Compensation Quarterly

Volume 26 • Number 3
Fall 2016

THE WORKERS' COMPENSATION UPDATE

Summary of Recent Opioid Legislation in Connecticut

By Attorney Danielle Jaffe

The Injured Workers' Pharmacy (IWP), a home delivery workers' compensation pharmacy, is licensed in all fifty states, and for more than fifteen years has been an industry leader in providing prescription services to injured workers. IWP works collaboratively with legal, medical and insurance interests to help injured workers receive appropriate medications in a timely manner. Its Government Affairs team constantly monitors legislation and regulations that impact the workers' compensation communities in every state. Attorney Danielle Jaffe, Manager of the IWP Government Affairs team, provided the following summary of legislation enacted by the Connecticut legislature in 2016, that affects the prescribing, use and monitoring of prescription medications.

The 2016 Connecticut legislative session was a quick, five-month session full of discussion on a host of topics, from expanding workers' compensation to include post-traumatic stress disorder, which failed to pass, to expanding insurance coverage for substance abuse treatment. But the biggest move for the legislature came in regards to fighting the nation's ever-growing opioid epidemic. Joining many of its fellow New England states, Connecticut focused on what it could do to help curb the problem within its borders.

With the support of Governor Malloy, the legislature crafted a bill designed to tackle the epidemic from several angles. House Bill 5053, Public Act No. 16-43, signed into law by Governor Malloy on May 27, 2016, revises several provisions of the General Statutes, including Titles 17a and 21a, and makes changes that affect health care practitioners and pharmacies. The most significant changes concern access to opioid antagonists, fill limits on certain prescriptions, and the use of the state's Prescription Drug Monitoring Program (PDMP).

The first three sections of the new law focus on increasing access and availability of opioid antagonists, such as Naloxone. Opioid antagonists can block or reverse the effects of most opioid medications, and Naloxone, one of the most prevalent opioid antagonists, is frequently administered to prevent overdoses. The new law amends C.G.S. § 17a-714a in two ways as a means of ensuring patient access. First, it clarifies that a licensed health practitioner will not face civil or criminal liability for administering an opioid antagonist, nor would the administration of an antagonist be considered a violation of the professional standard of care. Second, it mandates that municipalities train and equip emergency first responders with opioid antagonists by October 1, 2016.

continued on page 8

IN THIS UPDATE

1 ... *Summary of Recent Opioid Legislation in Connecticut*
2 ... *A Legacy of Diversity*
2 ... *2017 Commissioner Assignments*
3 ... *The Demise of the "Grand Bargain" and Birth of the "Opt-out Movement"*
4 ... *Medicare Advantage Plans Prevail Again, Double Damages and MAPs*
9 ... *18th Annual Verrilli-Belkin Workers' Compensation Charity Golf Event*
10 ... *2017 Workers Compensation Retreat*
12 ... *Case Comments*

A Legacy of Diversity

By Joseph Passaretti Jr., Workers' Compensation Section Chairman

In 1911, tragedy struck a New York sweatshop known as the Triangle Shirtwaist Factory. In a world without building codes or occupational safety regulations, a small fire instantly transformed a city block into a blazing death trap, resulting in the death of 146 employees, mostly young female immigrants, who came to America only weeks and months before, seeking to capture their piece of the dream.

One of the many horrified onlookers that day was 31 year old Frances Perkins. Perkins would, years later, credit the horror of what happened that day as her inspiration for doing what would eventually become her life's work – the protection of the rights, well-being, and lives of workers in a newly industrialized society. In 1933, Perkins would become Secretary of Labor under Franklin Delano Roosevelt, making her the first female member of the presidential Cabinet in United States history.

If Theodore Roosevelt was the soul of the workers' compensation system in the United States, then Frances Perkins was its heart. Indeed, many historians attribute the success of the New Deal to Perkins' tireless efforts, bringing a country out its worst economic depression in history and uniting it around a domestic war effort the likes of which had never before, and quite likely will never be rivaled.

One woman made a difference. Blazed a trail. Righted wrongs. Served without thought of reward. We live in a puzzling time – a time where a woman or person of color can be President, but where so many still struggle daily with active and passive restraints from the distant past which continue to pervade our society. Our challenge today is to recognize the talent, the greatness and the vision of those among us, without regard to how they look, where they are from, or what gender they may be, such that the legacy of leaders like Frances Perkins becomes the norm, and not the exception.

Our current CBA President, Monte Frank, is leading our Bar into a new era focused on diversity. I join him in these efforts and direct you to our website to look for events and opportunities that can bring more attention to these issues. But I say this – in the great tradition of Perkins, who would be proud to see that the workers' compensation section of the Bar is in the vanguard of this initiative already, with some of our most talented and accomplished commissioners and attorneys coming from every background, and representing a true cross-section of our society, in a way that would make those who have paved the way for these opportunities to see that their sacrifices, efforts, and struggles, bore the fruit of their hopes and dreams for a better future.

Joe

Editor's note: Joseph J. Passaretti, Jr. is a Partner at Montstream & May in Glastonbury, CT, and Chair of the Workers' Compensation Section of the Connecticut Bar Association.

2017 Commissioner Assignments

Effective January 1, 2017, the Commissioners of the Connecticut Workers' Compensation Commission will be assigned to the following districts:

District 1 (Hartford)
Ernie R. Walker
Daniel E. Dilzer

District 2 (Norwich)
Thomas J. Mullins
Peter C. Mlynarczyk *(2 wks/month)*

District 3 (New Haven)
Charles F. Senich
Scott A. Barton

District 4 (Bridgeport)
Jodi Murray Gregg
Randy L. Cohen

District 5 (Waterbury)
Jack R. Goldberg
Stephen M. Morelli

District 6 (New Britain)
Nancy E. Salerno
Christine L. Engel *(2 wks/month)*

District 7 (Stamford)
Michelle D. Truglia
Christine L. Engel *(2 wks/month)*

District 8 (Middletown)
David W. Schoolcraft
Peter C. Mlynarczyk *(2 wks/month)*

Editor's Note: All commissioner assignments are subject to change depending on need and availability.

The Demise of the "Grand Bargain" and Birth of the "Opt-out Movement" — *Can It Be Coming To Connecticut?*

By Angelo Sevarino

Prior to the creation of the various states' workers' compensation laws, injured workers could bring a common law negligence suit against their employers for work related accidents. Employers were subject to compensatory as well as punitive damages. These civil suits created "uncertainties for both employer and [injured] workers and the substantial costs arising from litigation over the degree and source of impairment."[i] With enactment of the various workers' compensation laws throughout the states a "Grand Compromise" was established wherein the employer gave up its traditional defenses (comparative negligence, fellow-servant rule, and assumption of risk) and the injured worker gave up his or her right to sue the employer for work related injuries.

In 1913, from the ashes of the 1911 Triangle Shirtwaist factory tragedy arose what became the "Grand Bargain": a statutory remedy for work related accidents which aimed to provide the injured worker with a no-fault speedy remedy for lost wage replacement and payment of work related medical bills. In exchange, employers were immune to civil negligent suits for work related accidents.

There has been a consistent trend in the states to "reform" or "carve-out" benefits by either eliminating certain injuries as compensable or reducing the benefits allowed for certain injuries.[ii] These changes in workers' compensation laws have shifted responsibility and costs for otherwise legitimate work related injuries and illnesses to others.

