Compensation Quarterly

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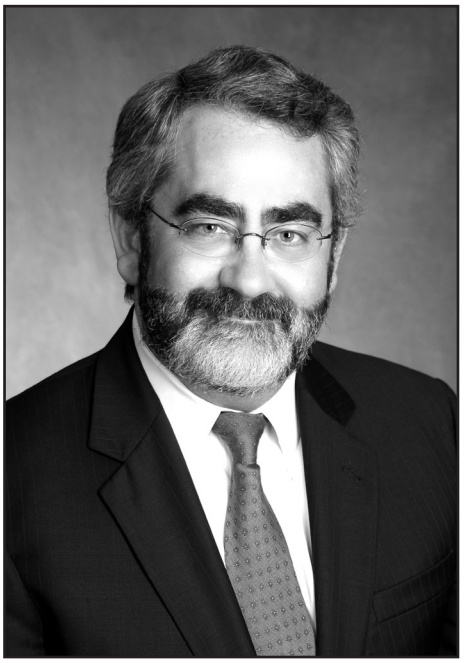
THE WORKERS' COMPENSATION UPDATE

Practice Tip

Workers' Compensation Quarterly asked Attorney Daniel Klau, a seasoned appellate advocate, to provide his insight into appellate practice, and to point out some of the pitfalls of appealing from the workers' compensation system, and how to avoid falling into them.

WCQ – Matthew Witt
DK – Daniel Klau



WCQ: Thank you for sitting down with me. What "go to" resources do you use in your appellate practice?

DK: The resources fall into two categories. One set of resources is books about appellate rules. Wes Horton, for example, has for years put out through West Publishing the "Annotated Appellate Rules." Judge Eliot Prescott has also teamed up with University of Connecticut Professor, Colin Tait, and they have a similar book called "Annotated Book of Appellate Rules." But those books are not resources if you want to understand nuggets about how to write briefs and how to improve your oral argument skills.

For improving oral argument, I have literally spent 20 years collecting the tips from Connecticut judges before whom I appear, federal judges before whom I appear, from appellate seminars where people always hand out tips, and so I don't have a single book, other than the one that I've written, that is a collection of these tips. I have collected things from CLEs and interviews that I've conducted. I had a folder, which got very large over the years, and that actually became the basis of my book.

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IN THIS UPDATE

The Beginning of the End

by Joseph Passaretti Jr., Workers' Compensation Section Chairman

BUSHVILLE,
EMPIRE OF TEXAS
September, 2047

As I write this, my final column (I am slated for scheduled extermination at age 70 per the Social Security Recovery Act of 2028), I pause to think about our history, our country, and how things might have been different. I remember back when Malia Obama defeated Ivanka Trump running for her second term, thinking this is probably it – the quota on lawyers will most likely give way to an all-out ban. The bard Shakespeare predicted this so many centuries ago, but the legal profession has finally met its match. For the second Obama administration to have its way, the lawyers will simply have to go. Not a wholesale slaughter to be sure, but a set of rules and restrictions making it as impossible to continue on as it was for the Israelites to follow the tenets of the Old Testament. Not really able to take it anymore, I finally renounced my U.S. citizenship, and immigrated to Texas, where Chancellor Cheney, on his 6th artificial heart if I am remembering correctly, has kept things quite a bit more tolerable than what remains of the rest of the continental U.S., from Ohio to Nevada.

It all started way back in 2016 with minimum continuing legal education. After a widespread debate, the controversy culminated in the Judges approving 12 credits per year of MCLE. This was only the beginning. With each passing year, the burden became more onerous. By 2022, when the "Every Day is a CLE Day" campaign was led by Governor Morizio, to remain admitted to the Bar, we had to do 365 credits a year. When the cost of a single credit shortly thereafter rose to $1,000, virtually all solos and small firms were eliminated. Many who remained would shortly thereafter be swallowed up when the perpetual CLE drones were unleashed, requiring 24/7 access to lawyers by flying robotic professors who would telepathically imbue even sleeping lawyers with annotations to the code of ethics, even in their most private moments.

So I was wrong, there I said it. The introduction of MCLE in Connecticut was the beginning of the end. I thought it would make us better. I thought it would elevate the practice. I thought the lawyers in the vanguard of this issue would be remembered for devoting tireless hours to advancing the cause for no other reason than to make us better than we are, and to make those we serve view us as protectors and professionals, instead of as punchlines. I remember in the recesses of my mind a politician, I can't remember who now, who said "Let's Make America Great Again". Did they do it? I'll let the history books decide. But when they made us start learning, reading, paying, becoming excellent, or in some cases, staying that way, which was truly the beginning of the demise of the American legal profession.

I'll rejoice in my only solace that the Crimson Knights of Rutgers University, now safely nestled in the comforts of Alabama, are about to begin what I hope will be their record breaking 10th consecutive national championship season. Roll Knights.

Joe

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

2016 Legislative Report

By Lucas Strunk

This year's 2016 regular session convened February 3rd and adjourned May 4th. The legislature faced serious budget issues, however, our State's red ink did not prohibit the passage of several bills relevant to the workers' compensation practitioner. The Governor has signed all the Public Acts into law. The special session after May 4th did not generate any additional relevant regulation.

A new public act that affects procedure is **Public Act No. 16-112 "An Act Concerning the Filing of Workers' Compensation Claims When a Municipality is the Employer."** This Act amends Section 31-294C, which requires that an employee of a municipality shall send a copy of notice of claim or Form 30C to the town clerk of the municipality in which he or she is employed. This requirement is, therefore, similar to a state employee who must send notice to the Commissioner of Administrative Services. The Act, which is effective July 1, 2016, will now define effective service on a municipality. The Act was viewed as having no fiscal impact.

