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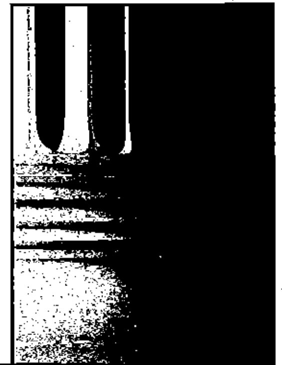

THE WORKERS' COMPENSATION UPDATE

The Changing Definition Of Family And Its Implications For Survivors' Benefits

By Marie Gallo-Hall

The definition of what constitutes a "family" in the 21st century is somewhat of a moving target. No longer is a family defined as merely a husband, wife and children. Same sex marriages, divorced families, blended families, foster care relationships, and adoptions along with an increased preference for co-habitation rather than marriage all add to the complexities of this issue. Consequently, when assessing a claimant's entitlement to survivor's benefits, one may need to look beyond the traditional concepts of family.

C.G.S. §31-306 provides for compensation to presumptive dependents, including a surviving spouse living with or regularly supported by the decedent and dependent children, who are children of the surviving spouse or who are living with the surviving spouse. The statute treats "dependents in fact" differently, that is persons who are not presumptive dependents, but are wholly or partially dependent upon the decedent. While these criteria may seem fairly straightforward, they are actually open to controversy in light of the expanded definition of family.

Should a spouse who is separated from the decedent and not receiving any financial assistance be entitled to benefits over another person? If there is a surviving spouse, should children from a prior marriage for whom child support is being paid but who are living with the birth mother, be entitled to benefits? Should individuals in civil unions be considered eligible for benefits? Should individuals who have co-habitated for a long period of time and may even own property together be considered eligible for benefits? Do foster children, adopted children and/or step children have rights to compensation under the Act? Is there any eligibility for benefits for individuals/friends who share a long-time living arrangement solely to share living expenses, because they are not be able to afford those costs on an individual basis?

At one time, an unmarried woman living with a man was not entitled to survivorship compensation under the Act. Piccinim v. CL&P, 93 Conn. 423 (1919) Children considered "illegitimate" may or may not have been considered dependents based on whether they lived with and were financially dependent upon a father. Id. Given these holdings, the Connecticut Supreme Court held in Wheat v. Red Star Express Lines, 156 Conn. 245 (1968) that the decedent's illegitimate children, no

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Harmless Isn't So Harmless Any More

By Joseph J. Passaretti Jr., Workers' Compensation Section Chairman

"Inconceivable!"
— Vizzini

"You keep using that word. I do not think it means what you think it means."
— I. Montoya

As attorneys, one of the many protections we take for granted is the time-honored usage of the "hold harmless agreement," or, to be more inclusive, the device that is meant to save, indemnify, defend and hold harmless. I will spare the reader the recounting of the history and origin of these particular phrases and how each one of them have their place and necessity in fully and finally barring further action by a payee against a payor to whom such an agreement is provided. But a review of the history would be well worth it.

When it comes to our old friend Medicare, however, it seems now the case that this behemoth has proven capable of breaching the heretofore impenetrable force field that is the hold harmless agreement. In August 2016, the Eleventh Circuit Court of Appeals issued their ruling in *Humana Medical Plan, Inc. v. Western Heritage Insurance Company,* 832 F.3d 1229 (11th Cir. 2016). In it, the Court upheld a lower court ruling that an insurer must pay a state administrator of a Medicare Advantage Plan (MAP) double damages for its failure to recompense benefits paid pursuant to the Medicare Secondary Payor Act (MSP) within sixty (60) days.

While the analysis is complex and perhaps a bit foreign, the facts are quite familiar. An individual injured in a slip and fall settled her case with the insurance company with potential liability. It was known to both sides that conditional payments had been made. The defendants, seeking an expedient resolution, made provisions to pay the amount of the conditional payments, as part of the negotiated settlement amount, over to plaintiff's counsel with the understanding that the funds would not be distributed to the plaintiff but rather paid over to Medicare. Not being any more trusting than any of us are, defense counsel wisely secured an indemnification agreement from the plaintiff and her attorney. You already know the rest: Sixty (60) days comes and goes, no payment, Medicare comes knocking.

