WORKERS' COMPENSATION UPDATE

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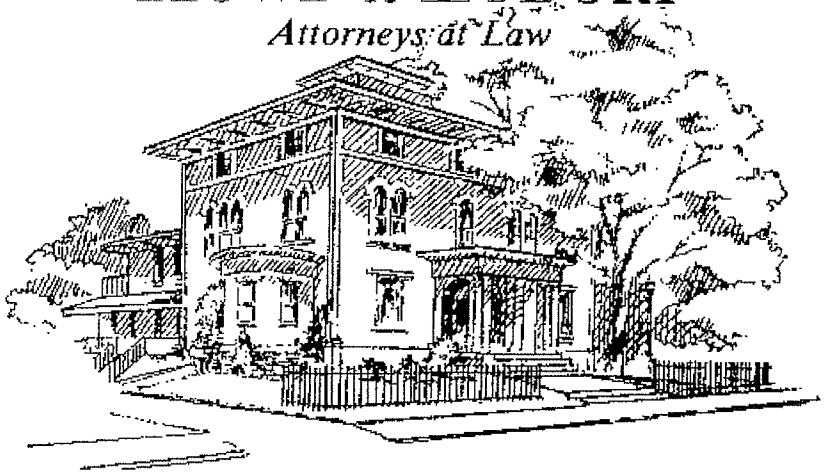

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Workers' Compensation Case Law Update
January 2015 – May 2016
Colette S. Griffin, Esquire

C.G.S. § 31-275(16)(B)(iii) Compensability of Psychiatric Injuries

Hart v. Federal Express Corporation, 321 Conn. 1 (April 19, 2016)

Relevant Facts: the claimant worked for the respondent as a courier from 1987 through his claimed date of injury on September 15, 2009. In 2009 the claimant's territory was expanded and his route became very difficult to complete. His managers were made aware that he was having difficulty completing his work load and did nothing to remedy the situation. On the date of injury, the claimant was asked to make more deliveries than ever before on a hot day and was rushing and unable to complete them. He experienced chest pain, stress and shortness of breath and was rushed to the hospital where he was assessed with possible dehydration, hypertension and an atrial flutter and fibrillation. The claimant's cardiac symptoms then improved however the claimant remained very stressed about work and was eventually treated for PTSD and was kept out of work in connection with both his cardiac and psychological conditions for approximately one year. The respondents asserted that the source of the claimant's psychiatric injuries were due to pre-existing anxiety over reprimands that he had received and his fear that he would be terminated from his job. They argued, therefore, that such injuries were not compensable under § 31-275(16)(B)(iii).

Procedural Posture: The trial commissioner found that the claimant's physical and psychological injuries were compensable under Chapter 568 and the CRB affirmed. The respondents appealed.

Issue: Was the CRB correct in upholding the trial commissioner's determination that the psychological condition was compensable?

Holding: Supreme Court affirmed.

Rationale: The Supreme Court held that the claimant did not have to prove that his compensable physical injury was the *sole cause of his mental ailments, only that they were a substantial factor.* Both the treating and RME physicians in Hart identified the work incident as substantial cause of his PTSD and the Supreme Court thus affirmed, finding that the CRB properly upheld the commissioner's determination that the claimant's psychological injuries were compensable.

C.G.S. § 31-306 Survivor's Benefits

McCullough v. Swan Engraving, Inc., et al. , 320 Conn. 299 (February 2, 2016)

Relevant Facts: The claimant sustained a compensable work-related lung injury on February 11, 2000, resulting in his death on March 31, 2005. A timely Form 30C was filed on May 30, 2002 and a VA accepting the lung injury was approved in February of 2013. The surviving spouse and dependent filed a widow's claim on April 19, 2006, 55 weeks following the death of the claimant. The dependent argued her claim was timely as her husband's underlying claim was timely. The respondents argued the claim was untimely as it was not commenced within one year following the death of the claimant as required by § 31-294c.

Procedural Posture: The Trial Commissioner found that the claim was timely and ordered the respondents to pay § 31-306 benefits. The CRB noted that a claimant's timely notice of his/her underlying compensation claim did not make any subsequent survivor's claim considered "timely" as a 31-306 claim is separate and distinct, requiring a separate notice of claim but reliant upon a viable Chapter 568 claim existing for the decedent at the time of his or her death The CRB reversed and the plaintiff appealed.

Issue: Did the CRB err in denying survivor's benefits?

Holding: The Supreme Court reversed.

Rationale:. The Supreme Court reviewed the language of § 31-294c(a) noting that the decedent's death did not occur within two years of the date of the first manifestation of symptoms and therefore § 294c did not apply. The Supreme Court found that there was no one year statute of limitations for the filing of survivor's benefits when a valid and timely claim was previously filed by the workers' compensation claimant. The Court noted that this issue should be left to the legislature should they desire to put a statute of limitations into effect.

C.G.S. § 31-294c(b) Sufficiency of Denial

Riveiro v. Fresh Start Bakeries, 159 Conn.App. 180 (August 11, 2015)

Relevant Facts: The claimant was employed by the respondent in 2010 when he claimed to have sustained a low back injury while disposing of contaminated dough at work. The claimant claimed to have reported it to a supervisor at work on the date of injury, however, the supervisor testified that she had not worked that day and did not learn of the alleged injury until the claimant requested FMLA leave to undergo back surgery two weeks later. The claimant ultimately underwent the recommended procedure. The claimant filed a Form 30C and a timely form 43 was issued stating that the defendants were contending that there was a "lack of medical evidence supporting [a] causal connection of the low back injury to the claimant's employment" and further that there was a lack of "documentation supporting current and ongoing disability". The matter proceeded to a formal hearing on compensability and the trial commissioner found that the witnesses other than the claimant were credible and that she did not credit the portion of the medical evidence supporting causation because, although the physicians were credible, their conclusions concerning causation were based solely on the claimant's unreliable narrative. The claimant appealed.

Procedural Posture: The CRB found that the Form 43 sufficiently put the claimant on notice that the defendants wee contesting causation of his injury. The CRB affirmed the dismissal of the claim

noting that when a commissioner finds a claimant's narrative unreliable, the commissioner is entitled to discredit medical evidence dependent on that narrative.

Issue: Was the trial commissioner correct in permitting the defendants to challenge the compensability of the claimed injury or was the Form 43 insufficient pursuant to C.G.S. § 31-294c (b)?

Holding: Appellate Court affirmed.

Rationale: The claimant argued on appeal that the Form 43 was insufficient as it specifically stated that they were challenging the sufficiency of the medical evidence. The claimant contended that the use of the term "medical evidence" was tantamount to a concession by the defendants that a compensable injury had occurred, precluding them from challenging compensability. The claimant further argued that as the denial was based on "lack of medical evidence" and all physicians agreed that the claimant had sustained an injury, it was unreasonable for the CRB to affirm the commissioner's dismissal. The Appellate Court noted that the commissioner had concluded that for a disclaimer to meet the specificity of notice requirements under 31-294c(b), it was required to challenge an element of the claimant's prima facie case. The commissioner found that the 43 allowed the defendant to challenge causation and the CRB agreed. The Appellate Court affirmed as to the sufficiency of the Form 43 and noted that the claimant had failed to offer corroborating evidence concerning the occurrence of his injury. The Appellate Court found that the trial commissioner had reasonably determined that the claimant's account of what caused his back injury was unreliable and the decision to discount the medical evidence based on the claimant's narrative was not unreasonable.

C.G.S. § 31-290a Retaliatory Discharge Claims

MacDermid, Inc. v. Leonetti, 158 Conn.App. 176 (June 30, 2015)

Relevant Facts: The plaintiff employed the defendant for 28 years until his termination in November 2009. In February 2010 the plaintiff, employer, and the defendant, employee, entered a termination contract, wherein the employer agreed to pay the employee over $70,000 in exchange for the employee's release of all legal claims he had or may acquire against the employer. After a formal hearing in the workers' compensation commission, the CRB concluded that absent approval by a commissioner, the contract did not waive the employee's rights under Chapter 568. The employer appealed to the Appellate court and further brought the relevant action against the former employer alleging civil theft, fraud, unjust enrichment and conversion premised on the employee's admission that he never intended to release his worker's compensation claim notwithstanding the parties' termination agreement. The employee counterclaimed for civil retaliation, alleging discrimination for his filing a workers' compensation claim. The employer filed a motion for summary judgment as to the counterclaim.

Procedural Posture: The Superior Court entered judgment in favor of the employer concerning the counterclaim, holding that it was premature and could not be brought until the employer's action against the employee concluded. The employee appealed.

Issue: Can a claim of civil retaliation under C.G.S. § 31-290a, alleging discrimination by an employer against an employee for filing a workers' compensation claim, be filed as a counterclaim in the same action in which the alleged litigation misconduct arose?

Holding: Appellate Court Affirmed.

Rationale: The Superior Court concluded that the plaintiff, employer's, case, had to resolve before the defendant, the employee, could raise a claim of litigation misconduct against the employer. The Appellate Court reviewed precedent concerning causes of action for vexatious litigation under C.G.S. § 52-568, noting that the same existed if a party lacks a good faith belief in the facts alleged and the validity of the claim asserted. In suits concerning vexatious litigation, the court noted that it was sound policy to "require the plaintiff to allege that prior litigation terminated in his favor." The court further reviewed abuse of process as a cause of action noting that the cause of action was considered premature until the underlying litigation was completed. The Appellate Court thus held that a claim of discriminatory retaliation against a workers' compensation claimant, brought by an employee pursuant to C.G.S. § 31-290a, when premised solely on litigation misconduct rather than conduct outside the judicial process, may not be brought prior to termination of the underlying litigation brought by the employer.

C.G.S. § 31-294c(a) Timely Notice of Claim

Izikson v. Protein Science Corp., 156 Conn.App. 700 (April 21, 2015)

Relevant Facts: On July 12, 2010, in the course of his employment for the defendant, the plaintiff injured his back and one leg while lifting a box. He notified the defendant's controller, verbally, two days later and prepared a First Report of Injury that day, which he transmitted to the defendant's insurer. The defendant's controller subsequently sent several e-mails noting that he was speaking with their insurer about the injury. On July 21, 2010, the defendant insurer mailed a prescription card to the plaintiff with accompanying correspondence noting that it had not accepted any claim. The claimant made no purchases with the card. On August 25, 2010 the defendant insurer filed a Form 43 contesting the injuries. The plaintiff did not file a Form 30C nor request a hearing within one year of his date of injury. At no point did the defendants furnish any medical treatment or make any indemnity payments to the plaintiff, nor did it represent that the claim was accepted. The plaintiff, instead underwent surgery and placed it through his group health carrier. More than one year after the incident, the claimant commenced pursuit of a workers' compensation claim. A commissioner determined that the commission lacked subject matter jurisdiction over the claim as the claimant had failed to file a Form 30C within one year of the injury. The claim was dismissed.

Procedural Posture: On appeal the CRB affirmed concluding that the plaintiff had failed to meet any of the express statutory exceptions to the notice requirement under § 31-294c(c). The CRB further concluded that the claimant had failed to prove that he had provided the defendants with adequate notice of his pursuit of a claim. The CRB further rejected the plaintiff's claim that the preemptive Form 43 indicated that the defendants had received sufficient notice that he was seeking workers' compensation benefits. The claimant appealed.

Issue: Under the totality of the circumstances did the claimant give sufficient notice to the defendants under § 31-294c that he was pursuing a workers' compensation claim?

Holding: Appellate Court affirmed.

Rationale: The Appellate Court noted that the WCC is a tribunal of limited jurisdiction and the claimant: did not file a 30C within one year of his injuries, did not request a hearing within one year of his injuries, did not execute a voluntary agreement with the defendants within one year of his injuries, and did not receive medical care for his injuries within one year of the date on which he

sustained them. The Appellate Court held that in order to satisfy the notice requirement of § 31-294c(a) an employee must affirmatively provide some form of written notice informing his or her employer of their intent to pursue a workers' compensation claim. The claimant did not do so, and accordingly the WCC lacked subject matter jurisdiction to entertain the claim. Further, the Appellate Court noted that a preemptive Form 43, as filed by the defendants, was not an exception to the notice requirement. Therefore the CRB decision was affirmed.

C.G.S. § 31-275(1)(E) Portal to Portal Coverage for Police Officers

McMorris v. City of New Haven Police Dept., 156 Conn.App. 822 (April 28, 2015)

Relevant Facts: The plaintiff, a patrol officer, lived in Hamden and at the time of his accident lived with Anais Rivera and his two children. The plaintiff and Rivera both worked the third shift from 11:00 PM to 7:00 AM for the Police Department. The two men took their children to a day care center for the purpose of sleeping and alternated who drove the kids to the day care. The plaintiff left his home intending to drive the children to day care on June 25, 2011 on his way to report for his night shift from June 25th to June 26th. When the plaintiff drove his children to day care, he followed the same route he took to work, altered slightly by one street, and then rejoined his normal route to work. He was wearing his uniform and gun belt when dropping his children off but was driving his personal vehicle. Prior to altering his normal route to work to drop the children at day care, the claimant was involved in a motor vehicle accident and sustained injuries. The commissioner found that the claimant had to take his children to day care on June 25th because he was scheduled to work that night, en route to the police station and further was a portal-to-portal police officer pursuant to C.G.S. § 31-275(1)(A)(i) and thus had sustained compensable injuries. The defendants appealed to the CRB contending that the claimant was performing a personal act at the time of his collision, dropping his children at day care, and thus his injuries did not arise out of or in the course of his employment.

Procedural Posture: The CRB affirmed the commissioner's holding that the claimant's injuries were compensable as he was en route to the police station for his shift when his injuries occurred and had not deviated from the route to the station at the time of the accident. The defendant's appealed.

Issue: Was the plaintiff, a police officer's, injury compensable when sustained while en route to drop off his children at day care prior to the start of the shift when he had not deviated from the route to the police station at the time of his accident?

Holding: The Appellate Court affirmed.

Rationale: At the time of his accident, the plaintiff had not yet slightly deviated from his normal route to the police station but rather was where he would have been expected to be in the course of his employment as a police officer. Thus, the Appellate Court found that the act of intending to drop his children at daycare was so inconsequential relative to his job duties, including driving to work, that it did not remove him from the course and scope of his employment.

C.G.S. § 31-307b Relapse Benefits

Gil v. Brescome Barton, Inc., 317 Conn. 33 (May 26, 2015)

Relevant Facts: The claimant sustained a compensable left knee injury on July 2, 1997 when Liberty Mutual was on the risk for the employer. The claimant later sustained a compensable right knee injury on April 3, 2002 when Chubb was on the risk. In 2011 the claimant required bilateral knee replacement surgery which both insurers agreed was medically necessary and reasonable. Preceding this surgery, in 2010, the insurers entered a VA stating that the second carrier, Chubb, would administer payment for the surgery and the first carrier, Liberty, would reimburse Chubb for half of the surgery and related costs. The carriers were unable to reach an agreement for payment of the claimant's temporary total disability benefits post-operatively. The commissioner determined that the claimant had sustained two separate and distinct knee injuries and was entitled to benefits at his relapse rate pursuant to C.G.S. § 31-307b. The commissioner further held that Chubb would administer the claim and that Liberty would reimburse Chubb for half of the temporary total disability post-operatively, paid at the claimant's relapse rate.

Procedural Posture: Liberty Mutual, the carrier on the risk for the second knee injury, appealed. The CRB held that the commissioner properly exercised his authority under C.G.S. § 31-278 by equitably resolving the insurance carriers' dispute concerning temporary total disability payments due the claimant. Liberty Mutual appealed to the Appellate Court, which likewise affirmed, and they appealed to the Supreme Court.

Issue: Did the commissioner have: (1) subject matter jurisdiction to adjudicate a dispute between insurers, and (2) statutory authority to order an insurer to reimburse another insurer one half of the benefits paid?

Holding: The Supreme Court affirmed.

Rationale: As both knee injuries were separate and distinct, the court reasoned that it was to the benefit of each insurer for the bilateral knee replacement surgeries to be performed at the same time. Accordingly, under those circumstances, the Supreme court held that the commissioner had the authority pursuant to C.G.S. § 31-278 to order Liberty to reimburse Chubb for 50 percent of the claimant's post-operative temporary total disability at the relapse rate in order to avoid double recovery by the claimant.

C.G.S. § 31-294d Cost of Compensable Medical Treatment

Caraballo v. Electric Boat Corp., 315 Conn. 704 (March 15, 2015)

Relevant Facts: The claimants suffered compensable injuries and received treatment at the defendant hospitals. The hospitals submitted medical bills to the employer. The bills conformed with the pricemaster lists filed by the hospitals under C.G.S. §19a-646. The employer referred the bills to a third-party vendor to determine the actual cost of the services performed. The employer paid the bills in accordance with the third-party vendor cost assessment. The amount paid was significantly less than the amount billed.

Procedural Posture: The commissioner determined that employers and insurers must either negotiate rates with hospitals (Chapter 368z) or pay the published pricemaster rates. The employer

appealed to the CRB, but the CRB reserved the case for appellate review and sent the case directly to the Supreme Court.