Public Act No. 16-73 "An Act Concerning Workers' Compensation Insurance in Sole Proprietors" addresses sole proprietors and amends Section 31-286a, which concerns contractors on public works projects. The sole proprietors on such projects will not need to comply with the insurance provisions of the Act as long as the sole proprietor is not contracting with subcontractors and is not acting as a principle employer. Also, the sole proprietor must not have accepted the provisions of Chapter 568 pursuant to Section 10 of Section 31-275 and must have liability insurance in lieu of workers' compensation insurance.

The Act was viewed as a cost savings provision by the legislature as apparently the costs of workers' compensation coverage are picked up by the State of Connecticut in many situations. Clearly, a sole proprietor at this point will not incur the costs of workers' compensation insurance if he or she qualifies under the amended provisions of Section 31-286a. The Act is effective October 1, 2016.

Practitioners should be aware that firefighters have successfully lobbied the legislature resulting in **Public Act 16-10 "An Act Establishing a Firefighters Cancer Relief Program."** The original house bill (No. 5262) described the Act's intent as "to provide workers' compensation for current or former uniformed members of a paid or volunteer fire department who suffer from certain diseases as a result of performing their jobs." This is not, however, a workers' compensation benefit and will be codified at Section 16-256g of the statutes. The Public Act may raise more questions than it answers as it attempts to establish a non-lapsing General Fund account for the purpose of providing wage replacement benefits to fire personnel who have developed certain cancers as defined in Section 5(b) of the Act. That section will look familiar to the extent it mirrors proposed legislation from past sessions in that the firefighter must have passed a physical examination upon entry into such service, submitted to annual physical examinations, and not used cigarettes or any other tobacco products within fifteen years of applying for wage replacement benefits. The firefighter must also have worked more than five years beyond the effective date of the Act (February 1, 2017) and complied with the Federal OSHA standards for not less than five years. The cancer in question must also be one that is known to result from exposure to heat, radiation, or a known carcinogen. The Act suggests that firefighters will not be eligible for these benefits until after July 1, 2019 (but likely February 1, 2022 given five year requirement above).

Wage replacement shall not exceed twenty-four months and is paid at a rate not to exceed the average wage of all workers in our state. If concurrent employer provided benefits are paid, the total received cannot exceed pay rate at the time of diagnosis.

Chapter 568 claims can still be pursued. The Act contains a provision that compensation from the fund cannot be collected concurrently with Chapter 568 benefits or unemployment benefits. Payment of these benefits will not to carry any weight in Chapter 568 proceedings.

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The Act establishes a firefighters' cancer relief subcommittee at Section 4 of the Act. Section 7 of the Act requires additional reporting requirements with respect to firefighters present on various calls, not only documenting exposure but the duration of exposure.

Benefits are ultimately subject to the availability of funds contained in the firefighters' cancer relief account. The benefits are stated to be solely for the purpose of wage replacement. The account is to be funded by utilizing one percent per month per line from the enhanced 911 telecommunications fund (although questions have arisen relative to the interaction with federal funding that may require further modification of the funding of the account). Firefighters who no longer actively serve would be eligible for wage replacement benefits but must apply within five years of their last service (and must have had annual physicals during that time).

I anticipate that you will see further amendment to this law before firefighters begin to access the account. Practitioners should be aware of this potential alternative in those cases in which causal relationship to employment cannot be established.

On an issue becoming ever more relevant to the practice of workers' compensation, the legislature continues to address opioid abuse and the control of opioids in our state. P**ublic Act 16-43 "An Act Concerning Opioids and Access to Overdose Reversal Drugs"** expands the use of opioid antagonists primarily for purposes of attempting to reduce opioid induced deaths. One provision of note is that the new law, with certain exceptions, prohibits a prescribing practitioner from authorizing more than a seven day supply of an opioid drug to an adult for first time outpatient use. The noted exception allows for professional medical judgment to determine if greater than a seven day supply is necessary for treatment of chronic pain or for palliative care. The practitioner must document the condition "triggering" a prescription of greater than a seven day supply and must document that an alternative to the opioid drug was not appropriate. (See Section 7). The Act is effective July 1, 2016.

Special Act 16-4 "An Act Concerning a Study of Impediments to Insurance Coverage for Substance Use Disorder Treatments" calls for a study to examine the impediments under health insurance policies or health benefit plans for insureds who receive treatment for substance use disorders. The insurance commissioner shall conduct a study and report to the joint standing committees cognizant of matters relating to insurance and public health.

Public Act 16-39 "An Act Concerning the Authority and Responsibilities of Advanced Practice Registered Nurses" (APRNs) provides authority for APRNs to certify, sign and otherwise document medical information in a number of situations currently required by a physician, including issuance of do not resuscitate orders, certifying the patient for medical marijuana use (except glaucoma), certifying disability for purposes of cancelling health club contacts, continuing education waivers or extensions for various health professions, and notification of specified people before removal of life support. The bill makes no reference to Chapter 568 but may provide some relevance in situations in which a workers' compensation claimant is receiving treatment at an office from an APRN and in particular to Forms 36.

Please note that the legislature belatedly took proper action by appointing Commissioner Scott A. Barton to a new five year term beginning January 26, 2015, and Chairman John A. Mastropietro to a new term of five years beginning April 1, 2015. Congratulations to the commissioners.

Also, a final note relative to the post traumatic stress disorder legislation. A late attempt was made to revive the PTSD bill but it failed when opponents, primarily municipalities, recognized the attempt to pass the exhaustively debated legislation at the eleventh hour.

Please do not hesitate to check the complete text of the 2016 Public Acts referenced above as well as the file copies, which contain excellent summaries of the bills and further explain in many cases the purpose of the legislation.
See www.cga.ct.gov.

Editor's Note: Lucas Strunk is a partner with Strunk, Dodge, Aiken & Zovas in Rocky Hill, Connecticut.

WCQ: What are the pitfalls that counsel who are not regular appellate practitioners fall into in the appellate system and how can they avoid them?

