Compensation Quarterly

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THE WORKERS' COMPENSATION UPDATE

Workers' Compensation Commission Mediation Program

An Interview with Chairman John A. Mastropietro

SAC – Attorney Scott A. Carta
JAM – Chairman John A. Mastropietro

SAC: Good morning Chairman.

JAM: Good morning Mr. Carta.

SAC: Thank you for taking the time to spend with me for Compensation Quarterly.

JAM: It's my pleasure.

SAC: We are going to discuss the mediation program that became effective on July 1, 2015. When did the process of developing this program begin?

JAM: Well, the process for this specific program probably began about 8 months prior to its rollout. But the mediation program evolved out of a larger issue that we were dealing with which goes back a considerable period of time. That issue is, how do you deal with cases that are complicated, most often with multiple issues to be litigated, resulting in multiple formal hearing sessions in order to bring it to a conclusion? We had been struggling with the idea of scheduling the formal hearing from beginning to end and not have the situation where there will be a session and then another session will be scheduled at some point in the future. For this group of complex cases, we're going to begin it, go right through to the end. That provides some degree of concern for us or difficulty, I should say, for scheduling. Because obviously, every day that a commissioner is doing that case, there are a multitude of informal hearings that are not going to be heard by that commissioner. Then we kind of toyed with the idea of perhaps echoing something that the judicial system did in creating a complex litigation docket where we would then move these cases to where the commissioner believed that it 1) would require multiple sessions, 2) is complicated and would require more

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IN THIS UPDATE

Continuing Legal… Excellence

by Joseph Passaretti, Workers' Compensation Section Chairman

Fear of what we do not understand. Belief based on that which is assumed, not that which is known. These are the demons that underlie a culture of dissent, denial, and even attack when we allow someone else to do our thinking for us. My focus here is not on a particular issue, but the general notion of mandatory continuing legal education for lawyers in the state of Connecticut.

Though the idea of continuing legal education has its origins in the early twentieth century, our jurisprudence first began a national discussion of mandatory CLE in the early 1970s. Ironically, MCLE was born out of fear. Fear of a president stealing secrets and making secret tapes. Fear of lawyers sending our sons to die in a war they did not understand. These attitudes translated into a genuine distrust of the legal profession, leading nine states by 1975 to adopt some form of mandatory continuing legal education. This era also saw the promulgation of a national ethics examination (MPRE) that most states now require new lawyers to pass before bar admission.

Lawyers being better lawyers is not about politics, it is not about money, it is about honor. A call that leads us to being better than we are, reaching our full potential and exceeding it, being a paragon instead of a punchline. When it comes to pass that a number of our brothers and sisters in the law do not see this imperative, it indeed falls to us who do to act. This is not a paternalistic power grab, it is a call to duty. A duty owed not to ourselves, but to the public we serve.

I will not speak to the particulars of the extant arguments in favor of, or in opposition to, MCLE in the form it has been most recently presented. But to those who seek to enter the fray, I challenge you: Educate yourself. Do not argue what you think or have heard are the issues. Engage in an informed debate, pro or con as the case may be, but do so with the goal of furthering our profession, not defending its right to stagnation.

The time has come for our state to adopt mandatory continuing legal education. For those of you who join me in the ranks of certified specialists, this has been our way of life since 2001. No one was killed, no one got rich, and no one went bankrupt. It all turns out okay, I promise you. For those of you who think you have nothing left to learn, then I challenge you: Teach. Write. Mentor. Mandatory CLE is not just about sitting in a classroom, or staring at a Power Point, and it's certainly not about sitting in your car waiting for the sound of an electronic beep. It is about becoming a better community of lawyers, a practice elevated to a level of public pride, confidence, and even hope, the likes of which our state has never seen.

Joe

Editor's Note: Joseph Passaretti, Jr. is Chair of the Workers' Compensation Section and Partner at Monstream & May, LLP in Glastonbury, Connecticut

The Bionic Man: *Fact or Fiction*

By Michael J. Finn

Advances in the fields of medicine, pharmacology, physics, engineering, dentistry and metallurgy have resulted in greater life expectancy for humanity and a greater understanding of the human body. While there are a multitude of benefits associated with the advances in science, this article focuses on the prosthetic and its application to an injured worker who has sustained an amputation which arose out of and in the course of employment. For purposes of this article, the definition of prosthetic is limited to a durable medical product utilized to replace an amputated appendage. While technically a dental implant, a dental bridge, or even dentures could qualify as a prosthetic, they are omitted from this discussion. Additionally, artificial disc replacement, hardware associated with a knee replacement either partial or total, hardware associated with a hip, shoulder or foot replacement, or eyeball or penis prosthetics, are likewise omitted.

The initial medical treatment after an injury focuses on keeping the injured employee alive, and at times this treatment itself may dictate the necessity of an amputation. The issue of a prosthetic arises after the traumatic injury has healed. It is at this time that the injured employee may request an evaluation for a prosthetic, or a prescription is generated by the treating physician.

The Act does not have a section that sets forth the duty of an employer to provide a prosthetic device if there is a compensable amputation as a result of a work-related accident. The legal basis to provide a prosthetic arises from the language of C.G.S. § 31-294d. This "reasonable or necessary" language has been interpreted to extend to the duty to provide a prosthetic. See C.G.S. § 31-294d; Attardo v. Temporaries of New England Inc., 5858 CRB-213-7 (June 19, 2014). As a general rule, respondents are required to provide the claimant with medical care that the authorized treating physician deems reasonable or necessary. Specifically, C.G.S. § 31-294d(a)(1) provides:

> The employer, as soon as the employer has knowledge of an injury, shall provide a competent physician or surgeon to attend the injured employee and, in addition, shall furnish any medical and surgical aid or hospital and nursing service, including medical rehabilitation services and prescription drugs, as the physician or surgeon deems reasonable or necessary. The employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall be responsible for paying the cost of such prescription drugs directly to the provider.

Shenkel v. Richard Chevrolet, Inc., 4639 CRB-8-03-3 (March 12, 2004).

