CASE NO. 5740 CRB-2-12-3 : COMPENSATION REVIEW BOARD
CLAIM NO. 200167534

BRIAN BOMBRIA
CLAIMANT-APPELLEE : WORKERS' COMPENSATION COMMISSION

v.

: MARCH 6, 2013

ANTHONY J. BONAFINE
EMPLOYER
RESPONDENT-APPELLEE

and

ACE/AMERICAN INSURANCE
c/o TRAVELERS INSURANCE
INSURER
RESPONDENT-APPELLANT

and

MICHAEL J. BONAFINE
D&M CUSTOM HOMES & REMODELING, INC.
and
EDWARD DUMAS
RESPONDENTS
NO RECORD OF INSURANCE

and

SECOND INJURY FUND
RESPONDENT-APPELLEE

APPEARANCES:

The claimant was represented by Michael D. Colonese, Esq., Brown Jacobson, PC, 22 Courthouse Square, Norwich, CT 06360.

The respondent Anthony Bonafine was represented by David C. Davis, Esq., McGann, Bartlett & Brown, LLC, 111 Founders Plaza, Suite 1201, East Hartford, CT 06108 who appeared at the trial level but did not attend oral argument. Correspondence indicates issues on appeal are

being addressed by counsel representing ACE/American Insurance.

The respondent-insurer ACE/American Insurance was represented by Sean Nourie, Esq., Conway & Stoughton, LLC, 643 Prospect Avenue, West Hartford, CT 06105.

At the trial level Michael J. Bonafine appeared on his own behalf and on behalf of D&M Custom Homes & Remodeling, Inc. He did not participate in the appeal proceedings.

At the trial level Edward Dumas appeared on his own behalf. He did not participate in the appeal proceedings.

At the trial level the Second Injury Fund was represented by Richard Hine, Esq., Assistant Attorney General, Office of the Attorney General, 55 Elm Street, Hartford, CT 06106. The Fund did not participate in the appeal proceedings.

This Petition for Review from the March 7, 2012 Finding and Award of the Commissioner acting for the Second District was heard September 28, 2012 before a Compensation Review Board panel consisting of the Commission Chairman John A. Mastropietro and Commissioners Jodi Murray Gregg and Daniel E. Dilzer.

OPINION

JOHN A. MASTROPIETRO, CHAIRMAN. The respondent ACE American Insurance ("ACE") has appealed from a Finding and Award issued to the claimant in this matter. They argue that the trial commissioner's orders concerning reimbursement of medical expenses were improper. We have reviewed the record of the hearing and the applicable law and are unable to discern the statutory authority or factual predicate for the trial commissioner's order of reimbursement for medical expenses. Accordingly, we

remand this matter back to the trial commissioner for new findings, and if necessary a new hearing, to properly justify the reimbursement orders herein.

The following facts are pertinent to this appeal. The claimant was injured on July 18, 2009 while working on a construction site in Ledyard. He filed a claim for benefits wherein the respondent challenged the existence of an employer-employee relationship, and disputed who the claimant's employer was if such an employer-employee relationship was found. The trial commissioner found the claimant was an employee of Anthony J. Bonafine and awarded benefits under § 31-307 C.G.S. and § 31-294d C.G.S. The trial commissioner further found the claimant had incurred medical bills from William W. Backus Hospital, Windham Memorial Hospital, Carlson Therapy Network and Connecticut Orthopaedic and Hand Surgery Center. The trial commissioner ordered ACE American Insurance through its TPA, Travelers Insurance, to pay Backus Hospital $4,116.20 and $811.10 to Windham Hospital, as well as ordering them to pay an unspecified amount to Carlson Therapy Network and Connecticut Orthopaedic and Hand Surgery Center at their "reasonable and customary rates." Orders, ¶¶ II, III, IV and V. March 7, 2012 Finding and Award.