The Occupational Safety& Health Administration report, "*Adding Inequality To Injury: The Costs of Failing To Protect Workers On The Job*,"[iii] provides some rather disturbing conclusions regarding this trend:

a. Employers now provide only a small percentage (about 21%) of the overall financial cost of workplace injuries and illnesses through workers' compensation. This cost shifting has forced injured workers, their families and taxpayers to subsidize the vast majority of the lost income and medical care costs generated by these conditions. The remainder is allocated: 50% to out of pocket costs to injured workers and their families, 13% to private health insurance, 11% to the federal government (Social Security and Medicare) and 5% State and Local Government (Medicaid and State subsistence).

b. Fewer than 40% of eligible workers apply for workers' compensation benefits. "...[A] worker who is eligible for benefits under Medicare, Medicaid, Veterans' Benefits or private insurers is more likely to take that route, and avoid the barriers to obtaining benefits through the workers' compensation system."

c. Misclassification of employees as independent contractors increases the risk of injury for these misclassified individuals. For example, in the construction industry, misclassification rates in Texas were 37.7%, in North Carolina 35.2% and in Florida 15.5%. "Misclassifying workers increases the likelihood of work injuries through two mechanisms. First, by misclassifying wage employees as independent contractors, employers do not have to worry about the OSHA requirements to provide a safe workplace, since the OSHA law does not cover the self-employed. Second, these employers avoid paying workers' compensation insurance premiums (as well as unemployment insurance and other benefits and taxes). The misclassifying employer is no longer concerned about workers' compensation premiums rising following a work injury, so is less likely to invest in safety. The result is increased risk of work injuries at workplaces where employees have been misclassified, and, when those injuries do occur, the injured workers, their families and the taxpayer bear the costs, subsidizing the employer's hazardous operations".

d. The number of Social Security Disability Insurance beneficiaries and the amount of benefits paid by that program has grown dramatically in recent years. An accumulating body of evidence shows that at least part of the growth in the Social Security disability payments is attributable to the program's subsidy for work injuries and illnesses.

continued on page 6

Medicare Advantage Plans Prevail Again, Double Damages and MAPs

By Annie M. Davidson, Esq.

On August 8, 2016, the U.S. Eleventh Circuit Court of Appeals upheld an order from the lower federal district court granting summary judgment in favor of Humana [i] regarding Western Heritage Insurance Company's (Western's) obligation to reimburse Humana for Medicare benefits paid on behalf of its Medicare Advantage plan enrollee, Mary Reale, and its claim for double damages pursuant to the Medicare Secondary Payer Act (MSP). In affirming the district court's order, the Eleventh Circuit specifically agreed with and adopted the Third Circuit Court of Appeals' reasoning and holding in *In re Avandia* [ii] a prior successful decision for Medicare Advantage plans.

We now have two clear federal appellate court decisions that Medicare Advantage Plans (MAPs) have a right to recover under the MSP Act and are thus entitled to double damages, one from the Third Circuit, which encompasses Pennsylvania, New Jersey and Delaware and now from the Eleventh Circuit, which encompasses Alabama, Georgia and Florida. Parties to cases arising in these jurisdictions should be especially sensitive to identifying MAPs that may have made payments in the claim and resolving any claim for recovery asserted by the MAP as part of settlement.

Recommendations

In resolving recovery claims by MAPs, the decision makes clear that either assuming the plaintiff or their attorney will repay the MAP from the settlement funds or agreeing to let the plaintiff's attorney hold funds in trust until the MAP recovery amount can be paid, is insufficient. The court emphasized federal regulation:

If a beneficiary or other party fails to reimburse Medicare within 60 days of receiving a primary payment, the primary plan "must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. § 411.24(i)(1). This regulation applies equally to Medicare Advantage Organizations (MAOs). See id. § 422.108(f).

Consequently, indemnification language in a release or settlement agreement will not protect a primary plan, i.e. insurance carrier, from a recovery claim by a MAP. While such language may allow for a subsequent claim by the carrier against the claimant, and perhaps attorney, to enforce the indemnification agreement, pursuing such a claim adds to the cost and time in handling the underlying workers' compensation or liability claim. Accordingly, in this light, the value of addressing reimbursement to the MAP at the time of settlement becomes apparent.

As CMS does not provide a centralized database of Medicare beneficiaries enrolled in a MAP and the name of the MAP if they are so enrolled, the claimant and the attorney, if represented, must be questioned as to whether the claimant is enrolled in a MAP or was enrolled in a MAP during the pendency of the claim. If so, then the identity of the MAP must be provided and any recovery claim investigated.

Background

Humana Medicare Advantage plan enrollee, Mary Reale was injured at Hamptons West Condominiums (Hamptons West) in January 2009. Hamptons West was insured for liability coverage by Western. Mrs. Reale's medical providers billed Humana.

In June 2009, Mrs. Reale and her husband sued Hamptons West. In March 2010, Humana issued Mrs. Reale an "Organization Determination" for $19,155.41 to be reimbursed pursuant to 42 U.S.C. § 1395y(b)(2). In April 2010, the Reales reached settlement with Hamptons West and Western for $115,000. The Reales represented in the settlement agreement that there existed no Medicare lien, and agreed to indemnify Hamptons West and Western against any Medicare or other subrogation lien.

No later than May 2010, Hamptons West and Western became aware of Humana Advantage plan lien and agreed to let the Reales' attorney hold $19,155.41 in trust until the Humana amount could be confirmed and paid. Mrs. Reale did not avail herself of her administrative rights to dispute the amount claimed by Humana.

In June 2010, the Reales sued Humana in state court to determine the amount owed. A Florida state court judge found $3,685.03 due and owing to Humana, not $19,155.41. Humana appealed.

While the case was pending in Florida state court, in 2011, Humana sued Western for reimbursement since the Reales never released the funds from their attorney's trust account. Humana claimed double damages under 42 U.S.C. §1395y(b)(3)(A), requested declaratory relief under MSP statute and regulations, and advanced claims for damages under several state law theories, including unjust enrichment and contract implied by law. Western moved to dismiss all Humana's claims. The court dismissed the state claims, but found Humana adequately pled claims for double damages and declaratory relief. In December 2014, Humana moved for summary judgment.

In March 2015, the Court granted summary judgment in favor of Humana finding the MSP private cause of action is available to Medicare Advantage Organizations (MAOs), commonly called Medicare Advantage Plans (MAPs), and that Humana is entitled to double damages in the amount of $38,310.82. Western timely appealed.

In December 2015, the Florida State court ruling for $3,685.03 was reversed for lack of jurisdiction. The Federal Statue preempts state law and the judge did not have jurisdiction to determine the issue.

This brings us to August 8, 2016 when the 11th Circuit Court of Appeals upheld the order from the district court granting summary judgment in favor of Humana and the award of $38,310.82 for double damages.

Analysis

The Eleventh Circuit found Humana's claims comported with CMS regulations, which provide that a MAP will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations [iii].

The majority noted CMS regulations clearly identify two causes of action available to the Secretary: one against a primary payer and another against any entity that receives primary payment. Based on these available causes of action, the Court found an MAP may sue a primary plan or a beneficiary under the MSP as the statutory text clearly indicates MAPs are included within the purview of parties who may bring a private cause of action.

MAP plaintiffs under the MSP must suffer actual harm to commence a suit using the MSP private cause of action. Western had actual and constructive knowledge of Humana's Medicare payments, and the regulations clearly state if the beneficiary or other party fails to reimburse Medicare within 60 days of receiving primary payment, then the primary plan must reimburse Medicare even though it may have already reimbursed the beneficiary or other party [iv]. Citing specific regulatory provisions, the Court ruled this provision applies equally to MAPs [v].

