116, C.R.S.

6. Whether Claimant proved by a preponderance of the evidence Respondent is subject to penalties for an alleged violation of Section 10-2-417, C.R.S.

Stipulation

The parties stipulated at hearing that Respondent will file a new Final Admission of Liability (FAL) reflecting the correct AWW of $763.74, as previously stipulated, resulting in an additional $550.02 in permanent partial disability (PPD) benefits, based on the previously admitted 3% whole person psychological rating.

Findings of Fact

1. Claimant is 52 years old. Claimant worked for Employer as a paraprofessional.

February 17, 2021 Work Injury - W.C. No. 5-178-127

2. Claimant sustained a prior admitted work injury to her right knee on February 17, 2021 (W.C. No. 5-178-127).

3. Authorized treating physician (ATP) Jay Reinsma, M.D. first placed Claimant at maximum medical improvement (MMI) for the February 17, 2021 work injury on June 23, 2021. Respondent filed a FAL in the claim on August 5, 2021 listing an MMI date of June 23, 2021 and admitting for a 13% lower extremity impairment rating and medical maintenance care pursuant to Dr. Reinsma's June 23, 2021 report.

4. On August 24, 2021, Claimant saw Frederic Zimmerman, D.O. for maintenance care and underwent a right knee steroid injection.

5. On September 17, 2021, Claimant saw Dr. Reinsma for a one-time maintenance evaluation. Claimant complained of ongoing right knee pain and swelling and reported that the recent knee injection was ineffective. Dr. Reinsma ordered a repeat right knee MRI.

6. Dr. Reinsma reevaluated Claimant as maintenance care on September 23, 2021. Claimant reported that she reinjured her right knee three days prior when attempting to restrain a combative student. Dr. Reinsma noted that a repeat right knee MRI was already scheduled and that he would await the results. Dr. Reinsma determined that Claimant was no longer at MMI for the February 17, 2021 work injury, placed Claimant on restrictions and prescribed medication.

7. Mor McClanahan initially worked as the adjuster on Claimant's claim. In an email to Claimant dated September 23, 2021, Ms. McClanahan explained that Respondent filed a FAL on 8/5/2021 with a 13% impairment rating for the right knee, pursuant to which PPD benefits were being paid. She further explained that, during Claimant's use of medical maintenance care, Dr. Reinsma determined that Claimant was no longer at MMI.

Accordingly, Respondent would be stopping bi-weekly payments of PPD, resuming temporary disability benefits, and filing a GAL to such effect. In an email dated September 24, 2021, Ms. McClanahan wrote to Claimant,

> The nurse will be a better source to answer questions in regards to anticipated medical care, as I do not have a medical degree and am not aware of all the treatment option [sic.] I think the doctor understands or at least see [sic] that there is something else concerns going on, since they took you off MMI status. We will have to wait and see what the MRI shows to get a better idea.

Cl. Ex. 1, p. 10.

The correspondence does not contain any reference to the September 20, 2021 incident as a separate work injury or a separate worker's compensation claim.

8. Based on Dr. Reinsma's determination that Claimant was no longer at MMI for the February 17, 2021 work injury, Respondent filed a GAL on October 4, 2021 in W.C. No. 5-178-127 admitting for medical benefits and Temporary Total Disability (TTD) benefits beginning on September 21, 2021, ongoing.

9. Claimant continued to undergo medical treatment for her right knee under the February 17, 2021 claim. At evaluations in October 2021, Dr. Reinsma noted that a repeat MRI of the right knee only demonstrated degenerative changes with no acute findings or significant changes compared to an April 2021 MRI. In December 2021, Claimant underwent a viscosupplementation injection performed by Dr. Zimmerman, with no reported improvement. Claimant continued to report right knee symptoms. Dr. Reinsma referred Claimant to an orthopedic specialist and for psychological evaluation.

10. On December 16, 2021, Claimant presented to orthopedic surgeon Mark Failinger, M.D., who noted a February 17, 2021 date of injury. He documented, "[Claimant] states she had 3 other injuries including that event in March 2021, with increased right knee pain and third event in May of 2021 when one of the children pushed on her right knee and then a 4th event in September 2021." R. Ex. J, p. 0250. Dr. Failinger opined that there

were no lesions or pathology that would be highly amenable to arthroscopic intervention and that he had little to offer Claimant from an intervention standpoint.

11. In February 2022 providers noted Claimant had maximized conservative therapies and failed injections. The only other treatment option at the time were PRP injections, which Claimant declined due to religious reasons.

12. On March 15, 2022, Dr. Reinsma placed Claimant at MMI for the February 17, 2021 work injury with 13% lower extremity impairment rating (5% whole person). He recommended medication and psychological counseling as maintenance care.

13. On March 28, 2022, Respondent filed a FAL listing an MMI date of March 28, 2022. Respondent admitted for a 13% lower extremity impairment rating and maintenance care, per Dr. Reinsma's March 15, 2022 report. Claimant requested a Division Independent Medical Examination (DIME).

14. On August 24, 2022, Claimant underwent a DIME performed by Justin Green, M.D. Dr. Green noted that Claimant injured her right knee in February 2021 with multiple interim right knee traumas. He opined that Claimant reached MMI on June 22, 2021 with 13% lower extremity impairment. He recommended maintenance care in the form of medication management and a patellar strap replacement.

15. On October 20, 2022, Respondent filed a FAL consistent with Dr. Green's DIME report.

16. Claimant received TTD benefits from September 21, 2021 through March 14, 2022 when she was placed at MMI as of March 15, 2022 in the February 17, 2021 claim, using an AWW of $763.74.

September 20, 2021 Work Injury - W.C. No. 5-258-854

17. Claimant testified that, based on conversations she had with Ms. McClanahan, she was under the impression Respondent had opened a separate worker's compensation claim for the September 20, 2021 work incident.

18. Claimant points to email correspondence between Claimant and Ms. McClanahan in June 2022. On June 29, 2022, Claimant wrote in relevant part, “I was also wondering what happened with the case that was opened in September? Do I need to close that one out separately?” Ms. McClanahan responded on June 30, 2022 stating, “That claim has been closed already.” Claimant replied, “…I’m looking through everything I have nothing stating that it was closed but I do recall us discussing that claim. Would you be able to send something stating that it was closed?” McClanahan replied, “The claim from 9/20/2021 was closed on 11/15/2021 as all medical care was handled under your 2/17/2021 claim.” Claimant responded, “I realize the claim was closed and if you recall, you were going to send something stating that it would be closed but I never received it. I am asking just proof that it was closed and when?” Cl. Ex. 1, pp. 14-15.

19. Claimant purports that she subsequently sought to “reopen” the September 20, 2021 claim and, at that time, became aware that no separate worker’s compensation claim had been filed for the September 20, 2021 work incident. On December 14, 2023, Claimant filed a worker’s claim for compensation, DOI September 20, 2021 (W.C. No. 5-258-854), which is the subject of this matter.

20. On December 18, 2023, the DOWC issued notice to Respondent that a worker’s compensation claim had been filed in W.C. No. 5-258-854. The notice instructed Respondent to file a position statement either admitting or denying liability within 20 days of the date of the notice, pursuant to Section 8-43-203, C.R.S. and WCRP 5-2.

21. On January 5, 2024, the DOWC issued a Notice Requiring Immediate Response with respect to filing a position statement regarding W.C. No. 5-258-854.

22. Claimant testified that the Director of the DOWC also issued an order on February 13, 2024 regarding Respondent’s need to file a position statement in W.C. No. 5-258-854.

23. On February 14, 2024, Respondent filed a GAL in W.C. No. 5-258-854, DOI September 20, 2021 admitting for medical benefits only.

24. Respondent did not present any evidence or explanation regarding the delay in filing the GAL.

25. Claimant subsequently underwent additional medical treatment under W.C. No. 5-258-854.

26. Claimant saw ATP Stephen Danahey, M.D. on October 22, 2024. He documented Claimant's injury course beginning with the February 17, 2021 injury, noting that Claimant had been put at MMI and then sustained an "aggravation of the right knee" on September 20, 2021. Dr. Danahey opined that Claimant reached MMI for the September 20, 2021 work injury and released Claimant from his care. However, Dr. Danahey's October 22, 2024 medical report failed to specify an MMI date or any permanent impairment rating. Under the category "Maximum Medical Improvement" it states, "Injured Worker has reached MMI on: as previously noted." Under the category "Permanent Medical Impairment" the report states "Permanent Impairment" with nothing further. R. Ex. K, pp. 503-506. As indicated by the date stamp on the report, Respondent's counsel received Dr. Danahey's October 22, 2024 report on October 28, 2024.

27. Dr. Danahey subsequently made multiple amendments to his October 22, 2024 report. On November 6, 2024, Dr. Danahey's office amended the report to reflect an MMI date of March 1, 2021. Dr. Danahey again amended the report on November 14, 15, and 16, 2024 reflecting an MMI date of March 15, 2022 and a total combined 9% whole person impairment consisting of 15% lower extremity impairment of the right knee (6% whole person) and 3% whole person psychiatric impairment. As indicated by the date stamp on the document, Respondent received an amended report on November 21, 2024,

28. On December 10, 2024, Claimant emailed Respondent's counsel inquiring as to why Respondent had yet to file a FAL in the matter. Claimant stated, in relevant part:

> I would like to bring to your attention that the medical records show that on 10/22/2024 Dr Danahey in his report, placed me at MMI. You received a copy of that report on 10/28/2024 being fully advised that I was placed at MMI. On 10/29/24 you reached out to Dr. Danahey requesting an exact

> date. On November 6th his Office Amended that report and added an MMI date of 03/01/21. Your office received that report the same day, and forwarded it to me at some point. I sent an email questioning how that was even possible. Medical records show that Dr. Danahey again amended his notes on 11/14/2024 to reflect an MMI date of 03/15/2022 your office received that report on 11/21/2024. You submitted an exhibit with a date of 11/25/2024 again requesting clarification on the MMI date of 03/15/22 and it is noted that your office received it on 11/26/2024. A Final Admission of Liability is due within thirty days of mailing or delivery of a medical report from the authorized treating physician, stating that the claimant has reached MMI.

Cl. Ex. 10, p. 303.

29. Respondent's counsel replied via email the same day stating, in relevant part:

> Dr. Danahey did not assign an MMI date until 11/26/24, at which point he stated the MMI date was 3/15/22. Therefore it is respondent's position that the 30 days begins as of the assignment of MMI date on 11/26/24 as that is the complete report as to MMI and impairment rating. Respondent is requesting clarification from Dr. Danahey as to the 15% impairment rating assigned as he did not address whether apportionment was applicable from the 13% prior scheduled rating in the February 2021 date of injury before determining whether to file the FAL or initiate the DIME process. Thank you.

Id.

30. Dr. Danahey subsequently completed an Apportionment Calculation Worksheet, dated February 24, 2025, in which he assigned a final combined apportioned rating of 3% lower extremity impairment (1% whole person) and 3% whole person psychiatric impairment for a total whole person impairment of 4% for the September 20, 2021 work injury. The document is not date stamped.

31. On March 5, 2025, Respondent filed a FAL in W.C. No. 5-258-854, listing a MMI date of March 15, 2022 and admitting for 3% whole person impairment, 3% lower extremity impairment, and medical maintenance, per Dr. Danahey's report.

32. Claimant filed an objection to the FAL on March 12, 2025 and applied for a DIME, which was performed by John Hughes, M.D. on August 5, 2025.

33. Claimant filed an Application for Hearing (AFH) in this matter on April 3, 2025 endorsing various issues, including compensability, medical benefits, reasonably necessary, AWW, PPD, permanent total disability, and penalties. At the commencement of the hearing, the ALJ determined that, other than penalties, the other endorsed issues were moot or unripe and reserved for future determination.

34. Claimant testified that the September 20, 2021 was her "fourth injury" at this job. Claimant testified that Ms. McClanahan told her the September 20, 2021 claim was closed, when in fact no FROI or FAL was ever filed. Claimant testified to her belief that Ms. McClanahan "knew what she was doing and knew that she was not being honest." Claimant further testified to her belief that Ms. McClanahan and other adjusters on her claim did not act in good faith. She testified that she has reached out to several adjusters and to Respondent's counsel asking about this claim, and that she was never given an honest reply as to what happened. Claimant testified that Ms. McClanahan made a misrepresentation and false statement by leading her to believe her claim was closed. Claimant testified that Respondent has a history of late filings and unjustified delays, which are unfair to her because it has prolonged her case.

35. Claimant did not present any evidence that she sustained any additional wage loss from September 20, 2021 through her MMI date of March 15, 2022 as a result of the September 20, 2021 work injury.

Ultimate Findings

36. Respondent failed to timely file a GAL in violation of WCRP 5-2(D). Respondent cured the violation by filing the GAL on February 14, 2024, prior the Claimant's AFH dated April 3, 2025. Nonetheless, the record demonstrates that t is highly probable and free

from substantial doubt Respondent knew or should have known it was in violation. Respondent is thus subject to penalties for the untimely filing of the GAL.

37. Claimant failed to prove penalties should be imposed for Respondent's failure to file a FROI and alleged failure to timely file a FAL. The preponderant evidence either does not establish a violation of WCRP 5-2 or WCRP 5-5 in the first instance, or that Respondent's conduct was objectively unreasonable.

38. Claimant failed to prove penalties should be imposed for an alleged violation of Section 8-43-402, C.R.S.

39. The ALJ does not have jurisdiction to impose penalties for alleged violations of Sections 10-3-1116 and 10-2-417, C.R.S.

40. Evidence and inferences contrary to these findings were not credible and persuasive.

Conclusions of Law

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *University Park Care Center v. Indus. Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it

is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Indus. Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Indus. Comm'n*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Penalties

The ALJ acknowledges that the pro se Claimant did not endorse the general penalty provision of § 8-43-304(1), C.R.S. in her AFH, Case Information Sheet, at hearing, or in her post-hearing position statement. Nonetheless, at no point has Respondent objected to Claimant's penalty allegations on the grounds of lack of specificity or proper notice. At the commencement of the hearing, the ALJ and the parties discussed the issues at length and identified the specific issues before the ALJ. Respondent offered evidence on the penalty issues and, in its position statement, argues Section 8-43-304(1), C.R.S.

A Rule is an order of the director, § 8-40-201(15), and compliance may be ensured through the application of § 8-43-304(1). *Madera v. Zak Dirt, Inc*., W.C. No. 5-085-650-003 (I.C.A.O. June 7, 2021), citing *Diversified Veterans Corporate Center v. Hewuse*, 942 p.2d 1312, 1313 (Colo. App. 1997). The penalties, as specifically endorsed by Claimant and tried by consent by the parties, require application of Section 8-43-304(1), C.R.S.

Whether statutory penalties may be imposed under Section 8-43-304(1), C.R.S. involves a two-step analysis. The statute provides for the imposition of penalties of up to $1,000 per day where the insurer "violates any provision of article 40 to 47 of [title 8], or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or the panel, for which no penalty has been specifically provided, or fails, neglects or refuses to obey any lawful order made by the director or panel…" Thus, the ALJ must first determine whether the insurer's conduct constitutes a violation of the Act, a rule, or an order. Second, the ALJ must determine whether any action or inaction constituting the violation was objectively unreasonable. The reasonableness of the insurer's action depends on whether it was based on a rational argument based in law or fact. *Jiminez v. Industrial Claim Appeals Office,* 107 P.3d 965 (Colo. App. 2003); *Gustafson v. Ampex Corp.,* W.C. No. 4-187-261 (I.C.A.O. August 2, 2006), *but see, Pioneers Hospital v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005) (standard is less rigorous standard of "unreasonableness"). However, there is no requirement that the insurer know that its actions were unreasonable. *Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996).

The question of whether the insurer's conduct was objectively unreasonable presents a question of fact for the ALJ. *Pioneers Hospital v. Industrial Claim Appeals Office,* 114 P.3d 97 (Colo. App. 2005); *see Pant Connection Plus v. Industrial Claim Appeals Office*, 240 P.3d 429 (Colo. App. 2010). A party establishes a prima facie showing of unreasonable conduct by proving that an insurer violated a rule of procedure. *See Pioneers Hospital* 114 P.2d at 99. If the claimant makes a prima facie showing the burden of persuasion shifts to the respondents to prove their conduct was reasonable under the circumstances. *Id.*

Penalties for Respondent's Failure to File a FROI

WCRP 5-2 provides that a FROI must be filed with the DOWC within ten days of an employer receiving notice or knowledge of any of the following, in relevant part: an injury that has resulted in lost time from work in excess of three shifts or calendar days; the occurrence of a permanently physically impairing injury; or notice of knowledge of any claim for benefits, including medical treatment only, that is denied for any reason.

Claimant argues that Respondent violated WCRP 5-2 by failing to file a FROI for her September 20, 2021 work injury. Respondent contends that it first learned that Claimant was alleging a specific, new injury of September 20, 2021 when Claimant filed a workers' claim for compensation on December 14, 2023; thus, none of the applicable conditions under WCRP 5-2 to file a FROI were triggered. The ALJ agrees.

At the time of the September 20, 2021, incident, Claimant was actively undergoing medical maintenance treatment for the same body part under W.C. No. 5-178-127 DOI 2/17/2021, including an injection on August 24, 2021. Just three days prior to September 20, 2021, Claimant saw Dr. Reinsma, who documented Claimant's ongoing complaints of right knee pain and swelling and ordered a repeat right knee MRI. In his September 23, 2021 report, Dr. Reinsma noted the September 20, 2021 incident and Claimant's continued right knee complaints, placed Claimant on restrictions and determined that she was no longer at MMI *for the February 17, 2021 work injury*. Respondent then filed a GAL in W.C. No. 5-178-127 on October 4, 2021 for additional right knee treatment and TTD benefits. In emails to Claimant on September 23 and 24, 2021, the adjuster specifically explained that, per Dr. Reinsma, Claimant was no longer considered at MMI and would thus continue to receive medical treatment and temporary disability benefits under her February 17, 2021 claim.

To the extent Claimant had lost time in excess of three shifts subsequent to September 20, 2021, Claimant received TTD benefits from September 20, 2021 through March 14, 2022 based upon Dr. Reinsma removing Claimant from MMI status and work as related to the February 17, 2021 work injury. Regarding the adjuster's reference to a 9/20/2021 "claim" that was closed on 11/15/2021 Respondent argues, and the ALJ is persuaded that, this referenced an internal administrative closure related to Claimant's removal from MMI status in September 2021 in the February 17, 2021 claim, for which Claimant continue to receive medical care under W.C. No. 5-178-127. There was no denial of any claim for benefits related to the September 20, 2021 incident.

There is insufficient credible and persuasive evidence establishing that, prior to Claimant filing a worker's claim for compensation, Respondent had knowledge or notice of a separate work injury on September 20, 2021 that resulted in lost time from work in excess of three shifts or calendar days, a permanently physically impairing injury, or the

denial of any claim for benefits necessitating the filing of a FROI under WCRP Accordingly, Respondent's failure to file the FROI did not violate WCRP 5-2.

In the alternative, if Respondent's failure to file a FROI was a violation of WCRP 5-2, Respondent's inaction was not objectively unreasonable. As discussed above, at the time of the September 20, 2021 incident, Claimant was actively undergoing treatment to her right knee for the February 17, 2021 work injury. Claimant continued to report ongoing right knee symptoms for which she had received an injection and for which a repeat MRI was ordered on September 17, 2021. There is no indication at the time Respondent was aware Claimant was alleging that the September 20, 2021 incident constituted a new, specific, separate work injury as opposed to yet another subsequent incident involving the same body part for which Claimant had ongoing complaints and continued to undergo treatment and receive temporary disability benefits.

Claimant herself refers to four "injuries" to her right knee while working for Respondent, which are referenced in the medical records as other "events" or "interim traumas" to the same body part under the February 17, 2021 claim. The record does not demonstrate that each incident was considered by the providers or otherwise reported to Respondent as separate, acute work injuries triggering the filing of a FROI, as opposed to incidents for which Claimant reported ongoing or worsening right knee symptoms and for which she continued to receive medical treatment.

Subsequent to the September 20, 2021 incident, Dr. Reinsma removed Claimant's MMI status *as related to the February 17, 2021 work injury* and Claimant continued to receive medical treatment and TTD benefits. Accordingly, even if the failure to file a FROI was in violation of WCRP 5-2, based on the totality of the circumstances, Respondent's failure to do so was objectively reasonable. Accordingly, the ALJ concludes that penalties are not appropriate.

Penalties for Respondent's Failure to Timely File a GAL

WCRP 5-2(D) provides that an insurer shall state whether liability is admitted or contested within 20 days after the date the DOWC mails to the insurer a worker's claim for compensation.

Claimant filed a workers' claim for compensation on December 14, 2023 regarding a right knee injury sustained on September 20, 2021. On December 18, 2023, the DOWC mailed Respondent notice of the claim, stating the requirement to admit or deny liability within 20 days of the notice. Respondent was thus required to admit or deny liability in the claim by January 8, 2024.[1] It is undisputed Respondent did not admit or deny liability in the claim until filing a GAL on February 14, 2024. Accordingly, Respondent failed to timely admit or deny liability in violation of WCRP 5-2(D).

Respondent does not dispute it violated WCRP 5-2(D) by failing to timely file a position statement. Respondent offered no explanation nor any evidence regarding the delay in filing the GAL. There is no evidence, nor does Respondent contend, that it did not receive the DOWC's notices, that there was some miscommunication, or that Respondent did, in fact, make an attempt to timely file the position statement. Without explanation, the ALJ concludes that Respondent's failure to timely file the GAL does not constitute the actions of an objectively reasonable insurance carrier.

Curing a Violation

While Respondent does not dispute it violated WCRP 5-2(D), Respondent does argue that no penalty should be assessed because the violation was cured and Claimant failed to meet her burden to prove by clear and convincing evidence Respondent knew or reasonably should have known it was in violation. While the ALJ agrees Respondent cured the violation, the ALJ disagrees that there is not clear and convincing evidence to support the imposition of penalties.

Section 8-43-304(4), C.R.S. permits an alleged violator 20 days from the date of mailing of an Application for Hearing that asserts penalties to cure the violation. If the violator cures the violation within the 20 day period "and the party seeking such penalty fails to prove by clear and convincing evidence that the alleged violator knew or reasonably should have known such person was in violation, no penalty shall be assessed." The cure statute adds an element of proof to a claim for penalties in cases where a cure is proven. Typically, it is not necessary for the party seeking penalties to

[1] 20 days from December 18, 2023 was Sunday, January 7, 2024. Accordingly, pursuant to WCRP 1-2(B), the deadline was Monday, January 8, 2024.

prove that the violator knew or reasonably should have known they were in violation. The party seeking penalties must only prove the putative violator acted unreasonably under an objective standard. *See Jiminez v. Indus. Claim Appeals Office*, 107 P.3d 965 (Colo.App.2003). Section 8-43-304(4), C.R.S. modifies the rule and adds an extra element of proof when a cure has been effected. Specifically, the party seeking penalties must prove the violator had actual or constructive knowledge that its conduct was unreasonable. *Diversified Veterans Corporate Center v. Hewuse*, 942 P.2d 1312 (Colo. App. 1997); *see In re Tadlock*, WC 4-200-716 (I.C.A.O., May 16, 2007).

As found, Respondent cured the violation of WCRP 5-2(D) by filing the GAL on February 14, 2024, prior to Claimant's April 3, 2025 AFH. Thus, to impose penalties, there must be clear and convincing evidence Respondent knew or reasonably should have known it was in violation.

On December 18, 2023, the DOWC sent notice to Respondent of W.C. No. 5-258-854, instructing Respondent to file a position statement either admitting or denying liability within 20 days of the date of the notice, pursuant to the Act and WCRP 5-2. On January 5, 2024, the DOWC issued a Notice Requiring Immediate Response with respect to filing a position statement in W.C. No. 5-258-854. Claimant also credibly testified that the Director issued an order on February 13, 2024 regarding Respondent's failure to timely file a position statement in W.C. No. 5-258-854. Respondent does not dispute this nor otherwise provide any argument or evidence demonstrating Respondent did not receive the initial notice, the follow-up notice, or the Director's order. Respondent does not contend, nor is there any evidence demonstrating, Respondent was unaware of the new claim filed by Claimant in December 2023 or the requirement to file the position statement within the applicable timeframe. Respondent argues that it first learned that Claimant was alleging a specific new injury/incident with a September 20, 2021 DOI when Claimant filed her Claimant for worker's compensation on December 14, 2023, indicating Respondent was aware of the new claim at such time.

