

## CONNECTICUT

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### Citation for the state workers' compensation statute.

Connecticut General Statutes Sections 31-275 through 31-355a (Chapter 568).

### SCOPE OF COMPENSABILITY

#### 2. Who are covered "employees" or "workers" for purposes of workers' compensation?

An "employee" is any person who has entered into or works under any contract of service or apprenticeship with an employer, whether such contact contemplated performance of duties within or without the state. C.G.S. §31-275(9).

A sole proprietor or business partner may elect to be covered under the Act. An independent contractor is not a covered employee, see Thompson v. Twiss, 90 Conn. 444 (1916), nor is a so-called "casual employee" (someone hired on a casual basis who is "employed otherwise than for purposes of the employer's trade or business"), C.G.S. §31-275(9)(B)(ii).

In determining whether the owner of a single-member liability company is an "employee" within the meaning of the Act, the test to be applied is "whether the member performed services for the company and was subject to the hazards of the company's business." Gould v. City of Stamford, 331 Conn. 289 (2019).

#### 3. Identify and describe any "statutory employer" provision.

C.G.S. §31-275(10) defines an employer as any person, corporation, limited liability company, firm, partnership, voluntary association, joint stock association, the state and any public corporation within the state using the services of one or more employees for pay. Connecticut has a "principal employer" statute (C.G.S. §31-291) which, in practice, applies generally to construction site injuries. A so-called "principal employer" (usually a general contractor) can be liable for injuries to subcontractors or their employees if four criteria are met: (1) there must be a "principal employer" relationship between the employer and the contractor whereby the contractor was hired to perform work for the principal employer; (2) the contractor must have been hired to perform work

which is "a part or process in the trade or business of such principal employer," i.e., work that is ordinarily or appropriately performed by the principal employer's own employees in furtherance of its business (e.g., a general contractor hiring a carpentry subcontractor); (3) the injury must occur on or about premises under the control of the principal employer; and (4) the employee's own employer must not have workers' compensation coverage as required by statute. The principal employer is not entitled to the exclusive remedy defense unless it has actually paid compensation benefits.

**4. What types of injuries are covered and what is the standard of proof for each:**

**A. Accidental Injuries, C.G.S. § 31-275(16)(A).**

An accidental injury is one "which may be definitely located as to the time when and the place where the accident occurred..." C.G.S. § 31-275(16)(A). The one-year notice period begins to run on the date of accident. The standard of proof upon an employee is that, to a reasonable degree of medical probability, the injury arose out of and in the course of the employment.

**B. Repetitive Trauma, C.G.S. § 31-275(16)(A).**

A repetitive trauma injury is caused by repetitive acts and stresses of the employment. Notice of claim regarded as timely if filed within one year from the last trauma (or micro trauma) that produced the incapacity. The standard of proof is the same as that for single occurrence claims.

**C. Occupational Disease, C.G.S. § 31-275(15).**

An occupational disease "includes any disease peculiar to the occupation in which the employee was engaged and due to causes in excess of the ordinary hazards of employment as such..." C.G.S. § 31-275(15). Occupational diseases such as asbestosis and symptoms caused by exposure to work-place chemicals are covered. The standard of proof is the same as that for single occurrence claims. Notice of claim is regarded as timely if filed within three years of being diagnosed with an occupational disease and informed of its relation to work exposures.

**D. Mental Stress Injury, C.G.S. § 31-275(16)(B).**

A mental or emotional injury is no longer a covered injury unless such impairment arises from a physical injury or occupational disease. However, the employer may now have exposure for damages in a civil action for a purely mental or emotional injury because the workers' compensation remedy no longer exists. Karanda v. Pratt & Whitney Aircraft, 1999 WL 329703 (Conn. Super.)

A new law took effect on July 1, 2019 to allow police officers, municipal constables, parole officers, and firefighters, both paid and volunteer, to receive limited workers' compensation benefits for PTSD. To be eligible for benefits the diagnosis must be made by a board-certified mental health professional, psychiatrist, or psychologist who has experience in the diagnosis and treatment of PTSD. Eligibility is triggered by a "qualifying event" in which the claimant, in the line of duty: (1) views a deceased minor; (2) witnesses the death of a person or an incident

involving the death of a person; (3) witnesses an injury to a person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of another intervening cause; (4) has physical contact with or treats an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of another intervening cause; (5) carries an injured person who subsequently dies before or upon admission to a hospital as a result of the injury and not as a result of another intervening cause; (6) witnesses a traumatic physical injury that results in the loss of a vital body part or a vital body function that results in permanent disfigurement of the victim. In order to receive benefits, a claimant must show that the qualifying event is a substantial factor in causing the PTSD.

Although PTSD claims are currently limited to certain first responders, Public Act No. 23-35 will go into effect on January 1, 2024, expanding the availability of workers' compensation claims for PTSD to all employees who meet the above-referenced criteria.

**5. What, if any, injuries or claims are excluded?**

The following "personal injuries" or injuries" are excluded: (1) an injury which result from voluntary participation in any activity the major purpose of which is social or recreational, including but not limited to athletic events, parties and picnics whether or not the employer pays some or all of the cost of such activity; (2) a mental or emotional impairment unless such impairment arises from a physical injury or occupational disease. Biasetti v. City of Stamford, 250 Conn. 65 (1999); or (3) a mental or emotional impairment which results from a personnel action including, but not limited to, a transfer, promotion, demotion or termination. C.G.S. § 31-275(16)(B).

