CASE NO. 4391 CRB-5-01-5
CLAIM NO. 500108768 : COMPENSATION REVIEW BOARD

HEYWARD SELLERS
CLAIMANT-APPELLANT : WORKERS' COMPENSATION COMMISSION

v. : APRIL 26, 2002

SELLERS GARAGE, INC.
EMPLOYER

and

ROYAL INSURANCE CO.
INSURER
RESPONDENTS-APPELLEES

and

WORK FORCE ONE
EMPLOYER

and

HANOVER INSURANCE CO.
INSURER
RESPONDENTS-APPELLEES

APPEARANCES:

The claimant appeared pro se at oral argument.

The respondent employer Sellers Garage and Royal Insurance Co. were represented by Richard Stabnick, Esq., Pomeranz, Drayton & Stabnick, 95 Glastonbury Boulevard, Glastonbury, CT 06033.

The respondent employer Work Force One and Hanover Insurance Co. were represented by Charlene Russo, Esq., Russo, LaRose & Bresnahan, 538 Preston Avenue, P.O. Box 1002, Meriden, CT 06450.

This Petition for Review from the May 9, 2001 Finding and Award of the Commissioner acting for the Fifth District was heard November 16, 2001 before a Compensation Review Board panel consisting of Commissioners George A. Waldron, Ernie R. Walker and Amado J. Vargas.

# OPINION

GEORGE A. WALDRON, COMMISSIONER. The claimant, who is appearing pro se before this board, has petitioned for review from the May 9, 2001 Finding and Award of the Commissioner acting for the Fifth District. He raises several claims of error on appeal. After reviewing the claimant's arguments, we find no legal error, and affirm the decision of the trial commissioner.

The trier found that the claimant suffered injuries to his right wrist and shoulder on September 25, 1995, while removing a transmission during the course of his employment. On or about November 14, 1995, he developed left wrist pain due to the consequent overuse of his other arm. On March 21, 1997, he was struck in the head with a falling frame, and injured his cervical spine. All of these injuries were eventually accepted by voluntary agreement, and the claimant received permanency ratings of 15% of his right master hand, 8% of his right master shoulder, 3% of his left wrist, and 10% of his cervical spine. Permanency benefits for the cervical spine were paid through March 3, 1998, while permanency for the other body parts was paid (collectively) through November 7, 1998.

The claimant initially treated with Dr. Chiappetta, an orthopedic surgeon, who referred him to a colleague, Dr. Watson, for surgical intervention on the claimant's right wrist. Surgery was performed on October 7, 1996, and the wrist reached maximum

medical improvement a little over one year later. Following the March 1997 spine injury, the claimant treated with Drs. Stern and Weiss of the Meriden Chiropractic Group, who eventually referred him to Dr. Levin at the Yale Center for pain management due to the claimant's post-concussive headaches. Dr. Levin diagnosed central and myofascial pain syndrome and tension headaches, which were related to the March 21, 1997 injury.

On April 20, 1998, the claimant was employed by Work Force One (whose workers' compensation insurer was the respondent Hanover Insurance Co.) at a job that entailed pushing or twisting tops onto containers. He sustained increased pain in his right wrist, and was advised not to return to work after seeking medical treatment the next day. Dr. Johnson at Industrial Health Care diagnosed probable tendonitis, and restricted the claimant's use of his right hand. Dr. Chiappetta followed up on his treatment, and diagnosed over-stress tenosynovitis and an acute exacerbation of right wrist symptoms. Several weeks later, following some physical therapy, Work Force One was advised not to hire the claimant unless there was extremely light work available.

