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THE WORKERS' COMPENSATION UPDATE

Injection Therapy:

A Summary of the Various Injections for Treatment of Common Workplace Injuries

By Tamer Ghaly, MD, DABA, DABPM

One of the most common forms of interventional pain management is injection therapy. The advantages of injection therapy include a non-invasive approach to alleviate the patient's pain which helps to improve patient functionality and reduce symptoms of many conditions within a few days. Some of the disadvantages are that the patient may experience pain or discomfort at the injection site during the first few days after the injection. Important considerations when performing an injection include ensuring that the patient is not on blood thinners as well as monitoring the blood sugar of diabetic patients. Below is a list of the most common injections and procedures used in interventional pain management.

Epidural, steroid injections

Indications: pain that radiates to arms or legs.

Medication: steroids.

Approaches: interlaminar approach, caudal or a transforaminal approach.

Interlaminar epidural injection is used for central disc herniation or spinal canal stenosis (narrowing).

Transforaminal epidural injection is used to address the radicular symptoms secondary to foraminal narrowing.

Location: it is done in the cervical, thoracic, or lumbar area.

Caudal epidural injection is usually done with a catheter to address the stenosis secondary to a fusion surgery when the interlaminar approach cannot be done.

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Administrative Law Judge District Assignments

By Jim Henke

With the recent retirements of sitting Administrative Law Judges and the appointment of two new Administrative Law Judges, there have been some district reassignments and some that have remained the same. Administrative Law Judge assignments:

In the **First** District (Hartford) Judge William J. Watson III and Judge Toni M. Fatone preside.

The **Second** District (Norwich) is presided over by Judge Soline M. Oslena and by Judge Zachary Delaney.

In the **Third** District (New Haven) Judge Shanique Fenlator joins Judge Maureen Driscoll.

Bridgeport's **Fourth** District is now presided over by Judges Carolyn Colangelo and Benjamin Blake.

The **Fifth** District (Waterbury) has Judge Scott A. Barton and Judge Pedro E. Segarra presiding.

In the **Sixth** District (New Britian) Judge Daniel E. Dilzer and Judge Zachary Delaney (2 weeks per month) preside.

In the **Seventh** District (Stamford), Judges Jodi Murray Gregg and Brenda Jannotta will hear claims.

Middletown's **Eighth** District is presided over by Judge Peter C. Mlynarczyk and Judge David W. Schoolcraft.

For Judges Randy Cohen and Nancy Bonuomo, their TWR (temporary work after retirement) eligibility continues through at least the end of 2023.

Editor's note: Jim Henke is a partner at Nuzzo & Roberts, LLC in Cheshire, CT where he handles workers' compensation claims.

Interview with Administrative Law Judge Shanique Fenlator

Interviewed by Meghan A. Woods

MW: Good morning Judge Fenlator. First, I'd like to congratulate you on your recent appointment! I also would like to thank you for sitting down for this interview so bright and early this morning. I know you are familiar with Compensation Quarterly so I won't explain our mission statement other than to say that I think the interviews with the new judges are a great part of our publication, and they allow us all to get to know some things that you want us to know, and that we might not otherwise know just by appearing before you. Now, I watched your confirmation hearing, and heard a little about your childhood. Your mother came to the United States from Jamaica, and you grew up in Hartford. But, for those that did not get to hear your story, tell us a little about your early childhood.

SF: I migrated to the US with my mother in 1991. My grandmother resided in Hartford at the time and had petitioned for my mother and her siblings to migrate to the U.S. I was the first grandchild to migrate to Connecticut, and the rest of the family joined us over the years. My extended family and I are all very close and reside close to one another throughout greater Hartford.

Some people think of Jamaica and picture beautiful beaches and relaxation, and while that it is true for vacationers, most people in Jamaica live in poverty. My family came to America in search of job and educational opportunities, and even though it meant starting over, my family knew that we would have a future living here. When we first moved, we were unfamiliar with the system, and everyone had to find their own way. My mom's first job was as a cashier at Stop and Shop. She worked full-time during the day, and went to school at night to become a CNA. After she finished that degree, she went back to school and earned her Associate's Degree in Nursing, finally becoming a Registered Nurse. That drive and motivation was my inspiration, and that was always the expectation that was set for me- to do my best.

MW: Your mom sounds like a pretty inspirational woman. Undoubtedly, it was hard for her too having to spend that time away from you when you were in school. During your Judicial Nomination hearing, you referred to yourself as a "latchkey kid", meaning you were often home alone after school while your mom was working or at school. Tell me what impact that experience had on you.

SF: It influenced me greatly. I became independent at a very early age. On most days, I was responsible for completing my homework and getting myself ready for school in the morning. The Hartford Public Library was a safe place for many students like myself, and I used the educational opportunities that it afforded to keep myself busy. The library offered free tutoring, access to computers, and countless books, and I took advantage of every opportunity I had to learn. My childhood was centered around education and being my best self- something that was encouraged by my mother and my uncles. I was also very fortunate to have teachers who supported me, saw my potential, and pushed me to challenge myself.

MW: After graduating high school, where did you attend college?

SF: I graduated from UConn in Storrs. I was accepted to the combined degree dental program and graduated with a Bachelor of Arts degree in Psychology.

MW: Did you know you wanted to be a lawyer while in college?

SF: No, actually, I was not interested in the law until after I graduated from college. I initially wanted to be a dentist and started college in the pre-dental program. I eventually changed majors to psychology when I discovered that my writing and analytical skills outweighed my abilities in math and science. After I graduated from UConn, I was hired by Catholic Charities as a Residential Counselor. I was trained as a State of Connecticut abuse and neglect investigator and managed several group homes for the agency. As part of the latter, I would travel to different group homes or individual families' homes, interview children, and perform an investigation. I gained significant exposure to juvenile law and the court system, and that is when I knew I wanted to go to law school.

