CASE NO. 6265 CRB-8-18-4 CLAIM NO. 800141130	:	COMPENSATION REVIEW BOARD
VINCENT GRECO CLAIMANT-APPELLANT	:	WORKERS' COMPENSATION COMMISSION
v.	:	JUNE 17, 2019

PRECISION DEVICES, INC.
EMPLOYER

and

AMERITRUST GROUP F/K/A
STAR INSURANCE COMPANY
INSURER
RESPONDENTS-APPELLEES

APPEARANCES:

The claimant was represented by Joseph O. Cogguillo III, Esq., Carter Mario Injury Lawyers, 12 Montowese Avenue, North Haven, CT 06473.

The respondents were represented by Joseph J. Passaretti, Jr., Esq., Monstream & May, L.L.P., 655 Winding Brook Drive, P.O. Box 1087, Glastonbury, CT 06033-6087.

This Petition for Review from the April 3, 2018 Finding and Order of David W. Schoolcraft, the Commissioner acting for the Eighth District, was heard October 26, 2018 before a Compensation Review Board panel consisting of Commission Chairman Stephen M. Morelli and Commissioners Scott A. Barton and Jodi Murray Gregg.[1]

[1] We note that three motions for extension of time were granted during the pendency of this appeal.

OPINION

STEPHEN M. MORELLI, CHAIRMAN. The claimant sustained a compensable injury on February 5, 2003, which left him dependent on opioids. In an April 3, 2018 Finding and Order (finding), the commissioner determined that the claimant's medical condition required him to receive in-patient detoxification treatment to address his drug dependency. The claimant has appealed to this tribunal, arguing that a different treatment regimen recommended by his treating physician should have been authorized by the commissioner. We have long held that when a commissioner is confronted with differing medical opinions, the determination of the most appropriate modality of treatment, consistent with the provisions of General Statutes § 31-294d, is factual in nature.[2] See Cervero v. Mory's Association, Inc., 5357 CRB-3-08-6 (May 19, 2009), *aff'd*, 122 Conn. App. 82, *cert. denied*, 298 Conn. 908 (2010). Upon review, we find that a substantial quantity of evidence, including, significantly, the opinion of the commissioner's examiner, supports the finding. Given that we may not retry factual determinations on appeal, we therefore affirm the finding.

The commissioner engaged in a thorough review of the long narrative of this claimant's medical history which encompassed seventy-five findings of fact. The following findings are pertinent to our inquiry. The claimant was born in 1969 and sustained a compensable injury to his neck and left arm in 2003 which caused him to

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[2] General Statutes § 31-294d states: "(a) (1) The employer, as soon as the employer has knowledge of an injury, shall provide a competent physician or surgeon to attend the injured employee and, in addition, shall furnish any medical and surgical aid or hospital and nursing service, including medical rehabilitation services and prescription drugs, as the physician or surgeon deems reasonable or necessary. The employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall be responsible for paying the cost of such prescription drugs directly to the provider. If the employer utilizes an approved providers list, when an employee reports a work-related injury or condition to the employer the employer shall provide the employee with such approved providers list within two business days of such reporting."

become unemployable. The parties closed the claimant's indemnity claims by way of a stipulation but the claimant continues to receive medical treatment. After the 2003 injury, the claimant underwent "left shoulder surgery performed by Dr. Ronald Paret on June 24, 2003 which, after physical therapy, initially left him with good range of motion but continuing complaints of pain." Findings, ¶ 4. Complaints of pain persisted and "[o]n February 5, 2009, Dr. Paret performed left cubital tunnel exploration, decompression and transposition of the ulnar nerve, and a medial epicondylar ostectomy. Following the surgery the claimant complained of severe pain and Dr. Paret prescribed Percocet." Findings, ¶ 6.

On June 1, 2009, Srinath Kadimi, M.D., a neurologist in Milford, examined the claimant and, following the examination, opined that the claimant could have complex regional pain syndrome (CRPS), formerly called reflex sympathetic dystrophy (RSD). An MRI performed on June 8, 2009 indicated "a small right-sided bulge at the C6-7 level, which [the radiologist] noted to be without any clear sign of impingement and which, in any event, was on the side opposite from the claimant's complaints." Findings, ¶ 10.

