CASE NO. 6207 CRB-7-17-7 : COMPENSATION REVIEW BOARD
CLAIM NO. 601059044

DEBORAH LIONETTI : WORKERS' COMPENSATION
CLAIMANT-APPELLANT COMMISSION

v. : JUNE 7, 2019

PAUL G. MESSINEO, L.L.C.
EMPLOYER

and

PROTECTIVE INSURANCE COMPANY
INSURER
RESPONDENTS-APPELLANTS

APPEARANCES:

The claimant was represented by Patrick D. Skuret, Esq., The Law Offices of Daniel D. Skuret, P.C., 215 Division Street, P.O. Box 158, Ansonia, CT 06401.

The respondents were represented by Jason M. Dodge, Esq., Strunk, Dodge, Aiken, Zovas, 200 Corporate Place, Suite 100, Rocky Hill, CT 06067.

This Petition for Review from the June 26, 2017 Finding by Michelle D. Truglia, the Commissioner acting for the Fourth District, was heard on June 29, 2018 before a Compensation Review Board panel consisting of Commission Chairman Stephen M. Morelli and Commissioners Scott A. Barton and Brenda D. Jannotta.[1]

[1] We note that five motions for extension of time and two motions for continuance were granted during the pendency of this matter.

OPINION

STEPHEN M. MORELLI, CHAIRMAN. The claimant has petitioned for review from the June 26, 2017 Finding (finding) by Michelle D. Truglia, the Commissioner acting for the Fourth District (commissioner). We find error and accordingly affirm in part and reverse in part the decision of the commissioner.

In her finding, the commissioner identified the following issues for determination: (1) whether the three-level fusion recommended by Abraham Mintz, M.D., constituted "reasonable and necessary" medical treatment; (2) whether, and the extent to which, the claimant is entitled to benefits pursuant to either General Statutes § 31-308 (a) or General Statutes § 31-308a for the period of January 28, 2010 to the date of the formal hearing(s); and (3) the amount of the moratorium to which the respondents are entitled from the proceeds of the claimant's third-party action.[2]

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[2] General Statutes § 31-308 (a) states in relevant part: "If any injury for which compensation is provided under the provisions of this chapter results in partial incapacity, the injured employee shall be paid a weekly compensation equal to seventy-five per cent of the difference between the wages currently earned by an employee in a position comparable to the position held by the injured employee before his injury … and the amount he is able to earn after the injury … except that when (1) the physician or the advanced practice registered nurse attending an injured employee certifies that the employee is unable to perform his usual work but is able to perform other work, (2) the employee is ready and willing to perform other work in the same locality and (3) no other work is available, the employee shall be paid his full weekly compensation subject to the provisions of this section. Compensation paid under this subsection shall not be more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, and shall continue during the period of partial incapacity, but no longer than five hundred twenty weeks. If the employer procures employment for an injured employee that is suitable to his capacity, the wages offered in such employment shall be taken as the earning capacity of the injured employee during the period of the employment."

General Statutes § 31-308a states in relevant part: "(a) In addition to the compensation benefits provided by section 31-308 for specific loss of a member or use of the function of a member of the body, or any personal injury covered by this chapter, the commissioner, after such payments provided by said section 31-308 have been paid for the period set forth in said section, may award additional compensation benefits for such partial permanent disability equal to seventy-five per cent of the difference between the wages currently earned by an employee in a position comparable to the position held by such injured employee prior to his injury … and the weekly amount which such employee will probably be able to earn thereafter … to be determined by the commissioner based upon the nature and extent of the injury, the training, education and experience of the employee, the availability of work for persons with such physical condition and at the employee's age, but not more than one hundred per cent, raised to the next even dollar, of the

The commissioner made the following factual findings which are pertinent to our inquiry. The claimant has pursued a claim for benefits for neck and back injuries following a motor vehicle accident which occurred on January 28, 2010, and arose out of and in the course of her employment as a residential package delivery driver. The claimant's employer was a subcontractor of Federal Express. On February 1, 2010, the respondent employer terminated the claimant's employment.

On February 3, 2010, the claimant drove herself to Griffin Hospital for treatment. The emergency room doctor prescribed medication and recommended that the claimant rest and restrict her activities. On Tuesday, February 9, 2010, the claimant sought medical treatment from Kristin Rayball, D.O., and Michael Troknya, D.O., of Physical Synergy; those doctors referred the claimant to James W. Depuy, M.D. The claimant also saw Rahul S. Anand, M.D., for pain management.

On May 6, 2013, the respondents filed a "form 36" seeking to discontinue or reduce payments based upon Anand's opinion that the claimant had reached maximum medical improvement for both her neck and back. Anand also indicated that the claimant would require "ongoing interventional procedures for work capacity and fundamental improvement." Findings, ¶ 6. On May 27, 2014, the Workers' Compensation Commission (commission) approved a voluntary agreement accepting a "chronic back pain" condition and recognizing Depuy as the claimant's treating physician. Findings, ¶ 7. The agreement memorialized a 5 percent permanent partial disability to the

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average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309. If evidence of exact loss of earnings is not available, such loss may be computed from the proportionate loss of physical ability or earning power caused by the injury. The duration of such additional compensation shall be determined upon a similar basis by the commissioner, but in no event shall the duration of such additional compensation exceed the lesser of (1) the duration of the employee's permanent partial disability benefits, or (2) five hundred twenty weeks. Additional benefits provided under this section shall be available only to employees who are willing and able to perform work in this state."

claimant's back with a maximum medical improvement date of January 6, 2014. To date, no voluntary agreement has been filed for the neck injury because the respondents are contesting the extent of disability and need for medical treatment for that body part.

