CASE NO. 5997 CRB-5-15-3 : COMPENSATION REVIEW BOARD
CLAIM NO. 500123273

CYNTHIA ZBRAS
CLAIMANT-APPELLANT : WORKERS' COMPENSATION COMMISSION

v.

: MARCH 29, 2016

NORTHEAST MORTGAGE CORP.
EMPLOYER

and

THE HARTFORD
INSURER
RESPONDENTS-APPELLEES

APPEARANCES:

The claimant filed the appeal on her own behalf. Claimant was formerly represented by David Morrissey, Esq., Morrissey, Morrissey and Mooney, 203 Church Street, PO Box 31, Naugatuck, CT 06770.

The respondents were represented by Tushar G. Shah, Esq., Montstream & May, LLP, 655 Winding Brook Drive, PO Box 1087, Glastonbury, CT 06033-6087.

This Petition for Review from the March 13, 2015 Finding & Decision of Charles F. Senich the Commissioner acting for the Fourth District was heard September 25, 2015 before a Compensation Review Board panel consisting of Commissioners Stephen M. Morelli, Christine L. Engel and Daniel E. Dilzer.

OPINION

STEPHEN M. MORELLI, COMMISSIONER. The claimant, Cynthia Zbras, has appealed from a Finding & Decision reached by Commissioner Charles F. Senich which directed the claimant to reimburse the respondent-insurer, The Hartford, $133,806.44 for medical expenses in an accepted claim for what now they argue was unauthorized medical treatment. She argues that respondents do not have the statutory authority under Chapter 568 to seek reimbursement of this expense and should be seeking to address this through civil litigation. She also argues that the respondents are somehow estopped from contesting this treatment once they advanced payment for it. We do not find either parties' legal arguments persuasive in this matter, although for differing reasons. After reviewing the totality of the record we conclude that the Finding & Decision is unsupported by probative evidence on the record. We also find the statutory authority cited by the respondents is inapplicable to the situation presented in this case. Therefore, we determine Order, ¶ 1 in the Finding & Decision must be vacated and we dismiss the respondents bid for reimbursement.

The following facts are relevant to our analysis of this appeal. As the trial commissioner explained in a January 9, 2012 Finding and Decision (hereinafter "2012 Decision") the claimant suffered a compensable injury to her right arm and wrist on or about August 14, 2000. She has treated since that time and was eventually referred to a pain management doctor, Terrence Brennan, M.D. Dr. Brennan diagnosed the claimant with reflex sympathy dystrophy (RSD) and prescribed numerous medications to the claimant to treat her pain. On November 20, 2003, Dr. Brennan prescribed Actiq in an attempt to control the claimant's pain. Actiq is a lollypop containing Fenantyl, which is

an extremely powerful narcotic. In December 2008 Dr. Brennan reported that he had reduced the claimant's frequency of Actiq lollypops with a goal to gradually wean her off Actiq by June 1, 2009. He also indicated the possibility of referring the claimant to a center to assist the claimant with opioid withdrawal. A formal hearing was held on January 20, 2009, and a stipulated agreement of the parties states that the claimant is to wean herself off of Actiq by June 1, 2009. January 20, 2009 Transcript (hereinafter "2009 stipulated agreement").

This did not occur. While the terms of the 2009 stipulated agreement did not require the respondents to pay for Actiq after June 1, 2009 and placed the burden on the claimant to prove this treatment was reasonable, the respondents continued to pay for Actiq prescriptions. Our review of the file indicates that after June 1, 2009 the respondents did not file a subsequent Form 43 until April 11, 2012, wherein they alleged the claimant had been overpaid for unauthorized treatment. At the formal hearing Commissioner Senich held prior to the 2012 Decision the claimant testified that she and Dr. Brennan never discussed weaning her off Actiq completely nor had they discussed inpatient detoxification. After considering Dr. Brennan's opinion as well as that of the commissioner's examiner, Dr. David Kost, 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. Commissioner Senich further determined "[g]iven all the prior medical reports and agreements entered into in regard to the prescription drug Actiq, I do not find that Dr. Brennan explained, based upon a reasonable medical basis, as to why the Claimant is still being prescribed Actiq." Conclusion, ¶ 6, 2012 Decision. As a result the claimant's request for authorization of Actiq was denied and dismissed.