If the insurer offers no explanation for its conduct, then the claimant has made a *prima facie* showing because the ALJ may infer that there was no reasonable explanation for the insurer's action. *See Human Resource Co. v. Industrial Claim Appeals*

Office, 984 P.2d 1194 (Colo. App. 1999)(imposition of penalties was proper where insurer failed to offer a reasonable factual or legal explanation for its actions); *Pioneers Hospital of Rio Blanco County v. Industrial Claim Appeals Office*, 114 P.3d 97 (Colo. App. 2005). The parties to a workers' compensation claim are presumed to know the applicable law. *Midget Consol. Gold Mining Co. v. Industrial Commission*, 64 Colo. 218, 193 P. 493 (Colo. 1920); *Paul v. Industrial Commission*, 632 P.2d 638 (Colo. App. 1981). While this presumption does not shift the burden of proof, it aids a party in meeting its burden of proof. *Salerno v. Allied Universal*, W.C. No. 5-210-972-001 (I.C.A.O., Jan. 2, 2024); *Union Ins. Co. v. RCA Corp*., 724 P.2d 80 (Colo. App. 1986).

The ALJ is persuaded that Respondent was aware that Claimant filed the worker's compensation claim in December 2023 and was aware of the requirement to timely file a position statement. *See Salerno v. Allied Universal, supra ("*In the absence of specific evidence to the contrary, the ALJ was required to presume that the respondents knew the requirements of the statute."); *see also Rogan v. United Parcel Service*, W.C. No. 4-314-848 (I.C.A.O., March 2, 1999). The DOWC issued written notice to Respondent on December 18, 2023 citing the applicable statute, rule and time period for filing a position statement, and a follow-up notice on January 5, 2024. Respondent failed to take any action to comply until one day after the issuance of an order by the Director.

Here, there is no factual or legal dispute that Respondent did not comply with WCRP 5-2(D) by failing to timely file a position statement, and Respondent provided no explanation or evidence whatsoever regarding its failure to timely do so. Accordingly, the ALJ concludes that it is highly probable Respondent reasonably knew or should have known it was in violation of WCRP 5-2(D) by not filing the GAL until February 14, 2024. *Salerno v. Allied Universal, supra* ("Because the respondents knew about the claim and did not present any factual or legal argument that their actions did not violate the statute or the Director's Order, the record compels the conclusion that the respondents knew or should have known that their actions violated the statute and the Director's Order.").

Section 8-43-305, C.R.S provides that "[e]very day during which any…insurer… fails to perform any duty imposed by articles 40-47 of this title shall constitute a separate and distinct violation thereof." The purpose of section 8-43-305 is to address "ongoing

conduct." *Spracklin v. Indus. Claim Appeals Office,* 66 P.3d 176, 178 (Colo.App.2002). When conduct is ongoing, imposition of a daily penalty is required. *Pueblo Sch. Dist. No. 70 v. Toth,* 924 P.2d 1094, 1097, 1100 (Colo.App.1996) (delay in paying bill for 645 days resulted in "645 separate offenses," and pursuant to predecessor statute to section 8-43-305, imposition of the penalty at a "daily rate" is "mandated").

The Colorado Supreme Court has adopted the “gross disproportionality” test for determining whether a regulatory fine violates the Excessive Fines Clause. *Colorado Dep’t of Labor & Empl. V. Dami Hospitality, LLC*, 442 P.3d 94 (Colo. 2019). The Court provided that, in assessing proportionality, an ALJ should "consider whether the gravity of the offense is proportional to the severity of the penalty, considering whether the fine is harsher than fines for comparable offenses in this jurisdiction or than fines for the same offense in other jurisdictions." *Dami Hospitality* at 103. The Court also explained that the evaluation of proportionality should include consideration of the company's ability to pay the fine. Additionally, the proportionality analysis should be conducted in reference to the amount of the fine imposed for each offense, not the aggregated total of fines for many offenses.

Here, there is insufficient persuasive evidence that Respondent’s failure to timely file a GAL in this matter resulted in significant hardship or prejudice to Claimant. Despite the untimely filing of the GAL in this specific claim, Claimant received medical care and temporary disability benefits under the February 17, 2021 claim as the time periods and injured body parts overlap. Additionally, there is no evidence of any malicious motivation on the part of Respondent. Applying the *Dami* gross disproportionality test, the ALJ concludes that a fine of $10.00 per day is appropriate. The period of violation runs from January 8, 2024 to February 14, 2024, a period of 37 days, resulting in a penalty of $370.00, apportioned 100% to Claimant.

Penalties for Respondent’s Alleged Failure to Timely File a FAL

WCRP 5-5(E) provides, in relevant part:

> Within 30 days after the date of mailing or delivery of a determination of medical impairment by an authorized Level II accredited physician, or within 30 days after the date of mailing or delivery of a determination by the

authorized treating physician providing primary care that there is no impairment, the insurer shall either:

(1) File an admission of liability consistent with the physician's opinion, or

(2) Request a Division Independent Medical Examination (IME) on the issue of medical impairment in accordance with Rule 11-3.

Claimant contends that Respondent was required to file a FAL or initiate the DIME process within 30 days of Dr. Danahey's October 22, 2024 report. Respondent argues that the 30-day timeframe did not commence until receipt of Dr. Danahey's Apportionment Worksheet on February 24, 2025.

As found, Claimant failed to prove penalties are appropriate here. Although Dr. Danahey issued a report on October 22, 2024 opining that Claimant reached MMI, the report did not specify the MMI date nor any impairment rating. There are multiple subsequent amendments to his report regarding the MMI date and permanent impairment rating. The record demonstrates that the amended report was delivered to Respondent on November 21, 2024 (per the date stamp), or November 26, 2024 (as acknowledged by both Claimant and Respondent's counsel in email correspondence on December 10, 2024). Nonetheless, Dr. Dananhey's amended report was not complete as it did not address apportionment as related to the February 17, 2021 work injury. WCRP 5-5(A) requires that, when a FAL is predicated upon medical reports, a narrative report and appropriate worksheets MUST accompany the admission. Additionally, a FAL that does not include the rating physician's entire report, including both the narrative discussion and the ratings worksheet, may be deemed legally insufficient. *See Sinkey v. Paint Connection Plus*, W.C. 4-714-996 (March 2, 2009), aff'd sub nom.; *Paint Connection Plus v. Industrial Claim Appeals Office*, Colo App No. 09CA0598, January 07, 2010); *McCotter v. U. S. West Communications*, Inc., W.C. No. 4-430-792 (March 25, 2002); *Siegmund v. Fore Property Company*, W.C. No. 4-649-193 (January 30, 2007).

Dr. Danahey made multiple amendments to his report regarding the MMI date and permanent impairment. Dr. Danahey's ultimate determination of medical impairment was not delivered until February 24, 2025, with the submission of the apportionment

worksheet. As Respondent filed the FAL on March 5, 2025, within 30 days of February 24, 2025, there was no violation of WCRP 5-5(E).

In the alternative, even if Respondent's failure to file the FAL prior to March 5, 2025 constitutes a violation of WCRP 5-5(E), Respondent's actions were not objectively unreasonable. Dr. Danahey's report necessitated multiple amendments regarding MMI and medical impairment. In documenting the "injury course" in his report, Dr. Danahey began with the February 17, 2021 work injury, and referred to the September 20, 2021 work injury as an aggravation. Claimant did not file a worker's compensation claim for a September 20, 2021 date of injury until December 14, 2023. As discussed at length herein, subsequent to the September 20, 2021 incident, Dr. Reinsma removed Claimant from MMI status as related to the February 17, 2021 work injury and Claimant continued to receive medical treatment and temporary disability benefits. Claimant was ultimately assigned a permanent impairment rating for the February 17, 2021 work injury.

Here, there was a documented history in the medical records, as noted by Dr. Danahey, of a pre-existing work-related impairment to the same body part related to the February 17, 2021 work injury. Considering the intertwined nature and history of the work injuries, consideration of apportionment was particularly relevant. As Dr. Danahey issued multiple amendments and still failed to address apportionment, Respondent reasonably requested clarification, as apportionment is inextricably linked to a rating physician's ultimate opinion on permanent impairment. By December 10, 2024 Respondent had reached out to Dr. Danahey to obtain clarification regarding apportionment in order to complete Dr. Danahey's report. Even assuming, arguendo, the FAL was required to be filed within 30 days of November 21 or November 26, 2024, Respondent made reasonable and timely efforts to obtain Dr. Danahey's entire report within such time frame.

Respondent was not informed of the factual predicates for determining whether to accept Dr. Danahey's opinion and file a FAL or contest the opinion by filing a Notice and Proposal to Select a Division IME until Dr. Danahey submitted the apportionment worksheet on February 24, 2025. That Dr. Danahey's report was not complete until February 24, 2025 is further buttressed by the fact that Dr. Danahey did, in fact, apportion a percentage of the impairment rating to the February 17, 2021 work injury. Thus, Dr. Danahey's ultimate determination on medical impairment occurred on February 24, 2025.

Had Respondent filed the FAL without Dr. Danahey's entire report, Respondent would have admitted for a permanent impairment rating that was ultimately not assigned by the rating physician. Similarly, initiating the DIME process without clarification and the entire report from Dr. Danahey may have resulted in additional costs and Respondent ultimately cancelling the DIME.

Respondent made an objectively reasonable and timely attempt to obtain the necessary clarification from Dr. Danahey regarding permanent impairment in order to complete his report. No evidence was offered demonstrating that Dr. Danahey's subsequent delay in providing the apportionment worksheet and opinion was within the control of Respondent. The preponderant evidence does not demonstrate Respondent was attempting to delay the filing of the FAL, the DIME process, or that its actions were otherwise objectively unreasonable. Accordingly, no penalties are appropriate.

Penalties Due to Alleged Misrepresentation of Facts

Claimant alleges entitlement to "penalties" under Section 8-43-402, C.R.S., which provides:

> If, for the purpose of obtaining any order, benefit, award, compensation, or payment under the provisions of articles 40 to 47 of [title 8], either for self-gain or for the benefit of any other person, anyone willfully makes a false statement or representation material to the claim, such person commits a class 5 felony and shall be punished as provided in section 18-1.3-401, C.R.S., and shall forfeit all right to compensation under said articles upon conviction of such offense.

Claimant argues that Ms. McClanahan's statement that a September 20, 2021 "claim" was closed in November 2021 constitutes a willfully false statement or representation material to the claim. The ALJ acknowledges that such reference could be reasonably misinterpreted by Claimant to mean a separate worker's compensation claim had been filed. Nonetheless, considering the specific circumstances of this case, the adjuster's statement could also reasonably be interpreted to refer to the internal administrative closure of a "claim" after being removed from MMI status in light of

Claimant continuing to receive medical treatment for the same body part under the February 17, 2021 worker's compensation claim.

To the extent the adjuster's statement could be considered a willful false statement or misrepresentation, the preponderant evidence does not establish that such statement was made for the purpose of obtaining any order, benefit, award, compensation or payment under the Act, for self-gain or for the benefit of Respondent. When Dr. Reinsma's removed Claimant from MMI status under the February 17, 2021 work injury, Respondent filed a GAL reinstating temporary disability benefits and continuing medical treatment. Ms. McClanahan explained this to Claimant in emails dated September 23 and September 24, 2021. Pursuant to the GAL, Claimant received additional temporary disability benefits and continued medical treatment for her condition. There is insufficient credible and persuasive evidence demonstrating that Ms. McClanahan's statement regarding a September 20, 2021 "claim" rises to the level of a willfully false statement or representation material to the claim made for a specific purpose as contemplated under Section 8-43-402, C.R.S. Accordingly, no violation is found and no "penalties" are appropriate.

Penalties Under Sections 10-3-1116 and 10-2-417, C.R.S.

Claimant argues that Respondent should be subject to penalties for violations of Sections 10-3-1116 and 10-2-417, C.R.S. for alleged bad faith and knowingly making material misrepresentations intended to injure an insured client.

Pursuant to Section 8-43-201(1), C.R.S., ALJs have original jurisdiction to hear and decide all matters arising under articles 40 to 47 of the Act. "ALJs are not judges of general jurisdiction*." Muragara v. Sears Roebuck & Co.*, W.C. Nos. 4-726-134, 4-712-263 (I.C.A.O., Sept. 8, 2015). Instead, "the administrative tribunals which adjudicate workers' compensation claims are created by statute, and the jurisdiction, powers, duties, and authority of these tribunals are limited to that provided by statute." *Lewis v. Scientific Supply Co., Inc.*, 897 P.2d 905, 908 (Colo. App. 1995). The imposition of penalties is restricted to the violation of provisions of the Act or orders, while damages for bad faith adjusting are left to the civil law and courts. *See Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995); *Dizmang v. Axis Financial Management*, W.C. No. 5-

013-335, (I.C.A.O., Oct. 17, 2017) (*aff'd* Colo. App. 2017CA2010, Oct. 25, 2018) (not published pursuant to C.A.R. 35(f)). The tort action of bad faith claims handling falls outside the parameters of the Act. *Travelers Insurance Co. v. Savio*, 706 P.2d 1258 (Colo. 1985); *Espinoza v. Baker Concrete Construction*, W.C. No. 5-066-313 (I.C.A.O., Jan. 31, 2020).

Nothing in the Act confers authority on the ALJ to assess penalties for alleged bad faith adjusting or alleged material misrepresentations under Sections 10-3-1116 and 10-2-417, C.R.S. Accordingly, Claimant's request for relief is denied.

Order

It is therefore ordered that:

1. Respondent shall pay Claimant penalties in the amount of $370.00, apportioned one hundred percent to Claimant, for the failure to timely file a GAL in violation of WCRP 5-2(D).

2. Claimant's request for penalties for Respondent's alleged failure to timely file a FAL under WCRP 5-5(E) is denied and dismissed.

3. Claimant's request for penalties for Respondent's alleged failure to timely file a FROI under WCRP 5-2 is denied and dismissed.

4. Claimant's request for penalties for Respondent's alleged violation of Section 8-43-402, C.R.S. is denied and dismissed.

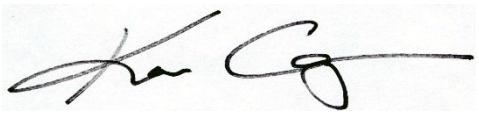
5. Claimant's request for penalties for Respondent's alleged violations of Sections 10-3-1116 and 10-2-417, C.R.S. is denied and dismissed.

6. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the

certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Dated: October 21, 2025



Kara R. Cayce

Administrative Law Judge

Issue

Whether Claimant has established by a preponderance of the evidence that he should be permitted to reopen his Workers' Compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S.

Findings of Fact

1. Claimant works for Employer's school as a building engineer and coach. His duties as a building engineer involve managing the school's plumbing, heating and air conditioning systems. Claimant's other duties include lifting lunch tables, removing snow, and cleaning. On February 14, 2024 Claimant suffered an admitted injury to his right elbow while lifting lunch tables.

2. Claimant received conservative medical treatment, including physical therapy (PT), through authorized treating physician (ATP) David Hnida, DO at Concentra Medical Centers. Dr. Hnida diagnosed Claimant with a right elbow sprain and medial epicondylitis.

3. On June 3, 2024 Claimant visited Dr. Hnida for an examination. Dr. Hnida remarked that Claimant had made good progress. Claimant specifically recounted that he had been working without restrictions. He had been able to perform all occupational duties and activities of daily living. Claimant had also been discharged from PT but was performing home exercises. Dr. Hnida commented that Claimant had returned to baseline range of motion but lacked full right arm function. He determined that Claimant had reached maximum medical improvement (MMI) with no restrictions or impairment. Dr, Hnida did not recommend medical maintenance treatment after MMI.

4. On July 25, 2024 Respondents filed a final admission of liability (FAL) consistent with Dr. Hnida's MMI and impairment determinations. The FAL specifically noted that Claimant had reached MMI on June 3, 2024 with no impairment rating or recommendation for medical maintenance benefits after MMI.

5. Claimant explained at the hearing that further PT and stretching could improve his right arm condition. He mentioned that his own doctor at Kaiser assessed his disability at 10%, compared to a previous assessment of 3%. Claimant noted he is currently paying for his own PT and medical visits but believes these costs should be covered by Insurer because he suffered a work-related injury.

6. Claimant seeks to reopen his claim based on a worsening of his right elbow condition. He detailed that his arm continues to bother him, especially with manual labor required to perform his job duties as a building engineer. Claimant explained that his arm has never been the same since the original injury and he experiences pain, particularly in the back and side of his right arm. He noted that his right arm is crooked and will not completely straighten. Claimant sought to reopen his claim so he could "try to be back as much as possible to 100%."

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things,

the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. At any time within six years of the date of injury, an ALJ may reopen an award on the grounds of fraud, overpayment, error or mistake, or change in condition. §8-43-303(1) C.R.S. The intent of the statute is to provide a remedy to claimants who are entitled to awards of both medical and disability benefits. *Cordova v. Indus. Claim Appeals Off.*, 55 P.3d 186 (Colo. App. 2002). Reopening is appropriate if the claimant proves that additional medical treatment or disability benefits are warranted. *Richards v. Indus. Claim Appeals Off.,* 996 P.2d 756 (Colo. App. 2000). The determination of whether a claimant has sustained his burden of proof to reopen a claim is one of fact for the ALJ. *In re Nguyen,* WC 4-543-945 (ICAO, July 19, 2004). An ALJ's decision to grant or deny a petition to reopen may therefore "be reversed only for fraud or clear abuse of discretion." *Wilson v. Jim Snyder Drilling*, 747 P.2d 647, 651 (Colo. 1987); *see also Heinicke v. Indus. Claim Appeals Off.*, 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.").

5. Section 8-43-303(1), C.R.S., provides that a Workers' Compensation award may be reopened based on a change in condition. In seeking to reopen a claim based on a change in condition, the claimant shoulders the burden of proving his condition has changed and is entitled to benefits by a preponderance of the evidence. *Berg v. Indus. Claim Appeals Off.,* 128 P.3d 270 (Colo. App. 2005). A change in condition refers either to a change in the condition of the original compensable injury or to a change in a claimant's physical or mental condition that is causally connected to the original injury. *Heinicke,* 197 P.3d at 222; *Jarosinski v. Indus. Claim Appeals Off.,* 62 P.3d 1082, 1084 (Colo. App. 2002). A "change in condition" pertains to changes that occur after a claim is closed. *In re Caraveo,* WC 4-358-465 (ICAO, Oct. 25, 2006). Reopening is appropriate if the claimant proves that additional medical treatment or disability benefits are warranted. *Richards v. Indus. Claim Appeals Off.,* 996 P.2d 756 (Colo. App. 2000). The determination of whether a claimant has sustained his burden of proof to reopen a claim is one of fact for the ALJ. *In re Nguyen,* WC 4-543-945 (ICAO, July 19, 2004).

6. Section 8-43-303(1), C.R.S. does not require an ALJ to reopen a claim based on a worsened condition whenever an ATP finds increased impairment following MMI. *Heineke*, 197 P.3d at 222; *see Cordova,* 55 P.3d at 189. Additionally, an ATP's increased impairment determination does not amount to the commencement of a new claim, and the statutory scheme differentiates between determinations of impairment and MMI for permanent partial disability benefits and petitions to reopen. *Heineke*, 197 P.3d at 223. Causation must be established, and an impairment rating alone is insufficient to justify reopening a claim. *Id.*; *see Snyder v. Indus. Claim Appeals Off.*, 942 P.2d 1337, 1339 (Colo. App. 1997).

7. Claimant has failed to establish by a preponderance of the evidence that he should be permitted to reopen his Workers' Compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S. Initially, on February 14, 2024 Claimant suffered an admitted right elbow injury while lifting tables at work. On June 3, 2024 ATP Dr. Hnida determined he had reached MMI with no impairment or restrictions. Because Claimant essentially seeks to reopen his claim because he disagrees with Dr. Hnida's MMI and impairment determinations, his claim fails.

8. Claimant's testimony reflects that he has had ongoing problems since the date of injury. Notably, he detailed that his arm continues to bother him, especially with manual labor required to perform his job duties as a building engineer. Claimant explained that his arm has never been the same since the original injury and he continues to experience pain. He seeks to reopen his claim so he can "try to be back as much as possible to 100%." Claimant's testimony demonstrates that he disagrees with Dr. Hnida's MMI determination, impairment rating, and conclusion that he does not require additional medical care for his right elbow. Although Claimant's testimony that he continues to experience right elbow symptoms, especially while performing manual labor is credible, he has not established that the physical condition of his right elbow has changed since reaching MMI. Finally, Claimant did not present any medical testimony or records that reveal his condition has changed since the case closed. Claimant's request to reopen the claim is thus effectively a challenge to his MMI determination. A petition to reopen based on a challenge to an ATP's MMI determination is not a showing of a change of condition that warrants reopening of a claim.

9. Claimant essentially seeks to challenge Dr. Hnida's determination that he reached MMI without impairment on June 3, 2024 for his right elbow injury. However, the ALJ lacks authority to resolve the issue because Claimant did not timely contest his MMI and impairment determinations or seek a division independent medical examination (DIME). Under §8-42-107(8)(b)(I), C.R.S. an ATP makes the initial determination as to whether a Claimant has reached MMI. If a party disputes the ATP's MMI determination, he may request a DIME in accordance with §8-42-107.2, C.R.S. to resolve the dispute. Specifically, §8-42-107.2 (2)(a)(I)(A), C.R.S. provides that when a claimant initiates an MMI dispute, the time for selection of a DIME commences with the date of mailing of an FAL that includes an impairment rating. Section 8-42-107.2 (2)(b), C.R.S. provides that the party seeking a DIME to dispute an ATP's determination must provide written notice and propose candidates to perform the DIME within 30 after the date of mailing of the FAL. If no notice is submitted within 30 days, the ATP's "findings and determinations shall be binding on all parties and on the division." *Id*. Importantly, "a DIME is a prerequisite to any hearing concerning the validity of an [ATPs] finding of MMI, and, absent such a DIME, an ALJ lacks jurisdiction to resolve a dispute concerning that determination." *Town of Ignacio v. Indus. Claim Appeals Off.*, 70 P.3d 513, 515 (Colo. App. 2002); s*ee In re Akouala*, WC 5-153-666 (ICAO, Oct. 9, 2023) (concluding that ALJ properly denied the claimant's petition to reopen because he was effectively challenging the ATP's MMI and impairment determinations without requesting a DIME). Because Claimant's claim remains closed, his request for medical maintenance benefits is denied and dismissed.

Order

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

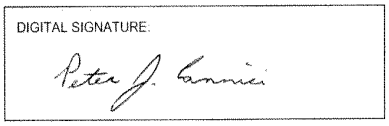
1. Claimant's request to reopen his Workers' Compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S. is denied and dismissed.

2. Any issues not resolved in this Order are reserved for future determination.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver,

Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at http://www.colorado.gov/dpa/oac/forms-WC.htm.*

Dated: October 28, 2025.



Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-273-015-001

Issues

1. Whether Claimant has proven by a preponderance of the evidence that he is entitled to have his permanent partial disability benefits for the below the knee, mid-tibia amputation he suffered because of his May 15, 2024 admitted industrial injury automatically converted from a scheduled to a whole person rating pursuant to §8-42-107(8)(c.5), C.R.S.

2. Whether Claimant has demonstrated by a preponderance of the evidence that his permanent partial disability benefits should be converted from a scheduled to a whole person rating because he suffered functional impairment beyond the schedule enumerated in §8-42-107(2), C.R.S.

Findings of Fact

1. Claimant is a 33-year-old male who worked for Employer as a commercial driver. On May 15, 2024 he sustained a crush injury to his left foot and ankle when a 2,000-pound steel pipe fell off a flatbed trailer onto his leg.

2. Claimant was transported to UCHealth Medical Center of the Rockies where he underwent surgical irrigation and debridement of the open left ankle fracture, wound closure, splinting in plantarflexion, and the administration of intravenous antibiotics. He was initially discharged on May 17, 2024 but returned to the emergency department later that day due to severe pain he could not manage at home. Claimant was readmitted and remained hospitalized until May 25, 2024.

3. Following his discharge from the hospital, Claimant's condition progressively deteriorated. On June 9, 2024 Claimant was admitted to Intermountain Health Platte Valley Hospital and underwent left partial first ray amputation, left partial second ray amputation, and extensive wound debridement. Surgical findings revealed extensive myonecrosis of all

compartments, little viable tissue, and death of nerve tissue. On June 12, 2024 Claimant underwent a below the left knee mid-tibia amputation. He was discharged on June 15, 2024.

