CASE NO. 6132 CRB-4-16-9 : COMPENSATION REVIEW BOARD
CLAIM NO. 400077977

LAVERNE E. JOHNSON
CLAIMANT-APPELLANT : WORKERS' COMPENSATION COMMISSION

v.

: AUGUST 21, 2017

STATE OF CONNECTICUT/
JUDICIAL DEPARTMENT/
JUVENILE DETENTION CENTER
EMPLOYER
SELF-INSURED
RESPONDENT-APPELLEE

and

GALLAGHER BASSETT SERVICES
ADMINISTRATOR

APPEARANCES:

The claimant was represented by John J. D'Elia, Esq., D'Elia, Gillooly, DePalma, L.L.C., Granite Square, 700 State Street, New Haven, CT 06511.

The respondents were represented by Joy L. Avallone, Assistant Attorney General, Office of the Attorney General, 55 Elm Street, P.O. Box 120, Hartford, CT 06141-0120.

This Petition for Review from the August 15, 2016 Finding and Dismissal of Michelle D. Truglia, the Commissioner acting for the Fourth District, was heard February 17, 2017 before a Compensation Review Board panel consisting of the Commission Chairman John A. Mastropietro and Commissioners Christine L. Engel and Daniel E. Dilzer.

OPINION

JOHN A. MASTROPIETRO, CHAIRMAN. This case involves a circumstance wherein the claimant presented a dispute to this commission regarding a medical care plan authorized under § 31-279(c) and § 31-279(d) C.G.S.,[1] yet neither the claimant nor the respondent submitted into the record the only documentary evidence that was relevant to the dispute. In the absence of having the utilization review decision denying the claimant's surgery submitted as evidence, the trial commissioner dismissed the claim. The claimant has appealed, arguing that she was entitled to a *de novo* review of the decision, which the trial commissioner's evidentiary rulings thwarted. The respondent

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[1] Section 31-279(c) C.G.S. (Rev. to 2009) states: "(1) Any employer or any insurer acting on behalf of an employer, may establish a plan, subject to the approval of the chairman of the Workers' Compensation Commission under subsection (d) of this section, for the provision of medical care that the employer provides for treatment of any injury or illness under this chapter. Each plan shall contain such information as the chairman shall require, including, but not limited to:
(A) A listing of all persons who will provide services under the plan, along with appropriate evidence that each person listed has met any licensing, certification or registration requirement necessary for the person to legally provide the service in this state;
(B) A listing of all pharmacies that will provide services under the plan, to which the employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall make direct payments for any prescription drug prescribed by a physician participating in the plan;
(C) A designation of the times, places and manners in which the services will be provided;
(D) A description of how the quality and quantity of medical care will be managed; and
(E) Such other provisions as the employer and the employees may agree to, subject to the approval of the chairman.
(2) The election by an employee covered by a plan established under this subsection to obtain medical care and treatment from a provider of medical services who is not listed in the plan shall suspend the employee's right to compensation, subject to the order of the commissioner."

Section 31-279(d) C.G.S. (Rev. to 2009) states: "Each plan established under subsection (c) of this section shall be submitted to the chairman for his approval at least one hundred twenty days before the proposed effective date of the plan and each approved plan, along with any proposed changes therein, shall be resubmitted to the chairman every two years thereafter for reapproval. The chairman shall approve or disapprove such plans on the basis of standards established by the chairman in consultation with a medical advisory panel appointed by the chairman. Such standards shall include, but not be limited to: (1) The ability of the plan to provide all medical and health care services that may be required under this chapter in a manner that is timely, effective and convenient for the employees; (2) the inclusion in the plan of all categories of medical service and of an adequate number of providers of each type of medical service in accessible locations to ensure that employees are given an adequate choice of providers; (3) the provision in the plan for appropriate financial incentives to reduce service costs and utilization without a reduction in the quality of service; (4) the inclusion in the plan of fee screening, peer review, service utilization review and dispute resolution procedures designed to prevent inappropriate or excessive treatment; and (5) the inclusion in the plan of a procedure by which information on medical and health care service costs and utilization will be reported to the chairman in order for him to determine the effectiveness of the plan."