The present dispute emanates from a Finding & Decision issued March 13, 2015 (hereinafter "2015 Decision") following formal hearings held on October 30, 2013 and July 30, 2014. A variety of issues were cited to be determined, including alleged reimbursements due to the respondent-insurer for overpayments, reimbursement to the claimant for out of pocket costs and medical treatment. Commissioner Senich noted the terms of the 2009 stipulated agreement, including that "[o]n January 20, 2009 it was agreed that the claimant would be weaned off Actiq by June 1, 2009." Findings, ¶ 5, 2015 Decision. The commissioner also noted the respondent-insurer continued to pay for the claimant's Actiq up until August 26, 2010. Id., Findings, ¶ 6. The trial commissioner reached factual findings on other issues which are not the subject of this appeal. On the issue of reimbursing the respondents for Actiq prescriptions, the trial commissioner relied upon this representation by claimant's former counsel, "[i]t shall be the claimant's burden to prove why any alteration or non-compliance is reasonable and necessary. I don't believe that it would be required of the respondent to file any further documentation; it would be our burden of proof." Findings, ¶ F.

Since the claimant failed to wean herself off Actiq in accordance with the January 20, 2009 agreement, the trial commissioner determined The Hartford was entitled to reimbursement in the amount of $133,806.44. The claimant filed a Motion to Correct. The gravamen of her Motion to Correct was that her Actiq use was reasonable and necessary medical treatment. The trial commissioner denied this motion and the claimant pursued this instant appeal. Her argument on appeal is that the respondents had a "moral and legal duty" to pay for her Actiq prescriptions. She also argues that the respondents had no means to recover medical expenses they advanced pursuant to § 31-294c(b)

C.G.S. and that the respondents only viable option for restitution was some form of civil action in Superior Court. She also argues that the respondents were somehow estopped from contesting payment for these medications after initially honoring payment for these prescriptions.

The respondents argue that the claimant is incorporating numerous arguments on appeal which were previously heard and found unpersuasive by the trial commissioner. They argue in their brief that it is solely a factual question whether they are entitled to reimbursement, and the trial commissioner resolved that issue in their favor. They also argue that § 31-294c(b) C.G.S. provides statutory authority for recoupment of unauthorized medical expenses that the insurer has paid, citing Sellers v. Sellers Garage, Inc., 4391 CRB-5-01-5 (April 26, 2002), *aff'd*, 80 Conn. App. 15, *cert. denied*, 267 Conn. 904 (2003).

On appeal, we generally extend deference to the decisions made by the trial commissioner. "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). Nonetheless, we may reverse such a decision if the commissioner did not properly apply the law or reached a decision unsupported by the evidence on the record. Christensen v. H & L Plastics Co., Inc., 5171 CRB-3-06-12 (November 19, 2007).

While we are not persuaded by the claimant's legal arguments, we still must review the Finding & Decision for compliance with the standards delineated under Christensen, supra. Having done so, we are unsatisfied with both the factual

underpinnings and the statutory rationale which the trial commissioner relied upon, and which respondents' counsel seeks us to adopt by affirming this decision. The respondents claim that they "paid without prejudice" for the medical treatment at issue. We find no evidence on the record that this was communicated to the claimant, and at best, it is a legal interpretation reached by respondents' counsel as to the facts on the record. As noted herein, the first Form 43 contesting this treatment occurred on April 11, 2012, after the treatment had ended. Moreover, the statute cited by the respondents, § 31-294c(b) C.G.S does not apply to a case where compensability is not contested and a respondent has withdrawn their Form 43's on the record.