The parties stipulated to the following facts on the record: the claimant filed a third-party suit arising out of a work-related motor vehicle accident which occurred on January 28, 2010, and for which the claimant recovered the sum of $260,000.00.[3] The respondents intervened in the third-party suit to recover their workers' compensation lien in the amount of $149,641.17. Out of the third-party proceeds, the claimant's attorney was paid $89,951.71 and the respondent insurer was reimbursed $20,407.12 against its workers' compensation lien. The claimant also discharged several personal debts unrelated to her workers' compensation claim which are in dispute relative to the moratorium in this matter: these payments consisted of $19,823.19 for miscellaneous debts and $10,265.79 to her bankruptcy attorney.

During the pendency of this claim, the claimant also signed a letter of protection with Physical Synergy in order to obtain treatment which was contested by the respondents. It is the claimant's position that she was entitled to pay a bill to Physical Synergy in the amount of $2,933 out of the third-party proceeds. The respondents contest the payment of this bill, arguing that the bill was for unauthorized chiropractic treatment which was obtained by the claimant after she had reached maximum medical improvement according to her treating physicians at Physical Synergy.

Also during the pendency of this claim, the claimant filed for personal bankruptcy and, at trial, testified that the bankruptcy attorney assumed management of her third-party

[3] The suit was entitled Deborah Lionetti v. Gabriel Golden and Brenda Lafleur and bore docket number AAN CV 12-600904S.

case. After payments to her creditors, the claimant was left with $116,619.19 from the third-party suit. The respondents argue that their moratorium should not be reduced by the appropriation of third-party proceeds for the payment of the claimant's personal debts. As such, the respondents claim a moratorium of $149,641.17. The claimant, however, argues that the respondents' moratorium should be limited to the $116,619.19 net distribution made to her by the bankruptcy trustee.

The claimant testified that her condition causes radiating pain in her arm which makes it difficult, inter alia, to sleep or do any heavy lifting. She also testified that she has low back pain radiating into both legs. She indicated that Depuy had referred her Mintz for a neurosurgical evaluation, after which Mintz recommended she undergo a three-level cervical fusion. The claimant testified that she was not taking any narcotic medication and had been employed as a bus driver since July 14, 2014. At the formal hearing held on August 2, 2016, the claimant indicated that she was working approximately thirty to thirty-five hours a week and earning $12.43 per hour, which was a lower hourly rate than she made when she worked for the respondent employer.

The claimant further testified that she was terminated by the respondent on the Monday after her date of injury and, since that time, had continued to look for work within her physical limitations. She estimated that she conducted approximately five job searches per day until she secured the bus-driving position in July 2014. She also accepted a number of temporary/seasonal positions between 2010 and July 2014. The claimant indicated that prior to her marriage on September 21, 2013, she took time off from her employment with Lifeline Nursing in order to make wedding plans, not because she was physically unable to work more hours.

The claimant also testified that from approximately 1993 or 1994 to 1999 or 2000, she worked for UPS and FedEx delivering packages. She admitted to having suffered a back injury while working for UPS for which she received chiropractic treatment. She also admitted, after being presented with the stipulation for a 1999 injury, that her neck was injured after a fall down a flight of stairs and she received a $20,000 settlement for that injury. The claimant also offered somewhat inconsistent testimony relative to her decision to leave UPS following the 1999 injury.

The claimant testified that she treated with Troknya and Rayball for most of 2010, and acknowledged that on November 4, 2010, their office issued a report stating that she had reached maximum medical improvement with a 5 percent permanent partial disability rating to her lumbar spine and an 8 percent permanent partial disability to her cervical spine. She also acknowledged that she continued to treat in 2011 and 2012 even though the doctors had told her there was nothing further they could do from a chiropractic standpoint.

The claimant first saw Depuy on September 20, 2010, and followed up seventeen months later on February 6, 2012. At the 2012 office visit, Depuy ascribed a 12 percent permanent partial disability rating to the claimant's neck and a 5 percent permanent partial disability rating to the claimant's low back. The claimant indicated that no treating physician had kept her out of work during the period between February 1, 2010, and November 5, 2010, although she was given restrictions by the Physical Synergy doctors. The claimant also testified that the physical therapy she received after 2010 helped her to hold down a job. The claimant indicated that she "probably" did not inform the physicians who treated her for the 2010 injury that she had previously hurt her neck in

the 1999 fall down the stairs, and attributed her failure to do so to "faulty memory." Findings, ¶ 27; see October 20, 2016 Transcript, pp. 20-21.

The claimant testified that she last treated with Mintz on June 27, 2014, and she did not believe she had seen any other physicians for treatment for the 2010 injury since that time. She indicated that she is pursuing a workers' compensation claim because she needs surgery. She also acknowledged that although she received more than $100,000 from her third-party lawsuit, she did not spend the money on surgery because she feels she needs those funds for her future.