Issue: Whether, prior to the effective date of Public Act No.14-167, an employer must pay for hospital services provided to a claimant based on a determination by the commissioner as to what the services "actually cost" (C.G.S. §31-294d(d)) or based on the hospital's published rates on the pricemaster list (C.G.S. §19a-646).

Holding: The Supreme Court held that the published rates in the pricemaster list (C.G.S. §19a-646) control.

Rationale: The court first reviewed the history of hospital rates and regulation in Connecticut. In 1913, the first workers' compensation statute provided, "The pecuniary liability of the employer for the medical, surgical, and hospital service required shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured persons." The legislature amended the workers' compensation scheme in 1921 to include "but the liability of the employer for hospital service shall be the amount it actually costs the hospital to render the service, said amount to be determined by the commissioner." Following this amendment, the commissioners met with hospital and insurance officials each year to reach an agreement on uniform statewide hospital rates for weekly charges rather than leave actual costs determinations to the commissioners in individual cases. In 1973, the legislature created the Commission on Hospitals and Health Care to in part review budgets and approve rate increases for hospitals. Following the creation of the hospital commission, workers' compensation commissioners routinely adopted hospitals' billed rates, approved by the hospital commission, for purposes of §31-294 (actual cost). In 1984, the legislature attempted to contain costs by creating the DRG rate system, where rates were determined based on "average charges for services rendered given similar categories of illness." The DRG scheme was repealed in 1989 because of resistance to the system of averaging costs. In 1994, the legislature permitted the market to control prices, so the hospital commission's power to approve billing rates ended. However, the legislature required hospitals to file fee schedules (pricemaster lists) and prohibited hospitals from departing from those published rates, except under specific circumstances.

The Supreme Court concluded that the legislature intended the rates published in the pricemaster list under §19a-646 to control.. The court pointed out that commissioners are ill equipped to make actual cost determinations and requiring them to do so would be inconsistent. The court found that allowing the pricemaster rates to control will be consistent with the underlying policies of the Workers' Compensation Act because (1) employers will pay the same rates as the general public; (2) administration of workers' compensation claims will be more prompt and efficient as mini-trials as to actual costs will be avoided; and (3) costs overall will be reduced.

C.G.S. § 31-294d Reasonable and Necessary Medical Treatment

Sellers v. Sellers Garage, Inc., 110 Conn. App. 110 (March 10, 2015)

Relevant Facts: The claimant sustained a compensable head injury on March 21, 1997. He reached maximum medical improvement nine months later and was awarded a 10% permanent impairment to the cervical spine. A specific VA was approved to this affect in September, 1998. In 2002 a neurological RME concluded that the claimant had sustained only a minor scalp contusion and some resulting headaches, neck and shoulder pain from the compensable incident. In 2010 a commissioner examination with a neurosurgeon concluded that the claimant had degenerative

changes typical of age but had no evidence of a brain injury. The commissioner examination further concluded that the claimant had a chronic cervical strain, had reached maximum medical improvement, had a 2% permanency rating to the neck and required no further treatment. In 2011 a subsequent commissioner's examination concluded that the claimant's cognitive impairments, headaches and neck pain were causally related to the compensable injury and recommended neuropsychological testing, an electromyogram and a nerve conduction study be performed. This exam further concluded that the claimant's medications may have cognitive side effects. The treating physician testified thereafter that he had been treating the claimant with medications and that those medications assisted the claimant in his activities of daily living, but did not help him to continue working. The claimant requested reimbursement for treatment and expenses from 2006 to the present. The trial commissioner found that the treatment for cognitive impairments, headaches and neck pain were causally related to the compensable incident, ordering the respondents to reimburse the claimant for those expenses and authorize the treatment recommended by the 2011 commissioner examination. The trial commissioner found, however, that as the medications prescribed by the pain management did not help the claimant to continue working, they were palliative rather than curative and not reasonable and necessary. Finally, the trial commissioner concluded that all medical treatment provided by other physicians beyond the treating physician was outside the chain of referral and not subject to compensation by the respondents.

Procedural Posture: The claimant appealed to the CRB. The CRB affirmed and the claimant appealed again.

Issue: Did the CRB properly affirm the trial commissioner's order dismissing the claim for certain treatment as not reasonable and necessary?

Holding: Affirmed.

Rationale: The Appellate Court noted that the treating physician had testified concerning the claimant having reached maximum medical improvement in 2002 but thereafter continuing treatment with him for pain management. The Appellate Court affirmed. The claimant also claimed that the trial commissioner properly found that the treatment with additional physicians was outside the chain of authorization and therefore not reasonable and necessary. The Appellate Court reviewed the language of C.G.S. § 31-294d and concurred that this treatment was outside the chain of authorization.

Curtis Nails v. Freddie's U.S. Mail, Inc., 5982 CRB-7-15-1 (December 8, 2015)

Relevant Facts: The claimant sustained a compensable back injury in 2006 and had been treating with a pain management physician since 2007, taking narcotics since that time. Dr. Kaplan performed an RME in July of 2011 at which time the claimant reported that he wanted to come off the strong narcotic medications he was taking. Dr. Kaplan recommended an intensive inpatient pain management program. A neuropsychology evaluation in 2013 concluded that the claimant suffered from pain syndrome and major depression and recommended an intensive residential pain management program such as Silver Hill. The treating physician was deposed and testified that the claimant continued to complain of pain despite taking narcotic medication, she however, did not agree with the detoxification program proposed. The treating physician further testified that she was unaware of the narcotics protocols promulgated by the WCC nor did she have a written narcotic protocol in place with the claimant. The claimant was evaluated at Silver Hill in February 2014 and invited to participate in their detoxification program which they believed would benefit him. The Respondents prepared a Form 36 dated March 19, 2014. The trial commissioner granted the Form

36 and directed the claimant to undergo the recommended detoxification program, noting that he would be entitled to one year of "after care" following completion of the program.

Procedural Posture: The claimant failed to respond to the Trial Commissioner's November 3, 2014 Ruling within twenty days and on December 30, 2014 filed a hearing request. The claimant appealed to the CRB on January 21, 2015 on the basis that the treatment proposed was not reasonable and necessary medical treatment under § 31-294e.

Issue: Is a drug detoxification program reasonable and necessary medical treatment under Chapter 568 that the trial commissioner has discretion to order the claimant to undergo?

Holding: Affirmed.

Rationale: The CRB found that the appeal was untimely and was jurisdictionally invalid. The CRB further found that the detoxification program was an appropriate modality of treatment for the claimant as determined by the trial commissioner. The CRB noted that the commissioner had relied on expert testimony supporting that the claimant would benefit from in-patient detoxification, noting that the reasonableness of a particular treatment is a question of fact for the commissioner to resolve. As the commissioner could reasonably find that in-patient detoxification was of therapeutic value to the claimant, the CRB affirmed the trial commissioner's ruling.

Zbras v. Northeast Mortgage Corp., 5997 CRB-5-15-3 (March 29, 2016)

Relevant Facts: The claimant sustained a compensable right arm injury in August 2000 and has treated since that time. She was diagnosed with RSD and prescribed narcotic medication to control her pain in 2003. In January of 2009 the parties stipulated that the claimant was to wean herself off of her narcotic, Actiq, by June 1, 2009. The agreement placed the burden on the claimant to prove that this treatment was reasonable but the respondents inadvertently continued to pay for the narcotic medications until August 2010. The trial commissioner determined that the claimant's continued use of Actiq was not reasonable and necessary medical treatment pursuant to C.G.S. § 31-294d subsequent to June 2009 and dismissed the claim for ongoing use of the drug. In 2013 the respondents sought reimbursement for payment of Actiq from June 2009 through August of 2010.

Procedural Posture: As the claimant failed to wean herself off Actiq in accordance with the stipulated agreement, the trial commissioner directed her to reimburse the respondent nearly $134,000 for payment of Actiq from June 2009 through August 2010. The claimant appealed.

Issue: Did the Trial Commissioner err in directing the claimant to reimburse the respondents for what the commissioner found was unauthorized treatment?

Holding: Vacated and dismissed claim for reimbursement.

Rationale: The respondents claimed that the paid for Actiq on a without prejudice basis from June 2009-August 2010, however, the first Form 43 contesting the treatment was filed on April 11, 2012, after the treatment had ended. Moreover, there was no representation to the claimant that payment was being made on a without prejudice basis at that stage and the underlying case had been accepted. The CRB found that the respondents failed to exercise their rights under the 2009 stipulated agreement and that therefore the award ordering reimbursement to the respondents for payment of the medication from 2009-2010 lacked sufficient evidential foundation.

Story v. Town of Woodbury, 159 Conn. App. 631 (September 15, 2015)

Relevant Facts: On October 21, 2002, the claimant, a then police officer employed by the respondent, was directing traffic at a construction site and was struck in the right knee, lower torso and right elbow by a car. The impact caused him to spin, twisting his head and neck from side to side. The claimant sought treatment in the ED for the above injuries but did not complain of dizziness. At two check ups with his primary physician thereafter, the claimant did not report any dizziness. Sometime later, the claimant's friends and family began complaining about his hearing and he began experiencing tinnitus and dizziness. He came under the care of an ENT in early 2004 reporting experiencing ringing in his ears, hearing loss and dizziness since the accident. A hearing test confirmed high frequency hearing loss in both ears and the treating ENT assessed hearing loss and vertigo due to the concussion sustained in his accident. An RME with an ENT thereafter opined that the claimant did not sustain a concussion as a result of the accident (as he sustained no head trauma at that time) nor was the accident a significant factor in his development of hearing problems or vertigo. The trial commissioner found the claimant's testimony and the opinion of the treating physician to be persuasive and concluded that the hearing loss and vertigo were related to the compensable injury.

Procedural History: The CRB affirmed the trial commissioner.

Holding: The Appellate Court affirmed the CRB decision.

Rationale: The Appellate Court noted that expert opinions must be based on reasonable probabilities rather than mere speculation if they are to be admissible in establishing causation. The treating ENT, who had prepared the opinion on which the trial commissioner had relied in establishing causation, did not review the claimant's treatment records from the hospital on the date of the accident, nor from his primary physician which failed to document his alleged hearing loss and vertigo for several months thereafter. The treating ENT, however, based his opinion on his own examination of the claimant and the results of the testing that he had commissioned. The court noted that the claimant had testified that he had experienced ear symptoms since the accident, but that those symptoms were secondary to other problems and thus, he did not bring it up to his medical providers. The Appellate Court ultimately held that the expert opinion as to the work-related accident being the cause of the claimant's hearing loss could be relied upon in establishing causation, although the expert did not review the records closest in time to the accident revealing that the claimant did not complain of dizziness and hearing loss. The Court further found that the expert's opinion pertaining to causation was sufficiently supported by subordinate facts in evidence as he testified that a labyrinthine concussion did not require a head injury and the claimant testified he experienced severe shaking of his head and neck during the accident. The Court discounted witness testimony that the claimant was merely "bumped" by the car although the RME physician testified that a whiplash injury sufficient to cause a labyrinthine concussion would knock an individual off his feet.

Wilson v. Maefair Health Care Centers, 155 Conn. App. 345 (February 10, 2015)

Relevant Facts: The claimant commenced employment with the defendant, Maefair, as a CNA in October of 2000. In 2006, the claimant sustained a compensable neck injury and soon thereafter resumed full duty work. In 2010, the claimant sustained a second compensable neck injury, leading to a four month course of chiropractic treatment. She then reported the resolution of her neck and

arm pain but ongoing numbness in her elbow and fingers. She was referred for a surgical consultation and recommended for surgery but as the carrier, Liberty Mutual, did not authorize a requested second opinion concerning surgery the claimant sought no treatment for the coming five months and continued to work full duty. In 2011 the claimant reinjured her neck at work when a new carrier, Gallagher Bassett, was on the risk for Maefair. Following the 2011 injury she was placed on light duty restrictions and as Maefair could not accommodate those restrictions, she ceased employment with it and was unsuccessful in finding work. The claimant was recommended for surgery a few months following the 2011 injury and the two carriers disputed who was responsible for surgery and the resulting lost time from work.

The claimant's treating surgeon testified that the claimant was a surgical candidate prior to the 2011 injury. An RME for the carrier, Liberty Mutual, opined that both the 2010 and 2011 dates of injury were substantial factors in causing her need for surgery. The claimant testified that the 2006 injury did not debilitate her in any way, that the 2010 incident worsened her arm symptoms but that she resumed full duty shortly thereafter. The trial commissioner found the 2010 and 2011 incidents to be substantial factors in the need for surgery and that the 2011 incident worsened the claimant's condition n a "material and substantial way". The commissioner therefore ordered Gallagher Basset to accept liability for the surgery and lost time.

Procedural Posture: Gallagher Bassett appealed to the CRB which affirmed the commissioner's decision pursuant to the binding decision in Hatt v. Burlington Coat Factory, 263 Conn. 279 (2003). Gallagher Bassett then appealed to the Appellate Court.

Issue: Did the CRB properly affirm the trial commissioner's determination that Gallagher Bassett was responsible for the claimant's surgery and resulting lost time?

Holding: Affirmed.

Rationale: The Appellate Court held that the CRB had properly construed its precedent and the language of C.G.S. § 31-349. Gallagher Bassett argued that Hatt did not apply as the claimant was a surgical candidate before the 2011 injury. The Appellate Court noted that proximate cause was the appropriate analysis for determining causation in Chapter 568 cases and that the trial commissioner had relied on evidence in determining that the 2011 incident was a substantial factor in bringing about the claimant's need for surgery. Most importantly, the Court noted that following the 2011 incident the claimant was unable to continue to perform the job she had been performing after the 2010 injury.

Sullins v. United Parcel Serv., Inc., 315 Conn. 543 (Feb. 17, 2015)

Relevant Facts: The claimant worked for UPS, unloading trucks and sorting small parts for 32 years. He was diagnosed with diabetic neuropathy in 1998, causing impairment to his arms and hands, including weakness and tingling. In 2003 the claimant suffered injuries to his upper arms and hands as a result of a work related accident, requiring medical treatment and surgery. In 2010 the claimant received a permanent impairment rating of 44% to his bilateral arms and 40% to his hands, at which time the physician assigned 10% of each rating to the work injuries and opined that the claimant's job had no influence on his development of diabetic neuropathy. Following a formal hearing, the trial commissioner determined that the claimant was entitled to receive only a 10% permanent partial disability to his arms and hands as the remainder of the permanency ratings were attributed to his personal condition.

Procedural Posture: The claimant appealed to the CRB on the basis that the disability impairment could not be apportioned. The CRB affirmed, concluding that § 31-349(a) did not apply. The claimant appealed to the Appellate Court which concluded that the permanent disability met the standard in § 31-349 and therefore, could not be apportioned and the respondents were liable for the entire disability of the claimant's upper extremities. The defendants appealed to the Supreme Court.

Issue: Whether a disability arising from a progressive nonoccupational condition that manifests prior to an occupational injury, that further disables the same body part, is a compensable preexisting injury or a noncompensable concurrently developing disease under the apportionment rule set forth in Deschenes v. Transco, Inc., 288 Conn. 303 (2008).

Holding: Affirmed the ruling from the Appellate Court.

Rationale: The Supreme Court noted that pursuant to § 31-349(a) employers are responsible for all consequences of compensable injuries, even though the consequences may be greater to an employee with a pre-existing injury than they would have been to a normal person. Thus, if the claimant sustains a permanent disability which is materially and substantially greater due to a work injury following a preexisting disability, a plaintiff must receive compensation for the entire amount of the disability. The Supreme Court reviewed the decision in Deschenes wherein the claimant concurrently developed two separate medical conditions involving his lungs, one occupational in nature and the other brought on due to asbestos exposure stemming from his employment. This court concluded in Deschenes that apportionment of permanency benefits was appropriate when an employer proves that: (1) a disability resulted from the combination of two concurrently developing disease prcesses, one that is nonoccupational, and the other that is occupational in nature; and (2) the conditions of the claimant's occupation have no influence on the development of the nonoccupational disease. The court did not find that Deschenes applied as the circumstances of this case fell within § 31-349(a) and that prior decision was only intended to resolve the narrow issue before it involving two concurrently developing disease processes. As the diabetic neuropathy was a previous disability and the claimant's permanent disability was greater than it would have been resulting from the second injury alone, the court determined that the disability resulting from a combination of diabetic neuropathy and his work related injuries could not be apportioned.

C.G.S. § 31-300 Sanctions

Ramsahai v. Coca Cola Bottling Company, 5991 CRB-1-15-2 (January 26, 2016)

Relevant Facts: The claimant sustained compensable injuries to his hip, back, groin & clavicle resulting from a fall in 2003. The claimant sought payment of past due TT benefits dating back to January 2011 and ongoing which the respondents had denied as their examiner had attributed the TT status to his underlying arthritic condition.

Procedural Posture: The trial commissioner concluded that the claimant was essentially unemployable due to his learning disabilities and his advancing arthritis, which was substantially aggravated by the compensable injury. The trial commissioner thus awarded TT benefits from January 11, 2011 and ongoing along with interest at the rate of 10% per year pursuant to C.G.S. § 31-300. Respondents appealed on several basis including that the trial commissioner should not have awarded interest under § 31-300 as the matter had not been properly noticed nor litigated.

