



HindmanSanchez

WORKERS COMPENSATION INSURANCE

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INTRODUCTION

We recommend that condominium and homeowners associations, whether managed or not, with or without employees, maintain at least a minimum premium workers' compensation policy in the association's name. A workers' compensation policy in the name of the manager or management company may not respond appropriately in the event of an employee related injury. Additionally, we recommend that the Association require certificates of insurance from all subcontractors, regardless of whether the subcontractor is considered an independent contractor and not an employee of the association.

Under Colorado law, anyone who subcontracts any of its work out to another is an employer for workers' compensation purposes, unless the entity to which the work is subcontracted fits within the specific definition of independent contractor set out in CRS § 8-40-202(2)(b); CRS § 8-41-401. To be an independent contractor under the workers' compensation law, the individual must be free from control and direction in performing the services and must be customarily engaged in an independent trade related to the service.

To be free from control and direction means that the hiring party does not have the right to control the worker. Simply because a worker has the freedom to exercise his own judgment in some details does not mean the hiring party does not have the right to control. Likewise, even if the hiring party chooses not to exercise control over the worker does not mean there is no right to control. *Allen Co., Inc. V. Industrial Commission*, 762 P.2d 677 (Colo. 1988).

There are only two ways to establish independence: by satisfying nine requirements set out by the statute or by a written document. If there is no written document, the parties can prove independence by demonstrating that the party who hired the service provider to perform services does not:

1. require exclusive work, though the service provider can work exclusively for the hiring party for a finite period of time;
2. establish quality standards, though the hiring party can provide plans and specifications;
3. pay salary or hourly rate rather than a fixed rate;
4. terminate the service provider before the end of the contract period if there has been no violation of the contract;
5. substantially train the service provider;
6. give the service provider tools or benefits, though he can supply materials and equipment;
7. dictate the time of performance that is not a negotiated schedule for completion;
8. pay the service provider personally instead of the trade name; and
9. combine the business operations of the two. CRS § 8-40-202(2)(b)(II).

The parties can also establish independence through a written document that shows the nine factors exist. The document can be part of the performance contract or a separate document; it must be signed by both parties and notarized. The document must contain a disclosure, in larger, bolded, or underlined print, that the independent contractor is not entitled to workers' compensation benefits and is responsible for paying tax on the money earned under the contract. If there is such a disclosure, there is a rebuttable presumption that the parties have an independent contractor relationship. CRS § 8-40-202(2)(b)(IV).

To be an independent contractor, the service provider must be free from control both under the contract and in fact. The actual circumstances will control over the writing.

If the service provider does not fit within this statutory definition, he will be deemed an employee for purposes of workers compensation. Therefore, an association which regularly contracts for a service, such as landscaping, may be considered an employer of the persons associated with the landscaping maintenance. The liability for injury travels "up the chain" from the injured person, to the subcontractor to the association. If the subcontractor fails to consistently carry worker's compensation coverage for laborers, the association may incur liability from two sources: first; claims due to injury or death and second; premiums. If a claim due to injury or death occurs, and the subcontractor for whom the injured party works fails to carry worker's compensation insurance, the association may be liable for 1 and 1/2 times the amount of the claim. Additionally, if the claim triggers an audit, or if a routine audit occurs and the subcontractor failed to carry adequate coverage, the association may be charged a premium for the period of time that the subcontractor failed to carry adequate coverage.

The premium paid is based on the amount of the payroll paid to employees. There is an annual audit at the end of each policy year where the premium for the past year is established. The amounts paid for coverage during the year are considered a deposit. At the audit, there must be certificates of coverage for all employees (including subcontractors who perform services as part of the regular business operation of the association). If there was an employee (contractor or subcontractor) who wasn't adequately covered for the full year, the employer (i.e. the association) will be liable for the amount that coverage would have cost for the period of the employment.