DK: The very first tip in my book, and the reason it's the first tip is because it's a pitfall, if you don't preserve, you don't deserve, right? The appellate courts only address issues that have been presented and litigated in the initial forum, whether it's a trial court in a civil case or an administrative matter that started out before an administrative agency. It is absolutely imperative for people to remember that if you haven't raised the issue in the initial forum, whether it's administrative or judicial, it's very, very difficult to raise the issue for the first time on appeal.

The second pitfall is that people who don't spend a lot of time in appellate court think that the facts, the way you might present them in a closing argument to a jury or to a judge if it's a bench side trial, are the most persuasive things that they have going for them. So what I see people frequently do to their detriment in the appellate court is remake their closing argument to the judge or the jury. That's not what the appellate court is there for. The appellate court is not the thirteenth juror.

When you go up on appeal, you need to understand that the audience that you are speaking to is concerned with legal errors. The facts, of course, are relevant, but if you think that you can tug at the heartstrings of the appellate judges to get them to go your way, that's a terrible mistake. So those are the top two on my list.

WCQ: Are there any pitfalls in appeals that you see specific to administrative systems like workers' compensation?

DK: The rules of the workers' compensation system are somewhat akin to an informal administrative hearing. No matter how informal the proceedings may be, as an attorney, you have to make sure that you take steps to create an adequate record, so that if you're not happy with the result, you have a proper record for appeal. What I'm really referring to is creating a record that is directed toward an appellate tribunal, which includes, for the purposes of this conversation, the Compensation Review Board.

If you're putting documents in, everything has to be marked clearly. It has to be marked clearly whether it's a full exhibit or just for ID. I know that the rules of evidence tend to be relaxed in the workers' compensation setting, but you still have to be clear about whether a document has been submitted and you have to be able to track it.

You want to make sure that the workers' compensation commissioner who is hearing the case has everything at the end of the day. I do a lot of work before the Freedom of Information Commission, and we pre-mark exhibits. When I am at the end of the hearing, I am never exactly sure whether the hearing officer has everything. I always stop to make sure that the hearing officer has the complete set of exhibits that both sides marked, because if something slips through the cracks, then it can be very problematic.

As informal as a proceeding may be, I think that if there's an objection to evidence, it needs to be made, and it should be made clearly on the record because it's important to note objections for possible appellate review. If you don't note objections properly in that initial proceeding, it's hard to introduce them later.

WCQ: Workers' compensation formal hearings often use deposition transcripts in lieu of live testimony. Any issues there?

DK: If a party is seeking to introduce a full deposition transcript and I'm on the other side, my view would be that the party introducing the transcript should be required to mark the excerpts they wish to submit in advance. The decision that the person on the other side has to make is whether or not to formally note objections to portions of that deposition transcript that are objectionable.

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WCQ: What challenges do you see for appeals coming out of a court of equity as opposed to a court of law?

DK: I don't think that the distinction, equity versus law, presents any particularly unique challenges from an appellate perspective. The courts of equity and law have been merged on the civil side for a long time and the things we care about don't distinguish between law and equity.

WCQ: Commissioners are given extremely wide discretion when it comes to the findings of fact, and at appeal those findings are, pursuant to appellate precedent, given wide deference. Do you have any strategies for attacking those findings of fact on appeal?

DK: Overturning a finding of fact, as you know, is one of the most difficult things you can ever do on appeal. A workers' compensation commissioner's findings are entitled to the same deference that a trial judge's findings would be. So, it's a clearly erroneous standard.

There is one case that I think is really important for your section to be aware of from an appellate perspective. They're probably aware of it already. Jacqueline Cable v. Bic Corporation, et al., 270 Conn. 433 (2004) talks about the importance of creating a record for review. It also talks about things that an appellate practitioner can do; requests that he or she can make of the workers' compensation commissioner, in terms of explaining factual findings and legal conclusions.

WCQ: When it comes to the finding of facts, is the only solution to attempt to show there was essentially no basis for the finding in the record?

DK: That's the only lawful ground on which an appellate tribunal can reject the finding of fact that was made by a hearing officer. You have to demonstrate that there was no evidence in the record from which a reasonable person could draw and make the finding that was made. And that's always going to vary from case to case. But let me just say this, that is one reason why making objections to written or oral testimony is so important. If your opponent wants to put an entire deposition transcript into evidence, that forces you to go through it and identify all the substantive objections that you might have to certain testimony. If you decide not to do that and just rely on the objections you made when the deposition was taken, you are at risk because everything comes in.

When the entire transcript is in evidence, it is something that the hearing officer can consider. Later, at the appellate level, you cannot argue, "Well, this bit of deposition transcript that the hearing officer relied on is improper," if you didn't object. So the best way to fight adverse findings is to fight them in the hearing because it's very hard to get them reversed at the appellate level.

WCQ: What's your greatest frustration when you take over a file to handle the appeal, but did not handle the file at the trial court level?

DK: What frustrates me is when the parties seem to dance around an issue but it hasn't been crystallized. Sometimes it would be so simple for counsel to put in a motion in limine. Instead of a written motion in limine that crystallizes an issue and makes it so clear in the record, you have this kind of vague conversation back and forth with the parties and the judge, and consequently you don't really know what's going on. So the thing that frustrates me is when issues aren't crystallized in the record.

WCQ: In workers' compensation, there is no formal motion practice, and introduction of evidence is within the commissioner's discretion. Would you suggest the parties have an explicit discussion on the record relative to the issue?

DK: Absolutely. And I would ask this question. I understand that the procedure is informal, and I understand that the practice may not be to file motions in limine, and I am not suggesting that there should be some grand overhaul. If you have some hot button legal issue that you want to raise, and if it is permissible, you might want to file a bench memo with the commissioner, even if it's not called a motion in limine. But if you anticipate raising an objection to a factual issue or legal issue, thinking about it in advance and putting together a short bench memo, which you can then hand over at the time of the hearing to supplement your verbal objection, unless the rules absolutely forbade that, I would think long and hard about doing that.

WCQ: As part of the formal hearing process, the parties submit findings of fact, and many practitioners add a legal argument section, so that might be a good opportunity to crystallize an issue. Are there certain arguments that you don't see commonly made, that you think should be made, arguments that are under-utilized?