4. Claimant underwent his initial prosthetic fitting on July 15, 2024. Between August and September 2024, Claimant began learning to walk on the prosthetic but noted soreness in the stump. Between October and November 2024, Claimant experienced challenges with his prosthetic leg including development of blisters after wearing the prosthesis for extended periods, swelling in the residual limb, and limitations on the exercises he was physically able to perform due to the lack of prosthesis availability. By mid-December 2024, Claimant was able to wear the prosthesis for nine hours. Claimant's medical records document his continued phantom limb sensation and he continues to require medication (Lyrica) to control the neurological pain. Claimant's medical records also document challenges in navigating various environments with his prosthesis, specifically uneven terrain and sloped surfaces.

5. On April 17, 2025 Claimant's Authorized Treating Physician (ATP), Nicholas K. Olsen, DO, determined he had reached Maximum Medical Improvement (MMI). He assigned a 70% lower extremity impairment rating based on Table 47 of the *AMA Guides*, Third Edition. The lower extremity impairment rating corresponds with a 28% whole person impairment rating. At the time of MMI, Claimant reported he had 0/10 pain and his prescription for Lyrica was providing "great control of his phantom pain."

6. On May 22, 2025 Respondents filed a Final Admission of Liability (FAL) acknowledging a 70% lower extremity rating.

7. On August 14, 2025 Claimant underwent an Independent Medical Examination (IME) with Sander Orent, MD. Dr. Orent discussed the statutory section that provides for "automatic conversion" for certain amputations. He noted that Claimant "no longer possesses an ankle or foot" and remarked he "obviously anatomically fits into this category without any dispute." Dr. Orent further discussed Claimant's phantom pain that requires ongoing medications and "substantial restrictions on his functional capabilities." He specifically identified Claimant's difficulties with uneven surfaces and inability to run, use ladders or work at heights due to the lack of sensation where his foot had been. Dr. Orent concluded that it was "clear and obvious that this has affected his whole person."

8. Claimant described that phantom pain was caused by his brain where his foot and lower leg had been prior to the amputation. He detailed that he does not suffer physical pain. Claimant testified that he experiences phantom pain below his amputation, going downward into his foot. The pain occurs about 3-4 times per week at night after he takes off his prosthesis. Claimant commented that the pain can disturb his sleep and some mornings he wakes up fatigued and wants to stay in bed but gets up to attend to his children. He remarked that he struggles with steps and noted the lack of sensation in the prosthetic where his left foot had been. It is thus difficult to gauge his position in relation to inclines and calculate the necessary weight needed to ascend or descend while maintaining his balance. Claimant commented that his inability to run hinders play with his children and other recreational activities. In addressing his functional limitations, Claimant attributed his functional difficulties to his foot, because he does not have feeling in his foot or use of the ankle.

9. Claimant displayed his left lower leg during testimony both with and without his prosthesis in place. His left leg is amputated mid-tibia. Claimant does not have a left ankle or foot because of the amputation. He acknowledged and demonstrated that he had full ability to flex at his knee and hip. Range of motion of the knee was a full 150 degrees at his permanent impairment evaluation. Restrictions at MMI were full duty with the exception that he must wear his prosthesis at work.

10. In June of 2025 Claimant obtained a new prosthesis. The medical records from the period reflect that Claimant is independent in his personal hygiene, takes care of animals on the farm, helps raise three children, mows the lawn, shovels the driveway, and maintains the house. The new prosthesis was requested because it would allow him to walk in water and mud on the farm without damaging his foot and still permit variable cadence on uneven terrain. Claimant had no significant deformity in the residual limb that would impair his ability to stride and no condition that limited ambulation. He exhibited the physical capacity for ambulation at variable walking speeds, with adequate strength and balance to stride and activate his prosthesis. Claimant was also able to transverse most environmental barriers. According to the assessment, Claimant’s prosthesis allowed him to return to his activities safely and without restrictions.

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Whole Person Conversion Pursuant to §8-42-107(8)(c.5), C.R.S.

4. Section 8-42-107(1)(a), C.R.S. limits medical impairment benefits to those provided in §8-42-107(2), C.R.S. when a claimant's injury is one enumerated on the schedule of impairments. When an injury results in a permanent medical impairment not on the schedule of impairments, an employee is entitled to medical impairment benefits paid as a whole person. *See* §8-42-107(8)(c), C.R.S. The classification of an injury as a scheduled or whole person impairment is a factual determination made by the ALJ.

5. The first step in statutory construction is to review the language of the statute, and

if it is unambiguous, there is no need to resort to interpretive rules and the inquiry stops. *PDM Molding, Inv. v. Stanberg,* 898 P.2d 592 (Colo. 1995); *Askew v. ICAO*, 727 P.2d 1333 (Colo. 1986). In considering a statute "[w]ords and phrases shall be read in context and construed according to the rules of grammar and common usage." C.R.S. §2-4-101. The primary task in evaluating a statute "is to ascertain and give effect to the intent of the General Assembly." *In re Marriage of Ikeler*, 161 P.3d 663, 666 (Colo. 2007). In doing so, a court must consider the statute, giving "consistent, harmonious, and sensible effect to all its parts." *Id.* at 666–67. A statute should be read in its entirely, considering the relationship between its parts to understanding the meaning of any single section of the statute. It is also essential to consider the entire statutory scheme. *See Dept't of Revenue v. Agilent Techs., Inc.,* 441 P.3d 1012 (Colo. 2019). Courts defer to the legislature's choice of language, and "we will not add words to a statute or subtract words from it." *Id.* at 1016. In cases where a conflict exists between earlier and later statutory provisions, Colorado courts generally give effect to the more recent enactment if it reflects the legislature's manifest intent to supersede the earlier law. This principle ensures that the legislature's most current policy choices are implemented *See Stackpool v. Dep't of Revenue*, 507 P.3d 100 (Colo. 2021).

6. Claimant has failed to prove by a preponderance of the evidence that he is entitled to automatically convert his below the knee, mid-tibia amputation from a scheduled to a whole person rating pursuant to §8-42-107(8)(c.5), C.R.S. An application of the relevant statutes reveals that Claimant's amputation between the knee and the ankle remains on the schedule of injuries and is not included in the exceptions. Notably, Claimant's amputation is specifically on the schedule under §8-42-107(2)(w.5), C.R.S. because it involves "[t]he loss of a leg above the foot including the ankle."

7. The General Assembly has repeatedly been clear that it is their intent to keep the Workers' Compensation schedule of injuries. *See Duran v. ICAO*, 883 P.2d 477 (Colo. 1994). Notably, §8-42-107(7)(b)(I), C.R.S. specifically states that the General Assembly intended to clarify the intent "that scheduled injuries shall be compensated as provided on the schedule and nonscheduled injuries shall be compensated as medical impairment benefits." The preceding section clarifies that the General Assembly, when enacting Senate Bill 91-218 "assumed that scheduled injuries would remain on the schedule and nonscheduled injuries would be

compensated as medical impairment benefits." *Id.* Scheduled injuries are those listed in §8-42-107(2), C.R.S. Non-scheduled injuries are not listed or excluded from the statutory schedule. *Diilard v. ICAO*, 121 P.3d 301. 304 (Colo. App. 2005).

8. There are distinct injuries that have been excluded from the statutory schedule. In 1992, specific exceptions to the schedule of injuries were created in §8-42-107(8)(c.5), C.R.S. This is the section of the statute involved in the current dispute and is discussed below. Notably, there have been no changes to the language of this section of the statutory scheme relating to the lower extremity over time, although there have been recent unrelated changes to the subsection in 2022 and 2023.

9. Section 8-42-107(8)(c.5), C.R.S. specifically provides that

> When an injury results in the total loss or total loss of use of an arm at the shoulder, a forearm at the elbow, a hand at the wrist, a leg at the hip or so near thereto as to preclude the use of an artificial limb, the loss of a leg at or above the knee where the stump remains sufficient to permit the use of an artificial limb, a foot at the ankle, an eye, an ear, or a combination of any such losses, the benefits for such loss shall be determined pursuant to this subsection (8), except as provided in subsection (7)(b)(IV) of this section.

10. Subsection (c.5) first lists a leg at the hip if no artificial limb can be used, then lists above the knee to hip when an artificial limb *can* be used. The subsection then anatomically skips the leg above the foot including the ankle but lists the foot at the ankle. At the same time, the leg above the foot including the ankle was added to and is addressed specifically in the schedule of injuries under §8-42-107(2)(w.5), C.R.S.

11. In 1994, after the addition of the exceptions in subsection (c.5), the General Assembly added the body part involved in the present matter to the schedule of injuries. The addition included §8-42-107(2)(w.5), C.R.S. and states "[t]he loss of a leg above the foot including the ankle."[1] The action of the General Assembly reflects that this type of loss of the leg

[1] There have only been two additions to the schedule since SB 218's changes to the Workers' Compensation Act, both of which were added after subsection (c.5) in 1994. These are (2)(a.5) "The loss of an arm above the hand including the wrist" and (2)(w.5) "The loss of a leg above the foot including the ankle." These were both added in 1994 after the creation of the specific exceptions listed in subsection (c.5) and show a parallel intent to address and

is not exempt from the schedule. Section 8-42-107(2)(w.5), C.R.S. was added to include loss between the knee and the ankle.

12. In contrast, the language “above the knee/with prosthetic” in §8-42-107(8)(c.5), C.R.S. addresses whole person impairments. The exceptions of subsection (c.5) include the foot at the ankle, with no language for loss of the foot at the ankle regarding prosthetic use.[2] Subsection (c.5) has eight separate, specific circumstances of application and is not ambiguous. The clear reading of the statute is that if an amputation occurs from the knee down to the ankle, it is a scheduled injury not included in the exceptions to subsection (c.5). An amputation that runs anatomically from the knee down to the ankle is specifically designated as a scheduled injury pursuant to §8-42-107(2)(w.5), C.R.S.

13. Claimant asserted that subsection (c.5) should be interpreted without consideration of anything between “total loss of or loss of use” in the first line to “a foot at the ankle.” Because any amputation would necessarily include loss of the foot at the ankle, Claimant’s amputation would be included. However, Claimant’s reading is contrary to numerous rules of statutory construction. The entirety of the statute and the inclusion of §8-42-107(2)(w.5), C.R.S. cannot be ignored. Importantly, courts cannot insert into statutes terms or provisions that do not exist. S*ee Allen v. United Services Automobile Ass’n,* 907 F.3d 1230 (2018) ("Under Colorado law, courts are not at liberty to supply the missing statutory language that a party believes should have been included in a statute but must respect the legislature's choice of language.")

14. Claimant also asserts that the language “or a combination of any such losses” in subsection (c.5) includes Claimant’s mid-tibia amputation. He reasons that any injury including the loss of the foot is a “combination of such losses.” However, Claimant’s approach is inconsistent with the principles of statutory construction. “Such losses” refers back to the specific listed injuries within subsection (c.5) and does not include Claimant’s amputation. The phrase “combination of such losses” simply does not add the missing anatomic loss below the knee and

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clarify any perceived ambiguity in the subsection regarding the limitations of either the upper extremity or the lower extremity.

[2] This anatomically parallels the treatment of the upper extremity injuries addressed by §8-42-107(2), C.R.S. and subsection (8)(c.5). The arm from the wrist to the elbow is not included in the listed exceptions of (c.5) but was added into the schedule in 1994.

above the ankle to the list of exceptions. The preceding portion of the leg was not included in the specific exceptions but was instead purposely later placed separately on the schedule in §8-42-107(2)(w.5), C.R.S. as ”the loss of a leg above the foot including the ankle.” Claimant’s proposed interpretation would make language in the statute superfluous. There would be no reason to include the leg at the hip or the leg at or above the knee if all injuries including the loss of the foot were automatically exceptions to the schedule. An amputation below the knee and above the ankle is not among the exceptions to the schedule articulated in subsection (c.5) and cannot be read into the statute. This is particularly clear based on the addition of subsection (w.5) and the timing of the inclusion on the schedule. *See Leffler v. Indus. Comm’n*, 252 P.3d 50, 52 (Colo. App. 2010) (“For purposes of calculating impairment benefits, the General Assembly has proven quite adept at making extremely fine distinctions as to the location of amputations”).

15. Based on the preceding statutory analysis, Claimant’s mid-tibia amputation is delineated in the schedule of impairments under §8-42-107(2)(w.5), C.R.S. The section specifically lists “[t]he loss of a leg above the foot including the ankle” as a scheduled impairment. In contrast, §8-42-107(8)(c.5), C.R.S. includes the loss of “a foot at the ankle” as a whole person impairment. Claimant contends that because he clearly no longer has his “foot at the ankle,” he has suffered a “total loss” of his foot at the ankle and thus a “total loss of use” of his foot at the ankle. However, Claimant’s interpretation constitutes a convoluted reading of the relevant statutes. Instead, §8-42-107(2)(w.5), C.R.S. clearly encompasses Claimant’s mid-tibia amputation without any unnecessary statutory interpretation and gives effect to the General Assembly’s specific language. Accordingly, Claimant has failed to prove by a preponderance of the evidence that his below the knee, mid-tibia amputation should be automatically converted to a whole person rating pursuant to §8-42-107(8)(c.5), C.R.S.

Whole Person Conversion Based on Functional Impairment

16. Section 8-42-107(1)(a), C.R.S. limits medical impairment benefits to those provided in §8-42-107(2), C.R.S. when a claimant’s injury is one enumerated in the schedule of impairments. When an injury results in a permanent medical impairment not on the schedule of impairments, an employee is entitled to medical impairment benefits paid as a whole person.

See §8-42-107(8)(c), C.R.S. The classification of an injury as a scheduled or whole person impairment is a factual determination made by the ALJ. The ALJ evaluates whether the injury is limited to the scheduled body part or involves additional impairments. *Morris v. ICAO*, 479 P.3d 49 (Colo. App. Aug. 27, 2020).

17. The question of whether a claimant sustained an "injury" that appears on the schedule found at §8-42-107(2), C.R.S. or an injury that entitles him to whole person impairment benefits pursuant to §8-42-107(8), C.R.S. depends on whether the claimant sustained a "functional impairment" to a portion of the body listed on the schedule. To resolve the preceding factual issue, the ALJ must determine the situs of the claimant's "functional impairment," as evidenced by the part or parts of the body that have been impaired or disabled. *Areas Santiago v. Arias Reconstruction, Inc.*, WC 5-255-714-001 (ICAO, Oct. 8, 2025). Notably, the term "injury," as used in §8-42-107(1)(a), C.R.S. refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss. *Walker v. Jim Fuoco Motor Co.*, 942 P.2d 1390 (Colo. App. 1997).

18. The situs of the functional impairment is not necessarily the site of the injury. *See In re Hamrick*, WC 4-868-996-01 (ICAO, Feb. 1, 2016). Pain and discomfort that limit a claimant's ability to use a portion of the body is considered functional impairment for purposes of determining whether an injury is off the schedule of impairments. *In re Johnson–Wood*, WC 4-536-198 (ICAO, June 20, 2005). However, under the functional impairment test, neither the situs of the injury nor the anatomical distinctions found in the *AMA Guides* controls the issue. Rather, the ALJ must consider all relevant evidence and determine what parts of the body have been functionally impaired. Even if the claimant proves tissue damage and pain in structures beyond the schedule, the ALJ may still find a scheduled injury. *See Barry v. Dep't of Human Services*, WC 5-150-172 (ICAO, Feb. 13, 2023).

19. Claimant has failed to demonstrate by a preponderance of the evidence that his permanent partial disability benefits should be converted to a whole person rating because he suffered functional impairment beyond the schedule enumerated in §8-42-107(2), C.R.S. The medical records and Claimant's testimony demonstrate that his complaints and treatment were associated with and limited to the function of the foot and ankle. Notably, Claimant's permanent restrictions permit him to work full duty except for wearing the prosthesis. Claimant demonstrated

full function of his knee at hearing and at the time of MMI. He also revealed full function of his hip. Difficulties with running, climbing ladders and walking on uneven ground are because of the functional limitations created at the foot and ankle. Claimant has difficulties with the preceding activities because of his mid-tibia amputation. It is thus Claimant's left lower extremity that sustained the ultimate loss.

20. Dr. Orent's conclusion that it was "clear and obvious that [the amputation] has affected his whole person." is not persuasive. Claimant's pain is limited to the "phantom pain" that is located where his lower leg and foot existed prior to the amputation. The area is below the amputation site into the foot. Dr. Orent failed to directly address that the origin of Claimant's phantom pain is below the amputation site within the left lower extremity. Although Claimant's amputation has impacted his activities, any functional limitations are related to his left lower extremity amputation. The situs of Claimant's functional impairment is limited to the area below his amputation and does not extend to areas beyond the schedule. Consequently, Claimant has not sustained a functional impairment to parts of the body not listed on the schedule that would warrant whole person conversion.

Order

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

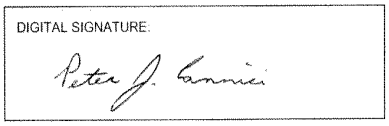
1. Claimant suffered a 70% scheduled left lower extremity impairment because of his May 15, 2024 admitted industrial injury.

2. Any issues not resolved in this Order are reserved for future determination.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, Colorado, 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or

service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at http://www.colorado.gov/dpa/oac/forms-WC.htm.*

Dated: October 21, 2025.



Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Office of Administrative Courts

State of Colorado

Workers' Compensation No. WC 5-276-784-003

Issues

1. Whether Claimant proved by a preponderance of the evidence that he sustained a compensable work injury on June 17, 2024.

2. Whether Claimant proved by a preponderance of the evidence that he is entitled to reasonable, necessary, and related medical benefits, including the right knee surgery recommended by Dr. Cooney on July 22, 2024.

3. Whether Claimant proved by a preponderance of the evidence that he is entitled to temporary total disability (TTD) benefits from June 18, 2024 to August 17, 2024.[1]

4. Determination of Claimant's average weekly wage (AWW).

5. Whether Respondent-Employer is subject to penalties pursuant to section 8-43-408, C.R.S. and section 8-43-409, C.R.S., for failure to carry workers' compensation insurance.

6. Whether Respondent-Employer is subject to penalties pursuant to section 8-43-203(2)(a), for failing to notify the Division of Workers' Compensation in writing of its admission or denial of liability as required by section 8-43-203(1)(a).

Findings of Fact

Notice to Respondent-Employer

1. The hearing took place on Claimant's Application for Hearing dated June 3, 2025, in which Claimant listed the following email address for Respondent-Employer: ecospringlandscaping@gmail.com.

2. The Office of Administrative Courts (OAC) did not receive a Response to Application for Hearing, other pleadings, or any communication from Respondent-Employer prior to hearing.

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[1] Claimant's counsel requested TTD benefits from June 17, 2024 through August 17, 2024. However, Claimant testified at hearing that completed work on June 17, 2024. Therefore, the ALJ begins Claimant's requested TTD period from the first day he had actual wage loss.

3. The OAC sent a Notice of Hearing (NOH) to the parties on July 2, 2025. The NOH was emailed to Respondent-Employer at the above-listed email address. Per the OAC case file, the NOH did not "bounce back" or return as undeliverable.

4. At hearing, the ALJ took judicial notice of the Colorado Secretary of State public records, accessed by the ALJ on the Colorado Secretary of State's website on August 26, 2025, which lists Respondent-Employer's principal office as 2063 Moon Rise Drive, Windsor, Colorado 80550.

5. Exhibit 2 includes checks issued to Claimant from Respondent-Employer. The checks list Respondent-Employer's address as 2063 Moon Rise Drive, Windsor, Colorado 80550.

6. On August 26, 2025, the ALJ issued an Order to Show Cause that was sent to Respondent-Employer at both 2063 Moon Rise Drive, Windsor, Colorado 80550 and ecospringlandscaping@gmail.com. The order gave Respondent-Employer fourteen days to provide good cause for its failure to appear at the August 26, 2025 hearing.

7. Respondent-Employer has not responded to the Order to Show Cause.

Work Injury

Based on the evidence introduced at hearing, including the credible testimony of Claimant, the ALJ finds the following:

8. Respondent-Employer is a residential landscaping business with about four employees.

9. Claimant was hired by Respondent-Employer as a laborer. Claimant's job duties included installing patios and water systems, carrying concrete in wheelbarrows, and carrying dirt. Respondent-Employer provided Claimant with tools, dirt, and materials when working on a job.

10. Claimant worked Monday to Friday from 7:30 a.m. or 8:00 a.m. until 4:00 p.m. Claimant was paid every Friday. Ex. 2. Claimant was paid $22.00 an hour and worked approximately 40 hours per week. Claimant was paid $176.00 for an eight-hour work day.

11. On June 17, 2024, Claimant sustained a work injury while performing his regular job duties during his work hours. Claimant was laying pavers for a patio at a job site when

he experienced pain and pulling in his right knee when transitioning from standing to kneeling to place the pavers.

12. On June 17, 2024, Claimant reported his injury to his boss Michael. Michael told Claimant to "be careful because . . . we don't have insurance." Tr. p. 18 ln. 22-23. Claimant finished working his shift on June 17, 2024.

13. Respondent-Employer did not provide Claimant with a designated providers list nor refer Claimant to a workers' compensation provider for medical care.

14. On June 18, 2024, Claimant presented to Denver Health Emergency Department with pain and swelling of his right knee. Ex. 8. Claimant was diagnosed with effusion of the right knee and pain and swelling of the right knee. *Id.* at p. 32.

15. On June 19, 2024, Claimant presented to Longmont United Hospital Emergency Department because of his knee injury. Ex. 9 p. 38. Claimant was diagnosed with acute internal derangement of the right knee. *Id*. Claimant was placed in an immobilizer and given crutches. *Id.*

16. On June 28, 2024, Claimant returned to Longmont United Hospital Emergency Department due to the pain in his knee. Ex. 9 p. 48. Claimant was referred to Orthopedic Medicine. *Id.*

17. Also on June 28, 2024, Claimant completed a Worker's Claim for Compensation with the Colorado Department of Labor and Employment Division of Workers' Compensation (Division). Ex. 1.

18. Twenty days from June 28, 2024 was July 18, 2024.

19. As of the date of the hearing, Respondent-Employer had not admitted or contested liability as required by section 8-43-302(1)(a), C.R.S.

20. Claimant was seen by Dr. George Chaus at Orthopedic and Spine Center of Rockies on July 2, 2024. Ex. 9 p. 62-63. Dr. Chaus diagnosed Claimant with a tear to his right lateral collateral ligament. *Id.* at p. 63. Dr. Chaus recommended an MRI to further evaluate the injury. *Id.*

21. Claimant underwent an MRI of his right knee on July 9, 2024. Ex. 10. Claimant's MRI revealed a complete or near-complete tear of the right anterior cruciate ligament, radial tear of the posterior horn of the lateral meniscus with severe meniscal extrusion, moderate lateral compartment chondromalacia, and moderate joint effusion. Ex. 10.

22. Claimant was seen by Dr. William Cooney at Orthopedic and Spine Center of the Rockies on July 15, 2024. Ex. 9 p. 60-61. Dr. Cooney discussed Claimant's MRI results but because no interpreter was present, Dr. Cooney scheduled Claimant to return on July 22, 2024 to discuss options based on Claimant's MRI results. *Id.* at p. 61.

23. On July 22, 2024, Claimant was seen by Dr. Cooney with the assistance of Claimant's friend as an interpreter. Ex. 9 p. 58-59. Dr. Cooney discussed surgical intervention with Claimant, which "would entail exam under anesthesia followed by diagnostic arthroscopy, anticipated anterior cruciate ligament reconstruction as well as meniscal management with probable partial lateral meniscectomy." *Id.* at p. 58.

24. Claimant has not undergone the surgery recommended by Dr. Cooney but would like to have the surgery.

25. Claimant was billed the following amounts for medical treatment related to his June 17, 2024 work injury:

a. Health Images - $550.00. Ex. 12 p. 73.
b. Orthopedic and Spine Center of the Rockies - $1004.00. Ex. 12 p. 75.
c. Longmont United Hospital Emergency Department - $1425.73. Ex. 12 p. 80-82.
d. Denver Health Emergency Department - $80.00. Ex. 12 p. 83-84.
e. Mango House Pharmacy - $8.00. Ex. 12 p. 85.

26. Claimant has personally paid $30.00 of the cost of his medical care. Ex. 12.

27. As a result of his work injury, Claimant did not earn any wages from June 18, 2024 through August 17, 2024. Claimant was unable to perform his regular job duties and the associated tasks due to pain in his right knee.

28. Claimant was notified by the Division that Respondent-Employer is uninsured.

29. The ALJ finds Claimant's testimony credible.

30. A preponderance of the evidence demonstrates that Claimant was an employee of Respondent-Employer.

31. Claimant proved it is more likely than not he sustained a compensable work injury arising out of and in the course of his employment for Respondent-Employer on June 17, 2024.