**6. What psychiatric claims or treatments are compensable?**

Psychological claims are compensable only if the claimed psychiatric or emotional problem arises from a compensable physical injury or occupational disease. C.G.S. §31-275(16)(B).

**7. What are the applicable statutes of limitations?**

There is a one-year limitations period for traumatic, single event. Regarding an occupational disease claim, the Supreme Court case of Ricigliano v. Ideal Forging Corp., 280 Conn. 723 (2006), the Court ruled that the limitations period does not commence until the claimant learns that there is a causal connection between his disease and employment. This typically occurs when a physician diagnoses a condition and advises the claimant of its causal relation to employment.

For death cases, the applicable statute of limitations is two years from the date of accident or onset of symptoms of the occupational disease, or one year from date of death, whichever is later. C.G.S. §31-294c.

**0. What are the reporting and notice requirements for those alleging an injury?**

"Notice of Injury" must be given to an employer "immediately," but failure to do so will not affect benefits unless prejudice is shown. The burden is on the employer to show prejudice.

Written "Notice of Claim," also referred to as a Form 30C, must be given to an employer within

the time-period outlined in answer 7, describing the date and place of the accident and a layperson's description of the injury, and providing the name and address of the employee and

the person in whose interest is claimed. Notice must be served personally or by registered or certified mail. The notice requirement is excused if, within the statutory period: (1) an informal hearing held within the applicable time-period; (2) a hearing is requested or scheduled; or (3) a voluntary agreement between the parties is signed and submitted to the commissioner for approval; (3) medical care is provided by the employer. C.G.S. §31-294.

For survivor's benefits under C.G.S Section 31-306, the Commission has introduced a new form called a Form 30D which is now used to place the employer on notice of claim for these benefits. Recent Connecticut Supreme Court caselaw has concluded that there is no statute of limitations on the filing of the Form 30D if the underlying claim was filed timely. See McCullough v. Swan Engraving, Inc., 320 Conn. 299 (2016).

**9. Describe available defenses based on employee's conduct:**

**A. Self-inflicted injury.**

Suicides or self-inflicted injuries are generally not compensable, unless they result from a mental condition arising from the employment. See Wilder v. Russell Library Co., 107 Conn. 56 (1927).

**B. Willful misconduct, "horseplay," etc.**

Injuries caused by the willful and serious misconduct of the employee are not compensable. C.G.S. §31-284 (a). If such conduct is condoned by the employer, it can be found compensable. Injury caused to an innocent bystander as a result of misconduct or horseplay is covered. Mascika v. Connecticut Tool & Engineering Co., 109 Conn. 473 (1929).

**C. Injuries involving drugs and/or alcohol.**

An injury caused by the employee's intoxication is not compensable. Conn. Gen. Stat §31-284 (a). Moreover, "in the case of an accidental injury, a disability or death due to the use of alcohol or narcotic drugs shall not be construed to be a compensable injury." Conn. Gen. Stat §31275(1)(c).

**10. What, if any, penalties or remedies are available in claims involving fraud?**

An employer is guilty of a Class D Felony if it fraudulently deceives any insurer by providing false or misleading information regarding employees, for the purpose of obtaining a lower premium. C.G.S. §31-288.

An employee (or anyone assisting an employee) who makes a fraudulent claim is guilty of a Class C Felony if the value of the benefits received or claimed is less than \$2,000. If the value exceeds \$2,000, it is considered a Class B Felony. Additionally, any such person is liable for treble damages in a civil action for damages. C.G.S. §31-290c. But, a claimant does not have an affirmative duty to disclose all potentially relevant evidence to an opposing party before entering into a stipulated agreement. Estate of Josephine Secola v. State of Connecticut, 1703 CRB-S-93-4 (January 31, 1995).

**11. Is there any defense for falsification of employment records regarding medical history?** There is no specific statutory defense for such actions.

**12. Are injuries during recreational and other non-work activities paid for or supported by the employer compensable?**

No. Recreational or non-work injuries occurring after July 1, 1993, are not compensable. C.G.S. §31-275(16)(B). However, if the employee can prove that his/her participation in the recreational activity was expected and incidental to employment, s/he may be able to establish compensability. Thomas v. City of Bridgeport, 6206 CRB-3-17-1 (July 30, 2018);

**13. Are injuries by co-employees compensable?**

An assault by a co-employee is generally not compensable, unless the assault was in some way incidental to the employment (rather than strictly personal), or if the existence of employee fighting was known to the employer. See Stulginski v. Waterbury Rolling Mills Co., 124 Conn. 355 (1938).

**14. Are acts by third parties unrelated to work but committed on the premises, compensable (e.g., "irate paramour" claims)?**

No.

## **BENEFITS**

**15. What criterion is used for calculating the average weekly wage?**

The "average weekly wage" is calculated by averaging the weekly gross wages for the 52-week period immediately preceding the week in which an accidental injury occurred. C.G.S. §31-310. In the case of an employee claiming an occupational disease or an injury from repetitive trauma, the week of injury is deemed to be the week the employee became totally or partially incapacitated. C.G.S. §31-310c.

**16. How is the rate of temporary/lost time benefits calculated, including minimum and maximum rates?**

The maximum weekly compensation rate is determined as of October 1<sup>st</sup> of each calendar year and is 100% of the average weekly earnings of all employees in the State, as determined by the State Labor Commissioner. Conn. Gen. Stat §31-309(a). "No employee entitled to compensation ... shall receive less than 20% of the maximum weekly compensation rate, as provided in §31-309, provided the minimum payment shall not exceed 75% of the employee's average weekly wage." Conn. Gen. Stat §31- 307(a).