DK: I'm a great fan of logical reasoning. I often find what I perceive to be flaws in the logic of an argument that was made below, for example, a logical flaw in a causation analysis. I'm a big fan of making causation arguments or lack of causation arguments. And it's not that I'm having a fight over the evidence, I'm having a fight over the logical reasoning that a party, or the hearing officer, or the judge was applying to the evidence.

Not enough lawyers spend time examining the logic of the court's reasoning or a hearing officer's reasoning. I think it can be attacked. I frequently find holes in logic, holes in the reasoning that I think could have been raised at the trial level and possibly have led to a more favorable outcome. So I see a lot of emotion, I see a lot of passion in the factual arguments. I don't see nearly as much logical analysis of facts as I would like to see.

WCQ: When a decision is rendered after a formal hearing, parties can file a "Motion to Correct," to ask the commissioner to revisit a ruling or finding. Would that be the type of tool you could use to make sure they connect the dots properly?

DK: That's one of the tools. Another tool that's mentioned in the Cable case is a motion for articulation. So my understanding is that, while the workers' compensation commissioner is required to issue findings, they're not necessarily required to explain the legal reasoning behind their decisions. And what the Supreme Court has said is that parties should not be reluctant to file a motion for articulation if they think there is ambiguity or deficiency in the commissioner's reasoning.

WCQ: The workers' compensation system has a fair number of pro se litigants. Do you have any suggestions on how to handle the pro se litigant in the appellate process?

DK: The chief justice has commanded that we use the term "self-represented" instead of "pro se".

On the civil side in family court, eighty percent of all cases have at least one side that is pro se. The thing you have to be careful about with pro se litigants in the appellate context is the appendix. The rules require the creation of an appendix. It used to be the old yellow record, the essential pleadings for the most part. People who aren't familiar with the appellate rules often stuff everything into an appendix. You need to resist allowing that to happen because it is often sort of a joint kind of appendix that is set up.

You can explain to the pro se litigant that the entire record that was created before the workers' compensation commissioner or the review board is made available to the appellate court. It doesn't have to be copied entirely and put in the appendix. The judges are driven nuts by folks who put too much stuff in an appendix. The greatest offenders are the pro se litigants. But I should say this, practitioners often make that same mistake too. They don't appreciate that you don't have to put everything in the appendix, and just because it's not in the appendix doesn't mean that you can't refer to it.

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WCQ: Do you have any other thoughts that you think are important for practitioners coming out of administrative systems to understand about the appellate system?

DK: I want to really re-emphasize something I said early on. It's very important, when you go into the appellate context, particularly the Appellate Court, because I can't speak to the Compensation Review Board, to understand that the dominant theme in that tribunal is legal error, not facts. The fight over evidence and facts is what you do below; once the decision is made about the facts and you decide to appeal, you need to understand that the appellate judges are concerned about legal mistakes.

And the single biggest error that I see attorneys who don't do a lot of appellate law make time and time again is they think they can retry the facts in the Appellate Court. And if you try to do that in your briefs and then again at oral argument, you send a message to the appellate judges that you have no clue about the appellate process. You're wasting their time. You don't understand the audience and you're doing a disservice to your client.

When you get to the appellate context, you have to understand it's about legal error, and if there isn't a good argument to be made that there was a legal error, then you need to think long and hard about whether your client should take an appeal.

WCQ: Mr. Klau, thank you very much.

DK: My pleasure, I hope it was worthwhile.

Daniel Klau, Esq. is a columnist and blogger [www.appealinglybrief.com] on appellate law and author of "*Appealingly Brief: The Little Book of Big Appellate Tips or How to Write Persuasive Briefs and Excel at Oral Argument.*" Mr. Klau has been a practicing lawyer for 25 years who has a self-described passion for appellate practice. Mr. Klau practices with McElroy, Deutsch, Mulvaney & Carpenter.

Matthew Witt, Esq. is a Senior Staff Attorney at the Law Offices of David J. Mathis.