While a more thorough reading of the decision is encouraged, here is the punchline: Indemnification language in a release or settlement agreement will not protect a primary plan, i.e. insurance carrier, from a recovery claim by Medicare (or in this case, by a state administrator of a MAP). The Court, in analyzing the applicable C.F.R. provisions, determined: "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.'"§ 411.24(i)(1) (emphasis added). This decision actually represents the second time a Court of Appeals has so interpreted this provision. See, *In re Avendia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F. 3rd 353, (3rd Cir. 2012). As such, it is not likely that this case represents an aberration.

So, what does this mean to us? These were not workers' compensation cases. But they did involve payments made pursuant to the MSP, which we deal with on a day-in and day-out basis. I think the inescapable conclusion is that a carrier cannot avoid its liabilities to Medicare by virtue of shifting that responsibility to any other party, no matter how iron-clad the agreement may be.

But there may be larger implications here: Consider what other obligations to Medicare we pass on via hold harmless/ indemnification agreements to injured workers or their attorneys. And claimants' counsel, please do not think this a one-sided concern, as most of you will bring your relationship with your clients to an end by thoroughly advising them in writing of their obligations to Medicare, and then send them on their merry ways. Query whether your liability to Medicare comes to a close at that point.

Maybe it is cliché to suggest that if one wants something done right, one must do it oneself, but that certainly seems to be the order of the day when it comes to our dealings with Medicare. If your confidence that your liabilities to Medicare have come to a close derives from a hold harmless agreement, then it may well be the case that the foundation upon which that confidence is built, will not stand.

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.

What Does this Improper Medical Treatment Sanction from OSHA Mean?

By Jon Rehm

For the first time ever, the Occupational Safety and Health Administration recently sanctioned (1) a Pilgrim's Pride chicken processing plant for providing improper medical treatment (2) for employees suffering from overuse injuries. While the hazards of meatpacking work (3) to employees is common knowledge and the packing industry is frequently sanctioned for unsafe work practices, (4) the sanction against Pilgrim's Pride for failing to provide medical care to their workers in Florida indicates OSHA is opening a new front in the battle for a safe workplace.

While OSHA's sanctioning Pilgrim's Pride for providing inadequate medical care to their injured workers is novel, their action is consistent with law that states access to prompt and appropriate medical care is crucial to pursuing a workers' compensation claim. OSHA sanctioned Pilgrim's Pride for failure to make timely and proper referrals to specialists for orthopedic injuries when employees sought treatment at company first-aid or nursing stations. According to OSHA, (5) delays in treatment can lead to permanent injuries.

The fact that OSHA deems inadequate medical care to be a violation of its regulations could also mean that employees have a statutorily protected right to oppose inadequate medical care. In Nebraska, this would mean that employees could possibly sue their employers (6) under the Nebraska Fair Employment Practices Act. Celeste Monforton, (7) a professor of public health at George Washington University, noted in her post that employers use company health clinics (8) not only to delay treatment but to discourage employees from seeking medical care. Some employers go so far as to discipline employees who do not get permission from their employer to seek outside medical treatment. A recent case in an Illinois federal court (9) stated such policies were illegal.

While Nebraska does not have any case law similar to Illinois about such policies, there is a strong argument to make that such policies would be illegal under Nebraska law and under the law of any state that prohibits retaliation against employees (10) for filing workers' compensation claims. Policies that require notification and permission to seek medical treatment from employers could also run afoul of Nebraska's laws allowing employees to choose their own doctors. (11) One Nebraska court has hinted that the right to pick a doctor (12) is a legally protected activity.

Monforton also pointed out that Pilgrim's Pride could be committing medical malpractice by failing to provide proper care and having nurses treat injured employees without proper medical supervision.

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What Does this Improper Medical Treatment Sanction from OSHA Mean?

However, packinghouses have some reason to believe that they are immune from medical malpractice suits filed by their employees against their employee health nurses. The legal shorthand for this is called the exclusive remedy. In practice, this means that an employer who (13) provides medical treatment in a negligent manner to an employee who is treating for a work injury can only be sued in workers' compensation court.

Of course, there are some ways around the exclusive remedy for medical care. The first exception would be that if employee health was outsourced. This would allow an employee to sue that provider directly (14) and could also allow for a civil conspiracy or civil RICO claim.

There may also be other exceptions as well. For example, Nebraska has a Meatpacking Industry Workers Bill of Rights (15) that states that workers employed at covered meatpacking houses have a right to a safe workplace and the right to seek benefits, including workers' compensation. If an employer does not provide adequate medical care or provides negligent medical care, that could certainly violate the public policy behind the Meatpacking Industry Workers Bill of Rights and warrant a tort case (16) against the packinghouses under the public policy of the state of Nebraska.