Applying that reasoning, the Court found Western failed to provide Humana "appropriate reimbursement." Further, the Court found that a beneficiary's procurement costs do not operate to offset a MAP's recovery if the MAO must litigate to secure payment [vi]. The Court noted this was the third lawsuit Humana had to file in order to enforce its rights, and could recover the full $19,155.41 claimed. Finally, the Court found double damages were required by statute as the private cause of action provisions use the word "shall" to describe the amount of damages to be awarded. Therefore, Western was ordered to pay Humana $38,310.82.

At this time it is uncertain whether Western Heritage will seek to appeal the decision to the U.S. Supreme Court.

Editor's Note: Annie M. Davidson, Esq. is a MSP Compliance Counsel at ExamWorks Clinical Solutions. ExamWorks Clinical Solutions services are readily available to investigate and assist in resolving any MAP recovery claim. Referrals may be made at: https://www.examworks-cs.com/make-a-referral.

[i] Humana Medical Plan, Inc. v. Western Heritage Insurance Company, F. 11th (11th Cir. 2016)
[ii] In re Avendia Mktg., Sales Practices & Prods. Liab. Litig., 685 F. 3rd 353, (3rd Cir. 2012)
[iii] Subparts B through D of 42 C.F.R. §411
[iv] 42 C.F.R. §411.24(i)(1)
[v] 2 C.F.R. §422.108(f).
[vi] 42 C.F.R. 411.37(e) and 422.108(f)

2016 ExamWorks Clinical Solutions | 375-63100-100-0089

The Demise of the "Grand Bargain" and Birth of the "Opt-out Movement" — *Can It Be Coming To Connecticut?*

In Connecticut, Public Act 93-228 was passed, largely due to the efforts of the Connecticut Business Industry Association, and cut workers' compensation permanent partial impairment benefits by one-third and reduced other benefits. That Act introduced the concept of managed medical care into the workers' compensation arena so as to reduce the medical cost of a workers' compensation claim. Two years earlier, Connecticut passed Public Act 91-339 centralizing the Workers' Compensation Commission and instituting other administrative changes in an effort to reduce the costs of running the Workers' Compensation Commission and thereby pass those savings onto Connecticut businesses. The genesis for these reductions in benefits was to reduce workers' compensation costs to employers.

Connecticut was not alone in reducing benefits in exchange for lower workers' compensation premiums as other states have also reduced their state's benefits to injured workers in an effort to reduce costs to their businesses. "This trend is reflected in laws that restrict the scope of coverage and the types of medical conditions that are compensable, require that employees treat with employer-designated physicians, limit the period during which medical benefits may be collected, and ensure that the law is not liberally construed." [iv]

Today we see a movement known as "Opt-Out" which is the ultimate demise of a State's workers' compensation statute in exchange for an ERISA-style benefits program to address work related accidents and illnesses. Opt-Out plans of various guises are in existence in Texas (Texas actually has an employer option to not fall under its Workers' Compensation Act entirely and as such is really not a true "Opt-Out" plan), Wyoming and Oklahoma and are under consideration in South Carolina, North Carolina, Georgia and Tennessee. Constitutional challenges to the Opt-Out concept are being made in Oklahoma and Tennessee. Recently the Oklahoma Supreme Court declared its Opt-Out statute unconstitutional as it "is an unconstitutional special law ...creating an impermissible select group of employees seeking compensation for work-related injuries for disparate treatment."[v] Following the decision, Partner/Source, a Texas company that helps craft laws allowing companies to opt out of state workers' compensation plans, including Oklahoma's statute, will most certainly be back with a different benefit version to once again market its business driven aim of reducing workers' compensation policy premiums by reducing the workers' compensation benefits and administrative costs and assessments.

Opt-Out is the process by which an employer removes itself from a state's workers' compensation system if it substitutes an ERISA-governed employee benefit plan for work accidents. The injured worker does not have the option to elect coverage under the Opt-Out plan or the State's workers' compensation law as this option is entirely the employer's choice. ERISA-type plans preempts state law. As with the rise of managed medical care legislation, Opt-Out was driven by the need for employers to further reduce their workers' compensation costs. Because these plans are ERISA-type plans, the benefit structure is far less comprehensive (fewer claims covered), the benefits are far lower than traditional States' Workers' Compensation Acts would provide, and mandate compromised settlements (so much for due process). Whereas, under state workers' compensation statutes settlements are optional allowing the injured worker to keep his or her case open for life. The employer has absolute and total control over the administration of and scope of the plan. As with the original social contract commonly known as the "Grand Bargain," the employer, in most Opt-Out plans, retains its immunity from civil liability regarding work related accidents or illnesses.

Opt-Out plans are supposed to have equivalent coverage to the state's workers' compensation statute, but in reality their benefit coverage is less, medical care is almost totally employer directed, and their administration is restrictive. Such plans include mandatory arbitration provisions in lieu of alternate dispute resolution hearings before impartial hearing officers. Unlike workers' compensation benefits, benefits paid under an Opt-Out plan are taxable. Most Opt-Out plans provide that should the injured worker receive collateral benefits, due to the work related accident or illness, those benefits offset the overall benefit payout to the injured worker under the plans.

Those states which adopt Opt-Out will have a significant economic advantage, due to lower premiums, than states that maintain traditional statutory workers' compensation plans. "Opt-Out plans provide a different path. A single piece of legislation in each state gives employers the ability to write their own workplace injury benefit plans. They avoid legislative battles over every benefit and gain far more flexibility." [vi]

Editor's Note: Angelo Paul Sevarino is the founder and first Chairperson of the Workers' Compensation Section, currently is Of Counsel to Morrissey, Morrissey & Mooney, LLC, a Fellow, College of Workers' Compensation Lawyers, a Board Certified Workers' Compensation Specialists and certified Medicare Set-aside Consultant.

---

[i] The Status of Workers' Compensation In The United States, Revisiting the Grand Bargain,, Workers' Injury Law & Advocacy Group(January 2016)
[ii] Bob Burke, The Status of Workers' Compensation In The United States "The Grand Bargain", Workers' Injury Law & Advocacy Group, Workers First Watch, November 2015 (National Public Radio March 2015 report indicated 33 states had cut workers' compensation benefits in the past 20 years, created hurdles to get medical care, or made it harder to qualify. Today, businesses are paying the lowest rate for workers' compensation since the late 1970s); see also, Howard Berkes, Injured Workers Suffer As 'Reforms' Limit Workers' Compensation Benefits, National Public Radio(March 4, 2015)
[iii] Report available at: www.dol.gov/osha/report/20150304-inequality.pdf
[iv] Alan Mooshekh, Acts That Chip Away At Workers' Compensation: The Grand Compromise Is Not So Grand After All (2016), citing, David B. Torrey, Lawrence D. McIntyre, Recent Developments in Workers' Compensation and Employers' Liability Law, 51 Tort Trial & Ins. Prac. L.J. 749, 750(2016)
[v] Vasquez v. Dillard's, Inc., 2016 OK 89, No. 114,800, Supreme Court of the State of Oklahoma (September 13, 2016)
[vi] Howard Berkes, Opt-Out Plans Let Companies Work Without Workers' Comp, Health News Florida Journalism for a Healthy State (October 24, 2015)

