IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

GARY ANDREASON,	)	
	)	
Appellant,	)	
	)	C.A. No. N12A-04-004 MMJ
v.	)	
	)	
ROYAL PEST CONTROL,	)	
	)	
Appellee.	)	

Submitted: January 2, 2013
Decided: March 19, 2013

On Appeal from Decisions of the Industrial Accident Board
AFFIRMED

MEMORANDUM OPINION

Walt F. Schmittinger, Esquire, Kristi Vitola, Esquire, Schmittinger and Rodriguez, P.A., Dover, Delaware, Attorneys for Appellant

John W. Morgan, Esquire, Anthony N. Delcollo, Esquire, Heckler & Frabizzio, Wilmington, Delaware, Attorneys for Appellee

JOHNSTON, J.

Gary Andreason ("Claimant") has appealed the January 21, 2011 ("2011 Decision") and the March 14, 2012 ("2012 Decision") Decisions of the Industrial Accident Board ("Board"). In the 2011 Decision, the Board denied in part Claimant's Petition to Determine Additional Compensation Due ("Petition") for his low back symptoms. The Board granted in part the Petition and awarded reimbursement for right shoulder injury, attorneys' fees, and medical witness fees. The 2012 Decision denied Claimant's Motion for Reargument.

Claimant contends that the Board's Decisions constituted legal error. Claimant requests that the Court reverse the Board's 2012 Decision and find that Employer's insurance carrier accepted the Claimant's low back injury as compensable, and award corresponding benefits. Employer requests that the Court affirm the Board's 2012 Decision on the basis that Employer's insurance carrier properly denied benefits for Claimant's low back injury.

FACTUAL AND PROCEDURAL CONTEXT

Claimant worked as a technician for Royal Pest Control ("RPC" or "Employer") for approximately six years. During the course of his employment, Claimant began to develop knee pain when kneeling and walking.[1] In an attempt to alleviate the pain,

[1] The Board determined this knee injury to be compensable, and awarded Claimant a total disability compensation rate of $500 per week, based on an average weekly wage of $750 per week at the time of the injury. That award is not in dispute, and therefore not a subject of this appeal.

Claimant underwent two surgeries between 2008 and 2009. Claimant was able to walk down stairs only with difficulty and he stated that his knee would "give out" occasionally. In November 2009, Claimant's knee gave out while he was walking down the stairs in his home, causing him to stumble and twist his body. As a result, Claimant alleged that he suffered injury to his right shoulder and low back.

On January 21, 2011, the Board granted in part and denied in part Claimant's Petition to Determine Additional Compensation Due. The Board determined that the injury Claimant suffered to his right shoulder was a result of his knee giving out on the stairs—constituting a compensable injury—and granted Claimant reimbursement of medical fees related to that injury. The Board also determined that the low back injury that the Claimant suffered was not a result of the knee giving out, and consequently denied reimbursement of those expenses.

Nevertheless, Employer's insurance carrier ("Carrier") paid various expenses relating to the back injury, later claiming these funds were paid by mistake. On February 8, 2011, Claimant filed a Motion for Reargument with the Board, requesting that the Board reconsider its decision in light of newly-found evidence of these payments made by the Carrier.[2] The Board determined that payments made in

[2] Subsequent to the January 10, 2011 hearing before the Board, Christiana Care sent a billing ledger to Claimant's attorney stating that the Worker's Compensation insurance carrier already had paid for Claimant's low back surgery.

compensation for Claimant's low back injury were made by mistake, and denied Claimant's Motion.

Claimant's Condition and Treatment

Claimant was being treated by Dr. Stephen Manifold, an orthopaedic surgeon, for problems with his knees beginning in 2008. During the same time period, Claimant was examined by Dr. Jerry Case, an orthopaedic surgeon. Claimant initially underwent surgery on April 22, 2008, performed by Dr. Manifold's partner, Dr. Easter. Dr. Manifold performed a second surgery on Claimant's knee on June 30, 2009. In November 2009, Claimant was walking down the stairs in his house, his knee gave out, and he twisted his body to arrest his fall.

On November 16, 2009, Claimant saw Dr. Manifold for treatment related to this fall. At that time, Claimant complained of shoulder and knee pain, but did not mention any pain in his low back. Dr. Manifold evaluated Claimant's complaints and ordered an MRI of the shoulder. Based on the results of the MRI and a physical examination of Claimant's shoulder, Dr. Manifold diagnosed partial tearing of Claimant's rotator cuff.

On November 23, 2009, Claimant returned to Dr. Manifold with continued shoulder discomfort. Dr. Manifold administered a cortisone injection to the right shoulder. This treatment did not provide any significant relief. Dr. Manifold

recommended physical therapy for Claimant, but Claimant never returned to Dr. Manifold after early December, and Dr. Manifold never received any physical therapy notes.

In December 2009, Claimant was "scouting" for deer in the woods when he slipped on leaves while stepping over a log. He felt a twinge in his back and into his buttocks while attempting to prevent himself from falling. Claimant's primary care physician, Dr. Pollner, prescribed hydrocodone and bed rest.