In response to a Form 30C that was filed by the claimant, Hanover Insurance filed a notice of its intent to contest liability on May 11, 1998. Meanwhile, the respondents paid the claimant 23 weeks of total disability benefits without prejudice, from April 22, 1998 to September 29, 1998. Because they did not issue a voluntary agreement, the trier held that Hanover was not required to file a Form 36 to discontinue these payments without prejudice. Dr. Chiappetta advised the claimant that his wrist problem was chronic, and then opined on October 27, 1998 that there was no increase in permanency to either hand. The trier found that there was no evidence to show that the claimant was totally disabled or attempting to find work from September 30, 1998 to October 26, 1998,

and denied his request for benefits spanning that brief time period. The claimant returned to Dr. Chiappetta in March 1999 with more complaints of pain in his left hand, and was referred to Central Connecticut Physical Therapy and Rehabilitation, Inc. His response to the physical therapy was slow. Upon another referral, Dr. Formica evaluated the claimant for possible arthritic etiology, but rejected that hypothesis after medication failed to alleviate his symptoms.

April 1999 saw the claimant commence treatment with Dr. Feldman, a urologist, for erectile dysfunction, which the doctor thought to be related to the compensable injuries. The doctor opined that the claimant was depressed over having to close his business as a result of his physical problems, and indicated that the claimant's hand and wrist injuries were causing him pain during sexual activities, which diminished arousal. He referred the claimant to Dr. Mackenzie, a psychiatric social worker, for further treatment. She noted that the claimant was concerned about his loss of income. The trial commissioner was ultimately not persuaded that the claimant's sexual dysfunction was caused by depression related to his injuries. Also, the absence of a referral left the treatment of Drs. Feldman and Mackenzie outside the chain of authorization, along with the charges of Drs. Eisen and Mari, whom the claimant visited of his own volition in August 1999. Thus, their fees were not the responsibility of the insurer.

On May 9, 2000, the claimant was evaluated by Dr. Kaplan at Gaylord Hospital, who recommended testing for memory impairment and the adjustment of medication to control pain. A vocational rehabilitation counselor indicated that the claimant had been active and cooperative since his acceptance by the Bureau of Rehabilitation Services, but his hand symptoms made him incapable of working. There was evidence submitted that

the claimant had contacted employers for a 17-week period between March and June 2000. The claimant did receive temporary partial disability benefits pursuant to § 31-308a for a 27-week period. Meanwhile, Dr. Thompson had seen the claimant upon referral from Dr. Levin, and recommended surgery on the right wrist involving the implantation of a radial nerve branch into muscle. This was done on July 24, 2000; on September 13, 2000, Dr. Thompson opined that the claimant was totally disabled because of his compensable right arm symptoms. However, no evidence was introduced to demonstrate that total disability continued after that date.

The trier eventually held that Dr. Chiappetta's bills for treatment between April 20, 1998 and October 27, 1998 were the responsibility of Hanover Insurance, and subsequent bills for his treatment were payable by the respondent Royal Insurance Company. He also found that physical therapy prescribed by Dr. Chiappetta after February 16, 2000 was unauthorized, as the claimant had switched to Dr. Thompson as his treating physician. The trier found that there was no evidence to demonstrate total disability between November 8, 1998 and July 23, 2000, and denied that claim. He likewise denied the claimant's request for § 31-308a benefits for that interval. The trier did award total disability from July 24, 2000 to September 13, 2000, and explained that further hearings may be held to determine total disability beyond that date, should the medical evidence warrant it. The claimant has appealed that decision to this board.[1]

Before we begin discussing the specific findings that have aggrieved the claimant, it would be wise for us to clarify the role of the Compensation Review Board in

[1] The claimant attempted to file a host of documents in support of his appeal on December 14, 2001 and December 17, 2001, approximately one month after the date of oral argument. As we informed the claimant on January 11, 2002, those documents will not be considered in our resolution of this appeal.