The respondent ACE did not file a Motion to Correct contesting the facts herein but filed Reasons of Appeal. The Reasons of Appeal asserted that the order in the Finding and Award was invalid as the orders in question lacked foundation in any evidence establishing that there was an outstanding balance due to those medical providers. ACE also argued the orders were erroneous as ACE had no duty to reimburse a medical provider for costs which were already paid or are otherwise not owed.

In their appeal ACE argues that the trial commissioner's orders were invalid as they were in contravention of our precedent in Dudley v. Radio Frequency Systems, 4995 CRB-8-05-9 (July 17, 2006) *quoting* Moutinho v. Planning & Zoning Commission, 278 Conn. 660, 665-666 (2006). "A finding of fact is clearly erroneous when there is no evidence in the record to support it . . . or when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." Id. ACE argues "there is no Finding & Conclusion which addresses the question of whether the medical bills remain outstanding or unpaid at the time of the Finding & Award." Appellant's Brief, p. 9. We must examine the record to ascertain if this is an accurate representation of the Commissioner's decision. "As with any discretionary action of the trial court, appellate review requires every reasonable presumption in favor of the action, and the ultimate issue for us is whether the trial court could have reasonably concluded as it did." Daniels v. Alander, 268 Conn. 320, 330 (2004).

The Finding and Award contains the following findings which reference medical bills incurred as a result of the claimant's compensable injury: Findings, ¶ 70, referencing bills by Backus Hospital; Findings, ¶ 72 referencing bills from Windham Hospital; Findings, ¶ 77 referencing bills from Carlson Therapy Network and Findings, ¶ 80 referencing bills from Connecticut Orthopaedic and Hand Surgery Center. The sole evidence on the record supportive of these factual findings is Claimant's Exhibit Z, which was a packet of medical bills introduced into evidence without objection by the respondents. We have reviewed the hearing transcript and find that no witness offered testimony before the Commissioner or testified at a deposition to explain the

circumstances as to these bills. Therefore, we must examine this evidence "as is" Berube v. Tim's Painting, 5068 CRB-3-06-3 (March 13, 2007). We also note that we cannot place the same weight on the relative credibility of documentary evidence as we would be able to place on witness testimony before the trial commissioner. Bode v. Connecticut Mason Contractors, The Learning Corridor, 130 Conn. App. 672, 685-686 (2011), *cert. denied*, 302 Conn. 942 (2011).

We have reviewed Claimant's Exhibit Z. While the cover sheet prepared by counsel asserts that $10,712.30 is owed to the aforementioned medical providers the actual invoices attached do not document these charges. The Windham Hospital invoice showed a zero balance, as did the Carlson Therapy Network invoice and the invoice from Connecticut Orthopaedic and Hand Surgery Center. The parties draw our attention to the fact that the claimant's mother, Marlene Bombria, appears as an insured party on those invoices, and there is a reference to "Healthnet" (presumably her insurance carrier) having paid these invoices. Appellant's Brief, pp. 10-12.[1] However, any conclusion on this point as to how these bills were paid would be purely speculation or surmise, as there was no testimony or documentary evidence from the claimant, Ms. Bombria, the insurance carrier, or the medical providers explaining this situation. The precedent in DiNuzzo v. Dan Perkins Chevrolet Geo, Inc., 294 Conn. 132 (2009) suggests that a commissioner cannot rely on such inconclusive evidence.