(1) http://scienceblogs.com/thepumphandle/2016/08/02/medical-malpractice-at-pilgrims-pridethe-poultry-company/

(2) https://www.dol.gov/sites/default/files/newsroom/newsreleases/OSHA20161541b.pdf

(3) https://www.propublica.org/article/tyson-foods-secret-recipe-for-carving-up-workers-comp

(4) https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=25260

(5) https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=25260

(6) http://workerscompensationwatch.com/2016/06/14/jon-rehm-to-speak-on-retaliation-at-nsba-seminar-on-friday/

(7) http://scienceblogs.com/thepumphandle/author/cmonforton/

(8) https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=25260

(9) https://scholar.google.com/scholar_case?case=6421837934498913709&q=workers+compensation%2Bretaliation&hl=en&as_sdt=4,332&as_ylo=2013&as_yhi=2015

(10) https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=31860

(11) http://workerscompensationwatch.com/2011/05/19/physician-choice-crucial-to-work-comp-claimants/

(12) https://scholar.google.com/scholar_case?case=15802753699862544640&q=gurrola%2Btyson&hl=en&as_sdt=3,28

(13) https://scholar.google.com/scholar_case?case=6016474241183407564&q=saint+elizabeth%2Bexclusive+remedy&hl=en&as_sdt=4,28

(14) http://workerscompensationwatch.com/2011/05/19/physician-choice-crucial-to-work-comp-claimants/

(15) http://www.nebraskalegislature.gov/laws/statutes.php?statute=48-2213

(16) http://workerscompensationwatch.com/2016/06/14/jon-rehm-to-speak-on-retaliation-at-nsba-seminar-on-friday/

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matter how deserving they may be, were not entitled to survivors' benefits because they were not living with and financially dependent upon him.

This decision was in line with the Connecticut Supreme Court's holding in Gagliardi v. Downing & Perkins, Inc. 152 Conn. 475 (1965) two years earlier. In that decision, the Supreme Court reiterated the well-established criteria for determining who should be considered a dependent in fact. The three factual elements necessary to establish dependency in fact are (1) reliance on the contributions of the decedent for necessary living expenses, judged by their class and position in life; (2) a reasonable expectation that contributions would continue; and (3) an absence of sufficient means at hand for meeting those living expenses. In the years that followed, the Connecticut Appellate Court refused to expand the class of persons eligible for survivors' benefits if such persons were not specifically mentioned in the Act. Wislocki v. Town of Prospect, 72 Conn. App. 444 (2002), cert. denied, 262 Conn. 906 (2002). A recent Compensation Review Board decision, however, may provide claimants with some wiggle room.

Sneed v PSEG Power of CT, 5988 CRB-3-15-2 (2/18/16) may become a pivotal case on this issue. The claimant and decedent in the Sneed case were not married on the original date of injury. They were, however, living together in a domestic relationship and the claimant alleged that she was wholly or partially dependent upon the decedent's income. The trial commissioner acknowledged that Connecticut does not recognize common law marriage but noted that this fact only barred a claim that the claimant was a presumptive dependent and not a dependent in fact. He further acknowledged that, pursuant to C.G.S. §31-275(6), to be a dependent in fact requires that a claimant be a member of the injured employee's family or next of kin. He denied the respondent's motion to dismiss, holding that the claimant had the right to demonstrate membership in the family or kinship, but he left open the question of what evidence is required. In doing so, the trial commissioner referenced Goshorn v Roger Sherman Transfer Co., 131 Conn. 200 (1944) wherein a mother-in-law was found eligible for survivor's benefits since she lived with the decedent over a long period of time, was a de facto mother to the decedent's child, and relied upon the claimant for financial support. He also referenced Kerrigan v. Commissioner of Public Health, 289 Conn. 135 (2008) and suggested that it would be difficult to forever disqualify a person in a long-term same sex domestic relationship from being considered a member of a decedent's family because the original date of injury was before same sex marriages were legal in Connecticut. The Compensation Review Board affirmed the trial commissioner's decision and remanded the case to the trial commissioner to allow the claimant the opportunity to submit evidence to support her claim of being a dependent in fact. No matter which way the evidence points in Sneed, however, the door has been opened to a case by case analysis of the facts premised upon a modernized definition of family.