The duty to provide a prosthetic for a work-related amputation is not of recent vintage. As early as 1918, the Connecticut Supreme Court explored whether requisite "surgical aid," now codified as C.G.S. § 31-294d, required an employer to provide an artificial leg after the claimant's leg was amputated as a result of a work related accident. Olmstead v. Lamphier, 93 Conn. 20 (1918). In Olmstead, the Court performed a detailed analysis and opined that "Our act contemplates the furnishing of all the medical and surgical aid that is reasonable and necessary." Id. at 24. The Court further noted that "[t]he duty of the surgeon does not end with the healing of the stump." Id. at 25. The Court further indicated that "surgical aid" is a term of medical significance and cited Keen's Surgery vol.5, p. 951, for the proposition that "[a]s soon as all sensitiveness has left the end of the bone, an artificial limb should be fitted and the patient urged to make efforts to use the extremity." Id. at 25.

The Court in Olmstead opined that the cost of an artificial limb was similar to the cost of bandages and ointments used by the surgeon in treatment of the patient and concluded that such costs are included in "surgical aid." Id. At 25. While the Olmstead Court analogized the artificial limb to the cost of bandages and ointments, the prosthetics of old are not the prosthetics that are currently available.

While the injured amputee must procure a prescription from his or her physician for a prosthetic, the presentation of this prescription to the respondent or its representative will not result in a carte blanche command in favor of the amputee. The applicable standard of review remains reasonable or necessary and it is the commissioner who must decide what is reasonable or necessary.

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attention to detail, and 3) not something that is going to be done in the normal course of a day, with any relative ease. While the idea of a complex litigation docket is not out of the question, the mediation program came more and more into view as a potential alternative. Let's face it, alternate dispute resolution is something that is very prevalent in the law today, or procedurally at least, in the law today. In many ways, the workers' compensation system was kind of the precursor to that. Our system was designed on the basis of resolving issues in an informal way most of the time, so that we don't need to go to final adjudication. So, that having been said, that being our background, if you will, our history, we decided to move into the mediation aspect, instead of creating a specialized docket devoting just one or two commissioners to it. By one or two, I don't mean that there would be one or two commissioners that would be hearing that docket continuously, but there would be a rotation. At any given time there would be one or two commissioners who would be dedicated to the complex litigation docket and those would be rotated on occasion. But in this case, we decided to instead institute this program, to see how this program works with respect to resolving some of these issues without having to do it within the normal course of the informal/pre-formal process. So, we're monitoring it, we'll see how it goes. The difference between this and the complex litigation docket is basically how the case gets there. With a complex litigation docket, it is the commissioner who makes the determination that this issue is complex enough that we need to devote considerable time and talent to it and that's going to be done outside of the scope of the normal course of business in the workers' comp commission. The mediation process is attorney driven. The commissioner doesn't decide this case is going to mediation, but rather the two attorneys involved say, you know this might be one of those cases where if we had the attention of a commissioner devoted strictly to this for a period of time, maybe we can take these complex issues and get them resolved. So, that's where we're going. This is kind of the hybrid of what I wanted to accomplish. We're going to give this a try and see how successful it is. If it's successful enough, we won't need a complex litigation docket. Or maybe the complex litigation docket is something in the future that becomes a very small component because this mediation program takes care of most of it. Time will tell.

SAC: Now what is the process if the parties decide they want to go ahead with mediation?

JAM: There is a memorandum that identifies what the process entails and identifies the commissioners who have agreed to serve as mediators on the system. I don't know if you've seen that or not.

(**Editor's Note:** the Memorandum is number 2015-04 and can be found on the WCC website under "Memorandums" which is under "Resources")

If the attorneys decide this is an avenue they wish to pursue, they contact the Oak Street office and we will then review, only for purposes of availability, what request is being made of the commissioner. If we have someone who is requesting Commissioner X be the mediator and that commissioner has already got six or seven backed up, we then contact the attorneys and say do you want to take another look at this, because we're not going to be able to accommodate this request, with this commissioner, for a considerable period of time. That's why we ask them to give us a first and second choice. Then, at that point, we will contact the individual district, get a little flavor for their caseload in that district and whether or not that commissioner can afford to take time away from the district's business in order to devote time to this. Assuming we do that, we would notify the district that a request has been made, Commissioner X has been requested and please forward it to Commissioner X. At that point, it's for Commissioner X to contact the two attorneys to begin the process. We do not provide or require a rigid component of obligations that need to be met. That's up to the commissioner. So that can involve the commissioner having a conference call with the two attorneys to get a flavor of what's going on with the case so the commissioner can let them know what information is necessary. Or it may require, and sometimes this does happen, the attorneys normally are regular participants in the district where the particular commissioner has been asked to serve, then they get together for a half hour and just discuss the why's and the wherefore's, to make a determination as to what is needed. Then it would

be up to the commissioner to tell them whether a position paper is required or what kinds of documents are to be given prior to the mediation session so the commissioner can get up to speed and be in a position to be as effective as possible on the day of the mediation.

SAC: So that was one of the questions I had – What is required of the parties prior to the mediation, such as a position statement? Is it something that is required all the time or is it up to the particular commissioner?

JAM: It is up to the particular commissioner. It is encouraged as a way to focus the parties. Oftentimes requests are made and I'm trying to prevent as much shoot from the hip as possible when we get to the session so that there is a thought process here, so that it is going to be as productive a session as possible. Oftentimes, things like position papers, et cetera, force the parties to kind of think in that vein, so it's encouraged for those reasons, but the ultimate decision as to what is needed or not needed is left to the commissioner who is chosen as the mediator.

SAC: On average, from the time that the mediation is requested, how long does it usually take to actually have the mediation?

JAM: Depending on the commissioner, somewhere between four and eight weeks. But that could change, for instance, if you're requesting it in the summer when the commissioner has already requested two weeks' worth of vacation time.

SAC: Are the clients for either side required to attend?

JAM: Unless physically or geographically impossible, the claimant is required to be there. The respondent is required to have someone who has the authority to act on behalf of the carrier available by telephone.

SAC: I know each case is different, but on average how long do the mediations take?