argues that although the claimant appealed the denial of her claim for surgery, her failure to submit the actual decision into evidence negated its obligation to present this evidence. Upon review, while we are frustrated that the formal hearing did not result in a decision on the merits, we conclude that the trial commissioner was not provided with a record from the underlying proceeding that would have enabled her to determine whether the denial of medical treatment was "unreasonable, arbitrary or capricious" as per Admin. Reg. § 31-279-10(f) C.G.S.[2] We conclude that Admin. Reg. §§ 31-279-10(e) and (f) C.G.S. place the burden of persuasion upon the claimant, and as the record presented did not present a *prima facie* case that the respondent was in violation of the statute, the trial commissioner had no choice but to dismiss this claim.[3]

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[2] Admin. Reg. § 31-279-10(f) C.G.S. (Rev. to 2009) states: "The necessity and appropriateness of medical and health care services recommended by providers of a medical care plan shall not be subject to review by a Workers' Compensation Commissioner until the plan's utilization review and dispute resolution review and appeal procedures, as described in subsection (e) have been exhausted. The decision of the chief executive officer of the plan relating to payment for such medical and health care services shall be subject to modification only upon showing that it was unreasonable, arbitrary or capricious."

[3] Admin. Reg. § 31-279-10(e) C.G.S. (Rev. to 2009) states: "(e) Each medical care plan shall include provision for both a service utilization review providing a method to evaluate the necessity and appropriateness of medical and health care services recommended by a provider, and a means of dispute resolution if payment for such medical and health care services is denied. Such service utilization review and dispute resolution shall include, at a minimum, the following review and appeal procedures:
(1) Initiation of a review by any one or more of the following parties: the employee, the provider, the employer, or the medical care plan itself, either directly or through a utilization review contractor. If a party other than the plan initiates the review, such party shall supply to the plan all information in its possession which is relevant to the review. The plan may also request such information as it deems necessary to conduct the review.
(2) Upon receipt of all proffered and requested information, the plan shall review such recommended treatment, utilizing written clinical criteria which have been established by the plan and periodically evaluated by appropriate providers of medical and health care services required under Chapter 568 of the Connecticut General Statutes.
(3) Not more than two (2) business days after receipt of all such information, the plan shall provide written notice to the provider and employee of its determination regarding the recommended treatment. Any written notice of a determination not to certify an admission, service, procedure or extension of stay shall include the reasons therefore and the name and telephone number of the person to contact with regard to an appeal. The provider and the employee shall also be provided with a copy of the written review and appeal procedures.
(4) The provider or the employee may, within fifteen (15) days of the written notice of determination, notify the plan of his or her intent to appeal a determination to deny payment for the recommended treatment.

The circumstances of the present matter are recounted in the trial commissioner's August 15, 2016 Finding and Dismissal. The sole issue was whether the decision of the respondent's utilization review committee to deny the claimant's requested left shoulder surgery was "unreasonable, arbitrary or capricious." The commissioner took administrative notice of a voluntary agreement approved by the Commission on May 20, 2010, and noted that the parties agreed to bifurcate the proceedings and address a Form 36, filed on April 13, 2016, relative to whether the claimant could return to regular duty work, separately. The record closed on the day of the formal hearing, August 15, 2016. At that hearing, the claimant refused to enter into evidence the relevant utilization review decision, which she complains was either unreasonable, arbitrary, or capricious, or any supporting medical documentation, on the grounds that the decision favored only the respondent's position. The claimant attempted to introduce additional evidence supportive of her claim which was outside the utilization review procedure, and the