The commissioner made the following additional findings relative to the claimant's medical history. Between February 9, 2010, and October 28, 2010, the claimant underwent approximately thirty chiropractic treatments with Physical Synergy. On June 17, 2010, a cervical MRI demonstrated:

> multilevel degenerative changes at the C3-4 through C6-7 levels. She also had a central/right disc herniation with mild central canal stenosis and mild cord impingement; a C6-7 left-sided foraminal disc herniation with mild right-sided foraminal, moderate left-sided foraminal and mild central canal stenosis; mild left-sided foraminal stenosis; and spondylitic ridging at the C5-6 level with mid right-sided foraminal, severe left-sided foraminal and moderate central canal stenosis.

Findings, ¶ 32; see Claimant's Exhibit B.

The claimant's physicians referred her to Depuy, an orthopedist who treated the claimant between September 20, 2010, and January 13, 2014. Depuy did not believe that the claimant was a candidate for surgery and ultimately recommended that she follow up with a pain management specialist for pharmacological intervention.[4] The claimant

[4] In Findings, ¶ 33, the commissioner indicated that the claimant was referred to Eric J. Katz, M.D.; however, the claimant contends that the medical reports attributed to Eric J. Katz, M.D., were in fact authored by James W. Depuy, M.D., Katz' partner. Our review of the record indicates that the reports do

subsequently saw Anand, who treated the claimant during the period between October 29, 2010, and January 11, 2013. Anand prescribed medication and topical gels for pain relief; in an office note dated November 8, 2012, he reported that "[t]he claimant received 'phenomenal' relief from two epidural injections and was encouraged to return on an as needed basis but she did not return after January 11, 2013." Findings, ¶ 40; Claimant's Exhibit G.

An October 28, 2010 office note from Rayball stated: "The patient has been discharged from care as she has reached maximum medical improvement, and subsequent visits for this specific condition are no longer needed." Claimant's Exhibit E. As previously mentioned herein, on November 4, 2010, Rayball issued a report in which she ascribed to the claimant a 5 percent permanent partial disability to the lumbar spine and an 8 percent disability to the cervical spine; she also gave the claimant a twenty-five pound lifting restriction. Id.

During the period between January 31, 2011, and January 18, 2012, the claimant underwent twenty-two palliative chiropractic treatments without authorization from the respondent employer or the commission. On February 22, 2012, the claimant underwent a cervical MRI, the results of which were summarized as follows:

> the claimant had a reversal of the normal cervical lordosis consistent with muscular spasm or ligamentous injury. Further she had moderate left foraminal narrowing at the C5/6 and C6/7 levels. She also had minimal retrolisthesis of C/5 with respect to C6. No mention was made of any disc herniations.

Findings, ¶ 37; see also Claimant's Exhibit B.

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appear to have been authored by Depuy. We deem this harmless scrivener's error. See D'Amico v. Dept. of Correction, 73 Conn. App. 718, 729 (2002), *cert. denied*, 262 Conn. 933 (2003).

On June 16, 2014, the claimant underwent another cervical MRI, the results of which were summarized as follows:

> the claimant had retrolisthesis of C-5 in the neutral position which became mildly more prominent during flexion. She had moderate to severe disk space narrowing at C5-6 and C6-7. A second MRI was taken of the cervical spine, without contrast, and revealed degenerative disc disease and foraminal narrowing with no interval change. No mention was made of any disc herniations.

Findings, ¶ 38; see also Claimant's Exhibit B.

On July 7, 2014, Mintz, in response to correspondence from claimant's counsel, opined that the claimant was a surgical candidate for an anterior cervical disc excision and fusion at C4/5, C5/6 and C6/7. Mintz also related the claimant's need for surgery to the January 28, 2010 date of injury.

On January 26, 2016, the claimant underwent a Respondents' Medical Examination with Glenn G. Taylor, M.D., who opined, inter alia, that the degenerative changes to the claimant's spine pre-dated the January 28, 2010 automobile accident. See Respondents' Exhibit 6, p. 2. The doctor indicated that the claimant's neck pain was "likely based on a whiplash type of neck injury superimposed on pre-existing cervical spondylosis. At most, the automobile accident may have aggravated an underlying condition." Findings, ¶ 42.f; see also Respondents' Exhibit 6, p. 2. Taylor also opined that "the notion that the operation would improve [the claimant's] pain is purely speculative" and assigned to the claimant's cervical spine a 6 percent permanent partial disability rating based solely on her condition from the whiplash injury. Findings, ¶ 43; Respondents' Exhibit 6, p. 2.

In addition, Taylor stated that he could "see no reason why [the claimant] cannot be gainfully employed other than her subjective complaints of pain which appear to be

rather extreme and unusual, and disproportionate to what one would normally expect with cervical spondylosis or indeed a chronic whiplash injury." Id., 3. Finally, with regard to the claimant's complaints of lower back pain, Taylor opined that the claimant was at maximum medical improvement and was not a surgical candidate at the time that he examined her.

On the basis of the foregoing, the commissioner concluded that:

> The standard utilized by the Workers' Compensation Act to determine whether or not a particular medical procedure should be approved is the "reasonable and necessary" standard. The medical evidence, taken as a whole, supports the reasonableness of the requested three-level cervical fusion, but not the necessity.