MW: And I understand you went to UConn for law school as well?

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SF: Yes.

MW: Connecticut all the way! What made you want to stay here in Connecticut?

SF: When I was applying to law school, UConn was a Tier 1 law school. Additionally, attending school in Hartford would allow me to stay close to home and my family.

Since that time, I have had many opportunities come my way, mostly because of my connection to the State and City of Hartford. I am proud to be a product of Hartford and to give back to my community.

MW: What is it about workers' compensation that appeals to you so much?

SF: I really love the intersection of the medical and legal analysis. I find biology and human anatomy very interesting, and I feel privileged to work in that sector every day in the workers' compensation section. I also love the people- the workers' compensation section is very kind, and my experience has been that the attorneys are genuinely good people to work with. I know everyone says that about our section, but it is true, and it is an honor to now be in a leadership position with this group.

MW: When you graduated, did you ever think of becoming a judge?

SF: Not directly, but I always knew I wanted to do more with my career. I am a hard worker and I strive to always challenge myself. This position is a wonderful opportunity for me to do both of those things in a rewarding way.

MW: Have you found any unexpected challenges in your new role since you've been appointed?

SF: I have found that seeking out the relevant issues in the cases before me has been the most challenging. As a Respondent's attorney, my experience has been that when I prepare for a hearing, I anticipate what issues opposing counsel may raise. I was prepared to answer questions regarding my own case and find ways to bolster my position. Now, being the person who is adjudicating the case, I find that I have to be aware of all of the issues and be prepared to question both sides. Quite naturally, most people will argue their strongest points, but finding the weakness and issues in every case is difficult to do. That challenge, coupled with the pace of our informal hearing system, makes this a daunting task.

MW: I am sure that your past experience with workers' compensation has helped you in that process?

SF: Tremendously. Knowing the acronyms, the levels of formality, the lingo- it all matters. Workers' compensation is unique for a judge in that every hearing is vastly different than the one before it, and in order to deal with those unique issues and advance the case along you need to know what a case looks like from a holistic standpoint. Having that experience has helped me to be efficient in the handling of cases.

MW: A follow-up question to that would be how can we assist you so that we can move these cases? What are you looking for from all of us when we appear before you, and what is your goal for yourself in this new role?

SF: My only ask is that the attorneys arrive prepared. As you know, there is limited time for each hearing, and very often, some attorneys are traveling to various districts throughout the day. I plan to be prepared, and my expectation is for the attorneys to do the same.

As far as my goals, I pride myself on being approachable, and my goal is to be fair. At the end of the day, the attorneys on both sides seek to represent their client to the best of their ability. I don't intend to make anyone's job more difficult than it already is. I understand that this field of law is not easy. It is fast-paced and sometimes the work is stressful. My approach is simple- I ask how can we get things done, what do we need to move business, and how can I help facilitate the resolution of claims? With that mindset, I believe the system will function efficiently.

MW: Judge Fenlator, it's been a pleasure speaking with you and hearing more about your background and your approach to your new appointment. On behalf of us at Compensation Quarterly and the workers' compensation section, congratulations on your appointment, and thank you for speaking with me today.

Editor's Note: Meghan A. Woods is a partner at Vargas Chapman Woods, LLC in Middletown, CT where she practices in workers' compensation and personal injury.

RACZ procedure

This is, in essence, a caudal epidural steroid injection, but hyaluronic acid is injected into the epidural space through the caudal approach to lysis the adhesions typically after a fusion surgery giving a better chance for the steroids to spread.

Diagnostic Medial Branch Block

Indications: it is typically a diagnostic test to determine how much of the patient's pain is coming from the facet joints.

Medications: local anesthetics only. It should not last more than only a few hours, and it typically must be repeated (it is done twice) before the radio frequency ablation is performed.

Approach: the needles are outside of the spinal canal.

Radio Frequency, Ablation

Indications: to treat the facet joint induced pain. Typically, is performed after two successful diagnostic medial branch blocks.

Approach: patient is placed in a prone position and 3-4 different needles are advanced under fluoroscopic guidance towards the medial branch block testing for the sensory and motor function. Once the placement of the needle is accurate, the radiofrequency ablation is performed for 90 seconds.

Duration lasts around 6 to 9 months, up to a year or two.

Sympathetic Blocks

Indications: complex regional pain syndrome (CRPS), phantom limb pain after amputation.

Medication: steroids.

Approaches: fluoroscopic guided. Stellate ganglion block is done on the cervical area to address the upper extremities CRPS. Lumbar sympathetic block is done on the lumbar area to address the lower extremities CRPS. Superior hypogastric plexus block is done on the lumbar area to address pelvic pain. Gangling impar, which is a term to describe the end of the sympathetic chain, is done in the tailbone area to address any pain after a history of fall on the tailbone area.

Sacroiliac joint injection

Indication: inflammation of the sacroiliac joint.

Medication: steroids.

Approach: fluoroscopic guided sacroiliac joint.

Trigger Point Injections

Indication: muscle pain.

Medications: steroids, and local anesthetics.

Approach: in office bedside procedure.

Trigger points: detected by palpating the muscles for tender spots. These are the spots that must be directly injected.

Provocative Discograms

Indications: diagnostic to determine if the pain is coming from the disc itself.

Medication: contrast dye.

Approach: fluoroscopic guided diagnostic procedure to see if the patient has any discogenic pain. A needle is introduced inside the disc itself and, using a gage monitor, increases the pressure inside the disc. By injecting a contrast, a leak can be found which would indicate if there are any annular tears.