Issue: Did the Trial Commissioner err in awarding interest pursuant to Section 31-300 when the matter had not been properly noticed?

Holding: Reversed and remanded on the issue of interest.

Rationale: The CRB held that the issue was not properly noticed during the proceedings. The CRB held that the respondents should have had an opportunity to be heard on whether they had any legal or factual defense to an award of statutory interest on the award of TT benefits. The CRB held that as the respondents had not been afforded such an opportunity the award could not stand and reversed and remanded the matter on the issue of interest for further proceedings.

C.G.S. § 7-433c Heart and Hypertension Benefits

Conroy v. City of Stamford, 161 Conn. App. 691 (December 15, 2015)

Relevant Facts: The claimant was hired as a firefighter in 1979 and underwent a pre-employment physical revealing no evidence of heart disease or hypertension. The claimant was later promoted to the role of city fire chief. On January 30, 2008 the claimant reported to his treating physician, where he underwent a normal echocardiogram and was advised that he could either make dietary changes or go on blood pressure medication and should monitor his blood pressure going forward. His treating physician testified that he did not diagnose the claimant with hypertension at this time. After receiving these recommendations, the claimant modified his diet and lost weight and his blood pressure came down "almost consistently". The claimant continued to monitor his blood pressure and his treating physician testified that later in 2008 and then in 2009, his blood pressure readings were not hypertensive. On January 6, 2012 he presented to the ED with a severe headache. He was advised that he had an "issue with high blood pressure" and was kept in the cardiac care unit overnight where he was placed on a Beta blocker. He received Benacar which he continued taking thereafter. An RME with Dr. Krauthamer concluded that the claimant began displaying elevated blood pressure readings in July, 2003 and that his readings in January 2008 met the criteria for a diagnosis of hypertension even if the treating physician didn't record such a diagnosis. The claimant filed a claim for hypertension benefits within one year of his January 6, 2012 visit and the trial commissioner reviewed the claimant and treating physician's testimony, concluding that it would be unfair to punish the claimant for an error in judgement of his treating physician in failing to diagnose hypertension sooner.

Procedural Posture: The trial commissioner concluded that as the claimant was not formally diagnosed with hypertension until January 6, 2012 in the ED, the notice of claim dated April 9, 2012 was therefore timely. The CRB affirmed the trial commissioner's decision awarding § 7-433c benefits to the fire chief and the City appealed.

Issue: *Was the claim for benefits pursuant to § 7-433c timely filed when the claimant was offered the option of taking medication for elevated blood pressure more than one year prior to the filing of his claim?*

Holding: Affirmed.

Rationale: The Appellate Court reviewed Supreme Court precedent holding that the one-year limitation period to file a § 7-433c claim began to run when the claimant's physician formally diagnosed him with hypertension and informed him of that diagnosis. The Court reviewed the trial commissioner's finding that the claimant was not formally diagnosed with hypertension until January 6, 2012, noting that this was supported by evidence in the record. The court found that the treating physician's offer of medication to the claimant for his elevated blood pressure was not

tantamount to a diagnosis of hypertension for purposes of commencing the one year statute of limitations to file a § 7-433c claim. Under the totality of the circumstances surrounding the January 30, 2008 visit, the court found that they did not support the conclusion that the claimant received a formal diagnosis of hypertension at that time and thus that the claim was timely filed.

Staurovsky v. City of Milford Police Department, 164 Conn. App. 182 (March 29, 2016)

Relevant Facts: The claimant worked for a police department from 1987 until his retirement on February 17, 2012. His last day working for the police department was February 2, 2012 and on February 13, 2012 he started a new job as a campus police officer for a university. On February 24, 2012 the claimant sustained a heart attack while shoveling his driveway, requiring a stent, bypass surgery and an angiogram indicating that the claimant had severe coronary artery disease affecting four major arteries. He filed a claim for heart and hypertension benefits a few weeks after leaving the employment of the respondent police department. The claimant testified at the formal hearing that he had never been told by a physician that he had heart disease or hypertension prior to his heart attack. The claimant's cardiologist testified that the coronary artery disease was chronic, had developed over a period of years and was present on January 30, 2012, the claimant's alleged date of injury. The cardiologist further testified that the claimant's heart disease and his snow shoveling were substantial factors in his heart attack, but noted that he had *no evidence that the claimant's heart functioning was impaired in January 2012*. The trial commissioner held that the claimant was neither diagnosed nor treated for heart disease until February 24, 2012 and therefore his notice of claim was filed timely. The trial commissioner further held that to be compensable under § 7-433c a claimant must have suffered a heart condition and disability while a member of a police or fire department. The commissioner denied the claim.as the claimant had not sustained any disability from his heart condition until he left the employ of the police department. The claimant moved for reconsideration asserting that pursuant to Arborio v. Windham Police Department, 103 Conn. App. 172 (2007), he need not have sustained a disability while employed by the police or fire department to have a viable claim for § 7-433c benefits; rather the claimant need only sustain an injury and file a claim within one year of that event.

Procedural Posture: The trial commissioner issued amended findings and concluded that the claimant had filed a timely claim and was entitled to benefits under § 7-433c. The respondents appealed arguing that pursuant to Gorman v. Waterbury, 4 Conn. App. 226 (1985), unless a claimant is disabled with a cardiac illness or hypertension while employed as a police officer or firefighter, they lack standing to receive an award under § 7-433c. The CRB concluded that a claimant *no longer need sustain a disability due to heart disease or hypertension in order to present a valid claim for § 7-433c benefits*. The CRB reviewed the cardiologist's testimony wherein he opined that the claimant had heart disease in January 2012, when he remained a police officer, and although it did not lead to disabling consequences until later, it had been developing for many years previously. The CRB affirmed the timeliness of the claim and the claimant's pursuit of same and the respondents appealed.

Issue: Did the CRB err in determining that a claimant's right to obtain benefits under § 7-433c does not terminate on the date he or she leaves the employment of a police or fire department?

Holding: Appellate Court reversed.

Rationale: The Appellate Court held that the one-year period to file a claim for benefits began to run when the claimant was formally diagnosed with coronary artery disease. As the claimant was not diagnosed with coronary artery disease until 2012, the statute of limitations did not begin to run

until that time. Although the claimant was offered medication in 2008, this was not tantamount to receipt of a diagnosis sufficient to commence the statute of limitations pursuant to § 31-294c(a). The Court reviewed the language of § 7-433c noting that it provided a special benefit to police officers and firefighters. The Court held that the evidence was insufficient to establish that the claimant suffered from coronary artery disease prior to retirement. The Appellate Court noted that to qualify for benefits under Section 7-433c, a claimant must establish the existence of a condition or impairment of health caused by hypertension or heart disease during the claimant's period of employment, which results in the claimant's death or disability. The Court reviewed the record noting that the claimant was never disabled from working for the City during his time with the department due to heart disease or hypertension.and thus concluded that the claimant did not qualify for § 7-433c benefits.

Holston v. City of New Haven Police Department, 5940 CRB-3-14-5 (May 27, 2015)

Relevant Facts: The claimant was hired by the Respondent Police Department in 1996 as a patrol officer and underwent a pre-employment physical revealing no evidence of any heart-related condition. On March 10, 2011 the claimant experienced chest pain and a heart attack at home resulting in a diagnosis of coronary artery disease and requiring stent implantation. Four days later the claimant filed a notice of claim seeking benefits for heart and/or hypertension pursuant to § 7-433c. The claimant's medical records and his primary care physician's testimony reflected pre-hypertensive blood pressure readings going back to 1998 and a diagnosis of hypertension on October 28, 2009, at which time he was advised to institute lifestyle changes. The claimant testified that he was never told by any medical provider that he had hypertension prior to his 2011 heart attack and was never prescribed blood pressure medication. The claimant's primary physician testified that: (1) he would have discussed the hypertension diagnosis with the claimant in 2009, though he may have used the words "elevated blood pressure" in lieu of hypertension, (2) the claimant's hypertension was a significant contributing factor to his coronary artery disease and heart attack, and (3) blood pressure elevation could be a precipitating factor in bringing it about. Dr. Krauthamer performed a records review opining that the claimant's hypertension was a significant factor in the causation of his coronary artery disease. He testified that the terms "high blood pressure" and "hypertension were synonymous and that the claimant's risk factors for coronary artery disease were high blood pressure, male gender and high cholesterol. Dr. Krauthamer further testified that: (1) the claimant's coronary artery disease and hypertension were substantial factors in his March 2011 heart attack and (2) both hypertension and coronary heart disease were separate diseases but could flow directly from the other.

Procedural Posture: The trial commissioner found the primary care physician and Dr. Krauthamer's opinions credible and persuasive and although the claimant testified that he did not recall his primary physician telling him about his hypertension diagnosis in October 2009, concluded that the doctor had likely conveyed it to the claimant. The commissioner found that the claimant should have put the respondent on notice for a claim for hypertension benefits at that time, and accordingly concluded that the March 14, 2011 notice was untimely as to the hypertension claim. The commissioner further concluded that the pre-existing hypertension was a significant factor in the development of his coronary artery disease and heart attack, but that the coronary artery disease was a separate injury, brought on also by additional risk factors. Accordingly, the claimant was permitted to pursue a claim for the heart attack of March 10, 2011 and the claimant had satisfied his burden of proof that he qualified for benefits for heart disease under § 7-433c.

Issue: Did the Trial Commissioner err in finding that the March 2011 notice of claim for the heart attack and heart disease was timely given the hypertension diagnosis in October 2009?

Holding: CRB Affirmed.

Rationale: The CRB reviewed its precedent in Mayer v. East Haven, 4620 CRB-3-03-2 (March 3, 2004), wherein the claimant was diagnosed with hypertension in 1987 and coronary artery disease in 1995 when he filed a Form 30C. In Mayer, the CRB concluded that § 7-433c does not create a bar for collecting benefits for one of the two ailments (hypertension and heart disease) when a claimant has previously suffered from the other. The CRB found that the claimant's hypertension, cholesterol and male gender may have played a role in bringing about his coronary artery disease, but that *hypertension and heart disease were separate diseases*. As such, under §7-433c, the special compensation afforded to police officers and firefighters, the March 14, 2011 notice of claim for *heart disease* was timely. In regards to the claimant's cross-appeal, the CRB affirmed that the claimant was advised he was suffering from high blood pressure at an office visit in October of 2009 such that he was obligated to put the respondents on notice within one year of their potential exposure for a hypertension claim. Accordingly the trial *commissioner's dismissal of the claim for § 7-433c benefits for hypertension* was affirmed.

C.G.S. § 31-299b Apportionment and Respondent Dismissal

Estate of John Graham v. Olson Wood Associates, Inc., 5911 CRB-4-14-2 (January 29, 2015)

Relevant Facts: In 2006 the claimant brought a C.G.S. § 31-299b claim alleging to have sustained a lung injury due to asbestos exposure during his employment with several employers. The claimant died in 2008 and his dependent widow filed a claim for survivor's benefits. Thereafter, one insurer became insolvent and its liability was transferred to the Connecticut Insurance Guaranty Association ("CIGA"). CIGA moved to dismiss on the basis that the WCC did not have jurisdiction over it. The matter proceeded to a formal hearing in 2011 where testimony was taken but no exhibits were entered as the trial commissioner opined that the purpose of that proceeding was solely to excuse all respondents who had no liability. The trial commissioner thereafter issued a decision which recited no findings of fact but granted several motions to dismiss, including CIGA's. No party appealed. In 2013, at the direction of the trial commissioner, the claimant and a co-respondent filed motions to cite in CIGA arguing that it's dismissal in 2011 was "interlocutory and provisional". The matter proceeded to a further formal hearing in 2013 where testimony was taken from the claimant's widow but the parties agreed that a determination as to her dependency status along with the other remaining issues would be reserved for the next formal. Following a further formal hearing in 2014 concerning the relevant motions to cite CIGA in, the trial commissioner granted said motions on the basis that: (1) at the formal hearing following which CIGA was dismissed, no testimony, nor evidence were presented, and (2) no parties in attendance at the hearing stipulated that CIGA had no liability.

Procedural Posture: The trial commissioner granted the Motions to Cite in CIGA as he reasoned until the last date of injurious exposure is ascertained, along with the identity of the party against whom the award will be made under § 299b, any agreements to release parties are interlocutory.

Issue: Did the Trial Commissioner err in granting the Motion to Cite in CIGA following the claimant's agreement to dismiss it from the claim three years' prior?

Holding: CRB Affirmed.

Rationale: CIGA argued on appeal that its dismissal from the claim in 2011 was a binding final judgment and not interlocutory. Further, CIGA argued that the 2011 hearing was still a full evidentiary hearing, notwithstanding that no evidence was submitted and no testimony was taken. Finally, CIGA argued that as no party appealed within 20 days after the Finding wherein it was dismissed in 2011, pursuant to §31-301, the decision was final. The CRB reviewed the language of § 31-299b opining that the apportionment of liability among the various respondents in those claims could *only occur after the conclusion of litigation on the merits of the underlying claim.* Thus, although it had been the practice, in the interests of efficiency, to excuse, by agreement, certain participants from attending all hearings in asbestos claims; the CRB concluded that any party who elects not to participate in hearings does so at its own risk. The CRB concurred with the trial commissioner that until the last date of exposure and the 299b carrier have been determined, agreements to release parties are interlocutory.

C.G.S. § 31-294c Preclusion

Geraldino v. Oxford Academy of Hair Design, 5968 CRB-5-14-10 (January 20, 2016)

Relevant Facts: The claimant was hired by the respondent in 2007 as a cosmetology instructor and she testified concerning what this entailed. In late October 2010 the claimant was instructed to pack up all equipment and records for the school so that it could be moved to a new location. This work caused a great deal of pain and after she carried the boxes up the stairs at the new location and unpacked them she experienced a strong pain in her left calf, neck, back arms, wrists, fingers, hands and legs. The claimant reported to her vascular surgeon November 5, 2010 with whom she had treated since 2008 for chronic venous insufficiency. The claimant was ultimately advised to undergo cervical spine fusion in early 2011 in relation to the packing and unpacking of boxes at work. She remained on light duty work restrictions until October 2013 but as there was no light duty available she engaged in weekly job searches and remained out of work. She commenced a new position in October 2013. In the interim, in the spring of 2012 the claimant was assessed with thoracic outlet syndrome and the treating physician causally related the neck and back conditions and need for surgery to lifting related injuries at work. The treating physician further opined that the claimant had carpal tunnel syndrome related to repetitive work activities preceding the compensable injury. A Motion to Preclude was previously affirmed by the CRB against the respondents in 2014 and the claimant was awarded benefits. The trial commissioner ordered the respondents to accept compensability of the cervical and lumbar spine injuries and pay TT/TP benefits and PPD benefits as assessed to the spine. The commissioner concluded that further hearings may be necessary to determine causation of the claimant's hand and leg injuries.

Procedural Posture: The respondent moved to correct the findings to state that the claimant had failed to sustain her burden as to compensable injuries involving bilateral carpal tunnel syndrome, a compensable leg injury and venous reflux. The respondents appealed on the basis that the elements of relief were inconsistent with the evidence on the record. The claimant argued that because of preclusion the respondent lacked the ability to seek any post-hearing relief and the appeal was not viable.

Issue: After a Motion to Preclude is granted and a respondent is precluded from contesting liability of a claim for benefits, is that party further barred from bringing legal error to the attention of the CRB?

Holding: Remanded for further proceedings

Rationale: The CRB first found that the respondents had the ability to appeal the decision of the trial commissioner notwithstanding the prior Motion to Preclude having been granted. The CRB reasoned that formal hearings are fact finding exercises; whereas appellate proceedings are contests as to legal sufficiency of the result reached at the formal hearing *and respondents cannot be barred from challenging an application of law as to do so would deny the respondents due process.* Although respondents are precluded from cross-examining witnesses or presenting evidence at a formal hearing, the CRB found that respondents were not precluded from pursuing an appeal where the trial commissioner did not sufficiently identify the factual basis in the record for various findings. The CRB reviewed precedent noting that even after preclusion a claimant must satisfy a trial commissioner through probative evidence that his or her injury results from a compensable injury. As the trial commissioner did not reach a definitive conclusion as to whether additional hearings were required to address the compensability of the claimant's alleged arm and leg injuries, the CRB found that the conclusion was inappropriate as it did not make the necessary conclusion as to compensability and remanded the case for further proceedings as it concerned the claimed arm and leg injuries.

Grzeszczyk v. Stanley Works, 5975 CRB-6-14-12 (December 9, 2015)

Relevant Facts: The claimant filed a Form 30C on February 7, 2006 alleging injuries to various body parts after a fall at work on March 10, 2005. A Form 43 was filed on June 28, 2006. The claimant moved to preclude the respondents from contesting the claim. Following the injury, the claimant sought treatment which was paid for in full by the respondents and a VA was later issued prior to the formal hearing. No additional billing was presented to the respondents. The trial commissioner concluded that the facts did not support granting preclusion pursuant to § 31-294c(b) as the respondents paid all applicable medical bills and prepared a VA concerning compensability within one year of the claim's commencement.

Procedural Posture: The claimant appealed from the denial of her Motion to Preclude.

Issue: Did the trial commissioner properly determine that preclusion was not appropriate pursuant to the safe harbor from preclusion provided under §31-294c?