Subject to the foregoing maximum and minimum rates, temporary total disability benefits are 75% of the average weekly wage, reduced by various deductions for federal taxes. Conn. Gen.

Stat §31-3-7(a). It is an extremely complicated formula (the result of an October 1991 statutory amendment). As a practical matter, compensation rates are generally not mechanically calculated, but instead require the employer/insurer to obtain a "weekly benefit table" published annually by the Workers' Compensation Commission.

**17. How long does the employer/insurer have to begin temporary benefits from the date disability begins?**

Benefits not paid within 35 days of Written Notice of Claim are deemed "unduly delayed," unless a Notice to Contest is timely filed. C.G.S. §31-300. In matters where compensability has been established either by way of a commissioner's award or a voluntary agreement, payment due under the award or the agreement must commence on or before the twentieth day following the award or agreement. Payments not made within that 20-day period are subject to a 20% penalty. C.G.S. §31-303. If an employer pays benefits within 28 days of receiving notice of a claim, it can make such payments on a without prejudice basis for up to one year before determining whether it will contest the compensability of the claim.

**18. What is the "waiting" or "retroactive" period for temporary benefits (e.g., must be out days before recovering benefits for the first days)?**

Compensation is not owed until the employee has been out of work for more than three days of work. If the incapacity continues for a period of more than three days but less than seven days, compensation shall begin at the expiration of the first three days of total or partial incapacity. If the incapacity continues for a period of seven days or beyond, compensation shall begin from the date of the injury. C.G.S. §31-295(a).

**19. What is the standard/procedure for terminating temporary benefits?**

Respondents must file a Form 36 to terminate temporary benefits. The Form 36 is a written petition filed by the Employer/Respondent to reduce or terminate benefits in accordance with C.G.S. § 31-296. In order to terminate benefits, the Form 36 must be approved by the commissioner.

Generally, the Form 36 will be approved by the commissioner as of the date the form is received in the commissioner's office unless contested by the employee within fifteen (15) days. Some commissioners automatically schedule hearings in response to a Form 36 filed in cases where claimant is pro se. If the Form 36 is contested by the claimant or his or her counsel, an informal hearing will be scheduled as quickly as possible by the Commissioner to discuss the proposed termination or reduction of medical or indemnity benefits.

If an employee objects to the Form 36, weekly benefits must continue pending the scheduling of an informal hearing. A respondent which fails to follow this procedure is exposed to monetary penalties at the discretion of the commissioner, which may include attorney's fees and costs. Although the Act generally requires a Form 36 to be approved, standard practice in the Connecticut forum does involve one exception to these requirements, i.e., if a claimant has

returned to full duty work and is already collecting wages, respondents generally will discontinue benefits before a Form 36 is approved.

If the basis for the reduction in benefits is a medical opinion of a treating physician or respondents' medical examiner (RME), a supporting medical report must be attached to the Form 36 to provide the basis for the termination of benefits.

It should also be noted that the Connecticut Supreme Court has held the temporary total benefits may not be discontinued because of the employee's incarceration for a crime, because the Act clearly requires the payment and contains no express exception for incarceration Laliberte v. United Security, Inc., 261 Conn. 181 (2002).

In order to receive temporary partial benefits (typically based on light duty restrictions) an injured worker must be ready, willing, and able to work. Consequently, injured workers that are incarcerated, terminated for cause, or who voluntarily resign from employment are not eligible to receive temporary partial disability benefits.

**20. Is the amount of temporary total disability paid credited toward the amount entitled for permanent partial disability?**

No, unless a Commissioner retroactively approves a Form 36 that sought to convert the claimant to permanent partial disability status while the claimant was collecting total disability benefits.

**21. What disfigurement benefits are available and how are they calculated?**

A commissioner may award up to 208 weeks of benefits for any "permanent, significant disfigurement or permanent significant scar on the face, head or neck or any other area of the body which handicaps the employee in obtaining or continuing to work." C.G.S. §31-308(c). In addition, "[t]hose who do not obtain an award for scarring within two (2) years of the date of injury, but not earlier than one (1) year from the date of injury, will not be entitled to this benefit" C.G.S. § 31-308(c). The calculation and scope of scarring awards rests within the discretion of the Trial Commissioner.

**22. How are permanent partial disability benefits calculated, including the minimum and maximum rates?**

**A. How many weeks are available for scheduled members/parts, and the standard for recovery?**

Benefits for permanent partial disability, known as a "specific disability award," are based on three factors: (1) the employee's weekly compensation rate; (2) the portion of the body injured; and (3) the percentage of disability to that portion of the body as a result of the injury, as found by the commissioner or agreed upon by the parties. Connecticut has a schedule under which the



complete loss of use of a particular portion of the body is assigned a specific number of weeks of compensation. C.G.S. §31-308(b).