Spinal Cord Stimulator

Indications: failed back surgery syndrome after fusion surgery or CRPS.

Medication: spinal cord stimulator leads.

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Approach: fluoroscopic guidance through an epidural space. Typically done in two steps.

During the trial step the lead is left in the body for five days for the patient to try it out, and if it works (reduces 70% to 80% of the pain) an implantation can be done.

The implantation step is through laminotomy (opening a small incision into the bone to implant the leads) and the lead will be left inside the spinal canal permanently and tunneled under the skin to be connected to a battery like a pacemaker.

Genicular Nerve Block

Indication: pain after total knee replacement, and multiple knee surgeries when everything else fails.

Medications: local anesthetics only.

Approaches: done on a diagnostic test basis first, and if it works for a few hours then coolief radio frequency ablation can be performed. Coolief radio frequency ablation is different than the regular thermal radio frequency ablation and is only used for knees, hips and shoulders. This is done by three different needles, two above the kneecap and one below the kneecap to the inner side.

Intra-articular Injection

Indication: osteoarthritis or tendon tears.

Medication: steroids.

Approaches:

Intra-articular hip injections: for hip osteoarthritis or labrum tear.

Intra-articular shoulder injection: for shoulder osteoarthritis or rotator cuff tear.

Intra-articular elbow injection: for tendinitis or osteoarthritis.

Intra-articular ankle injection: osteoarthritis or ligamentous tear.

Botox injection

Indication: Severe muscle spasms, cervical dystonia, migraine, and/or headache.

Medication: Botox.

Approach: direct injection into the muscle.

Injections can be highly effective treatment for cervical dystonia, headache, muscle spasms, and various other myofascial pains.

All of the above injections and procedures are typically performed by a board-certified and fellowship-trained pain management physician.

Editors' Note: Heather Porto is a partner at Strunk, Dodge, Aiken and Zovas in Rocky Hill, CT. Attorney Porto represents municipalities, insurers, third party administrators and employers in defense of workers' compensation matters throughout the state of Connecticut.

A Discussion With Michele DelNinno of Ametros

An Interview by Maribeth M. McGloin

Q. Thank you for meeting with me to discuss your company and its services. What is your position at Ametros?

A. I am a Senior Business Development Manager. I have worked for Ametros for almost 9 years, and my territory includes New England, Michigan, Ohio, Kentucky, and Indiana. There are three different departments within our sales organization. I am more on desk level as those of us in the business development group are more educators, with a little marketing. I work with new and existing partners, such as attorneys, adjusters, structured brokers, and injured individuals to educate them about how Ametros can assist in providing simplification, security and support for all.

Q. What services does Ametros provide?

A. We provide professional administration services through our CareGuard program, typically related to post-settlement medical funds. People who have received a settlement, usually from an insurance company or workers' compensation claim, use Ametros to administer the medical portion of the settlement on their behalf. Ametros calls these settlement recipients that elect to use our services our "members." Ametros places settlement funds in a custodial, interest-earning bank account for the benefit of the individual member and then pays medical claims out of the settlement funds on their behalf.

We also offer a service called Amethyst, which is a self-administration tool for people who are going to self-administer a Medicare Set-Aside (MSA). Amethyst allows them to have their bills reviewed and any applicable discounts applied. They are able to create an annual attestation report, and they use their own bank account.

Q. Why would you recommend professional administration for a MSA?

A. I think first and foremost, it is needed to protect the injured person if they are a Medicare beneficiary or if they will be one soon. Administration requirements as outlined by the Centers for Medicare and Medicaid Services (CMS) can be hard for the average person to understand and follow. Protection for them is the priority. When I talk to someone, the first thing I tell them is you need to do everything the way CMS wants you to do it. You need to follow the "rules" in the 31-page toolkit that CMS publishes. The problem is, it's like doing your taxes when you know nothing about doing taxes. Professional Administration can help take the burden off the injured individual when it comes to reporting to CMS, tracking funds, and managing funds. At Ametros, our goal is to create a simple process for the injured party to protect their Medicare benefits once they settle their case. With CareGuard, the member doesn't have to ever touch a bill or worry if they are keeping up to date with their annual Medicare reporting.

Q. What happens if a self-administered MSA account isn't properly managed?

A. CMS can potentially deny reimbursement for work-related bills otherwise covered by Medicare up to the amount misspent and all the way up to the entire settlement amount, before it will agree to begin covering injury-related bills. The injured individual will have to show CMS, through the attestation process, that they're administering and expending funds properly. The injured individual would have to pay back into the MSA account any amount that was used on an improper expense. Mismanaging the funds can jeopardize their future Medicare benefits for treatment related to the workplace injury, which is why it is important to be careful and seek assistance. Because it is so easy for the average person to unknowingly make mistakes, Medicare recommends the use of a professional administrator.

In a self-administration situation, if an injured individual spent all of their MSA money, they can have a hard time figuring out if it is a Medicare covered item or not or if the treatment related to the initial injury. They also might not know to get the state fee schedule, and because of this are paying the highest fees from the provider and retail pricing at the pharmacy. They are going to spend their money more quickly this way, and then expect Medicare to pick up the bills. Instead, Medicare will deny the bills and state there is plenty of money in the account or that money needs to be put back into the MSA account and spent properly. When managing the MSA on their own, they also may or may not have filed their annual reports. If they never filed a report, Medicare thinks they still have all of that money from the MSA.

Q. What happens if a self-administered MSA account isn't properly managed?

A. Medicare reserves the right to have reporting for up to the entire settlement amount on Medicare covered treatment before it will agree to begin covering injury-related bills. If the injured party doesn't properly manage their MSA account, Medicare will deny paying for their treatment until the reporting is corrected. The injured party would have to pay back any amount that was used on an improper expense. Mismanaging the funds will jeopardize their future Medicare benefits. This is why it is important to be careful and seek assistance. Medicare highly recommends the use of a professional administrator.