> Since 2009, the claimant has been under the care of Michael J. Robbins, D.O., a pain medicine specialist at Advanced Diagnostic Pain Treatment Centers (hereinafter Advanced Diagnostics). The claimant was first seen at that practice on August 27, 2009. At that time he was complaining of mild hyperesthesia and allodynia on the back and left side of his neck, with the symptoms extending to the scapula and down the left arm to the hand.

Findings, ¶ 11.

> While it is difficult to know what findings were made at the first visit or to identify the medications that were given, it is clear that Advanced Diagnostics began a long course of treatment through medication. The claimant would come in for an appointment at

> least once a month, meet with a clinician and be given prescriptions. It appears that, from the start, these medications included opiates, such as Percocet, in addition to non-opioid medications geared toward neurological pain and various muscle relaxants.

Findings, ¶ 14.

The claimant continued to complain of intractable pain, and in August 2010, Robbins suggested implanting a spinal cord stimulator, but the claimant initially rejected this modality of treatment.

> On March 23, 2011, the claimant was seen at Advanced Diagnostics. He complained that the Opana, one of his baseline meds, was not working and he wanted an increase in his Percocet. The clinician wrote: '*Again, I had a very long discussion with him in regard to the response of [his] nerve pain to opioids. In general it is always very poor response with a short duration.* I basically gave him the maximum dose of Percocet that you [can] be allowed to take in a day which would be [8] tablets.' The claimant asked about switching Opana to OxyContin. The clinician again warned about the ineffectiveness of opioids, but then gave him the requested prescription for OxyContin. (Emphasis in finding.)

Findings, ¶ 20, *quoting* Claimant's Exhibit B, #2, p. 13 (Advanced Diagnostic Pain Treatment Centers March 23, 2011 office visit note).

The commissioner noted that "Dr. Robbins had never accepted the diagnosis of CRPS and continued to seek evidence that the claimant's complaints were coming from either his cervical spine or, possibly, the shoulder." Findings, ¶ 21. The commissioner also noted that the claimant had tried a spinal cord stimulator in 2011, but "[t]he claimant complained that the stimulator was making his pain worse. Dr. Robbins abandoned the SCS trial as a failure and gave the claimant a script for oxycodone." Findings, ¶ 22.

> On February 1, 2012, the claimant was evaluated by Alfredo Axtmayer, M.D., an orthopedic surgeon in Wallingford. This was done at the request of Dr. Robbins, who was seeking an objective finding to account for the claimant's left arm complaints.
> Dr. Axtmayer concluded that the claimant had 'rotator cuff

> insufficiency' that was causing limitation of motion and weakness in the shoulder girdle. 'He does have ongoing neck pain that is being referred to the upper extremity and may be related to a diskogenic problem, a thoracic outlet problem, or to the reflex sympathetic dystrophy.' Dr. Axtmayer recommended a MRI of the shoulder with injection of gadolinium.

Findings, ¶ 24, *quoting* Claimant's Exhibit B, #15, p. 2 (February 1, 2012 office visit note of Alfredo L. Axtmayer, M.D.).

In 2012, the claimant also obtained a prescription for Valium from a family physician. He complained that his OxyContin was no longer working and he eventually was prescribed a fentanyl patch, although he had indicated that his skin is very sensitive and he has difficulty tolerating needle injections. The claimant reported "that the touch of his clothes on his skin is very painful to him." Findings, ¶ 26, *quoting* Claimant's Exhibit B, #2, p. 8 (Advanced Diagnostics Pain Treatment Centers May 11, 2012 office visit note). In May 2012, the claimant told Robbins that increasing the fentanyl was not working, and he was prescribed Kadian (morphine). "On July 2, 2012, he complained about the Kadian and asked to have his dosage of oxycodone increased back to eight tablets a day." Findings, ¶ 28.

During this period, Robbins posited "that the claimant had some sort of lesion, either in the neck or shoulder, that was causing his arm complaints," and sought to have "the claimant referred to Dr. [David] Kloth, a pain specialist in Danbury, because he felt Dr. Kloth might be willing to perform a cervical discogram that he hoped would prove the claimant's arm complaints were coming from the cervical spine…." Findings, ¶ 29; see Claimant's Exhibit B, #2, p. 3 (February 4, 2013 office note of Michael J. Robbins, D.O.). The discogram did not occur, and on August 29, 2013, the respondents had their expert, Robert H. Berland, M.D., a neurologist in Hartford, examine the claimant.