Holding: Affirmed.

Rationale: The CRB distinguished its precedent noting that a 43 had never been issued in Pringle v. National Lumber, Inc., 5912 CRB-3-14-1 (December 31, 2014), appeal pending, and that no medical treatment nor indemnity payments had been authorized and paid in the 28 day period after the claim was filed. In Pringle, the CRB had affirmed the trial commissioner's granting of preclusion. In the present case, as the single medical bill for treatment of the claimant's injury presented to the respondents was paid, VAs were issued and no lost time was incurred, the respondents fell within the safe harbor provision and preclusion was not appropriate. The claimant argued that there were additional medical bills for treatment presented to the respondents which they did not honor, however, on review of the evidence, the trial commissioner found and the CRB upheld that the respondents had not received any additional medical bills for treatment in connection with the claim. The CRB thus cited Adzima v UAC/Norden Division, 177 Conn. 107 (1979) for the proposition that when a respondent accepts compensability of an injury, they do not lose the right to contest the extent of disability. The CRB thus affirmed the trial commissioner's ruling.

Haines v. Turbine Technologies, Inc., 5932 CRB-6-14-4 (March 9, 2015)

Relevant Facts: The claimant sustained a compensable lumbar injury at work, filing three separate Form 30Cs in May of 2006, August of 2007 and claiming repetitive trauma up to December of 2011. The claimant testified concerning a twisting back injury sustained at work in May 2006, and that all of her work since 2012 "made her back hurt". She further testified that her back and leg pain had not changed since May of 2006. In 2012 she was advised to undergo surgery. The RME physician opined that the claimant's repetitive trauma at work until 2011 was a substantial contributing factor to her ongoing back symptoms and need for surgery. This opinion was echoed by more than one additional physician. However, the claimant's treating neurosurgeon found that the 2006 injury was the sole substantial factor in her need for back surgery. The trial commissioner found that the repetitive work activities were not a substantial factor in the claimant's need for back surgery and ordered the insurer on the risk for the 2006 injury to accept compensability of the claim.

Procedural Posture: The carrier on the risk for the 2006 injury appealed.

Issue: Did the trial commissioner properly determine that preclusion was not timely raised and therefore could not be addressed?

Holding: Affirmed.

Rationale: The 2006 carrier argued that the 2011 carrier should have been precluded from presenting evidence and contesting the claim for repetitive trauma as the 2011 carrier did not file a Form 43 contesting liability. The CRB noted that as the issue of preclusion was never raised prior to the closure of the record for the formal hearing, the 2006 carrier could not raise it for the first time on appeal. Moreover, the CRB held that the 2006 carrier lacked the standing necessary to raise the issue of preclusion at the formal hearing as no motion to preclude had been filed and held that *preclusion is a form of relief available only to claimants*. The CRB noted that the obligation for filing a Form 43 to a Form 30C is on the employer, not each insurer. Further, the CRB noted that an insurance carrier lacks standing to pursue legal relief on behalf of a claimant who did not exercise their rights.

C.G.S. § 31-278 Recusal of Trial Commissioner

Summers v. R R Donnelley Printing Company, 5914 CRB-1-14-2 (February 26, 2015)

Relevant Facts: The claimant brought a claim alleging a June 1, 2011 unwitnessed work injury to his knee and testified extensively regarding the circumstances and treatment for that injury. He reported the injury to his supervisor within one hour after its occurrence, completed an incident report and left work early. He did not seek immediate treatment but called his primary physician the next day who advised him to ice the knee and keep off the leg. He resumed light duty work on June 3rd and then went out of state on vacation from June 6-10, following which he resumed light duty work. He then worked regular duty from July, 2011 through December of that year and did not seek treatment for his injury until February 2012. The report concerning his initial treatment for the knee reflected a six month history of right knee pain, but no acute injury having occurred. The treating physician, Dr. Zimmerman, diagnosed a torn meniscus and in September 2012 recommended surgery, thereafter opining that the compensable injury was related to the need for surgery and tear. The RME physician, Dr. Selden, opined in March, 2013 that "if the pain began on [6/1/11] as the patient states] there would be a causal relationship of his meniscal tear with the work incident". The

claimant pursued a formal hearing concerning compensability and seeking sanctions for undue delay and unreasonable contest and failure to authorize medical treatment from February, 2012 – June, 2013.

The trial commissioner did not find the claimant fully credible but found that he did sustain a work-related knee injury on June 1, 2011 and that the need for surgery was causally related to that incident. The trial commissioner further found that the respondents did not unduly delay or unreasonably contest the claimant's benefits. Prior to receipt of the Finding and Award, the claimant filed a Motion for Testimony of the Respondent's Adjustor in November, 2013. The motion was denied as it sought live testimony but granted the motion to the extent that the respondent's non-privileged documents were added to the record.

Procedural Posture: The claimant appealed on the basis that his Motion for Testimony was denied to address the issue of undue delay and unreasonable contest.

Issue: Did the CRB properly affirm the trial commissioner's determination that Gallagher Bassett was responsible for the claimant's surgery and resulting lost time?

Holding: Reversed and remanded as to the issue of sanctions for a hearing with a new commissioner on the issue of whether to approve a deposition of the respondents' claim adjuster and award the claimant sanctions on the basis of undue delay and/or unreasonable contest.

Rationale: The claimant argued that he was denied due process as the trial commissioner had "predetermined the issue of undue delay and unreasonable contest before hearing any evidence in the case". In making this argument, the claimant pointed to the trial commissioner's failure to recuse himself after a request was made on the record at the formal hearing and the trial commissioner's response wherein he noted that there was a question of credibility given the claimant not having sought treatment for six months after his claimed injury. The CRB did not find that the claimant had met his burden of establishing that the trial commissioner was required to recuse himself. In reviewing State v. Rizzo, 303 Conn. 72 (2011), the CRB noted that "opinions that judges may form as a result of what they learn in earlier proceedings in the same case rarely constitute the type of bias that requires recusal...To do so, an opinion must be so extreme as to display clear inability to render fair judgment". (Internal citation omitted). Further, the bias sufficient to result in disqualification generally must stem from an extrajudicial source and result in an opinion on the merits on same basis other than what the judge learned from his participation in the case". Tracey v. Tracey, 97 Conn. App. 278, 283-284 (2006). Further § 31-278 makes it the prerogative of the trial commissioner to decide whether considerations of actual or potential bias mandate recusal as only the trial commissioner can know whether what he or she has heard will impact his or her ability to fairly preside over the formal hearing.

The claimant further argued that the trial commissioner erred in not approving his Motion to Depose the Respondents' adjustor as once the reports from the treating and RME physicians established a causal connection between the compensable injury and the injury, the respondents should have authorized surgery and the failure to do so warranted sanctions. The respondents argued that the deposition was likely to result in the disclosure of privileged information and that the claimant's credibility remained in question until the completion of the formal hearing. The CRB reviewed the recent decision in Gagne v. Vaccaro, 154 Conn. App. 656 (2015) holding that the "granting or denial of a discovery request rests in the sound discretion of the [trial] court, and is subject to reversal only if such an order constitutes an abuse of discretion. However, a claimant's credibility must be determined by a trial commissioner and cannot be imputed through referencing

documentary evidence presented. As the trial commissioner made a definitive statement at the inception of the formal hearing concerning his assessment of the claimant's bid with sanctions, and subsequently rendered a decision on an arguably "incomplete" record lacking the deposition of the respondent's adjustor, the CRB reversed as the claimant was not availed every opportunity to rebut the evaluation of the merit of sanctions by the trial commissioner.

C.G.S. § 31-275(1) Course and Scope of Employment

Maurice v. Healthtrax International, Inc., 5934 CRB-6-14-5 (March 24, 2015)

Relevant Facts: The claimant was employed by Healthtrax, a Connecticut firm, in 2007 and was working during that period on a facility owned by the firm in Rhode Island. The employer paid for the claimant's lodging and meals while in Rhode Island and the claimant was given a company issued credit card. After working in Rhode Island one evening the claimant went to a sports bar in Massachusetts with coworkers. When returning to the hotel the claimant fell out of a truck being driven by a coworker and owned by Healthtrax, when it was traveling between 30 and 40 miles per hour. The claimant testified at trial that the truck's door handle malfunctioned, causing him to fall out. An inspection of the vehicle revealed that there was no malfunction. The claimant's blood alcohol level at the time of the accident was found to be .205% and the Respondent's expert witness concluded that the claimant was intoxicated at the time.

Procedural Posture: As the claimant was unable to establish that the trip to the bar was incidental to his employment in Rhode Island the trial commissioner dismissed his claim for benefits.

Issue: Did the Trial Commissioner err in dismissing the claim?

Holding: Affirmed.

Rationale: The CRB reviewed the record and found no nexus between the respondent's business and the claimant's journey to a sports bar. On this basis, it affirmed the dismissal. Moreover, as the claimant's injuries were sustained when intoxication was a substantial factor in bringing them about, the claim was denied on that basis as well pursuant to C.G.S. § 31-284(a). Pursuant to this statute it is necessary to demonstrate both that the claimant was intoxicated and a nexus between said intoxication and the harmful event that injured the claimant in order to apply the statutory defense to compensability. In review of the record, the CRB found that the claimant's intoxication was a substantial factor in bringing about his injuries.

C.G.S. § 31-275(1) Course and Scope of Employment

Lopez v. Pannone, Indiv., et al., 5933 CRB-7-14-5 (April 29, 2015)

Relevant Facts: The claimant was injured while washing the rear part of a house that the respondent did not occupy, which was vacant and subsequently used as a rental property. After the incident, the co-respondent and brother of the first named respondent (who had solicited the claimant's handyman services) took him to the hospital, let the claimant stay at his home for two weeks, transported him to medical appointments and paid him $200 weekly. The claimant had done work at various times for the respondent brothers since 1998. In the summer of 2009 his usual rate of pay was $650 per week with an additional $100 if he worked Saturday or $150 if he worked Sunday. The respondent brothers had an LLC which received rental payments from the Stamford Housing Authority for the property where the claimant was injured and additional properties. The

trial commissioner found that the claimant was an employee of the respondent brothers at the time of his injury as they were in control of the premises, provided the tools and one of the brothers directed the claimant as to what to do. The respondent brothers argued that the claim was not compensable pursuant to the exemption for part-time household employee injuries.

Procedural Posture: The trial commissioner concluded that the statutory exemption to compensability did not apply as the home in which the claimant was injured was vacant at the time of injury and was thereafter a rental property. He thus found the claim compensable.

Issue: Does the statutory exemption in Chapter 568 for part-time household employees in §31-275(9)(B)(iv) cover workers on residential real property that the respondent uses as rental property and not their residence?

Holding: Affirmed.

Rationale: The appellant argued that as the property was not zoned by the city for use as a commercial property, it was a private dwelling and thus the claim was not compensable. The CRB reviewed various statutory definitions of dwelling, abode and premises as well as precedent and concluded that as neither of the respondent brothers had ever lived at the premises where the claimant was injured, and intended to use it as a rental property, it was not a residence. Therefore, the CRB concluded that the statutory exemption for part-time employees did not apply to employees injured in the rental real estate industry.

Velazquez v. Custom Recycling, et al. , 5921 CRB-3-14-3 (June 5, 2015)

Relevant Facts: The claimant alleged to have suffered a work related injury to his left middle finger while working for the Respondent Employer. The claim was timely denied. At the formal hearing the claimant testified that he built pallets for his employer but was injured when using a table saw to cut a piece of wood as a favor for his brother in law to fix a workbench. The claimant did not ask his supervisor for permission to use the saw and his brother in law was not a superior to him at work. Work records were produced reflecting that the claimant was disciplined for performing a personal task during work hours following this incident. The claimant signed these records. Testimony from the claimant's employer noted that all work assignments and changes in the same were made by the shop foreman. The claimant's supervisor testified that the claimant had occasionally used the saw on which he was injured the course of his employment, but always at the supervisor's orders.

Procedural Posture: The trial commissioner concluded that there was no persuasive credible evidence that the claimant was performing work for the employer when he sustained his injury. Although the injury arose during the hours of his employment, the commissioner found that it did not arise out of his employment and thus she concluded that the claimant did not suffer a work injury. The claimant appealed.

Issue: Was the claimant's injury compensable if performed during work hours but not during an activity of benefit to the employer?

Holding: Affirmed. Case dismissed.

Rationale: The CRB emphasized that the claimant was not directed by a supervisor to use the saw in which he was injured and was injured when his brother-in-law sought his assistance and not his

superior. The CRB further noted that the claimant was not permitted to use this saw without his superior's permission. Precedent, however, supports that an injury sustained while a claimant is engaged in a minor deviation from his or her work duties remains compensable under § 31-275(1). See McMorris v. New Haven Police Dept., 156 Conn. App. 822 (2015). The evidence in the case at hand supported that the employer had not acquiesced to the claimant using the saw for any purpose which his foreman had not directed him to perform. Although the claimant argued the workbench he was repairing was for the workplace, and thus benefited his employer, he did not raise this argument at the trial level and therefore the CRB found the injury was not compensable, upholding the commissioner's determination that the claimant's deviation from his employment duties were too significant to make the injury "incidental to employment".

C.G.S. § 31-275(1)(A)(i) Coverage for Police Officers and Firefighters

Balloli v. City of New Haven Police Department, 5950 CRB-6-14-7 (July 1, 2015)

Relevant Facts: On October 25, 2012 the claimant was scheduled to work an extra duty police shift beginning at 7:00 a.m. The claimant resided in a single family home and on this date was parked in his driveway. At approximately 5:30 a.m. the claimant moved his car from the driveway to the street in front of his home at his son's request as he was blocking his son's vehicle. At 6:00 a.m. the claimant walked to the street where his vehicle was parked. As he was about to enter his car, he dropped his keys which ricocheted off of his foot and went underneath the car. When the claimant squatted down and twisted to pick them up he felt a twinge in his lower back. The claimant then drove to work and his back pain became progressively worse with shooting pain down his leg.

Procedural Posture: The trial commissioner found that the claimant did not prove that the injury arose out of and in the course of his employment as he had not departed from his "place of abode" pursuant to C.G.S. § 31-275(1)(A)(i) and dismissed the claim.

Issue: Was the claim properly dismissed as the claimant, a police officer, had not departed his place of abode at the time of his injury?

Holding: Affirmed. Case dismissed.

Rationale: The CRB reviewed the language of § 31-275(1)(A)(i) and precedent in Perun v. Danbury, 143 Conn. App. 313 (2013) holding that the claimant's injury, sustained in his driveway, occurred at his "abode" and therefore was not compensable. Although the claimant and all police officers and firefighters were covered by Chapter 568 in their commute to and from work, the trial commissioner determined, and the CRB concurred, that Perun did not establish a bright line test. Rather, the CRB held that the fact that the claimant's car was parked in the street rather than in the driveway was a "distinction without difference" as the claimant in each case had not yet entered their vehicle at the time of their injuries and as such remained engaged in "a preliminary act or acts in preparation for work". The CRB accordingly affirmed the dismissal of the claim.

C.G.S. § 31-312 Additional Remedies

Corbin v. Saint Mary's Hospital, et al., 5965 CRB-5-14-10 (July 7, 2015)

Relevant Facts: The claimant sustained a compensable injury for which a voluntary agreement was approved resulting in ongoing treatment with a neurologist and biofeedback therapist to improve the claimant's short term memory loss and sleeping. The biofeedback therapist opined in April of 2014

that the claimant was halfway through her course of treatment and the respondents authorized further therapy sessions. The claimant testified concerning her need for transportation to the therapy sessions as her family owns one car which is used by her husband to drive back and forth to work at Federal Express in Watertown six days per week, twelve hours per day. This car is then parked at the Federal Express employee lot during the day as her husband used a company car during the work day. The claimant testified that there was no one else who was available to provide transportation to her therapy sessions, was not aware of any public transportation options and could not afford round trip taxi fare.

Procedural Posture: The trial commissioner held that the respondents could furnish transportation or reimburse the claimant the cost of transportation pursuant to § 31-312. The respondents appealed.

Issue: Did the trial commissioner properly find that the respondents were responsible for the claimant's transportation costs?

Holding: Affirmed.

Rationale: The respondents argued that § 31-312 limited the requirement for transportation to claimants who are medically incapacitated at the time they seek it. On all other occasions, the respondents asserted, the claimant was required to use a private car or public transport and then seek reimbursement. The CRB held that when a compensable injury is sustained it was the employer's unequivocal legal obligation under C.G.S. § 31-294d(a)(1) to provide reasonable or necessary medical treatment and that it is the trial commissioner's decision as to what modalities of treatment are appropriate. As the trial commissioner determined that the claimant's ongoing treatment was reasonable and that she was unable to attend it utilizing her personal vehicle or public transportation, the CRB concurred that it was reasonable to require the respondents to furnish transportation to the claimant.