32. Claimant proved it is more likely than not the medical treatment he received was reasonable, necessary, and related treatment to cure and relieve the effects of the June

17, 2024 work injury. Claimant is entitled to reasonably necessary medical treatment related to the work injury.

33. Claimant proved it is more likely than not that the surgical intervention recommended by Dr. Cooney on July 22, 2024 is reasonable, necessary, and related treatment that will cure and relieve Claimant of the effects of his June 17, 2024 work injury.

34. Claimant's AWW is $880.00.

35. Claimant proved it is more likely than not the June 17, 2024 work injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability related in actual wage loss from June 18, 2024 through August 17, 2024. Claimant is entitled to TTD benefits for such period of time.

36. A preponderance of the evidence demonstrates that Respondent-Employer did not carry workers' compensation insurance on the date of Claimant's work injury.

37. A preponderance of the evidence demonstrates that Respondent-Employer failed to comply with section 8-43-203(1)(a), C.R.S., and is subject to penalties pursuant to section 8-43-203(2)(a), C.R.S.

Conclusions of Law

The purpose of the Act is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 318 (1979). The facts in a workers' compensation case must be interpreted neutrally – neither in favor of the rights of the claimant, nor in favor of the rights of the respondents – and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *Univ. Park Care Ctr. v. Indus. Claim Appeals Off.*, 43 P.3d 637, 641 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible

inferences from the evidence. *Id*. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Bodensieck v. Indus. Claim Appeals Off.*, 183 P.3d 684, 687 (Colo. App. 2008).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Off.*, 5 P.3d 385, 389 (Colo. App. 2000).

Compensability

To establish a compensable injury an employee must prove by a preponderance of the evidence that his injury arose out of the course and scope of employment with his employer. § 8-41-301(1)(b), C.R.S.; *see City of Boulder v. Streeb*, 706 P.2d 786, 791 (Colo. 1985). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *Triad Painting Co. v. Blair*, 812 P.2d 638, 641 (Colo. 1991). The "arising out of" requirement is narrower and requires the claimant to demonstrate that the injury has its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Popovich v. Irlando,* 811 P.2d 379, 383 (Colo. 1991). The claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998).

As found, Claimant proved by a preponderance of the evidence that he sustained a compensable work injury on June 17, 2024. Claimant's right knee injury occurred while he was performing his regular work-related functions during the time and place limits of his work. Claimant credibly testified regarding how the work injury occurred and his testimony is corroborated by the medical records. Based on the totality of the evidence, Claimant proved it is more likely than not he suffered a compensable work injury on June

17, 2024 arising out of and in the course of his employment, resulting in disability and the need for medical treatment.

Medical Treatment

Respondents are liable for medical treatment that is causally related, reasonable, and necessary to cure and relieve the effects of the industrial injury. § 8-42-101(1)(a), C.R.S. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *City of Durango v. Dunagan*, 939 P.2d 496, 499 (Colo. App. 1997); *Hobirk v. Colo. Springs Sch. Dist. # 11,* W.C. No. 4-835-556-01 (ICAO, Nov. 15, 2012).

As found, Claimant proved by a preponderance of the evidence the medical treatment he received was reasonable, necessary, and related medical care. Claimant presented to Denver Health and Longmont United Hospital for emergency treatment of his right knee as a result of the work injury. Claimant was then seen by Drs. Chaus and Cooney at Orthopedic and Spine Center of the Rockies for further diagnosis and treatment. Similarly, Claimant underwent a diagnostic MRI and received medications all related to his work injury. The nature and severity of Claimant's work injury necessitated evaluation and treatment. The treatment Claimant received was a direct result of Claimant's June 17, 2024 injury and was reasonable and necessary to cure and relieve the effects of the work injury. Accordingly, Respondent-Employer is liable for the costs of the medical treatment Claimant received, as well as other reasonably necessary and casually related medical treatment, including the surgical intervention recommended by Dr. Cooney on July 22, 2024 which Claimant established by a preponderance is reasonable, necessary, and causally related to his industrial injury.

AWW

Section 8-42-102(2), C.R.S. requires the ALJ to base the claimant's AWW on his or her earnings at the time of injury. "The entire objective of wage calculation is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity." *Campbell v. IBM Corp.*, 867 P.2d 77, 82 (Colo. App. 1993).

Claimant credibly testified that he earned $22.00 per hour and worked approximately 40 hours a week. As found, an AWW of $880.00 is a fair approximation of Claimant's wage loss and diminished earning capacity.

TTD

To prove entitlement to TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. § 8-42-103(1), C.R.S.; § 8-42-105(1), C.R.S.; *Anderson v. Longmont Toyota*, 102 P.3d 323, 327 (Colo. 2004); *Martinez v. Performance Radiator Pacific LLC*, W.C. No. 5-233-367-001 (ICAO, Nov. 19, 2024).

Section 8-42-103(1)(a), C.R.S., requires the claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *Lindner Chevrolet v. Indus. Claim Appeals Off.*, 914 P.2d 496, 498 (Colo. App. 1995). The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage-earning capacity as demonstrated by claimant's inability to resume his or her prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). 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 or her regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595, 597 (Colo. App. 1998). Because there is no requirement that a claimant must produce evidence of medical restrictions, a claimant's testimony alone is sufficient to demonstrate a disability. *Lymburn v. Symbios Logic,* 952 P.2d 831, 833 (Colo. App. 1997).

TTD benefits shall continue until the first occurrence of any of the following: (1) the employee reaches MMI; (2) the employee returns to regular or modified employment; (3) the attending physician gives the employee a written release to return to regular employment; or (4) the attending physician gives the employee a written release to return to modified employment, the employment is offered in writing, and the employee fails to begin the employment. § 8-42-105(3)(a)-(d), C.R.S. Employers or insurers must pay statutory interest of 8% per annum on all benefits not paid when due. § 8-43-410(2), C.R.S.; *see Subsequent Inj. Fund v. Indus. Claim Appeals Off.*, 859 P.2d 276, 278 (Colo. App. 1993).

As found, Claimant proved it is more probable than not he is entitled to TTD benefits from June 18, 2024 through August 17, 2024. As a result of the June 17, 2024

work injury to his right knee, Claimant was unable to perform his regular job duties as a laborer and he could not return to work. Claimant's regular job duties required the use of his right knee, which was not possible due to the work injury. Claimant testified he finished working on June 17, 2024. Therefore, as a result of the June 17, 2024 work injury and resultant disability, Claimant did not earn any wages from June 18, 2024 through August 17, 2024, when he gained other employment, entitling him to TTD benefits for such period.

Based on an AWW of $880.00, Claimant's TTD rate is $586.67. Respondent-Employer thus owes Claimant $5112.41 in TTD benefits for the period of June 18, 2024 through August 17, 2024.

Uninsured Employer

Failure to Carry Workers' Compensation Insurance

Section 8-43-408(5), C.R.S. provides:

> In addition to any compensation paid or ordered . . . an employer who is not in compliance with the insurance provisions of [the Act] at the time an employee suffers a compensable injury or occupational disease shall pay an amount equal to twenty-five percent of the compensation or benefits to which the employee is entitled to the Colorado uninsured employer fund created in section 8-67-105.

The penalty for failure to insure only applies to indemnity benefits; it does not apply to medical benefits. *Indus. Comm'n v. Hammond*, 77 Colo. 414, 236 P. 1006 (1925); *Jacobson v. Doan*, 319 P.2d 975 (Colo. 1957); *Wolford v. Support, Inc*., W.C. No. 4-155-231 (Feb. 13, 1998). Although the ALJ is not aware of a case directly on point, statutory interest is not properly considered "compensation or benefits" within the meaning of section 8-43-408(5). Interest is a statutory right intended to secure claimants the present value of benefits to which they are entitled by creating an equitable remedy for the lost time value of money during the accrual period. *Subsequent Inj. Fund v. Trevethan*, 809 P.2d 1098, 1099 (Colo. App. 1991).

Respondent-Employer has been ordered to pay Claimant $5112.41 in TTD benefits. Twenty-five percent (25%) of the compensation awarded is $1278.10.

Failure to Admit or Deny Liability

"The employer . . . shall notify in writing the division and the injured employee . . . within twenty days after a report is, or should have been, filed with the division pursuant to section 8-43-101, whether liability is admitted or contested . . . ." § 8-43-203(1)(a), C.R.S.

> If such notice is not filed as provided in subsection (1) of this section, the employer . . . may become liable to the claimant, if the claimant is successful on the claim for compensation, for up to one day's compensation for each day's failure to so notify; except that the employer . . . shall not be liable for more than the aggregate amount of three hundred sixty-five days' compensation for failure to timely admit or deny liability. Fifty percent of any penalty paid pursuant to this subsection (2) shall be paid to the subsequent injury fund, created in section 8-46-101, and fifty percent to the claimant.

§ 8-43-203(2)(a), C.R.S.; *see Martinez v. Pic N Save*, W.C. No. 4-525-832 (ICAO, Mar. 24, 2003)("[T]he plain and clear language of the statute provides that the penalty period for failing to comply with § 8-43-203(1)(a) begins on the 21st day after the insurer has the requisite notice or knowledge.").

As found, Claimant credibly testified that he notified Respondent-Employer of his injury on June 17, 2024. Pursuant to section 8-43-101(1)(a), C.R.S., Respondent-Employer had ten days to report Claimant's injury to the Division. Moreover, Claimant completed a Claim for Workers' Compensation on June 28, 2024. Therefore, at the latest, Respondent-Employer should have filed notice admitting or contesting the claim by July 18, 2024. *See* § 8-43-203(1)(a), C.R.S. As of the date of the hearing, Respondent-Employer had not admitted or contested liability.

"Generally, a claim is successful when the employer's liability for disability benefits is established." *McManus v. Indus. Claim Appeals Off.*, 81 P.3d 1074, 1076 (Colo. App. 2003). "Under the holding of *Smith v. Myron Stratton Home*, [676 P.2d 1196, 1201 (Colo. 1984)], claimant was successful on his claim for compensation and thus eligible, without

more, for an award of a penalty for employer's failure to admit or deny liability for the injury." *Id.*

Under earlier versions of the Act, the penalty for failure to notify was mandatory. *Smith*, 676 P.2d at 1199 ("This penalty is mandatory; the referee, the Industrial Commission and the courts are given no discretion in its application."). Now, the penalty is discretionary. § 8-43-203(2)(a), C.R.S. ("the employer . . . *may* become liable") (emphasis added). "If an insurer offers no explanation for its conduct, then the claimant has made a *prima facie* showing because the ALJ may infer that there was no reasonable explanation for the insurer's actions." *Cardona v. Baker Concrete*, W.C. No. 5-219-483-002 (ICAO, Jul. 28, 2025).

The ALJ finds and concludes that a penalty of $5000.00 (approximately $13.70 a day for three hundred and sixty five days) for Respondent-Employer's failure to comply with section 8-43-203(1)(a), C.R.S. is appropriate. Claimant's daily compensation was $176.00. Three hundred and sixty five days of Claimant's daily compensation totals $64,240.00. However, the record before the ALJ is "devoid of reprehensible conduct or significant prejudice" to Claimant which would support such a hefty award. *See Hulstrom v. Liberty Energy Inc.*, W.C. No. 5-263-944 (ICAO, Apr. 29, 2025). Instead, the record establishes that Claimant was out of work from June 18, 2024 to August 17, 2024 and that Respondent-Employer owes Claimant $5112.41 in TTD benefits for that time. The ALJ determines that a penalty in a similar amount for Respondent-Employer's failure to comply with section 8-43-203(1)(a), C.R.S. is reasonable and proportionate to the conduct in question. *Cf. Cardona*, W.C. No. 5-219-483-002 (ICAO, Jul. 28, 2025).

Pursuant to section 8-43-203(2)(a), C.R.S., Respondent-Employer shall pay $2500.00 to Claimant and $2500.00 to the Subsequent Injury Fund, for a total penalty of $5000.00, for violation of section 8-43-203(1)(a), C.R.S.

Posting Bond

Section 8-43-408(2), C.R.S. provides:

> In all cases where compensation is awarded under the terms of this section, the director or an administrative law judge of the division shall compute and require the employer to pay to a trustee designated by the director or administrative law

> judge an amount equal to the present value of all unpaid compensation or benefits computed at the rate of four percent per annum; or, in lieu thereof, such employer, within ten days after the date of such order, shall file a bond with the director or administrative law judge signed by two or more responsible sureties to be approved by the director or by some surety company authorized to do business within the state of Colorado. The bond shall be in such form and amount as prescribed and fixed by the director and shall guarantee the payment of the compensation or benefits as awarded. The filing of any appeal, including a petition for review, shall not relieve the employer of the obligation under this subsection (2) to pay the designated sum to a trustee or to file a bond with the director or administrative law judge.

As Respondent-Employer was uninsured at the time of Claimant's work injury, the provisions of section 8-43-408(2), C.R.S. apply.

Order

It is therefore ordered that:

1. Claimant sustained a compensable work injury on June 17, 2024 arising out of and in the course and scope of his employment with Respondent-Employer.

2. Claimant is entitled to reasonable and necessary medical benefits related to his June 17, 2024 work injury. Claimant's treatment at Denver Health, Longmont United Hospital, Orthopedic and Spine Center of the Rockies, Mango Pharmacy, and Health Images were reasonable, necessary, and related to his June 17, 2024 work injury. Respondent-Employer shall pay for the associated costs of such treatment, as well as other reasonable, necessary and related medical treatment, including the right knee surgical intervention recommended by Dr. Cooney on July 22, 2024.

3. Claimant's AWW is $880.00.

4. Respondent-Employer shall pay Claimant TTD benefits in the amount of $5112.41 for the period of June 18, 2024 to August 17, 2024.

5. Respondent-Employer shall pay $1278.10 to the Colorado Uninsured Employer Fund pursuant to section 8-43-408(5), C.R.S.

6. Pursuant to section 8-43-203(2)(a), C.R.S., Respondent-Employer shall pay $2500.00 to Claimant and $2500.00 to the Subsequent Injury Fund for a total penalty of $5000.00 for violating section 8-43-203(1)(a), C.R.S.

7. Respondent-Employer shall pay statutory interest at a rate of 8% per annum on compensation benefits not paid when due.

8. In lieu of payment of the above compensation, penalties, and benefits to Claimant the Respondent-Employer shall:

a. Deposit $11,390.51 with the Division of Workers' Compensation, as trustee, to secure payment of all unpaid compensation, penalties, and benefits awarded, or

b. File a surety bond in the amount of $11,390.51 with the Division of Workers' Compensation within ten (10) days of the date of this order:

i. Signed by two or more responsible sureties who have received the prior approval of the Division of Workers' Compensation; or

ii. Issued by a surety company authorized to do business in Colorado.

The bond shall guarantee payment of the compensation, penalties, and benefits awarded.

9. Respondent-Employer shall notify the Division of Workers' Compensation and Claimant's attorney of payments made pursuant to this Order.

10. Filing any appeal, including a petition to review, shall not relieve Respondent-Employer of the obligation to pay the designated sum to Claimant, the Colorado Uninsured Employers Fund, the Colorado Subsequent Injury Fund, the trustee, or to file the bond required above.

11. All matters not determined herein are reserved for future determination.

Signed: October 14, 2025.

Robin E. Hoogerhyde

Robin E. Hoogerhyde
Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after

mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-279-004-004

Issues

- Whether Claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer?

- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that the treatment he received was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the injury?

- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that he is entitled to select his own authorized treating physician ("ATP") based on Employer's failure to properly provide Claimant with a list of physicians who could treat Claimant?

- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that he is entitled to an award of temporary total disability ("TTD") benefits for the period of June 27,2024 until August 1, 2025?

- If Claimant has proven a compensable injury, what is Claimant's average weekly wage ("AWW")?

Findings of Fact

1. Claimant was employed by Employer working on a farm as a laborer with job duties that included maintaining ditches. Claimant testified that on May 15, 2024, he was driving a water truck following the burning of ditches and when he got out of the truck, he hit his knee on the truck door and twisted his right knee. Claimant testified he told Employer of the injury, but was not provided with a list of medical providers.

2. Claimant eventually sought medical treatment at Sunrise Community Health Center on June 26, 2024. Claimant reported to Physicians' Assistant ("PA") Gerrity that he had pain in his knee related to hitting the knee on a truck door frame twice in one (1) day about one (1) month earlier. Claimant reported his pain had gotten worse and it was now painful to walk. Claimant was provided with x-rays of the knee and referred for physical therapy. The x-rays demonstrated medium joint effusion in the right knee. PA Gerrity provided Claimant with work restrictions that included minimal walking for the next week.

3. Claimant testified at hearing that after his injury he continued working his regular job with Employer until June 26, 2024 when he could not perform his job duties any longer.

4. Claimant was subsequently returned to Sunrise Community Health on July 16, 2025 and was examined by PA Olson. PA Olson noted Claimant's continued complaints of knee pain and recommended a magnetic resonance image ("MRI"). PA Olson provided Claimant with restrictions that kept Claimant off of work until further evaluation after her exam.

5. The MRI was performed on August 24, 2024 and showed a medial meniscus tear along with subchondral stress reaction of the medial tibial plateau and a small joint effusion.

6. Claimant underwent surgery on the right knee under the auspices of Dr. Matthew Javernick consisting of an arthroscopy with partial medial meniscectomy. The surgery was performed on October 30, 2024.

7. Claimant testified he was paid $2,000 every 15 days. Claimant entered into evidence copies of checks from Employer made out in the amount of $2,000 dated May 9, 2024, and May 20, 2024. Claimant also entered into evidence checks made out in the amount of $1,670 dated June 3, 2024, June 14, 2024 and July 2024.

8. Employer testified at hearing in this matter that Claimant reported that he had injured his knee at the end of the day on May 15, 2024 when he hit his knee on the door of the truck. Employer testified that he believed Claimant had his knee

checked and then returned to work cleaning ditches and spraying weeds. Employer testified that Claimant continued to work after May 15, 2024 ten (10) hour days which required Claimant to be on his feet 5-6 hours per day.

9. Employer testified that Claimant continued to work until June 26, 2024 when he was bailing alfalfa and when Claimant finished around 9:30 or 10:00 a.m., Claimant said his knee hurt and he had to go to the doctor.

10. Employer testified that Claimant was paid $16,70 per hour and worked ten (10) hour days. Employer testified that Claimant went from working six (6) days a week to five (5) days a week at the end of May at Claimant's request because Claimant wanted to spend more time with his family.

11. Employer testified at hearing that he did not provide Claimant with a list of medical providers at any time.

12. The ALJ credits the testimony of the Claimant along with the medical records entered into evidence in this case and finds that Claimant has established that it is more probable than not that he sustained a compensable injury arising out of the course and scope of his employment with Employer when he struck his right knee on the frame of the truck door and twisted his right knee on May 15, 2024.

13. The ALJ credits the medical records entered into evidence in this case and finds that the medical treatment Claimant received was reasonable and necessary to cure and relieve Claimant from the effects of the industrial injury, including the treatment from Sunrise Community Health and the surgery performed by Dr. Javernick.

14. The ALJ further finds that Employer did not provide Claimant with a list of medical providers and Claimant was allowed to select a physician to treat his injury. The ALJ credits the medical records and finds that Claimant selected Sunrise Community Health as the medical provider to treat his injury and the treatment with Sunrise Community Health is therefore authorized medical treatment.

15. The ALJ credits Claimant's testimony at hearing along with the medical records from PA Gerrity that provided Claimant with work restrictions effective June 26, 2024 and finds that Claimant has established that it is more likely than not that as a result of the injury, Claimant's injury resulted in a disability, and Claimant left work as a result of that disability and the disability lasted for more than three (3) days. Claimant has therefore established that he is entitled to an award of TTD benefits.

16. The ALJ credits the testimony of Claimant and Employer along with the checks entered into evidence at hearing and finds that Claimant has established that his AWW at the time of his injury was $1,000. Employer testified that Claimant was paid $16.70 per hour and worked ten hour days six days per week. This would equate to weekly earnings of $1,002.00 ($16.70 x 10 x 6 = $1,002.00). The checks entered into evidence, however, establish that Claimant was being paid $2,000 by check every two weeks at the time of the injury, and therefore, the ALJ finds that the evidence establishes that Claimant's proper AWW is $1,000 per week.

17. While Employer testified that Claimant voluntarily reduced his hours at the end of May, and the checks entered into evidence in this case support that testimony, the ALJ must consider the weekly earnings of Claimant at the time of the injury. Therefore, the AWW is determined to be $1,000 per week.

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2016.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with "a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, the ALJ credits the testimony of the Claimant along with the medical records entered into evidence at hearing and finds that Claimant has established by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer when he struck his knee on the frame of the truck door and twisted the knee on May 15, 2024.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Pursuant to Section 8-43-404(5), C.R.S., Respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once Respondents have exercised their right to select the treating physician, Claimant may not change physicians without first obtaining permission from the insurer or an ALJ.

See Gianetto Oil Co. v. Industrial Claim Appeals Office, 931 P.2d 570 (Colo. App. 1996). In order to properly exercise its right of selection, the employer must provide the claimant with a list of at least four providers from which he can choose. Section 8-43-404(5)(a)(I)(A).

6. "Authorization" refers to the physician's legal authority to treat, and is distinct from whether treatment is "reasonable and necessary" within the meaning of Section 8-42-101(1)(a), C.R.S. 2008. *Leibold v. A-1 Relocation, Inc.*, W.C. No. 4-304-437 (January 3, 2008). Section 8-43-404(5)(a) specifically states: "In all cases of injury, the employer or insurer has the right in the first instance to select the physician who attends said injured employee. If the services of a physician are not tendered at the time of the injury, the employee shall have the right to select a physician or chiropractor." "[A]n employee may engage medical services if the employer has expressly or impliedly conveyed to the employee the impression that the employee has authorization to proceed in this fashion…." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985), *citing*, 2 A. Larson, *Workers' Compensation Law* § 61.12(g)(1983).

7. As found, Claimant has established by a preponderance of the evidence that the treatment at the Sunrise Community Health and surgery performed by Dr. Javernick represents reasonable medical treatment necessary to cure and relieve Claimant from the effects of the industrial injury.

8. As found, Claimant has established that Employer failed to refer Claimant for medical treatment and Claimant is therefore entitled to select the physician who is authorized to treat Claimant for his injuries. As found, Claimant has selected Sunrise Community Health as his provider for the compensable injury.

9. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM*

Molding, Inc. v. Stanberg, supra. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). 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. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

10. As found, Claimant has established by a preponderance of the evidence that he is entitled to an award of TTD benefits commencing on June 27, 2024 and continuing until August 1, 2025.

11. The ALJ must determine an employee's AWW by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of the injury, which must include any advantage or fringe benefit provided to the Claimant in lieu of wages. Section 8-42-102(2), C.R.S.; *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995).

12. As found, based on the credible testimony of Claimant and Employer, along with the checks entered into evidence, the ALJ finds that Claimant's AWW was $1,000.00 while employed with Employer. Respondents are therefore required to pay Claimant TTD benefits based on an AWW of $1,000.00.

Order

It is therefore ordered that:

1. Respondents shall provide reasonable medical treatment necessary to cure and relieve Claimant from the effects of the work injury including the treatment from Sunrise Community Health and Dr. Javernick.

2. Respondents shall pay Claimant TTD benefits for the period of June 27, 2024 through August 1, 2025 based on his AWW of $1,000.00

3. All issues not herein decided are reserved for future determination.

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts.

DATED: October 22, 2025

Keith E. Mottram

Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

Issues

- Did Claimant prove he suffered a compensable injury on July 17, 2024?
- If the claim is compensable, did Claimant prove entitlement to TTD benefits from July 18, 2024, through July 16, 2025?
- If the claim is compensable, did Respondents prove indemnity benefits should be reduced 50% for willful violation of a safety rule?

Findings of Fact

1. Employer's business involves receiving crashed and salvaged vehicles, providing estimates and reports to insurance companies, and conducting auctions for vehicles that retain salvage value.

2. Claimant works for Employer as a Receiving Specialist. His primary duties involved inspecting received vehicles, checking their operability, and making minor repairs. Occasionally, he needed to test drive vehicles.

3. On July 17, 2024, Claimant's supervisor, Mr. Ramsey, instructed him to work on a "side-by-side" off-road vehicle located in the motorcycle receiving area.

4. When Claimant arrived at the motorcycle receiving area, he saw two co-workers, Steven Perry and Jason Campos, working on a Vespa scooter. Mr. Perry had just finished moving the vehicle and had "tumbled" upon dismount. Claimant stated, "that looks fun!" Claimant got on the Vespa and drove approximately 70 yards. He then turned around and rode back toward Mr. Perry and Mr. Campos. When he attempted to stop, the front brake locked up, and Claimant was thrown off. The Vespa landed on Claimant's right foot, causing serious injuries.