2016 Verrilli-Belkin Charity Golf Event Sponsors

Commissioner George A. Waldron
Commissioner Nancy Salerno
Commissioner Michelle Truglia
Commissioner Christine Engel
Miller, Rosnick, D'Amico, August & Butler, P.C. *(Sponsor of On Course Refreshments)*
Strunk Dodge Aiken Zovas, LLC
McGann, Bartlett & Brown, LLC
Montstream & May, LLP
Pomeranz, Drayton & Stabnick, LLC
Attorney Cori-Lynn S. Webber
Attorney Kenneth Katz
Attorney Angelo Paul Sevarino
CRC Services, LLC (5)
Cousins, Desrosiers & Morizio
Morrissey, Morrissey & Mooney, LLC
Nuzzo & Roberts, LLC
Leighton, Katz & Drapeau
Kocian Law Group
Quinn & Quinn, LLC
Niziankiewicz & Miller
Gillis Law Firm
Carter & Civitello
Attorney Jack Clarkson
McHugh, Chapman & Vargas, LLC
Anthony & Reale
Coles, Baldwin & Kaiser, LLC
Law Offices of Peter Quay, LLC
Williams Moran, LLC
MES Solutions, Inc.
Morrison Mahoney LLP
D'Elia Gillooly & DePalma, LLC
Falzarano Court Reporting
Sousa & Minoque, LLC
Attorney Christopher C. Setaro
The Senich Law Firm, LLC
Suisman & Shapiro
McCarthy, Coombes & Costello, LLP
Howd & Ludorf, P.C.
Sayet & Seder
Kerin Law Offices
Cramer & Anderson, LLP
Letizia, Ambrose & Falls, PC
Orthopedic Associates of Hartford
Neurosurgery, Orthopaedics & Spine Specialists, P.C.
Pavano & Dombrowski LLC
The Quinn Law Firm LLC
Carter Mario Injury Lawyers (2)
Attorney Mark Merrow
The Dodd Law Firm, LLC
Ashley Furst/Renew Spinal Care (3)

To coincide with the expanded access to opioid antagonists, Public Act No. 16-43 also prohibits individual and group health plans from requiring prior authorization for opioid antagonists covered under the plan. This change not only ensures coverage for the administration, but acknowledges that most often; the use of an opioid antagonist to prevent a drug overdose is a spur of the moment decision.

Section 7 of the new law, focusing on practitioner requirements and restrictions when prescribing an opioid, is one of the more noteworthy provisions. As of July 1, 2016, initial opioid prescriptions for adults are limited to a 7-day supply. After the 7-day fill is exhausted, a patient is required to return to the doctor in order to receive a refill. Although the law allows for exceptions in the setting of a cancer diagnosis, palliative care, and where deemed appropriate by the physician, the law significantly shifts requirements for opioid prescriptions, which used to be limited to a 30-day supply under federal guidelines. This limit is an attempt to decrease the prescribing of excessive opioid prescriptions that patients may over-use, or leave unused, making drugs accessible for illicit use. 7-day opioid fill limits have been a common theme in opioid abuse legislation, and by June of 2016, most New England states had passed such limits, including Massachusetts.

Additionally, under the new law, prescribing an opioid to a minor is always limited to a 7-day supply, whether it's the first fill or fifth. The practitioner prescribing the opioid to a minor is also required to discuss with the patient, and a legal guardian, the risks associated with opioids, including addiction and overdose, and the medical reasons why an opioid prescription is necessary for that patient's situation.

The final major provision of the new law involves the PDMP, and places new requirements on pharmacies and health practitioners. Effective July 1, 2016, C.G.S. § 21a-254 is amended to require that all pharmacies or dispensers report information regarding a controlled substance prescription that is dispensed within twenty-four hours – a process IWP implemented years ago as a preemptive strike against drug diversion and potential abuse. Prior to July 1, dispensers were required to report within a week, but the shortened time line aims to ensure the PDMP is an accurate resource for prescribers when monitoring their patients' controlled substance use.

While current law already requires practitioners to consult the PDMP before prescribing more than a 72-hour supply of a controlled substance, the new law aims to make the consultation easier for practitioners. C.G.S. § 21a-254 (j)(10) will now allow a prescribing practitioner to designate an authorized staff person to review the PDMP in the doctor's stead. The practitioner who authorizes the agent, referred to as a delegate, is still responsible for protecting the confidentiality of the information, and for ensuring that the information pulled from the PDMP is for a legitimate purpose. However, by allowing a delegate to query the PDMP, the new law allows practitioners to continue to provide quality care to their patients without being burdened with more administrative duties.

As part of a treatment team, IWP can work closely with medical practitioners to monitor the use and potential abuse of opioids for their patients. Through programs such as Morphine Equivalency Dosage (MED) and Risk Evaluation and Mitigation Strategies (REMS), IWP helps balance the medication needs of injured individuals – concentrating on safer, more effective outcomes. IWP pharmacists monitor patients and their prescription histories, and its system is able to flag those patients who are receiving potentially dangerous drug combinations or high opioid doses. Once those patients are identified, IWP pharmacists are able to reach out to the treating physicians to discuss reducing the number or dosage of high-risk medications, or to explore alternate treatment options. These efforts can help to ensure the safe and appropriate use of opioid medications in the treatment of injured workers.

The new law makes clear that changes to coverage, prescribing, and dispensing of opioids in Connecticut are likely to continue for the next few years as the state and nation continue to battle the opioid epidemic. Section 4 of the law amends C.G.S. §17a-667, which had established the Connecticut Alcohol and Drug Policy Council in 2015. The statute now tasks the Council with developing measurable goals for a state-wide, interagency action plan for substance abuse treatment, preventative services, and criminal sanctions. The goals, which are to be established by January 1, 2017, must focus on reducing opioid-related deaths in Connecticut. These goals, the state-wide action plan, and the increased responsibility of providers, pharmacies, and insurers, make it clear this new law is not the last of the changes we will see in Connecticut.

Editor's note: Attorney Danielle Jaffe is Manager of Government Affairs for IWP, Injured Workers Pharmacy.

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

By Richard L. Aiken, Jr.

Thursday, September 15, 2016 was a top five weather day at Shuttle Meadow Country Club in Kensington. Following a wonderful lunch, Commissioners Goldberg and Barton were joined by 118 other golfers comprised of attorneys, doctors and other individuals involved in Connecticut workers' compensation. Following the golf event, the reception and dinner were attended by Mrs. Belkin. Also in attendance were Chairman Mastropietro and Commissioners Salerno, Mlynarczyk and Delaney.

This year there were fifty-five sponsors. Miller, Rosnick, D'Amico, August and Butler, PC made a special donation to sponsor the on-course refreshments. Commissioners Truglia, Salerno and retired Commissioner Waldron were also hole sponsors.

Additionally, Kerry Skillin and Erin Bailey of CRC Services, LLC were kind enough to host the "Hit-The-Green" contest on the sixth hole. CRC Services, LLC, which had five representatives attend the event, donated cigars for the contestants on Hole 6. Individuals who entered and landed a tee shot on the green of the sixth hole were automatically entered into the 50/50 drawing. Dr. Stephan Lange was this year's winner.

We continue to be very fortunate to have Ken Katz take photographs of all participating foursomes. Each year Ken spends the entire day at the event and, prior to the reception, develops and posts photographs of all of the golfers.

The low gross golfers in the Men's Division were Dominic Statile and Chris D'Angelo. Carm Chapman was the Women's Division low gross winner. Other net score winners included Brian Kenney, Brian Smith, Richard Green, Matt Reale, Al Mossein, Colin Mahon, Mark Leighton, Jon August and Emily Casey. The long drive winners were Mark Merrow and Joy Avallone. The closest to the pin winners were Jim Baldwin on Hole six, Rich Bartlett on Hole nine, Richard Green on Hole eleven, Rich Bartlett on Hole thirteen, and Richard Aiken on Hole fifteen.