The statute contains a schedule of compensation for specified body parts:

SCHEDULED INJURIES

Loss of the master arm at or above the elbow	208 Weeks
Loss of the other arm at or above the elbow	194 Weeks
Loss of the master hand at or above the wrist	168 Weeks
Loss of the other hand at or above the wrist	155 Weeks
Loss of one leg at or above the knee	155 Weeks
Loss of one foot at or above the ankle	125 Weeks
Complete and permanent loss of hearing in both ears	104 Weeks
Complete and permanent loss of hearing in one ear	35 Weeks
Complete and permanent loss of sight in one eye	157 Weeks
The reduction in one eye to one-tenth or less of normal vision	157 Weeks
Complete and permanent loss of thumb on the master hand	63 Weeks
Thumb on the other hand	54 Weeks
Complete and permanent loss of first finger	36 Weeks
Complete and permanent loss of second finger	29 Weeks
Third Finger	21 Weeks
Fourth Finger	17 Weeks
Great Toe	28 Weeks
Any other toe	9 Weeks
Loss of the use of back	max. 374 Weeks

The following guideline for additional “non-scheduled” injuries has been developed by the Compensation Commissioners:

Heart	520 Weeks
Liver	347 Weeks
Lung	117 Weeks
Cervical Spine	117 Weeks
Kidney	117 Weeks
Rib Cage (bilateral)	69 Weeks
Nose (sense and respiratory function)	35 Weeks
Jaw (mastication)	35 Weeks
Testis	35 Weeks
Mammary	35 Weeks
Penis (within discretion of Commissioner)	35 to 104 Weeks
Senses (smell, taste)	17 Weeks
Spleen (in addition to scar)	13 Weeks
Tooth	1 Week
Speech	163 Weeks
Pancreas	416 Weeks
Carotid Artery	520 Weeks
Brain	520 Weeks
Coccyx (actual removal)	35 Weeks
Stomach	260 Weeks
Bladder	233 Weeks
Gall Bladder	13 Weeks

Loss of drainage- duct of eye:

Corrected	17 Weeks
Uncorrected	33 Weeks

**B. Number of weeks for "whole person" and standard for recovery.**

Connecticut does not recognize a permanent partial disability rating for the "whole person."

**23. Are there any requirements/benefits for vocational rehabilitation, and what is the standard for recovery?**

Vocational rehabilitation benefits are available to workers who suffer from a permanent impairment which substantially disables them or a significant period of time from performing the workers most recent or customary type of work. C.G.S. Section 31-283a. An employee may receive support for basic living expenses if they are not entitled to other enumerated benefits.

**24. How are permanent total disability benefits calculated, including the minimum and maximum rates?**

Permanent total disability benefits are calculated in the same manner as temporary total disability benefits. See answer 16. Certain injuries which are presumed to result in permanent total disability are listed in the statute. C.G.S. §31- 307(c).

**25. How are death benefits calculated, including the minimum and maximum rates?**

**A. Funeral expenses.**

Four thousand dollars (\$4,000) shall be paid for burial expenses in any case where the employee died on or after 1988. C.G.S. §31-306(a)(i).

**B. Dependency claims.**

A qualified dependent, such as a surviving spouse, receives the same weekly benefit as provided for temporary total or permanent total disability benefits. See answer 16. Special rules apply for allocating this benefit if there is a surviving spouse as well as dependent children who are not the offspring of the surviving spouse. C.G.S. §31-306.

**26. What are the criteria for establishing a "second injury" fund recovery?**

Transfer of claims to the Second Injury Fund for injuries after June 30, 1995 was eliminated by Public Act 95-277, §3. Public Act 96-242, §§1 and 2 imposed a "drop dead" transfer date of July 1, 1999 for all pending cases. While the Second Injury Fund is no longer acting in its former capacity, it still exists to administer non-insurance claims pursuant to § 31-355(b), and reimburse respondents in cases involving concurrent employment pursuant to § 31-310.

**27. What are the conditions for re-opening a claim for worsening of condition, including applicable limitations periods?**

The commissioners may modify both awards and voluntary agreements whenever it appears "that the incapacity of an injured employee has increased, decreased or ceased, or that the measure of the dependency on account of which the compensation is paid has changed, or that changed conditions of fact have arisen which necessitate a change of such agreement or award in order to properly carry out the spirit [of the Act]." C.G.S. § 31-315. There is no statute of limitations applicable to such requests for modifications. No modification is allowed if the employee has agreed to, and the commissioner has approved, a final settlement known as a "full and final stipulation," with the exception that the claimant can request a modification in order to prevent a reduction in Social Security benefits. In such situations, even when the full and final stipulation is modified, it cannot be done so in a manner that requires employers to pay benefits beyond the settlement payment.

**28. What situation would place responsibility on the employer to pay an employee's attorney fees?**

Such fees may be awarded if: (1) through fault or neglect, there is an unreasonable delay in paying benefits where no Notice to Contest is filed (thirty-five days is presumed to be "unreasonable"); or (2) the commissioner finds, after a hearing, that the employer/insurer has unreasonably contested liability. C.G.S. §31-300. If a claimant sustains a relapse of his or her injury, he or she may be entitled to a relapse rate for the calculation of benefits pursuant to C.G.S. §31-307b. The claimant has the ability to choose a compensation rate in effect at the original time of injury or at the time of relapse, whichever higher.

**EXCLUSIVITY/TORT IMMUNITY**

**1. Is the compensation remedy exclusive?**

**A. Scope of immunity.**

The compensation remedy is generally exclusive. C.G.S. §31-284.

**B. Exceptions (intentional acts, contractual waiver, "dual capacity," etc.).**

**i. Independent Legal Relationship**

The employer-employee relationship does not bar a claim brought by a party against the employer where the employer has agreed to provide indemnification to the entity sued by the employee. Ferryman v. Groton, 212 Conn. 138 (1999).