5. Claimant testified he was trying to "help" Mr. Perry and Mr. Campos with the Vespa. However, that assertion is refuted by Mr. Ramsey's and Mr. Perry's credible testimony.

6. Claimant was specifically instructed to work on the side-by-side, which had no connection to Vespa, other than the fact that they happened to be stored in the same

area. Even if a test drive of the Vespa had been necessary, it would have involved moving it a few feet, not 70 yards. The fact that Claimant drove it such a great distance further removed him from his assigned duties. In any event, Mr. Perry had already completed the test drive, and the Vespa was ready to be queued for sale once Mr. Perry had dismounted. Furthermore, it was a slow day, and "there was no need for extra help" with the Vespa. Therefore, Claimant's actions conferred no benefit on Employer. In Mr. Ramsey's view, Claimant was simply "goofing around" when the accident occurred.

7. Mr. Perry confirmed he and Mr. Campos had finished working on the Vespa by the time Claimant appeared. As a result, Claimant was not "helping" them because the work was done. In fact, Mr. Perry testified that Claimant's interaction with the Vespa was not helpful and was completely unnecessary. Rather, to him, it appeared that Claimant simply wanted to have fun and joyride.

8. Mr. Ramsey's and Mr. Perry's testimony is credible and more persuasive than any contrary testimony offered by Claimant.

9. Claimant failed to prove his injury arose out of his employment. The persuasive evidence shows Claimant was joyriding when the accident occurred. Claimant's injury occurred during, and because of, a personal deviation from his employment. Therefore, Claimant did not prove a compensable injury.

Conclusions of Law

To receive compensation or medical benefits, a claimant must prove they suffered an injury arising out of and in the course of employment. Section 8-41-301(1). The "course of employment" requirement is met if the injury "occurred within the time and place limits of the employment relationship and during an activity that had some connection with the employee's job-related functions." *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). The term "arising out of" is narrower and requires that an injury "has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered a part of the employee's employment contract." *Horodysyj v. Karanian*, 32 P.3d 470, 475 (Colo. 2001).

The claimant need not actually be performing work duties at the time of the injury, nor must the activity be a strict employment requirement or confer an express benefit on the employer. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996).

"Many job functions involve discretionary or optional activities on the part of the employee, devoid of any duty component and unrelated to any specific benefit to the employer, but nonetheless sufficiently incidental to the work itself as to be properly considered as arising out of and in the course of employment." *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The ultimate question is whether the activity is sufficiently "interrelated to the conditions and circumstances under which the employee generally performs the job functions that the activity may reasonably be characterized as an incident of employment." *Price, supra* at 210.

An employee can step outside the scope of employment by engaging in a purely personal deviation. When a personal deviation is asserted, the question is "whether the claimant's conduct constituted such a deviation from the circumstances and conditions of the employment that the claimant stepped aside from his job and was performing an activity for his sole benefit." *Panera Bread, LLC v. Industrial Claim Appeals Office*, 141 P.3d 970, 972 (Colo. App. 2006). The deviation must be "substantial" to remove the claimant from the course and scope of employment. *Kelly v. Industrial Claim Appeals Office*, 214 P.3d 516 (Colo. App. 2009).

As found, Claimant's injury occurred during, and was directly caused by, a substantial personal deviation. At the time of the accident, Claimant was not performing any action in furtherance of, or incidental to, his employment. He was simply joyriding. All necessary work on the Vespa was complete, and it was ready for sale when Claimant started riding it. His actions conferred no benefit on Employer. Claimant's testimony he was "helping" his co-workers is not persuasive. Claimant said riding the Vespa looked "fun," but said nothing about offering any assistance. Mr. Perry and Mr. Campos neither requested nor needed any help, and in fact, Claimant's actions were not helpful. Although Claimant's injury occurred during work hours, thereby satisfying the "course of employment" requirement, it did not "arise out of" his work. Therefore, his injuries are not compensable.

Because the claim is not compensable, the other issues are moot and need not be addressed.

Order

It is therefore ordered that:

1. Claimant's claim for workers' compensation benefits is denied and dismissed.

If you are dissatisfied with this order, you may file a Petition to Review with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail by sending it to the above address for the **Denver Office of Administrative Courts** within twenty (20) days after mailing or service of the ALJ's order. In the alternative, you may file your Petition to Review electronically by email to the following email address: oac-ptr@state.co.us. If the Petition to Review is timely served via email, it is deemed filed in Denver pursuant to OACRP 27(A) and § 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it need not also be mailed to the Denver Office of Administrative Courts. For statutory reference, see § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms

DATED: October 24, 2025

DIGITAL SIGNATURE

Patrick C.H. Spencer II

Patrick C.H. Spencer II
Administrative Law Judge
Office of Administrative Courts

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-290-810-003

Issues

1. Whether Claimant established by a preponderance of the evidence that he sustained a compensable injury arising out of the course of his employment with Employer on October 31, 2024.
2. Whether Claimant established an entitlement to medical benefits.
3. Whether Claimant established an entitlement to temporary disability benefits.
4. Determination of Claimant's average weekly wage.

Findings of Fact

1. Claimant worked for Employer, an HVAC company, as a field technician beginning in December 2021. Claimant's average weekly wage was $1,560.00. To perform his job duties, Employer provided Claimant with a company-owned van which was used to service calls, and for which Claimant was permitted to use for limited personal reasons. Claimant was permitted to drive the van to and from Employer's office, and to service calls directly from his home without coming into Employer's office. Claimant testified that his job duties typically required him to be at customer locations for service calls at 8:00 a.m. Claimant used the Employer-provided van to transport the tools and equipment necessary to perform his job to off-site locations, including customer service calls. Joshua Sands, Employer's director of operations, testified that Employer dispatched field technicians from their homes, and that they were only required to come to Employer's shop for scheduled meetings and to obtain parts from Employer's stock.

2. As a part of Employer's regular practice, field technicians and other employees are periodically assigned "on-call" status for one-week periods. Mr. Sands testified that on-call employees used an Employer-issued cell phone to respond to after-hours calls. On-call employees were expected to answer and respond to calls received between 5:00 p.m., and 9:00 p.m. on weekdays, and 8:00 a.m. to 9:00 p.m. on weekends. Mr. Sands testified, credibly, that on-call employees were not required to answer or respond to calls

received outside those hours, but could do so at their option. On-call employees are paid wages for two additional hours while on call during the weekend, and are paid their regular rate for responding to after-hours calls.

3. Claimant was scheduled to be "on-call" beginning Friday, November 1, 2024. At the close of business on October 31, 2024, Claimant received the Employer-issued "on-call" phone for use the following day. Mr. Sands testified that if Claimant received calls before his on-call shift began, he was expected to forward any messages to the existing on-call employee. No credible evidence was admitted demonstrating that Claimant received any after-hours on-call messages or calls on October 31, 2024.

Claimant's Alleged Injuries and Medical Treatment

4. On October 31, 2024, Claimant was involved in an one-vehicle accident on I-225 at approximately 9:00 p.m., while driving the Employer-provided van. On the day of the accident, Claimant had worked for Employer until 4:00 p.m., then attended a party at Employer's office until approximately 6:00 p.m., and then drove to a friend's house. Claimant left his friend's house at approximately 8:30 p.m., and was driving to his home when the accident occurred. During the accident, the van apparently struck a highway median and rolled onto its side. Claimant's testimony that the vehicle rolled four times is not supported by the evidence.

5. Claimant testified that the van's steering stopped functioning while he was driving, causing the accident. Respondents accident reconstruction expert, Adam Michener, testified that based on his investigation, there was no evidence that the van malfunctioned causing the accident. Notwithstanding, the cause of the accident is not relevant to the determination of compensability in this matter.

6. When emergency medical personnel arrived at the scene of the accident, Claimant was ambulatory and sitting by the side of the road. On examination, Claimant was noted to complain of right shoulder pain, which was not tender to palpation, noting that it was possibly related to a recent surgery he had on his bicep. Claimant's head, neck, back, shoulders, arms, abdomen, chest, and lower extremities were all noted as atraumatic, and Claimant reported that he did not hit his head or lose consciousness. With the

exception of his right shoulder, Claimant did not report other symptoms or injuries. Claimant was then transported by ambulance to UC Health. (Ex. G).

7. At the UCH emergency department, Claimant reported pain in the right hip and right shoulder, and denied loss of consciousness or a head injury. The ER physician noted that the only concern for extremity trauma was Claimant's right shoulder. He underwent imaging studies, including a CT scans of the chest and abdomen, cervical spine, and head, and a right shoulder x-ray. The chest/abdominal CT showed mildly displaced right L3 and L4 transverse process fractures. The remaining imaging studies showed no evidence of fractures, dislocations, or intracranial injury. On examination, he was noted to have general tenderness, and a superficial abrasion of the left knee. Claimant's left shoulder was noted to be tender, with normal range of motion, and no swelling or deformity. Claimant was then discharged at approximately 12:20 a.m., on November 1, 2024. (Ex. H).

8. On November 1, 2024 and November 2, 2024, Claimant exchanged text messages with Mr. Sands, indicating that his injuries were limited to fractured vertebrae (which were believed to be "probably older damage"), "2 small scrapes," and being sore, and that the seatbelt "saved me from almost all damage." Claimant further indicated that he had personal work to do that weekend, and that he could continue to perform work for Employer using his own car. (Ex. K).

9. Claimant's next documented medical visit was a telemedicine appointment on November 15, 2024, with Ryan Mansholt, PA-C, at Guardian Medical. Claimant reported seeing a chiropractor and a workers' compensation orthopedic surgeon – "Dr. Ricer" – whom he indicated provided work restrictions. (No records from a chiropractor or Dr. Ricer were offered or admitted into evidence.) At the visit with Mr. Mansholt, Claimant reported for the first time striking his head and losing consciousness as a result of the October 31, 2024[1] accident. Claimant reported "severe cognitive deficits: including memory issues, moderate to severe PTSD and anxiety when driving, tinnitus, headaches, cervical, thoracic, and lumbar spine pain, left knee pain, right shoulder pain, and headaches. Claimant indicated he had completed physical therapy for a labral repair surgery and

[1] Mr. Mansholt's record incorrectly states a date of injury as October 3, 2024.

biceps tenodesis in his right shoulder three months earlier. (No records of this prior surgery or physical therapy were offered or admitted into evidence). Although Claimant reported memory issues, Mr. Mansholt's examination noted that Claimant's recent and remote memory was intact. Despite not performing a physical examination, Mr. Mansholt diagnosed Claimant with post-concussion syndrome, spondylosis and sprains of the cervical, thoracic, and lumbar spine, muscle spasms of the back, cervical and lumbar radiculopathy, right shoulder sprain, left knee sprain, anxiety disorder, and acute PTSD. He recommended conservative care, including chiropractic, massage, and physical therapy, and recommended MRIs of the cervical spine and right shoulder. He recommended undefined light duty work restrictions but also a full work-restriction. (Ex. I).

10. Mr. Mansholt included the following statement regarding causation: "Based on the information available today, there is a causal relationship between the date of injury above and the patient's ongoing complaints and diagnoses. Patient notes history of a Worker's Compensation injury to right shoulder and was doing well post arthroscopy making any recovery at the time of his accident therefore he has suffered a new injury to the right shoulder as well as possible exacerbation of underlying condition." He offered no other opinions as to the relatedness of Claimant's remaining complaints to the October 31, 2024 accident. (Ex. G).

11. Claimant continued to see Mr. Mansholt over the following six months in a combination of in-person and telemedicine visits. At a November 18, 2024 visit, in addition to the complaints previously reported, Claimant reported left shoulder pain for the first time. Mr. Mansholt also added a diagnosis of brachial plexopathy. He performed trigger point injections and an occipital nerve block, and recommended additional evaluations for PTSD, and a neurological consultation. (Ex. I).

12. At his December 2, 2024 visit, Mr. Mansholt added a diagnosis of left shoulder sprain. Mansholt documented that Claimant underwent a lumbar MRI on November 15, 2024, and cervical and right shoulder MRIs on November 25, 2024, indicating "Imaging Reviewed." Mr. Mansholt's report includes a recitation of impressions from the MRIs, but does not identify the facility at which the MRIs were performed or the interpreting

radiologist. It is unclear from the record whether the impressions included in Mr. Mansholt's records are his or those of a qualified radiologist. Nonetheless, the December 2, 2024 report indicates that Claimant's lumbar MRI showed disc herniations at L3-S1 with disc bulges and protrusions, and posterior annular fissures, and "new involvement of L5-S1 that results in some mild left lateral recess and mild left neural foraminal narrowing." He also documented "Unchanged disc pathology L3-5, with unchanged neural foraminal mild/moderate bilateral L3-4 and L4-5 narrowing that may abut and irritate the exiting bilateral L3 andL4 nerve roots." The ALJ infers from this that Claimant had a previous lumbar MRI which showed pre-existing disc pathology at L3-5, and preexisting foraminal narrowing with nerve root irritation at L3-4 and L4-5." The record does not indicate the date of the prior scan to which this MRI was purportedly compared or the conditions for which it was performed, and no records related to a prior lumbar MRI were offered or admitted into evidence. (Ex. I).

13. In the December 2, 2024 report, Mr. Mansholt also included impressions from the November 25, 2024 cervical and right shoulder MRIs, as follows:

a. Cervical MRI: "Decreased lordosis can be seen in the setting of injury. Multilevel disc herniation with bulge and protrusion. Moderate C5-C6 disc extrusion with posterior annular fissure. Moderate to severe right and moderate left C3-C4 and severe bilateral C6-C7 neuroforaminal narrowing may compress and irritate the exiting bilateral C4 and bilateral C7 nerve root Multilevel thecal sac and lateral recess narrowing could a moderate right C6-C7 involvement that may compress the traversing right C8 nerve root."
b. Right Shoulder MRI: "1. Postoperative acromioclavicular joint and biceps tenodesis 2. Progressive moderate supraspinatus and infraspinatus tendinopathy or strain versus sprain. – Moderate subacromial subdeltoid bursitis. – Posterior superior type II SLAP tear is again seen"

14. Again, neither the provider nor the interpreting radiologist is identified in the medical record, and it is unclear if the impressions listed in the record are Mr. Mansholt's or a qualified radiologist. Although Claimant's right shoulder MRI appears to reference a

prior MRI (i.e., “SLAP tear is *again* seen”), no record of a previous right shoulder MRI was offered or admitted into evidence. Also at the December 2, 2024 visit, Mr. Mansholt noted that Claimant continued to report tenderness in his left knee, and left shoulder, and recommended MRIs of both. (Ex. I).

15. On December 4, 2024, Claimant filed a workers’ claim for compensation. (Ex. A).

16. On December 5, 2024, Employer filed a First Report of Injury, indicating that Claimant had notified employer of his injuries on October 31, 2024. (Ex. B).

17. On December 9, 2024, Insurer sent Claimant a list of designated worker’s compensation providers. (Ex. C).

18. On December 20, 2024, Employer filed a Notice of Contest. (Ex. D).

19. At his February 18, 2025 visit, Mr. Mansholt noted that Claimant had seen a Dr. Allen for interventional pain treatment, and had undergone cervical and right shoulder injections, and was undergoing chiropractic treatment at Dorsa chiropractic, but had not begun physical therapy. Mr. Mansholt also indicated that Claimant had “been contacted” for a neurology consultation and a “formal evaluation and treatment for PTSD and anxiety,” and that Claimant had seen an orthopedist. No records from any of the providers referenced in Mr. Mansholt’s records were offered or admitted into evidence. Mr. Mansholt’s February 18, 2025 record includes impressions from left knee and left shoulder MRIs. The left knee MRI impression is documented as showing a horizontal tear in the medial meniscus and posterior horn, small parameniscal cyst, and extrusion of the body portion, with mild chondromalacia, and small effusion, without a ligament or tendon injury. The left shoulder MRI is documented as showing moderate supraspinatus and infraspinatus tendinopathy or strain with bursal surface fraying without a tear, posterior and superior type II SLAP tear of the glenoid labrum, and moderate AC arthropathy and moderate effusion with bony remodeling distal clavicle and osteophyte formation. (Ex. I). As with the prior MRI impressions listed, no evidence was admitted identifying the interpreting radiologist or the facility at which the MRIs were performed.

20. Notably, Mr. Mansholt offered no opinions regarding the cause of Claimant’s alleged injuries other than his right shoulder. (Ex. I).

21. In his March 11, 2025 report, Mr. Mansholt indicated that Claimant was scheduled for a consultation with "Dr. Bess" and that Claimant "may be a candidate for surgery for his knee and/or bilateral shoulders." In his April 1, 2025 report, Mr. Mansholt indicated that Claimant "continues treatment for PTSD and anxiety," although the provider is not identified. He also indicated that Dr. Bess had recommended arthroscopic left knee surgery, and discussed "possible C5-C6 disc replacement and possible shoulder arthroscopy." (No records from Dr. Bess were offered or admitted into evidence). (Ex. I).

22. Claimant's last documented medical visit was a telehealth visit with Mr. Mansholt on June 5, 2025. At that time, Mr. Mansholt noted that Claimant was continuing with chiropractic, physical therapy, and massage therapy. He recommended new lumbar and cervical MRIs due to Claimant's reports of increasing symptoms. (Ex. I).

23. At hearing, Claimant testified that after the accident, he attempted to report to work, but Employer did not permit him to return until he received medical clearance, which his physicians did not provide. Ultimately, Claimant did not return to work for Employer, and was terminated on February 14, 2025. Claimant testified that he received a letter regarding his termination, but the letter was not offered or admitted into evidence. Claimant received a severance payment of $5,000, and testified that he has not earned other wages since the accident. No credible evidence was admitted explaining the terms of Claimant's severance payment.

Conclusions of Law

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of

the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *University Park Care Center v. Indus. Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Indus. Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors Ltd. v. Indus. Comm'n*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

Relief Requested By Claimant in Position Statements

In his position statement, Claimant requests various relief, including a variety of workers' compensation benefits and, apparently, a monetary award directly to Claimant. Claimant seeks this monetary award for estimated past and future medical expenses; temporary total disability (TTD) benefits until Claimant reaches maximum medical improvement; permanent partial disability benefits (PPD) based on impairment ratings that have not been determined; disfigurement benefits for surgeries that have not been

performed; attorney fees, litigation costs, and interest. In total, Claimant requests that the ALJ award Claimant $366,000 to $409,750, exclusive of TTD benefits and interest. Setting aside that Claimant's alleged "damages" are speculative, unsupported evidence, premature, exceed the permissible amounts awardable under the Act, and/or are not recoverable under the Act, the majority of these issues are not before the ALJ. This Order is limited to those issues identified at hearing, which specifically include 1) whether the Claimant sustained a compensable injury; 2) entitlement to medical benefits (not direct monetary compensation for medical benefits); 3) entitlement to temporary disability benefits; and 4) determination of Claimant's average weekly wage. Claimant's request for such items as PPD benefits, disfigurement payments, attorney fees, and litigation costs are not addressed in this Order.

Compensability

To establish a compensable injury an employee must prove by a preponderance of the evidence that his injury arose out of the course and scope of employment with his employer. §8-41-301(1)(b), C.R.S. (2006); *see City of Boulder v. Streeb*, 706 P.2d 786, 791 (Colo. 1985). An injury occurs "in the course of" employment when a claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *Triad Painting Co. v. Blair*, 812 P.2d 638, 641 (Colo. 1991). The "arising out of" requirement is narrower and requires the claimant to demonstrate that the injury has its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Popovich v. Irlando,* 811 P.2d 379, 383 (Colo. 1991). The claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998).

The primary "compensability" issue before the ALJ is whether the one-vehicle accident in which Claimant was involved arose out of the course of his employment with Employer. Generally, injuries sustained by employees while they are traveling to or from work are not compensable because such travel is not considered the performance of services arising out of and in the course of employment. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999). However, injuries incurred while traveling

are compensable if “special circumstances” exist that demonstrate a nexus between the injuries and the employment. *Id.* at 864. In ascertaining whether “special circumstances” exist the following factors should be considered:

- Whether travel occurred during working hours;
- Whether travel occurred on or off the employer's premises;
- Whether travel was contemplated by the employment contract; and
- Whether obligations or conditions of employment created a “zone of special danger” out of which the injury arose.

Id. In considering whether travel is contemplated by the employment contract the critical inquiry is whether travel is a substantial part of service to the employer. *See id.* at 865.

“Special circumstances” may be found where the employment contract contemplates the employee’s travel or the employer delineates the employee’s travel for special treatment as an inducement. *See Staff Administrators Inc. v. Reynolds,* 977 P.2d 866, 868 (Colo. 1999). While an employer paying for transportation is indicative of travel status, permitting an employee to drive a company vehicle does not necessarily compel the conclusion that the employee is in travel status on the way to and from work. *See Shepard v. Argus Contracting*, W.C. No. 4-512-380 (ICAO May 21, 2003); *Warren v. Olson Plumbing & Heating*, W.C. No. 4-701-193 (ICAO Aug. 24, 2007). In considering whether travel was contemplated by the employment contract, the exception applies when an employer requires a claimant to come to work in an automobile that is then used to perform job duties. This is because the vehicle confers a benefit to the employer beyond the employee’s mere arrival at work. *See Whale Comm’s v. Osborn,* 759 P.2d 848 (Colo. App. 1988); *Benson v. Colorado Comp. Ins. Auth.*, 870 P.2d 624 (Colo. App. 1994).

Claimant has established by a preponderance of the evidence that he sustained a compensable injury arising out of the course of his employment with Employer. The evidence establishes that Claimant’s use of Employer’s van provided a benefit to Employer beyond Claimant’s mere arrival at work. Specifically, the Employer-provided van was used to permit Claimant to respond to customer service calls, and to transport tools and equipment required for the performance of Claimant’s job. Because Claimant

was injured while transporting the Employer-provided van from the work-place to his home, the injury had its origin in Claimant's work-related functions and is sufficiently related thereto to be considered a part of his service to Employer, and is therefore compensable.

The ALJ does not find that Claimant's injuries arose out of or occurred during a deviation from "travel status." When an employee in travel status departs from the employer's business on a personal errand and is injured during the errand, the injury is not compensable. *Silver Eng'g Works, Inc. v. Simmons,* 505 P.2d 966 (Colo. 1973). "When a personal deviation is asserted, the issue is whether the activity giving rise to the injury constituted a deviation from employment so substantial as to remove it from the employment relationship." *Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9, 12 (Colo. App. 1995), *citing Silver Engi' Works, Inc., supra; Roache v. Indus. Comm'n,* 729 P.2d 991 (Colo. App.1986). If an employee is injured after concluding a personal deviation and returning to travel status, the injury is generally compensable. *See Phillips Contracting, Inc., supra.* Here, Claimant deviated from his employment by using the Employer-provided van to attend a function at a friend's house. The accident from which Claimant's injury claims arises occurred after that deviation had ended, and while Claimant was on the way to his home. No credible evidence was admitted demonstrating that the accident occurred either during Claimant's deviation or as a result of the deviation.

Claimant's "On-Call" Status

Because the ALJ finds Claimant's injuries are compensable for the reasons set forth above, the ALJ does not address whether Claimant's purported "on call" status constitutes an independent basis for compensability.

Medical Benefits

Under section 8-42-101(1)(a), C.R.S., respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of the industrial injury. *See Owens v. Indus. Claim Appeals Office*, 49 P.3d 1187, 1188 (Colo. App. 2002). The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Indus. Claim Appeals Office,* 53 P.3d 1192

(Colo. App. 2002). All results flowing proximately and naturally from an industrial injury are compensable. *Id., citing Standard Metals Corp. v. Ball*, 474 P.2d 622 (Colo. 1970).

Claimant has established by a preponderance of the evidence an entitlement to medical treatment that is reasonable and necessary to cure or relieve the effects of his industrial injury. Claimant has failed, however, to establish by a preponderance of the evidence that any specific treatment he received after his October 31, 2024 emergency room visit was authorized, reasonable, necessary and/or related to his work injury. The admitted medical records include only narrative records from a physician assistant (Mr. Mansholt) who offered no credible causation analysis of any of the conditions Claimant attributes to his work accident other than his right shoulder. Moreover, the record contains insufficient information to determine the identity of Claimant's authorized treating physician (ATP), and whether treatment Claimant received (including that from Mr. Mansholt) was provided by an ATP or another physician within the chain of referrals from an ATP. Accordingly, whether any specific treatment Claimant received other than that received on October 31, 2024 is authorized, reasonable, necessary, and causally-related to the October 31, 2024 accident is reserved for future determination.