> Dr. Berland agreed the shoulder and neck complaints were related to the work accident. He could not comment on the cause of the ulnar problem, however. He agreed the claimant had CRPS that was most likely related to the elbow surgery. Given that diagnosis, he endorsed the use of a nerve stimulator. Dr. Berland also addressed the seizure-like complaints described by the claimant. 'I believe these episodes of shaking are not seizures. They are pain related … and not due to a brain generated seizure disorder.'

Findings, ¶ 31, *quoting* Claimant's Exhibit B, #19, p. 4 (August 30, 2013 correspondence of Robert H. Berland, M.D.).

On the other hand, in August and September of 2013, Robbins continued to opine that the claimant did not have RSD.

> On March 5, 2014, Dr. Robbins wrote in the claimant's chart that the 'patient is totally and permanently disabled in regard to his ability to work. [MR]'

Findings, ¶ 35, *quoting* Claimant's Exhibit B, #1 (March 5, 2014 office visit note of Michael J. Robbins, D.O.).

> On March 28, 2014, Dr. Robbins wrote another argument against the notion that the claimant suffers from CRPS: Although he has nerve related pain in the left upper extremity with intermittent swelling and the statement that he is having some sweating of the palm, he really doesn't have any other clinical features suggestive of reflex sympathetic dystrophy such as atrophy, coolness or decreased circulation or loss of hair. He does have intermittent swelling about extremity which clinically in addition to his hyperesthesia and allodynia suggests that he does have nerve etiology. He did not have response to a stellate ganglion block and therefore by definition although he has nerve pain, it is not with the sympathetic nervous system.

Id., *quoting* Claimant's Exhibit B, #1 (March 28, 2014 office visit note of Michael J. Robbins, D.O.).

Robbins started the claimant on methadone at that time. The claimant returned to Kadimi on July 1, 2014, who diagnosed the claimant with non-epileptic seizures and recommended further pain management with Robbins. Findings, ¶ 35. On October 15,

2014, the respondents had the claimant examined by another expert, Jerrold Kaplan, M.D.

> Dr. Kaplan noted the claimant's current complaints of pain throughout his body, and his complaints about sweating, discolored skin, and perceived changes in his nails and hair. He noted the claimant's complaints of limited ability to perform activities of daily living. He then listed the medications that the claimant was then taking to deal with his pain: Kadian 100 mg bid, Klonopin bid, Percocet 15 mg 8 times per day, Soma three times per day, gabapentin 600 mg three times a day, Valium 10 mg three times a day, and Doxepin 10 mg.

Findings, ¶ 38; see also Respondents' Exhibit 3, p. 2.

Kaplan noted that the claimant had swelling in both hands, and "[h]e detected a 1.0 to 1.5 degree temperature difference in the extremities, with the left extremities being the cooler." Findings, ¶ 39.

> Dr. Kaplan noted that the shoulder MRI showed some residual cuff disease but did not think that would account for the degree of symptoms throughout his body. Rather, Dr. Kaplan's impression was that the claimant had CRPS. He disagreed with Dr. Robbins' recommendation for a cervical discectomy, writing, 'I feel attempting a CT diskogram would be a mistake since this is an extremely painful procedure and would [be] likely to exacerbate his condition and be poorly tolerated.'

Findings, ¶ 40, *quoting* Respondents' Exhibit 3, p. 3.

Noting that the claimant had been undergoing pain management for many years with deteriorating results, Kaplan suggested that the claimant either see Pradeep Chopra, M.D., at Brown University in Rhode Island, who had successfully treated patients with ketamine injections, or undergo a "comprehensive inpatient pain management program such as the Rosomoff Center in Florida." Respondents' Exhibit 3, p. 3.

> On April 30, 2015, the claimant was examined by Pradeep Chopra, M.D., director of the Interventional Pain Management Center at Brown University Medical School in [Pawtucket], RI. The

> claimant's medications at that time were as follows: Kadian 100 mg q 12 hours, oxycodone 15 mg about eight times a day 'which [has a total of] 120 mg for breakthrough' pain, diazepam 10mg, methadone 10mg twice a day, Klonopin 10mg twice a day, gabapentin 600mg three times a day, and Soma three times a day. Collectively, those medications were the equivalent of 460 mg of morphine per day, i.e., a 460mg MED.

Findings, ¶ 43, *quoting* Respondents' Exhibit 5, p. 3.