The respondents' argument before the trial commissioner at the hearing for the 2015 Decision and before this tribunal has focused on their position that once the time period for weaning the claimant off Actiq in the 2009 stipulated agreement ended, further payment for this medication was on a "payment without prejudice" basis. The record herein does not include any contemporaneous communication to the claimant documenting that was the position of the respondents, nor any statement from a trial commissioner on the record during 2009 or 2010 advising the claimant that this was the respondents' position. The sole source for this position is an argument on page 10 of respondents' trial brief, dated January 23, 2014, which does not cite any documentary evidence or testimony. Our review of the October 30, 2013 and July 30, 2014 hearing transcripts also indicates no witness from the respondents testified as to this point.[1] As noted in Christensen, supra, "our appellate review must consider whether the facts found are supported by competent evidence."

[1] This case therefore is similar to Stiber v. Marks Total Security, 5479 CRB-4-09-7 (July 8, 2010), where we concluded a statement from counsel was the sole evidence on the record regarding an issue in a Finding.

Indeed, there is a lack of any documentary or testimonial evidence from the carrier as to the reason why they did not exercise their rights under the 2009 stipulated agreement to deny the claimant's Actiq prescriptions after June 1, 2009. The 2015 Decision provides no finding of fact as to the respondents' conduct, and in the absence of any probative evidence on the record, this was not an oversight by the trial commissioner. The only evidence cited in the 2015 Decision that supports the respondents' position on this issue relies on Finding, ¶ D, i.e. that the claimant was put on notice by the respondents having filed numerous Form 43's that they were contesting the use of Actiq. We do not find this a reasonable inference from the evidence on the record. The 2009 stipulated agreement acted to supersede whatever representations that preceded that event. That stipulated agreement made the use of Actiq reasonable and necessary medical care for a time and provided a mechanism for the claimant to continue its use, and for the respondents to discontinue its approval. Neither party exercised their rights under the 2009 stipulated agreement and the respondents offered no probative evidence at the formal hearing for the 2015 Decision justifying their actions. The post-2009 Form 43 contesting treatment post dated the treatment having been provided and the respondents having paid for it. Since the trial commissioner granted the respondents relief based on representations that predated the 2009 stipulated agreement, we determine the 2015 Decision lacks sufficient evidential foundation.[2]

[2] We note that that at the October 30, 2013 formal hearing counsel for the respondents advised the issue under discussion was "the enforcement of a stipulated judgment that was entered on the record before Commissioner Salerno on January 20, 2009. That stipulated judgment served as the resolution of several Forms 43 filed by my client in 2008." October 30, 2013 Transcript, p. 6. We reviewed the 2009 stipulated agreement and note that it contains representations both from the claimant *and* the respondents that they would act in a manner to wean the claimant off Actiq within six months. As respondents' counsel stated to Commissioner Salerno "[a]nd just so it's clear, I will be instructing my client that *as of June 1st they will not pay for* ***any*** *additional Actiq prescriptions* ***unless ordered to do so by a commissioner*** *after a formal hearing.*" (Emphasis added.) January 20, 2009 Transcript, pp. 9-10. While the respondents failed to adhere

As we review the totality of the facts as presented on the record, the circumstances herein are akin to a matter of mistake. Our precedent in cases such as Krol v. A.V. Tuchy, Inc., 5562 CRB-4-10-6 (June 1, 2011), *aff'd,* 135 Conn. App. 854 (2012), *cert. denied*, 305 Conn. 923 (2012) and Macon v. Colt's Manufacturing, 5505 CRB-1-09-10 (September 27, 2010), *appeal dismissed*, A.C. 32785 (December 13, 2010), stands for the principle that a unilateral mistake cannot justify reopening a prior agreement in order to offer a party relief. In the present case, the evidential record is inadequate for a finding of "mutual mistake" taking this matter beyond the agreement reached in the 2009 stipulated agreement. Our review of the 2009 stipulated agreement indicates it did not clearly specify that the relief reached in the 2015 Decision was appropriate. The 2015 Decision thus is inadequately supported by evidence and the prior "law of the case."[3] In a case involving a respondent seeking reimbursement of allegedly overpaid indemnity benefits,

Gibson v. State/Department of Developmental Services-North Region, 5422 CRB-2-09-2 (January 13, 2010), we made clear "[t]he respondent was the moving party on the issue of

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to that representation, they argue that they still should obtain reimbursement from the claimant for "unauthorized medical treatment." However, we also note that until the 2012 Decision there was no decision in the record determining that Actiq was not reasonable or necessary medical treatment for the claimant. The respondents appear to argue that the 2012 Decision should be given retroactive effect to the period in 2009 and 2010 where they provided Actiq. We have been provided with no precedent from respondents' counsel wherein such a decision may be accorded retroactive effect.