I. CLAIMS

A. Worker's compensation claims are initiated in two ways:

1. The employer files an Employer's First Report Of Injury; generally, this only needs to be filed with the insurance carrier. However, in certain situations, a first report of injury must also be filed with the Division of Workers' Compensation (DOWC). These situations are:
 - a. If the disability will remain for longer than three shifts or three working days or if there is permanent physical impairment, a report must be filed within 10 days of the injury or illness.
 - b. If there is a fatality or the incident involves three or more employees, a report must be filed immediately.
2. The employee files a Worker's Claim For Compensation.

While an employer is required to report a loss-time injury to the Division of Workers' Compensation (CRS § 8-43-101), there is no statutory provision requiring that he report the injury to his worker's compensation insurance carrier. However, once an insurer is so notified, it must admit or deny liability for the injury within twenty days of the date it received knowledge of the injury (CRS § 8-43-203). Where an employer's report of the injury indicates that the employee is temporarily disabled for three days or less (and if medical benefits have been

provided) then the carrier need not file an admission or denial of liability unless and until it has knowledge of a claim being filed by the claimant.

In some instances, the employer does not bother to report the injury to his insurance carrier, or for some other reason the insurance carrier does not notify the Division of Workers' Compensation of the injury. A claim may therefore be initiated directly by the Claimant filing of a Worker's Claim For Compensation with the Division of Workers' Compensation. Once the insurance carrier receives knowledge of the claim being filed, it must admit or deny liability within twenty days (CRS § 8-43-203).

An insurance carrier may be penalized for up to one day of compensation for every day it is late in filing an admission or denial of liability [CRS § 8-43-203(2)]. However, fifty percent of the penalty assessed is paid to the Subsequent Injury Fund, with the rest going to the claimant.

B. Statute of Limitations

Generally, a claim for compensation will be barred unless it is filed within two years after the work related injury or death. The time limit can be extended by the Director of the Division of Workers' Compensation to three years if it is shown to his satisfaction that there is reasonable excuse for the failure to file the claim and if the employer's rights will not be prejudiced by the granting of the extension (CRS § 8-43-103(2)). Claimant's to whom compensation benefits have already been paid need not file a claim for benefits. However, the furnishing of medical expenses by the employer is not, for Statute of Limitation purposes, considered the payment of compensation (CRS § 8-43-103(2)).

If an employer who has knowledge of an injury does not report it to the Division of Workers' Compensation as provided by law, the Statute of Limitation does not begin to run until he does so (CRS § 8-43-103(2)). Also, the limitation period only begins to run when the claimant reasonably should have recognized the nature, seriousness and probable compensatory character of his injury. *Intermountain Rubber Industries v. Valdez*, 688 P.2d 1133 (Colo. App. 1984).

C. Dual Claims.

There are eight primary categories of non-worker's compensation claims which have an impact on worker's compensation benefits. These are:

1. Social Security Disability benefits;
2. Social Security Death benefits;
3. Personal Injury Protection under No-fault Act;
4. Claims against third party tortfeasors;
5. Uninsured motorist claim;
6. Employer-paid disability benefits;
7. Retirement benefits;
8. Unemployment insurance benefits.

Social Security Disability benefits received by an injured employee are deducted from his worker's compensation benefits in an amount equal to 50% of the weekly Social Security Disability benefit [CRS § 8-42-103(1)(c)(1)].

Social Security Death benefits are also offset by worker's compensation benefits which are otherwise paid to dependents. Such benefits are offset by worker's compensation benefits in the amount of 50% of the Social Security Death benefit paid (CRS § 8-42-114).

Personal Injury Protection claims (PIP) arise pursuant to the Colorado Auto Reparations Act (No-fault Act). When a work related injury involves an automobile accident both the No-fault Act and the Worker's Compensation Act come into play. Under CRS § 10-4-705(5) worker's compensation benefits are primary over PIP benefits to the extent that worker's compensation benefits are "available and covered". Therefore, PIP benefits would only come into play when a benefit is claimed which is not covered by worker's compensation. For example, if the PIP wage benefit would result in more benefit being paid to the claimant than worker's compensation would provide, the PIP insurance policy would pay the excess.