Conclusion, ¶ A.

The commissioner further noted that neither Depuy nor Taylor had opined that the claimant was a surgical candidate. Moreover, although Mintz had recommended a three-level fusion, "he makes no comment on the 'necessity' of the surgery." Conclusion, ¶ A.5. The commissioner determined that the respondents' form 36 of May 6, 2013, established that the claimant had reached maximum medical improvement for her neck condition, and the parties' voluntary agreement of May 22, 2014, established that the claimant had reached maximum medical improvement for her lower back condition on January 6, 2014. The claimant was therefore entitled to benefits pursuant to General Statutes § 31-308 (a) for the period of February 1, 2010, when she was terminated by the respondent, and January 6, 2014, when she was found to have reached maximum medical improvement for the final body part implicated in the accident of January 28, 2010.[5] The claimant was also entitled to wage differential benefits pursuant

[5] We note that in Order, ¶ 2, the commissioner erroneously indicated that the claimant should be paid benefits pursuant to General Statutes § 31-301 (a) rather than § 31-308 (a). For purposes of clarity, we

to General Statutes § 31-308a. The commissioner concluded that the claimant's objections to the form 36 were without merit.

Relative to the dispute regarding the moratorium, the commissioner concluded that the respondent was entitled to claim $149,641.17, stating that:

> debts legally paid by the trustee and which are unrelated to the workers' compensation claim … cannot be used to reduce the claimant's moratorium in the Workers' Compensation forum. Similarly, debts for denied Workers' Compensation treatment become a personal debt of the claimant and cannot … be used to diminish the scope of the respondents' moratorium.

Conclusion, ¶ E.

As such, the commissioner determined that the deduction of $89,951.71 from the third-party proceeds for the attorney's fees and costs associated with the third-party claim was appropriate, as was the payment in satisfaction of the workers' compensation lien in the amount of $20,407.12. The commissioner found that the miscellaneous deductions in the amount of $19,823.19 and the bankruptcy attorney's fee in the amount of $10,265.79 "were personal debts of the claimant for which there is no statutory authority to support a reduction in a workers' compensation moratorium." Conclusion, ¶ E.2. The commissioner concluded that the debt for the unauthorized chiropractic visits which occurred after the maximum medical improvement date of November 4, 2010, was "personal in nature" and the payment of that debt by the bankruptcy attorney could not be used to reduce the respondent's moratorium.[6] Conclusion, ¶ E.3.

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would suggest that the finding be corrected to reflect the correct statute under which the claimant was awarded benefits.

[6] With regard to the claimant's argument that the bankruptcy trustee's payment for the unauthorized chiropractic visits should be applied to the workers' compensation moratorium, the commissioner noted that "[c]ontrary to implications in the claimant's brief, the claimant cannot circumvent the dictates of due process of law simply by issuing a letter of protection to the treating chiropractor." Conclusion, ¶ E.3.

Consistent with these conclusions, the commissioner denied the three-level fusion recommended by Mintz, ordered that the respondents pay to the claimant benefits pursuant to §§ 31-308 (a) and 31-308a in accordance with her findings, and concluded that the amount of the respondents' moratorium was $149,641.17.

The claimant filed motions for extension of time on July 7, 2017, July 17, 2017, July 23, 2017, December 5, 2017, May 21, 2018, and May 29, 2018. On July 7, 2017, the claimant filed a motion for extension of time to file her motion to correct, seeking an extension from July 10, 2017, until August 31, 2017. On July 12, 2017, the commissioner granted the claimant's motion for extension of time to file her motion to correct until July 24, 2017. On July 23, 2017, the commissioner denied the claimant's second motion for extension of time to file the motion to correct filed on the same date. On August 8, 2017, the claimant filed a motion to correct which was denied in its entirety on the same date; on August 15, 2017, the commissioner granted the respondents' Objection to Claimant's Motion to Correct Decision and Order filed on the same date. On February 23, 2018, the respondents filed a motion to dismiss the appeal for failure to file timely reasons of appeal pursuant to the provisions of § 31-301-2 C.G.S., to which the claimant objected on June 1, 2018.[7]

The claimant raises several claims of error in her rather voluminous appeal. The claimant contends that the commissioner erred in: (1) allowing the respondent to obtain and submit records from a respondents' medical examination (RME) after commencement of the formal hearing; (2) refusing to allow the claimant to submit

[7] Admin. Reg. § 31-301-2 states: "Within ten days after the filing of the appeal petition, the appellant shall file with the compensation review division his reasons of appeal. Where the reasons of appeal present an issue of fact for determination by the division, issue must be joined by a pleading filed in accordance with the rules applicable in ordinary civil actions; but where the issue is to be determined upon the basis of the finding of the commissioner and the evidence before him, no pleadings by the appellee are necessary."

additional medical records from her treating physicians at the formal hearing; (3) reaching factual findings unsupported by the evidence; (4) concluding that the three-level fusion surgery recommended by Mintz was reasonable, but not necessary; (5) including in the respondents' claimed moratorium the payments made by the bankruptcy trustee to creditors of the claimant and in satisfaction of the bankruptcy attorney's fees and costs, as well as the compromised payment on the letter of protection for Physical Synergy; and (6) failing to grant the claimant's motion to correct. The claimant also argues that the commissioner abused her discretion by failing to grant the claimant's second motion for extension of time to file her motion to correct.