[3] We are perplexed as to why the respondents did not seek to press the issue of reimbursement from the claimant for the allegedly unauthorized Actiq prescriptions at the hearings culminating in the 2012 Decision. Based on the April 11, 2012 Form 43 the respondents were aware of the cost of such prescriptions and could have raised this matter in those proceedings. The precedent in Kalinowski v. Meriden, 5028 CRB-8-05-11 (January 24, 2007) indicates this Commission may deny relief to a litigant who sleeps on their rights and does not present a claim in a timely fashion. Since the claimant in this matter did not advance a laches defense at the formal hearing herein, we shall not decide this matter on those grounds.

overpayment and had the burden of persuasion on this issue." It is not clear from the record how this burden was met by the respondents.

This is an accepted claim and therefore in light of the 2009 stipulated agreement regarding claimant's use of Actiq after June 1, 2009, there is a reasonable inference that can be made that as claimant's treater continued to prescribe Actiq after June 1, 2009, claimant's treater deemed such continued use reasonable and necessary, and the respondent's continued payment for Actiq despite having no obligation to do so per the 2009 stipulated agreement, is an indication that respondents either did not dispute, or did not choose to dispute, the treater's opinion at that time. In fact, there is nothing in the record which indicates that respondents' position that claimant's continued use of Actiq was NOT reasonable and necessary until the filing of a Form 43 on April 11, 2012, and that issue was not adjudicated until January 9, 2012, well after the period for which respondents now claim rights of reimbursement (June 1, 2009 – August 26, 2010). Under these circumstances and without any evidence on the record which sufficiently characterizes why respondents continued to pay for the Actiq after June 1, 2009, there is no statutory basis by which respondents can now claim reimbursement. Additionally, in an accepted claim, respondents' payment for the claimant's use of Actiq after June 1, 2009, in light of the above fact pattern, acts as a waiver of respondents' claim for reimbursement.

In addition, we do not find the respondents reliance on § 31-294c(b) C.G.S.[4] as statutory grounds for reimbursement tenable. Section 31-294c(b) C.G.S. is entitled

[4] This statute reads as follows. The relevant section is in *italics.*
"(b) Whenever liability to pay compensation is contested by the employer, he shall file with the commissioner, on or before the twenty-eighth day after he has received a written notice of claim, a notice in accord with a form prescribed by the chairman of the Workers' Compensation Commission stating that the

"**Notice of Claim for Compensation**" and it is applicable at the inception of a claim. The section respondents cites herein regarding a "payment without prejudice" period is aligned in the statute with circumstances where a claim has been denied by the respondent, or the respondent is exercising their "safe harbor" rights against preclusion by advancing medical treatment or indemnity benefits. The respondents are not contesting compensability of the claimant's injury at this time and the "safe harbor" investigatory period has long expired. Therefore, we can distinguish this on the facts from Sellers, supra. In Sellers, the respondents clearly had contested liability via a Form 43 before advancing payment for medical treatment on "without prejudice" basis.[5] We held they did not have to file a Form 36 before terminating such payments and had the right to pay without prejudice after the filing of their Form 43. At the hearing for the