Chopra noted the claimant had swelling of the wrists and fingertips as well as bilateral swelling of the ankles, more so on the left side than the right. The claimant's right forearm was two degrees warmer than the left, and the claimant's left arm and leg were darker than his right arm and leg. Chopra also reported "[d]iffuse allodynia and paraesthesias to his entire posterior cervical neck region, upper back, thoracic region, lower back, both upper and lower extremities anteriorly and posteriorly, anterior chest, and abdomen." Respondents' Exhibit 5, p. 4.

> Dr. Chopra made two diagnoses pertinent to this formal hearing: (1) 'Complex Regional Pain Syndrome Global' and (2) 'Significant Central Sensitization.' His first recommendation pertained to the 'central sensitization,' for which he wrote that the claimant should be tapered off of opioid medication. His second recommendation was to switch anxiety medications to something other than benzodiazepines (e.g., Valium). His final recommendations were addressed to the diagnosis of CRPS….

Findings, ¶ 46, *quoting* Respondents' Exhibit 5, p. 5.

With regard to the claimant's opioid intake, Chopra recommended that the claimant "[a]void opioids for the treatment of neuropathic pain and Complex Regional Pain Syndrome." Id.

On July 13, 2015, the respondents filed a form 43 and a form 36 based on their position that the claimant had failed to obtain reasonable medical care consistent with

Chopra's recommendations. Following an informal hearing, a commissioner's examination was ordered to be performed by Jonathan Kost, M.D.[3]

Prior to that examination, the respondents sent the claimant back to Kaplan for a follow-up RME on September 29, 2015. Kaplan observed that the claimant's "'current treating physicians Dr. Kadimi, neurologist, and Dr. Robbins, pain specialist, have really just been renewing pain medications without putting [forth] a new treatment plan.' He noted the claimant reported he felt 'that things have gotten worse' over the last year." Findings, ¶ 50, *quoting* Respondents' Exhibit 4, p. 1. Kaplan reiterated his opinion that the claimant needed "either a trial of ketamine with Dr. Chopra or 'a comprehensive inpatient pain management program"' at the Rosomoff Center or the Rehabilitation Institute of Chicago (RIC). Findings, ¶ 52, *quoting* Respondents' Exhibit 4, p. 2.

The claimant was scheduled for a commissioner's examination on January 19, 2016, but did not attend this examination. The examination was re-scheduled for January 10, 2017, and the claimant was examined by Kost at that time.

> In his report, Dr. Kost summarized the history of the claimant's orthopedic findings and surgical treatment, and included MRIs of the cervical spine and shoulder in 2013. He noted the claimant had been seeing Dr. Robbins for some time for pain treatment, and the history of the claimant having undergone a spinal cord stimulator trial that was aborted due to reports of increased pain. Dr. Kost also made note of the consultation with Dr. Chopra but added, '[h]e [the claimant] states that he is hesitant to have ketamine treatment due to the possible side effects.'

Findings, ¶ 61, *quoting* Respondents' Exhibit 1, p. 3.

> Dr. Kost reviewed the claimant's current medication, which at the time consisted of: 'Kadian/Morphine 100mg BID, oxycodone

[3] In his May 14, 2018 Ruling on Motion to Correct, the commissioner corrected Findings, ¶ 49, to reflect that the form 36 was held in abeyance at an informal hearing on September 14, 2015, and was subsequently denied at a pre-formal hearing on September 25, 2015, at which time the commissioner's examination with Jonathan Kost, M.D., was ordered.

> 15mg (6/day for breakthrough pain), gabapentin 600mg TID, Soma 350mg TID, methadone 10mg TID, diazepam 10mg BID & Klonopin 1mg BID.' Regarding the effect of his medications, the claimant reported having had 'increased pains and withdrawal-like symptoms when he went without the medications in the past due to insurance not covering them.' Dr. Kost noted that, despite the extensive treatment and medication regimen, the claimant was still complaining of 'whole body pain' and hypersensitivity throughout his body. The claimant also complained of hypersensitivity to light touch in his abdomen and all four extremities, and intermittent sweating, as well as 'color changes' in all four extremities. At the time of this examination, the claimant reported his current pain level as 7 out of 10, with his typical lowest pain level being 5 and his highest being 10.

Findings, ¶ 62, *quoting* Respondents' Exhibit 1, pp. 2,3.

> In the report of his examination, Dr. Kost recounted a number of inconsistencies between the claimant's demonstrated ability to move when asked to do so in formal testing and movements he made when not being formally examined. This included the ability to move his head and lift his arms. He felt there were inconsistencies in the motor examination of the upper extremities. He did not feel there was any 'notable' swelling in the upper extremities and found the temperature of both arms to be equal.