While this matter is pending in the workers' compensation forum, another case that originated as a planning and zoning issue may open the door even further on the question of what defines a family. The case that has become known as "the Scarborough 11" involves a large home on Scarborough Street in Hartford where eight adults and three children, some of whom are related by blood and some who are not, live together in what they describe as a loving family. The West End community and the Planning and Zoning Commission disagreed that the eleven people were a single family and contended that the number of unmarried/unrelated people living in the house violated the zoning laws. City of Hartford v. Laura Rozza, et al, HHD-CV15-6058199. The case was then brought to the federal district court on the constitutional issues of whether the homeowners were denied equal protection and if their due process rights were violated. Since the City of Hartford recently dropped the state claim, the constitutional issues will not be answered. The status of the Scarborough 11 remaining in a "family living" situation, however, may still have far-reaching implications with respect to the definition of the concept of family.

The definition of family will likely continue to develop as our society evolves. The Sneed decision may well allow a case by case analysis of future claims for survivors' benefits to allow the trial commissioner the ability to make judgments that reflect the new reality of the family.

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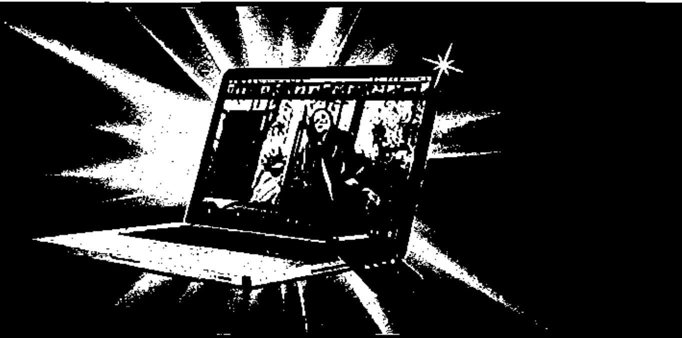
TECH TIPS #13