this system. When someone makes a claim under the Workers' Compensation Act, as the claimant has here, and the parties are unable to resolve that claim by mutual agreement, a workers' compensation commissioner may have to hold formal hearings to decide the facts of the claim. Warren v. Federal Express Corp., 4163 CRB-2-99-12 (Feb. 27, 2001). The commissioner's fact-finding role is similar to that of a trial judge in Superior Court. Both parties are allowed to present medical evidence and testimony using the relaxed procedural rules of § 31-298 C.G.S. The commissioner evaluates that evidence, and decides which of it, if any, he finds believable. However, the parties do not start from a precisely equal position, because the claimant carries the burden of proving that he suffered a compensable injury, that he has a disability, and that his disability was caused by that compensable injury. As an illustration of the effect of this burden of proof, if a commissioner found none of the witnesses to be credible and none of the documentary evidence to be trustworthy, the employer would essentially prevail by default. Id.

The trier of fact has the sole authority to make decisions regarding the credibility of evidence. Tartaglino v. Dept. of Correction, 55 Conn. App. 190, 195 (1999); Mosman v. Sikorsky Aircraft Corp., 4180 CRB-4-00-1 (March 1, 2001). On appeal, this review board does not have the power or the authority to retry the facts of a case by second-guessing the commissioner's decisions as to what evidence was most believable. Pallotto v. Blakeslee Prestress, Inc., 3651 CRB-3-97-7 (July 17, 1998). When we review a commissioner's findings, we may alter them only if they contain facts found without any supporting evidence at all, or if the findings fail to include material facts (facts that affect the outcome of the case) that are truly undisputed. Warren, supra; Webb v. Pfizer, Inc., 14 Conn. Workers' Comp. Rev. Op. 69, 70-71, 1859 CRB-5-93-9 (May 12, 1995). The

legal conclusions of the trial commissioner also must remain intact unless they result from an incorrect application of the law to the underlying fact, or from an inference unreasonably or illegally drawn from that set of facts. Fair v. People's Savings Bank, 207 Conn. 535, 539 (1988). An appeal to the CRB, therefore, is not the equivalent of a "second chance" to prove one's case; it is a means of obtaining review in the event of a legal error. Warren, supra.

Also, if a claimant wishes a trial commissioner to reconsider those findings of fact that are based on the impressions that he has drawn from the evidence, the claimant is required to file a Motion to Correct those findings as per Admin. Reg. § 31-301-4. Marcoux v. Allied Signal, 4366 CRB-4-01-3 (Jan. 16, 2002). This motion gives the claimant an opportunity to call the trier's attention to evidence that he believes may have been overlooked or misinterpreted, and gives the trier a chance to reconsider those findings. When a claimant fails to file such a motion, this board is very limited in its ability to scrutinize the facts found by the commissioner, as we do not have the power to substitute our own judgment regarding the weight of the evidence for the judgment of the trial commissioner. Mitchell v. J.B. Retail Inventory Specialists, 3458 CRB-2-96-10 (March 31, 1998). The claimant did not file a Motion to Correct in this case. Because he did not take that step, this board has no latitude to question certain findings of fact.

Specifically, the claimant sought to challenge the trier's finding that he failed to sustain his burden of proving that his physical injuries had produced depression and sexual dysfunction. Because he did not use the requisite Motion to Correct procedure to direct the trial commissioner's attention to the evidence in the record, we now have no basis on appeal to question whether the trier impermissibly misinterpreted that evidence.

This finding is purely based on the commissioner's assessment of evidentiary credibility—that is, whether the reports of Drs. Feldman and Mackenzie were persuasive enough to prove the claimant's case. The trial commissioner evidently did not find their medical opinions to be sufficiently persuasive. We have no ground upon which to overturn that finding on appeal.

Similarly, the claimant contends in his brief that Dr. Chiappetta's letter of October 27, 1998 to the claimant's then-attorney, Sandra Gerber, mistakenly states that the claimant had reached maximum medical improvement with no increase in permanency since the injury of April 20, 1998.[2] See Respondent's Exhibit 1. We note that the additional correspondence with Dr. Chiappetta that the claimant relies upon does not purport to revoke his earlier opinion; rather, his August 21, 2000 letter to the claimant states that he was "not aware of further testing, nor further evidence of deterioration in functioning," and suggests that the claimant contact his other physicians if any misconceptions exist regarding maximum medical improvement or increase in disability. Claimant's Exhibit M. Without a Motion to Correct, and without a more direct refutation of his earlier report, we cannot fault the trial commissioner for relying on Dr.