C.G.S. § 31-306 Enforceability of Prior Award in Separate Venue

Larocque v. Electric Boat Corporation, 5942 CRB-2-14-6 (July 2, 2015)

Relevant Facts: The claimant worked for Electric Boat Corporation from March 17, 1969 until February 26, 1996 as a painter or painting foreman where he was exposed to dust, fumes, solvent and debris, and during the 1960s and 1970s, was exposed to asbestos. The claimant died on November 30, 2009. Prior to his death the claimant brought claims under Chapter 568 and the federal Longshore Act alleging lung injury as a result of exposure to asbestos at work. During his adult life the decedent was a heavy smoker. His cardiologist in the mid 1990s opined that the claimant's dyspnea was due to underlying lung disease stemming from tobacco abuse and prolonged occupational exposure as a painter. An RME physician examined the claimant prior to his death and assessed COPD, attributable to cigarette smoking, and found no evidence of asbestosis. The RME physician opined that work temporarily exacerbated the claimant's lung symptoms but was not the cause of his lung impairment. In 1998 the claimant received an award under the Longshore Act for his lung condition from an administrative law judge as the respondents had failed to rebut the statutory presumption of compensability under that act. Between 1996-2004, the claimant continued heavy cigarette use. In 2004 he was assessed with metastic neuroendocrine carcinoma and brought a separate claim asserting that his lung cancer resulted from his work injury. The treating physician opined that 80% of the causation for the cancer resulted from the claimant's cigarette smoking and the remaining 20% resulted from his work exposure. The RME physician found no causal relationship between the claimant's work history and lung cancer. The claimant

died in 2009. His causes of death were listed as: coronary artery disease, hypertension and hyperlipidemia leading to a myocardial infarction.

The claimant's surviving spouse filed a Form 30D thereafter, alleging that her husband's death was due to workplace exposure to carcinogens. The treating physician opined that the claimant's death was due to his lung cancer, stemming from his smoking and occupational exposure to asbestos. The surviving spouse further pursued a claim for widow's benefits under the federal Longshore Act. In this action, the parties stipulated that the decedent's death resulted from the work injury for which a judge had awarded benefits in 1998. In 2011, the respondents were ordered to begin paying widow benefits and did so, but maintained their denial of the Chapter 568 claim. A respondents' records review in 2012 concluded that there was no evidence of asbestosis and attributed the lung cancer to heavy smoking.

Procedural Posture: The trial commissioner found that the claimant's lung cancer stemmed from his heavy cigarette smoking and not asbestosis. He further concluded that the stipulation of facts entered into under the Longshore Act did not bind the respondents to those stipulations in the Workers' Compensation forum. The commissioner dismissed the claim and the widow appealed.

Issue: Did the trial commissioner properly find that the respondents were not bound by the award and stipulation under the Longshore Act and dismiss the claim?

Holding: Affirmed.

Rationale: The claimant argued that collateral estoppel required the commissioner to find the Longshore Act determination binding on the claim for Chapter 568 benefits. The respondents argued on appeal that they had not conceded the issue of an award for § 31-306 benefits by resolving the Longshore Act claim. The CRB cited Birnie v. Electric Boat Corp., 288 Conn 392 (2008) wherein the Supreme Court noted that when the award under the Longshore Act is determined under a less stringent standard of proof than would be necessary to prove compensability under Chapter 568, the WCC can reasonably determine such an award lacks the force of collateral estoppel in this forum. The CRB noted that under Birnie the commissioner was required to review the evidence presented in the Longshore proceeding and the standards applied to that evidence to determine whether or not to give effect to the force of collateral estoppel. The CRB found that the commissioner had done so and concurred that the Longshore Act award did not estop the respondents from disclaiming liability under Chapter 568. The CRB further held that pursuant to Supreme Court precedent, claimants are required to present reliable, non-speculative evidence and to carry their burden of proof that there is a clear nexus of proximate cause between employment and injury. The commissioner found that the claimant had failed to present such a case and following review of the evidence, the CRB concurred. Finally, the CRB noted that stipulations reached between parties in other proceedings were not entitled to conclusive effect in WCC proceedings. Leonette vi. MacDermid, 310 Conn. 195 (2013) and affirmed the dismissal.

C.G.S. § 31-307 Total Disability Benefits

Goulbourne v. State of Connecticut Dept. of Correction, 5955 CRB-1-14-8 (July 29, 2015)

Relevant Facts: The claimant began working for the respondent as a correction officer on August 16, 1996 after passing a pre-employment physical revealing no evidence of heart or hypertension illness. The claimant found his employment "stressful" and began to complain of chest pain. He came under the care of a cardiologist in 1999 and continued working until February 2001. The

following month he filed what was ultimately held to be a timely notice of claim for benefits concerning his cardiac condition arising from repetitive trauma at work. In July 2001 underwent cardiac bypass surgery. The claimant subsequently underwent a number of cardiac procedures and as of the formal proceeding continued to take medication related to his cardiac symptoms. The claimant thereafter brought a claim for total disability benefits pursuant to C.G.S. § 31-307 or the decision in Osterlund v. State, 135 Conn. 498 (1949).

Procedural Posture: The trial commissioner dismissed the claims for temporary total disability benefits and the claimant appealed.

Issue: Did the Trial Commissioner err in failing to conclude that the claimant was totally disabled and/or unemployable under the Osterlund doctrine?

Holding: Affirmed.

Rationale: The claimant argued that as his treating physician opined that he was totally disabled from all work due to his coronary artery disease and this opinion was not contradicted, the trial commissioner was not within his discretion in failing to find that he was totally disabled. On review of the RME report, the CRB noted that the RME physician could not "agree or disagree" with the treating physician's opinion that the claimant was totally disabled from all employment. The claimant argued that the trial commissioner substituted his opinion for that of a medical expert as the only medical opinion addressing the issue of disability was from the treating physician. The CRB reviewed the commissioner's findings which concluded that the treating physician's opinions concerning the claimant's level of disability were not credible or persuasive as in May 2013 the treating physician provided a light duty work capacity and in September 2013, without having seen the claimant and the claimant having sought no treatment for four months, opined that he was totally disabled. The CRB noted that the treating physician had not testified at the formal proceeding nor in a deposition and that the claimant had failed to meet his burden in establishing his total disability status. As to the commissioner's failure to conclude that the claimant was totally disabled under the Osterlund doctrine, the CRB reviewed the claimant's testimony representing that he spent 5-8 hours per day online researching employment opportunities and experienced bouts of chest pain, fatigue and nausea. The CRB pointed out that the claimant had reportedly earned a Masters Degree online between 2006 and 2009 and thus found that it was not an abuse of the commissioner's discretion to conclude that the claimant was essentially unemployable and affirmed the trial commissioner's decision.

CASE NO. 6021 CRB-7-15-7
CLAIM NO. 700150964

: COMPENSATION REVIEW BOARD

DAVID PETRINI
CLAIMANT-APPELLEE

: WORKERS' COMPENSATION COMMISSION

v.

: MAY 12, 2016

MARCUS DAIRY, INC.
EMPLOYER

and

GALLAGHER BASSETT SERVICE
INSURER
RESPONDENTS-APPELLANTS

APPEARANCES:

The claimant was represented by John Jowdy, Esq., Jowdy & Jowdy, 67 West Street, Danbury, CT 06810.

The respondents were represented by Nicholas W. Francis, Esq., Law Office of Jonathan M. Zajac, LLC, 152 Simsbury Road, P.O. Box 699, Avon, CT 06001.

This Petition for Review from the July 2, 2015 Findings and Orders of Randy L. Cohen, Commissioner acting for the Seventh District, was heard on December 18, 2015 before a Compensation Review Board panel consisting of Chairman John A. Mastropietro and Commissioners Ernie R. Walker and Stephen M. Morelli.

OPINION

JOHN A. MASTROPIETRO, CHAIRMAN. The respondents have petitioned for review from the July 2, 2015 Findings and Orders of Randy L. Cohen, Commissioner acting for the Seventh District. We find no error and accordingly affirm the decision of the trial commissioner.

The trial commissioner identified the following three issues for analysis: (1) whether the claimant's use of medical marijuana for pain management constitutes reasonable and necessary medical treatment; (2) whether mental health therapy to assist the claimant with pain management is reasonable and necessary medical treatment; and (3) whether the claimant is entitled to reimbursement of certain medical expenses. The trier made the following factual findings which are pertinent to our review. The claimant, whose date of birth is October 20, 1979, sustained a compensable low back injury on August 15, 2008. After unsuccessfully undergoing conservative treatment, the claimant underwent an L5-S1 discectomy with Frank Hermantin, MD, in December 2008. Following the discectomy, the claimant continued to experience pain in his low back and right lower extremity and, in April 2009, had a spinal cord stimulator permanently implanted. As of the date of the formal hearing, the spinal cord stimulator was not functioning.

The claimant's injuries have rendered him totally disabled and the respondents have been paying the claimant weekly temporary total disability benefits. As a result of his injuries, the claimant has been on various medications for more than six years, including but not limited to Nucynta, Methadone, Cyclobenzaprine, Clonazepam,

Oxycodone-APAP, Opana, Fentanyl, Lidoderm Patches, Alprazolam, Lexapro, Percocet, and Oxycontin. At trial, the claimant expressed misgivings regarding the medications, and testified as to the numerous side effects of the narcotics such as lethargy, possible tooth loss, nausea, irritability, weight gain, insomnia, and stress. Moreover, despite ingesting all of the above medications, he has not been able to adequately manage the significant pain associated with the injury. The claimant indicated that he feels medical marijuana, as a natural substance, is much easier for his body to tolerate and will provide him with greater longevity. He stated that since he began using medical marijuana, he is no longer taking six of his prior medications.

The claimant testified that prior to June 2014, he approached his treating physician, Daniel Southern, MD, for his opinion regarding replacing the narcotic prescriptions with medical prescribed marijuana, but the doctor "didn't seem overly enthused." January 14, 2015 Transcript, p. 14. On June 11, 2014, the claimant was examined by Judith Major, MD, one of three physicians licensed in Connecticut to dispense medical marijuana. Major diagnosed the claimant with damage to the spinal cord nerve tissue and, based on that diagnosis, issued to the claimant a Connecticut Registration Certificate for the Connecticut Medical Marijuana Program with an authorized amount of 2.5 ounces per month. In a report dated June 30, 2014, Southern indicated that the claimant, who had been brewing the marijuana as a tea, told him that the effects of the marijuana lasted six to eight hours and obviated the need for the Klonopin and Nucynta which the claimant had been using for breakthrough pain. The

claimant also reported that the marijuana had helped to ease the chronic constipation he experiences on his opiate regimen.

In correspondence dated January 9, 2015, Angela D'Amico of the Compassionate Care Center of CT, a licensed medical marijuana facility, reported that the monthly cost for 2.5 ounces (70 grams) of medical grade marijuana is $1,488.90, including tax. At trial, the claimant testified that he has been unable to afford the full 2.5 ounces of medical marijuana prescribed to him, and submitted receipts in the amount of $771.79 covering the period from September 24, 2014 to January 9, 2015.

In a report dated October 2, 2014, Southern reported that the claimant had also been cleared for the use of medical marijuana through his office and that the marijuana was "admirably" controlling the claimant's pain symptoms and had "dramatically" lessened the gastrointestinal side effects. Claimant's Exhibit A. Southern noted that the claimant was still taking two to three Methadone tablets daily but was titrating it down, and stated that "[j]udging by success to date, it is hopeful that David can be removed entirely from opiate medications relying on medical marijuana solely to control pain symptoms." Id. Southern also indicated that "there should be no question of the medical necessity in substituting medical marijuana for opiate medications." Id. In an office note dated December 31, 2014, Southern reported that the claimant was "rarely" using methadone anymore.

In 2009, prior to the spinal cord stimulator trial, Southern had referred the claimant to Robert McEvoy, Ph.D., a psychiatrist. In correspondence dated June 28, 2015, McEvoy reported that he saw the claimant on five occasions between

August 11, 2009 and October 23, 2012 for therapy focused on dealing with the claimant's pain, anxiety, depression and frustration associated with his injury and loss of function. On April 8, 2013, Southern again referred the claimant to McEvoy for depression. The claimant had an office visit on August 1, 2013; the respondents have declined to pay the outstanding invoice from August 1, 2013 or authorize the claimant to treat with McEvoy because the doctor has provided no notes or records to substantiate the services rendered. The claimant is currently seeking authorization to treat with McEvoy for mental health issues arising from his work-related injury.

At trial, the claimant testified that since he began using medical marijuana, he has been "up off the couch more" and is more engaged in his children's lives. January 14, 2015 Transcript, p. 20. He also has been better able to help with the cooking and housecleaning and was able to assist his son in crafting a leather journal as a gift for a family member. The claimant indicated that he is still experimenting with the various strains, strengths, and means of ingestion of marijuana as well as the amount needed to adequately control his pain. However, although he has not been able to afford to buy as much medical marijuana as Major prescribed, his use of medical marijuana thus far has been a great success. In addition, he testified that he was familiar with the regulations governing the use of medical marijuana, such as not using it in the presence of a person under the age of eighteen, and he had been careful about becoming too "foggy" or allowing his children to smell the marijuana. He also indicated that, as was the case when he was taking narcotic medications, he asks his wife to drive if necessary.

Based on the foregoing, the trial commissioner found the claimant credible and persuasive, and concluded that "the Claimant's use of medical marijuana has afforded him significantly greater energy and greater mobility" in that "[h]e is more actively engaged with his family..., less anxious, [and] more optimistic." Conclusion, ¶ B. As a result of using the medical marijuana, the claimant has also "experienced significant weight loss, improved his sleep and eliminated the significant side effects he has suffered as a result of the narcotic medications he was taking. In short, the use of medical marijuana has significantly increased his function, and is remedial in nature." Id. The trial commissioner noted that "[u]nder our law, reasonable or necessary medical care is that which is curative or remedial. Curative or remedial care is that which seeks to repair the damage to health care caused by the job even if not enough health is restored to enable the employee to return to work." Conclusion, ¶ C.

The trier also found credible Southern's opinions and reports, including Southern's opinion that there should be "no question" regarding the medical necessity for substituting medical marijuana for opiate medications. Conclusion, ¶ D. The trial commissioner determined that in light of the claimant's concerns about the effects of the narcotic medications, it was reasonable for him to seek out Major, and also found Major's opinion credible and persuasive, particularly with regard "to her diagnosis of the claimant and his qualification as a patient with a debilitating medical condition within the purview of C.G.S. Section 21a-408(2)(A)."[1] Conclusion, ¶ F. In addition, based on the totality of

[1] Section 21a-408(2)(A) C.G.S. [P.A. 12-55, § 1] (Rev. to 2013) defines "debilitating medical condition" as: "cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with

the circumstances, the trier authorized "Major as one of the Claimant's treating physicians, particularly for the purpose of certifying his entitlement to and his continued use of medical marijuana." Conclusion, ¶ E.

Noting that the claimant's use of medical marijuana has thus far been "judicious," Conclusion, ¶ H, the trial commissioner concluded:

> Based on the totality of the surrounding circumstances, including the fact that the Claimant's use of medical marijuana has been endorsed by his treating physicians; and considering this Claimant's age; his medical history; the fact that his prior treatment with narcotic medications and a spinal cord stimulator exposed him to harsh side effects and considerable anxiety; and considering that so far the use of medical marijuana has provided the Claimant with only positive results, which seem to have improved his health and his outlook on life, I find this Claimant's use of medical marijuana is reasonable and necessary, remedial medical treatment.

Conclusion, ¶ I.

The trial commissioner also found that the mental health therapy recommended by Southern was reasonable and necessary, but declined to authorize any additional treatment with McEvoy in light of that doctor's apparent lack of cooperation in providing contemporaneous medical reports with his bills.[2] The trier indicated that the parties needed to select a different mental health provider who would be more compliant in providing treatment records. The trier also ordered the respondents to pay for the cost of

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objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or (B) any medical condition, medical treatment or disease approved by the Department of Consumer Protection pursuant to regulations adopted under section 21a-408m."

[2] The trial commissioner also found that there was insufficient evidence to substantiate a bill purporting to be for services rendered at the office visit of August 1, 2013 with Robert McEvoy, Ph.D.

medical marijuana going forward as prescribed by the claimant's physicians and to reimburse the claimant for his out-of-pocket medical marijuana expenses.

The respondents filed a Motion to Correct, which was denied save for several corrections pertaining to the claimant's out-of-pocket costs, and a Motion to Submit Additional Evidence, which was also denied, and this appeal followed. On appeal, the respondents have raised a lengthy list of objections to the trier's findings. First, they contend that the trier erred in concluding that the claimant's use of medical marijuana was compensable because the claimant's medical condition does not meet the criteria for certification by the State. The respondents support this contention by pointing out that the claimant does not have an ongoing physician/patient relationship with the prescribing physician, i.e., Judith Major, MD, and post-laminectomy syndrome is not an approved "debilitating condition" for the use of medical marijuana. The respondents also contend that because the claimant's use of marijuana is palliative rather than curative, it does not constitute "reasonable or necessary" medical treatment as contemplated by the provisions of § 31-294d(a) C.G.S.[3] In addition, the respondents raise a number of general negative policy implications arising from the use of medical marijuana, such as the fact that (1) the improper use of medical marijuana could subject the claimant to criminal penalties; (2) the use of medical marijuana challenges an employer's right to a drug-free workplace; (3)

[3] Section 31-294d(a)(1) C.G.S. (Rev. to 2007) states: "The employer, as soon as the employer has knowledge of an injury, shall provide a competent physician or surgeon to attend the injured employee and, in addition, shall furnish any medical and surgical aid or hospital and nursing service, including medical rehabilitation services and prescription drugs, as the physician or surgeon deems reasonable or necessary. The employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall be responsible for paying the cost of such prescription drugs directly to the provider."

marijuana is still classified as a Schedule I substance and is illegal under federal law; (4) medical marijuana businesses cannot access banking services, which impacts insurers; and, (5) the use of medical marijuana is not approved by the FDA. Finally, the respondents claim as error the trier's refusal to grant all the proposed corrections in their Motion to Correct.[4]

The standard of deference we are obliged to apply to a trial commissioner's findings and legal conclusions is well-settled.