JAM: We leave that request to the attorneys. Most of the attorneys have been requesting a half-day session. We have found that in a few of them, they have required an additional half-day session. I know that none of them have gone more than the equivalent of a full day, so far. Most are within the half day, but again as I said there have been a couple where it has gone a full day, but in two separate sessions. There have been a couple where it has gone a full-day period. But how long is it generally going to take? Usually at the request of the attorneys, they are the ones who are intimately knowledgeable about a case, so when we are requesting the time to block out, from our perspective, so that commissioner is available to do it, the attorneys usually helps us gear how long it is going to be.

SAC: Can you describe what occurs at a typical mediation?

JAM: It can vary in any way that you have seen mediations occur in any other setting. The parties get together, articulate where things stand, then separate. The commissioner will meet with one, then meet with the other, and do a little bit of what I call shuttle diplomacy, back and forth between the conference rooms to try to define how large a schism exists between the two parties. There are often times when the commissioner will lean on someone in the sense that, come on, you're being unrealistic – that's not the value of this case, or that expectation is kind of a pipedream. Now let's get down to what really can happen in this instance so that your client is protected, the system is providing you something that's within the capacity of the system to provide, and we all go about our way with as much of a win-win as we can get. So those kinds of things are happening and when those kinds of discussions take place, that's when the claimant needs to be consulted. The person who is on call for the respondent needs to be available. The commissioner can do that directly with the parties. There have been instances in which the commissioner has met with the claimant without the claimant's attorney there if claimant's attorney is in agreement. The two attorneys are the ones who are going

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to some degree control the procedure, maybe not the process, but the procedure. Now if they put too many restrictions on it, the commissioner is going to say thanks for stopping by, let's set it down for a formal and we'll resolve it that way, because there is not a real willingness to give and take.

SAC: Should claimants be expected to be asked questions by the commissioner?

JAM: Yes and no. Sometimes, as you are well aware, a claimant's perspective is not based on the law itself, but is motivated by the treatment that the claimant has received, whether that is by an employer or whether it is by an insurance company, so a lot of what the claimant is feeling and what the claimant wants to do is generated out of hurt, generated out of anger sometimes, feelings that they have been treated inappropriately and as a result, this is their time to make their stand and let everyone know that. Oftentimes, that's kind of a healing process the claimant can go through with the commissioner because there is someone there that he or she can really let loose and let them know how they feel. So in that respect, yes, there may be questions that are posed to the claimant. It can also be kind of an instructional thing and educational kind of thing. The claimant says "I understand what you're saying, but, I was in such great pain." I get it, I appreciate it, I understand it, I sympathize, but the system doesn't recognize pain and suffering as a reimbursement for what you have been through. I can't manufacture that which doesn't exist. So do I recognize it and sympathize with it – yes, but no matter how much pain you suffer – you're still not going to get anything for it. It is an educational process. Even when their attorneys have already suggested it to them a half a dozen times if not more, I've seen attorneys walk out of the room saying I think I've used the exact same words you used, why you got through and I didn't, I don't know. I think I've said exactly the same words you're using, the same inflections of the voice, etc. I don't know why he listened to you and he wouldn't listen to me. It's just human nature.

SAC: Do you have any statistics as to how many mediations have taken place since the program's inception?

JAM: We're in the 20's, between 20 and 30. I think we are about 26 now, give or take one or two. There are about half a dozen that are still in the pipeline to be mediated.

SAC: On the ones that have been completed, what are the percentages that have resulted in resolution?

JAM: There are usually several issues, for example, compensability followed by physical therapy, followed by temporary partial or possibly an affirmative defense. But if you just term success to mean it did not need to go to a formal hearing, the issues have been resolved, one way or another, then at about 80%. So it's working out very well.

SAC: That's great. What has the feedback been that you've received?

JAM: So far I've gotten very good feedback in two ways. I've gotten very favorable and I've gotten very good and constructive suggestions for changes or tweaking of the system. As you are aware, we have a Legal Advisory Board that has been established. They were very helpful in articulating ways in which we can cause documents that are presented during the course of the mediation to be segmented out so that they are not included in the general file so that should a mediation not be successful, we can avoid having the file tainted by positions taken that were solely for purposes of mediation, but not for purposes of continuing the case in a solely litigated manner. We have a little bit of a difficulty in that regard because since we are under the executive branch and not under the judicial branch, we're subject to freedom of information requests and so, to some degree, that becomes an issue we need to deal with. But what we are doing with those is adopting the same procedure that we are using with the informal and pre-formal commissioner notes. What we are doing is segmenting them out. When it gets to go to a formal, they are put in separate envelopes and held aside. The case then continues through to its end result and once the end result is done, the commissioner issues the decision, the case is now final, then we take that packet of information that otherwise has been segmented

out and put it back in the file and it goes to archives. So it eventually ends up back in the file so it meets FOI requirements, et certera, should it ever require, but it isn't used against the parties in any way during the course of the formal hearing.

SAC: Are there any final comments you would like to add?

JAM: So far, I've been very pleased with the way things are going. I would encourage those who utilize the services to advise ways in which changes could be made to make it more productive or proactive, and those are primarily procedural. I've had a couple of attorneys who have contacted me saying the way that the commissioner went about doing this, how he met with whom or whatever, didn't think that that was the best way to go. Then next time around they need to choose a different commissioner. You know, everybody has their own way and style of doing things. But it's not a cookie cutter type of thing. Every case has its own set of facts that may require variations on a theme so I can't sit here and suggest that this is the procedure that is to be utilized in every case and every case will be successful if this procedure is utilized. That's just not going to happen. So, procedurally, like I just explained, keeping the paperwork segmented out so that clients are not going to feel as if they could potentially be compromised by providing this information in an informal mediation atmosphere, those kinds of procedural suggestions I very much welcome. As things go on we will try to make the adaptations necessary to make it the most successful program possible. Again, as I said, we'll monitor it for another year or so, then we'll see whether or not it's doing what it's supposed to do, or what we hoped it would do and whether or not that negates the need for a complex litigation docket. I foresee at some point in the future that being the end result, with complex litigation being very truncated, very few cases, very focused on those that are the most complicated, with mediation being the hybrid that's going to take care of the bridge between the pre-formal process and complex litigation in order to resolve as many cases as possible.