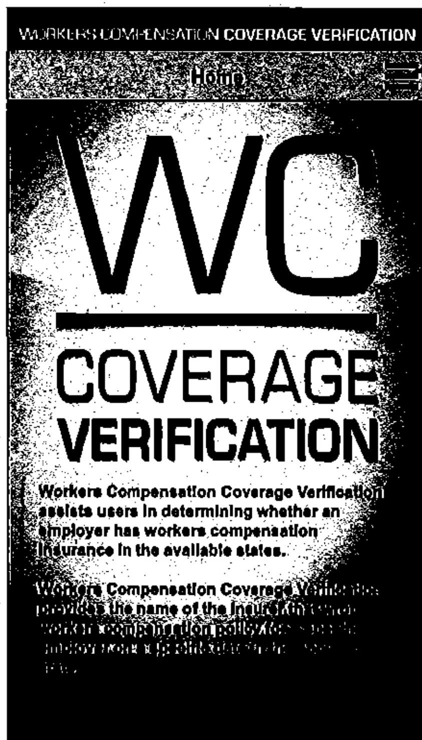
By Scott A. Carta

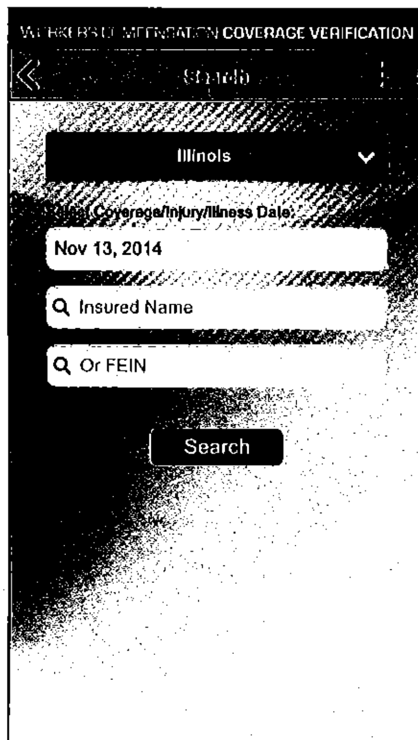


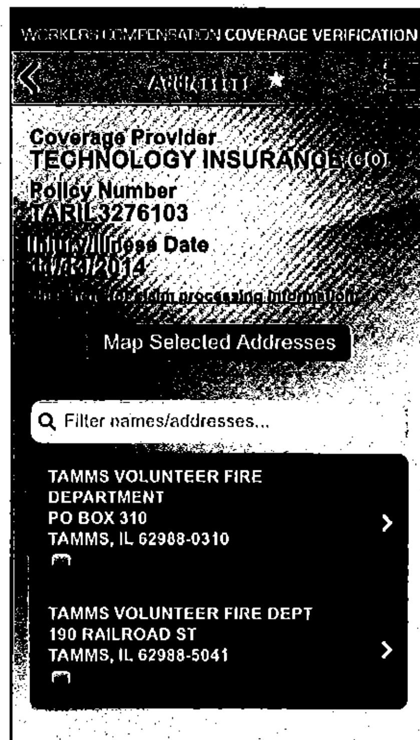
There are often times in our workers' compensation practice where the identity of the insurer on a particular date is important, such as with repetitive trauma and occupational disease cases. It is also helpful for claimants' attorneys, particularly when opening the file, to send out the initial letters. Most of us are aware that we can find this information on the Connecticut Workers' Compensation website under the "verify coverage" tab on the left side of the screen. However, what if you are at a hearing or meeting a client out of the office and you need the information? You guessed it! There's an app for that. There is a free app called "Workers' Compensation Coverage Verification."

Once you download the app and open it, you are first asked to register. However, you only have to check the "register" box and tap "register". You are not required to set up an account or enter any information. You are simply registering your device. You are then brought to the search screen which provides a drop down box to select a state. Not all 50 states are represented, but fortunately for us, the app includes Connecticut. There are three fields under the state selection tab: coverage date, insured name and FEIN (Federal Employer Identification Number). You are not required to enter both the insured name and the FEIN. Also, you do not need to enter the full name of the employer. The full name would, however, narrow your search.

Once you enter the information and tap the "Search" tab, one or more results will show up and you need to tap on the one you want. You will then be given the name of the "Coverage Provider", the "Policy Number" and the "Coverage Date". At the bottom, the employer name and address is listed. This is a great tool that I have used at hearings and know many of you will find the need for it as well.







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Case Comments

By Matthew B. Witt

CONNECTICUT SUPREME COURT DECISIONS

Does an estate have standing to seek benefits under the Workers' Compensation Act?
Estate of James Rock v. University of Connecticut, 323 Conn. 26 (2016)

The decedent died from mesothelioma as a result of occupational exposure to asbestos. At the time of his death, June 27, 2010, he did not have dependents. The decedent never filed a claim for workers' compensation benefits. The decedent's estate filed a notice of claim for benefits on October 19, 2011. The claim was contested.

At the formal hearing, the commissioner granted the respondent's motion to dismiss on the ground that the estate did not have standing to pursue permanent partial disability or temporary total disability benefits. The estate filed a motion to substitute the administrator of the estate as the claimant, and a request to change the case caption, but both motions were denied.

The Compensation Review Board upheld the dismissal of temporary total and permanency benefits for lack of standing. However, the Board determined that the estate qualified as a legal entity under the Act and, as such, the estate had standing to seek burial expenses, medical expenses, and actual lost wages. On appeal, the claimant's estate challenged the standing determination, but not the commissioner's denial of the motion to substitute the administrator of the estate as the claimant and the request to change the case caption.

Noting that it was well established in the law that an estate is not a legal person, but merely a name to indicate the sum total of the assets and liabilities of the decedent, the Court held that the estate was incapable of bringing a claim under the Workers' Compensation Act. Accordingly, the Supreme Court concluded that the estate did not have standing to pursue any type of workers' compensation benefits, and reversed the Board's decision that the estate had standing to seek burial expenses, medical expenses, and actual lost wages.

Editor's note: Practitioners are cautioned, however, that this case does not necessarily stand for the proposition that the executor or administrator of an estate cannot file on behalf of the decedent employee under the Act. Cases cited in support of the decision note that a wrongful death action or other legal action can be maintained on behalf of a decedent only by the executor or administrator of his estate (as opposed to the estate itself).

Can a workers' compensation carrier maintain an action for equitable subrogation against third-party tortfeasors?
Pacific Insurance Company, Limited v. Champion Steel, LLC, et al., 323 Conn. 254 (2016)

In the underlying workers' compensation case, the claimant was injured when a retractable lifeline he was wearing failed causing physical injury. The workers' compensation insurer for the employer paid workers' compensation benefits. The insurer brought a civil action against the defendants, claiming negligence for failure to provide an adequate fall arrest system. The defendants moved to dismiss the complaint arguing that the insurer did not have standing under C.G.S. § 31 – 293 or the common-law doctrine of equitable subrogation. The insurer objected, and filed an amended writ and amended complaint adding the employer as a plaintiff. The employer filed a motion to intervene in the action. The trial court denied the motion to substitute party, granted the motion to dismiss, and held that the employer's motion to intervene was rendered moot by the dismissal of the insurer's action.