**ii. Statutory Exceptions**

An employee can sue a fellow employee for an injury caused by negligence if the action is based on the fellow employee's negligence in the operation of a motor vehicle. C.G.S. § 31-293a.

iii. Intentional/Reckless Misconduct

The Connecticut Supreme Court has carved out an exception to the exclusive remedy provisions of the Connecticut Workers' Compensation Act by allowing causes of action against employers for certain workplace injuries involving allegation of intentional or near certain injuries. Suarez v. Dumont Industries, 242 Conn. 255 (1997).

a. Intended tort theory – employer must have intended both the act itself and injuries, which are consequences of the act.

b. Substantial certainty theory – employer must have intended the act and have known that injury was substantially certain to occur from the act.

iv. Bad Faith Claim Against Insurer

The exclusivity provision of the Workers' Compensation Act bars a cause of action against an insurer for the bad faith processing of a workers' compensation claim. DeOliveira v. Liberty Mutual Ins. Co., 273 Conn. 487 (2005).

**30. Are there any penalties against the employer for unsafe working conditions?**

If an employee is injured due to the employer's violation of any state or federal OSHA regulation for which the employer has previously been cited but has not corrected, the employee shall receive weekly compensation equal to 100% of such employee's average weekly earnings. C.G.S. §31-307(b).

**31. What is the penalty, if any, for an injured minor?**

There is no specific penalty for an injured minor, although the commissioner has certain discretion with respect to establishing the rate of compensation. "For the purpose of determining the amount of compensation to be paid in the case of a minor under the age of 18 years who has sustained an injury entitling him to compensation for total or partial incapacity for a period of 52 or more weeks, or to specific indemnity for any injury ... , the commissioner may add 50% to his average weekly wage, except in the case of a minor under 16 years of age, in which case the commissioner may add 100% to his average weekly wage." C.G.S. §31-310.

**32. What is the potential exposure for "bad faith" claims handling?**

Attorneys' fees can be awarded by the commissioner if it is determined that an employer/insurer has unreasonably delayed payments or unreasonably contested liability. C.G.S. § 31-300. Civil actions for "bad faith" are barred by exclusivity unless there is egregious behavior by the claims handler that results in the insurer no longer acting on behalf of the insured.

**33. What is the exposure for terminating an employee who has been injured?**

An employer cannot discharge, or cause to be discharged, or in any manner discriminate against any employee because the employee has filed a claim for workers' compensation benefits or otherwise exercised the rights afforded to him pursuant to the provision of the Act. C.G.S. §31-290a.

An aggrieved employee may,

A. Bring a civil action in the superior court for reinstatement, payment of back wages and re-establishment of employee benefits. The court may also award punitive damages.

B. File a complaint with the chairman of the Commission. The Trial Commissioner may award reinstatement, payment of back wages and re-establishment of employee benefits. Any appeal proceeds directly to the Appellate Court.

### **THIRD PARTY CLAIMS**

**34. Can third parties be sued by the employee?**

Yes.

**35. Can co-employees be sued for work-related injuries?**

Yes, but only if the injury was caused intentionally or was the result of the negligent operation of a motor vehicle (there is extensive litigation over the meaning of "motor vehicle").

**36. Is subrogation available?**

Yes. C.G.S. §31-293, which authorizes an injured employee to maintain an action at law against any third party which may be liable for the injury, also creates a right in the employer to recover from the third party any amounts paid as compensation for the injury. Enquist v. General Datacom, 218 Conn. 19 (1991). If an employee initiates a third-party action against the tortfeasor, s/he is statutorily entitled to keep keeps one-third of the net proceeds of the settlement, regardless of the amount of the employer's lien. Although an employer is entitled to a moratorium against future benefits, the amount of that moratorium does not include the one-third portion paid to the employee. Callahan v. Car Parts International, LLC., 329 Conn. 564

(2019). The lien reduction is only applicable in those cases where the employee brings the third-party action; an employer can avoid the reduction by bringing the action itself.

If the employer, insurance company or Second Injury Fund does not intervene, a lien letter will protect the right of the two-thirds reimbursement of the workers' compensation lien.

## MEDICALS

### **37. Is there a time limit for medical bills to be paid, and are penalties available for late payment?**

Theoretically, the provisions outlined in answer 17 may be applicable to medical payments. As a practical matter, this issue does not arise often since payments are made directly to the medical provider.

### **38. What, if any, mechanisms are available to compel the production of medical information (reports and/or an authorization) at the administrative level?**

All medical reports concerning any injury of an employee sustained in the course of employment must be furnished to the employer. C.G.S. 31-294f. Although there is no statutory requirement that an employee produce an authorization, in practice they are routinely provided. If necessary, a party can seek an order from the commissioner for an authorization. Attorneys may also subpoena medical records from providers.

### **39. What is the rule on (a) Claimant's choice of physician; (b) Employer's right to second opinion and/or Independent Medical Examination?**

#### **A. Claimant's choice of physician.**

The claimant is permitted to select the physician. Conn. Gen Stat. § 31-294d. However, an employee may be limited to a list of providers who participate in the employers' Medical Care Plan. The employee may refuse the medical and surgical aid or hospital and nursing service provided by the employer and obtain the same at their own expense. § 31-294e.

#### **B. Employer's right to second opinion and/or Independent Medical Examination.**

Pursuant to C.G.S. § 31-294f, the employer is entitled to an Independent Medical Examination, also known as a respondents' medical examination (RME). A respondents' medical examination is used to obtain a second opinion on issues such as medical causation, diagnosis, need for surgery and extent of disability. A credible physician will carry more weight with the commissioner than a physician who has a reputation of being used exclusively by claimants. If there is a dispute in opinion between the treating physician and respondents' medical examiner the commissioner has the discretion to order a commissioner's examination. Although not binding, in practice this third opinion serves as a de facto "tie breaker".