SAC: Thank you very much. I appreciate your time Chairman.

JAM: My pleasure. Thank you.

Retreat to the Exotic
Workers' Compensation Retreat 2016
San Juan, Puerto Rico

by Jeremy Brown

From March 6 to 8, the Marriott Stellaris Resort and Casino located on stunning Condado Beach in San Juan, Puerto Rico served as home for the first annual Workers' Compensation Retreat, formerly known as the Exotic Seminar. In planning this year's seminar, I realized that after two decades, "exotic" no longer described what this seminar truly means - community. As a community, the workers' compensation section retreats each year to learn, relax and strengthen bonds that make our section so special. While future retreat destinations will remain elite, the focus is, and should always be, on maintaining the uniqueness of our section.

That being said, San Juan served a spectacular exotic location for the first retreat! Although the weather did not always cooperate, attendees were greeted with eighty plus degree weather and a cool ocean breeze. The thirty registrants who attended this year's seminar learned from Michael Karnasiewicz, M.D., Dean Mariano, M.D., Frank Pallaria, R.Ph., Commissioner Randy Cohen, Commissioner Charles Senich and Attorney Amado Vargas as they addressed pre-existing conditions, opioid abuse and misuse as well as the complex world of pain management.

While spending time together sightseeing and sipping mojitos may create memories, the time spent in the classroom improves our skills as workers' compensation practitioners. Dr. Mariano opened the seminar with a thorough and lively presentation aptly titled, "Pain Management 101: For the Busy Attorney." The presentation guided the attendees through the basics of pain management. Dr. Mariano discussed treatment methods for localized pain and how to identify and address addiction in drug recipients. He also explained the substance abuse/misuse detection methods, such as mouth swabs, urine screens and metabolic testing.

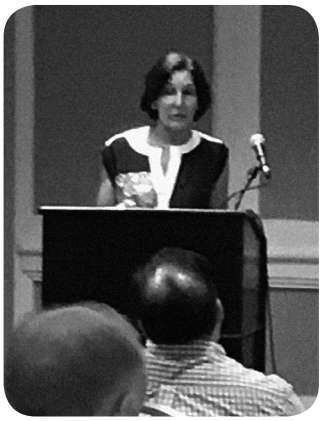
Dr. Karnasiewicz followed Dr. Mariano with a comprehensive review of common underlying or pre-existing conditions that frequently present in the adult population. Dr. Karnasiewicz used a number of fact patterns to give practical examples of the interplay between a patient's history and the impact of a newly suffered injury.

Day one of the seminar concluded with an energetic discussion led by retired Commissioner, Amado Vargas. Attorney Vargas discussed changes that have occurred in workers' compensation over the years, both positive and negative, with an eye towards the need to correct past wrongs. Principally, Attorney Vargas addressed the hole left in our statute by the removal of transfer provisions relating to the Second Injury Fund, and in particular, how it impacts litigation over pre-existing conditions.

Commissioner Cohen, buttressing the presentation of Dr. Karnasiewicz, discussed a commissioner's perspective towards pre-existing conditions. This talk emphasized the uncertainty left in the wake of *Deschenes* and the calming of the waters by the *Sullins* decision. Commissioner Cohen presented various fact patterns that made clear the difficulty that persists in determining compensability where pre-existing conditions exist. Needless to say, unanimity could not be reached.

Commissioner Senich led a discussion of ethics and current issues in workers' compensation. The topic always leads to spirited debate and it was no different this time around. Commissioner Senich served as an able moderator. In discussing current issues in workers' compensation, he encouraged practitioners to remain civil and to work towards resolution of matters prior to entering a hearing room.

Frank Pallaria, R.Ph., a representative of the Injured



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Workers' Pharmacy (IWP), joined our section for the second time in recent years, speaking on various issues relating to opioid drugs and alternatives. While the topic can often be a bit dry, that is not a concern when Frank is presenting as he keeps the crowd at attention by weaving any number of stories from his life as a pharmacist into the discussion. Of note, were the recent formulaic changes made to many common narcotic medications with the goal of deterring abuse.

I would like to issue a special thanks to IWP for once again sponsoring this event. IWP's sponsorship assists our section in covering the many costs associated with this event. Its support of our section and the work it does to assist the injured worker and compensation practitioner does not go unnoticed.

Lastly, I would like to thank Attorney Joseph Passaretti for, once again, serving as the Master of Ceremonies and to each and every person who attended this year's event. For those of you with a Facebook account, please visit www.facebook.com/workerscompretreat for news regarding the next Retreat.