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(5) Upon such appeal, the plan shall provide, at the request of the employee or provider, a practitioner in a specialty relating to the employee's condition for the purpose of reviewing the plan's initial decision.
(6) Within fifteen (15) days of the request for such review and submission of any further documentation regarding the review, the reviewing practitioner shall submit his opinion regarding such recommended treatment to the medical director of the medical care plan who shall, within fifteen (15) days thereafter, render a written decision regarding such treatment.
(7) The employee, the provider or the employer may request a further review of the medical director's written decision; such request for further review shall be in writing and shall be submitted to the chief executive officer of the medical care plan within fifteen (15) days of the medical director's written decision. The party requesting further review shall have an opportunity for a hearing if such party requests it in writing and may, at such party's expense, produce whatever written support or oral testimony it wishes at any such hearing. Such hearing shall be conducted within fifteen (15) days of the written request therefore. The chief executive officer of the medical care plan shall make any final determination of such request for further review and may utilize an advisory committee to assist him in his determination. The chief executive officer shall issue a final written decision on the request for further review as soon as practical but, in any event, within thirty (30) days of the later of the date of submission of the written request for such review or the date of conclusion of the hearing requested as part of such review.
(8) In the case of an emergency condition, an employee or his representative shall be provided a minimum of twenty-four (24) hours following an admission, service or procedure to request certification and continuing treatment for that emergency condition before a utilization determination is made. If a determination is made not to provide such continuing treatment and the employee or his representative, the provider, or the employer requests a review of such determination, an expedited review shall be conducted by the medical director and a final decision rendered within two (2) days of the request for review."

respondent filed a timely objection. The trial commissioner sustained the objection. In light of the fact that the claimant put no evidence into the record, the respondent declined to offer any evidence of its own. Based on this record, the trial commissioner concluded as follows:

> A. The objections by respondents to the submission of testimonial and documentary evidence outside of the Utilization Review committee record sought to preclude the introduction of evidence at the present trial based upon the fact that such evidence could have been presented by the claimant to the Utilization Review committee during the pendency of her appeal, but was not, and that it is prejudicial to the Utilization Review process to challenge its decision based on testimonial and documentary evidence it never saw or heard prior to the rendering of its final decision.
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> B. The claimant has not met her burden of showing that the decision rendered by the respondent's Utilization Review committee was either unreasonable, arbitrary or capricious, principally on the grounds that she has submitted no evidence in support of her claim.

August 15, 2016 Finding and Dismissal.

The trial commissioner dismissed the claim. The claimant filed a Motion to Correct, seeking to replace the findings with findings supportive of a conclusion that the respondent's utilization review process was inadequate. The trial commissioner denied this motion in its entirety and the claimant has pursued this appeal.

The gravamen of the claimant's appeal is that the trial commissioner failed to hold a *de novo* proceeding relative to the propriety of the respondent's utilization review process, instead choosing to focus on whether the record generated, as a result of that process, comported with the requirements of our statute and our regulations. As the claimant views the statute, she had the right to proceed to seek approval for medical treatment from the commissioner in exactly the same manner as if there had been no medical care plan in effect. She cites the decision in Figueroa v. Rockbestos Co.,

4633 CRB-1-03-2 (July 20, 2004), as authority for this position. We have reviewed Figueroa and are not persuaded by this argument.

In Figueroa, the respondent appealed from a trial commissioner's decision reversing a determination pursuant to a utilization review process that the claimant should be denied surgery. In reaching that decision, the trial commissioner considered evidence outside the record which had been presented to the respondent's chief executive officer, who made the final decision to deny surgery. We ordered the matter remanded, noting in part:

> We also cannot tell how much weight, if any, the trier placed on the additional evidence that was not before the CEO at the time of his decision. Therefore, we believe that this matter should be remanded to the trial commissioner for a reconsideration of his conclusion that the CEO's denial of surgery was unreasonable. We note that, on remand, the trier must limit his consideration of medical evidence to the reports and data that were previously submitted to Borgia in determining whether his denial of surgery was reasonable.

Id.

The claimant in this case argues that it was error for the trial commissioner to refuse to admit evidence which the claimant had not presented during the utilization review process. The precedent established by Figueroa indicates that had the trial commissioner admitted this evidence, it would have gone beyond the scope of what the formal hearing on this issue should have considered, which was whether the decision reached by the respondent on the record presented in its review, was unreasonable, arbitrary or capricious. In Figueroa, the Compensation Review Board engaged in a detailed examination of the text of the regulations governing the utilization review

process, and determined that a trial commissioner was essentially bound to consider only the record generated in the proceedings held by the medical care plan.