The standard of review we are obliged to apply to a trial commissioner's findings and legal conclusions is well-settled. The trial commissioner's factual findings and conclusions must stand unless they are without evidence, contrary to law or based on unreasonable or impermissible factual inferences." Russo v. Hartford, 4769 CRB-1-04-1 (December 15, 2004), *citing* Fair v. People's Savings Bank, 207 Conn. 535, 539 (1988). Moreover, "[a]s 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." Burton v. Mottolese, 267 Conn. 1, 54 (2003), *quoting* Thalheim v. Greenwich, 256 Conn. 628, 656 (2001). "This presumption, however, can be challenged by the argument that the trial commissioner did not properly apply the law or has reached a finding of fact inconsistent with the evidence presented at the formal hearing." Christensen v. H & L Plastics Co., Inc., 5171 CRB-3-06-12 (November 19, 2007).

We begin our analysis with the respondents' motion to dismiss due to the claimant's failure to file timely reasons of appeal. Our review of the record indicates that the claimant filed a motion for an extension of time to file her reasons of appeal on July17, 2017, which motion was granted. The claimant sought an extension until one month after receipt of the commissioner's decision on the motion to correct. On July 23, 2017, the commissioner denied the claimant's second motion for extension of time to file her motion to correct. The motion to correct therefore remained due on July 24, 2017, and the reasons of appeal became due on or about August 24, 2017. However, the reasons of appeal were not filed until September 6, 2017, and the respondents filed a motion to dismiss the appeal on February 23, 2018.

There is no question that "this board has discretion to dismiss an appeal for failure to prosecute with due diligence, which includes the failure of a party to file a brief on time." Walter v. Bridgeport, 5092 CRB-4-06-5 (May 16, 2007), *citing* Reaves v. Brownstone Construction, 3930 CRB-4-98-11 (November 30, 1999). As such, when "an appellant fails to file timely a preliminary statement of issues as required by Practice Book § 4013(a)(1) [now Practice Book § 63-4], the appeal is voidable." Sager v. GAB Business Services, Inc., 11 Conn. App. 693, 697 (1987). "The appellee may then move to dismiss the appeal in accordance with Practice Book § 4056 [now Practice Book § 66-8]," id., but such a motion must be filed within the ten-day period following the expiration of the appellant's filing deadline. "Where an appellee fails to move for dismissal within the ten day period, the motion to dismiss comes too late and the defect is deemed waived." Id.

Our review of the file indicates that the respondents' motion to dismiss was filed on February 21, 2018, well after the expiration of the ten-day deadline which began to run when the claimant failed to file her reasons for appeal on or before August 24, 2017. Consistent with the court's reasoning in Sager, supra, we therefore find the respondents have waived any alleged defect arising from the claimant's late filing of her reasons for appeal. The record also reflects that the claimant did file her reasons for appeal two weeks later, on September 6, 2017, and also ultimately filed a comprehensive brief from which the respondents were able to fashion their own responsive brief.

The respondents have failed to explain, and we are unable to discern, how the late filing of the claimant's reasons of appeal may have prejudiced their ability to defend this claim. As such, we decline to dismiss the claim on the basis of a procedural deficiency. As this board has previously remarked, "[w]e believe some indicia of prejudice to the respondents should generally exist before we dismiss a claim initiated in a timely manner, as the sole dispute herein is over the adequacy of the pleadings." Vitoria v. Professional Employment & Temps, 5217 CRB-2-07-4 (April 4, 2008).

Turning to the merits of the underlying appeal, we begin with the claimant's contentions regarding the commissioner's decision relative to the admission of the RME report and deposition. We note at the outset that the provisions of General Statutes §§ 31-278 and 31-298 afford a commissioner considerable latitude in the exercise of discretion with regard to the conduct of hearings and the admission of evidence.[8] Our

[8] General Statutes § 31-278 states in relevant 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."

review of the record indicates that at the formal hearing held on November 30, 2015, the claimant objected to the admission of Taylor's RME report and deposition. The commissioner overruled the objection, indicating that the formal hearing was respondents' counsel's first contact with the file and any prior representations relative to the RME of the insurance adjustor who had attended previous hearings were not relevant to the formal proceedings. The commissioner also noted that the claimant's most recent visit with Mintz had occurred on July 7, 2014. In addition, the commissioner, having pointed out that the claimant had postponed without penalty formal proceedings scheduled for the prior September and October, stated that the decision to allow the RME was procedural in nature and therefore "discretionary, and yes, I'm allowing them for reasons that I think are solid in this case." November 30, 2015 Transcript, pp. 37-38.

It is axiomatic that "[a]n abuse of discretion exists when a court could have chosen different alternatives but has decided the matter so arbitrarily as to vitiate logic, or has decided it based on improper or irrelevant factors." In re Shaquanna M., 61 Conn. App. 592, 603 (2001). In view of the degree of discretion afforded to the commissioner by the provisions of §§ 31-278 and 31-298, we do not find that under the specific factual circumstances of the present matter, the commissioner's decision to admit Taylor's RME report and deposition constituted an abuse of discretion.