Temporary Total Disability

To prove entitlement to TTD benefits, a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, he left work as a result of the disability, and the disability resulted in an actual wage loss. *See* §§8-42-(1)(g) & 8-42-105(4), C.R.S.; *Anderson v. Longmont Toyota,* 102 P.3d 323 (Colo. 2004); *City of Colorado Springs v. Indus. Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S. requires the claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. The term "disability" connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage-earning capacity as demonstrated by claimant's inability to resume his or her prior work. *Culver v. Ace Electric*, 971 P.2d 641, 649 (Colo. 1999). 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 or her regular employment. *Ortiz*

v. Charles J. Murphy & Co., 964 P.2d 595, 597 (Colo. App. 1998). Because there is no requirement that a claimant produce evidence of medical restrictions, a claimant's testimony alone is sufficient to demonstrate a disability. *Lymburn v. Symbios Logic,* 952 P.2d 831, 833 (Colo. App. 1997).

Claimant has established by a preponderance of the evidence that he sustained a work injury resulting in medical incapacity and impairment of wage-earning capacity. Specifically, Claimant was unable to work and experienced an actual wage loss beginning on November 1, 2024. Although Claimant indicated in text messages that he would like to return to work, he credibly testified that Employer did not permit him to return to work until he received "medical clearance." Claimant did not earn wages from Employer after October 31, 2024, and no credible evidence was admitted demonstrating that Claimant earned wages from another source. Employer's payment of severance package does not constitute wages, or diminish Claimant's entitlement to temporary disability benefits. *See Rogers v. James and Virginia Neece, et al,* W.C. No. 4-421-787 & 4-829-364 (ICAO Sep. 20, 2011). Moreover, no credible evidence was admitted demonstrating that any of the events for termination of TTD under §8-42-105(3)(a)-(d), C.R.S., have occurred. Accordingly, Claimant is entitled to TTD benefits, until terminated pursuant to the Colorado Workers' Compensation Act.

Average Weekly Wage

Section 8-42-102(2), C.R.S. requires the ALJ to calculate Claimant's average weekly wage (AWW) based on the earnings at the time of injury as measured by the Claimant's monthly, weekly, daily, hourly, or other earnings. However, if for any reason, the ALJ determines the default method will not fairly calculate the AWW, § 8-42-102(3), C.R.S. (2016) affords the ALJ discretion to determine the AWW in such other manner as will fairly determine the wage. § 8-42-102(3), C.R.S. establishes the so-called "discretionary exception". *Benchmark/Elite, Inc. v. Simpson*, 232 P.3d 777 (Colo. 2010); *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of Claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp*., *supra*; *Avalanche Indus. v. ICAO*, 166 P.3d 147 (Colo. App. 2007). As set forth in Findings of Fact 1, the ALJ concludes that Claimant's average weekly wage at the time of injury was $1,560.00.

Order

It is therefore ordered that:

1. Claimant sustained compensable injuries arising out of the course of his employment with Employer on October 31, 2024.
2. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of the industrial injury.
3. Claimant is entitled to temporary total disability benefits from November 1, 2024 until terminated pursuant to the Act.
4. Claimant's average weekly wage at the time of his injury was $1,560.00.
5. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Dated: October 3, 2025

Steven R. Kabler
Administrative Law Judge

ISSUES

1. Whether Claimant proved by a preponderance of the evidence that she sustained a compensable work injury on October 17, 2024.

2. Whether Claimant proved entitlement to medical benefits to cure and relieve her of the effects of her October 17, 2024, injury.

3. Whether Claimant is entitled to select her own authorized treating physician.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. On October 17, 2024, Claimant was employed as a general manager for Employer.

2. On October 17, 2024, during the course and scope of her employment, Claimant was on a stool organizing her office when she fell striking her head and right upper extremity. She injured her right elbow, right shoulder, and her head. She reported the injury to Employer that same day.

3. On October 21, 2024, Claimant sought treatment at the CareNow Urgent Care. Imaging showed a non-displaced impaction fracture of the right radial head and neck, but no acute fractures to the shoulder or wrist. She was placed on a splint and given restrictions of no use of her right arm. She continues to receive treatment from CareNow Urgent Care.

4. Claimant was not provided with a designated provider list of physicians.

5. Employer did not carry workers compensation insurance on October 17, 2024.

6. Claimant continues to experience physical limitations as a result of the injuries she sustained on October 17, 2024.

7. Claimant proved by a preponderance of the evidence that she sustained a compensable injury on October 17, 2024, arising out of and in the course of her employment with Employer.

8. Claimant has proved by a preponderance of the evidence that she is entitled to medical benefits reasonably necessary to cure and relieve her

of the effects of her work injury, including reimbursement for expenses incurred during her treatment at CareNow Urgent Care.

9. Claimant has proved by a preponderance of the evidence that she is entitled to select her own authorized treating physician. She has selected CareNow Urgent Care.

ORDER

It is therefore ordered:

1. Claimant suffered a compensable injury under the Colorado Workers' Compensation Act.

2. Respondent shall pay for medical treatment reasonably necessary to cure and relieve Claimant of her October 17, 2024 injury, including, but not limited to, the cost of treatment at CareNow Urgent Care.

3. Claimant is entitled to select her authorized treating physician. She has selected CareNow Urgent Care.

4. In lieu of payment of the above compensation and benefits to Claimant, Respondent shall deposit a sum equal to the total amount of TTD and medical benefits owed, plus 4% per annum, with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Trustee. Alternatively, Respondent, within ten days after the date of this Order, shall file a bond with the Director, guaranteeing payment of the compensation and benefits awarded, and signed by two or more responsible sureties who have received prior approval by the Division of Workers' Compensation, or with any other surety company authorized to do business within the state of Colorado. Respondent shall immediately notify the Division of Workers' Compensation and Claimant of payments made pursuant to this Order.

5. All other issues are reserved for later determination.

This decision is final and not subject to appeal unless a full Order is requested. The Request shall be made at the Office of Administrative Courts,

1525 Sherman Street, 4th Floor, Denver, CO 80203 within ten working days of the date of service of this Summary Order. § 8-43-215 (1), C.R.S. (2023). Such a Request is a prerequisite to review under § 8-43-301, C.R.S.

If a Request for Specific Findings of Fact and Conclusions of Law is made, Claimant's or Respondents' counsel may submit proposed Amended Specific Findings of Fact, Conclusions of Law, and Order (Amended) that substantially incorporates the above findings of fact and conclusions of law within five working days from the date of the Request. The proposed order must be submitted by e-mail in Word or Rich Text format to oac-dvr@state.co.us. The proposed order shall also be submitted to opposing counsel and unrepresented parties by e-mail, facsimile, or same day or next day delivery.

DATED: October 22, 2025

Office of Administrative Courts

/s/ Stephen J. Abbott

_____

Stephen J. Abbott
Administrative Law Judge

State of Colorado
Workers Compensation Number: 5-294-649-001

ISSUES

I. Whether Claimant established, by a preponderance of the evidence that he sustained a compensable injury to his right shoulder on August 21, 2024?

II. If Claimant established that he sustained a compensable right shoulder injury, whether he also established that he is entitled to all reasonable, necessary, and related care for his right shoulder.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. Claimant was employed by the employer on August 21, 2024. He testified that he had been preparing the school for the return of the students. This included lifting and moving desks, chairs, large group-sized tables and scrubbing carpets.

2. Claimant had a prior work related injury to the right shoulder on February 24, 2022 when he was performing snow removal with a shovel. Claimant received 8 weeks of physical therapy and had one steroid injection. His shoulder improved with this treatment. Although surgery was discussed, it was not recommended.

3. Claimant testified that the carrier at that time, Pinnacol Assurance filed a final admission of liability on July 26, 2022. Claimant was released to full duty work but was careful with what he did, physically.

4. Prior to the date of injury, Claimant had been working hard to get the 18 classrooms ready for the new school year. He testified that on the date of injury, he was going to lock a glass door with a lock on the top of the door. He stopped before he locked the door and he felt a tug on his right shoulder. At that point, he was unable to move his arm. He reported the injury to his direct supervisor and the administrator of the building, Kelly Jones. He filled out paperwork and was told to go to urgent care.

5. Claimant went to urgent care, and they did an x-ray of his shoulder. Claimant was seen by Dr. Quackenbush. Dr. Quackenbush took a history that Claimant was performing his usual activities including scrubbing floors, mopping, dusting, lifting and pushing and pulling. In the history, Dr. Quackenbush indicated “He states there was no

specific injury on that date no specific time when symptoms developed into his right shoulder". This is different from the Claimant's testimony that he felt a tug was he was beginning to lock the glass door on the date of injury.

6. Dr. Quackenbush referred him to physical therapy and in mid-September referred him to a surgeon, Dr. Friedman. Dr. Friedman reviewed the MRI that was taken and recommended surgery.

7. At Respondents' request, Claimant was seen by Dr. Ciccone for an independent medical evaluation. Dr. Ciccone was of the opinion that Claimant did not sustain an injury in 2022 or on August 21, 2024. His opinion was that Claimant did not sustain any acute injury and the findings on the MRIs were due to normal degenerative changes.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

Generally

A. The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979).

B. Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is exclusive domain of administrative law judge. *University Park Care Center v. Industrial Claim Appeals Office*, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 57

P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008); *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission,* 441 P.2d 21 (Colo. 1968).

C. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

Compensability

D. To recover benefits under the Worker's Compensation Act, the Claimant's injury must have occurred "in the course of" and "arise out of" employment. *See* § 8-41301, C.R.S.*; Horodyskyj v. Karanian* 32 P.3d 470 (Colo. 2001). The phrases "arising out of" and "in the course of" are not synonymous and a claimant must meet both requirements to establish compensability. *Younger v. City and* County of Denver, 810 P.2d 647, 649 (Colo. 1991); *In re Question Submitted by U.S. Court of Appeals,* 759 P.2d 17, 20 (Colo. 1988). The latter requirement refers to the time, place, and circumstances under which a work-related injury occurs. *Popovich v. Irlando,* 811 P.2d 379, 381 (Colo. 1991). Thus, an injury occurs "in the course of" employment when it takes place within the time and place limits of the employment relationship and during an activity connected with the employee's job-related functions. *In re Question Submitted by U.S. Court of Appeals, supra; Deterts v. Times Publ'g Co.,* 38 Colo. App. 48, 51, 552 P.2d 1033, 1036 (1976).

E. The "arising out of" element required to prove a compensable injury is narrow and requires a claimant to show a causal connection between his/her employment and the injury such that the injury has its origins in work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Horodyskyj v. Karanian*, 32 P.3d 470, 475 (Colo. 2001)*; Madden v. Mountain West Fabricators, 977 P.2d 861* (Colo. 1993). Specifically, the term "arising out of" calls for examination of the causal connection or nexus between the conditions and obligations of employment and the claimant's injury. *Horodysky v. Karanian, supra*. The determination of whether there is a sufficient "nexus" or causal relationship between a claimant's employment and the injury is one of fact, which the ALJ must determine, based on the totality of the circumstances. *In Re Question Submitted by the United States Court of Appeals,* 759 P.2d 17 (Colo. 1988); *Moorhead Machinery & Boiler Co. v. Del Valle,* 934 P.2d 861 (Colo. App. 1996).

F. The fact that Claimant may have experienced an onset of pain while performing job duties does not mean that he/she sustained a work-related injury or occupational disease. Indeed, an incident which merely elicits pain symptoms without a causal connection to the industrial activities does not compel a finding that the claim is compensable. *F.R. Orr Construction v. Rinta*, 717 P.2d 965 (Colo. App. 1985); *Parra v. Ideal Concrete,* W.C. No. 3-963-659 and 4-179-455 (April 8, 1988)*; Barba v. RE1J School District,* W.C. No. 3-038-941 (June 28, 1991); *Hoffman v. Climax Molybdenum Company,* W.C. No. 3-850-024 (December 14, 1989).

G. While pain may represent a symptom from the aggravation of a pre-existing condition, the fact that Claimant may have experienced an onset of pain while performing job duties does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent, as asserted by Respondents in this case, the natural progression of a pre-existing condition that is unrelated to the employment. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005). Based upon the evidence presented, the ALJ is not persuaded that the Claimant suffered a compensable work related injury on August 21, 2024. I find Dr. Ciccone to be credible that the Claimant's symptoms are due to underlying degenerative changes.

ORDER

It is therefore ordered that:

1. Claimant has failed to prove by a preponderance of the evidence that he sustained a work-related injury to his right shoulder on August 21, 2024. As such, his claim is denied and dismissed.

DATED: October 29, 2025.

/s/ Michael A. Perales

Michael A. Perales
Administrative Law Judge
Office of Administrative Courts
1330 Inverness Dr. Suite 330
Colorado Springs, CO 80910

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 27(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts. For statutory reference, see Section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-299-272-001

Issues

- Whether Claimant has proven by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer?

- If Claimant has proven a compensable injury, whether Claimant has proven by a preponderance of the evidence that the treatment he received at the Banner Hospital Emergency Room ("ER")was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the injury?

Findings of Fact

1. Claimant was employed by Employer working on a farm. Claimant testified he began working for Employer in 2017. Claimant's job duties included moving farm animal excrement to a waste pond. Claimant testified that on February 28, 2025, while moving chicken excrement with a loader, he was driving on very rough road on the farm which caused the loader he was operating to jump up and down. Claimant testified that the loader did not have a suspension. Claimant testified that as a result of the loader jumping up and down, Claimant developed pain. Claimant testified he reported the pain to a co-worker who provided him with pills. Claimant testified that the pain continued to get worse and he was eventually sent home around 3:00 p.m.

2. Claimant testified he sought treatment the next Monday, March 3, 2025 and the Banner Hospital ER. According to the medical records from the ER, Claimant presented with complaints of neck, right back pain and left hip pain after operating a lorry 3 days ago for his job when he got onto an uneven surface and felt acute pain in his right scapular region as well as his midline low back and left hip. Claimant denied a prior history of neck, low back or hip pain.

3. Claimant underwent a series of x-rays at the ER including x-rays of his chest, hips, lumbar spine and thoracic spine. The x-rays were negative and Claimant was discharged with instructions to follow up with his primary care physician.

4. Claimant presented to Medicine for Business and Industry ("MBI") on March 5, 2025 after being referred by Employer. Claimant provided an accident history of operating machinery when he hit a bump and felt intense pain in his upper back, sides, neck and lower back. In addition to his back and neck complaints, Claimant also reported a feeling of numbness in his face. Claimant was diagnosed with a neck, low back and thorax strain. Claimant was referred for physical therapy.

5. Claimant returned to MBI on March 7, 2025 at which time it was noted that Claimant was attending physical therapy. Claimant noted that his pain increased if he were to sit for too long. Claimant was referred for a computed tomography ("CT") scan of his head due to his continued complaints of face numbness.

6. Claimant was next examined on March 11, 2025 at MBI. Claimant reported that he was continuing to have pain in the shoulders and middle of his upper back, which was noted to be in the lower part of his scapula. Claimant also reported a tired feeling in his upper lumbar region. Claimant was provided with work restrictions that included no climbing into heavy machinery. Claimant was instructed to continue his physical therapy and home exercises.

7. Claimant returned again to MBI on March 14, 2025. Claimant reported continued pain that was worse in his neck with prolonged walking and worse in his lumbar spine with prolonged sitting. Claimant reported the facial pain would come and go. It was noted that the CT scan had not yet been approved.

8. Claimant was again examined on March 21, 2025 and noted that he continued to complain of pain. Claimant was referred for chiropractic treatment based on his complaints. Claimant returned on March 28, 2025 and reported his upper back and lower back were still hurting. It was noted that Claimant had begun massage therapy, but had not begun chiropractic treatment. Claimant reported he had received

a letter from the adjuster that indicated his case was being investigated. The medical provider, Makenna Schmidgall, recommended he bring the letter with him at the next appointment and if it indicated his case was closed, they would need to close his case at MBI.

9. Claimant testified that his medical treatment after March 28, 2025 was denied and he had not received any further medical treatment since that time.

10. Respondents obtained a physician advisor report from Dr. Larimore on May 2, 2025. Dr. Larimore reviewed Claimant's medical records and opined that in order to have a work related condition the injured worker must have had specific incident or injury at work and that did not appear to be the case. Dr. Larimore further opined that if Claimant was experiencing the pain levels that he was reporting, he would not have waited "four days" to seek medical care. Dr. Larimore further opined that there "is no way, with greater than 50% probability, to attest that IW (injured worker) did not have a non-work-related condition or trauma between the DOI (date of injury) and the ED (emergency department) visit four days later."

11. Respondents obtained an independent medical examination ("IME") with Dr. Raschbacher on July 10, 2025. Dr. Raschbacher reviewed Claimant's medical records, obtained a medical history and performed a physical examination in connection with his IME. Dr. Raschbacher noted that Claimant reported an accident history of riding on a tractor moving waste from one place to another, and was driving on a road that was very bumpy, which caused him to be bumped up and down in his seat. Dr. Raschbacher noted that Claimant reported that his seat on the tractor was very stiff.

12. Dr. Raschbacher opined in his IME report that Claimant did not sustain an injury at work on February 28, 2025. Dr. Raschbacher noted in his report that it was not clear what Claimant was alleging was his mechanism of injury. Dr. Raschbacher further opined that there was no objective evidence of an injury to any body part.

13. Dr. Raschbacher testified at hearing consistent with his IME report.

14. The ALJ credits Claimant's testimony at hearing along with the medical records entered into evidence at hearing and finds that Claimant has established that it is more probable than not that he sustained an injury at work on February 28, 2025 arising out of and in the course of his employment with Employer.

15. The ALJ finds that Claimant's testimony at hearing is consistent with the medical records and establishes that Claimant had an onset of symptoms involving his neck, back and hips after operating the tractor on a bumpy road on February 28, 2025. The ALJ further finds that Claimant's testimony that he reported his injury to a co-worker on the day of the injury and was provided with pain pills to be credible and persuasive.

16. The ALJ notes the opinions provided by Dr. Larimore and Dr. Raschbacher that Claimant did not sustain an injury on February 28, 2025, but rejects those opinions. Notably, Dr. Larimore's opinion that if Claimant had been experiencing pain he would not have waited four days to seek medical treatment is not supported by the records, which establish that Claimant sought treatment three days after the injury. Additionally, Dr. Raschbacher's opinion that Claimant's accident history was inconsistent is not persuasive. Dr. Raschbacher relies on particular inconsistencies, including whether Claimant was operating a lorry or a tractor, and whether Claimant reported that the seat on the tractor was stiff to establish what he considers inconsistency in the accident history. The ALJ is not persuaded that the accident history in this case is inconsistent and finds Claimant's testimony at hearing to be credible and persuasive and finds that Claimant has established that it is more probably than not that he sustained an injury on February 28, 2025 while operating the tractor in the course and scope of his employment with Employer.

17. The ALJ credits the testimony of Claimant and the medical records entered into evidence in this case and finds that Claimant has established that it is more probably than not the medical treatment Claimant received from the Banner ER was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the industrial injury. The ALJ finds that the examination and radiological

testing Claimant received on March 3, 2025 represent reasonable medical treatment necessary to cure and relieve Claimant from the effects of the February 28, 2025 work injury.

Conclusions of Law

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2016.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

3. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also*

Subsequent Injury Fund v. Thompson, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with "a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

4. As found, the ALJ credits the testimony of the Claimant along with the medical records entered into evidence at hearing and finds that Claimant has established by a preponderance of the evidence that he sustained a compensable injury arising out of and in the course and scope of his employment with Employer when he developed neck, back and hip pain after operating Employer's tractor on a bumpy road on February 28, 2025.

5. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

6. As found, Claimant has established by a preponderance of the evidence that the treatment at the Banner Hospital ER on March 3, 2025 was reasonable medical treatment necessary to cure and relieve Claimant from the effects of the industrial injury.

Order

It is therefore ordered that:

1. Respondents shall provide reasonable medical treatment necessary to cure and relieve Claimant from the effects of the work injury including payment of the March 3, 2025 ER visit pursuant to the medical fee schedule.

2. All issues not herein decided are reserved for future determination.

NOTE: If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service;

otherwise, the ALJ's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm. You may file your Petition to Review electronically by emailing the Petition to Review to the following email address: oac-ptr@state.co.us. If the Petition to Review is emailed to the aforementioned email address, the Petition to Review is deemed filed in Denver pursuant to OACRP 26(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts.

DATED: October 17, 2025

Keith E. Mottram

Keith E. Mottram
Administrative Law Judge
Office of Administrative Courts
222 S. 6th Street, Suite 414
Grand Junction, Colorado 81501

Office of Administrative Courts
State of Colorado
Workers' Compensation No. WC 5-299-715-001

Issues

I. Whether Claimant established by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course of her employment when she fell and broke her hip in the employer's parking lot shortly before her shift was to begin at midnight.

Stipulations

If the claim is found to be compensable, the parties stipulated that:

- Claimant is entitled to temporary disability benefits;
- Claimant is entitled to medical benefits;
- The treatment Claimant has received up through the date of the hearing is authorized; and
- Claimant may choose her own authorized provider.

Findings of Fact

1. Claimant works for Employer as a store clerk. At the time of the accident, Claimant was 53 years old.
2. Claimant worked overnight shifts when she first started working for Employer but was not working overnight shifts at the time of her injury.

Accident at Work

3. On March 4, 2025, at approximately 11:45 p.m., right before her midnight shift was to begin, Claimant drove into the Employer's parking lot and parked in a handicap spot in front of the store. Claimant parked there for safety reasons because it was late, just like she and other employees usually did during night shifts because the store was closed.

4. Claimant got out of her car and fell to the ground in the parking lot. After falling, she had the immediate onset of left-sided hip pain.
5. A co-worker obtained a motorized scooter and moved her into the store. While Claimant was inside the store, she called 911 for an ambulance.
6. An ambulance arrived, assessed Claimant's condition, and administered fentanyl and Toradol for pain management. She was then transported to the Emergency Room at Good Samaritan Medical Center in Lafayette and was diagnosed with a broken left hip.
7. But for the requirement that Claimant be at work for her midnight shift, she would not have been present in Employer's parking lot on March 4, 2025, at 11:45 p.m. She would not have been exiting her vehicle at that time and place, and she would not have fallen and sustained a broken hip in the Employer's parking lot at that time and place.

Workers' and Employer's First Report of Injury

8. Both an Employer's First Report of Injury and a Worker's First Report of Injury indicate that, as of March 9, 2025, the Claimant reported she did not know what caused her fall. The reports state that the cause of the fall was unknown, and the Workers First Report specifically notes that the Claimant did not know whether she fell, tripped, or slipped.

Claimant's Testimony Regarding Preexisting Medical Conditions

9. At hearing, Claimant testified she was diagnosed with epilepsy as a teenager. She takes medication daily for her epilepsy. Claimant testified she's been taking this medication for years and that she has never experienced dizziness as a side effect of the medication. Claimant testified she has no history of falling or blackouts. Claimant testified she does have hypoglycemia. In a 2023 medical report she stated if her blood sugar drops, she experiences lethargy and weakness. However, Claimant testified that when her blood sugar drops even into the 40s, she does not get dizzy, and she can still do her work just fine. At the time of the injury, Claimant was treating for an unrelated shoulder injury. She was not taking any medication for the shoulder injury, and she was not treating for any other condition outside of her daily epilepsy medication. Claimant testified she underwent a labral reconstruction in her hip over five years ago. She fully healed, she had no work restrictions, and she was not treating for any hip related issues leading up to this injury.

Claimant's Testimony Regarding the Accident

10. At hearing, Claimant testified that she believed she slipped on gravel after getting out of her car and denied feeling dizzy immediately prior to the fall. Claimant also testified that following the administration of the pain medications, fentanyl and Toradol, she does not recall what she told EMS personnel or medical providers at the hospital regarding the circumstances of her fall, including any statements documented in the medical records. In other words, she does not recall telling the medical providers she felt dizzy immediately before her fall. Claimant does not have any recollection as to what happened after the accident until after she woke up from having surgery for her broken hip.

Medical Treatment after Fall

Claimant's Statements to Medical Providers

11. Claimant arrived at the Good Samaritan Medical Center Emergency Department at 1:11 a.m. on March 5, 2025 (approximately 90 minutes after her fall). The triage notes entered by Samantha Doolittle, RN, at 1:12 a.m. document that "Patient states she was in the parking lot, went to get out of her car and began to feel dizzy. Patient then fell post the dizziness and had a LOC with head strike." The triage notes make no mention of Claimant stating that her foot slipped gravel or anything else. Claimant's level of consciousness is listed as "Alert" and Claimant's Glasgow Coma Score was 15. Claimant was diagnosed with a broken left hip.