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[2] The claimant also argued that this letter should not have been introduced into evidence because it was offered as an exhibit by Charlene Russo, the attorney for Hanover Insurance, but was not addressed to her. Simply put, the respondents are entitled to copies of all medical reports prepared by the claimant's treating physician as per § 31-294f(b) C.G.S, and would be entitled to offer such a report as evidence under § 31-298. There is nothing improper about an insurance company's attorney introducing a letter such as this into evidence, as Dr. Chiappetta's October 27, 1998 letter was clearly intended to provide the claimant's counsel with a report regarding his condition. Indeed, our system could not function properly if a claimant could prevent a respondent from seeing the reports of a treating physician. See also Admin. Reg. § 31-279-9(c) (duty of attending physician to keep employer apprised of significant developments).

We also disagree with that the claimant's argument that Attorney Russo should not have been allowed to represent Hanover Insurance at the November 13, 2000 formal hearing due to the claimant's lack of awareness that she was representing that client. Apparently, when counsel filed her appearance on the date of the formal hearing, the name of the claimant's former counsel had been placed on the appearance, rather than that of the pro se claimant. The claimant would have us hold that, due to this defect, there was no one legally present to represent Hanover at the formal hearing, which invalidates the letter she introduced into evidence, and requires an award of the full 33 months of total disability benefits that the claimant sought

Chiappetta's opinion of October 27, 1998. He was, after all, the claimant's treating physician at that time. Dr. Chiappetta also did not state that the claimant was totally disabled beyond June 29, 1998, and the trier was entitled to rely on that medical opinion.

Continuing on that theme, the claimant's argument that he was totally disabled from November 8, 1998 through July 23, 2000 directly contradicts the trier's factual finding that there was no credible evidence to support such a conclusion. Findings, ¶ K. Again, we cannot second-guess the trial commissioner's determination of this claim by re-evaluating the evidence in the record, particularly in the absence of a Motion to Correct. Whether or not a claimant is totally disabled is a question of fact that ultimately rests on the judgment of the trial commissioner. Fusciello v. Ronnie Demeo, Inc., 4340 CRB-6-01-1 (Jan. 7, 2002); Brown v. State/Dept. of Mental Health and Addiction, 4053 CRB-2-99-5 (July 27, 2000). We must also honor the trier's finding that the claimant performed 17 weeks of job searches between November 8, 1998 and July 23, 2000, while receiving 27 weeks of discretionary benefits under § 31-308a C.G.S., thereby entitling him to no additional benefits. The evidence supports this finding, as the claimant offered no proof that he made a concerted effort to find work within his enumerated job restrictions outside of the March 26, 2000 – July 23, 2000 time period. See Claimant's Exhibits C, D.

The one argument raised by the claimant that we may review fully is his contention that the respondent Hanover Insurance improperly discontinued his benefits without filing a Form 36. As noted above, the claimant was paid 23 weeks of total disability benefits without prejudice following the April 20, 1998 injury. This

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below. We do not believe that such a minor and inconsequential defect warrants such a draconian remedy, and decline to issue such a holding.

compensation ran from April 22, 1998 to September 29, 1998, after which benefits were discontinued. The trier held that, without a voluntary agreement, Hanover was not required to file a Form 36 pursuant to § 31-296 before discontinuing these payments. The claimant maintains, however, that Admin. Reg. § 31-296-2 in effect obligated the respondents to file a Form 36, as an employer may pay no more than six weeks of benefits without prejudice under the regulation.