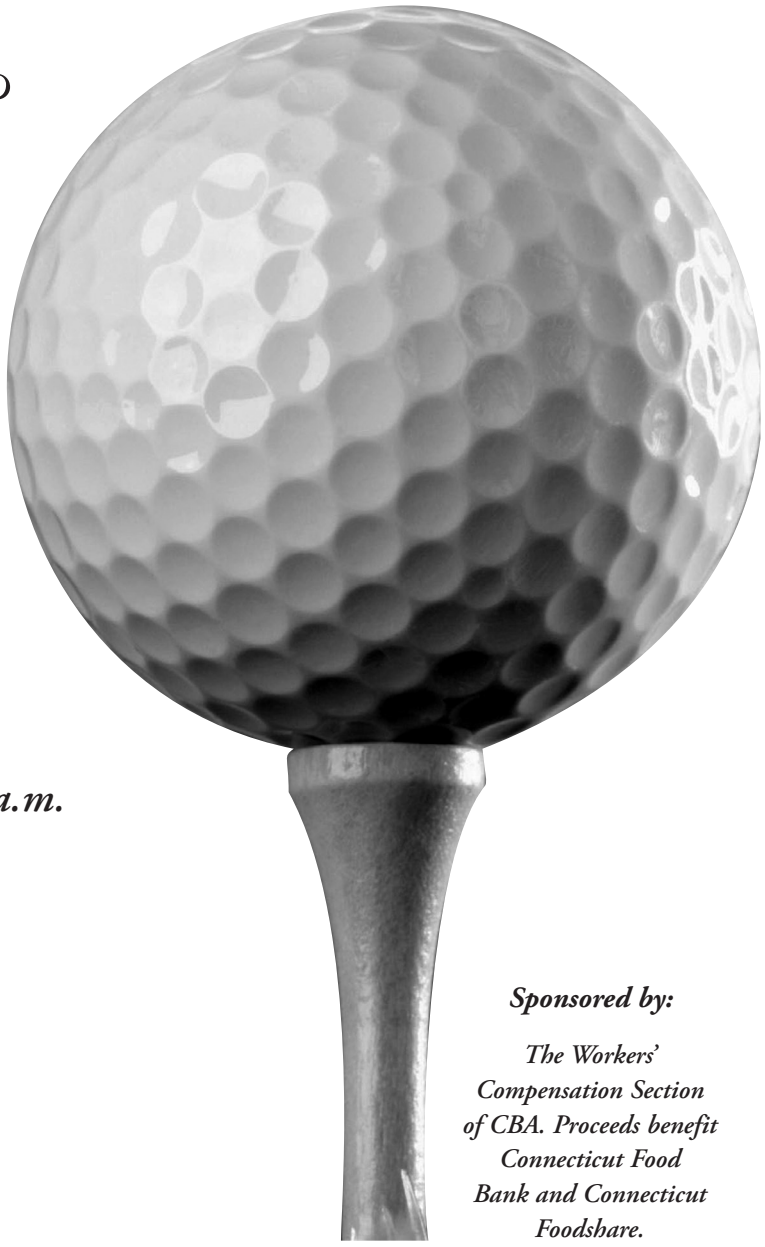
Editor's Note: Jeremy Brown is an attorney at McCarthy, Coombes & Costello, LLP in Hartford, CT and coordinator of the Workers' Compensation Retreat.

All Commissioners, Workers' Compensation Practitioners and Staff Members of the Workers' Compensation Commission Offices Are Invited to Participate at the…

18th Annual Verrilli-Belkin Workers' Compensation Charity Golf Event

Shuttle Meadow Country Club
51 Randeckers Lane
Kensington, CT
860-229-6000

Thursday, Sept. 15, 2016



- *Registration Begins at 10:30 a.m.*
- *Lunch will be from 11:00 to 11:45 a.m.*
- *Shotgun Start at 12:00 p.m.*
- *Cocktail Reception at 5:00 p.m.*
- *Dinner at 6:00 p.m.*

Connecticut Bar Association

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> Reasonable or necessary medical care is that which is curative or remedial. Curative or remedial care is that which seeks to repair the damage to health caused by the job even if not enough health is restored to enable the employee to return to work. Any therapy designed to keep the employee at work or return him to work is curative.

Cummings v. Twin Tool Manufacturing, 2008 CRB-1-94-4 (April 12, 1995). (Citation omitted)

These prosthetics are not those worn by Captain Ahab or preferred by Captain Hook. The range of modern prosthetics available is light years away from those of the late 19th Century. There is variation in the type of prosthetic, the composition of the prosthetic, and the physiological anatomy necessary for some prosthetics. For example, there is the sport prosthetic (Blade Runner [Oscar Pistorius]; Ronan Tynan medalist 1984, 1988 Summer Paralympics, MD, Tenor), the "dress" prosthetic (Ronny [Nicholas Cage] Moonstruck Film; Chubbs Peterson [Carl Weathers] Happy Gilmore film) and the old standby prosthetic arm with an articulating hook. The current technology associated with hand/elbow/ wrist prosthetics continues to evolve from the hook, to the myoelectric prosthesis which is externally powered and utilizes electrical signals generated naturally by the amputee's own muscle, to the state of the art iLimb produced by Touch Bionics. The iLimb prosthetic is externally powered, utilizing electric impulse from muscle, assisted by a grip chip, proximity control and app control to offer the amputee a variety of different tasks from the multi-articulating prosthetic hand. This prosthetic can change function via a cell phone app thus eliminating the need for multiple devices. The hardware of the prosthetic truly is similar to the endoskeleton of the Terminator (The Terminator [Arnold Schwarzenegger] The Terminator Franchise). This prosthetic is covered by a skin tone synthetic resembling a tight-fitting glove. To date, science has not produced a skin-like covering for the prosthetic that bleeds and is capable of regeneration, thereby necessitating the need to purchase a "case of skin" that may be changed by the amputee as the skin-like covering of the prosthetic wears out.

It should be anticipated that an amputee requesting a prosthetic will demand a top of the line, state of the art, cutting-edge prosthetic. A respondent can expect a plea by the claimant to the commissioner that the Workers' Compensation Act is remedial in nature and the broad humanitarian nature of the Act should be sufficient basis for the "best" product available. The entitlement to a particular prosthetic, or numerous prosthetics, or a prosthetic for a particular activity, is subject to the reasonable or necessary qualification of all medical treatment in the Workers' Compensation setting. The amputee claimant must justify the desire for a particular prosthetic. The treating physician and the prosthetist, working in concert along with the amputee, must put together an argument to justify the desired prosthetic. In this regard, one should recognize that the physician alone does not provide the exclusive rationale for a particular prosthetic. The physician refers the amputee to a prosthetist to assess the integrity of the stump, the probability of success in maximizing the use of the particular prosthetic, the motivation of the amputee to learn and utilize the prosthetic, as well as commenting on the training program, cost of the prosthetic, refit, and general maintenance of the device. The respondent is entitled to its own evaluation by a physician and prosthetist.