We also note that none of the documentary evidence provided herein were in the forms of public documents, which we have generally considered reliable evidence which

[1] The insured party is identified as "Marlene Bombria" in the records affixed to Claimant's Exhibit Z. We note the claimant's mother is identified as "Marlene Czajka" in the Appellant's Brief, as well as the records admitted in Claimant's Exhibit T.

should be credited by the trier of fact. See Stevens v. Raymark Industries, Inc., 5215 CRB-4-07-4 (March 26, 2008) and Samaoya v. William Gallagher, 4951 CRB-7-05-6 (April 26, 2006), *aff'd*, 102 Conn. App. 670 (2007). The documents in question were business records. While the respondents waived their objections to the admission of these records, May 25, 2010 Transcript, p. 22, even properly admitted evidence may fail to prove what the moving party seeks to establish as a fact.[2]

We also note that two statutes must be considered in this matter. The claimant argues that the trial commissioner's order effectuates compliance with § 31-294d C.G.S., wherein the respondent is obligated to provide reasonable medical care to an injured worker.[3] As the respondent herein failed to accept compensability for the injury, the

[2] For an example of this situation see Gibson v. State/Department of Developmental Services-North Region, 5422 CRB-2-09-2 (January 13, 2010), where even after a witness attempted to explain properly admitted business records the trial commissioner was left unconvinced as to the alleged overpayment.

[3] The statute reads as follows:
Sec. 31-294d. Medical and surgical aid; hospital and nursing service. (a)(1) 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.
(2) If the injured employee is a local or state police officer, state marshal, judicial marshal, correction officer, emergency medical technician, paramedic, ambulance driver, firefighter, or active member of a volunteer fire company or fire department engaged in volunteer duties, who has been exposed in the line of duty to blood or bodily fluids that may carry blood-borne disease, the medical and surgical aid or hospital and nursing service provided by the employer shall include any relevant diagnostic and prophylactic procedure for and treatment of any blood-borne disease.
(b) The employee shall select the physician or surgeon from an approved list of physicians and surgeons prepared by the chairman of the Workers' Compensation Commission. If the employee is unable to make the selection, the employer shall do so, subject to ratification by the employee or his next of kin. If the employer has a full-time staff physician or if a physician is available on call, the initial treatment required immediately following the injury may be rendered by that physician, but the employee may thereafter select his own physician as provided by this chapter for any further treatment without prior approval of the commissioner.
(c) The commissioner may, without hearing, at the request of the employer or the injured employee, when good reason exists, or on his own motion, authorize or direct a change of physician or surgeon or hospital or nursing service provided pursuant to subsection (a) of this section.

claimant believes it is equitable at this point for ACE to reimburse whoever provided medical care responsive to the injury. Chapter 568 however, specifically § 31-299a C.G.S. provides a specific mechanism to effectuate such reimbursement. The record is bereft of any evidence of compliance with this statute.[4] There is no evidence that any of the claimant's medical providers or his group health insurer protected their interest by means of perfecting a lien against an award. We note "[T]he workers' compensation system in Connecticut is derived exclusively from statute. . . . A commissioner may exercise jurisdiction to hear a claim only under the precise circumstances and in the manner particularly prescribed by the enabling legislation." Cantoni v. Xerox Corp., 251

(d) The pecuniary liability of the employer for the medical and surgical service required by this section shall be limited to the charges that prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when the similar treatment is paid for by the injured person. The liability of the employer for hospital service shall be the amount it actually costs the hospital to render the service, as determined by the commissioner, except in the case of state humane institutions, the liability of the employer shall be the per capita cost as determined by the Comptroller under the provisions of section 17b-223. All disputes concerning liability for hospital services in workers' compensation cases shall be settled by the commissioner in accordance with this chapter.
(e) If the employer fails to promptly provide a physician or surgeon or any medical and surgical aid or hospital and nursing service as required by this section, the injured employee may obtain a physician or surgeon, selected from the approved list prepared by the chairman, or such medical and surgical aid or hospital and nursing service at the expense of the employer.