**40. What is the standard for covered treatment (e.g. chiropractic care, physical therapy, etc.)?**

Virtually every type of care is compensable, including chiropractic care, physical therapy, podiatry, dentistry, psychiatry, and naturopathy, as long as it is deemed to be "reasonable or necessary." C.G.S. §31-294d. In addition, palliative treatment such as acupuncture and massage have been held, in certain instances, to be reasonable and necessary treatment. See Zalutko v. Danbury Hospital, Case No. 4299 CRB-7-00-4. Palliative care that allows an injured worker to maintain a work capacity is given the same level of credibility as curative medical treatment.

**41. Which prosthetic devices are covered, and for how long?**

All prosthetic devices are covered, and an employer is responsible for providing, maintaining, and replacing those devices throughout the employee's life. C.G.S. §31-294d. Generally, glasses only need to be replaced if they were damaged as part of a compensable injury.

**42. Are vehicles and/or home modifications covered as medical expenses?**

Although not specifically authorized by statute, such modifications are generally reimbursable when prescribed by a physician.

**2. Is there a medical fee guide or schedule, or other provisions for cost containment?**

Yes. The commission is required to publish annually a fee schedule setting the fees payable for services rendered by an approved medical provider. Payment of the established fee by the employer/insurer shall constitute full payment to the practitioner. The practitioner may not recover any additional amount from the employee. C.G.S. §31-280(b)(11)(B). A fee schedule for hospital and ambulatory surgical centers was created pursuant to Connecticut Public Act 14167.

**43. What, if any provisions or requirements are there for "managed care?"**

Employers with an approved managed care plan must provide employees with a listing of all physicians and pharmacies that will provide medical services and pharmaceutical services at which the employer or insurer is obligated to make direct payment. (§31-279 (c)).

### PRACTICE/PROCEDURE

**44. What is the procedure for contesting all or part of a claim?**

**Form 43 – Notice to Contest**

The employer/respondent is given a period of twenty-eight (28) days during which it may contest liability following receipt of a Form 30C Notice of Claim for compensation, or its



equivalent. However, an employer who commences payment to the claimant before the expiration of the twenty-eight (28) day period has up to one (1) year after such notice to contest compensability. This process is intended to encourage payment to the employee pending investigation of a claim while preserving an employer's defenses to a non-compensable event.

It is imperative that both employers, and insurance providers and/or third-party administrators be aware of this twenty-eight (28) day deadline if a disclaimer is necessary in order not to prejudice a claim. In the absence of a timely disclaimer a claimant will file a Motion to Preclude seeking to bar the employer from asserting defenses to compensability.

The employer and its insurance carrier should therefore be aggressive in its preliminary investigation so it can determine whether a denial is appropriate. Any payments issued during this investigation must be made on a "without prejudice" basis. The following considerations apply:

- A. The reasons for denial set forth on the Form 43 must be specific and not overly vague or general. "Alleged injury did not arise out of or in the course of employment" has been held sufficient for purposes of an initial denial.
- B. If the respondent fails to file a proper disclaimer or issue payments without prejudice within the twenty-eight-day time period, the respondent will be precluded from contesting compensability.
- C. The Form 43 should be filed by certified mail or hand delivered to the employee and the Commission. C.G.S. § 31-321. A Form 43 cannot be filed with the commission via fax. Woodbury-Correa v. Reflexite Corp., 190 Conn. App. 623 (2019).
- D. Defense counsel and claim handlers must be certain that the Form 43 is sent to the person claiming compensation. For example, if a death claim is pursued the disclaimer should be sent to the representative of the estate of the person who has died as well as any dependents who may have filed a written notice of claim for compensation.

#### 46. What is the method of claim adjudication?

##### A. Administrative level.

A commissioner is the "fact finder" at so-called "Formal Hearings" and enters a "Finding and Award" or a "Finding and Dismissal" following a bench trial. Within ten days from receiving meaningful notice of the commissioner's decision, either party may file an appeal to the Compensation Review Board. C.G.S. §31-301. Conaci v. Hartford Hospital, 36 Conn. App. 298 (1984). Three members of the Compensation Review Board, which is comprised of the Chairman

of the Workers' Compensation Commissioner and all of the state workers' compensation commissioners, then hear the appeal. C.G.S. §31-301 (b).

**B. Trial court.**

The trial courts do not hear workers' compensation appeals in Connecticut.

**C. Appellate.**

Any appeal from the Compensation Review Board must be filed within 20 days of the rendering of a decision. Such appeals are heard by the Connecticut Appellate Court. Any further appeal to the Connecticut Supreme Court may be made only by certification, and not as a matter of right.

**47. What are the requirements for stipulations or settlements?**

Under Connecticut law, there is no mandate that claims be settled or closed. Moreover, unlike some states, a claim under the Connecticut Act remains "open" for the life of the claimant or until the claim is settled. The claimant, however, continues to have the burden to prove that any ongoing claims relate back to the original work-related injuries. The parties may, however, elect to enter into a full and final settlement of the pending claims. Settlements are not final until they are approved by a commissioner at a stipulation approval hearing.