The parties must be concerned with the cost of the device, the maintenance of the device, the training involved, the age of the claimant and his motivation, the life expectancy of the device, the ability to maximize the function of the prosthetic as well as the suitability of the amputation site (muscle mass, sensation). The commissioner thereafter, using the standard of reasonable or necessary medical treatment, will render an opinion on the propriety of the device desired. The reasonable or necessary standard does not mandate that the "best of the best" prosthetic be selected and approved by the commissioner. Nor does the reasonable or necessary standard dictate that the lowest and cheapest prosthetic be provided. From that point forward, the analysis gets more complicated. Thus, a respondent must anticipate that the quality of the prosthetic is going to be very good and the cost is going to be high regardless of which prosthetic is chosen. Since the prosthetic is a quality durable device, one can expect that the basic styling will be proven technology, but with the up-grades, the prosthetic becomes a high-tech item. Therefore, the maintenance necessary to keep it working properly is also costly. The prosthetic will require some training. A prosthetic can be damaged easily if a claimant does not provide the necessary care and maintenance properly. Lastly, there will be the claimant who gets a performance prosthetic and then determines that it really demands more attention and care to use correctly than he or she is willing to provide. This could result in a high-priced prosthetic sitting on a shelf collecting dust.

One must be sensitive to the amputee claimant and his or her desire to be made as whole as possible. This is what drives the amputee claimant's choice of prosthetic. The commission has adopted C.G.S. § 31-294d as the statute that justifies the duty of the respondent to provide a prosthetic. The commission interprets reasonable or necessary medical treatment to include a device that assists in getting the claimant back to work. The "back to work" clause is also a factor in limiting the type of prosthetic approved. While the parties must acknowledge that the type of prosthetic requested will most likely be on the more expensive part of the equation, there is no outright mandate that "top of the line" is always required. The applicability of the prosthetic to the employment may be one of the key factors in the determination of the type of prosthetic required. As in Attardo, supra, the opinion of a physician and a prosthetist are instrumental in the prosthetic ultimately provided. The analysis incorporates the design of the prosthetic and the function sought by the claimant. Thus, the prosthetic ultimately approved by the commission will be one justified by the opinion of the physician and the prosthetist, with a view by the commissioner of the prosthetic which is most suitable for the type of work anticipated by the claimant. Id.

The type of prosthetic, the cost of the prosthetic, the care necessary to fit the prosthetic properly as well as the future need for a re-fit of the prosthetic, or a surgical procedure to the stump to make it more conducive to the fitting process, and the life expectancy of a prosthetic, remain at the forefront of the science of prosthetics. The financial resources going into research and development are significant. The present military conflict has resulted in a dramatic increase in traumatic amputations. The advent of significant medical intervention immediately following the trauma has resulted in a high percentage of surviving military personnel with amputations. This factor has stimulated research and development in the field of prosthetics. More than ever, the refinement in design and function of prosthetics have led to more amputees living productive lives following post-traumatic amputations. It goes without saying that the amputee-claimant has benefited from the prosthetic research stimulated by the high numbers of returning military with amputations.

Unfortunately, the high numbers of returning veterans with amputations has resulted in a phenomenon that is impacting budgetary allocations to Medicare and Medicaid, through the Centers for Medicare and Medicaid Services (CMS). The increase in cost has resulted in a push by CMS to limit the veteran amputee's right to new prosthetics. The proposal by CMS seeks to limit a veteran's prosthetic care to his or her current level of mobility, rather than to provide improved mobility with advanced prosthetic technology. The goal of this legislation proposed by CMS is to reduce costs by limiting veterans to the prosthetic originally provided. In doing so, CMS eliminates requests for newer, more functional prosthetics as they become available.

The suggested legislation has resulted in public outcry, and there is an active campaign to have the legislation quashed. Senator Richard Blumenthal spearheads the Connecticut opposition. His stance is clear- the amputee veteran should have access to the best prosthetic device available. This opposition has, at least currently, caused CMS to abandon the suggested legislation.

The cost associated with a prosthetic, the therapy required to maximize the potential of the prosthetic, and the routine maintenance necessary, coupled with the desire for the newest and best prosthetic has caused similar concern with employers and workers' compensation insurers. Currently, there is no rule in Connecticut which would limit the number of prosthetics available to an amputee claimant. As with the standard utilized by the Commission to determine entitlement to a prosthetic, the question of how many prosthetics may be requested, and what would lead to the right to a newer prosthetic, are governed by the same reasonable or necessary medical treatment standard noted in C.G.S. § 31-294d. It is fair to assert that the question falls within the ambit of the "reasonable man" standard.

The cost of a prosthetic is governed in part by the technology associated with its function. There are also ancillary costs including the cost of therapy and training, and the need for a re-fit periodically. Connecticut had adopted a CPT value for a prosthetic at 125% of the cost paid by CMS. In my experience, at least one noted vendor of prosthetics was more than happy to accept 125% of the price paid by CMS for the prosthetic, the training and the fitting process.

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In conclusion, the Connecticut Workers' Compensation Act anticipates that a prosthetic is reasonable and necessary medical treatment of an amputation which arose out of and in the course of employment. The type of prosthetic is initially recommended by the treating physician in concert with a prosthetist. The claimant must justify that the type of prosthetic requested is reasonable or necessary medical treatment. The respondent may challenge that the requested prosthetic is necessary by providing evidence that another, likely less expensive type, is more reasonable. The type of prosthetic, the anticipated use of the prosthetic, the life expectancy of the prosthetic, are all factors to be considered by the commissioner when determining whether the prosthetic is reasonable or necessary. There is no rule that the best prosthetic on the market must be provided, or that the cheapest prosthetic on the market can be provided. The cost of the prosthetic and all ancillary costs are 125% of the cost of the device paid by CMS. The right to a number of different prosthetics based on the desired uses by the claimant has no support in Connecticut Workers' Compensation law. The entitlement to and the frequency of a replacement prosthetic are governed by the reasonable man standard. It is anticipated that CMS and the insurance community will continue to attempt to limit the number of prosthetics available to an amputee.

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Case Comments

By Marie Gallo-Hall

CONNECTICUT SUPREME COURT DECISIONS

***McCullough v. Swan Engraving, Inc.*, 320 Conn. 299 (2016)**

The sole issue in the appeal was whether or not a surviving spouse was required to file a separate, timely notice of claim for survivor's benefits when the decedent had filed a timely claim during his lifetime.