> ... the role of this board on appeal is not to substitute its own findings for those of the trier of fact. Dengler v. Special Attention Health Services, Inc., 62 Conn. App. 440, 451 (2001). The trial commissioner's role as factfinder encompasses the authority to determine the credibility of the evidence, including the testimony of witnesses and the documents introduced into the record as exhibits. Burse v. American International Airways, Inc., 262 Conn. 31, 37 (2002); Tartaglino v. Dept. of Correction, 55 Conn. App. 190, 195 (1999), *cert. denied*, 251 Conn. 929 (1999). If there is evidence in the record to support the factual findings of the trial commissioner, the findings will be upheld on appeal. Duddy v. Filene's (May Department Stores Co.), 4484 CRB-7-02-1 (October 23, 2002); Phaiah v. Danielson Curtain (C.C. Industries), 4409 CRB-2-01-6 (June 7, 2002). This board may disturb only those findings that are found without evidence, and may also intervene where material facts that are admitted and undisputed have been omitted from the findings. Burse, supra; Duddy, supra. We will also overturn a trier's legal conclusions when they result from an incorrect application of the law to the subordinate facts, or where they are the product of an inference illegally or unreasonably drawn from the facts. Burse, supra; Pallotto v. Blakeslee Prestress, Inc., 3651 CRB-3-97-7 (July 17, 1998).

McMahon v. Emsar, Inc., 5049 CRB-4-06-1 (January 16, 2007).

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[4] The Appellants have not appealed the trial commissioner's denial of their Motion to Submit Additional Evidence.

In commencing our analysis of this matter, we observe at the outset that the issue of whether a claimant's use of medical marijuana can constitute "reasonable or necessary" medical treatment pursuant to § 31-294d C.G.S. is one of first impression for this board. Our review of the enabling legislation for the medical marijuana program ([P.A. 12-55] §§ 21a-408 et. seq.) indicates that neither the Commissioner of the Department of Consumer Protection nor the members of the program's Board of Physicians have retained jurisdiction over claims arising from a patient's acceptance or exclusion into the medical marijuana program. See [P.A. 12-55, §§ 13, 14;] §§ 21a-408l/m C.G.S. (Rev. to 2013) We also note that while the legislation specifically excludes health insurance coverage for the palliative use of marijuana, the statute is silent with respect to workers' compensation insurance. See [P.A. 12-55 § 16] § 408o C.G.S. (Rev. to 2013) Thus, although neither of the parties in this appeal has challenged the subject matter jurisdiction of this Commission, we deem it worthy of mention that the enabling legislation does not appear to deprive this agency of the jurisdiction to hear the matter.

Turning to the merits of the appeal, we begin with the respondents' first claim that the trier erroneously concluded that the claimant's use of medical marijuana is compensable because the claimant's medical condition does not meet criteria for certification by the state. The respondents point out that "physicians who want to certify a patient must have a bona fide relationship with the patient in order to register them with the program," Appellants' Brief, p. 3, and a "bona fide relationship" is defined as "a relationship in which the physician has ***ongoing responsibility for the assessment, care,***

and treatment of a patient's debilitating medical condition or a symptom of the patient's debilitating medical condition." (Emphasis in the original.) Respondents' Exhibit 4, *quoting* information posted on the Department of Consumer Protection's web site relative to "Physician Requirements and Eligibility."

The respondents argue that the record does not support such an inference because the claimant testified that he will see Major only once a year, and "Major does not prescribe physical therapy, refer the claimant for diagnostic testing, or make determinations as to the claimant's work capacity." Id., 4. The respondents assert that the trier's designation of Major as "an authorized treating physician for the purpose of certifying the claimant's entitlement to and continued use of medical marijuana," Appellants' Brief, p. 4, fails to meet the Department of Consumer Protection's requirement that the physician/patient relationship be for "***actual*** debilitating condition." (Emphasis in the original). Id. We decline to read the Consumer Protection mandate so narrowly.

As discussed previously herein, the Department of Consumer Protection website states that physicians who wish to certify a patient for medical marijuana must, inter alia:

> have a bona fide relationship with the patient in order to register them with the program. A bona fide physician-patient relationship means a relationship in which the physician has ongoing responsibility for the assessment, care and treatment of a patient's debilitating medical condition or a symptom of the patient's debilitating medical condition whereby the physician has:
>
> * Completed a medically reasonable assessment of the patient's medical history and current medical condition;

* Diagnosed the patient as having a debilitating medical condition;

* Prescribed, or determined it is not in the best interest to prescribe, prescription drugs to address the symptoms or effects for which the certification is being issued;

* Concluded that, in the physician's medical opinion, the potential benefits of the palliative use of marijuana would likely outweigh the health risks to the patient; and

* Explained the potential risks and benefits of the palliative use of marijuana to the patient or, where the patient lacks legal capacity, to the parent, guardian or other person having legal custody of the patient.

In addition, the physician should be reasonably available to provide follow-up care and treatment for the patient, including any examinations necessary to determine the efficacy of marijuana for treating the patient's debilitating medical condition, or a symptom thereof. [5]

In the matter at bar, the record contains an office note dated January 13, 2015 signed by Major indicating that the claimant was seen in her office on June 11, 2014 and entered into the medical marijuana program on the basis of a diagnosis of "damage to nerve tissue of the spinal cord." Claimant's Exhibit E. In addition, the record contains a "Patient Medical Information" sheet indicating, inter alia, that the signing physician had diagnosed the claimant with "Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity" and answered "yes" to the question: "Is the patient under your care for the condition(s), or for a symptom of the condition(s), identified above?" The signing physician also answered "yes" to the question: "Do you have a bona fide physician-patient relationship with the above named

[5] See [P.A. 12-55, § 4] § 21a-408c C.G.S. (Rev. to 2013)

patient such that you are available to provide follow-up care for this patient?" Claimant's Exhibit D. We also note that the record contains a set of documents compiled by Major's office dated December 2, 2014 and entitled "Inventory for David Petrini" which includes the Danbury Hospital Operative Report dated April 30, 2009; the Wilton Surgery Center operative note of September 16, 2008; and a "Yearly Physical" report completed on June 11, 2014. Respondents' Exhibit 5.

Given the nature of the evidence submitted into the record on this issue, we concede that it is somewhat difficult to ascertain the exact parameters of the physician-patient relationship contemplated by either the claimant or Major. It should also be noted that the pertinent statutory provision does not appear to define "bona fide physician-patient relationship" with much specificity.[6] Nevertheless, the exhibits submitted into the record do suggest that the doctor clearly felt comfortable enough with the relationship to certify the claimant for the program. Moreover, in Southern's correspondence of October 2, 2014, the doctor stated that "there should be no question of the medical necessity in substituting medical marijuana for opiate medications." Claimant's Exhibit A. Given that the trier did not have the benefit of live testimony by Major, which might have addressed some of the concerns articulated by the respondents, it was within the trier's discretion to rely upon the evidentiary submissions in the record. We therefore find no basis for reversing the trial commissioner's conclusion that the claimant successfully established a bona fide relationship with Major such that the

[6] Section 21a-408c(c)(3) C.G.S. [P.A. 12-55, § 4] (Rev. to 2013) merely states that "[t]he written certification issued by the physician is based upon the physician's professional opinion after having completed a medically reasonable assessment of the qualifying patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship...."

claimant could be properly certified into the medical marijuana program in compliance with the Department of Consumer Protection's mandate.[7]

The respondents also contend that the trial commissioner erroneously concluded that the claimant's medical condition satisfied the requirements for entry into the medical marijuana program because he suffered from post-laminectomy syndrome, which is not an approved "debilitating condition" for the use of medical marijuana. The respondents argue that the reports relied upon by Major do not support her diagnosis of the claimant as suffering from "Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity." Claimant's Exhibit D. Thus, given that the medical reports relied upon by Major indicate that the claimant suffered from post-laminectomy syndrome, which "is not an approved condition for the use of medical marijuana, the claimant was incorrectly and improperly certified by Dr. Major." Appellants' Brief, p. 6.

We concede that the instant record does contain correspondence to the Medical Marijuana Program Board of Physicians at the Department of Consumer Protection in which a legislative analyst for the Marijuana Policy Project (based in Washington, D.C.) stated:

> Medical marijuana's use as a pain reliever and anti-inflammatory agent would be a significant and direct help for those suffering from severe psoriasis, and psoriatic arthritis, sickle cell disease, and post laminectomy syndrome.... We strongly urge the Board of

[7] We note that in Southern's correspondence of October 2, 2014, the doctor indicated that his office had also cleared the claimant for the use of medical marijuana. Claimant's Exhibit A. It is anticipated that Southern's involvement will alleviate any lingering concerns the respondents may have concerning the claimant's certification into the medical marijuana program on the basis of a bona fide physician-patient relationship.

> Physicians to recommend that the Department of Consumer Protection add these medical conditions to this list of qualifying medical conditions recognized by the State.

Respondents' Exhibit 6.

However, we also note that the current version of the "Qualification Requirements" page on the Consumer Protection website indicates that "Post Laminectomy Syndrome with Chronic Radiculopathy" has since been added to the list of qualified debilitating medical conditions. In addition, while the record does reflect that the claimant suffers from post-laminectomy syndrome, it also indicates that the claimant suffers from the following injuries:

* Severe L4-5 and L5 S-1 protrusions;
* Right L5/S1 radiculitis secondary to L4-L5 and L5-S-1 disk protrusions;
* Status post right L5-S-1 laminectomy (twice) with post laminectomy syndrome;
* Lumbar spondylosis L4-5;
* Facet arthropathy, lumbar spine;
* Nerve root stenosis;
* Acute cervicalgia;
* Low back pain;
* Bi-lateral leg pain;
* GI disturbance;
* Neck pain;
* Anxiety syndrome.

Appellee's Brief, p. 2.

At trial, the claimant testified regarding his current pain levels and the contrasts between the effects of the narcotics and medical marijuana on his pain management. The Consumer Protection website states that "the physician has ongoing responsibility for the assessment, care and treatment of a patient's debilitating medical condition *or a symptom of the patient's debilitating medical condition.*" (Emphasis added.) As such, the trier

may have reasonably inferred that the pain management treatment contemplated by Major satisfied the program requirement because it was geared toward addressing a symptom of the claimant's medical condition. Moreover, the respondents have offered no medical evidence which would contradict Major's diagnosis. Thus, given the extensive evidence in the record regarding the claimant's injuries and seemingly intractable pain, we find that the medical reports relied upon by Major, combined with the claimant's narrative associated with his medical history and pain levels, provided a reasonable basis for the trier's inference that the claimant was properly certified into the medical marijuana program on the basis of Major's diagnosis that the claimant was suffering from "Damage to the Nervous Tissue of the Spinal Cord with Objective Neurological Indication of Intractable Spasticity." Claimant's Exhibit D.

The respondents also contend that the trial commissioner erroneously concluded that the claimant's use of medical marijuana is "reasonable or necessary" rather than merely palliative. The respondents assert that "[n]o evidence was presented that the use of marijuana would repair the damage caused by the claimant's work injury and, frankly, there is nothing to suggest the use of marijuana would, in fact, do so." Appellants' Brief, p. 7. The respondents also point out that "no probative evidence was presented that any alleged pain relieving effects from the marijuana would be sufficient enough to return the claimant to work." Id.

In Bowen v. Stanadyne, 2 Conn. Workers' Comp. Rev. Op. 60, 232 CRD-1-83 (June 19, 1984), we articulated the "reasonable or necessary standard" as follows:

> Reasonable or necessary medical care is that which is curative or remedial. *Curative or remedial care is that which seeks to repair the damage to health caused by the job even if not enough health is restored to enable the employee to return to work.* Any therapy designed to keep the employee at work or to return him to work is curative. Similarly, any therapy designed to eliminate pain so that the employee can work is curative. Finally, any therapy which is life prolonging is curative. (Emphasis added.)

Id., 64.

We concede that the evidentiary record before us does not support the inference that the claimant's current pain management regimen, regardless of the type of medication utilized, will supply sufficient pain relief such that the claimant will be able to return to work in the foreseeable future. We also recognize that historically, this board has generally been inclined to affirm findings reflecting that the medical treatment in question satisfied the "reasonable or necessary" standard because the treatment enabled a claimant to either maintain or return to employment. *See*, e.g., Zalutko v. Danbury Hospital, 4229 CRB-7-00-4 (May 23, 2001). However, we have on occasion also upheld findings indicating that the treatment in question satisfies the standard because it "seeks to repair the damage to health caused by the job...." Bowen, supra. *See also* Outlaw v. Pray Automotive of Greenwich, 3981 CRB-7-99-2 (March 23, 2000).

Ultimately, "[w]hether or not medical care satisfies the 'reasonable and necessary' standard of § 31-294d is a factual issue to be decided by the trial commissioner." Zalutko, supra, *citing* Cummings v. Twin Tool Mfg., 13 Conn. Workers' Comp. Rev. Op. 225, 228, 2008 CRB-1-94-4 (April 12, 1995), *appeal dismissed*, A.C. 14747 (June 29, 1995). In the matter at bar, both the claimant's testimony and the medical opinions contained in the record clearly attest to the necessity for an aggressive

pain management regimen in order to address the sequellae of the claimant's original low back injury. Under the facts in this matter, we find no basis for reversing the trial commissioner's conclusion that the claimant's participation in the medical marijuana program satisfies the standard for reasonable or necessary medical treatment as contemplated by § 31-294d(a) C.G.S. and Bowen, supra.[8]

The respondents have also put forward a number of public policy arguments militating against the use of medical marijuana, most of which are beyond the purview of this board to address. However, we note that with specific regard to the respondents' concerns regarding the potential criminal penalties which attach to the improper use of medical marijuana, we would point out that there are also significant criminal penalties associated with the misuse of prescription opioids. Similarly, relative to the respondents' concerns about an employer's "right to a drug free work place," Appellants' Brief, p. 10, and the observation that "[m]arijuana can impair mental and physical abilities and affect employee safety," id., there is little question that similar charges may easily be leveled against the use of prescription narcotics in the workplace or while operating a motor vehicle.[9]

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[8] We acknowledge the accuracy of the appellants' observation that the Workers' Compensation Commission has not yet formulated protocols for the use of medical marijuana. However, given that the Connecticut Workers' Compensation Act was enacted in 1913, and the first medical protocols were not introduced until January 1, 1996, we decline to hold that the lack of protocols for medical marijuana automatically dictates that the treatment cannot be deemed reasonable or necessary.

[9] The appellants contend that because the monthly cost of the claimant's recommended marijuana dosage is more than three times the cost of his prescription medications, the use of medical marijuana is therefore neither reasonable nor necessary. While it might theoretically be possible for this board to sustain a finding that the cost of a proposed treatment in and of itself precludes the treatment from satisfying the "reasonable or necessary" standard, the appellants have provided us with no legal authority for determining why that might be the case in this matter.

The respondents also point out the use of medical marijuana has not been approved by the federal Food and Drug Administration. "Without the study of marijuana in clinical trials, the FDA cannot determine whether a drug product is safe and effective.... Moreover, there is no guarantee the marijuana meets appropriate quality standards as you would find with traditional prescriptive medications." Id., 13. We concede that the FDA has not approved medical marijuana. This board previously addressed the role of FDA certification in Vannoy-Joseph v. State/DMHAS, 5164 CRB-8-06-11 (January 29, 2008), wherein we observed that "[t]he FDA's mission is to promote public health by reviewing clinical research on the marketing of regulated products in order to ensure their safety and, in the case of drugs and medical devices, their effectiveness." Id., *citing* 21 U.S.C. § 393(b). An "off label" use for a medical device is "an accepted and necessary corollary of the FDA's mission to regulate in this area without directly interfering with the practice of medicine." Buckman Co. v. Plaintiff's Legal Committee, 531 U.S. 341, 350 (2001). In addition:

> A physician may prescribe a legal drug to serve any purpose that he or she deems appropriate, regardless of whether the drug has been approved for that use by the FDA.... Although the parties have differing views about the health risks and benefits of off-label uses, it is undisputed that the prescription of drugs for unapproved uses is commonplace in modern medical practice and ubiquitous in certain specialties. (Internal citation omitted.)

Washington Legal Found. v. Henney, 202 F.3d 331, 333 (D.C. Cir. 2000).

In light of the latitude afforded to physicians in utilizing FDA-approved medical devices and/or drugs for an off-label use, we concluded that "the absence of FDA approval for a physician's proposed 'off-label' use of a legally marketed device should

not be treated as a proxy for a factual determination that the 'off-label' use would be unreasonable...." Vannoy-Joseph, supra. We hold that this board's reasoning in Vannoy-Joseph is equally applicable to our considerations in the instant matter regarding the lack of FDA approval for medical marijuana.