A full and final settlement closes the workers' compensation case entirely. This settlement takes the form of a written document, a "stipulation", which must be approved at a hearing by a commissioner. Once a stipulation is approved by a commissioner the claimant will no longer be able to pursue benefits, either medical or indemnity, for the injury which was the subject of the stipulation. Parties can also enter into "stipulation to date" agreements, whereby all issues up to the date of the document's approval are resolved. The claimant then retains the right to pursue future benefits and the respondents reserve the right to contest the same.

Commissioners will, however, refuse approval of settlement where, in their judgment, the best interests of the claimant are not met. The commissioner will examine all the facts carefully before approving a stipulation because of the serious consequences of entering into a stipulation. The factors considered by the trial commissioner include:

- A. Whether there are any past due lost wages or permanent partial benefits owed;
- B. Whether there are any outstanding medical bills relating to the compensable injury;
- C. Present and future medical needs including the possibility of surgery;
- D. Whether the claimant is currently employed;

- E. Whether the claimant currently has health insurance benefits;
- F. Collateral claims such as social security/Medicare, pension offsets, disability claims;
- G. Anticipated future exposure to the respondent for both medical and indemnity benefits;
- H. Life expectancy of the claimant and/or spouse; and,
- I. Whether the proposed settlement amount adequately reflects the future exposure of the claim.

The commissioner will discuss the settlement with the claimant to assure that the claimant fully understands the stipulation and its effect. Once the settlement is approved, the respondent has twenty (20) days in which to pay the stipulation. C.G.S. 31-303.

An original stipulation along with at least four (4) signed copies should be sent to claimant's counsel, who will have the claimant sign the documents and make arrangements for approval. Most district offices will schedule stipulation approval hearings on an expedited basis. The claimant and his/her counsel must attend the stipulation approval hearing so that the commissioner can ensure the meaning and effect of settlement are understood by the claimant. Respondents should be present in cases involving pro se claimants to ensure accuracy of the agreement and to explain the settlement to the commissioner.

Claims administrators should contact defense counsel for additional information on settlement procedure in Connecticut, especially for cases involving out of state claimants, multiple parties (employers and/or insurers), multiple injuries, and recovery of workers' compensation liens in third party actions. It should also be noted that in certain cases the underlying claim can be left open, but contested issues can be resolved through the present date and compromised by agreement, under what is called a "stipulation-to-date."

In order to properly evaluate future exposure in a workers' compensation case, thus valuing a claim for settlement, the following factors should be considered:

- A. Type of injury;
- B. Amount of benefits received to date;
- C. Amount of future benefits owed;

- D. Amount of future treatment and type of treatment;
- E. Recommended or anticipated future treatment;
- F. Age of the claimant;
- G. Age of dependents;
- H. Whether respondent's medical expert (IME) supports causal relationship;
- I. Is the claimant currently working for the same employer?
- J. If working for a new employer, what is the likelihood of new and/or intervening injury?

**48. Are full and final settlements with closed medicals available?**

Yes.

**49. Must stipulations and/or settlements be approved by the state administrative body?**

All stipulations and/or settlements must be submitted in writing to, and approved by, the Workers' Compensation Commissioner. C.G.S. §31-296.

**RISK FINANCE FOR WORKERS' COMPENSATION**

**50. What insurance is required, what is available (e.g. private carriers, state fund, assigned risk pool, etc.)?**

All workers' compensation policies sold in Connecticut must provide for complete coverage of all benefits allowable under the Act. Deductibles on such policies are not permitted. Insurance is available through private insurers, and there is an assigned risk pool administered by the State Insurance Department for the benefit of those employers who cannot obtain coverage through commercial insurers. Collective bargaining agreements can provide injured workers with rights above and beyond those available under the Act but cannot diminish or eliminate such rights.

**51. What are the provisions/requirements for self-insurance?**

- A. For individual entities.

An employer which does not insure the liability imposed by the Act may be authorized to act as a self-insurer by either securing a Certificate of Solvency from the Board of Compensation Commissioners or by filing with the Insurance Commissioner, in a form acceptable to the commissioner, security guaranteeing the performance of the obligations of the Act. To provide coverage against catastrophic loss from one accident, a self-insurer must purchase excess coverage from an insurer licensed by the Insurance Commissioner to write workers' compensation insurance. The assessments made by the state treasurer for the expenses of the operation of the Second Injury Fund and the Workers' Compensation Commission must be paid in full by the self-insured entity.

**B. For groups or "pools" of private entities.**

Employers who wish to insure their liabilities collectively as a mutual association must submit a plan to the Insurance Commissioner for approval. The association is subject to the jurisdiction of the Insurance Commissioner, as are other insurers. A mutual association must apply for a Certificate of Solvency, obtain excess coverage, and pay all assessments made by the state treasurer, like an individual self-insurer. A mutual association must be comprised of employers in the same industry which employ persons who perform comparable work. The group members must agree to provide for the joint and several liabilities of the group, and the other members' obligations.

**52. Are "illegal aliens" entitled to benefits of workers' compensation in light of The Immigration Reform and Control Act of 1986, which indicates that they cannot lawfully enter into an employment contract in the United States, although most state acts include them within the definition of "employee"?**

The Connecticut Workers' Compensation Act does not expressly include "illegal aliens" within the definition of "employee." However, the Connecticut Supreme Court has ruled that a claim for a work-related injury by an "illegal alien" is within the jurisdictional confines of the Connecticut Workers' Compensation Act. Dowling v. Slotnick, et al, 244 Conn. 781 (1998). Illegal aliens are permitted to collect total disability and permanent partial disability benefits. There remains a question of whether they are eligible for temporary partial disability benefits or post-specific benefits, although the general practice is to assume they are ineligible for those benefits based on the prerequisite of being "ready, willing, and able" to work in order to receive the same.