The Supreme Court concluded that the insurer had a broad common-law right to bring a subrogation action when the insurer paid on behalf of an insured (in this case the employer) for a loss caused by a third party tortfeasor, and that the workers' compensation statutory scheme did not abrogate that right. The Supreme Court noted that the legislature was aware of the long-standing and strong doctrine of equitable subrogation, and intentionally did not include a prohibition against equitable

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subrogation actions in the Act. Allowing equitable subrogation serves the public policy of containing the cost of workers' compensation insurance, prevents unjust enrichment of tortfeasors, and allows the insurer to proceed in those situations where the claimant employee or insured employer may not wish to incur the cost of civil litigation.

The insurer's right of equitable subrogation was noted to be distinct from the statutory right of recovery embodied in C.G.S. § 31-293, which created a right for employers that did not exist at common law. While the employer's right to intervene in or bring an action against a third-party tortfeasor is bounded by the terms of C.G.S. § 31-293, the insurer's right to equitable subrogation is derived from the common law, and is not so circumscribed.

The Court cautioned, however, that while the insurer in this case could assert an equitable subrogation claim, it was not deciding that subrogation should be ordered. The Court expressed no opinion as to whether or not the insurer had established its right to recover from the defendants. Such determinations depend on the equities, facts, and circumstances of each individual case.

C.G.S. 7-433c.
Reginald Holston v. New Haven Police Department, et al., 323 Conn 607 (2016)

The claimant police officer suffered a myocardial infarction, and made a claim for benefits under C.G.S. § 7-433c for hypertension and heart disease. At the formal hearing, the commissioner concluded that the claimant's action for benefits for hypertension was untimely because the claim was filed more than one year after the claimant became aware of his diagnosis of hypertension. The commissioner allowed the claim for benefits related to heart disease and the myocardial infarction. The commissioner found that the pre-existing hypertension was a significant contributing factor in the development of heart disease, but also found there were other significant contributing factors such as high cholesterol and the claimant's gender. The Compensation Review Board affirmed the findings.

The employer argued that because the claimant's hypertension was a significant contributing factor to his heart disease and myocardial infarction, the claim for the latter benefits was also untimely. The Supreme Court disagreed, indicating that the argument that heart disease and hypertension were necessarily interrelated was not supported by the case law. The Court ruled that the case law did not indicate that a prior diagnosis of hypertension would bar a later claim for benefits related to heart disease. In this case, evidence presented showed that the hypertension and the myocardial infarction were separate medical conditions, and other risk factors also played a role in the development of heart disease. The court ruled that the facts demonstrated that the claimant met the requirements for benefits under C.G.S. § 7-433c, and affirmed the Board's decision.

CONNECTICUT APPELLATE COURT DECISIONS

Is the equitable doctrine of laches available as a defense to a motion to preclude?
John M. Wiblyi, Jr. v. McDonalds Corporation, et al., 168 Conn. App. 92 (2016) & 168 Conn. App. 77 (2016)

The claimant filed a form 30C on June 28, 2000, claiming injury. The employer filed a form 43 contesting liability on August 3, 2000. Almost nine and a half years later, on February 25, 2010, the claimant filed a motion to preclude the respondent from contesting liability, indicating that the respondent-employer had failed to file a notice contesting liability on or before the twenty-eighth day after it received written notice of the claim. The employer objected.

At the formal hearing, the commissioner denied the motion to preclude and ordered the case to proceed on the merits. The commissioner was persuaded that the motion to preclude was prejudicially late, and was barred by the doctrine of laches. The Compensation Review Board remanded the matter for additional proceedings after indicating that the commissioner was prohibited as a matter of law from denying the motion to preclude on the basis of the equitable doctrine of laches.

The Appellate Court noted that the issue of whether laches is available as a defense to a motion to preclude had not previously been decided by the Appellate or Supreme Courts. Laches bars a plaintiff from seeking equitable relief in those cases where there has been an inexcusable delay that has prejudiced the defendant. This doctrine has, at best, limited

applicability. For example, laches does not apply to claims at law. The Appellate Court held that the limited applicability of the equitable defense of laches does not extend to a statutory mechanism found in a system derived exclusively from statute. The Appellate Court refused, in the absence of legislative action, to recognize a time limitation within which an employee must file a motion to preclude, since there is no time limitation specifically delineated in the Act.