[4] The statute reads as follows:
Sec. 31-299a. Payments under group medical policy not defense to claim for benefits. Health insurer's duty to pay. Lien. (a) Where an employer contests the compensability of an employee's claim for compensation, proof of payment made under a group health, medical or hospitalization plan or policy shall not be a defense to a claim for compensation under this chapter.
(b) Where an employer contests the compensability of an employee's claim for compensation, and the employee has also filed a claim for benefits or services under the employer's group health, medical, disability or hospitalization plan or policy, the employer's health insurer may not delay or deny payment of benefits due to the employee under the terms of the plan or policy by claiming that treatment for the employee's injury or disease is the responsibility of the employer's workers' compensation insurer. The health insurer may file a claim in its own right against the employer for the value of benefits paid by the insurer within two years from payment of the benefits. The health insurer shall not have a lien on the proceeds of any award or approval of any compromise made by the commissioner pursuant to the employee's compensation claim, in accordance with the provisions of section 38a-470, unless the health insurer actually paid benefits to or on behalf of the employee.

Conn. 153, 159-160 (1999). We therefore are uncertain what legal authority exists to reimburse the medical providers or health insurers in this matter if at this point in time no money is owed to them by the claimant.

The claimant cites Pokorny v. Getta's Garage, 219 Conn. 439 (1991) and argues that the facts in this case may be distinguished from that precedent, and the award should therefore be upheld for equitable reasons. We are not persuaded. Pokorny found that reimbursing a claimant for medical expenses previously paid by his medical insurance carrier would result in an impermissible double recovery. Id., 448. The Pokorny decision points out that the appropriate contractual relationship is between the medical providers and the claimant's employer. Id., 456. In the present instance, however, if the present balance due a certain medical provider is zero, reimbursing them for services which were paid for previously would yield a double recovery to the medical provider. The claimant argues that once the employer paid the medical providers they in turn would reimburse the insurance carrier for the previous amount paid. Claimant's Brief, p. 4. The record however, contains no evidence that the medical providers would actually perform this undertaking if they were paid again, nor is there evidence Healthnet affirmatively sought reimbursement, nor is there any order language in the Finding and Award directing the medical providers to make such reimbursement.[5]

ACE argues that our precedent in Besitko v. McDonald's Restaurant, 12 Conn. Workers' Comp. Rev. Op. 111, 1415 CRB 8-92-5 (February 28, 1994) governs the fact

[5] We note that the Supreme Court later distinguished Pokorny v. Getta's Garage, 219 Conn. 439 (1991) in Doucette v. Pomes, 247 Conn. 442 (1999), where the court held that the multiple recovery issue was not present. Id., 473. We defer consideration of these issues to the trial commissioner on remand, while also keeping in mind Pokorny, supra, specifically noted that when a party fails to seek timely reimbursement of an amount due, a court may not find the other party was unjustly enriched. Id., 459-463.

pattern in this case. We are persuaded the present case is indistinguishable from Besitko. In Besitko, the claimant sustained an injury but did not introduce evidence as to doctor bills or hospital bills. The trial commissioner included in the award an order directing the respondent to pay the claimant's unpaid medical bills. The Compensation Review Board vacated this relief as since "the claimant did not introduce evidence regarding any outstanding doctors or hospital bills, the commissioner's order regarding payment of these bills cannot stand. On remand the parties will have the opportunity to present evidence and be heard on the issue of the respondent's liability for any outstanding doctor or hospital bills." Id.

In the present case the claimant did present evidence to the trial commissioner in the form of Exhibit Z, but this evidence is too confusing and ambiguous to support the Orders appealed from by ACE. See DiNuzzo, supra. We believe the precedent in Besitko requires that we remand this matter to the trial commissioner to find the subordinate facts that would either support the claimant's bid for reimbursement, or justify the denial of some or all of the claim.

In Cormican v. McMahon, 102 Conn. 234 (1925), the Supreme Court held "[n]o case under this Act should be finally determined when the trial court, or this court, is of the opinion that, through inadvertence or otherwise, the facts have not been sufficiently found to render a just judgment." Id., 238. This is precisely the scenario that is presented in regards to the claimant's medical bills in this case. Therefore, we remand that issue to the trial commissioner for further proceedings.

Commissioners Jodi Murray Gregg and Daniel E. Dilzer concur in this opinion.