> By allowing modification of a CEO's decision regarding payment for recommended treatment only upon a showing that the decision was unreasonable, arbitrary or capricious, the drafters of Admin. Reg. § 31-279-10 presumably intended to grant substantial deference to the decisionmaker. The claimant nonetheless contends that the language of § 31-279-10(f) may not abridge a trial commissioner's power to exercise his traditional factfinding authority over the credibility of the medical evidence in a workers' compensation case. Although the regulation seems to allocate that factfinding authority to the medical plan's CEO as part of the dispute resolution process, the claimant argues that allowing such an individual to act as the ultimate factfinder concerning medical treatment would defeat the humanitarian purpose of the Workers' Compensation Act by substituting an interested party for an impartial judge.

Id.

The Appellate Court reached a similar decision in its sole opinion considering this statute, Byrd v. Bechtel/Fusco, 90 Conn. App. 641 (2005). In that case, the plaintiff sought a review of the entire utilization review process of the plan managed by the respondent's plan administrator. The commissioner determined that he lacked the jurisdiction to consider the claims presented by the claimant. The Appellate Court affirmed that decision, stating that "the commissioner does not have jurisdiction to hear the [claimant's] claims regarding alleged improprieties in the administration of the managed care plan." Id., 648.

We note that in a case where a managed care plan is not involved and an insurance carrier fails to authorize surgery or other treatment, it is the claimant who is the moving party before our Commission to demonstrate that the treatment sought is

reasonable or necessary as defined by § 31-294d(a)(1) C.G.S.[4] See Cervero v. Mory's Assn., Inc., 122 Conn. App. 82 (2010), *cert. denied*, 298 Conn. 908 (2010). Our review of the regulations herein does not suggest that the burden of persuasion has been shifted to the respondent under managed care plans.

Figueroa does stand for the proposition that our review cannot go beyond the scope of the record the parties generated during the utilization review process. In some ways, this can be compared to the process a trial commissioner must utilize subsequent to granting a claimant preclusion pursuant to § 31-294c(b) C.G.S.[5] In preclusion cases, the trial commissioner must determine if the claimant's evidence as to causation establishes a

[4] Section 31-294d(a)(1) C.G.S. (Rev. to 2009) states, in pertinent part: "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."

[5] Section 31-294c(b) C.G.S. (Rev. to 2009) states: "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 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."

prima facie case for benefits. See Wilson v. Capitol Garage, Inc., 6109 CRB-2-16-6 (May 16, 2017), *citing* Donahue v. Veridiem, Inc., 291 Conn. 537 (2009). If the record of the utilization review process yields an outcome which is not unreasonable, arbitrary or capricious, the decision, as per Admin. Reg. § 31-279-10(f), should be upheld.

While the trial commissioner had the obligation, pursuant to Byrd and Figueroa, to ascertain whether the manner in which the managed care plan was administered in the instant case was unreasonable, arbitrary or capricious, we note that in the absence of any evidence presented by the claimant, the commissioner could not meet that obligation. Although the respondent, whose judgment had been questioned in this matter, had an opportunity to vindicate its actions and the interest in vindicating its actions, it chose not to present the single piece of evidence, the record of the utilization review appeal, which would have established that its decision was reasonable. Our holding in Figueroa speaks to providing due process to both parties in disputes before our tribunal.[6] When relevant