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right to compensation is contested, the name of the claimant, the name of the employer, the date of the alleged injury or death and the specific grounds on which the right to compensation is contested. The employer shall send a copy of the notice to the employee in accordance with section 31-321. 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, provided the employer shall not be required to commence payment of compensation when the written notice of claim has not been properly served in accordance with section 31-321 or when the written notice of claim fails to include a warning that (1) the employer, if he has commenced payment for the alleged injury or death on or before the twenty-eighth day after receiving a written notice of claim, shall be precluded from contesting liability unless a notice contesting liability is filed within one year from the receipt of the written notice of claim, and (2) the employer shall be conclusively presumed to have accepted the compensability of the alleged injury or death unless the employer either files a notice contesting liability on or before the twenty-eighth day after receiving a written notice of claim or commences payment for the alleged injury or death on or before such twenty-eighth day. *An employer shall be entitled, if he prevails, to reimbursement from the claimant of any compensation paid by the employer on and after the date the commissioner receives written notice from the employer or his legal representative, in accordance with the form prescribed by the chairman of the Workers' Compensation Commission, stating that the right to compensation is contested.* Notwithstanding the provisions of this subsection, an employer who fails to contest liability for an alleged injury or death on or before the twenty-eighth day after receiving a written notice of claim and who fails to commence payment for the alleged injury or death on or before such twenty-eighth day, shall be conclusively presumed to have accepted the compensability of the alleged injury or death."

[5] As noted in footnote 2, herein, in the present case counsel for the respondents affirmatively represented all the pending Form 43s had been resolved at the hearing for the 2009 stipulated agreement. See October 30, 2013 Transcript, p. 6.

2009 stipulated agreement Commissioner Salerno stated as to the various Form 36s filed by the respondents that "all these Form 36s are denied with the caveat that the Respondent . . . [could] use [them] . . . to file a future Form 36. January 20, 2009 Transcript, pp. 5-6. The commissioner also stated "[w]e have resolved the Form 36 issues with the multiple Form 36s, and at this time *we have now resolved the medical treatment aspect* as our agreement stands today." Id., p. 11 (Emphasis added.)

This is not a circumstance within the scope of § 31-294c(b) C.G.S. where a respondent unilaterally advances payment for medical treatment without prejudice and then contests the necessity or reasonableness of that treatment, or the treatment's link to a compensable injury. The parties reached a stipulated agreement as to the claimant's medical treatment which was approved by a trial commissioner. That was not "payment without prejudice" as described by the statute; it was "payment subject to an agreement with the trial commissioner" as the trial commissioner specifically stated that in the 2009 stipulated agreement, *"we have now resolved the medical treatment aspect"* of the claim. Id. In addition, at the time of the 2009 stipulated agreement the claimant's treater deemed Actiq "reasonable and necessary." Therefore, we do not find the statute cited by the respondents, or the precedent in Sellers compels us to affirm the 2015 Decision.[6]

In considering the impact of this decision, we note that we do not want this case to establish a precedent that when an insurance carrier represents to a trial commissioner that they will wean a claimant off the excessive use of an opioid they then can obtain reimbursement from the claimant when this does not occur. While the 2009 stipulated agreement originally placed the onus for authorizing further treatment on the claimant,

[6] We note also respondents' counsel at page 6 of his brief concedes that there is no precedent from appellate courts or this tribunal supporting his interpretation of this statute.

the respondents inarguably waived their defense to further treatment when they authorized it, in derogation of their representations to the trial commissioner.

As an appellate panel this tribunal may not retry the facts of the case. However, we must review the ultimate conclusion reached by a trial commissioner as to whether it complies with the law, our public policy, and the evidence on the record. See Christensen, supra. See also Dudley v. Radio Frequency Systems, 4995 CRB-8-05-9 (July 17, 2006).

> The scope of review of a trial court's factual decision on appeal is limited to a determination of whether it is clearly erroneous in view of the evidence and pleadings. . . . Conclusions are not erroneous unless they violate law, logic or reason or are inconsistent with the subordinate facts. . . 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. (Citations omitted; internal quotation marks omitted.) citing Moutinho v. Planning and Zoning Commission, 278 Conn. 660, 665-666 (2006).

We believe after reviewing the record and the legal arguments advanced that it was erroneous for the 2015 Decision to order the claimant to reimburse the respondents for fentanyl prescriptions the respondents chose to provide and therefore, we have a "definite and firm conviction that a mistake has been committed." Dudley, supra. Accordingly, we determine that Order, ¶ 1 in the March 13, 2015 Finding & Decision must be vacated and the respondents' claim for reimbursement must be dismissed.

Commissioners Christine L. Engel and Daniel E. Dilzer concur in this opinion.