For the eighteenth year, the Workers' Compensation Section of the Connecticut Bar Association will donate the net proceeds from the event to Connecticut Food Bank and Foodshare. The donations are largely funded by sponsorships and the "Hit-The-Green" contest.

Finally, I want to thank the members of the 2016 event committee, including Erik Bartlett, Heather Porto and Nancy Berdon.

Editors' note: Attorney Richard L. Aiken, Jr. of Strunk Dodge Aiken Zovas LLC in Rocky Hill is a Board Certified Workers' Compensation Specialist.

Connecticut Bar Association Workers' Compensation Section

2017 Workers' Compensation Retreat

Stowe, Vermont
March 5-7, 2017

Sponsored by Ringler Associates and the Injured Workers' Pharmacy

Sunday, March 5, 2017

6:00 p.m. to 8:00 p.m.	Reception at Stowe Mountain Lodge – Cocktails and Hors d'oeuvres

Monday, March 6, 2017

2:30 p.m. to 3:30 p.m.	Ringler Associates – The Wide World of Structures
3:30 p.m. to 4:30 p.m.	Commissioner Daniel Dilzer – Catastrophic Claims and Voc. Rehab
4:30 p.m. to 5:45 p.m.	Commissioner Ernie Walker – Ethics

Tuesday, March 7, 2017

8:00 a.m. to 8:45 a.m.	IWP on MSA Management – Taking the Burden off of the Claimant
8:45 a.m. to 10:00 a.m.	CRC – Vocational Rehabilitation & Employability: Tips & Trends
10:00 a.m. to 10:15 a.m.	Break
10:15 a.m. to 11:30	CRC – Continued
11:30 a.m. to 12:15	Roundtable with Commissioners Dilzer and Walker with CRC

Stowe Awaits

2017 Workers' Compensation Retreat Registration Form

March 5-7, 2017 Stowe, Vermont

Please fill out this registration form and return it, with your payment, to:
Connecticut Bar Association
30 Bank St, New Britain, CT 06051
or fax with your credit card information to (860)223-4488.
You may also call the CBA Member Service Center to register at (844)469-2221.

Please check the appropriate price category:

______CBA Member $295
______CBA Member with Reception Guest $345
______Non-member $375
______Non-member with Reception Guest $425
______Ski/Lift Ticket $70.00 per ticket (please indicate quantity of tickets desired); if the requisite number of tickets required for the group ticket rate (20 tickets) is not met by our group, this portion of registration fees will be refunded.

Please Print Full Name

Name:________________________ Phone:________________________

Firm/Company:________________________

Address :________________________

City:________________ State:________ Zip:________________

Payment Method

_____ Check (payable to Connecticut Bar Association)

_____ American Express _____ MasterCard _____ Visa

Card #: ________________________

Exp. Date:__________ CW Code:__________

Name on ________________________

Zip Code:______________ Signature: ________________________

Total Payment Enclosed: $ ______________

Except in compelling circumstances, refunds of seminar payments will not be granted for cancellations received after 10:00 a.m. on January 18, 2017.

_____PLEASE CHECK IF JUDGE, PUBLIC OFFICIAL, OR STATE EMPLOEE
(FOR COMPLIANCE WITH STATE OF CT CODE OF ETHICS)

Hotel Room Reservation Details
Stay at the Stowe Mountain Lodge on March 4, 5, and 6 for $259.00 per night. All rooms equipped with a king bed, gas fireplace, balcony and convertible sofa. Rooms are available for double occupancy with two queen beds without fireplace or balcony. State your accommodation needs at the time of reservation. A limited block of rooms has been reserved and are being held on a "first come, first served" basis. Please contact Stowe Mountain Lodge at 1-888-478-6938 and reference the Connecticut Bar Association to receive the above rates.

Semlna'code'EWC170304

Case Comments

By Margaret Crawford

CONNECTICUT SUPREME COURT DECISIONS

When is a principle employer entitled to immunity under C.G.S. §31-291?
***Gonzalez, et al v. O & G Industries, Inc., et al,* (SC 19377) (August 2, 2016)**

In this case, the general contractor hired a subcontractor to assemble scaffolding and hired another subcontractor to perform inspections and testing of instrumentation. The latter subcontractor in turn hired a third subcontractor. Employees of the first subcontractor and the third subcontractor were injured when an explosion occurred on the construction site. The plaintiffs brought a civil action against the general contractor seeking damages resulting from negligence. The defendant argued that it was a principle employer entitled to immunity under C.G.S. §31-291. The parties agreed that the general contractor was a principle employer under C.G.S. §31-291. The sole issue presented was whether the principle employer "paid" workers' compensation benefits in order to qualify for immunity.

In the defendant's standard subcontract, all bidders to the project had to include a line item for insurance costs, which included workers' compensation insurance premiums. However, the contract also included a provision that the general contractor may elect to implement a CCIP to "centralize the purchasing of insurance" for the project. There was no question as to whether the general contractor paid the premium for the policy and paid the deductible when the injuries occurred, however, the argument by the plaintiff was that the general contractor passed that cost onto the subcontractors and therefore really did not pay compensation benefits. In addition, the plaintiffs argued that the defendant did not pay all of the compensation benefits.

The Supreme Court held that in order to benefit from immunity, the principle employer must bear the financial burden of the benefits and cannot pass that burden onto its subcontractors or the Second Injury Fund. In addition, the Supreme Court held that C.G.S. §31-291 requires the payment of all, not some, of the injured worker's workers' compensation benefits.

The Supreme Court, based upon the wording of the subcontract, that the defendant procured at his own cost workers' compensation insurance for the subcontractors and that policy paid all of the benefits. Therefore, the Supreme Court upheld the trial court's granting of a motion for summary judgment which was filed on behalf of the general contractor.

Whether a widow's claim of bystander emotional distress is barred by the exclusivity provision of the Workers' Compensation Act.
Jenny Velecela v. All Habitat Services, LLC, 322 Conn. 335 (2016)

In this case, the decedent was repairing an all-terrain vehicle which was elevated on a lift. The vehicle slipped off the lift, crushing and killing the decedent. The plaintiff widow discovered the body when she arrived at the scene. The widow received funeral expenses under the workers' compensation insurance policy. She also made a claim pursuant to C.G.S. §31-306, which resulted in a settlement.

The Supreme Court found that a claim of emotional distress is by definition a derivative claim. Since the underlying claim of the decedent arose out of and in the course of the employment, any derivative claim would be barred by the exclusivity provision of the workers' compensation statute.

SUPERIOR COURT DECISIONS

C.G.S. Section 31-290a
***Peters v. Hartford Hospital,* CV-14-6055702S (June 6, 2016)**

The plaintiff sustained a work-related injury and as a result filed a workers' compensation claim. She was released to a sedentary work capacity approximately two months thereafter. Given her limitations, she could not perform her regular

duties. The defendant terminated the plaintiff's employment. The plaintiff filed a two count complaint. The first count was filed pursuant to C.G.S. §46a-60 and the second count pursuant to C.G.S. §31-290a.

As to C.G.S. §46a-60, the court held that the defendant had offered a legitimate nondiscriminatory reason for failing to hire the plaintiff. The plaintiff applied for three positions. The plaintiff was not qualified for one of the positions and as to the other two positions, no one was hired.