[6] We look to the following sections of Figueroa v. Rockbestos Co., 4633 CRB-1-03-2 (July 20, 2004) for guidance: "We remind the claimant that, as an administrative review body, this board lacks the authority to hold that § 31-279-10(f) is invalid based on constitutional principles of due process. Insofar as the regulation sets forth a standard of review, we must apply it as written. However, our inability to adjudicate the constitutionality of laws does not obscure our awareness of due process issues in our efforts to apply those laws. See Melendez v. Valley Metallurgical, 4178 CRB-2-00-1 (May 1, 2001). An injured worker has a substantial interest in obtaining medical treatment for a work-related injury, and our Workers' Compensation Act is designed to protect that right. Giaimo v. New Haven, 257 Conn. 481, 512 (2001), citing Mathews v. Eldridge, 424 U.S. 319, 335 (1976). Due process concepts therefore remain relevant, especially when one considers that the terms 'unreasonable,' 'arbitrary' and 'capricious' are by definition vague terms that refer to decisions made in the absence of due process…. It follows that a commissioner must be able to review the decision of a medical care plan in order to ensure that clearly erroneous factual findings are corrected, and the correct legal standards have been applied. See Giaimo, supra (due process required commissioner to be able to review medical panel decision to correct clear factual errors and mistakes of law).

Unlike a hearing before an impartial government body whose procedures are designed by law to protect the rights of both parties; see, e.g., Rosado v. Bridgeport Roman Catholic Diocesan Corp., 77 Conn. App. 690, 713 (2003)(procedural due process guarantees fundamental fairness); the dispute resolution process set forth in Admin. Reg. § 31-279-10(e) involves decision making by both agents of the medical care plan and private, for-profit utilization review companies. The presumption of impartiality that accompanies a governmental decision is therefore absent under the regulatory process. Accordingly, it falls on the trial commissioner and this agency to scrutinize the dispute resolution review process that the medical care plan

evidence is withheld from consideration due to tactical considerations, it can result a situation in which the ultimate outcome does not comport with the spirit of our statutes, especially § 31-278 C.G.S.[7] and § 31-298 C.G.S.[8]

We also note that the claimant's strategy in the present case yielded an unfavorable result, and the trial commissioner's decision on evidentiary issues, while consistent with the holding in Figueroa, kept evidence the claimant deemed relevant out of the record. However, as an appellate panel, we may not intercede on that issue at this juncture. We find our precedent in Barichko v. State/Department of Transportation, 5813

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has followed in determining whether a medical care plan's decision is unreasonable, arbitrary or capricious." (Internal citation omitted.)

[7] Section 31-278 C.G.S. (Rev. to 2009) states, in pertinent part: "Each commissioner shall, for the purposes of this chapter, have power to summon and examine under oath such witnesses, and may direct the production of, *and examine or cause to be produced or examined, such books, records, vouchers, memoranda, documents, letters, contracts or other papers in relation to any matter at issue as he may find proper*, and shall have the same powers in reference thereto as are vested in magistrates taking depositions and shall have the power to order depositions pursuant to section 52-148. He shall have power to certify to official acts and shall have all powers necessary to enable him to perform the duties imposed upon him by the provisions of this chapter. Each commissioner shall hear all claims and questions arising under this chapter in the district to which the commissioner is assigned and all such claims shall be filed in the district in which the claim arises, provided, if it is uncertain in which district a claim arises, or if a claim arises out of several injuries or occupational diseases which occurred in one or more districts, the commissioner to whom the first request for hearing is made shall hear and determine such claim to the same extent as if it arose solely within his own district." (Emphasis added.)

[8] Section 31-298 C.G.S. (Rev. to 2009) states: "Both parties may appear at any hearing, either in person or by attorney or other accredited representative, and no formal pleadings shall be required, beyond any informal notices that the commission approves. In all cases and hearings under the provisions of this chapter, the commissioner shall proceed, so far as possible, in accordance with the rules of equity. He shall not be bound by the ordinary common law or statutory rules of evidence or procedure, *but shall make inquiry, through oral testimony, deposition testimony or written and printed records, in a manner that is best calculated to ascertain the substantial rights of the parties and carry out the provisions and intent of this chapter*. No fees shall be charged to either party by the commissioner in connection with any hearing or other procedure, but the commissioner shall furnish at cost (1) certified copies of any testimony, award or other matter which may be of record in his office, and (2) duplicates of audio cassette recordings of any formal hearings. Witnesses subpoenaed by the commissioner shall be allowed the fees and traveling expenses that are allowed in civil actions, to be paid by the party in whose interest the witnesses are subpoenaed. When liability or extent of disability is contested by formal hearing before the commissioner, the claimant shall be entitled, if he prevails on final judgment, to payment for oral testimony or deposition testimony rendered on his behalf by a competent physician, surgeon or other medical provider, including the stenographic and videotape recording costs thereof, in connection with the claim, the commissioner to determine the reasonableness of such charges." (Emphasis added.)