Q. How does professional administration work?

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A. We follow all of the guidelines that Medicare sets forth. An interest bearing bank account is set up for the injured party's settlement funds in their name and SSN. The money is deposited there. The company acts as the custodian of the funds and is the third-party administrator for all healthcare expenses related to the injury. CareGuard, Ametros' professional administration service, manages everything for the injured party, including the coordination and payment of medical bills as well as the necessary reporting to Medicare through the annual attestation. They receive a card, similar to an insurance card, to show at their doctor's office and pharmacy. The provider will send the bills to Ametros, we will re-price to the state fee schedule (if the jurisdiction has one) and we pay them. At the same time, we are re-pricing the bills like a carrier would, so we are getting discounts and applying the state fee schedules, and sometimes there are additional discounts from our network partners. If the doctor is in that network, they are getting an additional discount. The member also gains access to our Care Advocate team, who can answer all of their questions and be a resource for them after settlement.

A. Yes, we use bill review companies. They know what is a Medicare-covered item and will know what is related. If anything is denied, we have a team who will review it, explain the reasoning for the denial and help find alternatives for our members.

Q. You mentioned services for a self-administered MSA. What are those?

A. Yes, our Amethyst product. Ametros provides a platform that is typically used for self-administration of post-settlement medical funds. The funds are placed by the injured individual into their own personal bank account that contains their MSA funds. They provide Ametros with their bank account information for that personal account and permission for Ametros to charge the account for eligible medical claims. Ametros will receive medical claims on behalf of the member and review them for potential discounts and then charge the individual's personal bank account. We do offer additional discounts for PPO networks and pharmacies, but they are not as much of a discount compared to what is available under the CareGuard program.

It is also a self-service portal. Members can upload information and create a report they can send to Medicare for reporting purposes. Funds are not supposed to be mixed, but if they were, items can be removed from the report by the injured party through the Amethyst portal. So if they bought Susie skis last week, they can delete that amount from the Medicare report.

Q. It sounds like it can help them with the paperwork aspect of the annual filing?

A. Yes, but again, we aren't looking at it and saying no you can't include that. So it's completely for them to use as a tool for those who think they should do it on their own.

Q. What can an injured party spend his/her Medicare Set-Aside money on?

A. The MSA money can only be used to pay for medical treatment, prescription drugs, and durable medical equipment that Medicare would cover and the treatment must be related to the injury. That is the bottom line. As long as it is related to the injury and Medicare covered, then it's fine. If the funds are spent on other things, there may be issues with respect to Medicare coverage. Medicare will deny all related claims until the MSA administrator can demonstrate appropriate use equal to the full amount of the MSA.

Q. Does a claimant have to see specific doctors?

A. No, they can see whomever they want. Ametros members are not restricted to Ametros' medical network partners and can choose to go to any pharmacy or provider in the United States. Ametros' medical network partners offer the upside of potential discounts, but Ametros' members are free to choose their own providers and pharmacies. When we onboard someone who comes on our platform, we explain that to them. They can find out if their doctors are part of our network, and if they are, there is an added benefit of savings for them, but they can see whomever they want.

Q. Does Ametros dictate any treatment?

A. No, treatment is at the discretion of the member and their doctors.

Q. Does Ametros determine medical necessity or reasonableness?

A. We do not determine medical necessity and do not authorize services based on medical necessity. The member's doctors determine what treatment is necessary or reasonable. We only look at whether the treatment is related to the injury and a Medicare-covered service in order to keep the member in compliance. In most cases, the software programs typically know if it is related due to the ICD codes and there can be a review if there are any questions.

Q. Does Ametros put any limits on treatment?

A. The only limit on treatment is that the service is a Medicare benefit and related to the injury, assuming there are funds available for the member. If the member exhausts or depletes their account properly, Medicare will then step in and pay. We do not limit the number of visits a member may have if the service is related and a Medicare covered expense.

Q. Does the workers' compensation insurance carrier or employer have any input into any of the treatment?

A. No, in the case of a MSA, Ametros will follow CMS guidelines and pay for only items that are related to the injury or Medicare covered. The carrier and the employer are not involved once the case settles.

A. That is completely up to parties that settled the case and what was put in the settlement documents. Upon the death of the member, Ametros reviews the terms in the settlement agreement and disburses funds to the beneficiaries that were named. If no beneficiary was named, the funds will pass to the member's estate or according to their will. If there is no beneficiary named in the settlement agreement, the member can fill out a beneficiary form with Ametros. In some cases, it is reverting back to the carrier. Any instructions in the settlement agreement take priority in the disbursement.

Q. If there is a reversionary interest on the money, does that impact or effect how the MSA is handled by Ametros or how the money is spent?

A. No, not how it is spent at all, absolutely not.

Q. What happens if Ametros ever went out of business?

A. We are backed by a private equity company. The chances of us ever going out of business, of closing our door tomorrow, would probably never happen. But if we were to scale down and be no more, the CareGuard accounts are set up under the members' names and Social Security numbers or Tax Identification Numbers. Each account is a separate bank account with FDIC insurance. They are not a business asset of Ametros. We would find a way for them to either get their money or get the funds to another third-party administer.

Q. What happens when the Medicare Set-Aside money is exhausted?

A. When MSA funds are exhausted, Medicare will begin to pay for all covered items related to the individual's injury, but only if they have properly managed their MSA funds and reported their spending to Medicare. They also have to be enrolled as a beneficiary on Medicare. If Medicare steps in to begin covering treatment related to a member's injury, they will be covered just like any other Medicare beneficiary and are subject to corresponding co-pays, co-insurance and deductibles. Also, when the MSA funds are exhausted, when bills come in, we deny them. We send an explanation report to the provider. At that point, they know that they are supposed to bill the member's private insurance or Medicare, as they become the primary payer.