As to the C.G.S. §31-290a claim, the court cited Chiaia v. Pepperidge Farm, Inc., 24 Conn. App. 362 cert. denied, 219 Conn. 907 (1991), holding that "[i]f suitable work is not available or the employee is unable to work due to infirmity, there is no hindrance to an employer, apart from whatever contract of employment or company policy exists, to discharge a workers' compensation claimant because of the neutral operation of an absence control policy." Id. at 368-69. The court found that the defendant applied a neutral leave of absence policy and therefore granted the motion for summary judgement filed by the defendant.

C.G.S. §31-284 Exclusive Remedy Provision
***Feliciano v. Atlantic Plywood Corporation,* HHD-CV-14-6051448-S (June 13, 2016)**

The plaintiff was employed by a temporary agency who contracted to have him work at the defendant's place of business. While in the course of his employment, he suffered an injury. The plaintiff filed a civil action against the defendant on numerous grounds involving negligence.

The defendant argued that it was either the employer or the dual employer of the plaintiff, and therefore entitled to immunity under C.G.S. §31-284. The plaintiff argued that he was an employee only of the temporary agency and accordingly the defendant was not entitled to immunity. The defendant filed a motion for summary judgment.

The trial court noted that there is disagreement in Superior Court decisions as to whether putative two employers may equally be employers under the statute and consequently, both entitled to the immunity afforded by C.G.S. §31-284. The court however, indicated it did not need to reach that issue to rule on the motion for summary judgment.

The defendant argued that it controlled the means and manner in which the work was done and therefore was the employer. The court held that the exercise of actual control and direction over the plaintiff is not sufficient. The issue is whether the defendant had the right to exercise control and direction over the plaintiff. The court found that since the contract between the temporary agency and the defendant was not placed into evidence, a genuine issue of material fact remained as to whether the defendant had the right to exercise control over the plaintiff's work. Therefore, the court denied the motion for summary judgement.

C.G.S. §31-290a
***D'Amato v. State of Connecticut Board of Pardon and Paroles,* CV-13-6037167-S (June 14, 2016)**

The plaintiff was employed by the defendant as a parole officer, a position that involved hazardous duty. The plaintiff was injured when she tripped over boxes. She was given a light duty position, however, eventually was transferred to a hazardous assignment despite the fact that she was still limited to light duty work.

Once the plaintiff reached maximum medical improvement and received permanent restrictions, the defendant sent the plaintiff a letter explaining her employment options on the basis of her permanent disability. The plaintiff alleged she felt "frustrated and devastated" by the letter and felt she was coerced into voluntarily resigning from employment.

The original complaint contained two counts. The first count alleged violation of C.G.S. §31-290a(a). The second count alleged intentional infliction of emotional distress. The second count was dismissed based upon jurisdictional grounds. The defendant filed a motion to strike the first count based upon C.G.S. §31-290a. The trial court granted the motion to strike indicating that in order for a plaintiff to establish a prima facie claim, the plaintiff must first allege she was injured in the course of her employment and filed a workers' compensation claim. The plaintiff did in fact make such an allegation.

continued on page 14

However, the second requirement for a prima facie case is either to allege an adverse employment action including actual discharge or discrimination, or constructive discharge. The court found that the "[t]he plaintiff's allegation that she voluntarily resigned [did] not constitute an allegation of discharge or discrimination." Similarly, the court held that to survive a motion to strike a constructive discharge allegation, the plaintiff must allege that the defendant acted deliberately to create an intolerable work environment and the working conditions were intolerable. The court held that the employee's subjective beliefs about the working conditions were not sufficient to survive a motion to strike.

The court also discussed the plaintiff's allegation that she was transferred to hazardous duty while still on light duty restrictions. The court found that the specific time frame in which the claimant alleges she was transferred to hazardous duties was over three years prior to the filing of her complaint and therefore time barred, and her allegations of ongoing discrimination were vague and non-specific as to the timeframe involved.

COMPENSATION REVIEW BOARD DECISIONS

Coming and Going Rule
Helaine DeOliveira v. Florenee Cleaning, LLC and Second Injury Fund, CRB-4-15-18 (June 6, 2016)

In *DeOliveira,* the employer did not have insurance and therefore the Second Injury Fund was a party to the claim. The case was presented to the trial commissioner based upon a Stipulation of Facts. No testimony was taken at the time of the formal hearing. The claimant was injured while on route to her first work assignment of the day in a car owned by the employer and driven by a member of the respondent, Florenne. The trial commissioner found that the claimant was not "furnished" transportation by the employer and held that the injury was not compensable. The claimant filed a Motion to Correct which was denied in total. The Second Injury Fund argued on appeal that the CRB should deduce that the trial commissioner found the stipulation that the claimant was being transported from her home to her initial work assignment by a principle of the respondent in a motor vehicle owned by the respondent did not constitute "probative and reliable evidence." The CRB held that although commissioners are usually given deference in credibility determinations, when the determination is based solely on documentary evidence, the reviewing court is as able to gauge reliability.

The CRB held that this case falls within an exception to the coming and going rule in that the employer furnished transportation to and from work for the mutual benefit of the claimant and respondent. Therefore, the CRB held that the claimant's injury was compensable.

Does a medical opinion based upon an inaccurate narrative of the mechanism of injury render it unreliable?
Willodene Allen v. Connecticut Transit, 6036 CRB-3-15-9 (June 9, 2016)

In *Allen,* the claimant sustained a left shoulder injury as a result of a motor vehicle accident in February of 2010. The claimant deferred shoulder surgery at that time and indicated he would only have surgery if his symptoms worsened. Thereafter, in May of 2013, the claimant sustained a work-related injury. The claimant had surgery in February of 2014. The history of the mechanism of injury provided by the claimant to the treating physician was inaccurate based upon a videotape of the motor vehicle accident. The commissioner found the case compensable. The CRB upheld the commissioner's decision noting that in prior cases in which an award was overturned, the physician upon hearing the accurate mechanism of injury had recanted the opinion. In the present case, the respondents failed to present a report from the treating physician indicating that inaccuracies with respect to the mechanism of injury impacted his reasoning. They also did not take the doctor's deposition to attempt to get the doctor to recant his opinion. Therefore, the trial commissioner may rely on the reports as they are written and draw any reasonable inference from them.

Whether the claimant was an employee under the statute.
Victor Melendez, Jr. v. Fresh Start General Remodeling & Contracting, LLC and Michael Gramegna and Second Injury Fund, 6001 CRB-2-15-4 (June 10, 2016)

The claimant was a self-employed window washer and laborer. The respondent owned two businesses, Fresh Start Realty, LLC and Fresh Start General Remodeling & Contracting, LLC. The principle of each company was Michael

Gramegna. Mr. Gramegna stated that he has had business relationships with skilled tradesmen, but also has had less formal relationships with people who owed him money. He would allow a person to work off his debt by performing short term work on various properties. If the debtor provided reliable and skilled work, Mr. Gramegna would, on occasion, continue to employ him and issue a Form 1099.

The claimant's girlfriend knew Mr. Gramegna's girlfriend socially. The claimant was in need of additional money and therefore Mr. Gramegna, who was in the process of moving his home, hired the claimant to help out with the move. However, during the time the claimant was assisting Mr. Gramegna, the claimant also worked on some of the properties on which Fresh Start General Remodeling & Contracting was working.

When the claimant worked for Gramegna, he was given a ride to work. On the day of the injury, the claimant was driven to a diner to meet Gramegna. The claimant was wearing his Fresh Start uniform. Gramegna told the claimant that he was not going to work that day, but that the claimant could earn money by chopping wood at Gramegna's house. On the way to the house, the claimant was injured as a result of a motor vehicle accident while a passenger in a vehicle driven by an employee of Gramegna and owned by Fresh Start.