12. Ryan Harold Wyatt, M.D., was assigned as Claimant's attending physician at 1:18 a.m. At 1:19 a.m. Dr. Wyatt documented his conversation with Claimant regarding the fall in detail:

> Patient tells me she works overnight at a supermarket, was going into work at midnight, stepped out of her car, became dizzy and fell to the ground. Patient landed on her left hip. She is unsure if she struck her head, but she thinks she may have. Patient tells me that she had a transient period of time where she was having difficulty with her speech after she fell. She denies any loss of consciousness. Patient denies any neck pain, chest pain, back pain, abdominal pain. Her main concern is the pain in her left hip. Patient

denies any associated chest pain or palpitations with feeling dizzy. She tells me she is not currently feeling dizzy.

[Exhibit C, p. 130].

13. Dr. Wyatt did not document Claimant reporting that her foot slipped on gravel or that she lost consciousness.

14. At 3:11 a.m., Dr. Wyatt documented his "medical decision making." The note indicates that this was a "shared" decision making with the Claimant. Thus, Dr. Wyatt documented his thought process as he discussed with Claimant her condition and history to determine the cause of Claimant's fall. He specifically documented that Claimant was at the ED with "left hip pain after she got dizzy and fell. Patient was stepping out of her car, got dizzy, fell to the ground." He considers possible causes for the fall, including arrythmia, ACS, or a pulmonary embolism. He also indicated that the cause of Claimant's fall "[s]ounds suspicious for orthostatic hypotension especially given the position change." Dr. Wyatt then states that Claimant "tells me that she has been exhausted due to working." There is no mention of Claimant stating that she slipped on anything.

15. Claimant was then seen by David Jackson, M.D. at 3:35 a.m. Dr. Jackson documented the History of Present Illness as:

> Hx from the pt. She reports coming in to work early at King Soopers to help with a delivery, and on getting out of her car got dizzy and fell. She did not have LOC or seizure. No recent illness. No CP/ palpitations. Feeling tired and sleep deprived. Immediate L hip pain, and unable to walk. Called a coworker for help and got into a powered cart to come inside.

[Exhibit C, p. 138].

16. Dr. Jackson is the third provider to document that Claimant stated she fell after feeling dizzy, and the third medical provider who made no mention of Claimant stating that her foot slipped on gravel or anything else. He is also the second medical provider to whom Claimant stated she felt tired, sleep deprived, and exhausted - apparently from working. It is notable that each medical provider documented that Claimant made the statements directly to them, and each statement from Claimant contains different details and specificity from the statements documented by the other medical providers. This indicates

that the providers were not simply copying what was already in the medical record but were independently documenting what they heard from Claimant. However, as discussed below, the reliability of these statements is questionable given the medication administered and Claimant's lack of recollection. Moreover, she again indicated that she did not lose consciousness.

Speculation Regarding Potential Cause of Fall

17. No medical provider offered an opinion, to a reasonable degree of medical probability, identifying what caused Claimant's dizziness and fall. For example, Dr. Wyatt's comment that the fall "[s]ounds suspicious for orthostatic hypotension" constitutes speculation, not a diagnosis or medical opinion establishing causation. Additionally, no provider diagnosed Claimant with orthostatic hypotension as an underlying condition that had previously caused dizziness and falls. Nor did any provider opine that Claimant's known conditions - including seizure disorder, hypoglycemia, bipolar disorder (treated with various medications), or heart palpitations - caused her dizziness or fall. No diagnostic testing identified the cause of any possible dizziness or the fall.

18. Thus, the medical records present only speculative possibilities for what could have caused Claimant's possible dizziness and fall - such as sleep deprivation, orthostatic hypotension, polypharmacy, or work-related exhaustion.

19. The evidence does not establish that any specific medical condition more likely than not caused her to possibly become dizzy and fall. The distinction between theoretical possibility and reasonable medical probability is significant. A theoretical possibility arises when a condition could cause a symptom and consequence, but there is insufficient evidence to conclude that it is a probable cause. In contrast, a conclusion based on reasonable medical probability requires evidence showing that a condition more likely than not caused the dizziness and fall in this specific claimant at this specific time.

20. While Claimant may have experienced dizziness in temporal proximity to her fall, the cause of any dizziness and the cause of the fall itself have not been established by a preponderance of the evidence. Because no medical, idiopathic, or other cause specific to Claimant has been established, the proximate cause of her fall remains unexplained.

Credibility Determinations

21. The ALJ credits Claimant's testimony that she does not have any preexisting conditions, nor does she take any medication, that would cause dizziness, blackouts, or falls. This testimony is supported by the absence of credible medical evidence documenting any history of recurring dizziness, falls, or blackouts. There are no medical records predating the work incident that reflect such problems.

22. The ALJ also credits Claimant's testimony that, after being administered fentanyl prior to arriving at the hospital, she has no memory of events until she awoke from surgery. Accordingly, the ALJ finds credible her assertion that she does not recall speaking with medical providers at the hospital or making statements about feeling dizzy or being exhausted before the fall.

23. Nonetheless, the medical records document what providers heard and recorded from Claimant while she was medicated. The records contain slightly different accounts from various providers, suggesting that the statements were separately reported and not merely repeated or copied forward. However, because these statements were made while Claimant was under the influence of strong medication and she has no recollection of making them, the reliability and precision of those statements is questionable. Given the contradictory evidence and the unreliability of the medicated statements, the ALJ cannot find by a preponderance of the evidence that Claimant actually experienced dizziness or that the documented statements accurately reflect what occurred.

24. The ALJ has considered Claimant's testimony at hearing that she slipped on gravel while exiting her car. This account is not documented in her medical records, nor is it referenced in either the Employer's First Report of Injury or the Worker's First Report of Injury.

25. Both the Employer's First Report of Injury and the Worker's First Report of Injury reflect that, as of March 9, 2025, shortly after the accident, Claimant specifically reported that she did not know what caused her fall. Such reports make no reference to being dizzy before her fall. According to the reports, she only knew that she fell, tripped, or slipped, and sustained a hip fracture.

26. Based on the totality of the evidence, the ALJ finds that Claimant does not actually know or remember what caused her to fall. Her testimony that she slipped on gravel appears

to be a post hoc attempt to provide an explanation - potentially one that would support a work-related connection - for a fall whose true cause is unknown to her. The inconsistency between her hearing testimony and her contemporaneous reports, along with her lack of memory following the administration of medication, supports the conclusion that whether she became dizzy prior to her fall cannot be determined and that the cause of her fall remains unexplained.

Conclusions of Law

Generally

The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *University Park Care Center v. Indus. Claim Appeals* Office, 43 P.3d 637 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Ins. Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Indus. Claim Appeals Office*, 183 P.3d 684 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a

matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Indus. Comm'n*, 441 P.2d 21 (Colo. 1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

The ALJ's factual findings regarding causation are based on all of the evidence, both lay and medical. The ALJ has not required any party to establish any fact, or establish causation, by medical evidence. *See Lymburn v. Symbios Logic*, 952 P.2d 831, 833 (Colo. App. 1997) (holding that substantial evidence of causation is not restricted to credible medical testimony).

I. Whether Claimant established by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course of her employment when she fell and broke her hip in the employer's parking lot shortly before her shift was to begin.

To be compensable, a workplace injury must both occur "in the course of" and "arise out of" employment. C.R.S. § 8-41-301(1)(c). The employee bears the burden to prove both elements by a preponderance of the evidence.

A. Course of Employment

By the time Claimant arrived at work, parked in Employer's parking lot in front of the store, and started getting out of her car to go into work and start her shift, she was within the course of her employment. The course of employment includes a reasonable interval before and after work hours when on the employer's property. *Indus. Comm'n v. Hayden Coal Co.*, 155 P.2d 158 (Colo. 1944). Parking lots adjacent to the employer's business are considered part of the employer's premises, regardless of ownership or control. *Wilson v. Dillon Companies, Inc.*, W.C. No. 4-937-322-01 (March 16, 2015).

Injuries in employer parking lots are "normal incidents to the employment relationship." *Seltzer v. Foley's Department Store*, W.C. No. 4-432-260 (September 21, 2000).

Claimant arrived at Employer's parking lot just before midnight to begin her overnight shift, arriving early to help with a delivery. She parked in a handicapped space directly in front for safety reasons because the store was closed to customers. Under *Hayden Coal Co.*, arriving for work falls within the reasonable pre-shift interval. Under *Wilson*, the parking lot constitutes part of the employer's premises where "compensation coverage attaches to any injury that would be compensable on the main premises." The fact that Claimant had not yet clocked in is immaterial.

As a result, the ALJ finds and concludes that Claimant established by a preponderance of the evidence that her accident occurred during the course of her employment.

B. Arising Out of Employment

The Three-Category Framework

City of Brighton v. Rodriguez, 318 P.3d 496 (Colo. 2014), establishes three risk categories for workplace injuries: (1) employment risks, which are directly tied to the work itself; (2) personal/idiopathic risks, which are inherently personal or private to the employee; and (3) neutral risks, which are neither employment-related nor personal. *Id.* at 502-03.

An unexplained fall - a fall with a truly unknown cause or mechanism - constitutes a neutral risk subject to the but-for test. *Id.* at 503. Under this test, an injury is compensable if it would not have occurred but for the fact that the conditions and obligations of employment placed the claimant in the position where the injury occurred. *Id.* at 504-05.

The distinction between an "unexplained fall" and an "unexplained injury" is immaterial; both are analyzed identically under this framework. *King Soopers Inc. v. Indus. Claim Appeals Office*, 538 P.3d 347, 353-54, ¶ 42 (Colo. App. 2023). The critical analysis requires determining which of the three risk categories applies.

Application of the Three-Category Test

1. Is this an Employment Risk?

An employment risk is one directly tied to the work itself such as hazardous working conditions, dangerous equipment, or risks inherent in the specific job tasks. *City of Brighton*, 318 P.3d at 502-03.

Here, neither the physical condition of the parking lot nor the specific activity of exiting her vehicle caused the injury. The parking lot was not hazardous. No employment condition such as ice, debris, uneven pavement, or dangerous equipment caused the fall. Claimant was simply in the parking lot before starting her shift. As a result, the ALJ finds and concludes that the injury did not arise from an employment risk.

2. Is This a Personal/Idiopathic Risk?

A personal or idiopathic risk is one that is "inherently personal or private to the employee." *City of Brighton*, 318 P.3d at 502-03. The term "idiopathic" means "'self-originated,' [and] injuries usually spring from a personal risk of the claimant, e.g., epilepsy, heart disease, and the like." *Id.* at 503 n.2. To establish that a fall resulted from an idiopathic condition, there must be credible evidence - whether through medical opinion, diagnostic testing, medical records, witness testimony, or other sources - that a personal condition exists and caused the fall. The evidence must establish causation to a reasonable degree of medical probability.

The Evidence Does Not Establish Idiopathic Causation

The record contains no credible evidence that any personal condition caused the fall. The record contains no diagnostic testing establishing causation. The record contains no medical opinion rendered to a reasonable degree of medical probability. The record contains no lay testimony, witness observations, or other evidence establishing that any personal condition caused the fall.

The medical records contain only speculation. Multiple physicians used tentative language: "sounds to be related to sleep deprivation," "sounds suspicious for orthostatic hypotension," "likely in the setting of chronic illness." No physician provided a non-

speculative causation opinion stating what caused Claimant's dizziness or that any specific medical condition caused her fall. Dr. Wyatt's statement that the fall "[s]ounds suspicious for orthostatic hypotension" constitutes speculation, not a diagnosis or medical opinion establishing causation.

Moreover, the evidence does not establish whether Claimant actually experienced dizziness prior to the fall. The only evidence of dizziness comes from statements documented by medical providers while Claimant was medicated with fentanyl and Toradol. Claimant has no recollection of making those statements. The Workers' and Employer's First Reports of Injury completed on March 9, 2025 - just five days after the accident - make no mention of dizziness and state only that the cause of the fall was unknown. Claimant's testimony at hearing was that she slipped on gravel and denied feeling dizzy. Given these contradictions and the questionable reliability of the medicated statements, the ALJ cannot find by a preponderance of the evidence that Claimant experienced dizziness prior to the fall, much less that any dizziness was caused by a personal condition.

Theoretical Possibility vs. Reasonable Medical Probability

The medical records establish only theoretical possible causes, rather than reasonable medical probabilities based on substantial evidence. A theoretical possibility exists when a medical condition could potentially cause a symptom, but there is no credible and persuasive evidence it did so in the specific case. *See Denver & R. G. R. Co. v. Thompson*, 169 P. 539, 540 (1917) ("A resort to mere conjecture or possibilities will not take the place of direct or circumstantial evidence. No number of mere possibilities will establish a probability.") A reasonable medical probability exists when evidence supports a conclusion that a specific condition more likely than not caused the specific symptom in the specific patient at the specific time and also caused the fall. The preponderance of the evidence standard is that which leads the trier of fact, after considering all the evidence, to find that the existence of a contested fact is more probable than its nonexistence. *Life Care Centers of Am. v. Indus. Claim Appeals Office*, 553 P.3d 905, 909 (Colo. App. 2024).

The evidence in this case does not establish causation to a reasonable degree of medical probability. Thus, the cause of any possible dizziness remains unknown and the cause of Claimant's fall remains unexplained.

Comparison to *City of Brighton* and *King Soopers*

In *City of Brighton*, the employer presented expert medical testimony that the claimant's brain aneurysms were the "most likely" cause of her fall. 318 P.3d at 501. The ALJ evaluated and rejected that testimony. *Id.* at 503. Once the evidence of idiopathic causation was rejected, the fall was properly categorized as unexplained and therefore a neutral risk. *Id.*

In *King Soopers*, the employer presented expert testimony that degenerative changes caused the knee injury. 538 P.3d at 349. The ALJ rejected this testimony as "speculative and unpersuasive." *Id.* at 352. The court held the injury was not idiopathic and therefore constituted a neutral risk. *Id.* at 353-54.

Thus, in this case, the ALJ finds and concludes that the preponderance of the credible and persuasive evidence does not establish that Claimant’s injury arose from a personal or idiopathic risk.

3. Therefore: This Is a Neutral Risk

Having eliminated both employment risks and personal/idiopathic risks, the injury necessarily falls within the third category: neutral risks. An unexplained fall "necessarily" constitutes a neutral risk. *City of Brighton*, 318 P.3d at 503. As found, the cause of Claimant's fall is unexplained. Multiple potential causes exist but none is established by a preponderance of the evidence.

The Court of Appeals in *King Soopers* held that "requiring more precision from the employee, when an ALJ has specifically found that the cause of the harm was not pre-existing and truly unexplained, is inconsistent with the spirit of the Act." 538 P.3d at 354.

The But-For Test

For injuries arising from neutral risks, the but-for test applies. *City of Brighton*, 318 P.3d at 505. Claimant satisfies this test. But for her employment requiring her presence

for the overnight shift, she would not have been in the parking lot at 11:45 p.m. exiting her vehicle. She would have likely been elsewhere rather than standing in her employer's parking lot at 11:45 p.m. in a position where she could and did fall and break her hip. The act of exiting her vehicle in the Employer's parking lot, necessitated by her employment duties, placed her in the specific time, place, and physical position where the fall occurred. Her employment created the positional risk that resulted in her injury. Thus, the ALJ finds and concludes that the preponderance of the evidence establishes that the but-for test is satisfied.

Conclusion

Claimant's injury did not arise from an employment risk. Claimant's injury did not arise from a personal/idiopathic risk. Therefore, Claimant's injury arose from a neutral risk, and as found above, the but-for test is satisfied.

The evidence is insufficient to establish by a preponderance of the evidence that Claimant experienced dizziness prior to the fall. Moreover, even assuming Claimant did experience dizziness, the evidence is insufficient to establish that any personal or idiopathic condition caused the fall. Whether dizziness occurred or not, the cause of the fall remains unexplained, thereby classifying it as a neutral risk under *City of Brighton*. The Colorado Supreme Court has held that unexplained falls arising from neutral risks are compensable when the but-for test is satisfied, which Claimant has met. *City of Brighton*, 318 P.3d at 505-06.

Based on the totality of the evidence, the ALJ finds and concludes Claimant established by a preponderance of the evidence that her claim is compensable. She established the fall occurred in the course of her employment and arose out of her employment under the neutral risk/but-for test.

Order

It is therefore ordered that:

1. Claimant's claim is compensable.
2. Respondents shall pay for Claimant's reasonable, necessary, and related medical treatment.

3. Claimant's medical treatment through the date of the hearing is authorized.

4. Respondents shall pay Claimant temporary disability benefits.

5. Claimant may select an authorized treating physician.

6. All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 27, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Dated: October 23, 2025

/s/ Glen Goldman
Glen B. Goldman
Administrative Law Judge

ISSUES

1. Whether Claimant proved by a preponderance of the evidence that she sustained a compensable mental-stress injury on May 16, 2025, arising out of and in the course of her employment with Respondent-Employer.

2. Whether Claimant proved by a preponderance of the evidence that she is entitled to reasonable medical treatment with Dr. Wistoff for her alleged May 16, 2025 mental-stress injury.

FINDINGS OF FACT

1. Claimant is a senior accountant for Respondent-Employer who alleges a mental stress injury arising from a toxic workplace during 2023 through 2025. Claimant was taken off work by her doctor for chronic anxiety on May 16, 2025, and remained off work with Respondent-Employer through the date of hearing.

2. Respondent-Employer is a dental care provider with multiple locations. Claimant worked at the corporate offices for Respondent-Employer. Her job responsibilities as a senior accountant involved processing company expenses on credit cards. Her role included following up with cardholders for receipts to verify that the purchases were for company expenses and not personal expenses. Her job included downloading credit card statements, formatting them, sending them to cardholders, and then asking cardholders to return Excel spreadsheets with the location and class of the expense. Claimant was supervised by the assistant controller, Stacy Alvarez, who was in turn supervised by the controller, Karen Harrity. Claimant did not supervise any employees.

3. Claimant testified that she worked remotely in Tulsa, Oklahoma from 2023 to 2024, and that during that time her employer asked her to work more, increasing her hours to 50 hours per week, despite Claimant's need to socialize in her new city. Claimant also testified that she felt unseen, despite having public speaking skills.

4. On March 21, 2024, Claimant and a fellow senior accountant, Melissa Talcott, had a generally professionally toned e-mail exchange disagreeing as to whether there was sufficient documentation to support payment of an invoice. Claimant indicated that she preferred to work her own location's issues. The Court infers that Claimant and Melissa performed similar work at different locations and that the invoice in dispute concerned Claimant's location. At some point in time afterward, on an unknown date, the two had a similar exchange via instant messenger. Claimant made a private note to herself afterward indicating that she felt slighted, writing, "She is sending me emails while she is in a different meeting but thinks her decision making is better than mine. Stay in your lane Melissa."

5. On March 28, 2024, Ms. Harrity had a phone call with Claimant in which the two discussed Claimant's failure to meet deadlines, the lack of quality of information Claimant would receive for processing the credit card charges, and a plan for Claimant to copy Ms. Harrity on e-mails to cardholders going forward regarding missing information. Ms. Harrity sent Claimant a follow-up e-mail the next day documenting the conversation and committing to "fostering a positive work environment where your input is valued."

6. Claimant later testified that she began taking medications at the end of 2024 for anxiety and depression and that she was currently receiving therapy twice monthly at the time of her testimony.

7. On or about March 1, 2025, Ms. Harrity and Claimant had a miscommunication in which Ms. Harrity asked Claimant why Claimant had changed the password for

one of their systems. Claimant clarified that only Ms. Harrity had sign-in access, implying that Claimant could not have been the one who changed the password. Claimant later testified that this incident occurred on the Friday before Claimant was to take paid time off. Claimant testified that Ms. Harrity wrote up a performance letter for Claimant based on this incident.

8. Claimant testified that on one occasion Claimant hosted a virtual meeting which Ms. Harrity attended. At one point during the meeting, Ms. Harrity made a joke about enjoying being "a Karen." Claimant also felt that Ms. Harrity was making jokes off camera at Claimant's expense, though Claimant provided no credible explanation as to why she believed this. Claimant testified that she could neither eat nor sleep after Ms. Harrity's joke about being "a Karen."

9. On March 18, 2025, Claimant filed an EEOC complaint for discrimination for the period from 2022 through continuing. In that complaint, Claimant stated:

> *I have filed EEOC Claim for discrimination and durig that time I have also taken FMLA. I was out from 10/23/20334 to 02/03/2025 due to high blood pressure and anxiety. I have reported since 2022 the actions of Jennafer Correll, Revenue Cycle Manager who was using her company American Express card for personal expenses. I was required to request receipts for purchases and post expenses by deadline so I can do our month end close. There is no company policy on turning in receipts. Jennafer was spending the card on personal expenses and told me they were personal expenses. She asked me to put these expenses in the business account. I told her there was no account to put an employee's personal expenses. I feel that this is fraud. . . . Jennafer was made to pay back her personal expenses that came from the company through payroll deductions. Jennafer repaid thousands of dollars through payroll deductions. I am made to look like the bad guy. Jennafer has been here a long time. Without having a policy in place Jennafer is causing me lots of extra stress. There is no accountability.*

Jennafer is maiking my life difficult. There are things I have to do correctly. There are laws What Jennafer is doing is fraud in my eyes. . . . I am ready to get mediation started because I am tired of this feeling of toxicity.

10. On May 16, 2025, Claimant sought treatment at Concentra where she was attended by Dr. Mark Yelderman. Dr. Yelderman's assessment of Claimant included chronic anxiety. Dr. Yelderman recommended that Claimant remain off work from May 16 to May 21, 2025, and referred Claimant to psychiatry for chronic anxiety. There is no credible evidence that Dr. Yelderman is a licensed psychiatrist or psychologist. Given that Dr. Yelderman referred Claimant out to psychiatry, the Court infers that Dr. Yelderman is not a psychiatrist and likely not a psychologist. Claimant presented no credible evidence that a licensed psychiatrist or psychologist determined that Claimant had a mental impairment.

11. Around May 27, 2025, Claimant filed a Worker's Claim for Compensation. Respondents denied the claim.

12. At hearing, Claimant testified that she wanted to work for a company that she believed in and that she enjoyed working for. She testified that she took the job believing that she was joining an organization that would bring "beautiful smiles to children." Claimant believed that she could contribute her experience and intelligence to the organization, and she felt she had a greater purpose of protecting the integrity of the organization.

13. Claimant testified that she was discouraged from speaking up and that she "was not making any friends" in the process of trying to hold cardholders accountable for their expenses. Claimant testified that she was told to post the expenses even if there was no receipt submitted. Claimant began to feel worn down in the job when she began processing the credit card expenses and receipts, as she had difficulty following up for receipts and was not receiving the assistance she felt she needed. Moreover, Claimant testified that she did not want to be complicit in

misuse of company funds. Claimant also expressed frustration with the lack of formalized written protocols in the workplace despite the company growing.

14. The Court finds Claimant's testimony credible insofar as it regards her subjective interpretation of events. However, the Court does not accept Claimant's impression of events as fact, except insofar as otherwise indicated in this Order.

15. At hearing, Suzanne Reams, the chief people officer for Respondent-Employer, also testified. She testified that she had worked for Respondent-Employer for seven years. Her job involved overseeing payroll, recruiting, human resources, and the learning and development departments. Ms. Reams testified that she would get involved in investigations of complaints and assist some managers with coaching when needed.

16. Ms. Reams testified that the Employer's expense policy was that cardholders were supposed to submit receipts in a Sharepoint Vault along with an expense report. The credit cards were not to be used for personal expenses.

17. The incident involving Ms. Harrity's joke at Claimant's meeting was on May 9.[1] Ms. Reams testified that she investigated the incident, interviewing each of the witnesses who were present at the meeting. She testified that none of the other participants thought anything of the joke. Ms. Reams testified that she provided a post-incident coaching to Ms. Harrity and the CFO regarding Ms. Harrity's joke.

18. Ms. Reams testified that Claimant had been consistently missing deadlines. Many cardholders were not providing Claimant the expense reports or receipts that she requested, and Claimant was getting frustrated. As a means of coaching, Ms. Reams testified, Ms. Harrity instructed Claimant to copy her on the e-mails to the cardholders to give the e-mails more authority. However, Ms. Reams testified that

[1] The evidence is unclear as to what year this occurred.

Claimant did not accept the coaching well and felt stressed that her performance was being scrutinized. Ms. Reams acknowledged that Claimant received the employee-of-the-year award on one occasion but did not recall what year that was.