Because worker's compensation coverage is primary, problems also arise when an employer is not insured for worker's compensation. Also a number of independent contractors do not purchase worker's compensation coverage on themselves, yet may be injured in automobile accidents during employment. Whether PIP benefits are payable in such circumstances has not been addressed by an appellate court.

Uninsured motorist recoveries are treated differently from other thirty party lawsuits. Any damages a claimant receives as a result of an uninsured motorist claim are not offset against his worker's compensation benefits. Thus, a claimant can receive policy limits on an uninsured motorist claim and suffer no reduction in worker's compensation benefits.

Employer paid disability benefits result in a reduction of worker's compensation benefits to the extent the employer has paid the premiums on the disability policy. For example, if an employer pays 60% of the premium and the weekly disability benefit is \$100.00, \$60.00 of the disability benefit is deducted from the weekly worker's compensation benefits.

Retirement benefits through Social Security are offsettable against worker's compensation in the same manner as are disability benefits, but are only offsettable against permanent total disability benefits. The offsetting of retirement benefits applies only if the injury upon which the permanent total disability award was based occurred after the claimant reached age 45. If the employer does not participate in Social Security, but there is an employer-paid retirement benefits program payable when the person turns 65, the workers' compensation benefits are reduced by a percentage of the employer-paid retirement benefits. CRS § 8-42-103(c).

Unemployment insurance benefits received while a claimant is receiving temporary total disability or permanent total disability benefits will reduce the amount of those worker's compensation benefits by the total amount of the unemployment insurance benefits [CRS§ 8-42-103(1)(f)].

The above described offsets, unless specifically limited, apply to worker's compensation benefits payable for temporary total disability, temporary partial disability, permanent partial disability, and permanent total disability benefits. They do not, however, apply to rehabilitation maintenance benefits payable during the vocational rehabilitation plan.

II. JURISDICTION

Generally, injuries occurring within the State of Colorado are subject to the provisions of the Colorado Worker's Compensation Act.

A more difficult problem presents itself for Colorado employees who are injured or working outside of the State. CRS § 8-41-204 sets forth the requirements which must be met in order for Colorado jurisdiction to attach to an out-of-state injury. These requirements are that an employee must have been hired in Colorado or must have been regularly employed in Colorado. In addition, the injury must have occurred within six months after the employee left Colorado unless the employer has filed with the Division of Labor a notice that he has elected to extend Colorado compensation coverage for a greater period of time.

In interpreting CRS § 8-41-204, the Courts have enumerated three requirements, any two of which, when met, can qualify the employee for compensation under the Colorado act. The requirements are:

- A. **The contract of employment created in the State;**
- B. **Employment in the State under a contract created outside the state;**
- C. **Substantial employment in the State.**

RCS Lumber Company v. Worthy, 369 P.2d 985 (1982).

Also for purposes of the six month limitation period, the period begins to run anew every time the employee enters the State. Employer's Liability Assurance Corp. v. Industrial Commission, 363 P.2d 646 (1961).

III. PETITION TO REOPEN

A workers' compensation claim can be reopened if there was an error, a mistake, or a change in condition. These requirements for reopening are set forth in CRS § 8-43-303. If the employee was determined to be permanently totally disabled, the case can be reopened at any time to determine if he has returned to work or has taken part in activities that indicate he can return to work. A claim can be reopened in certain circumstances even if the parties entered into a settlement in which the employee waived his right to reopen.

A party may petition to reopen a claim within six years from the date of injury. The ground most frequently used to support a petition to reopen is that the claimant has experienced either a worsening or improvement in his condition. The change of condition, however, must be a change in physical or mental condition, and cannot be a change in claimant's economic condition or situation. Lucero v. Climax Molybdenum, 732 P.2d 642 (Colo. 1987). Therefore, a claimant will not be able to support a petition to reopen by showing that he has lost employment which he had obtained through a vocational rehabilitation plan and because of his injury is not able to find other employment.