The respondent, Michael Gramegna, chose to represent himself at the formal hearing. The trial commissioner held that the claimant was an employee of Mr. Michael Gramegna. Mr. Gramegna appealed, indicating that he was unaware that he could be found personally liable and if he had been made aware, he would have hired counsel. The CRB rejected that argument based upon the fact that three Form 30Cs had been filed, including one naming Mr. Gramegna individually. In addition, there was a statement made at a formal hearing by claimant's counsel that the Form 30C was filed so that the claimant could proceed against Mr. Gramegna as an individual. The CRB acknowledged that the caption on the notices for the formal hearing did not include Mr. Gramegna individually.

Mr. Gramegna also argued that the claimant was not an employee under the Act because the work performed was casual in nature. The CRB held that the claimant worked for Mr. Gramegna in excess of 26 hours per week even though most of the work performed by the claimant occurred at Mr. Gramegna's personal residence. The CRB also acknowledged that there was no evidence that there was an expectation regarding how long the employment relationship might have continued. The evidence showed that the claimant worked on average 38.5 hours per week for approximately 16 weeks. In addition, Mr. Gramegna provided transportation to job sites, tools, and when the claimant was on a Fresh Start General Remodeling & Contracting job site, the claimant had to wear a shirt and cap with the company logo. The trial commissioner determined that Mr. Gramegna had the authority to control "the means and order of the work performed by the claimant."

Mr. Gramegna argued that the claimant should be excluded from the definition of employee because he was employed for purposes other than the employer's trade or business. The CRB determined that even if the trial commissioner reasonably inferred that was true, the claimant would still be an employee because he averaged 38.5 hours of work per week.

It should be noted that Mr. Gramegna failed to file a motion to correct and therefore the CRB had to accept the validity of all the factual findings by the trial commissioner.

Motion to Preclude
***Marcella Woodbury-Correa v. Reflexite Corporation*, 6032 CRB-6-15-9 (June 22, 2016)**

The claimant filed a Form 30C for repetitive trauma to multiple body parts on April 17, 2009. A Form 43 was not filed until July 24, 2009. The claimant filed a motion to preclude.

The trial commissioner found that an untimely Form 43 had been filed, however, the respondents offered a persuasive defense of "impossibility." The commissioner determined that the claimant had not provided any credible evidence that she had lost any time from work or submitted any medical bills related to the claimed work injury before the respondents filed the Form 43. Therefore, the respondents did not have the opportunity to preserve their safe harbor.

Under the facts of the case, the CRB upheld the trial court's denial of the motion to preclude.

continued on page 16

Case Comments

Arising Out Of And In The Course of Employment
***Sharon Clements v. Aramark Corporation*, Case No. 6034 CRB-2-15-10 (July 18, 2016)**

The claimant alleged an injury when she fell in the parking lot while reporting for work. The claimant testified that she was just walking, became dizzy, fainted, and fell to the ground. The initial treating physician indicated that the claimant suffered from a syncopal episode, likely cardiac in etiology.

The trial commissioner dismissed the case. On appeal, the claimant argued her head injury, as a result of the fall, was more severe because she had been walking on cement and therefore the fall was an incidental risk associated with her place of work. The CRB reasoned that in order for an injury to arise in the course of employment, it must be "(a) within the period of the employment; (b) at a place the employee may reasonably be; and (c) while the employee is reasonably fulfilling the duties of the employment or doing something incidental to it." Citing *Daubert v. Naugatuck*, 267 Conn. 583, 588-89 (2004).

The CRB noted that since the fall occurred before the claimant commenced her duties, the claimant must prove that she was fulfilling job duties or doing something incidental to her job duties. In addition, the CRB noted that even if the claimant were to establish the injury arose in course of her employment, she must also establish that the injury arose out of her employment. Therefore, she must prove that the employment was a proximate cause of the injury. The claimant argued that the fall on cement was a risk inherent to coming to work. The CRB stated that to be a proximate cause, the risk has to be higher than that to which the public is exposed.

The claimant also contended that since the risk was a neutral risk rather than a personal risk, the employment was the proximate cause. A neutral risk would be one that does not derive from a characteristic personal to the employee, such as an attack by a fellow employee. In this case, the trial commissioner's conclusion was that the fall was caused by a syncopal episode, likely cardiac in etiology.

The CRB upheld the dismissal of the claim. The decision has been appealed.

C.G.S. §31-249
***Harminder Singh v. CVS,* 6038 CRB-7-15-10 (July 20, 2016)**

The claimant suffered a compensable frostbite injury to the right great toe on December 20, 2008. He also had pre-existing diabetes. A respondents' medical examiner indicated that the claimant had pre-existing diabetes and suffered frostbite which was a substantial factor in causing an ulcer. However, he indicated that the ulcer from the frostbite resolved and the claimant had recurring ulcerations because of the underlying diabetes. He specifically testified that the work-related frostbite was not a substantial factor in the recurring ulcers or in the claimant's inability to work. Two commissioner's examinations were performed. One commissioner's examiner opined that the claimant had ulcerations of the right great toe and lesser toes. He testified that he could not state with a reasonable medical probability that the subsequent ulcerations, especially to the lesser toes, were related to the frostbite. He indicated that the claimant had a very limited work capacity and had reached maximum medical improvement.

The trial commissioner found that any treatment beyond the right great toe was not compensable, that the claimant was not totally disabled and that permanency benefits should commence.

The CRB found that it was a factual determination as to whether the claimant's disability was materially and substantially greater under C.G.S. §31-249 because of the compensable injury. The trial commissioner concluded that the proximate cause of the claimant's medical condition was the pre-existing diabetes. The CRB upheld the commissioner's factual findings.

C.G.S. §31-315
Rene T. Nielsen v. MNS Therrien Construction Company, 6040 CRB-1-15-10 (July 21, 2016)

The claimant sought to reopen a stipulation which, by its terms, would be paid by an annuity. The claimant moved to reopen the stipulation on the basis of a mutual mistake of fact. He stated that he was unaware he would not be able to convert the annuity to a lump sum payment if it became necessary.

The claimant testified that he has dyslexia and needs verbal communication. The claimant denied that the stipulation was ever explained to him. The trial commissioner noted that the claimant had added a handwritten addendum to the stipulation stating that in the event of his death, the balance of the annuity would be paid to his children in equal shares.

The trial commissioner found that she did not have jurisdiction over the annuity company to recalculate the annuity and pay a lump sum. She also denied the claimant's motion to open the stipulation.

The claimant also made a claim pursuant to C.G.S. §52-225i which allows the commissioner to permit the claimant to transfer the annuity to a third party in exchange for a lump sum. In this case, the commissioner found that it was not in the claimant's best interest.

The claimant appealed. The CRB indicated that the annuity company was not an employer or insurer which would be liable for payment under the Workers' Compensation Act. Therefore, the commissioner's finding that she did not have jurisdiction over the annuity company was not clearly erroneous. The CRB found that even if the commissioner had jurisdiction, the mistake would not have been a mutual mistake. The CRB noted that the claimant had executed the documents after having been canvassed by a commissioner prior to the approval. In addition, if there was a mistake, it was unilateral.

As to C.G.S. §52-225i, the respondents argued that the claimant failed to follow the statutory requirements. The CRB indicated that even if it were to waive the statutory requirements, the determination whether it would be in the best interest of the claimant to allow a liquidation of the structured settlement is a factual finding. The CRB deferred to the trial commissioner's factual determination. Therefore, the CRB affirmed the finding and dismissal.