In discussing this question, the Supreme Court agreed that the claim for survivor's benefits was a derivative claim from the prior timely claim of the decedent. In making this decision, the Court found that the language of CGS §31-294c was not dispositive because it spoke only to the initial filing of a claim and not to subsequent, derivative claims. Furthermore, it noted that the legislature did not set forth any specific provisions for the filing of a claim for survivor's benefits. Consequently, the Court held that to impose a statute of limitations on this type of action would create a new judicially-created exclusion for dependents. Since such action would be inappropriate, the widow was allowed to pursue her claim on the merits.

CONNECTICUT APPELLATE COURT DECISIONS

***Conroy v. City of Stamford,* 161 Conn. App. 691 (2015)**

This case concerns the appropriate filing of a claim under the Heart & Hypertension Act. The Appellate Court reiterated the Supreme Court's analysis in Chiarlelli v. Hamden, 299 Conn. 265 (2010) in which it held that the statute of limitations does not begin to run until a physician has made a diagnosis of either hypertension or heart disease and has transmitted that diagnosis to the claimant. The fact that, as here, a claimant had been informed of some elevated blood pressure readings and advised that these needed to be lowered through diet and/or exercise to avoid the necessity of medications, does not necessarily satisfy the requirement of issuance and transmittal of an actual diagnosis.

***Dickman v. UConn Health Center,* 162 Conn. App. 441 (2016)**

The claimant filed a claim for discrimination pursuant to C.G.S. §31-290a after the respondents failed to accommodate her physical restrictions and initiated criminal and civil ethics investigations into her behavior (which eventually led to her conviction on multiple forgery charges).

In his denial of this claim, the trial commissioner set forth facts that comported with the burden shifting analysis in Ford v. Blue Cross & Blue Shield of Connecticut, 216 Conn. 40 (1990). The Appellate Court reviewed those findings, affirmed the trial commissioner's decision and acknowledged the proper application of the analysis.

***Lazzari v. Stop & Shop Supermarkets, et al,* 162 Conn. App. 769 (2016) (2016)**

The claimant brought a claim alleging bodily injuries sustained during the course of his employment. The claim was denied by the respondents, who sought to take the claimant's deposition in order to complete their investigation and/or

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in furtherance of litigation. After the claimant questioned the respondents' legal authority to take his deposition, the trial commissioner issued a letter which sought to explain the legal authority and the process to the claimant. The claimant appealed this letter and the CRB remanded the issue to the trial commissioner as there was no record upon which it could base a decision. The claimant appealed that decision as well.

Established Connecticut law requires there to be a record upon which an appellate body can review any decision. Consequently, the remand of the issue of the need for the claimant to sit for a deposition was found to be appropriate by the Appellate Court since the "letter" from the trial commissioner was not issued following a full evidentiary hearing.

***Menard v. Willimantic Waste Paper Co., et al,* AC 37252 (3/1/16)**

The question addressed by the Appellate Court was whether weeks for which an employee received vacation pay while he was not physically at work should be included in the calculation of his average weekly wage.

In considering this question, the Appellate Court looked to the statutory interpretation of CGS §31-310(a). It noted that questions of statutory interpretation are subject to plenary review. It further noted the standard of looking to the plain language of the statute and, only if that language is not plain or unambiguous, do you look for interpretive guidance from legislative history, circumstances surrounding enactment, public policy, and its relationship to other legislation.

The Appellate Court agreed with the CRB that the language of the statute was ambiguous. It, therefore, looked beyond that language. Legislative history was not found to be helpful. It then looked to the definition of "average" and determined that a logical interpretation of the phrase "average weekly wage" contemplated the inclusion of all wages received within the applicable time period. Thus, the vacation time was properly included in the calculation of the AWW.

COMPENSATION REVIEW BOARD DECISIONS

***Nails v. Freddie's U.S. Mail, Inc.,* Case No. 5982 CRB-7-15-1 (12/8/15)**

The claimant had an accepted injury for which he was receiving ongoing narcotic pain management. Based on an RME opinion, the respondents sought to have the claimant participate in a detoxification program. A neuropsychologist who saw the claimant at the referral of the treating physician agreed that an intensive residential pain management program was appropriate. Despite an evaluation at Silver Hills, the claimant did not participate in that program.

Thereafter, the trial commissioner granted a Form 36 for a discontinuance of benefits but advised that the order would be vacated if the claimant entered into an in-patient detox program within thirty days. The claimant disagreed that the program was reasonable or necessary. He did not, however, file an appeal of the trial commissioner's decision within the required twenty days. Instead, an informal hearing was requested to further discuss this matter. Subsequent thereto, the trial commissioner issued a memorandum explaining the obligations of the treating physician with respect to this issue. The claimant filed a Petition for Review of that memorandum.

The respondents argued that (1) the appeal was untimely; and (2) the underlying decision was appropriate. In contrast, the claimant argued that the trial commissioner's decision did not properly consider the danger and suffering that might ensue as a result of the order.

After consideration, the Compensation Review Board agreed with the respondents on both issues. Since the original decision was issued after a full evidentiary hearing, the appropriate time to appeal was within twenty days of that decision and not following the subsequent memorandum. Furthermore, the CRB ruled that, even on the merits, the trial commissioner had acted within her discretion in assigning credibility to one expert over another and that the claimant should not be given the opportunity to retry his case.

Grzeszczyk v. Stanley Works, Case No. 5975 CRB-6-14-12 (12/9/15)

The claimant filed a motion to preclude the respondents from contesting liability based on a filing of a Form 43 four months after the issuance of the Form 30C. The trial commissioner denied that motion because the respondents paid a medical bill in full and issued Voluntary Agreements. Furthermore, at the time of the formal hearing, the adjuster testified that the respondents had accepted the claim.

After argument before the CRB, it was held that the concept of the "safe harbor" was a reasonable defense in the current action. The respondents had paid a medical bill prior to the filing of the Form 30C and had not been presented with any claim for lost wages. Consequently, the respondents were afforded the protection of the "safe harbor" when a Form 43 was not filed within 28 days of the Form 30C. The respondents, therefore, were not barred from contesting other aspects of the claim that arose years later.