The worker's compensation rules of procedure provide that if a claimant is alleging a change of condition, the petition to reopen must be accompanied by a physician's report which contains the following: a statement of the claimant's present condition; a statement as to how the claimant's

condition has changed; an estimate of the percentage of impairment; and an estimate of additional periods of temporary disability, if any.

The claim may also be reopened on the grounds that an error or mistake was made. The error or mistake may be either of fact or of law. *Gregorich v. Industrial Commission*, 188 P.2d 886 (Colo. 1948) but it does not include the neglect of a party. *Klosterman v. Industrial Commission*, 694 P.2d 873 (Colo. App. 1984). Even a claim which has been denied can be reopened on the grounds of error or mistake. *Standards Metals Corporation v. Gallegos*, 781 P.2d 142 (Colo. App. 1989) (Cert. den.).

A petition to reopen which does not comply with the rules of procedure may be dismissed by an administrative law judge, but it is not an abuse of discretion for the judge to consider a petition to reopen which does not meet the procedural guidelines.

The six-year time limit for reopening is extended in certain cases. First, a claim may be reopened within two years after the last temporary or permanent disability benefits became due and payable. CRS § 8-43-303(2). A claim may also be reopened beyond the six year period within two years after the last medical benefits are paid if there was an error, mistake or change of condition.

Before trying to reopen a claim, it is important to first determine whether the claim was properly closed. If no final Admission Of Liability is in the Division of Labor files, then file is still open (unless it was closed by an order of an administrative law judge). If there is a final admission, the case may still be open if the law concerning such an admission was not followed. CRS § 8-43-203(2) mandates that a final admission needs the following requirements:

- A. It must state that it is a final admission;**
- B. It must state that the claimant may contest the admission and where such notice of contest must be sent;**
- C. If the final admission is based on medical reports, the report must be sent to the claimant with the admission;**
- D. If the admission is not contested within sixty days, the case will be closed as to the issues admitted.**

Requirements C and D are frequently overlooked by insurance companies and this can be used to argue that the claim was never closed. When making such an argument, it is usually wise to have also filed the Petition To Reopen, so that a fall-back position exists.

The employer and employee can enter into a final settlement; it must be approved by the ALJ or the Division of Workers' Compensation to be effective. Final settlements in which the injured worker waives the right to reopen can be reopened on the grounds of fraud or a mutual mistake of material fact. To prove mutual mistake of material fact, it must be shown that at the time the settlement agreement was signed by the parties a mistake was made. The mistake must be of importance to the settlement, and not merely a minor or typographical error. It must also be a mutual mistake made by all parties to the settlement agreement.

The Industrial Claim Appeals Panel has upheld a reopening of a settlement agreement where ALJ found that at the time of the settlement the injured worker did not understand the settlement agreement. He further found that the parties entered into the settlement with the belief that the claimant understood it, and that a mutual mistake occurred which the ALJ found to be a material issue. *Alexander v. Midwest Barricade Co., Inc.*, 1 Colo. Worker's Comp. Journal 71 (ICAO 1990).

It can be argued that any settlement can be reopened using the Alexander reasoning. Essentially, all that is necessary is for the injured worker to claim that he did not understand the settlement agreement. Of course it is still necessary that the ALJ believe the claimant, but considering the complexity of most settlement agreements, this may not be difficult to achieve. It practically goes without saying that parties entering into a settlement assume the claimant's understands it, and certainly the understanding of the settlement is a material element in its approval.

Diminished mental incapacity, *Olmi v. U.S. Pipe and Foundry*, 1 Colo. Worker's Comp. Journal 127 (ICOA 1990), and mental incompetence, *Powderhorn Coal Co. v. Weaver*, 835 P.2d 616 (Colo. App. 1992), at the time the agreement is executed are grounds which have been used to set aside settlements.