CRB-4-12-12 (January 13, 2014) and Gibson v. State/Department of Developmental Services-North Region, 5422 CRB-2-09-2 (January 13, 2010) applicable.

> In Gibson, we pointed out that as the respondent is the moving party on the issue of repayment of allegedly overpaid benefits, they have the burden of persuasion before this forum. Advocates for respondents in such cases should not assume that asserting a claim is the functional equivalent of proving a claim, and should endeavor to provide all necessary evidence to the trial commissioner before the record closes. Parties should not proceed under the belief this appellate body will remedy an unfavorable result resulting from an advocate's ineffective factual presentation. As the Appellate Court held in McGuire v. McGuire, 102 Conn. App. 79, 83 (2007), "[w]e have made it clear that we will not permit parties to anticipate a favorable decision, reserving a right to impeach it or set it aside if it happens to be against them, for a cause which was well known to them before or during the trial.

Barichko, supra.

In the present case, Figueroa limits the consideration at a formal hearing to the record which was presented to the respondent during the utilization review process. Consistent with our holding in Barichko, the claimant should have presented her most persuasive evidence at that forum. In any event, we further note Valiante v. Burns Construction Company, 5393 CRB-4-08-11 (October 15, 2009), stands for the proposition that our "case law has been unequivocal." Id.

> Our case law clearly states, "a trial commissioner has broad discretion to determine the admissibility of evidence, and an evidentiary ruling will not be set aside absent a clear abuse of that discretion." Lamontagne [v. F & F Concrete Corp., 5198 CRB-4-07-2 (February 25, 2008)]. Keeney v. Laidlaw Transportation, 5199 CRB-2-07-2 (May 21, 2008). See also Mosman, supra, and Vetre v. State/Dept. of Children and Youth Services, 3443 CRB-6-96-10 (January 16, 1998) which states that "[d]ecisions regarding the relevance and remoteness of evidence in workers' compensation proceedings fall solely within the discretion of the trier of fact."

Id.

We do not find that discretion was abused in this case. Nonetheless, after consideration of the totality of the circumstances, we are troubled by the implications of this situation. Our duty to rely on *stare decisis,* see Chambers v. General Dynamics/Electric Boat Division, 4952 CRB-8-05-6 (June 7, 2006), *aff'd*, 283 Conn. 840 (2007), bars us from reaching a decision in this case inconsistent with the holding of Figueroa. As we previously discussed, in cases dealing with utilization review disputes, we find parallels with cases wherein preclusion has been ordered pursuant to § 31-294c(b) C.G.S. and limits exist on the ability of parties to submit evidence. In cases under § 31-279 C.G.S., a trial commissioner cannot conduct a *de novo* inquiry as to the propriety of the respondent's medical decisions, and the claimant is barred from presenting medical opinions which challenge the decision subsequent to completion of the utilization review process. Essentially, the claimant is facing the same onerous limitations under this statute as the respondent faces once it has been precluded under § 31-294c(b) C.G.S. See Donahue, supra, and Mehan v. Stamford, 5389 CRB-7-08-10 (October 14, 2009), *aff'd*, 127 Conn. App. 619 (2011), *cert. denied*, 301 Conn. 911 (2011). The commissioner must confine his or her review to the record which is presented. The difference is that in preclusion cases, a trial commissioner may seek to complete an otherwise incomplete record. See Wilson, supra, *citing* Donahue, supra. Our analysis of the due process concerns expressed in Figueroa would suggest that a trial commissioner could conduct such an inquiry in cases under § 31-279 C.G.S.[9]