Raphael v. Connecticut Ballet, Inc., Case No. 5985 CRB-7-15-2 (12/10/15)

There were multiple dates of loss and multiple insurer-respondents involved in this matter. Some of the alleged dates of loss resulted in the filing of a Form 30C. Some claims were accepted, while others were denied via a Form 43. There were also some periods of time for which there was no coverage. To complicate matters even further, the claimant was the employer-respondent.

Questions arose as to medical treatment, eligibility for benefits, and to which claims potential liability should be assigned. Following formal litigation, the trial commissioner ordered that liability be allocated between four distinct dates of injury and apportioned between the employer for periods of no insurance and two other insurers. The claimant filed an appeal of that decision.

Ultimately, the CRB found error and reversed in part with a remand to the trial commissioner. Specifically, it held that the trial commissioner ruled on matters well beyond the scope of the noticed issues, thereby infringing on the claimant's due process rights and necessitating a remand. The CRB also reversed the trial commissioner's findings regarding causation for medical treatment as there was insufficient factual evidence to support that decision. Finally, while the CRB acknowledged that the trial commissioner was under no obligation to "advise" the pro se claimant of the law, it also held that the claimant's withdrawal of one aspect of his claim was the result of his misunderstanding of the system.

Mase v. Branhaven Chrysler Plymouth, Case No. 5983 CRB-3-15-1 (1/14/16)

The claimant had an accepted back injury for which the respondents paid for two surgeries as well as indemnity benefits, including specific benefits. Subsequent thereto, the claimant informed the respondents that he was undergoing a third

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surgery just days before the procedure, which was processed through his group health insurance. Despite the inability of the respondents to timely investigate the third surgery, indemnity benefits were paid to the claimant at the request of the commissioner during informal hearings, although payment was not made immediately. A request for attorneys' fees was then made and denied after a formal hearing since there was no "order" to pay benefits and there had been no fault or neglect in the administration of the claim. The claimant appealed.

The CRB upheld the denial of attorneys' fees. It noted that the decision to apply sanctions for unreasonable delay and/or contest is discretionary. It further noted that recommendations by a commissioner at an informal hearing are not binding on the parties.

***Fields v. 550 Stewart Acquisitions Corporation, et al,* Case No. 5993 CRB-1-15-2 (1/15/16)**

A Finding and Dismissal was issued by the trial commissioner based on the finding that there was no employer-employee relationship in existence at the time of the alleged injury.

Twenty-four days after the trial commissioner's decision, the claimant filed an appeal and sought to submit additional evidence. The Second Injury Fund raised a jurisdictional challenge to the appeal as not being timely filed.

The CRB agreed that the appeal should be dismissed since it was not timely. It also noted, however, that the trial commissioner's decision was based on evidence in the record and not contrary to the law.

***Geraldino v. Oxford Academy of Hair Design, et al,* Case No. 5968 CRB-5-14-10 (1/20/16)**

This appeal involved a case wherein a motion to preclude was granted against the respondents. Following the granting of the motion to preclude, the respondents claimed that the relief was inconsistent with the evidence on the record. The claimant argued that the respondent was forever barred from seeking any post-hearing relief.

The CRB disagreed with the claimant. It held that, just because a respondent was precluded from contesting the liability for a claim for benefits, does not mean that it is forever precluded from bringing legal error to the attention of the CRB. Consequently, after a review of the issues, the CRB remanded those issues to the trial commissioner for further proceedings.

***Ramsahai v. Coca Cola Bottling Company,* Case No. 5991 CRB-1-15-2 (1/26/16)**

The claimant had a compensable injury to his left hip, low back, groin, and clavicle. He later claimed that his injuries aggravated his underlying polyarthritis condition such that, when also combined with his learning disabilities, he was permanently and totally disabled. The claimant further claimed that he suffered from depression due to his compensable injury. The trial commissioner found the aggravation of the claimant's polyarthritis to be compensable. He further found the depression compensable and ruled that the claimant was totally disabled. Finally, the trial commissioner awarded interest to the claimant.

On appeal, the CRB affirmed the finding of compensability of the polyarthritis as there was sufficient medical evidence in the record to support it. The finding that the claimant's depression was also compensable, however, was vacated and remanded for further findings. In so doing, the CRB held that (1) the psychiatric issue was not clearly raised prior to the commencement of the formal hearing; and (2) the expert opinions relied upon by the trial commissioner were insufficient

to support the decision. Finally, the CRB vacated and remanded the award of interest to afford the respondents the opportunity to defend against such an award. In ruling on issues that were not properly noticed, the CRB held that the respondents were denied their due process rights.

***Sneed v. PSEG Power LLC of CT & United Illuminating, et al,* Case No. 5988 CRB-3-15-2 (2/18/16)**

The sole issue on appeal was whether a claim for survivor's benefits should be dismissed on the grounds that an unmarried, domestic partner of a deceased worker cannot, as a matter of law, qualify as a dependent in fact under the Act. Although the claimant was not married to the decedent on the date of injury, she was married to him at the time of his death.

The CRB reiterated the standard that, in order to be deemed a dependent in fact, a claimant must first establish that she comes within the definition of "dependent" as set forth in CGS §31-275(6). This requires the claimant to prove that she was (1) either a member of the decedent's family or his next of kin, and (2) wholly or partially dependent upon his wages. The CRB looked past the argument regarding common law marriage in the State of Connecticut and found that the claimant should be given the opportunity to prove that she was a member of the decedent's family or next of kin. The case was remanded for further findings.

***Frantzen v. Davenport Electric,* Case No. 5990 CRB-7-15-2 (2/24/16)**

The primary issue before the CRB in this matter involved a fee dispute between current and former counsel for the claimant. Before addressing that issue, though, the CRB needed to resolve the question of whether the trial commissioner had jurisdiction to hear argument and decide that issue. In so doing, the CRB agreed that CGS §31-327(b) provides sufficient authority for a trial commissioner to settle disputes between attorneys regarding entitlement to fees.

With respect to the manner in which such a dispute is handled, the CRB held that any decision needed to be issued following a properly noticed formal hearing and had to be based upon sufficient evidence in the record.

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