IV. CURRENT WAGE AND MEDICAL ISSUES.

A. Temporary Total Disability and Temporary Partial Disability

When an injured worker misses three regular working days or three regular shifts from work, he is eligible to receive 66 2/3 percent of his average weekly wage, not to exceed a statutory maximum, as temporary total disability (CRS § 8-42-105). The first payment must be made within 20 days of the time the insurer has written notice of the claim unless the claim is denied. Temporary total disability benefits cease when an employee reaches maximum medical improvement from medical care (see discussion and exceptions below) or returns to regular or modified work or is able to return to regular or modified work unless vocational rehabilitation is offered and accepted.

If an employee is able to work part-time as a result of the injury, he is entitled to temporary partial disability benefits (CRS § 8-42-106). Temporary partial disability is generally calculated by taking 66 2/3 percent of the difference between the injured worker's full average weekly wage and his or her part-time average weekly wage. However, the true measure of temporary partial disability is the employee's temporary loss of earning capacity. In *Hendricks v. Industrial Claim Appeal Office*, 20 Colo. Law 117 (Colo. App. 1990) the claimant was employed at the time of injury at \$6.65 per hour for 41 hours per week. He then returned to light duty on a part-time basis for seventeen months. Although he was working 18% fewer hours, during the time he performed light duty his hourly rate was raised to \$7.23. In determining the claimant's temporary disability, the administrative law judge subtracted the claimant's light duty earnings from his average weekly wage at the time of his injury, and then awarded the claimant two-thirds of the difference.

The claimant argued that he suffered an 18% diminishment in his work capacity during his light duty employment, and therefore his temporary partial disability benefit should be calculated by using the number of hours he could work light duty, without taking into account that those hours were being compensated at a higher rate.

The Court of Appeals ruled that post-injury earnings are not dispositive of a loss of earning capacity for permanent partial disability purposes, and likewise they should not be for temporary partial disability purposes. The court pointed out that CRS § 8-42-106 provides that temporary partial disability benefits are calculated on the basis of two-thirds of the claimant's "impairment of . . . earning capacity." Since earning capacity means the loss of the ability to earn, not simply lost wages, the court held that to accurately determine temporary partial disability benefits for the claimant, the post-injury merit increases must be excluded from the calculation of the post-injury average weekly wage.

Generally, temporary partial disability payments end when the employee reaches maximum medical improvement or returns to work full time.

Even though an employee may be disabled, if he is able to perform light duty but he is terminated from his employment for reasons unrelated to his injury, he will not receive temporary disability benefits if he is at fault for his termination. *Monfort of Colorado v. Husson*, 725 P.2d 67 (Colo. App. 1986). This is one of the few places that the concept of fault has any place in the worker's compensation system.

If an injured worker's employment would have ended even without the injury (for example, seasonal employment), he is still entitled to temporary disability beyond the date the employment would have ended if the injury prevented him from finding alternate employment. *City of Aurora v. Dortch*, 799 P.2d 461 (Colo. App. 1990).

An injured worker is not entitled to compensation benefits while in jail or prison following conviction of a crime. CRS § 8-42-113; *Wood v. Beatrice Foods Company*, 15 Brief Times Reporter 387 (Colo. App. 1991).

B. Dual Employment

If the claimant is working more than one job at the time of the injury, and as a result of the injury is disabled for all employments, his average weekly wage will be based upon all employment. *St. Mary's Church and Mission v. Industrial Commission*, 735 P.2d 902 (Colo. App. 1986), cert.den.; *Jefferson County Public Schools v. Drago*, 765 P.2d 636 (Colo. App. 1988).

C. Average Weekly Wage

The Director of the Department of Workers' Compensation establishes the average weekly wage on or before July 1 of each year. Because both types of temporary disability (and permanent total disability) benefits are based on the employee's average weekly wage, this is a factor which must be carefully examined.