If Ametros is administering the MSA funds that are being paid through an annuity and a member's funds temporarily exhaust, we send BCRC a temporary exhaustion letter with the estimated date the account will fund again. In that case, if they exhaust at nine months, as long as they are a Medicare beneficiary, Medicare will pick up the bills until the next annuity payment. Although for prescriptions, the person must already have Medicare Part D, otherwise Medicare won't pay the medication.

Q. Are Medicare Set-Aside funds taxed?

A. In most cases, the amount paid out in the workers' compensation settlement is non-taxable. The MSA funds, as part of that settlement, are also not taxed upon receipt. However, whatever money the member has in the account, because it earns interest, can be taxed on any interest income. If the interest earned in a year is over $10, typically the bank will provide the injured party a 1099-INT to use in their tax filing. If they were taxed for the interest, that amount can be paid for out of the MSA account according to Medicare's guidelines. There are very few things you can take out of your MSA for, the taxes on interest income are one and also postage, if you wanted to mail something to CMS.

Q. Is there a dispute resolution process if there was ever a disagreement or an issue between the injured worker and Ametros?

A. There is. It is set forth in our member agreement. If the parties cannot resolve any issues or disputes through negotiation between themselves, there is a mediation process. If mediation is unsuccessful, there is then a binding arbitration process.

Q. If any attorneys wanted more information on Ametros, where would they go?

A. They can reach out to me. They can also go to the Ametros website www.ametros.com. We have education galore on the website, including FAQ and videos. The marketing team has done a great job making information accessible on the site.

Q. Is there any other information the workers' compensation attorneys should know?

A. It is about education more than anything. A lot of people don't truly understand what Ametros does, and I think they have a lot of ideas about what used to be or assumptions that their clients don't need these type of services. I tell people that I think you are doing a disservice to your client if you don't recommend that they have professional administration, and as so many of the carriers now will pay for the service, it's a free service. It's something that should be an automatic thought.

Editors' note: Maribeth M. McGloin is an attorney at Williams Law Firm LLC in Shelton, Connecticut. She is also a member of the CBA's Workers' Compensation Section's Executive Committee, on the Board of Editors for Compensation Quarterly, and is a Board-Certified Workers' Compensation Specialist.

Smooth as Tennessee Whiskey... Except for that Storm

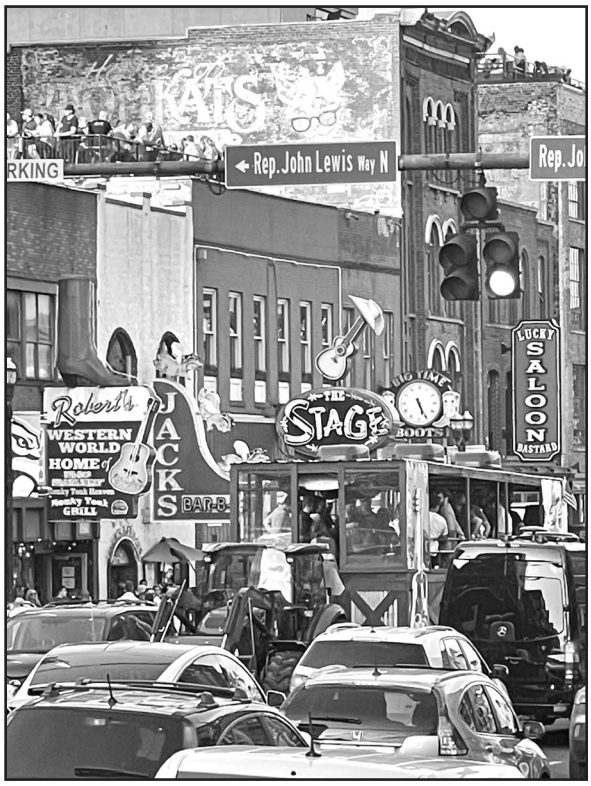
By Jeremy Brown

One could sense the coming storm as the Workers' Compensation section members arrived in Nashville amid the hordes of Swiftees. Glee filled the streets as sequin clad folks strolled down Broadway exploring bars from Rippy's to the Redneck Riviera, all waiting for the main event. For them, it was the opportunity to see one of the greatest musicians in the modern era perform, for us- less sparkly folk- it was the kickoff of the 2023 Workers' Compensation Retreat. Little did we know that as Taylor began her last night in Nashville and the section uncorked the first bottle of wine at the welcome reception, the beautiful weather would turn black, and lightning would fill the sky.

The storm raged as the attendees reveled. The welcome reception was a great time as always and Swift, being the performer she is, gave her crowd what they had paid for and finished her full show. The day unfolded as a nightmare for a few members who sat captive as their flights were delayed, rerouted, and cancelled. Unfortunately, Chief Judge Morelli was unable to make it to Nashville as the fates cast him to Atlanta.

The 2023 Workers' Compensation Retreat was sponsored by Ametros, Ringler, and Injured Workers' Pharmacy. I truly appreciate and thank each one of these wonderful sponsors for their continued support of this event. Much of what I accomplished in planning this event would not be possible without them. Lynn Demauro Clark, President of Ringler Associates Central CT, suffered a similar fate to Chief Judge Morelli, as her connecting flight from BDL was cancelled causing her to miss the retreat.