19. Ms. Reams testified that Claimant did not report a workplace injury but instead requested FMLA leave, complaining of other employees' improper use of company credit cards causing her stress. Claimant indicated to Ms. Reams that she wanted to leave the employer and wanted severance pay but then recanted her desire to quit.

20. The Court finds Ms. Reams's testimony credible. Ms. Reams testimony appeared impartial and dispassionate in its presentation. Aside from Ms. Reams's role in management for Respondent-Employer, the Court identifies no motive for Ms. Reams to misrepresent her recollection of events, particularly insofar as Ms. Reams was not personally involved in Claimant's allegations.

21. The Court observes that much of the testimony and documentary evidence in this case is confusing, often devoid of specific dates, and frequently presented without sufficient context. Nevertheless, based on the record as outlined above, the Court finds that Claimant harbored personal resentment toward her employer arising from a series of passive-aggressive exchanges and petty slights characteristic of ordinary office-work incivilities and miscommunications—particularly in environments where communication occurs primarily by e-mail and tone is easily misconstrued.

22. The Court finds that the events causing Claimant's mental stress are not outside a worker's usual experience, as such interpersonal tensions are common to all fields of employment, even if more prevalent in the office-work environment where e-mail communication is standard.

23. Furthermore, the Court finds Claimant's reaction to the normal interpersonal stressors of the workplace evident in this case to be disproportionate and that such

stressors, while unpleasant, would not evoke significant symptoms of distress in a worker in similar circumstances. Claimant appears to have been primed to receive her coworkers' ambiguous communications or actions in the most uncharitable light, resulting in cumulative resentment and reinforcing her suspicion of her coworkers' motives. However, the Court finds that Claimant's uncharitable perception of these perceived slights to be unreasonable. The evidence does not support a finding of hostile or abusive conduct, but rather ordinary and reasonable disagreements over work quality, deadlines, and documentation.

24. Furthermore, to the extent that Claimant alleges that her mental stress arises from Respondent-Employer's supervision and evaluation of Claimant's work, the Court finds that such supervision and evaluation was performed in good faith and that there is no credible evidence that it was for some malign purpose such as harassment or intimidation. The supervisory actions documented—including discussions of missed deadlines, instructions to copy supervisors on e-mails for added authority, and coaching following a distasteful workplace joke—are all within the bounds of legitimate personnel management. While Claimant may have experienced such oversight as stressful or discouraging, the Court finds that these measures were reasonable under the circumstances.

25. To be clear, the Court neither endorses nor condemns Respondent-Employer's practices with regard to its review of cardholder expenditures, nor does it doubt Claimant's genuine desire to improve processes and documentation at Respondent-Employer. However, the facts of this case demonstrate a good-faith disagreement between Claimant and Respondent-Employer with regard to business practices, and the Court finds that Claimant has not presented any credible evidence that Respondent-Employer's conduct toward Claimant was in bad faith.

CONCLUSIONS OF LAW

Generally

1. The purpose of the Workers' Compensation Act of Colorado, §§ 8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. *See* § 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. *See* § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 592 P.2d 792 (Colo. 1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

2. Assessing weight, credibility, and sufficiency of evidence in Workers' Compensation proceeding is the exclusive domain of the administrative law judge. *University Park Care Center v. Industrial Claim Appeals* Office, 43 P.3d 637 (Colo.App.2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. at 641. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); *Bodensieck v. Industrial Claim Appeals Office*, 183 P.3d 684 (Colo.App.2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Industrial Claim Appeals*

Office, 55 P.3d 186 (Colo.App.2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colorado Springs Motors, Ltd. v. Industrial Commission*, 441 P.2d 21 (Colo. 1968).

3. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo.App.2000).

Compensability

4. To establish a compensable claim, a claimant must prove they suffered an injury while "performing service arising out of and in the course of his employment." Section 8-41-301(1)(b). The "course of employment" requirement is satisfied if the injury occurred within the time and place limits of the employment relationship and during an activity that had some connection with the employee's job-related functions." *Popovich v. Irlando*, 811 P.2d 379, 383 (Colo. 1991). The term "arising out of" is narrower and requires that an injury "has its origin in an employee's work-related functions and is sufficiently related to those functions to be considered a part of the employee's employment contract." *Horodysyj v. Karanian*, 32 P.3d 470, 475 (Colo. 2001). There is no presumption that an injury occurring at work during work hours necessarily arises out of employment. *Finn v. Indus. Comm'n*, 437 P.2d 542 (Colo. 1968). The claimant must prove a causal nexus between the injury and their employment by a preponderance of the evidence. *Ramsdell v. Horn*, 781 P.2d 150 (Colo. App. 1989).

5. The Workers' Compensation Act imposes additional conditions for compensability of a claim for "mental impairment." Among those conditions is a requirement that

the claim be "supported by the testimony of a licensed psychiatrist or psychologist." Section 8-41-301(2)(a), C.R.S. The requirement for "testimony" has been interpreted broadly to include "the work product" of a psychiatrist or psychologist, which "may include letters, reports, affidavits, depositions, documents, an/or oral testimony." *Colorado Dept. of Labor & Empl. v. Esser*, 30 P.3d 189, 196 (Colo. 2001).

6. The term "mental impairment" means a disability resulting from an accidental injury "when the accidental injury involves no physical injury and consists of a psychologically traumatic event." Section 8-41-301(3)(a), C.R.S. A "psychologically traumatic event" includes:

    - An event generally outside of a worker's usual experience, and which would evoke significant symptoms of distress in a worker in similar circumstances;

    - An event within a worker's usual experience only when the worker is diagnosed with PTSD by a licensed psychiatrist/psychologist upon exposure to one of the following:

        - Being subjected to attempted SBI/death by use of deadly force, and worker reasonably believes himself to be the object of the attempt;
        - Visually witnessing a death (or the immediate aftermath) resulting from a violent event;
        - Visually witnesses SBI (or immediate aftermath).

7. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, lay-off, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. *Id*.

8. As found Claimant harbored personal resentment toward her employer arising from a series of passive-aggressive exchanges and petty slights characteristic of ordinary office-work incivilities and miscommunications—particularly in environments where communication occurs primarily by e-mail and tone is easily misconstrued.

9. The Court finds that the events causing Claimant's mental stress are not outside a worker's usual experience, as such interpersonal tensions are common to all fields of employment, even if more prevalent in the office-work environment where e-mails communication is standard.

10. Furthermore, the Court finds Claimant's reaction to the normal interpersonal stressors of the workplace evident in this case to be disproportionate and that such stressors, while unpleasant, would not evoke significant symptoms of distress in a worker in similar circumstances. Claimant appears to have been primed to receive her coworkers' ambiguous communications or actions in the most uncharitable light, resulting in cumulative resentment and reinforcing her suspicion of her coworkers' motives. However, the Court finds that Claimant's uncharitable perception of these perceived slights to be unreasonable. The evidence does not support a finding of hostile or abusive conduct, but rather ordinary and reasonable disagreements over work quality, deadlines, and documentation.

11. Furthermore, to the extent that Claimant alleges that her mental stress arises from Respondent-Employer's supervision and evaluation of Claimant's work, the Court finds that such supervision and evaluation was performed in good faith and that there is no credible evidence that it was for some malign purpose such as harassment or intimidation. The supervisory actions documented—including discussions of missed deadlines, instructions to copy supervisors on e-mails for added authority, and coaching following a distasteful workplace joke—are all within the bounds of legitimate personnel management. While Claimant may have experienced such oversight as stressful or discouraging, the Court finds that these measures were reasonable under the circumstances.

12. Furthermore, as found, Dr. Yelderman is not a psychiatrist and likely not a psychologist and Claimant presented no credible evidence that a licensed psychiatrist or psychologist determined that Claimant had a mental impairment. The Court concludes, therefore, that Claimant did not present a claim for mental impairment "supported by the testimony of a licensed psychiatrist or psychologist."

13. Claimant has failed to prove that she sustained a compensable injury arising out of and in the course of her employment.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation is denied and dismissed.

DATED: October 7, 2025.

/s/ Stephen J. Abbott

Stephen J. Abbott
Administrative Law Judge
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, Colorado, 80203

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, *see* § 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

Issues

Has Claimant demonstrated, by a preponderance of the evidence, that the right shoulder surgery recommended by Dr. Thomas Hackett constitutes reasonable medical treatment necessary to cure and relieve Claimant from the effects of the admitted October 31, 2023 work injury?

Findings of Fact

1. Claimant began working for Employer as a ski lift mechanic during the winter months of 2022. As a ski lift mechanic, Claimant performed inspections and maintenance of the ski lifts. Claimant testified that this involved a great deal of overhead work using tools such as wrenches.

2. On October 31, 2023, Claimant suffered an injury at work. Claimant testified that two incidents occurred on that date. The first involved him slipping on ice. Claimant testified that as he slipped he was able to catch himself with his left arm/hand on a car, while reaching out with his right arm to grasp some railing. Claimant testified that at that time, he felt a little bit of pain, but he continued with his work day. Later during that same shift, Claimant was performing an inspection that involved turning the ski lift by hand, with a wrench. This overhead activity caused pain in Claimant's right shoulder. Claimant testified that following this second incident the pain in his right shoulder was so severe he was unable to lift a screwdriver above his head.

3. Respondents have admitted liability for Claimant's October 31, 2023 work injury.

4. Following his injury, Claimant began treatment through Work Partners as his authorized treating provider (ATP). Claimant was first seen at Work Partners on November 2, 2023 by Eugene Lucero, PA-C. At that time, Claimant reported severe pain in his right shoulder and limited range of motion. On examination, PA Lucero noted pain to palpation over the entire shoulder girdle, most noticeable over the posterior. PA Lucero recorded a number of

tests were negative. Those tests are listed as Hawkin's test, Sulcus sign, O'Brien's test, Speed's test, and empty can test. PA Lucero opined that Claimant has suffered an acute shoulder strain and recommended conservative treatment of "RICE"[1], ibuprofen, and stretching. He also ordered a right shoulder x-ray and prescribed Flexeril (cyclobenzaprine).

5. On November 9, 2023, Claimant returned to PA Lucero and reported slight improvement in his symptoms, and some relief with the muscle relaxer. On examination, PA Lucero noted improved range of motion that included active forward flexion and abduction. PA Lucero also noted that the November 2, 2023 x-rays were negative. Treatment recommendations were unchanged.

6. On November 28, 2023, Claimant was seen at Work Partners by Dr. Steven Brown. At that time, Claimant reported aching, shooting, and stabbing pain in his right shoulder. Claimant also reported limited range of motion and popping in his shoulder. Dr. Brown opined that Claimant has suffered a rotator cuff injury, with subscapularis involvement. Dr. Brown referred Claimant to physical therapy and ordered magnetic resonance imaging (MRI) of Claimant's right shoulder. Dr. Brown also noted that a steroid injection would be considered if Claimant did not improve.

7. On December 6, 2023, Claimant underwent a right shoulder MRI. The MRI showed no significant joint effusion, or injury of the rotator cuff; and minimal nondescript hyperintensity of the scapula in the juxta-glenoid region. The radiologist, Dr. Carl Blunk also noted abnormal distal right clavicular changes. Dr. Blunk listed differential diagnoses that included possible bone bruise, bone marrow edema, or early post-traumatic osteolysis.

8. Subsequently, Claimant's ATP was changed to SCL Health Occupational Medical Clinic. Claimant was first seen in that practice on April 10, 2024, by Dr. Spencer Olsen. At that time, Claimant described his mechanism of injury and reported his current symptoms to include right shoulder achiness, pain anteriorly with heavy lifting, dull pain frequently, and sharp pain intermittently. On examination, Dr. Olsen noted stiff and limited range of motion overhead, with mildly limited internal rotation. Dr. Olsen listed Claimant's diagnoses as right shoulder sprain, and chronic right shoulder pain. In addition, Dr. Olsen

[1] Rest, ice, compression, and elevation.

noted that the MRI was “mildly abnormal” and that he suspected AC joint[2] pathology. Dr. Olsen referred Claimant for massage therapy and for an orthopedic consultation.

9. On May 16, 2024, Claimant was seen at Rocky Mountain Orthopedics by Dr. Justin McCoy. Claimant described his mechanism of injury and reported right shoulder pain with any activity. On examination, Dr. McCoy noted tenderness over the anterior aspect of the AC joint. With regard to range of motion, Dr. McCoy noted pain with resisted internal and external rotation. Dr. McCoy reviewed the December 6, 2023 MRI and opined that Claimant had distal clavicular osteolysis. Dr. McCoy further opined that physical therapy and work activities could be worsening these symptoms. Dr. McCoy recommended an AC joint injection.

10. Also on May 16, 2024, Claimant was seen by Dr. Olsen. At that time, Claimant reported that massage therapy helped his symptoms, but that relief did not last long. Claimant also reported that the pain was over the top of his right shoulder and anteriorly. Dr. Olsen opined that Claimant’s symptoms were from the AC joint and agreed with the recommended AC joint injection.

11. On May 22, 2024, Claimant returned to Dr. McCoy. On that date, Dr. McCoy administered an ultrasound guided AC joint injection.

12. Claimant returned to Dr. McCoy on July 2, 2024, and reported improvement of 70 percent, but that he had plateaued. At that time, Claimant had been off work for approximately one month, and planned to be off an additional two months for paternity leave. Dr. McCoy noted that rest would be beneficial to Claimant and also recommended the use of Voltaren gel.

13. Claimant returned to Dr. Olsen on July 23, 2024. In the medical record of that date, Dr. Olsen noted that Claimant had a “good response” from the steroid injection administered by Dr. McCoy. However, Dr. Olsen also noted that Claimant was “very symptomatic”. Dr. Olsen referred Claimant for additional massage therapy and recommended a home exercise program. Dr. Olsen noted that Claimant might need a distal clavicle resection, and referred Claimant for a surgical consultation.

[2] Acromioclavicular joint.

14. On August 14, 2025, Claimant was seen at Rocky Mountain Orthopedics by Dr. Mark Luker. Claimant reported pain in his upper lateral arm that increased with "any kind of persistent use, driving, or when pushing away from his body. Claimant also reported that the AC joint injection provided 60 to 70 percent relief. Following examination, Dr. Luker opined that Claimant likely had internal derangement of the joint space, with "a labral problem". Dr. Luker recommended a diagnostic injection into the joint space, with the possibility of a subacromial injection to follow. Dr. Luker also recommended an MRI arthrogram. It was Dr. Luker's opinion that Claimant's pain generator was not the AC joint.

15. On September 3, 2024, Dr. Luker administered an injection into the right glenohumeral joint. In the medical record of that date, Dr. Luker noted that following the injection, Claimant "reported complete early pain relief". Dr. Luker opined that Claimant had internal derangement in his right shoulder consisting of a possible labral tear and a SLAP[3] lesion. Dr. Luker further opined that as a result of the work injury, Claimant had "a mechanical failure of his labrum". Dr. Luker recommended surgery that would include arthroscopic labral repair, or long head biceps tenodesis. He recommended an MRI arthrogram, as the prior MRI was performed without contrast.

16. At the request of Respondents, Dr. William Ciccone reviewed Claimant's medical records. In a report dated September 17, 2024, Dr. Ciccone opined that on October 31, 2023 Claimant suffered a minor strain to his right shoulder, specifically an injury to the right AC joint. In support of this opinion, Dr. Ciccone noted that the December 6, 2023 MRI showed edema in the distal clavicle of the AC joint, which indicates an acute injury to that joint. Dr. Ciccone also noted that on examination on August 14, 2024 there was no evidence of an AC joint injury, however, it was at that time that Claimant first reported that he was experiencing biceps pain. Additionally, Dr. Ciccone opined that Claimant had reached maximum medical improvement (MMI) as of August 14, 2024, for the October 31, 2023 injury.

17. Respondents relied upon the opinions of Dr. Ciccone and denied the surgery requested by Dr. Luker.

[3] Superior labrum anterior-posterior.

18. On October 31, 2024, Dr. Luker authored a response to the surgery denial, and more specifically the opinions of Dr. Ciccone. Dr. Luker opined that Claimant's mechanism of injury "fits better with an intra-articular labral tear problem than an AC joint injury." Dr. Luker argued for authorization of the surgery. Absent such authorization, he recommended an MRI arthrogram.

19. After reviewing additional medical records, on December 13, 2024, Dr. Ciccone authored a supplemental report. Dr. Ciccone noted that his opinion remained unchanged. He noted the records demonstrated "inconsistent findings on examination". Specifically, Dr. Ciccone noted that if Claimant had suffered a superior labral or biceps injury on October 31, 2024, he would have had positive results from both an O'Brien's test and a Speed's test. However, on November 2, 2023, both of these tests were recorded as negative. Dr. Ciccone reiterated his opinion that Claimant suffered a minor AC joint injury. In addition, Dr. Ciccone opined that even if Claimant did have a labral tear, it would be unrelated to the work injury.

20. On December 23, 2024, Claimant underwent a right shoulder MRI arthrogram, with contrast. The MRI showed findings "most consistent with a tear of the anterior superior labrum."

21. On January 8, 2025, Claimant returned to Dr. Luker who stated his agreement that the December 23, 2024 MRI arthrogram showed an anterior and superior labral tear. Dr. Luker reiterated his recommendation for a right shoulder arthroscopic repair of the SLAP lesion and labral tear. Dr. Luker opined that treatment of Claimant's AC joint "distracted from the deeper problem in this shoulder joint."

22. On January 22, 2025, Claimant was seen by Dr. Olsen. At that time, Dr. Olsen noted that the MRI arthrogram showed a labral tear and SLAP lesion. Dr. Olsen opined that Claimant had failed conservative treatment and given the findings on MRI, surgery was "the most reasonable next step."

23. On January 23, 2025, Dr. Ciccone authored another supplemental report. At that time, Dr. Ciccone agreed that the December 27, 2024, MRI showed evidence of a labral tear and biceps tendonitis. However, Dr. Ciccone continued to opine that this was unrelated to Claimant's October 31, 2023 work injury. Dr. Ciccone further opined that the recommended surgery was not causally related to Claimant's work injury.

24. Respondents continued to rely upon the opinions of Dr. Ciccone and denied the requested surgery.

25. On February 10, 2025, Claimant returned to Dr. Olsen. At that time, Dr. Olsen stated that Claimant continued to be symptomatic. In addition, Dr. Olsen noted that the MRI arthrogram showed evidence of a labral tear and SLAP lesion. In light of the denial of the requested surgery, Dr. Olsen referred Claimant to Dr. Thomas Hackett at The Steadman Clinic for evaluation.

26. Claimant was first seen by Dr. Hackett on February 25, 2025. Claimant described the mechanism of injury as he had with all prior providers. Dr. Hackett recorded Claimant's symptoms as pain "deep within the shoulder", weakness, and loss of range of motion. Dr. Hackett noted that the MRI arthrogram showed a right shoulder SLAP lesion with labral and bicep anchor detachment. Dr. Hackett also noted that Claimant had exhausted conservative treatment modalities and recommended surgical intervention that would include a right shoulder arthroscopy with labral debridement and open biceps tenodesis.

27. On March 10, 2025, Dr. Olsen authored a statement to Pinnacol regarding the continued denial of the requested right shoulder surgery. Dr. Olsen stated:

> [Claimant] was misdiagnosed originally by me based on imaging that did not pick up the labral tear initially. Misdiagnosis does not make the shoulder injury not work-related. I think it's clearly work-related and will keep insisting his surgery be authorized. I cannot close his claim. He is not at MMI."

28. On April 25, 2025, Dr. Ciccone authored a third supplemental report. Dr. Ciccone was specifically asked to state his opinion regarding whether the right shoulder arthroscopy, subacromial decompression, limited debridement, and open biceps tenodesis was medically necessary and related to Claimant's work injury. Dr. Ciccone stated that his opinions remain unchanged from his prior report. Although the recommended surgery is reasonable to treat Claimant's condition, it is not causally related to Claimant's work injury.

29. Dr. Ciccone wrote another supplemental report of May 28, 2025. At that time, Dr. Ciccone noted his review of radiographs from November 2, 2023 and the December 6, 2023 MRI. Dr. Ciccone again stated his opinion that Claimant's initial examinations were not

consistent with an acute labral tear and biceps injury. Rather, Claimant's initial examinations demonstrated a sprain/strain of the AC joint.

30. On August 12, 2025, counsel for Claimant sent a letter to Dr. Hackett asking him to respond to a number of questions regarding Claimant's treatment and the requested surgery. Dr. Hackett responded to that letter on August 19, 2025 and opined that either of the incidents on December 31, 2023 (the slip or the use of the wrench overhead) could have resulted in a labral tear. Dr. Hackett further opined that it was more likely caused by the torquing movement during the wrench activity. Dr. Hackett also explained that the first MRI in December 2023 was done without contrast, while the December 2024 MRI was done with contrast. This difference may explain why the labral tear was not evident in 2023, but was in 2024. Dr. Hackett also stated his continued opinion that Claimant's right shoulder condition (and the need for the recommended surgery) is work related.

31. Dr. Ciccone's deposition testimony was consistent with his written reports. Dr. Ciccone explained that the recommended surgery is intended to address superior labral pathology that impacts the biceps tendon. It continues to be Dr. Ciccone's opinion that this surgery is reasonable and necessary to address the biceps irritation and a possible labral tear. It also continues to be Dr. Ciccone's opinion that the requested surgery is not related to Claimant's work injury. Dr. Ciccone explained that when Claimant was initially seen after his injury, his symptoms were most consistent with an injury to the AC joint. Dr. Ciccone also testified that at those same appointments, Claimant showed negative signs of biceps issues. It was eight months later that Claimant began to show biceps related findings on examination. Dr. Ciccone further testified that following an injection to the AC joint, Claimant experienced relief. This indicates that this was the source of Claimant's pain.

32. The ALJ credits the medical records and the opinions of Drs. Olsen, Luker, and Hackett over the contrary opinions of Dr. Ciccone. The ALJ specifically credits the December 2024 MRI arthrogram with contrast that demonstrates the existence of the labral tear and SLAP lesion. The ALJ is further persuaded by Dr. Hackett's explanation that the prior 2023 MRI (without contrast) may have missed the labral tear that was later seen on the MRI arthrogram with contrast. The ALJ finds that the current condition of Claimant's right shoulder, and his need for surgical intervention is causally related to his October 31, 2023 work injury. Therefore, the ALJ finds that Claimant has successfully demonstrated that it is more likely than

not that the surgery recommended by Dr. Hackett is reasonable medical treatment necessary to cure and relieve Claimant from the effects of the work injury.

Conclusions of Law

1. The purpose of the Workers' Compensation Act of Colorado is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probable than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16.

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

4. Respondents are liable for authorized medical treatment reasonably necessary to cure and relieve an employee from the effects of a work related injury. Section 8-42-101, C.R.S.; *see Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

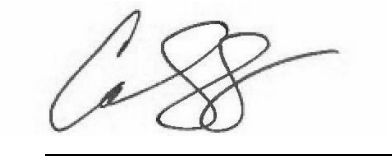
5. As found, Claimant has demonstrated, by a preponderance of the evidence, that the right shoulder surgery recommended by Dr. Hackett constitutes reasonable medical treatment necessary to cure and relieve Claimant from the effects of the admitted October 31,

2023 work injury. As found, the medical records and the opinions of Drs. Olsen, Luker, and Hackett are credible and persuasive on this issue.

Order

It is therefore ordered that Respondents shall authorize the surgery recommended by Dr. Hackett, pursuant to the Colorado Medical Fee Schedule. All matters not determined here are reserved for future determination.

Dated October 23, 2025.



Cassandra M. Sidanycz
Administrative Law Judge
Office of Administrative Courts

If you are dissatisfied with the ALJ's order, you may file a Petition to Review the order with the **Denver Office of Administrative Courts**, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after service of the order, as indicated on the certificate of mailing or service; otherwise, the ALJ's order will be final. Section 8-43-301(2), C.R.S. and OACRP 27. You may access a petition to review form at: https://oac.colorado.gov/resources/oac-forms.

You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the ALJ; and (2) That you mailed it to the above address for the **Denver Office of Administrative Courts**. You may file your Petition to Review electronically by emailing the Petition to Review via email to either **oac-ptr@state.co.us** or to **oac-dvr@state.co.us**. If the Petition to Review is emailed to either of the aforementioned email addresses, the Petition to Review is deemed filed in Denver pursuant to OACRP 27(A) and Section 8-43-301, C.R.S. If the Petition to Review is filed by email to the proper email address, it does not need to be mailed to the Denver Office of Administrative Courts. **It is also recommended that you provide a courtesy copy of your Petition to Review to the Grand Junction OAC via email at oac-gjt@state.co.us.**