**53. Are terrorist acts or injuries covered or excluded under workers' compensation law?**

In Parsons v. United Technologies Corp., et al, 243 Conn. 66 (1997), the Court recognized a clear and defined public policy requiring an employer to provide a reasonably safe work place to its employees. In this regard the Court noted that the relevant inquiry is whether the employer directed the employee to work in a place or condition that posed an objectively substantial risk of death, disease, or serious bodily injury to the employee. Thus, if an employee could prove that a terroristic threat negated the employer's ability to provide a safe work-place, any resulting injury could arguably be covered under the Workers' Compensation Act.

**54. How are workers' compensation settlements affected by Medicare trusts and liens?**

Under Medicare regulations (42 CFR 411.46), Medicare is secondary payer to the payment of workers' compensation by a workers' compensation carrier or self-insured employer. The obligation to pay medical for a compensable condition cannot be shifted to Medicare. Therefore, Medicare has an interest in all lump sum settlements of a workers' compensation matter if at the time of the settlement the employee meets the following criteria:

- A. the employee is already a Medicare enrollee, in which case there is not a threshold settlement amount; or
- B. there is a reasonable expectation that the employee will be a Medicare enrollee within 30 months of the settlement *and* the settlement amount is greater than \$250,000.

If the employee meets the criteria for consideration by Medicare, Medicare must be notified in the event of a settlement. Upon review of the file, Medicare may conclude that the settlement does not meet its criteria, or it may require a Medicare set aside trust for large settlements, or it may require merely a custodial self-administered trust account. (Reference 42 CFR 404, 411; 42 USC 1395)

Medicare has several options and sanctions, but the enforcement varies for geographical regions of the country. Consult your ALFA lawyer for the current practice in your state for this evolving area of the law.

There is no Connecticut case law with regard to Medicare trusts. C.G.S. Section 38a-470 provides that "any insurer or medical service corporation, health care center, or employee welfare benefit plan" that has furnished benefits to any person suffering an injury or an illness covered by the workers' compensation act has a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner.

**55. How are subrogation liens of Medicaid and health insurers treated under workers' compensation law?**

The Federal Medicaid statute requires States to include in their plan for medical assistance provisions (1) that the individual will assign to the State any rights to payment for medical care from any third party and (2) that the individual will cooperate with the State in pursuing any third party who may be liable to pay for care and services available under the Medicaid plan. 42 U.S.C.A. 1396k(a). The State is authorized to retain such amount as is necessary to reimburse it (and the Federal Government as appropriate) for medical assistance payments and to pay the remainder to the individual. 42 U.S.C.A. §1396k(b).

Connecticut law provides that "any insurer or medical service corporation, health care center, or employee welfare benefit plan" that has furnished benefits to any person suffering an injury or an illness covered by the workers' compensation act has a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner.

**56. What are the requirements for confidentiality and privacy of medical records under workers' compensation law and how are they affected by state and federal law (HIPAA)?**

HIPAA law provides an exception for workers' compensation claims so as to allow the collection of medical records by employers and insurers. [45 C.F.R. 164.512(1)]

Under Connecticut General Statute Section 31-128f, no individually identifiable information contained in the personnel file or medical records of any employee shall be disclosed by an employer to any entity not affiliated with the employer in the absence of the employees' express written consent.

**57. What are the provisions for "Independent Contractors"?**

The determination of whether an employment relationship existed at the time of the injury is largely a factual question to be resolved by the commissioner. See, Merlin v. Labor Force of America, Inc., 3920 CRB-4-98-10 (December 22, 1999), *aff'd*, 62 Conn. App. 906 (2001)(per curiam), *cert. denied*, 256 Conn. 922 (2001)."

The test to be applied by the trial commissioner is set forth in Malchik v. Division of Criminal Justice, 266 Conn. 728 (2003). "[T]here is no dispute about the ultimate test [for deciding whether a worker is an employee under the Workers' Compensation Act]. It is the right of general control of the means and methods used by the person whose status is involved." Malchik, Id., 743.

In Dupree v. Masters, 1791 CRB-7-93-7 (April 25, 1995), *aff'd*, 39 Conn. App. 929 (1995 per curiam) it was found that when the nature of the work could have been performed as either an independent contractor or as an employee, the decisive factor is the claimant's tax filings.

**58. Are there any specific provisions for "Independent Contractors" pertaining to professional employment organizations/temporary service companies/leasing companies?**

There are no specific provisions. The issue is factual for the commissioner to decide.

**59. Are there any specific provisions for "Independent Contractors" pertaining to owner/operators of trucks or other vehicles for driving or delivery of people or property?**

As stated above, there are no specific provisions. If there is any question as to the right of control issue, then the commissioner will rely on the claimant's tax filing status and tax records. Independent Contractors are not covered by the Workers' Compensation Act, but often the question of whether an injured party is an employee or independent contractor is one that must be litigated.

**60. What are the "Best Practices" for defending workers' compensation claims and controlling workers' compensation benefits costs and losses?**

Financial exposure to workers' compensation is an expensive and complex challenge for every business. The best means for reducing and eliminating that exposure is a strong and individualized "Best Practices" plan.

Every business must deal with the expense of workers' compensation in its risk management and in dealing with the inevitable claim. The best approach to ameliorating a business exposure is a strong and individualized "Best Practices" plan.