The storm raged Sunday night, but you know what happened next? What happens most of the time- the sun came out in the morning, and we were greeted by another beautiful day full of promise. Dr. Tamer Ghaly presented through the morning session in what was one of the better, more lively and informative presentations we have had in quite some time. Dr. Ghaly, a pain management specialist and owner of ISpine, discussed the finer points of ablation procedures, injections, low dose narcotics, and CRPS. It was truly a joy working with Dr. Ghaly in preparation for this event and I am glad that his enthusiasm shone through during his presentation.



As Chief Judge Morelli was stranded in Atlanta, Marie Gallo-Hall, the Agency Legal Director for the Workers' Compensation Commission, took the bull by the horns and delivered the Chief Judge's presentation marvelously. Attorney Gallo-Hall encouraged debate on pre-surgical psychiatric screening and issues relating to attorney's fees. What could have been a disastrous situation was, instead, another opportunity to highlight the talent and knowledge of our section.

Mark Doherty, Executive Vice President of Sales for Ametros was the third presenter of the day. Mr. Doherty presented an abridged version of a joint presentation from Workers' Injury Law and Advocacy Group (WILG) and Centers for Medicare and Medicaid Services (CMS). This was an interesting opportunity to hear directly from the folks at CMS what their expectations are with respect to medical costs and conditional payments related to a workers' compensation claim.

Judge Peter Mlynarczyk led off day two of the event discussing the expectations set by the Workers' Compensation Commission relating to settlements, stipulations and the stipulation process. While this is a topic that may seem rudimentary, I think we can all say that there have been issues of late completing even the simplest processes. Whether it is Covid fatigue or shear laziness, Judge Mlynarczyk emphasized the reasonable expectations and responsibilities of each party and made clear that errors must cease. The same is to be said for the WCC mediation program where attorneys continue to misuse the program.

As stated above, Lynn Demauro Clark was unable to attend due to travel issues and, while we tried to facilitate her presentation via Teams, it just wouldn't work. I delivered the Ringler presentation on her behalf and, while it undoubtedly would have been 100% better coming from Ms. Demauro Clark, I believe the message was received by the folks in attendance. We can all appreciate the value of a structure and the role of the structure professional in facilitating settlement of large or complex claims.

The seminar came to a close with a discussion of ethics using fact patterns designed to highlight incompetence and poor decision making we should all strive to avoid in practice. At the outset of this presentation, I posted a slide of the Attorney's Oath found on page 1 of the Practice Book. This is a lovely oath that I think every attorney should read to remind themselves that we, as attorneys, have a high standard of character that must be maintained. Once that character is tarnished, it is hard to regain the shine.

In summation, Smashville, er Nashville, was an amazing time and I believe the opinion is shared by all who made it to the party. The city is exploding with energy, and I would not count it out as a return destination at some point in the future for the Workers' Compensation Retreat. See you next year! Oh, and this wasn't written by AI.

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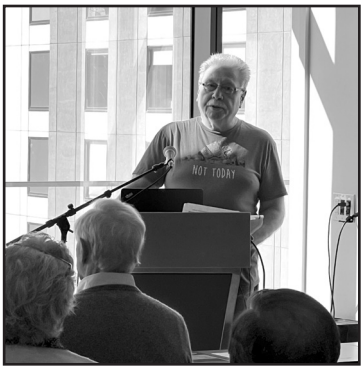

Case Comments

By Maribeth M. McGloin

SUPREME COURT DECISIONS

A part-time firefighter who customarily works fewer than twenty hours per week does not fall within the definition of "member" in §7-433c

Clark v. Town of Waterford - Cohanzie Fire Dept., ___ Conn. ____ (2023)

The Supreme Court reversed the decision of the Appellate Court, Compensation Review Board and trial administrative law judge. The plaintiff firefighter, who sought eligibility for heart and hypertension benefits pursuant to C.G.S. §7-433c as a result of a myocardial infarction, was initially hired on a part-time basis and did not become full-time until after the statute was repealed. The underlying decision found that the definition of "member" encompasses both full and part-time firefighters and that the definition of "members" in C.G.S. §7-425(5) that excluded employees who work fewer than twenty hours for municipal retirement eligibility was not relevant. The Supreme Court disagreed and found that the definition of member in §7-425(5) controls the definition of member in §7-433c and remanded the matter for the trial judge to determine whether the plaintiff customarily worked twenty hours or more per week before being hired as a full-time firefighter. One justice dissented.

APPELLATE COURT DECISIONS

Employer's awareness of common practice of bringing work gear home does not create a mutual benefit and injuries during preliminary acts of preparation for work not directed or requested by the defendant are not compensable.

White v. Waterbury Fire Dept., 218 Conn. App. 711 (2023)

The Appellate Court affirmed the Compensation Review Board and trial administrative law judge's dismissal of the plaintiff's claim. The plaintiff firefighter sustained injuries when he fell leaving his home while carrying work gear for an overtime shift. He had agreed to work the overtime shift at a fire station different from the one where he worked his regular shift. He had taken his work gear home with him so he would not have to stop at his regular work location before going to the overtime shift. His employer neither directed nor requested that he bring his work gear home. The Court affirmed the underlying decision that the plaintiff's injuries were not compensable pursuant to C.G.S. §31-275(1)(E) because they occurred at his abode as a result of a preliminary act in preparation for work that was not directed or requested by the defendant. The Court went on to state that the plaintiff's contention that the defendant was aware of the common practice to bring work gear home did not mean that this act was mutually beneficial to both parties and therefore compensable.

Plaintiff's change in employment position within department and pension status did not change his status as a regular member of the police department for purposes of eligibility for §7-433c benefits.