[9] We note an incongruity in our statutes which we are not, as an administrative body, in a position to address. The limitations on adding evidence to the record or challenging evidence pursuant to preclusion granted under § 31-294c(b) C.G.S. exist as a sanction to respondents for failing to present a timely response to a claim for benefits. The limitations faced by a claimant, pursuant to § 31-279 C.G.S., when challenging a utilization review decision by presenting evidence outside the proceedings, on the other hand, constitute an impediment to the claimant which bears no relation to any neglect or malfeasance. While the General

Our reasoning behind this principle is as follows. While a trial commissioner cannot conduct an independent inquiry relative to the propriety of the respondent's medical decisions under the statutory scheme embodied in § 31-279 C.G.S., we believe that the concepts of due process and fundamental fairness, as delineated in cases such as Bryan v. Sheraton-Hartford Hotel, 62 Conn. App. 733 (2001) and Passalugo v. Guida-Seibert Dairy Co., 149 Conn. App. 478 (2014), require that some mechanism exist which would enable fact finders to satisfy themselves that the record which does exist is consistent with the respondent's statutory obligation to conduct its review process in a manner that is not "unreasonable, arbitrary or capricious." As we noted in Figueroa:

> [t]he presumption of impartiality that accompanies a governmental decision is … absent under the regulatory process. Accordingly, it falls on the trial commissioner and this agency to scrutinize the dispute resolution review process that the medical care plan has followed in determining whether a medical care plan's decision is 'unreasonable, arbitrary or capricious.'

Id.

If a trial commissioner, upon reviewing the record, were to determine the respondent's supportive evidence was inconsistent or inconclusive, we believe that the trial commissioner would have the authority to seek any clarification or augmentation which would permit a fair decision to be reached. Were a commissioner to be deemed to lack that power, we believe that it would be contrary to the clear imprimatur of DiNuzzo v. Dan Perkins Chevrolet Geo, Inc., 294 Conn. 132 (2009), wherein our Supreme Court held that all decisions reached before our Commission be based on reliable, non-speculative evidence. While the General Assembly may have devised a scheme for managed care plans which bars a claimant in our forum from having the right to cross-

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Assembly clearly intended to streamline decision-making for managed care plans, we question whether it intended to place limitations on the due process rights of claimants.

examine witnesses and present evidence to contest the respondent's determination (which, pursuant to Balkus v. Terry Steam Turbine, Co., 167 Conn. 170 [1974] would exist in an ordinary claim under Chapter 568), we find no limitation under § 31-279 C.G.S. on trial commissioners' powers under § 31-298 C.G.S. to satisfy themselves that they have sufficient evidence to render a fair and just decision.

Nonetheless, in order to provide relief to the claimant in the present dispute, we would need to find that it was the respondent's obligation to present the record of the utilization review process to the trial commissioner. While presenting this documentation would have enabled the respondent to obtain a vindication on the merits, rather than essentially a mere tactical victory, we have reviewed the statute consistent with our obligations under § 1-2z C.G.S.[10] We do not find that the respondent has an affirmative obligation under the statute to justify its deliberations in utilization review decisions; rather, the burden of persuasion and the burden of presenting the record of such proceedings in a case under § 31-279 C.G.S. rests with the claimant.

Since presenting the record of the utilization review determination was the sole means available to the claimant present a *prima facie* case that the respondent was in violation of the statute, and the claimant chose not to present this record, the trial commissioner had no choice but to dismiss this claim.

We affirm the trial commissioner.

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

[10] Section 1-2z C.G.S. requires that the interpretation of a statute be confined to its "plain meaning." See Vincent v. New Haven, 285 Conn 778 (2008). Nothing in Admin. Reg. §§ 31-279-10(e) or (f) suggests that the burden of persuasion in our forum rests with the respondents.

CERTIFICATION

THIS IS TO CERTIFY THAT a copy of the foregoing was mailed this 21st day of August 2017 to the following parties:

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