CRS § 8-40-201(19) defines what elements are included in the term "wages." These elements are:

1. The claimant's rate of pay under the contract of hire in force at the time of the injury;
2. Reportable tips;
3. The amount of the employee's cost of continuing an employer's group health insurance plan, and, when that plan is terminated, the employee's cost of conversion to a similar plan;
4. The reasonable value of board, rent, housing and lodging received from the employer.

If the employer continues to pay any of the above, it is not included in the determination of wages. Per diem payments are not wages unless reported for federal income tax purposes. Benefits which are not specifically enumerated in the statute cannot be part of the average weekly wage.

In many cases, the insurance carrier will calculate an average weekly wage simply by multiplying the claimant's hourly rate by 40. This does not take into account overtime, which is a part of the average weekly wage. *Sterling Colorado Beef v. Baca*, 699 P.2d 1347 (Colo. App. 1985). A reasonable method of determining the value of fringe benefits is by calculating their replacement cost to the claimant. *State Compensation Insurance Authority v. Smith*, 768 P.2d 1256 (Colo. App. 1988).

1988). In deciding the value of such items as food and lodging, the administrative law judge may rely on the testimony of the claimant. *Western Cultural Resource Management, Inc. v. Krull*, 782 P.2d 870 (Colo.App. 1989).

Commissions are included in the average weekly wage [*Oxford Chemical, Inc. v. Richardson*, 782 P.2d 843 (Colo.App. 1989)] as are annual bonuses. *Simmonds v. Eastman Kodak Company*, 781 P.2d 140 (Colo.App. 1989), cert.den.

A claimant's average weekly wage will not be increased by the amount of the employer's FICA contribution on the employee's behalf. *Gregory v. Crown Transportation*, 776 P.2d 1163 (Colo.App. 1989), cert.den., nor will the average weekly wage be increased by the amount of the employer's contribution to the Public Employees Retirement Association (PERA) if the claimant's PERA benefits have not yet vested. *Russell v. Colorado Division of Employment*, 687 P.2d 483 (Colo.App. 1989), cert. den.

CRS § 8-42-102 provides that, for hourly employees, the average weekly wage is calculated by multiplying the hourly rate by the number of hours per day the employee worked to find the daily wage; then multiply the daily wage by the number of days and fractions of days the employee worked per week. The Division of Workers' Compensation has the discretion to use any other method he wishes to fairly determine an employee's average weekly wage when the specified method will not do so. CRS § 8-42-102(3).

It frequently occurs that a highly paid worker may, because of general economic circumstances, find himself temporarily unemployed. If he takes lower paying temporary employment and is injured in that employment, his average weekly wage will be based upon what he was earning at the time of the injury. Previous earnings in other employment will not have any bearing on the ALJ's decision of the claimant's loss of earning capacity for permanent disability purposes. *Dugan v. Industrial Commission*, 690 P.2d (Colo.App. 1984).

D. Medical Benefits and Change of Physician

Pursuant to CRS § 80-42-101, the injured employee is eligible for medical, surgical, dental, nursing and hospital treatment and supplies which may be reasonably needed to cure and relieve the employee from the effects of his injury. The employer or insurer has the right to select the treating physician for the injured worker [CRS § 8-43-404(5)(a)], but this must be done at the time they have knowledge of the injury. In *Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo.App.1987), it was held that if the employee selects a medical provider after the employer or insurer has failed to do so, he may continue with that physician even though the employer may later direct him to a different doctor. A claimant who obtains treatment from a medical provider who is not authorized, however, is liable for the costs himself. *Pickett v. Colorado State Hospital*, 513 P.2d 288 (Colo.App. 1973).

The injured worker is entitled to other benefits which may not be thought of as traditional medical expenses. These include room and board while undergoing treatment [*Industrial Commission v. Pacific Employers Insurance Company*, 682 P.2d 513 (Colo.App. 1949)], hot tubs (*City and County of Denver v. Industrial Commission*, 682 P.2d 513 (Colo.App. 1984)), mileage for travel to treatment (*Sigman Meat Company v. Industrial Claim Appeals Office*, 761 P.2d 265 (Colo.App. 1988)), and housekeeping and attendant services (*Atention v. Quality Care, Inc.*, 791 P.2d 7 (Colo.App.1990)).