Findings, ¶ 63, *quoting* Respondents' Exhibit 1, p. 4.

Following his examination of the claimant, Kost "raised concerns about the inconsistencies and, indeed, about the diagnosis of 'total body complex regional pain syndrome,' and he questioned whether the claimant's current opioid dosage could be associated with his hyperalgesia state." Findings, ¶ 64, *quoting* Respondents' Exhibit 1, p. 5. Kost also noted that the claimant is "very verbally fixated on … staying on his present pain medications as it relates to any future medical treatment." Id. "Dr. Kost recommended the following: '[*i*]*t is my medical impression that he should undergo an inpatient detox off of these pain medications. I believe it would be much too difficult to do this on an outpatient basis with him. One facility may be The Rosomoff*

Comprehensive Rehab Pain Center in Miami, FL.' Dr. Kost made no comment about the recommendation for ketamine infusion in his treatment recommendation." (Emphasis in finding.) Findings, ¶ 65, *quoting* Respondents' Exhibit 1, p. 5.

The claimant continued to treat with Robbins during 2016 and 2017. Robbins also addressed the question of reducing the claimant's opiates, stating that:

> as far as his opiates are concerned, the patient is maintained the best he has been so far on his current regimen. I certainly would not recommend tapering off his medications as he has no recourse otherwise. I would say that if he has an excellent response to a ketamine infusion, that tapering [off] his pain medications could be a distinct reality without offering him the ketamine infusion first, it makes absolutely no clinical sense to send the patient somewhere to have him taper off of his pain medications without having an alternative plan.

Findings, ¶ 66, *quoting* Claimant's Exhibit B, #1 (February 21, 2017 office note of Michael J. Robbins, D.O.).

In early 2017, informal hearings were held at which the respondents offered to pay for an inpatient detoxification program for the claimant. The mechanism of tapering the claimant's opioid use was discussed and Robbins was asked to offer a response to Kost's recommendations. He responded on March 21, 2017 as follows:

> I advise *against* referring [the claimant] to a detox center as this does not address his underlying pain problem. I have previously made my recommendations in my office notes as to the plan to treat this patient's pain, yet, his Workers' Compensation carrier has not yet made comment or have they authorized approval for such treatment. My plan outlined in my office notes provides details on the [rationale] for the approach I've recommended. Once his pain problem is adequately addressed, then, the focus can be made on minimizing his medications. (Emphasis in the original.)

Claimant's Exhibit B, #1 (March 21, 2017 correspondence of Michael J. Robbins, D.O.).

Kost responded that he "'would be *unable to support the utilization of ketamine as a treatment*' because, while in some cases of clearly documented CRPS 'ketamine could be considered an optional treatment,' the claimant's findings did not support a diagnosis of CRPS." (Emphasis in finding.) Findings, ¶ 70, *quoting* Respondents' Exhibit 2. At the formal hearing held on October 26, 2017, the commissioner noted that the claimant was seeking a conclusion that he "has been 'clearly, fully, and repeatedly diagnosed with RSD,' that Dr. Kost is clearly incorrect in his assessment that the claimant does not have RSD…." Findings, ¶ 74. The claimant sought an order allowing him to undergo ketamine infusion therapy rather than being forced into a detox program. The respondents, on the other hand, sought "a conclusion that the current treatment regimen has failed and is no longer reasonable, and an order that the claimant 'must submit to an inpatient detoxification treatment center.'" Findings, ¶ 75.

> The respondents propose an order that the claimant be given 30 days to choose between the Rosomoff Center and the Rehabilitation Institute of Chicago (RIC). The respondents also seek an order that, should the claimant refuse to participate, he must obtain a plan from Dr. Robbins to taper opiate medication within 90 days. The respondents seek additional orders relieving [them] of the obligation to pay for opiate medication after a set period of time should Dr. Robbins decline.

Id.

Based on the foregoing, the commissioner reached seventeen conclusions. The most salient to this board's consideration of this appeal are the following:

> N. The parties have framed the question presented as whether the claimant should be allowed to have ketamine infusion therapy or be forced into a detox program. I think this misstates the issue. The question before me is whether the claimant should be sent for ketamine infusion therapy on an outpatient basis while continuing to take large quantities of opioid analgesic medication that may or may not be

causing some or all of his pain symptoms, or whether he should be sent to a comprehensive, multidiscipline, inpatient pain management program for detailed assessment of what he needs, followed by comprehensive treatment in a controlled environment by a team of specialists in the various medical fields relevant to his condition.