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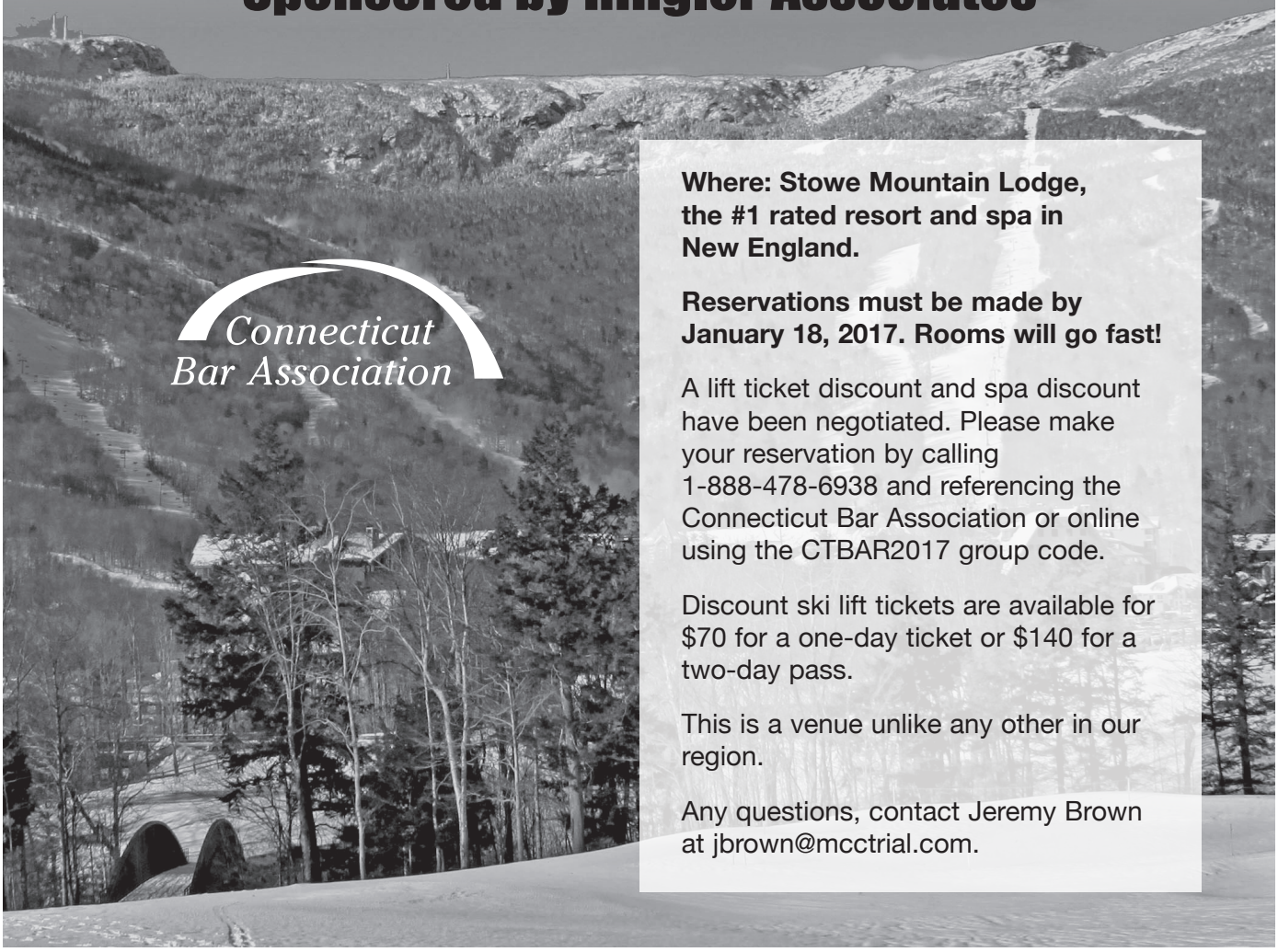

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Case Comments

By Scott Carta

CONNECTICUT SUPREME COURT DECISIONS

PTSD found compensable when resulting from cardiac malfunction that was due to being overworked.
Hart v. Federal Express Corporation, 321 Conn. 1 (2016)

The claimant, a FedEx delivery driver, began working under a new manager in 2009 and, as a result, the demands of his job began to escalate due to his delivery area being enlarged, increasing his number of stops. He asked the manager for help and nothing was done. During the summer of 2009, the claimant often found he was unable to find time for bathroom or lunch breaks. Again, the manager took no steps to assist. In June 2009, the claimant failed to secure the fill pipe after refueling and was reprimanded. He received another warning due to taking time off following his mother's death. These warnings in conjunction with the steady increases in his workload caused the claimant to became greatly distressed and concerned he may lose his job.

On September 15, 2009 the claimant began his workday as usual. After loading his truck he realized there were too many stops to possibly complete the deliveries on time. He reported this to his manager, asking if some stops could be assigned to another driver, but the request was refused. The day was very hot and there was no air conditioning in the truck. In an effort to try to make his deliveries timely, the claimant rushed through his stops, running between his truck and customers' houses, carrying heavy packages. He began to feel ill and lightheaded and noticed a fluttering sensation in his chest with shortness of breath. Despite these symptoms, the claimant pressed on out of fear that he would be written up again. One of his deliveries was to a fire station and he asked to be checked out only to find that his heart rate was more than 200 beats per minute. An ambulance was called and took him to the emergency room where his heart rate was found to be at 300 beats per minute. The claimant was diagnosed with arrhythmia or an arterial flutter caused by an electrical short circuit in the right atrium of his heart. Bloodwork was also taken which showed low potassium levels known as hypokalemia, resulting from dehydration.

Following a psychiatric evaluation due to reported anxiety and depression, the claimant reported feeling depressed, overwhelmed, stressed, anxious, humiliated, embarrassed and resentful. He reported difficulties with sleep and concentration and a tendency to avoid any objects or places that identified with FedEx. The symptoms were magnified at times when the claimant had communications or interaction with FedEx. The claimant associated his mental health symptoms with the heart problems experienced on September 15, 2009. He noted flashbacks and vivid dreams of the 2009 ambulance ride. He was ultimately diagnosed with post-traumatic stress disorder.

Three psychiatrists, including one on behalf of FedEx, agreed that the claimant's work at FedEx aggravated his cardiac problems and that his work was the cause of, or a significant factor in, the development of his PTSD. Dr. Okasha explained that the consequences of being disabled from his employment and the fear of future cardiac episodes had resulted in symptoms that fulfill the criteria for PTSD.

Following a formal hearing, the commissioner concluded that the claimant sustained physical and psychological injuries arising out of and in the course of his employment. Specifically, the commissioner found that on September 15, 2009, FedEx subjected the claimant to an unmanageable workload, forcing him to work at an unreasonably rapid pace without allowing time for breaks for food, hydration or personal comfort and as a result the claimant became dehydrated resulting in depressed potassium levels making him more susceptible to cardiac arrhythmia. Additionally, the commissioner concluded that the physical trauma that the claimant experienced on that day and ensuing emergency treatment were substantial factors in causing PTSD and related psychological symptoms. The Compensation Review Board upheld the trial commissioner's decision and this appeal ensued.

The respondents first argued that the commissioner's finding that the claimant's heart condition arose out and his employment was unsupported by the record. Specifically, the respondents argued that, since the claimant was in great physical shape, that it was counterintuitive to think that a physical specimen such as the claimant could have been even phased by having to run back-and-forth from his truck in the heat carrying heavy packages. Furthermore, they argued that the shear reality is that most employers ask a great deal of their workers and the stress associated with the claimant's workload was nothing out of the ordinary. The court disagreed, noting that the respondents' argument required that the commissioner reject the opinions of five medical experts including their own expert. The court held that the commissioner rejected the respondents' theory and they would not disturb that finding on appeal. The court noted further that the respondents offered no authority for their intuitive belief that an individual who is capable of exercising intensely necessarily was immune from types of work related physical and psychological stresses that might aggravate a latent heart condition. In fact, the respondents' intuitions were contradicted by the preponderance of expert medical evidence in the record.