Due to the great increase in industrial medicine clinics which cater to the needs of employers and insurance carriers, injured workers are increasingly attempting to change

from the company-authorized doctor. Generally, once an authorized medical provider has been selected, the injured worker may not change to another physician without the approval of the employer or insurer or the Division of Labor. However, a claimant may request a new authorized treating physician by filing a written request with his employer or insurer [CRS § 8-43-404(5)(a)]. The employer or insurer has twenty (20) days to provide a written response pursuant to the request. If the response is not made within that time, the employer or insurer is deemed to have waived any objection to the requested change. Another way of changing physicians is for the employee to obtain a referral from an authorized physician. While no one's permission is needed for such a change, in order to provide that the referral took place, it is best to obtain it in writing. This protects the employee against the employer calling the referring physician and trying to get the doctor to "forget" that such a referral was made. In *Greager v. Industrial Commission*, 701 P.2d 168 (Colo.App. 1985), it was held that any referral made in the normal course of authorized treatment is valid. However, if it appears that a referral is merely an acquiescence by the authorized treating physician of the claimant's selection of a new physician, the new physician may be considered unauthorized.

E. Maximum Medical Improvement

Maximum medical improvement is defined as "a 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." CRS § 8-40-201(11.5).

The concept of maximum medical improvement is important because it usually signals the end of temporary benefits. Also, without a finding of maximum medical improvement a claimant cannot obtain an award for permanent disability.

Whether an employee has reached maximum medical improvement is a question of fact, and the administrative law judge is not bound by the opinion of a physician. *A & R Concrete Construction Company v. Lightner*, 759 P.2d 831 (Colo.App.1988). However, the rules of the Division of Labor allow an insurance carrier to terminate temporary benefits without a hearing when the treating physician finds that the claimant has reached maximum medical improvement. While this action can be contested before an ALJ, the employee could be financially devastated while waiting for the hearing.

For injuries occurring on or after July 2, 1987, vocational rehabilitation is not a benefit which can be claimed. Therefore, temporary benefits end on the date of maximum medical improvement. However, if the insurance carrier voluntarily offers vocational rehabilitation (which usually only happens in cases of potential permanent total disability) temporary benefits continue after maximum medical improvement and throughout the vocational plan [CRS § 8-42-105].

V. GETTING THE EMPLOYEE OFF WORKER'S COMPENSATION

A. Termination of Benefits Through Admission

The statute at Section 8-42-105, entitled temporary total disability, provides that:

Temporary total disability payments shall cease when the employee reaches maximum improvement from medical care or returns to work or is able to return to work or as otherwise determined by the director.

Likewise, Section 8-42-106, "temporary partial disability" provides:

Temporary partial payments shall cease when the employee reaches maximum improvement from medical care or as otherwise determined by the director.

Even though the statute is mandatory by use of the word "shall", the Rule of Procedure at Part IX, provides for the termination of disability benefits by an admission of liability. This Rule provides that in the case of claims that arose before July 2, 1987, at 4:16 p.m., that temporary disability could be terminated:

1. By filing an admission of liability together with a report from a treating physician stating that the claimant has reached maximum medical improvement and is released to return to an occupation which the claimant regularly performed at the time of injury.
2. By filing an admission of liability together with a report from a treating physician stating that the claimant has reached maximum medical improvement and a director's determination that the claimant is not eligible for vocational rehabilitation services.
3. By filing an admission of liability which is supported by a written report from an employer stating that the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned; provided that such admission shall admit temporary partial benefits. . .
4. By filing an admission of liability which is supported by a written statement from the claimant indicating that the claimant has returned to work, and setting forth the wages paid for the work to which the claimant has returned; provided that such admission shall admit temporary partial disability benefits. . .