> Evaluating the appropriateness of a proposed medical treatment is a delicate task. While respecting the complex diagnostic and outcome-predictive skill that is central to a physician's expertise, a workers' compensation commissioner must assess the credibility of the evidence supporting the various treatment options and decide which is the most reasonable under all of the circumstances.

Vannoy-Joseph, supra. *See also* Tartaglino v. State/Dept. of Correction, 3519 CRB-5-97-1 (June 15, 1998), *aff'd*, 55 Conn. App. 190 (1999), *cert. denied*, 251 Conn. 929 (1999).

Thus, in light of the testimonial and medical evidence presented in the proceedings below, we find no basis for concluding that the current lack of FDA approval for medical marijuana compelled the trial commissioner to find that the claimant's use of medical marijuana failed to satisfy the "necessary or reasonable" standard.

Finally, the respondents claim as error the trial commissioner's refusal to grant all of the corrections proposed in their Motion to Correct. Our review of the denied corrections indicates that the respondents were merely reiterating the arguments made at trial which ultimately proved unavailing. As such, we find no error in the trier's decision to deny those corrections. D'Amico v. Dept. of Correction, 73 Conn. App. 718, 728 (2002), *cert. denied*, 262 Conn. 933 (2003).

There is no error; the July 2, 2015 Findings and Orders of Randy L. Cohen, Commissioner acting for the Seventh District, is accordingly affirmed.

Commissioners Ernie R. Walker and Stephen M. Morelli concur in this opinion.

STATE OF CONNECTICUT

QUI TRANSTULIT SUSTINET

House Bill No. 5620

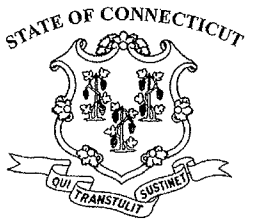
Special Act No. 16-4

AN ACT CONCERNING A STUDY OF IMPEDIMENTS TO INSURANCE COVERAGE FOR SUBSTANCE USE DISORDER TREATMENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (*Effective from passage*) The Insurance Commissioner shall, within available appropriations, study the impediments that exist, if any, for insureds to receive treatments for substance use disorders under their health insurance policies or health benefit plans. Such study shall include, but need not be limited to, (1) the extent to which coverage is provided under health insurance policies or health benefit plans, (2) the types of treatments covered under such policies or plans, (3) the requirements, if any, that insureds must meet for such treatments to be covered under such policies or plans, and (4) the cost-sharing requirements for insureds for such treatments. Not later than January 31, 2017, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health, summarizing the commissioner's findings.

Approved June 3, 2016



House Bill No. 5262

Public Act No. 16-10

AN ACT ESTABLISHING A FIREFIGHTERS CANCER RELIEF PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 16-256g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective February 1, 2017*):

(a) By June first of each year, the Public Utilities Regulatory Authority shall conduct a proceeding to determine the amount of the monthly fee to be assessed against each subscriber of: (1) Local telephone service, (2) commercial mobile radio service, as defined in 47 CFR Section 20.3, and (3) voice over Internet protocol service, as defined in section 28-30b, to fund the development and administration of the enhanced emergency 9-1-1 program and the firefighters cancer relief program established pursuant to section 5 of this act. The authority shall base such fee on the findings of the Commissioner of Emergency Services and Public Protection, pursuant to subsection (c) of section 28-24, taking into consideration any existing moneys available in the Enhanced 9-1-1 Telecommunications Fund. The authority shall consider the progressive wire line inclusion schedule contained in the final report of the task force to study enhanced 9-1-1 telecommunications services established by public act 95-318. The authority shall not approve any fee (A) greater than seventy-five cents

per month per access line, (B) that does not include the progressive wire line inclusion schedule, or (C) for commercial mobile radio service, as defined in 47 CFR Section 20.3 that includes the progressive wire line inclusion schedule.

(b) Each telephone or telecommunications company providing local telephone service, each provider of commercial mobile radio service and each provider of voice over Internet protocol service shall assess against each subscriber, the fee established by the authority pursuant to subsection (a) of this section, which shall be remitted to the office of the State Treasurer for deposit into the Enhanced 9-1-1 Telecommunications Fund established pursuant to section 28-30a, not later than the fifteenth day of each month. To the extent permitted by federal law, on and after February 1, 2017, and not later than the fifteenth day of each month thereafter, an amount equal to one cent per month per access line shall be remitted from the fees imposed under this section to the office of the State Treasurer for deposit in the firefighters cancer relief account established pursuant to section 3 of this act.

(c) The fee imposed under this section shall not apply to any prepaid wireless telecommunications service, as defined in section 28-30b.

Sec. 2. (NEW) (*Effective February 1, 2017*) For purposes of this section, sections 3 to 6, inclusive, of this act and sections 29-303 and 3-123 of the general statutes, as amended by this act, "firefighter" shall include any (1) local fire marshal, deputy fire marshal, fire investigator, fire inspector and such other classes of inspectors and investigators for whom the State Fire Marshal and the Codes and Standards Committee, acting jointly, have adopted minimum standards of qualification pursuant to section 29-298 of the general statutes; and (2) uniformed member of a paid municipal, state or volunteer fire department.

Sec. 3. (NEW) (*Effective February 1, 2017*) (a) There is established an account to be known as the "firefighters cancer relief account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account, including any moneys deposited pursuant to section 16-256g of the general statutes, as amended by this act. Moneys in the account shall be expended by the cancer relief subcommittee of the Connecticut State Firefighters Association, established pursuant to section 4 of this act, for the purposes of providing wage replacement benefits to firefighters who are diagnosed with a condition of cancer described in section 5 of this act.

(b) The State Treasurer shall invest the moneys deposited in the firefighters cancer relief account in a manner reasonable and appropriate to achieve the objectives of such account, exercising the discretion and care of a prudent person in similar circumstances with similar objectives. The State Treasurer shall give due consideration to rate of return, risk, term or maturity, diversification of the total portfolio within such account, liquidity, the projected disbursements and expenditures, and the expected payments, deposits, contributions and gifts to be received. The moneys in such account shall be continuously invested and reinvested in a manner consistent with the objectives of such account until disbursed in accordance with section 3-123 of the general statutes, as amended by this act, and section 4 of this act.

(c) The moneys in the firefighters cancer relief account shall be used solely for the purposes of providing wage replacement benefits to firefighters who are diagnosed with a condition of cancer described in section 5 of this act and to fund the expenses of administering the firefighters cancer relief program established pursuant to section 5 of this act.

Sec. 4. (NEW) (*Effective February 1, 2017*) (a) There is established a

firefighters cancer relief subcommittee of the Connecticut State Firefighters Association that shall consist of one member from the Connecticut State Firefighters Association, one member from the Connecticut Fire Chiefs Association, one member from the Uniformed Professional Firefighters of the International Association of Firefighters, one member from the Connecticut Fire Marshals Association, and one member from the Connecticut Conference of Municipalities. Such subcommittee shall review claims for wage replacement benefits submitted to the firefighters cancer relief program established pursuant to section 5 of this act and provide wage replacement benefits, in accordance with the provisions of subsection (b) of section 3-123 of the general statutes, as amended by this act, to any firefighter who the subcommittee determines is eligible for such wage replacement benefits pursuant to the provisions of section 5 of this act. The subcommittee may determine the weekly wage replacement benefits provided to a firefighter in accordance with the provisions of chapters 104 and 568 of the general statutes.

(b) A firefighter who is approved for wage replacement benefits by the subcommittee pursuant to subsection (a) of this section shall be eligible for such benefits on and after July 1, 2019, and for a period determined by the subcommittee, provided such period shall not exceed twenty-four months. The maximum weekly wage replacement benefit under this section shall be determined by the subcommittee, provided such maximum weekly wage replacement benefit shall not exceed one hundred per cent, raised to the next even dollar, of the average weekly earnings of all workers in the state for the year in which the condition of cancer was diagnosed. The average weekly earnings of all workers in the state shall be determined by the Labor Commissioner on or before the fifteenth day of August of each year, to be effective the following October first, and shall be the average of all workers' weekly earnings for the year ending the previous June thirtieth and shall be so determined in accordance with the standards

for the determination of average weekly earnings of all workers established by the United States Department of Labor, Bureau of Labor Statistics.

(c) A firefighter may receive wage replacement benefits under this section concurrently with any employer-provided employment benefits, provided the total compensation of such firefighter during such period of receiving benefits under this section shall not exceed such firefighter's pay rate at the time such firefighter was diagnosed with a condition of cancer described in section 4 of this act.

(d) No firefighter shall receive compensation under this section concurrently with the provisions of chapter 567 or 568 of the general statutes or any other municipal, state or federal program that provides wage replacement benefits.

(e) No approval of wage replacement benefits for a firefighter by the subcommittee pursuant to subsection (a) of this section shall be used as evidence, proof or an acknowledgement of liability or causation in any proceeding under chapter 568 of the general statutes.

(f) Notwithstanding any other provision of the general statutes, any employer who provides accident and health insurance or life insurance coverage for a firefighter or makes payments or contributions at the regular hourly or weekly rate for the firefighter to an employee welfare plan, shall provide to the firefighter equivalent insurance coverage or welfare plan payments or contributions while the firefighter is eligible to receive or is receiving wage replacement compensation under this section. As used in this section, "employee welfare plan" means any plan established or maintained for such firefighter or such firefighter's family or dependents, or for both, for medical, surgical or hospital care benefits.

(g) The State Treasurer shall remit wage replacement benefits that

are approved by the subcommittee from the firefighters cancer relief account established pursuant to section 3 of this act not later than thirty days after such benefits have been approved.

Sec. 5. (NEW) (*Effective February 1, 2017*) (a) There is established a firefighters cancer relief program, the purpose of which is to provide wage replacement benefits to firefighters who are diagnosed with certain conditions of cancer as a result of their service as firefighters.

(b) A firefighter shall be eligible for wage replacement benefits for any condition of cancer affecting the brain, skin, skeletal system, digestive system, endocrine system, respiratory system, lymphatic system, reproductive system, urinary system or hematological system that results in death, or temporary or permanent total or partial disability, provided (1) such firefighter successfully passed a physical examination upon entry into such service, or subsequent to entry, as the case may be, that failed to reveal any evidence of such cancer, (2) such firefighter has submitted to annual physical examinations subsequent to entry into such service that have failed to reveal any evidence of such cancer or a propensity for such cancer, (3) such firefighter has not used any cigarettes, as defined in section 12-285 of the general statutes, or any other tobacco products, as defined in section 12-330a of the general statutes, within fifteen years of applying for wage replacement benefits pursuant to subsection (b) or (c) of this section, (4) such firefighter has worked for not less than five years on or after the effective date of this section as (A) an interior structural firefighter at a paid municipal, state or volunteer fire department, or (B) a local fire marshal, deputy fire marshal, fire investigator, fire inspector or such other class of inspector or investigator for whom the State Fire Marshal and the Codes and Standards Committee, acting jointly, have adopted minimum standards of qualification pursuant to section 29-298 of the general statutes, at the time such cancer is discovered, or should have been discovered, (5) such firefighter has

complied with the federal Occupational Safety and Health Act standards adopted pursuant to 29 CFR 1910.134 and 29 CFR 1910.156 for a period of not less than five consecutive years, and (6) such cancer is one that is known to result from exposure to heat, radiation or a known carcinogen as determined by the International Agency for Research on Cancer or the National Toxicology Program of the United States Department of Health and Human Services. For purposes of this subsection, "interior structural firefighter" means an individual who performs fire suppression, rescue or both, inside of buildings or enclosed structures that are involved in a fire situation beyond the incipient stage, as defined in 29 CFR 1910.155.

(c) Any individual who is no longer actively serving as a firefighter but who otherwise would be eligible for wage replacement benefits pursuant to the provisions of subsection (b) of this section, may apply for such benefits not more than five years from the date such individual last served as a firefighter.

(d) A firefighter or individual applying for wage replacement benefits pursuant to subsection (b) or (c) of this section shall be required to submit to annual physical examinations, including blood testing, during his or her active service and for a period of five years after the date such individual last served as a firefighter as a condition of receiving such benefits. An individual who no longer serves as a firefighter shall bear the cost of any physical examination required under this subsection.

Sec. 6. (NEW) (*Effective February 1, 2017*) Not later than January 1, 2018, and annually thereafter, the State Treasurer, in consultation with the Connecticut State Firefighters Association, shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public safety on the status of the firefighters cancer relief account established pursuant to section 3 of

this act and the firefighters cancer relief program established pursuant to section 5 of this act. Such report shall include (1) the balance of the account, (2) the projected and actual participation in the program, and (3) the demographic information of each firefighter who receives benefits pursuant to such program, including gender, age, town of residence and income level.

Sec. 7. Section 29-303 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective February 1, 2017*):

The fire chief or local fire marshal with jurisdiction over a town, city, borough or fire district where a fire, explosion or other fire emergency occurs shall furnish the State Fire Marshal a report [of] that shall include (1) all the facts relating to its cause, its origin, the kind, the estimated value and ownership of the property damaged or destroyed, (2) the name of each firefighter who was (A) present at such fire, explosion or other fire emergency, and (B) exposed to heat, radiation or a known or suspected carcinogen as a result of such fire, explosion or other fire emergency, including the duration of each such firefighter's exposure, and (3) such other information as called for by the State Fire Marshal on forms furnished by the State Fire Marshal, or in an electronic format prescribed by the State Fire Marshal. The fire chief or fire marshal may also submit reports regarding other significant fire department response to such fire or explosion, and such reports may be filed monthly but commencing January 1, 2008, such reports shall be filed not less than quarterly.

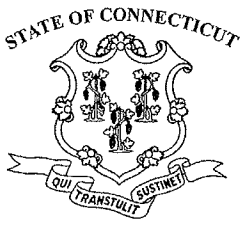
Sec. 8. Section 3-123 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective February 1, 2017*):

(a) Whenever a person, under the provisions of the constitution and bylaws of The Connecticut State Firefighters Association, is entitled to relief from said association, as a firefighter injured in the line of duty, or rendered sick by disease contracted while in the line of duty, or as

the widow or child of a firefighter killed in the line of duty, the Commissioner of Emergency Services and Public Protection shall, upon the delivery to said commissioner of proper proofs from said association of the right of such person to relief as aforesaid, process payment for such person or persons entitled to such relief, or their legal representative, for the amount to which such person or persons are entitled as relief as aforesaid, provided such orders shall be limited to available appropriations.

(b) Whenever a firefighter, under the provisions of the constitution and bylaws of the Connecticut State Firefighters Association, is entitled to wage replacement benefits from said association pursuant to the firefighters cancer relief program established pursuant to section 5 of this act, the State Treasurer shall, upon the delivery to the State Treasurer of proper proof from said association of the right of such firefighter to wage replacement benefits as aforesaid, process payment for such firefighter entitled to such wage replacement benefits, or their legal representative, for the amount to which such firefighter is entitled as wage replacement benefits as aforesaid, provided such orders shall be limited to available funds contained in the firefighters cancer relief account established pursuant to section 3 of this act.

Approved May 6, 2016



Substitute House Bill No. 5053

Public Act No. 16-43

AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-714a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

(b) A licensed health care professional who is permitted by law to prescribe an opioid antagonist may prescribe **[**,**]** or dispense **[**or administer**]** an opioid antagonist to any individual to treat or prevent a drug overdose without being liable for damages in a civil action or subject to criminal prosecution for prescribing **[**,**]** or dispensing **[**or administering**]** such opioid antagonist or for any subsequent use of such opioid antagonist. A licensed health care professional who prescribes **[**,**]** or dispenses **[**or administers**]** an opioid antagonist in accordance with the provisions of this subsection shall be deemed not to have violated the standard of care for such licensed health care

professional.

(c) A licensed health care professional may administer an opioid antagonist to any person to treat or prevent an opioid-related drug overdose. Such licensed health care professional who administers an opioid antagonist in accordance with the provisions of this subsection shall not be liable for damages in a civil action or subject to criminal prosecution for administration of such opioid antagonist and shall not be deemed to have violated the standard of care for such licensed health care professional.

[(c)] (d) Any person [,] who in good faith believes that another person is experiencing an opioid-related drug overdose may, if acting with reasonable care, administer an opioid antagonist to such other person. Any person, other than a licensed health care professional acting in the ordinary course of such person's employment, who administers an opioid antagonist in accordance with this subsection shall not be liable for damages in a civil action or subject to criminal prosecution with respect to the administration of such opioid antagonist.

(e) Not later than October 1, 2016, each municipality shall amend its local emergency medical services plan, as described in section 19a-181b, to ensure that the emergency responder, including, but not limited to, emergency medical services personnel, as defined in section 20-206jj, or a resident state trooper, who is likely to be the first person to arrive on the scene of a medical emergency in the municipality is equipped with an opioid antagonist and such person has received training, approved by the Commissioner of Public Health, in the administration of opioid antagonists.

Sec. 2. (NEW) (*Effective January 1, 2017*) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the

general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs and includes on its formulary naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose shall require prior authorization for such drug.