O. On the evidence presented, I am convinced that continuation of long-term use of opioid medication on an outpatient basis is not reasonable or necessary medical care and is, in fact, detrimental to the claimant's health.

P. On the evidence presented, I am satisfied that instituting ketamine infusion therapy while the claimant is still in his home environment and taking high doses of opioid medication is not reasonable or necessary medical care for purposes of section 31-294d.

Q. I am convinced that the only reasonable course of treatment at this point is referral to a comprehensive, inpatient pain program such as those provided at Rosomoff or RIC. Referral to such a specialized, multi-discipline program does not necessarily rule out ketamine infusion therapy any more than it necessarily means removal of all opioid analgesic medication. It does, however, provide the claimant with the best chance of regaining control over his pain and his life.

Conclusion, ¶¶ N-Q.

The commissioner then ordered the claimant to choose between an inpatient program at Rosomoff or RIC, and ordered the respondents to pay for the inpatient detoxification program. His order provided a timeline for the respondents to cease paying for opioid medication should the claimant fail to obtain inpatient treatment.

The claimant filed a motion to correct seeking thirty separate proposed corrections to the finding. The gravamen of this motion was that the commissioner should approve ketamine injections based on Robbins' opinion and reject Kost's opinion that the claimant should undergo inpatient detoxification. The commissioner approved

only one correction which did not materially impact the relief ordered in the finding. The claimant has now pursued this appeal, contending that Robbins' proposed treatment regimen was more reasonable than the treatment proposed by Kost, and Kost's opinions should be afforded lesser weight than the opinions of the claimant's long-time treating physician.

The standard of deference we are obliged to apply to a commissioner's findings and legal conclusions on appeal 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 also note that appellate tribunals are expected to extend great deference to the manner in which a finder of fact evaluates expert testimony. For instance, in State v. Trotman, 68 Conn. App. 437 (2000), our Appellate Court remarked:

> Because the … claim challenges the sufficiency of the evidence, which is based on the court's factual findings, the proper standard of review is whether, on the basis of the evidence, the court's finding … was clearly erroneous…. In other words, a court's

> finding of fact is clearly erroneous and its conclusions drawn from that finding lack sufficiency 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…. Moreover, we repeatedly have held that [i]n a [proceeding] tried before a court, the trial judge is the sole arbiter of the credibility of the witnesses and the weight to be given specific testimony…. Where there is conflicting evidence … we do not retry the facts or pass on the credibility of the witnesses…. The probative force of conflicting evidence is for the trier to determine. (Citations omitted; internal quotation marks omitted.)

Id., 441, *quoting* State v. Nelson, 67 Conn. App. 168, 179 (2001).

In the present matter, the commissioner clearly assigned more weight to Kost's opinion than Robbins' opinion. We note that the claimant did not take the deposition of Kost; nor did Kost testify at the formal hearing. As a result, a written report issued by Kost under these circumstances may be evaluated "as is" and afforded the weight assigned by the trier. As this board has previously observed:

> The appellee in this case points out that had the appellant wanted to challenge the opinions of Dr. Selden … they had the chance to depose him and elicit a clarification as to his opinions. The appellant chose not to depose the doctor, however. Berube v. Tim's Painting, 5068 CRB-3-06-3 (March 13, 2007), stands for the proposition that when medical evidence is presented under these circumstances, "the respondents must accept the testimony 'as is,' as well as the permissible inferences which the trial commissioner drew from it." Id., n.3. We find the situation in Berube congruent with the present case; in both cases uncontested medical evidence established causation to the trial commissioner's satisfaction.

Chmielewski v. Reno Machine Company, Inc., 5273 CRB-6-07-9 (May 4, 2009); see also Seiler v. Ranco Collision, LLC, 5377 CRB-1-08-9 (August 27, 2009).

In the matter at bar, Kost recommended that the claimant undergo inpatient detoxification. Robbins put forward specific objections to this recommendation, but the commissioner offered a cogent explanation as to why he decided to proceed with Kost's

proposed treatment, noting in part that the claimant's condition had continued to deteriorate while he was being treated by Robbins. See Conclusion, ¶ H. The claimant argues that the commissioner failed to follow precedent established in Marandino v. Prometheus Pharmacy, 294 Conn. 564 (2010), and, consistent with our Supreme Court's analysis of the factual circumstances in that case, should have found the opinion of the instant claimant's treater more persuasive. We disagree; the commissioner is under no obligation to place more reliance upon the opinion of a treating physician than that of a commissioner's examiner. See Carroll v. Flattery's Landscaping, Inc., 5385 CRB-8-08-10 (September 24, 2009).