C.G.S. §31-307(e)
Barbara Dahle v. Stop & Shop, 6035 CRB-6-15-10 (August 8, 2016)

The claimant argued that she should be relieved from the Social Security offset under C.G.S. §31-307(e). She alleged that because of the delays in the case, her Social Security benefits should not be offset.

The commissioner found that there were no delays in the case. In addition, the trial commissioner indicated that the claimant was bound by the date of injury rule. On the date of injury, C.G.S. §31-307(e) mandated that total disability benefits be offset for old age Social Security benefits.

The CRB upheld the commissioner, indicating that there is no law or language in the legislative history that would provide a waiver of the offset under any circumstances.

Heart and Hypertension
David Collins v. Town of Wilton, 6023 CRB-7-15-8 (August 19, 2016)

The claimant successfully passed a pre-employment physical examination for the police department in 1992. As early as 2001, the claimant had blood pressure readings that were borderline hypertensive. However, the commissioner found that the claimant was not diagnosed with hypertension until 2005. Therefore, the claim filed pursuant to C.G.S. §7-433c(a) was filed timely.

continued on page 18

Case Comments

The respondents argued that the rebuttable presumption should be applied based upon the claimant's date of hire. However, the commissioner found that C.G.S. §7-433c did not provide for a rebuttable presumption on the date of injury in 2005.

The CRB agreed with the trial commissioner that the applicable version of C.G.S. §7-433c is based upon the date of injury rather than the date of hire.

The respondents also argued that the claimant failed to make a timely claim. The claimant had high blood pressure readings beginning in 2001. However, the claimant's treating physician testified that he recommended a change in lifestyle rather than a pharmacological approach. The first time the claimant was prescribed blood pressure medication was in 2005. The treating physician made the diagnosis of hypertension in 2005.

The CRB therefore upheld the trial commissioner's decision that the claim was timely filed and that the date of injury rule applied.

Notice and Due Process
Nicholas Tiffany v. Cheer Virtue Evolution & Athletic Training Center, LLC, 6046 CRB-7-15-11 (August 23, 2016)

The trial commissioner found that the claimant sustained a compensable injury in the course of his employment. The respondent, an uninsured employer, appealed to the CRB. The respondent argued before the CRB that the employer's due process rights were violated in that the employer did not receive notice of the formal hearing and also argued that the Workers' Compensation Commission did not have jurisdiction because the claimant was not an employee.

The respondent contended that there had been problems with the postal service in the employer's area and therefore the employer did not receive the formal hearing notice. The CRB did not find that argument credible since no substantiating evidence was presented.

Although the CRB acknowledged that there are circumstances in which a finding and award would be reopened on jurisdictional grounds, in those cases, the respondent was able to persuade the CRB that it had not received notice of the formal hearing and therefore, did not appear. In this case, the respondent was unable to so persuade the CRB. The CRB upheld the finding and award.

Preclusion
Diana D. Mott v. KMC Music, Inc. a/k/a Fender Musical Instruments Corporation, 6025 CRB-1-15-8 (August 23, 2016)

The trial commissioner granted a motion to preclude and also ordered medical treatment. The respondents appealed arguing that preclusion was not supported by the facts and that the claimant had not provided a *prima facie* case that the medical treatment was related to a compensable injury.

The commissioner found that the claimant filed a Form 30C listing head, neck, back, left arm/elbow, left shoulder, right hand, right ankle, and both knees. The respondent did not issue a Form 43. However, the respondent paid medical expenses and issued three voluntary agreements accepting the neck, back, ankle and hands/contusion. The issue was the compensability of the claimant's post-concussive headaches. A Form 43 pertaining to treatment for the headaches was filed after the motion to preclude was filed. The commissioner held that the respondent made payments within 28 days following the Form 30C, however, did not file a disclaimer for the headaches within one year.

The respondents argued that they accepted the incident by voluntary agreement, therefore, preclusion should not have been granted. In addition, the respondents argued that there were no medical reports which would causally relate the headaches to the work incident.

The CRB held that the voluntary agreements were not given to the claimant until more than one year after the Form 30C was filed and therefore would not provide a basis for a one year "safe harbor" to file a Form 43.

The CRB acknowledged the case of *Quinones v. RW Thompson Company, Inc.* 5953 CRB-6-14-7 (July 29, 2015) *appeal pending*, AC 38256 which found that although the voluntary agreement had not been filed within one year, based upon the totality of the circumstances, the claimant knew or should have known that the respondents had accepted the claim. The CRB noted that in the present case, the payments that had been made were not substantial but rather sporadic.

The respondents also argued that C.G.S. §31-294c(b) provides that if a respondent makes payment, it can contest liability within a year, however, once the respondents commence payment of the claim, the respondents have an unlimited time to contest the extent of disability. The CRB did not agree with that argument.

On the other hand, the CRB remanded the issue of medical treatment. The CRB held that even after preclusion is granted, a claimant must prove entitlement to benefits. If the respondents do not stipulate to the benefits claimed, an evidentiary hearing is necessary.

In a dissenting opinion, Chairman Mastropietro indicated that it was his opinion that the respondents paid substantial sums during the initial year post-Form 30C. However, more importantly, it is Chairman Mastropietro's opinion that when the claimant accepted the voluntary agreements prior to the motion to preclude being filed, the claimant waived any argument that preclusion may lie.

Editor's note: Margaret Crawford is a partner at Montstream & May in Glastonbury, CT, a Board Certified Workers' Compensation Specialist and an editor of Compensation Quarterly.

Connecticut Bar Association Compensation Quarterly

Connecticut Bar Association
P.O. Box 350 • 30 Bank Street
New Britain, CT 06050

PRSRT STD
U.S. POSTAGE
PAID
Permit No. 1048
Hartford, CT

Board of Editors
Volume 26 • Number 3

Editor-in-Chief
Frank V. Costello

Coordinating Editor
Scott Carta

Scott Carta

Jane Carlozzi

Margaret E. Crawford

Marie Gallo-Hall

Colin P. Mahon

Maribeth McGloin

Matthew Witt

Editorial Policy and Purpose

Compensation Quarterly (CQ) is an independent and non-partisan publication which tracks developments in the area of workers' compensation as practiced in the State of Connecticut. It is the purpose of CQ to foster the goals of the Workers' Compensation Section of the Connecticut Bar Association and it is provided to Section members as part of their dues. Individual, non-member and bulk subscriptions are available. Readers of CQ should refer to the complete decisions of case citations for full details. CQ and its authors do not render legal advice by means of this publication.

Publishing and editorial decisions are based on the editors' judgment of the quality and length of the writing, the timeliness of the article and the potential interest of the readers of CQ as well as the fair presentation of material consistent with professional standards.

From time to time, CQ will publish articles dealing with controversial issues. The statements, opinions or conclusions are those of the author and may not reflect the official policy of the Workers' Compensation Section and/or the Connecticut Bar Association. No endorsement of those views should be inferred unless specifically identified as the official policy of the Workers' Compensation Section or the Connecticut Bar Association.

Compensation Quarterly is a quarterly publication of the Workers' Compensation Section of the Connecticut Bar Association. To subscribe contact the Connecticut Bar Association, Compensation Quarterly, P.O. Box 350, 30 Bank St., New Britain, CT 06050. Annual Subscription Rates: Members of the Workers' Compensation Section - Free; CBA Members - $50.00 per year to join Section and subscribe; Non-CBA Members - $45.00 per year. Bulk Subscription Rates: available upon request.

The Connecticut Bar Association website is www.ctbar.org