Sec. 3. (NEW) (*Effective January 1, 2017*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs and includes on its formulary naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose shall require prior authorization for such drug.

Sec. 4. Section 17a-667 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) There is established a Connecticut Alcohol and Drug Policy Council which shall be within the Department of Mental Health and Addiction Services.

(b) The council shall consist of the following members: (1) The Secretary of the Office of Policy and Management, or the secretary's designee; (2) the Commissioners of Children and Families, Consumer Protection, Correction, Education, Mental Health and Addiction Services, Public Health, Emergency Services and Public Protection and Social Services, Commissioner on Aging, and the Insurance Commissioner, or their designees; (3) the Chief Court Administrator, or the Chief Court Administrator's designee; (4) the chairperson of the Board of Regents for Higher Education, or the chairperson's designee;

(5) the president of The University of Connecticut, or the president's designee; (6) the Chief State's Attorney, or the Chief State's Attorney's designee; (7) the Chief Public Defender, or the Chief Public Defender's designee; and (8) the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, criminal justice and appropriations, or their designees. The Commissioner of Mental Health and Addiction Services and the Commissioner of Children and Families shall be cochairpersons of the council and may jointly appoint up to seven individuals to the council as follows: (A) Two individuals in recovery from a substance use disorder or representing an advocacy group for individuals with a substance use disorder; (B) a provider of community-based substance abuse services for adults; (C) a provider of community-based substance abuse services for adolescents; (D) an addiction medicine physician; (E) a family member of an individual in recovery from a substance use disorder; and (F) an emergency medicine physician currently practicing in a Connecticut hospital. The cochairpersons of the council may establish subcommittees and working groups and may appoint individuals other than members of the council to serve as members of the subcommittees or working groups. Such individuals may include, but need not be limited to: (i) Licensed alcohol and drug counselors; (ii) pharmacists; (iii) municipal police chiefs; (iv) emergency medical services personnel; and (v) representatives of organizations that provide education, prevention, intervention, referrals, rehabilitation or support services to individuals with substance use disorder or chemical dependency.

(c) The council shall review policies and practices of state agencies and the Judicial Department concerning substance abuse treatment programs, substance abuse prevention services, the referral of persons to such programs and services, and criminal justice sanctions and programs and shall develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions.

(d) Such plan shall be amended not later than January 1, 2017, to contain measurable goals, including, but not limited to, a goal for a reduction in the number of opioid-induced deaths in the state.

Sec. 5. Subsection (h) of section 20-206bb of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(h) Notwithstanding the provisions of subsection (a) of this section, any person [certified by an organization approved by the Commissioner of Public Health] who maintains certification with the National Acupuncture Detoxification Association may practice the five-point auricular acupuncture protocol specified as part of such certification program as an adjunct therapy for the treatment of alcohol and drug abuse and other behavioral interventions for which the protocol is indicated, provided the treatment is performed under the supervision of a physician licensed under chapter 370 and is performed in [either] (1) a private freestanding facility licensed by the Department of Public Health [for the] that provides care or treatment [of] for substance abusive or dependent persons, [or] (2) a setting operated by the Department of Mental Health and Addiction Services, or (3) any other setting where such protocol is an appropriate adjunct therapy to a substance abuse or behavioral health treatment program. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to ensure the safe provision of auricular acupuncture [within private freestanding facilities licensed by the Department of Public Health for the care or treatment of substance abusive or dependent persons] in accordance with the provisions of this subsection.

Sec. 6. Subdivision (4) of subsection (a) of section 20-74s of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (A) conducting a substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk for substance abuse, (B) developing a preliminary diagnosis for the individual based on such screening or evaluation, (C) determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (D) developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (E) developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record;

Sec. 7. (NEW) (*Effective July 1, 2016*) (a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(2) "Adult" means a person who is at least eighteen years of age;

(3) "Prescribing practitioner" has the same meaning as provided in section 20-14c of the general statutes;

(4) "Minor" means a person who is under eighteen years of age;

(5) "Opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependence on an opioid drug;

(6) "Opiate receptor" means a specific site on a cell surface that interacts in a highly selective fashion with an opioid drug;

(7) "Palliative care" means specialized medical care to improve the quality of life of patients and their families facing the problems associated with a life-threatening illness; and

(8) "Opioid antagonist" has the same meaning as provided in section 17a-714a of the general statutes, as amended by this act.

(b) When issuing a prescription for an opioid drug to an adult patient for the first time for outpatient use, a prescribing practitioner who is authorized to prescribe an opioid drug shall not issue a prescription for more than a seven-day supply of such drug, as recommended in the National Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain.

(c) A prescribing practitioner shall not issue a prescription for an opioid drug to a minor for more than a seven-day supply of such drug at any time. When issuing a prescription for an opioid drug to a minor for less than a seven-day supply of such drug, the prescribing practitioner shall discuss the risks associated with use of an opioid drug, including, but not limited to, the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reasons why the prescription is necessary with (1) the minor, and (2) the custodial parent, guardian or other person having legal custody of the minor if such parent, guardian or other person is present at the time of issuance.

(d) Notwithstanding the provisions of subsections (b) and (c) of this section, if, in the professional medical judgment of a prescribing practitioner, more than a seven-day supply of an opioid drug is required to treat an adult patient's or minor patient's acute medical

condition, as determined by the prescribing practitioner, or is necessary for the treatment of chronic pain, pain associated with a cancer diagnoses or for palliative care, then the prescribing practitioner may issue a prescription for the quantity needed to treat the acute medical condition, chronic pain, pain associated with a cancer diagnosis or pain experienced while the patient is in palliative care. The condition triggering the prescription of an opioid drug for more than a seven-day supply shall be documented in the patient's medical record and the practitioner shall indicate that an alternative to the opioid drug was not appropriate to address the medical condition.

(e) The provisions of subsections (b), (c) and (d) of this section shall not apply to medications designed for the treatment of abuse of or dependence on an opioid drug, including, but not limited to, opioid agonists and opioid antagonists.

Sec. 8. Subdivision (3) of section 21a-240 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(3) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, [or] dispenser or prescribing practitioner. It does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

Sec. 9. Subsection (j) of section 21a-254 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances that are dispensed by pharmacies,

nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional practice.

(2) The commissioner may identify other products or substances to be included in the electronic prescription drug monitoring program established pursuant to subdivision (1) of this subsection.

(3) Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution and dispenser shall report to the commissioner, at least weekly, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy: (A) Dispenser identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

(4) [On] <u>(A) Except as provided in this subdivision, on</u> and after July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section

20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner by electronic means, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy immediately upon, but in no event [more] later than [twenty-four hours] the next business day after, dispensing such prescriptions: [(A)] (i) Dispenser identification number; [(B)] (ii) the date the prescription for the controlled substance was filled; [(C)] (iii) the prescription number; [(D)] (iv) whether the prescription for the controlled substance is new or a refill; [(E)] (v) the national drug code number for the drug dispensed; [(F)] (vi) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; [(G)] (vii) a patient identification number; [(H)] (viii) the patient's first name, last name and street address, including postal code; [(I)] (ix) the date of birth of the patient; [(J)] (x) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and [(K)] (xi) the type of payment.

(B) If the electronic prescription drug monitoring program is not operational, such pharmacy or dispenser shall report the information described in this subdivision not later than the next business day after regaining access to such program. For purposes of this subdivision, "business day" means any day during which the pharmacy is open to the public.

(C) Each veterinarian, licensed pursuant to chapter 384, who dispenses a controlled substance prescription shall report to the commissioner the information described in subparagraph (A) of this subdivision, at least weekly, by electronic means or, if the veterinarian does not maintain records electronically, in a format approved by the commissioner.

(5) The commissioner may contract with a vendor for purposes of

electronically collecting such controlled substance prescription information. The commissioner and any such vendor shall maintain the information in accordance with the provisions of chapter 400j.

(6) The commissioner and any such vendor shall not disclose controlled substance prescription information reported pursuant to subdivisions (3) and (4) of this subsection, except as authorized pursuant to the provisions of sections 21a-240 to 21a-283, inclusive, as amended by this act. Any person who knowingly violates any provision of this subdivision or subdivision (5) of this subsection shall be guilty of a class D felony.

(7) The commissioner shall provide, upon request, controlled substance prescription information obtained in accordance with subdivisions (3) and (4) of this subsection to the following: (A) The prescribing practitioner [,] or such practitioner's authorized agent, [who is also a licensed health care professional,] who is treating or has treated a specific patient, provided the information is obtained for purposes related to the treatment of the patient, including the monitoring of controlled substances obtained by the patient; (B) the prescribing practitioner with whom a patient has made contact for the purpose of seeking medical treatment or such practitioner's authorized agent, provided the request is accompanied by a written consent, signed by the prospective patient, for the release of controlled substance prescription information; or (C) the pharmacist who is dispensing controlled substances for a patient, provided the information is obtained for purposes related to the scope of the pharmacist's practice and management of the patient's drug therapy, including the monitoring of controlled substances obtained by the patient. The prescribing practitioner, such practitioner's authorized agent, or the pharmacist shall submit a written and signed request to the commissioner for controlled substance prescription information. Such prescribing practitioner or pharmacist shall not disclose any such

request except as authorized pursuant to sections 20-570 to 20-630, inclusive, or sections 21a-240 to 21a-283, inclusive, as amended by this act.

(8) No person or employer shall prohibit, discourage or impede a prescribing practitioner or pharmacist from requesting controlled substance prescription information pursuant to this subsection.

(9) Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized agent [who is also a licensed health care professional] shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes a controlled [substances] substance, other than a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent, [who is also a licensed health care professional,] shall review, not less than once every ninety days, the patient's records in such prescription drug monitoring program. Whenever a prescribing practitioner prescribes a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescribing practitioner, or such prescribing practitioner's authorized agent, shall review, not less than annually, the patient's records in such prescription drug monitoring program. If such electronic prescription drug monitoring program is not operational, such [prescriber] prescribing practitioner may prescribe greater than a seventy-two-hour supply of a controlled substance to a patient during the time of such program's inoperability, provided such [prescriber] prescribing practitioner or such authorized agent reviews the records of such patient in such program not more than twenty-four hours after regaining access to such program.

(10) (A) A prescribing practitioner may designate an authorized agent to review the electronic prescription drug monitoring program

and patient controlled substance prescription information on behalf of the prescribing practitioner. The prescribing practitioner shall ensure that any authorized agent's access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. The prescribing practitioner and any authorized agent shall be subject to the provisions of 45 CFR 164.308, as amended from time to time, concerning administrative safeguards for the protection of electronic protected health information. A prescribing practitioner may receive disciplinary action for acts of the authorized agent as provided in section 21a-322, as amended by this act.

(B) Notwithstanding the provisions of subparagraph (A) of this subdivision, a prescribing practitioner who is employed by or provides professional services to a hospital shall, prior to designating an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner, (i) submit a request to designate one or more authorized agents for such purposes and a written protocol for oversight of the authorized agent or agents to the commissioner, in the form and manner prescribed by the commissioner, and (ii) receive the commissioner's approval to designate such authorized agent or agents and of such written protocol. Such written protocol shall designate either the hospital's medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner as the person responsible for ensuring that the authorized agent's or agents' access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. A hospital medical director, a hospital department head, who is a prescribing practitioner, or another

prescribing practitioner designated as the person responsible for overseeing an authorized agent's or agents' access to such program and information in the written protocol approved by the commissioner may receive disciplinary action for acts of the authorized agent or agents as provided in section 21a-322, as amended by this act. The commissioner may inspect hospital records to determine compliance with written protocols approved in accordance with this section.

[(10)] (11) The commissioner shall adopt regulations, in accordance with chapter 54, concerning the reporting, evaluation, management and storage of electronic controlled substance prescription information.

[(11)] (12) The provisions of this section shall not apply to (A) samples of controlled substances dispensed by a physician to a patient, or (B) any controlled substances dispensed to hospital inpatients.

[(12)] (13) The provisions of this section shall not apply to any institutional pharmacy or pharmacist's drug room operated by a facility, licensed under section 19a-495 and regulations adopted pursuant to said section 19a-495, that dispenses or administers directly to a patient an opioid agonist for treatment of a substance use disorder.

Sec. 10. Section 21a-322 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

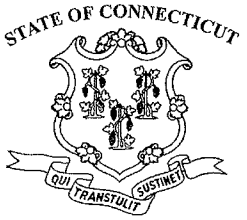
The commissioner may suspend, revoke or refuse to renew a registration, place a registration on probation, place conditions on a registration and assess a civil penalty of not more than one thousand dollars per violation of this chapter, for sufficient cause. Any of the following shall be sufficient cause for such action by the commissioner: (1) The furnishing of false or fraudulent information in any application filed under this chapter; (2) conviction of a crime under any state or federal law relating to the registrant's profession, controlled substances

or drugs or fraudulent practices, including, but not limited to, fraudulent billing practices; (3) failure to maintain effective controls against diversion of controlled substances into other than duly authorized legitimate medical, scientific, or commercial channels; (4) the suspension, revocation, expiration or surrender of the practitioner's federal controlled substance registration; (5) prescribing, distributing, administering or dispensing a controlled substance in schedules other than those specified in the practitioner's state or federal registration or in violation of any condition placed on the practitioner's registration; (6) suspension, revocation, expiration, surrender or other disciplinary action taken against any professional license or registration held by the practitioner; (7) abuse or excessive use of drugs; (8) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other proper medical or scientific purpose; (9) a practitioner's failure to account for disposition of controlled substances as determined by an audit of the receipt and disposition records of said practitioner; **[**and**]** (10) failure to keep records of medical evaluations of patients and all controlled substances dispensed, administered or prescribed to patients by a practitioner; (11) failure to establish and implement administrative safeguards for the protection of electronic protected health information pursuant to 45 CFR 164.308, as amended from time to time; and (12) breach of any such safeguards by a prescribing practitioner's authorized agent.

Sec. 11. (*Effective from passage*) Not later than October 1, 2016, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group concerning the issuance of opioid drug prescriptions by prescribing practitioners, as defined in section 7 of this act. The working group shall study whether it is a best practice for prescribing practitioners to limit prescriptions to not more than a three-day supply of opioid drugs for the purpose of treating a minor patient's acute medical condition. Not later than February 1, 2017, the working group

shall report, in accordance with the provisions of section 11-4 of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the results of such study.

Approved May 27, 2016



Substitute Senate Bill No. 101

Public Act No. 16-73

AN ACT CONCERNING WORKERS' COMPENSATION INSURANCE AND SOLE PROPRIETORS.

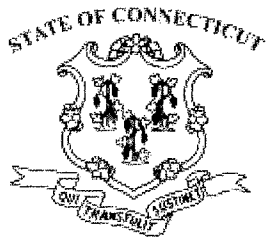
Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 31-286a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Notwithstanding any provision of any general statute, special act, charter or ordinance, neither the state, or its agents, nor any political subdivision of the state, or its agents, may enter into any contract on or after October 1, 1986, for the construction, remodeling, refinishing, refurbishing, rehabilitation, alteration or repair of any public works project before receiving from each of the other parties to such contract (1) sufficient evidence of compliance with the workers' compensation insurance and self-insurance requirements of subsection (b) of section 31-284, and (2) a current statement from the State Treasurer that, to the best of his knowledge and belief, as of the date of the statement, the particular party was not liable to the state for any workers' compensation payments made pursuant to section 31-355, except that any sole proprietor who is a party to such contract shall not be subject to the provisions of this section, provided such sole proprietor (A) does not utilize any subcontractor in performing such

contract, (B) is not acting as a principal employer, (C) has not accepted the provisions of chapter 568 in accordance with subdivision (10) of section 31-275, and (D) has liability insurance in lieu of workers' compensation insurance.

Approved June 1, 2016



House Bill No. 5364

Public Act No. 16-112

AN ACT CONCERNING THE FILING OF WORKERS' COMPENSATION CLAIMS WHEN A MUNICIPALITY IS THE EMPLOYER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 31-294c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(a) No proceedings for compensation under the provisions of this chapter shall be maintained unless a written notice of claim for compensation is given within one year from the date of the accident or within three years from the first manifestation of a symptom of the occupational disease, as the case may be, which caused the personal injury, provided, if death has resulted within two years from the date of the accident or first manifestation of a symptom of the occupational disease, a dependent or dependents, or the legal representative of the deceased employee, may make claim for compensation within the two-year period or within one year from the date of death, whichever is later. Notice of [a] claim for compensation may be given to the employer or any commissioner and shall state, in simple language, the date and place of the accident and the nature of the injury resulting from the accident, or the date of the first manifestation of a symptom of the occupational disease and the nature of the disease, as the case may be, and the name and address of the employee and of the person in whose interest compensation is claimed. An employee of the state shall send a copy of the notice to the Commissioner of Administrative Services. An employee of a municipality shall send a copy of the notice to the town clerk of the municipality in which he or she is employed. As used in this section, "manifestation of a symptom" means manifestation to an employee claiming compensation, or to some other person standing in such relation to him that the knowledge of the person would be imputed to him, in a manner that is or should be recognized by him as symptomatic of the occupational disease for which compensation is claimed.

Approved June 3, 2016