Gaudett v. Bridgeport Police Dept., 218 Conn. App. 720 (2023)

The plaintiff appealed the Compensation Review Board's affirmance of the trial administrative law judge's dismissal of his §7-433c claim. The issue was whether he began employment with the defendant on or after July 1, 1996. The trial judge had dismissed his claim because although he was hired as a police officer in 1983, the effective date of his employment as chief of police in 2010 constituted a new date of hire. The Appellate Court reversed the decision as they agreed with the plaintiff that he fell within the definition of a regular member of the Bridgeport Police Department from 1983 until he retired from his position as the chief of police in 2016, that his change in position did not change his status and that his pension status was not relevant.

Claimant's intentional lighting of incendiary device found on the job broke the chain of causation for the injuries to be found to arise out of his employment.

Bassett v. Town of East Haven, 219 Conn. App. 866 (2023)

The Appellate Court affirmed a dismissal of a traumatic amputation hand claim. The claimant was a supervisor of a summer youth program for the municipality. As part of his job, he would supervise and assist teenagers in cleaning up areas of East Haven. While picking up an area outside a school, he found a small brown sphere with paper wrapped around it, foil stuck on it, and with an attached wick. The claimant had a lighter, which he used to light the wick. The sphere exploded causing serious injuries and an amputation of the hand. The administrative law judge had concluded that the intentional lighting of the wick broke the chain of causation with respect to the scope of his employment and therefore, the resulting injuries did not arise out of the employment. The trial judge did not accept the claimant's contention that he lit the wick to protect the other employees. The Appellate Court found that the trial judge's decision was logically and legally correct.

COMPENSATION REVIEW BOARD DECISIONS

Due process requires administrative law judges to limit issues to those raised at beginning of formal hearing and must allow parties notice if other issues are to be addressed in decision.

Riggins v. State of Connecticut/Dept. of Correction, 6452 CRB-6-21-11 (April 4, 2023)

The claimant had two left ankle injuries, a December 12, 2000 date of injury for which a 10% permanent partial impairment was paid and a December 6, 2016 date of injury for which an additional 4% permanent partial impairment was paid. While the claimant was previously represented by counsel, she was self-represented at the appeal and the underlying formal hearing. The claimant sought a formal hearing on the issues of whether she was underpaid her permanency benefits and whether any interest or penalties were due for a claim of untimely payments. The trial administrative law judge did not find the testimony of the claimant credible. He found credible the testimony of the adjuster for the third-party administrator. The trial judge found that the claimant had failed to meet her burden of proof that any of the permanency had been paid in an untimely manner and went on to find that she had been paid some of the benefits at an incorrect higher rate and that there was an overpayment of $2,808.50. The Compensation Review Board found that the judge had gone beyond the stated issue for the formal hearing when he determined that there was an overpayment and that due process required a trial de novo on the specific issue raised by the claimant of whether she was timely paid or the administrative law judge should hold a global hearing to determine whether the claimant was underpaid or overpaid for any of her injuries for all dates of injury.

Prior compensability of non-occupational disease medical condition does not preclude review of future medical treatment and whether causally related to workers' compensation injury. Also, commission lacks subject matter jurisdiction regarding contractual arguments between excess workers' compensation carrier and third-party group health administrator for self-insured employer.

Hadden v. Capitol Region Education Council, 6471 CRB-6-22-4 (April 5, 2023)

The Compensation Review Board affirmed the dismissal of a claim by CREC's group health administrator, Anthem Blue Cross and Blue Shield, requesting reimbursement for costs associated with the medication Aubagio. The claimant, a school teacher with multiple sclerosis, was physically assaulted by a student when attempting to break up a fight. A prior decision found that the assault materially contributed to her condition and caused her condition to deteriorate beyond that which the pre-existing multiple sclerosis would have caused by itself. The Board rejected Anthem's argument that the prior decision precluded the current findings due to

continued on page 14

res judicata, collateral estoppel or the law of the case doctrine. A prior finding of compensability of a condition does not impose a requirement for a blanket acceptance of all future medical treatment and an analysis must be made as to whether the underlying workers' compensation injury is a substantial contributing factor to the need for the new treatment. In this case, the trial judge found that the testimony of the treating physician, Dr. Wade, and the respondent's examiner, Dr. Conway, consistently linked Aubagio solely to the treatment of MS exacerbations, noted that the claimant was experiencing such exacerbations prior to the date of injury and reflected that the claimant would have required medications to control her exacerbations regardless of whether she had ever sustained any physical trauma. The Board went on to agree with the trial judge that there was a lack of jurisdiction over the issue of whether there is a right of reimbursement regarding the medication as that is a contractual dispute between an excess carrier and the third-party administrator for a self-insured employer. This case has been appealed to the Appellate Court.

Factual findings of the administrative law judge will not be overturned if there is sufficient evidence in the record to support the ruling.

Holbrook v. State of Connecticut/Dept. of Economic and Community Development, 6455 CRB-1-21-12 (April 6, 2023)

This decision was following a prior remand from the Compensation Review Board asking the trial administrative law judge to identify the factual basis of how the injury arose out of the claimant's employment. The claimant fell at work and sustained a right knee injury. She could not recall why she fell but noted that it had rained earlier in the day, she saw other employees lose their footing in the same area previously, and her hair was wet after the incident. The respondents had denied the claim, alleging that pursuant to the precedent of Clements v. Aramark, 339 Conn. 402 (2021), the fall did not arise out of her employment but was due to a pre-existing personal pituitary adenoma that was mentioned in the medical records after the fall as that condition can cause dizziness and unsteady gait. The respondents relied on the medical records and did not submit expert testimony or opinion. The trial administrative law judge found that claimant credible and determined that the injury was due to a defect in the premises and not a pre-existing personal condition. On appeal, the Compensation Review Board affirmed the decision, finding that there was sufficient evidence in the record to support the ruling.