The Appellate Court, while recognizing that C.G.S. § 31-298 provides that the commissioner should proceed so far as possible in accordance with the rules of equity in all cases and hearings under the Act, declined to graft equitable doctrines such as latches onto all aspects of the Act.

The Court also addressed the remand by the Compensation Review Board. The Board remanded the case with directions that the commissioner reconsider his findings on the ground that there were ambiguities in the record. The Appellate Court found that despite inconsistencies and conflicts in the evidence presented to the commissioner, the commissioner's findings were not inconsistent or contradictory. Accordingly, the Appellate Court concluded that the Board improperly reassessed the credibility of witnesses, and weighed the evidence usurping the authority of the commissioner as the finder of fact.

Whether or not to remand a case for further proceedings generally presents a question to be determined by the Board in the exercise of its sound discretion. When a commissioner's findings are too ambiguous to serve as the basis for appellate review, it may be appropriate for the Board to remand the case. However, the commissioner drew reasonable inferences from the evidence presented, and the Board abused its discretion remanding the matter in this particular case.

C.G.S § 31-294f.
Jan Jodlowski v. Stanley Works, 169 Conn. App. 103 (2016)

The holding in this case is a recitation of the well-worn principle that the commissioner serves as the finder of fact, and it is generally not the province of the Appellate Court to second-guess these factual determinations. The Appellate Court agreed with the Compensation Review Board that it was bound to accept the commissioner's decision on the medical evidence in this case.

The claimant also argued that the commissioner was required to order a commissioner's examination under C.G.S § 31-294f when conflicting medical evidence was presented. Upon review, the Appellate Court found that the statute does not require the commissioner to order a commissioner's examination to resolve conflicting evidence, as the decision whether or not to invoke the provisions of the statute is within the commissioner's discretion.

COMPENSATION REVIEW BOARD DECISIONS

Untimely appeal under C.G.S. 31-301.
Charles v. Bimbo Foods, Inc., 5986 CRB-7-15-2 (November 30, 2016)

The respondents filed a motion to dismiss the claimant's appeal as untimely, challenging the jurisdiction of the Compensation Review Board to act on the appeal pursuant to the terms of C.G.S. § 31-301. Noting that the courts have determined that the failure of a party to file a timely appeal deprives the Board of jurisdiction over the appeal, the Board found that the claimant was obligated either to appeal to the board within 20 days or file an appropriate motion with the trial commissioner within that 20-day period. Failure to do either extinguishes the claimant's appellate rights. Since the claimant took no action within 20 days, the Board lacked subject matter jurisdiction to consider the claimant's appeal.

Penalties and interest unwarranted.
Collier v. Logistec USA, Inc., 6059 CRB-4-15-12 (October 4, 2016)

This matter arises from injuries for which there was concurrent jurisdiction under the Act and the Longshore Act. A stipulation was agreed to by the parties and approved on June 1, 2015. The stipulation specifically held that it would be

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null and void if the settlement was not successfully approved under each individual act. The bulk of the award was paid in a timely fashion, however the agreed-upon attorney's fees and costs were not paid until the Labor Department approved the same. An erratum order was issued by the Labor Department relative to attorney's fees due under the stipulation on August 11, 2015. Full payment of the fees and costs due the claimant's attorney was made on August 26, 2015. The trial commissioner indicated that since the agreement between the parties regarding payment of attorney's fees was not finalized until Longshore Act approval occured on August 11, 2015, respondents could not make a payment earlier. Thus, the payment of attorney's fees and costs on August 26, 2015 was timely. The claimant contended that penalties and interest were due under C.G.S. § 31-303 as the attorney's fees in this case were paid more than 20 days from the state approval of the stipulation. The commissioner disagreed, indicating that the respondent should not be penalized in this particular case where the federal administrative procedures required separate approval of the attorney's fees and costs. The Board agreed with the commissioner, indicating that in this particular case, the respondent's payment of the bulk of the award in a timely fashion, and then waiting to pay the attorney's costs and fees agreed upon when approved by the Labor Department, was the appropriate and prudent course.