We next turn to the claimant's contention that the commissioner erred in denying authorization for the three-level fusion recommended by Mintz on the basis that the

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General Statutes § 31-298 states in relevant part: "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."

surgery was reasonable, but not necessary. As mentioned previously herein, in Conclusion, ¶ A, of her finding, the commissioner stated that "[t]he standard utilized by the Workers' Compensation Act to determine whether or not a particular medical procedure should be approved is the "reasonable and necessary" standard. The medical evidence, taken as a whole, supports the reasonableness of the requested three-level cervical fusion, but not the necessity."

The commissioner's conclusion in this regard implicates the provisions of General Statutes § 31-294d (a) (1), which state in relevant part that "[t]he 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." (Emphasis added.) It is well-settled that this board is bound by the provisions set forth in General Statutes 1-2z, which require that:

> The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered.

Given that the commissioner specifically concluded that the three-level fusion recommended by Mintz was reasonable, and therefore satisfied the requirements of § 31-294d (a) (1), we are unable to sustain the commissioner's decision to deny the surgery. We acknowledge that the respondents have pointed to a number of prior cases in which the phrase "reasonable and necessary" was used interchangeably with the phrase "reasonable or necessary," and the findings of the commissioner on the issue of medical

care in those cases were ultimately upheld. However, we would note that in the examples cited by the respondents, the medical care in question was deemed either *both* reasonable and necessary, or *neither* reasonable *nor* necessary.[9] The respondents have not cited, and we are not aware of, any prior cases in which this board sustained either a denial of or authorization for surgery which was deemed reasonable but not necessary, or vice versa.[10]

We turn next to the claimant's contentions of error regarding the commissioner's determination that the respondents' were entitled to a moratorium in the amount of $149,641.17. It is the claimant's position that the commissioner's failure to deduct from the respondents' moratorium the bankruptcy trustee's payments to Physical Synergy in the amount of $2,933 constituted error; the claimant also argues that the commissioner erred in concluding that "[t]he unspecified miscellaneous deductions in the amount of $19,823.19, as well as the bankruptcy attorneys' fees in the amount of $10,265.79 were

[9] The respondents point to Cervero v. Mory's Association, 12 Conn. App. 82, *cert denied*, 298 Conn. 908 (2010); Chimblo v. Connecticut Light Power, 5417 CRB-7-09-1 (December 30, 2009); Dahle v. Stop & Shop Companies, Inc., 5356 CRB-6-08-6 (June 5, 2009), *aff'd*, 185 Conn. App. 71 (September 25, 2018), *cert. denied*, 330 Conn. 953 (December 5, 2018); Vannoy-Joseph v. State/DMHAS, 5164 CRB-8-06-11 (January 29, 2008); Jolicoeur v. Duncklee, Inc., 5150 CRB-2-06-10 (November 8, 2007); Thomas v. Mohegan Sun Casino, 4754 CRB-2-03-11 (February 18, 2005); and Caprio v. Stop & Shop, 4028 CRB-3-99-4 (July 26, 2000).

[10] We confess to being somewhat troubled by the claim of error alleging a deprivation of due process attributed to the commissioner's decision to deny additional medical submissions by the claimant in response to the RME with Taylor. We note that at the formal hearing of February 29, 2016, the commissioner accurately pointed out that the scope of the RME would of necessity be limited to records already on file, and Mintz had already provided a medical opinion. However, we also note that the most recent medical report from Mintz was dated July 7, 2014. Although it could conceivably be argued that the responsibility rested with the claimant to provide a more updated report for a formal hearing occurring nearly two years later, we also note that the claimant did appear to be laboring under the misapprehension that the respondents would not be seeking an RME. See November 30, 2015 Transcript, p. 38. The respondents have argued that the commissioner's denial of additional records from Mintz was essentially moot, because the claimant never actually attempted to provide any additional records. However, the respondents fail to address the issue of why the claimant would have bothered to obtain such records, having already been informed that they would not be admitted. Nevertheless, despite our significant concerns relative to the commissioner's decision to allow the respondents an RME while denying the claimant the opportunity to submit rebuttal evidence for same, we decline to reach this claim of error in light of our decision to reverse the commissioner's denial of the surgery with Mintz.

personal debts of the claimant for which there is no statutory authority to support a reduction in a workers' compensation moratorium." Conclusion, ¶ E.2.

This claim of error implicates the provisions of General Statutes § 31-293 (a), which allow for the "deduction of reasonable and necessary expenditures, including attorneys' fees, incurred by the employee in effecting the recovery" when calculating the total amount of the moratorium due to respondents.[11] As such, the burden rests with the claimant to prove that the payments in dispute constituted "reasonable and necessary expenditures." With regard to the payment to Physical Synergy, we note that the record indicates, and the commissioner so found, that the payment was for visits which occurred