Pre-emptive Form 43 provided sufficient information to overcome motion to preclude.

Desimone v. Griffin Health Services, 6479 CRB-4-22-7 (April 13, 2023)

The claimant filed a Form 30C regarding a March 8, 2018 date of injury on October 10, 2018 alleging a bilateral knee repetitive trauma claim. The respondents filed a pre-emptive Form 43 on April 9, 2018. A motion to preclude was filed and later granted on the basis that no Form 43 was filed within twenty-eight day of the filing of the Form 30C and the Form 43 cited an earlier date of injury involving a prior compensable left knee injury and the repetitive trauma box was not checked. The Compensation Review Board overturned the granting of the motion to preclude as the Form 43 and its cover letter provided sufficient information to a reasonable person that the bilateral knee repetitive trauma claim was being contested.

Trial administrative law judge can credit all or part of an expert's opinion and the judge's credibility determinations will not be overturned as long as there is sufficient evidence to support the findings.

Wickson v. A.C. Moore, 6478 CRB-2-22-6 (May 1, 2023)

Due to prior work-related injuries, the claimant utilized the services of the state bureau of rehabilitative services to obtain a job with A.C. Moore in 2000. The claimant testified that while her job started as light duty, her duties increasingly required heavy-duty tasks. The claimant ultimately underwent bilateral shoulder replacement surgeries. She alleged a specific injury to her left shoulder on September 17, 2015 but also alleged a repetitive trauma claim regarding her bilateral shoulders. The treating physician, Dr. Anbari, provided a causation opinion that her left shoulder replacement was due to the specific injury but also that repetitive trauma over her fourteen to sixteen years of employment caused the need for the bilateral shoulder replacements. Dr. Jambor, the respondent's medical examiner, opined that the 2015 alleged incident was not adequately documented and that the claimant had pre-existing chronic rotator cuff tears and glenohumeral osteoarthritis and a specific injury would not have impacted her condition. Dr. Barnett

performed a commission examination and felt that the claimant had long-standing chronic issues that were not impacted by a specific injury and that her shoulder issues were nontraumatically induced and developmental in nature with all accumulative use of her upper extremities contributing, both work and non-work related. The administrative trial judge dismissed the specific injury claim but found compensable the bilateral shoulder repetitive trauma claim. The Compensation Review Board reiterated that a trial judge can use all or part of a doctor's opinion and that they felt the judge resolved any inconsistencies in the opinions and evidence and that there was sufficient evidence to support the judge's decision.

For a non-facial scarring award, the claimant must provide credible evidence that the scar and not the underlying injury has caused impediments to employment.

Cruz v. Interim Healthcare of Eastern & Southwestern Connecticut, 6480 CRB-2-22-7 (May 19, 2023)

The claimant sustained a compensable right knee injury, which treatment included a total right knee replacement. She was paid a 45% permanent partial impairment and C.G.S. §31-308a benefits at a reduced rate. The claimant then sought a scar award pursuant to C.G.S §31-308(c), arguing that this non-facial scar handicapped her ability to find and maintain employment. The claimant testified that the scar is sensitive and requires her to wear shorts, which she is uncomfortable wearing to work, and that she cannot kneel, squat or stand for long period of time. She relied on the opinion of her treating physician, Dr. Zimmerman, that her scar is hypersensitive and would hinder her ability to obtain certain types of work where she would be required to kneel, squat or do other activities with her knee which might exacerbate her scar sensitivity. The trial administrative law judge dismissed the scar claim as she did not find the claimant credible, interpreted the opinion from the treater as stating that the underlying injury rather than the scar caused any issues with finding employment, and found there was no evidence of specific jobs the claimant could not obtain due to the scar. The claimant argued on appeal that she should have prevailed premised upon her testimony and her allegation that Dr. Zimmerman's opinion was uncontroverted. The Compensation Review Board did not find that the record compelled the trial judge to issue an award for the scar and determined that the trial judge was within her discretionary fact finding rights as an administrative law judge to make the findings that she did. The dismissal of the scar award was upheld.

Without any impacting ambiguities, agreements, or stipulations, the respondents were limited to a credit for the permanency ratings memorialized in their prior Voluntary Agreements.

Recinos v. State of Connecticut/Dept. of Transportation, 6483 CRB-4-22-9 (June 23, 2023)

The claimant sustained compensable back injuries in 2006, 2008 and 2017. For the 2006 date of injury, the treating physician, Dr. Lewis, opined that the claimant had a 7.5% permanent partial impairment while the respondent's examiner, Dr. Brown, gave a 0%. A voluntary agreement was subsequently approved for a compromised 3.75% permanent partial impairment. In 2009, the claimant's new treating physician, Dr. Opalak, opined that the claimant had a 10% permanent partial impairment for which a voluntary agreement was approved. After subsequent surgeries in 2018 and 2020, Dr. Opalak assigned a 20% permanent partial impairment, inclusive of all prior ratings, with a January 5, 2021 date of maximum medical improvement. The parties disputed the permanent partial disability rating that was currently due. The trial administrative law judge found that the respondents had paid and were entitled to a credit for the 13.75% that was previously paid and memorialized in the voluntary agreements and that a 6.25% permanent partial impairment was currently due. The respondents argued that they should have been entitled to a 17.5% impairment credit. The Compensation Review Board disagreed as the parties had voluntarily compromised the initial ratings, had memorialized what was paid in the voluntary agreements, and no agreement had been reached by the parties that no additional benefits would be owed until the claimant's disability exceeded the initial 7.5% nor had any stipulation-to-date or full and final settlement of any of the claims been approved that would impact the facts of the case. The trial judge's decision was affirmed.

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