B. With respect to terminating benefits by an admission for cases that arose after July 2, 1987, the rules provide that disability benefits can be terminated without a hearing:

1. By filing an admission of liability together with a medical report from a treating physician stating that claimant has reached maximum medical improvement.
2. By filing an admission of liability together with a medical report from a treating physician stating that the claimant is able to return to an occupation which the claimant regularly performed at the time of injury.
3. By filing an admission of liability which is supported by a written report from an employer stating that the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned; provided that such admission of liability shall admit for temporary partial disability benefits. . .
4. By filing an admission of liability which is supported by a written statement from the claimant indicating that the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned; provided that such admission of liability shall admit for temporary partial disability benefits. . .
5. This section shall not apply in cases where vocational rehabilitation is offered. . .

These rules are being strictly followed and enforced by the Division of Workers' Compensation.

C. Termination of Benefits By Petition

If the facts of the case do not fit within the foregoing Rules of Procedure, then benefits can only be suspended upon the filing of a Petition To Suspend setting forth the grounds for such suspension. The Division of Labor has a prescribed form for this Petition. The claimant is given an opportunity to respond to the Petition to Suspend within thirty days. If the claimant does not object to the suspension, then the Petitioner may apply for an Order suspending such benefits. If, on the other hand, the claimant does not object to the suspension, then the matter is scheduled for hearing before an Administrative Law Judge.

D. Use of Re-employment Statute

The legislature, through CRS § 8-42-107.6 provides an incentive to the employer to re-employ injured employees at their preinjury rate of pay, including any pay increases to which they would have been entitled, by providing a premium dividend of up to 10%.

E. Permanent Partial and Permanent Total Disability.

An employee is permanently totally disabled is if he is unable to earn any wages in the same or other employment. CRS § 8-40-201(16.5)(a). This definition has been changed to delete any reference to "suitable, gainful" employment and now simply requires that the employee not be able to earn wages. A disabled employee will not be awarded permanent total disability if he is capable of rehabilitation that would allow him the earn wages if any type of employment and he refuses an offer of employment or the employer's offer of vocational rehabilitation.

Section 8-42-107, although the title remains "permanent partial disability", nowhere else in the Section is the word "disability" used. The new terminology is "permanent medical impairment" and is handled in one of two ways. For those injuries which fall under the schedule, including the loss of, loss of use of, or partial loss of use of an extremity or injury falling under the schedule, the payment of benefits is exclusively under the schedule. The scheduled benefits are paid at the rate of \$150.00 per week.

The other provision with respect to permanent medical impairment is found at Section 8-42-107(8). This provision provides:

When an injury results in a permanent medical impairment not set forth in the schedule of injuries, the employee shall be limited to medical impairment benefits calculated as provided in this subsection.

Once the employee has reached maximum medical improvement, the percentage of impairment is determined according to the American Medical Association Guides to the Evaluation of Permanent Impairment, 3rd Edition, as it is in effect on July 1, 1991. The physician who determines the level of medical impairment must be accredited to do so. Merely being a licensed physician is not sufficient for accreditation.

The statute then provides that the medical impairment rating from the AMA Guide is multiplied by an age factor and by 400 weeks and is then calculated at the temporary total disability rate in effect. The resulting number is the permanent medical impairment benefit. Up to \$10,000 of any award is paid in a lump sum unless the injured employee requests otherwise.

Section 8-42-111(3) provides that a disabled employee, capable of rehabilitation, which would enable the employee to earn any wages in the same or other employment, who refuses an offer of employment by the same or other employer or an offer of vocational rehabilitation paid for by the employer, shall not be awarded permanent total disability.

Additionally, at Section 8-40-201, definitions, a new definition for permanent and total disability is found at subsection (16.5) provides:

"Permanent total disability" means the employee is unable to earn any wages in the same or other employment. The burden of proof shall be upon the employee to prove that he is unable to earn any wages in the same or other employment. The employee is awarded 66 2/3 percent of average weekly wages up to a statutory maximum until death. CRS § 8-42-111(1).