The respondents next argued that the claimant's PTSD and other psychological injuries were not compensable under the act as they resulted from personnel action, which is not compensable per Section 31-275(16)(B)(iii). The court was not persuaded stating that, while the trial commissioner agreed that the loss of the claimant's job likely aggravated his psychological condition, she rejected the respondents' theory that personnel considerations were the primary cause of his anxiety and effectively eclipsed all other factors. Rather, the commissioner credited the opinions of the medical experts that the emotional trauma of having a cardiac malfunction requiring emergency transport with advanced life support to a hospital represented a life threatening event that was sufficient to cause PTSD. The court concluded that the Board properly upheld the commissioner's determination that the claimant's psychological as well as physical injuries were compensable under the act.

CONNECTICUT APPELLATE COURT DECISIONS

Respondent not entitled to apportionment of liability due to non-occupational preexisting disease.
Hadden v. Capital Region Education Council, 164 Conn. App. 41 (2016)

The issue in this case was whether the claimant's injury received as a result of being punched on October 8, 2010 aggravated her preexisting multiple sclerosis, causing her total disability or whether the punch merely dislocated her jaw with her total disability resulting, instead, from the natural progression of her preexisting disease. The claimant had two medical witnesses who were of the opinion that she suffered a traumatic brain injury that exacerbated her multiple sclerosis. The respondents' medical expert disagreed. The respondents also argued that the commissioner should decide which portion of the total disability was caused by the work injury's aggravation of the preexisting multiple sclerosis and which portion was caused by the disease's natural progression.

The court disagreed with the respondents' proposition that the Board erred in denying apportionment of the total disability benefits. The court held that since the claimant's preexisting multiple sclerosis was not occupational, they were bound by the Supreme Court's holding in Cashman v. McTernan School, Inc., 130 Conn. 401 (1943), that a non-occupational preexisting disease does not entitle a defendant to apportionment under 31-275(1)(D).

Paid vacation weeks cannot be excluded from the number of weeks used to calculate an average weekly wage.
Menard v. Willimantic Waste Paper Company, 163 Conn. App. 362 (2016)

The issue in this case is whether the weeks for which an employee has received vacation pay, and was not physically at work, are to be included in the divisor of a formula for wage replacement benefits pursuant to Section 31-310. The claimant's position was that his pay for the two weeks for which he received vacation pay and was not working should be included in the amount of total wages but in order to calculate the average weekly wage, the total amount of wages should be divided by 50 rather than 52 because he did not perform work during the two paid vacation weeks.

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The respondents' position was that the pay for the two weeks of vacation should be included in the amount of wages and that amount should be divided by 52 in order to calculate an average weekly wage. The trial commissioner agreed with the respondents stating that there was no reason to eliminate any wages received or any weeks of employment as the claimant was employed and received wages from the employer throughout the entire 52 week period preceding the injury.

In the appeal to the appellate court, the claimant argued that the board erred in its calculation of the average weekly wage because the plain language of 31-310(a) mandates exclusion of all periods of absence of seven consecutive days, including those absences for paid vacation, from the number of weeks used in the calculation of average weekly wage. The claimant argued further that the phrase "absence for seven consecutive days" is not ambiguous and dictates that his vacation-related seven consecutive day absences should be subtracted, leaving the total amount of wages received during the 52 calendar weeks preceding his injuries to be divided by 50. This would result in a higher average weekly wage.

The statute clearly states that the total wages are to be divided by the number of calendar weeks "actually employed" which, here, is 52. The dispute is whether the two weeks of paid vacation constitute an absence for seven consecutive calendar days that must be subtracted from the divisor. The court found that the claimant's interpretation of the statute leads to bizarre results. For example, not performing work related tasks for one's employer during paid vacations would increase the average weekly wage while performing activities benefiting the employer during that time decreases the compensation rate. Accordingly, the court upheld the decisions of the trial commissioner and the Compensation Review Board.

The existence of a condition or impairment due to hypertension or heart disease must be present during the period of employment in order for 7-433c benefits to apply.
Staurovsky v. City of Milford Police Department, 164 Conn. App. 182 (2016)

This case involves a police officer who suffered a heart attack at home while shoveling snow a week after he retired. He timely filed a claim for heart and hypertension benefits under Section 7-433c. The trial commissioner concluded that, despite the fact that the claimant was not disabled form his work as a police officer due to his coronary artery disease in January, 2012, he had developed a condition during his tenure as an officer that could spawn a claim for monetary benefits in the future. The Compensation Review Board affirmed the commissioner's decision.

The appellate court reversed the board's decision relying upon *Gorman v. Waterbury, 4 Conn. App. 226 (1985)*. In Gorman, the claimant suffered hypertension while he was a regular member of a paid police department fulfilling part of the statutory requirements. However, he did not die or suffer any disability from the hypertensive condition while so employed and therefore was not entitled to 7-433c benefits. The court in the instant matter found that *Gorman* instructs that proof of heart disease or hypertension during a claimant's period of employment alone is not sufficient to satisfy the statutory criteria. Rather, to qualify for the benefits the claimant must have established the existence of a condition or impairment of health caused by the hypertension or heart disease during that time period which results in the claimant's death or disability, as the plain language of the statute requires.

The court noted further that *Gorman* was decided more than 30 years ago and although the general assembly has since amended 7-433c, it has not taken any corrective action in response to the court's construction of the requirements of the statute in *Gorman*. Accordingly, bound by the precedent in *Gorman*, the court concluded that the board improperly affirmed the commissioner's determination that the claimant established a compensable claim for heart disease and hypertension benefits pursuant to 7-433c.