[11] General Statutes § 31-293 (a) states in relevant part: "When any injury for which compensation is payable under the provisions of this chapter has been sustained under circumstances creating in a person other than an employer who has complied with the requirements of subsection (b) of section 31-284, a legal liability to pay damages for the injury, the injured employee may claim compensation under the provisions of this chapter, but the payment or award of compensation shall not affect the claim or right of action of the injured employee against such person, but the injured employee may proceed at law against such person to recover damages for the injury; and any employer or the custodian of the Second Injury Fund, having paid, or having become obligated to pay, compensation under the provisions of this chapter may bring an action against such person to recover any amount that he has paid or has become obligated to pay as compensation to the injured employee…. If the employer and the employee join as parties plaintiff in the action and any damages are recovered, the damages shall be so apportioned that the claim of the employer, as defined in this section, shall take precedence over that of the injured employee in the proceeds of the recovery, after the deduction of reasonable and necessary expenditures, including attorneys' fees, incurred by the employee in effecting the recovery…. The rendition of a judgment in favor of the employee or the employer against the party shall not terminate the employer's obligation to make further compensation which the commissioner thereafter deems payable to the injured employee…. For the purposes of this section, the claim of the employer shall consist of (1) the amount of any compensation which he has paid on account of the injury which is the subject of the suit, and (2) an amount equal to the present worth of any probable future payments which he has by award become obligated to pay on account of the injury. The word "compensation," as used in this section, shall be construed to include incapacity payments to an injured employee, payments to the dependents of a deceased employee, sums paid out for surgical, medical and hospital services to an injured employee, the burial fee provided by subdivision (1) of subsection (a) of section 31-306, payments made under the provisions of sections 31-312 and 31-313, and payments made under the provisions of section 31-284b in the case of an action brought under this section by the employer or an action brought under this section by the employee in which the employee has alleged and been awarded such payments as damages…. Notwithstanding the provisions of this subsection, when any injury for which compensation is payable under the provisions of this chapter has been sustained under circumstances creating in a person other than an employer who has complied with the requirements of subsection (b) of section 31-284, a legal liability to pay damages for the injury and the injured employee has received compensation for the injury from such employer, its workers' compensation insurance carrier or the Second Injury Fund pursuant to the provisions of this chapter, the employer, insurance carrier or Second Injury Fund shall have a lien upon any judgment received by the employee against the party or any settlement received by the employee from the party, provided the employer, insurance carrier or Second Injury Fund shall give written notice of the lien to the party prior to such judgment or settlement."

after the Physical Synergy doctors had determined that the claimant was at maximum medical improvement on or about November 4, 2010. See Claimant's Exhibit E. In her report of that date, Rayball indicated that she had "nothing further to offer this patient in order to correct her condition." Id. In addition, all of the notes generated for some twenty-plus office visits commencing on January 31, 2011, and continuing until January 18, 2012, contain the following assessment: "The patient has been discharged from care as she has reached maximum medical improvement, and subsequent visits for this specific condition are no longer needed." Id.

The claimant contends that the payments to Physical Synergy constitute a "reasonable and necessary expenditure" because several of the claimant's other physicians deemed the chiropractic treatments "reasonable and necessary." Appellant's Brief, p. 36. In addition, the claimant points out that Taylor, in his RME, stated that the claimant's "treatment to date has been appropriate." Respondents' Exhibit 6, p. 2. We also note that the claimant testified that the chiropractic treatments with Physical Synergy helped to keep her "functional." October 20, 2016 Transcript, p. 85. It is of course well-settled in our case law that:

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

Bowen v. Stanadyne, Inc., 2 Conn. Workers' Comp. Rev. Op. 60, 64, 232 CRD-1-83 (June 19, 1984).

However, this board has also previously observed that "[w]hether or not medical care satisfies the 'reasonable and necessary' standard of § 31-294d is a factual issue to be decided by the trial commissioner." Zalutko v. Danbury Hospital, 4229 CRB-7-00-4 (May 23, 2001), *citing* Cummings v. Twin Tool Mfg., 13 Conn. Workers' Comp. Rev. Op. 225, 228, 2008 CRB-1-94-4 (April 12, 1995), *appeal dismissed*, A.C. 14747 (June 29, 1995). In the present matter, the commissioner was not persuaded that the chiropractic care received by the claimant after her date of maximum medical improvement constituted "reasonable or necessary" medical care as contemplated by the provisions of § 31-294d (a). Absent such a factual finding by the commissioner or, in the alternative, an agreement with the respondents to pay for the medical care rendered during this time period, there exists no statutory basis for deeming those payments a "reasonable and necessary expenditure" thereby eligible for deduction from the respondents' moratorium.[12]

The claimant also argues that the bankruptcy trustee's payments for miscellaneous expenses in the amount of $19,823.19 and his attorney's fee in the amount of $10,265.79 constituted "reasonable and necessary expenditures" because the "termination and refusal to pay entitled benefits to the Claimant severely prejudiced the Claimant and she was forced to file for bankruptcy by the actions of the Respondent as she could not pay her bills and survive economically." Appellant's Brief, p. 40. We recognize that the commissioner, in her June 26, 2017 finding, did in fact award the claimant benefits pursuant to § 31-308 (a) for the period between February 1, 2010, and January 6, 2014, as well as an award for § 31-308a benefits as appropriate. However, prior to the date of the

[12] The fact that the respondents may have paid for some of this treatment is not dispositive of the issue of whether they were legally obligated to do so.

award on June 26, 2017, the claimant's eligibility for both pre- and post-specific benefits was in dispute and, as such, the respondents had no legal liability to commence payment for those benefits.