Section 31-296 states that an employer who has entered into a voluntary agreement with an employee in regard to compensation must notify the commissioner and the employee, by certified mail, of any proposed discontinuance or reduction of compensation payments on account of total or partial incapacity. In 1971, Admin. Reg. § 31-296-2 was enacted, stating as follows:

> In any case in which the employer or the insurer doubts the fact of accident or the causal relationship between the accident and the disability, but wishes to make payment without prejudice and without admitting liability, he shall notify both the claimant and the commissioner by letter that payment will be made without prejudice. Such letter shall contain a statement of the average weekly wage, the compensation disability rate, the number of dependent children or stepchildren and the total weekly benefit to be paid. A formal notice of the employer's intention to contest liability (Form 43) shall accompany such letter to protect the respondent's rights. Payments without prejudice shall be made for not more than six weeks. If, at the end of such period, the employer or insurer has completed his investigation and determines the accident is compensable, a voluntary agreement shall be offered. Otherwise, the employer shall promptly request an informal hearing.

At the time of its passage, this regulation was compatible with the employer's requirement to contest compensability under § 31-297(b), which gave the employer 20 days after receiving a written notice of claim to contest a claimant's right to compensation. If the employer failed to file such a notice within those 20 days, it was conclusively presumed to have accepted the compensability of the alleged injury. In

1989, the 20-day period was extended to 28 days, and two years later the entire notice provision was moved to § 31-294c.

Then, in 1993, Public Act No. 93-228 made another important change to this statute. It was amended to read, "If the employer or his legal representative fails to file the notice contesting liability on or before the twenty-eighth day after he has received the written notice of claim, the employer shall commence payment of compensation for such injury or death on or before the twenty-eighth day after he has received the written notice of claim, *but the employer may contest the employee's right to receive compensation on any grounds or the extent of his disability within one year from the receipt of the written notice of claim . . . .*" (Emphasis added.) Under this statute, an employer must decide whether or not to file a Form 43 contesting liability for the injury itself within 28 days of receiving the notice of claim, but the employer is not required to decide whether a claimant's condition warrants the payment of total disability benefits, for example, until one year after the notice of claim has been received.

Given this change in the language of § 31-294c(b), we believe that the legislature committed a minor oversight by failing to amend Admin. Reg. § 31-296-2 to reflect this expansion of the employer's statutory rights. It is clearly beneficial under our system for an employer to be able to pay benefits without prejudice to a claimant during the investigatory time period following an injury, as many claimants who cannot return to work need an immediate substitute for their paychecks. It would be unfortunate if an employer who was doubtful of the relationship between accident and disability could only pay without prejudice for six weeks while the claimant's medical status was being investigated. This would leave many claimants without compensation for the remainder

of the one-year time period during which the employer would have the statutory right not to accept liability for disability payments, as employers would not continue to advance payments without prejudice if doing so meant having to accept the disability claim.

In this case, the respondents did not enter into a voluntary agreement with the claimant, and had the right to pay without prejudice after the filing of their Form 43. As we stated in Lee v. Bridgeport Housing Authority, 12 Conn. Workers' Comp. Rev. Op. 58, 1416 CRB-4-92-5 (Jan. 27, 1994), "To hold that a respondent who has issued a notice contesting liability and who continues to contest a claim in good faith cannot advance compensation payments at the request of the commissioner without thereby accepting the claim would not serve the purposes of the Workers' Compensation Act." Id., 61. This is even truer now, given the amendment to § 31-294c. We thus hold that the respondents were not required to file a Form 36 before discontinuing payment without prejudice in this case, as they had not accepted liability for the claim. Instead, the long-standing "payment without prejudice" language in § 31-296-2 must be read consistently with the legislature's more recent amendment to § 31-294c. We would also urge the legislature to rectify this discrepancy.

The trial commissioner's decision is accordingly affirmed.

Commissioners Ernie R. Walker and Amado J. Vargas concur.