COMPENSATION REVIEW BOARD DECISIONS

Amount netted in third-party case as a result of the lien reduction per 31-293(a) was subjected to moratorium on future benefits.
Callahan v. Car Parts International, LLC, 5992 CRB-1-15-3 (March 2, 2016)

The claimant was involved in a work-related motor vehicle accident which resulted in a third-party claim that settled for $100,000.00. The respondents intervened in the lawsuit and claimed reimbursement of $44,041.33, which was two thirds

of the net proceeds as required by Section 31-293(a), as amended. The claimant retained $22,020.67.

Following the settlement, the claimant made an appointment with his treating physician which was denied by the respondents on the basis that the claimant would need to exhaust $22,020.67 before it would be obligated to pay. The claimant argued there should be no moratorium since Section 31-293(a) now requires that the reimbursable portion of any third-party recovery is to be reduced by one third for the benefit of the claimant and therefore does not permit the respondent to reclaim the one third reduction by way of a moratorium. The claimant relied on the following portion of the statute: "which reduction should inure solely to the benefit of the employee".

The respondents argued that the legislative history of the amendment contains no evidence that it was meant to eliminate an employer's moratorium. The trial commissioner agreed with the respondents and ordered a moratorium of $22,020.67 to be honored by the claimant.

The claimant appealed to the Compensation Review Board which concluded that the statute was ambiguous and, therefore, they went beyond the plain meaning of the statute and reviewed legislative history. After reviewing the full legislative history, the Board was struck as to what was not discussed, noting that the floor debate and committee testimony did not address the moratorium statute in any manner. The board did not find any discussion from the legislators that in anyway affected the prior decision regarding liens in *Thomas vs. Department of Developmental Services, 297 Conn. 391 (2010)*. The Supreme Court in *Thomas* stated that if "an employee's net proceeds from a third-party recovery are greater than the employee's future compensable expenses, then that employee would not be permitted to claim additional workers' compensation benefits and thereby realize a windfall recovery." Thomas, at 410.

Ultimately, the Board found that a reasonable interpretation of the purpose of the amendment was to create a situation when a large compensation lien would not present an insurmountable obstacle to settling tort law suits. They believed the trial commissioner's interpretation was consistent with that approach.

Trial commissioner's decision dismissing medical treatment does not bind future commissioners from ruling on future medical treatment.
Kladanjcic v. Woodlake at Tolland, 5995 CRB-1-15-3 (March 2, 2016)

The Compensation Review Board upheld the trial commissioner's decision that, based on the record presented at the formal hearing, the claimant failed to prove her current need for medical treatment was due to her compensable injury. However, the Board acknowledged that the claimant raised a valid argument that this finding is legally unenforceable against future trial commissioners. Citing to *Attardo v. Temporaries of New England, Inc., 5858 CRB-2-13-7 (June 19, 2014)* and Serluca v. *Stone & Webster Engineering, 5118 CRB-8-06-8 (July 13, 2007)*, the Board stated that a trial commissioner today cannot rule prospectively on the issue of a claimant's future need for medical treatment. At such time as the claimant seeks to establish future treatment as reasonable and necessary for the compensable injury, this can be pursued as a de novo request. Accordingly, the Board found that the finding here does not bind future commissioners who may rule on this claim.

Claimant not required to pay back carrier for unauthorized treatment despite stipulated agreement.
Zbras v. Northeast Mortgage Corp., 5997 CRB-5-15-3 (March 29, 2016)

The claimant appealed from a finding and decision rendered by the trial commissioner which directed the claimant to reimburse the respondent $133,806.44 for unauthorized medical expenses it paid. The claimant was prescribed Actiq in an attempt to control her pain. Actiq is a lollypop containing Fentanyl, an extremely powerful narcotic. Following a formal hearing in January of 2009, the parties entered into a stipulated agreement stating that the claimant was to wean herself off of Actiq by June 1, 2009. However this did not occur and the respondents continued to pay for Actiq after June 1, 2009. The respondents did not file a Form 43 until April 11, 2012 wherein it alleged the claimant had been overpaid for unauthorized treatment. The trial commissioner found that the claimant failed to wean herself off in accordance with the stipulated agreement and determined that the respondents were entitled to reimbursement.

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The Compensation Review Board noted there was lack of any documentary or testimonial evidence from the respondents as to why they did not exercise their rights under the stipulated agreement to deny the Actiq after June 1, 2009. The Board stated that this was an accepted claim and after June 1, 2009 the treating physician deemed the continued use reasonable and necessary and the respondents continued to pay for the treatment despite having no obligation to do so. This was an indication that the respondents either did not dispute or did not choose to dispute the treater's opinion at that time. The Board found that under the circumstances and without any evidence in the record which sufficiently characterized why the respondents continued to pay for the medication, there was no statutory basis by which the respondents could claim reimbursement. In fact, the payment of continued use of the medication acted as a waiver of the respondents' claim for reimbursement. The Board, however, pointed out that they did not want this case to establish a precedent that when a respondent represents to a trial commissioner that they will wean a claimant off of the excessive use of narcotic pain medication, that they can obtain reimbursement from the claimant when this does not occur.

There is no requirement to file notice of a widow's claim if the death resulted from an injury that was previously properly noticed.
Quinn v. Stone & Webster Engineering Corp., 6016 CRB-8-15-5 (March 31, 2016)

A surviving spouse' claim for benefits was dismissed by the trial commissioner on the basis that she did not file a widow's claim in a timely manner. In this particular case the claimant was diagnosed with lung cancer and timely notices of claim were filed on July 23, 1998. The claimant died on February 19, 1999, at which time the surviving spouse did not file a claim for survivor's benefits within one year of the death. The widow appealed.