Moreover, we find that the commissioner clearly explained his rationale for reliance upon Kost's opinion in the text of his decision. See Madden v. Danbury Hospital, 5745 CRB-7-12-4 (April 22, 2013). The commissioner also articulated the perceived limitations of Robbins' opinion. See Conclusion, ¶ M. It is axiomatic that "'it is the trial commissioner's function to assess the weight and credibility of medical reports and testimony,'" and in the matter at bar, the commissioner placed greater weight on Kost's opinion. O'Reilly v. General Dynamics Corp., 52 Conn. App. 813, 818 (1999), *quoting* Gillis v. White Oak Corp., 49 Conn. App. 630, 637, *cert. denied*, 247 Conn. 919 (1998).

This tribunal has previously examined the standard for reviewing a commissioner's decision regarding the efficacy of medical treatment. In Attardo v. Temporaries of New England, Inc., 5858 CRB-2-13-7 (June 19, 2014), we restated the standard set forth in Cervero v. Mory's Association, Inc., 5357 CRB-3-08-6 (May 19, 2009), *aff'd*, 122 Conn. App. 82, *cert. denied*, 298 Conn. 908 (2010), which stands for the

proposition that the decision regarding the optimal modality of treatment for an injured claimant belongs to the trier of fact. Moreover, our Appellate Court has adopted the utilization of this standard when determining whether a commissioner is obligated to approve medical treatment. "The board's written opinion provides a careful and precise analysis of the Cirrito [v. Resource Group Ltd. of Conn., 4248 CRB-1-00-6 (June 19, 2001)] decision. 'Whether a proposed course of treatment is reasonable or necessary is a factual issue to be decided by the trier based on the medical opinions in the record.'" Cervero v. Mory's Assn., Inc., 122 Conn. App. 82, 92, *cert. denied*, 298 Conn. 908 (2010), *quoting* Irizarry v. Purolator Courier Corp., 4382 CRB-4-01-4 (May 2, 2002). The Cervero court also stated that "*[i]t [is] the province of the commissioner to accept the evidence which impress[es] him as being most credible and more weighty.*" (Emphasis in the original; internal quotation marks omitted.) Id., 93, *quoting* Anderson v. R & K Spero Co., 107 Conn. App. 608, 617 (2008).

The commissioner's decision in this matter was neither arbitrary nor capricious, particularly in light of the fact that his finding contains a thorough and painstaking review of the claimant's entire medical history. Having reviewed the totality of the evidence, the commissioner concluded that Kost's recommended modality of treatment was the most reasonable alternative for the claimant. We believe that the commissioner reached a reasonable conclusion on the basis of the record presented. Although the claimant argues that the proposed treatment would be disruptive, and Kost offered his opinion after conducting only one examination, these arguments are essentially factual, rather than legal, in nature, and their resolution is more appropriately left to the discretion of the

commissioner.[4] See Fair, supra. Our Appellate Court's analysis in Cervero suggests that when the record contains evidence which supports the commissioner's findings, this board is not empowered to disturb those findings on appeal.

There is no error; the April 3, 2018 Finding and Order of David W. Schoolcraft, the Commissioner acting for the Eighth District, is accordingly affirmed.

Commissioners Scott A. Barton and Jodi Murray Gregg concur in this Opinion.

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[4] As previously mentioned herein, the commissioner granted one of the claimant's corrections proposed in the motion to correct. The claimant claims as error the commissioner's denial of the balance of the proposed corrections; however, we are not so persuaded. A commissioner is not bound to accept the view of the case presented by a litigant, and is therefore legally empowered to deny such a motion. See D'Amico v. Dept. of Correction, 73 Conn. App. 718, 728 (2002), *cert. denied*, 262 Conn. 933 (2003); Brockenberry v. Thomas Deegan d/b/a Tom's Scrap Metal, Inc., 5429 CRB-5-09-2 (January 22, 2010), *aff'd*, 126 Conn. App. 902 (2011) (per curiam); Liano v. Bridgeport, 4934 CRB-4-05-4 (April 13, 2006).