Moreover, although we concede that the claimant's equitable arguments in this regard are not without a certain logic, we would also note that workers' compensation law is a "creature of statute," and it is axiomatic that "a court which exercises a limited and statutory jurisdiction is without jurisdiction to act unless it does so under the precise circumstances and in the manner particularly prescribed by the enabling legislation." Heiser v. Morgan Guaranty Trust Co., 150 Conn. 563, 565 (1963). As such, in the absence of any statutory eligibility for either § 31-308 (a) or § 31-308a benefits for the period in question which had been established by virtue of either a commissioner's award or an agreement with the respondents, the commissioner could not reasonably infer that the bankruptcy trustee's payments for the claimant's miscellaneous expenses or the payment of the bankruptcy attorney's fee constituted "reasonable and necessary expenditures" warranting exclusion from the respondents' moratorium. We therefore affirm the commissioner's conclusion that the respondents' moratorium is $149,641.17.

We turn next to the claimant's contentions that the commissioner (1) abused her discretion by denying the claimant's motion for an extension of time to file her motion to correct; and (2) erred in failing to grant the motions to correct. As discussed previously herein, the record indicates that on July 7, 2017, the claimant filed an initial motion for extension of time until August 21, 2017, to file her motion to correct, which was due on July 10, 2017. The commissioner granted the extension until July 24, 2017. On July 23, 2017, the claimant filed a second motion for extension of time until August 21, 2017, to

file her motion to correct and this request was denied.[13] The claimant filed her motion to correct on August 8, 2017, and the motion was denied in its entirety by the commissioner.

We have previously discussed herein the considerable latitude afforded a commissioner by the provisions of §§ 31-278 and 31-298. Admin. Reg. § 31-301-4 states:

> If the appellant desires to have the finding of the commissioner corrected he must, within two weeks after such finding has been filed, *unless the time is extended for cause by the commissioner*, file with the commissioner his motion for the correction of the finding and with it such portions of the evidence as he deems relevant and material to the corrections asked for, certified by the stenographer who took it…. (Emphasis added.)

In the present matter, the claimant correctly points out that in Greene v. Ansonia Copper & Brass, 6111 CRB-5-16-6 (June 9, 2017), this board remarked that "[i]n light of our Supreme Court's pronouncement in Jackson [v. Commissioner of Correction, 227 Conn. 124 (1993)], we deem it well within the prerogative of an appellate board to review a trier's denial of a request for a continuance."[14] In Greene, the issue on appeal concerned the dismissal of a claim for § 31-308a benefits due to the failure of the claimant to appear at a formal hearing. The evidentiary record in that matter contained an affidavit signed by the claimant indicating that although he remembered having a telephone conference with his lawyer in which the formal hearing was discussed, the claimant forgot the date on which the hearing had been scheduled and, in the interim, accepted an invitation to attend his granddaughter's graduation in Virginia. The record

[13] In her brief, the claimant contends that on July 28, 2017, she filed a third motion for an extension of time to file her motion to correct, seeking an extension until August 7, 2017. The respondents objected on August 15, 2017. The third extension request was denied by the commissioner on August 2, 2017; however, the commission file does not appear to contain a record of that extension request.

[14] In its majority opinion in Jackson v. Commissioner of Correction, 227 Conn. 124 (1993), our Supreme Court stated that "[w]e have repeatedly recognized … that the denial of a request for a continuance is appealable." Id., 136.

also indicated that the claimant's wife had been in ill health and the claimant had assumed more responsibility for caring for her since being laid off from his employment.

We are not persuaded that the issues relative to the "remedial nature and humanitarian purpose of the Workers' Compensation Act" examined in Greene, supra, are implicated in the matter at bar. Dubois v. General Dynamics Corporation, 222 Conn. 62, 67 (1992). The record clearly demonstrates that the instant commissioner in fact granted the claimant a two-week extension in which to file her motion to correct. We do not believe that the commissioner's decision to deny the second, or third, motion for extension of time constituted an abuse of discretion as contemplated by In re Shaquanna M., supra. Moreover, even were we inclined to reverse the commissioner's decision to deny the motion to correct, we note that the proposed corrections, apart from those addressing several scrivener's errors which do not affect the overall tenor of the decision, largely reiterated arguments made at trial which ultimately proved unavailing.[15] As this board has previously observed, when "a Motion to Correct involves requested factual findings which were disputed by the parties, which involved the credibility of the evidence, or which would not affect the outcome of the case, we would not find any error in the denial of such a Motion to Correct."[16] Robare v. Robert Baker Companies, 4328 CRB-1-00-12 (January 2, 2002).

[15] We would also note that the commissioner's decision to deny the proposed corrections pertaining to the issue of the claimant's surgery is now moot, in light of our decision herein to reverse the denial of the surgery.

[16] The claimant has also asserted that the commissioner erred in reaching factual findings unsupported by the evidence. However, in light of the commissioner's decision to deny the motion to correct for untimeliness, the claimant's ability, and that of this board, to challenge the factual findings is constrained, as we are essentially "limited to reviewing how the commissioner applied the law." Corcoran v. Amgraph Packaging, Inc., 4819 CRB-2-04-6, 4948 CRB-2-05-5 (July 26, 2006).

There is error; the June 26, 2017 Finding by Michelle D. Truglia, the Commissioner acting for the Sixth District (commissioner), is accordingly affirmed in part and reversed in part.

Commissioners Scott A. Barton and Brenda D. Jannotta concur in this Opinion.