The Compensation Review Board reversed the decision of the trial commissioner based on *McCullough v. Swan Engraving, Inc., 320 Conn. 299 (2016*). The Supreme Court in *McCullough* stated that "there is no language in section 31-294c creating a statute of limitations for a claim for survivor's benefits or language requiring that a dependent file a separate claim for survivor's benefit if the employee filed a timely claim for benefits during his or her lifetime. If the legislature had intended to require such a filing and to provide a statute of limitations period, it could have done so. In the face of a legislative omission, it is not our role to engraft language onto the statute to require a dependent to file a claim for survivor's benefits in such a situation." McCullough, at 310.

No error on trial commissioner who declined to rule on an issue not noticed for the formal hearing.
Rivera v. Patient Care of CT, 6005 CRB-6-15-4 (April 12, 2016)

The claimant appealed the trial commissioner's decision on a trial de novo of a Form 36. The claimant argued that the trier erred by ignoring the total incapacity issue raised at the formal hearing. The Board noted, however, that the respondents were not seeking to terminate the claimant's temporary total disability benefits by way of filing the Form 36 but were requesting to transfer the benefit status from temporary partial to permanent partial disability based on the commissioner's examination that placed the claimant at maximum medical improvement.

The Board found that the claimant's claim for temporary total incapacity benefits constituted a "new issue" outside the scope of the Form 36 and it was, therefore, incumbent upon the claimant to apprise the respondents either by amendment to the hearing notice or other means that they would be required to defend against a claim for temporary total disability benefits. That process was not followed and the Board stated that the tribunal does not condone trial by ambush. Furthermore, it is "fundamental in proper judicial administration that no matter shall be decided unless the parties have fair notice that it will be presented in sufficient time to prepare themselves upon the issue." *Osterlund v. State, 129 Conn. 591, 596 (1943)*. The Board found that it was within the trial commissioner's discretion to bifurcate the issues of temporary total disability benefits and work capacity.

Benefits per 7-433c are payable in the same manner as those under the act.
Liano v. City of Bridgeport, 6010 CRB-4-15-4 (April 22, 2016)

In this appeal the claimant argued that when he was originally deemed to qualify for Section 7-433c benefits over 30 years ago, the law that was in effect at the time did not require him to prove continued entitlement to temporary total disability

benefits. The Board, however, citing to *Revoir v. New Britain, 2 Conn. App. 255, 260 (1984)*, stated that the statute clearly provides that benefits for compensation and medical care shall be payable under 7-433c in the same amount and the same manner as that provided under Chapter 568. Therefore, they found that once it is established that a claimant qualifies under 7-433c, Chapter 568 then controls the amount of benefits to which the claimant is entitled.

Providing medical care prior to a Form 30C provides respondent with safe harbor protection against preclusion.
Shymidt v. Eagle Concrete, LLC, 6018 CRB-7-15-6 (May 4, 2016)

In this preclusion case, the Compensation Review Board found that the provision of medical care prior to the receipt of a Form 30C can act in the same manner as a "pre-emptive disclaimer" meeting the requirements in *Donahue v. Verideim, Inc., 291 Conn. 537 (2009)* and *Lamar v. Boehringer Ingelheim, Inc., 138 Conn. App. 826 (2012)*. Accordingly, preclusion was not granted and the respondents were entitled to "safe harbor" protection to contest the extent of disability.

Medical marijuana for pain management found compensable.
Petrini v. Marcus Dairy, Inc., 6021 CRB-7-15-7 (May 12, 2016)

In this case of first impression for the Compensation Review Board, the issue was whether the claimant's use of medical marijuana for pain management constituted reasonable and necessary medical treatment. The trial commissioner found the treatment reasonable and necessary based on the claimant's testimony that since he began using medical marijuana he has been up off the couch more, more engaged in his children's lives and had been better able to help with the cooking and housecleaning and assist other family members. The commissioner found the claimant credible and persuasive and concluded that his use of medical marijuana had afforded him significantly greater energy and greater mobility and that he was more actively engaged with his family, less anxious and more optimistic.

The respondents appealed claiming that the trier erred in concluding the claimant's use of medical marijuana was compensable. First, they argued that the claimant's medical condition did not meet the criteria for certification by the state on the basis of no physician/patient relationship as well as the claimant's injury not being considered a "debilitating condition." They argued that post laminectomy syndrome was not an approved condition and that the claimant's use of the marijuana was palliative rather than curative. The respondents further argued that the use of the marijuana raised a number of general negative policy implications such as criminal penalties, the right to a drug-free workplace, the fact that marijuana is an illegal substance under federal law, that businesses cannot access banking services to pay for marijuana and, finally, that the use of the marijuana is not approved by the FDA.

The Compensation Review Board did not agree with the respondents and addressed each of their concerns. First, they felt that the claimant successfully established a bona fide relationship with his treating physician, noting that the exhibits submitted into the record suggest that the doctor clearly felt comfortable enough with the relationship to certify the claimant for the medical marijuana program. Second, the Board found that the claimant met the criteria for "debilitating condition" given the extensive evidence in the record regarding the claimant's injuries and seemingly intractable pain. It further found that the medical reports relied upon by the treating physician, combined with the claimant's narrative associated with his medical history and pain levels, provided a reasonable basis for the trier's inference that the claimant was properly certified into the medical marijuana program. Third, the Board found no basis to reverse the trial commissioner's finding that the treatment was reasonable and necessary stating that the claimant's testimony and the medical opinions clearly attested to the necessity for an aggressive pain management regimen in order to address the sequelae of the claimant's original low back injury. Fourth, the Board did not address the public policy arguments raised by the respondents noting that they were beyond the purview of their authority to address. Finally, the Board addressed the respondents' argument that medical marijuana is not approved by the FDA. They stated that, in light of the latitude afforded treating physicians in utilizing FDA approved medical devices and/or drugs for off-label use, the absence of FDA approval for a physician's proposed off label use of a legally marketed device should not be treated as a proxy for a factual determination of the off-label use would be unreasonable. The Board found that this reasoning from Vannoy-Joseph vs. State/DMHAS, 5164 CRB-8-06-11 (January 29, 2008) was equally applicable to the considerations in the instant matter. Accordingly, the Board affirmed the trial commissioner's decision.

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