C.G.S. § 31-310
Gould v. City of Stamford, 6063 CRB-7-15-12 (November 14, 2016)

The claimant alleged he held concurrent employment and claimed benefits under C.G.S. § 31-310. In addition to working for the City of Stamford, the claimant was the sole member of a limited liability corporation. The Second Injury Fund denied that the claimant qualified for concurrent employment as there was no employer – employee relationship between the claimant and the limited liability corporation, and that the chairman's memorandum 2003 – 02 barred single-member limited liability corporations from coverage under the Act unless they have elected to be covered by the filing of a Form 75 (which was not filed in this case). The commissioner found that the limited liability corporation maintained a workers' compensation insurance policy that was in effect as of the date of the injury. The commissioner ultimately found that the claimant was not an employee of the limited liability corporation given the evidence presented, and thus denied the claim for benefits as a result of concurrent employment. The Board affirmed the commissioner's decision because the conclusions were reasonable factual findings given the evidence presented. Further, since the claimant was not an employee of the limited liability corporation, the commissioner lacked jurisdiction over the claimant's relationship with said limited liability corporation.

Affirming finding and dismissal based upon lack of employer – employee relationship.
Veilleux v. Dehm Drywall, LLC 6057 CRB-8-15-12 (September 26, 2016)

The commissioner concluded after a formal hearing that the claimant was a self-employed drywall installer rather than an employee when providing services to the respondent employer. The commissioner found the claimant represented himself as a self-employed drywall installer, the claimant received a Form 1099, filed his taxes based on business profit and loss, was paid a gross amount with no tax deduction, received no other benefits, and did not receive a pink slip when work from respondent- employer was unavailable. The claimant worked for other contractors when work from the respondent-employer was unavailable. While the employer directed the claimant and his co-workers as to the location and the scope of each job, and provided a schedule for completion, otherwise the claimant completed each job autonomously. The claimant relied upon his own expertise and training in completing the actual installation of sheet rock. Based upon these findings, the commissioner determined that claimant was an independent contractor on the date of loss and dismissed the claim for workers' compensation benefits. No motion to correct was filed.

The Board stated that well-litigated precedent holds that the determination of whether or not an employee – employee relationship exists is based upon the totality of factors test, and the Board extends significant deference to the findings of the trial commissioner in making this determination. The finding that the claimant was not an employee was reasonable and the Board affirmed the commissioner's dismissal.

C.G.S. §31 – 290a
Williams v. City of New Haven, 6050 CRB-3-15-10 (October 18, 2016)

At the formal hearing, the sole issue for determination was whether or not the commission had jurisdiction to hear a wrongful termination claim despite an earlier dismissal of an arbitration by the Labor Board that was followed by denial of a motion to vacate the arbitration decision by the Superior Court.

The claimant, a union employee covered by a collective bargaining agreement, alleged he was terminated for pursuing his rights to workers' compensation benefits. A written arbitration decision was issued by the state labor board that found the city had just cause to terminate the claimant's employment. A motion to vacate this award filed in Superior Court was denied. The claimant contended that the Labor Board decision did not have preclusive effect in the workers' compensation forum and, therefore, the claimant was entitled to pursue the wrongful termination claim in the commission. The respondents maintained that the Superior Court decision was the final and conclusive ruling on the issue of the termination. The claimant further argued that C.G.S. § 31-51bb was enacted to ensure that employees covered by a collective bargaining agreement have the same opportunity to litigate their statutory claims as employees who are not covered by a collective bargaining agreement, and this statute does not bar the claimant from litigating a statutory wrongful termination claim before the commission.

The commissioner ultimately determined that because the legal issues in a wrongful termination claim differ from the issues considered in the state Labor Board proceeding, claim preclusion did not lie. The commissioner, therefore, determined that the commission had jurisdiction to hear the claimant's wrongful termination claim.

Looking to the decision in *Genovese v. Gallo Wine Merchants, Inc., 226 Conn. 475 (1993)*, the Board noted that an employee can assert statutory rights in a court action despite a prior adverse determination of the same or similar claim in an arbitration proceeding brought pursuant to a collective bargaining agreement. The respondents attempted to distinguish this case by arguing that when a party's cause of action has been fully adjudicated in one administrative agency a claimant should not be allowed to move to a second agency to essentially retry the claim. Respondents further argued that the issues considered in the arbitration were the same presented for determination in the commission. The Board disagreed with both these points. Ultimately the Board found that the doctrine of collateral estoppel did not preclude the claimant from moving forward with his wrongful termination claim in the commission.

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