In mid-December 2009, Claimant suffered severe pain and sought treatment from the VA hospital where the doctor said Claimant "blew his back out." On December 24, 2009, Claimant went to the Emergency Room at Christiana Hospital seeking further care. Dr. Michael Sugarman, a neurosurgeon, began treating Claimant at Christiana Hospital on December 26, 2009. Claimant complained of back pain that had begun roughly three weeks prior to arriving at the Hospital, and claimed that he had no other significant history of back problems. Dr. Sugarman recommended immediate surgery, which he performed on Claimant's back on December 29, 2009.

Following the surgery, Dr. Sugarman examined Claimant in January and March of 2010, and recommended physical therapy as part of the on-going treatment of Claimant's back. Dr. Sugarman performed a second surgery on Claimant's lumbar

spine on July 22, 2010, fusing L4-5 and L5-S1.

Payments by Employer's Insurance Carrier

Nesta Henlon, an adjuster who had worked for Chartis Insurance Company ("Carrier") for 25 years, had worked on Claimant's case since its origination. Claimant's April 6, 2008 work-related injury had been accepted as compensable at the beginning of the case. Henlon testified that her practice upon receipt of a case is to mark it with a certain code, signifying whether it had been accepted as compensable. An "A" on the file indicated it was compensable. A mark of "D" indicated the case was denied. When she had not made a final determination as to acceptance, the case was marked with a "P," for pending. Claimant's case was marked with an "A."

Henlon paid the bills related to knee treatments as she received them from medical providers. Henlon testified that she was aware that a hearing had been held before the Board to determine Claimant's eligibility to receive compensation for a low back injury, and that the Board had denied compensability for that injury. Henlon nevertheless paid an $18,667.30 bill from Christiana Care related to treatment for the low back.

Henlon maintained that she paid this bill in error. When she learned of the mistaken payment, Henlon stated that "in the back of her mind" she believed that the

bills she paid were related to Claimant's knee injury, although she did not review every bill to ensure they were related to a compensable injury.[3] Henlon discovered the mistaken payment following a routine audit of the case. She informed the Board that this particular bill would likely have been independently discovered since a bill of this large amount would have been further audited. After discovering the mistaken payment to Christiana Care, Henlon investigated the case further and discovered roughly forty (40) additional bills between March 2010 and October 2010 related to Claimant's low back treatment. Those approved payments totaled $33,050. Henlon requested a refund in a letter dated February 1, 2011. Christiana Care subsequently refunded that amount.

While Henlon alleged that all of the bills related to treatment of Claimant's low back injury were erroneously paid, the only payment for which Henlon requested and received reimbursement was the $18,667.30 payment to Christiana Care. Henlon further admitted that the insurance company had considered paying for Claimant's low back injury until it received a report prepared by Dr. Case on May 11, 2010 indicating that the back injury was unrelated to Claimant's work-place injury.

[3] Henlon testified that, as she handled roughly 150 cases at the time, it would have been impossible to review each bill as she received it. She further stated that, while other employees of the insurance company might review a bill to determine the amount to pay, she had the sole discretion over whether to pay a bill or not.

The Board's Decision

Following a hearing on Claimant's Motion for Reargument, the Board found that the Carrier made payments on behalf of Claimant by mistake rather than under a feeling of compulsion. Therefore, there was no implied agreement to accept the low back bills as compensable. The Board determined that Henlon did not approve payment of the bills relating to Claimant's low back under a belief that the Carrier or Employer was obligated to do so. Rather, Henlon mistakenly approved all of the bills received for treatment of Claimant, instead of appropriately approving the payment of bills relating to Claimant's shoulder and knee treatment and denying the payment of bills relating to treatment of Claimant's low back injury.

STANDARD OF REVIEW

On appeal from the Industrial Accident Board, the Superior Court must determine if the Board's factual findings are supported by substantial evidence in the record.[4] "Substantial evidence" is less than a preponderance of the evidence but is more than a "mere scintilla."[5] It is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[6] The Court must review the record

---

4 *Histed v. E.I. DuPont deNemours & Co.*, 621 A.2d 340, 342 (Del. 1993).

5 *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

6 *Histed*, 621 A.2d at 342 (citing *Olney v. Cooch*, 425 A.2d 610, 614 (Del. 1981)).

to determine if the evidence is legally adequate to support the Board's factual findings. The Court does not "weigh evidence, determine questions of credibility or make its own factual findings."[7] If the record lacks satisfactory proof in support of the Board's finding or decision, the Court may overturn the Board's decision. On appeal, the Superior Court reviews legal issues *de novo*.[8]

DISCUSSION

Failure to Prosecute

As a threshold matter, RPC urges this Court to dismiss Claimant's appeal for a failure to prosecute under Superior Court Rule 72(i) on the grounds that Claimant filed his Opening Brief after the deadline had passed.

Superior Court Rule 72(i) states in relevant part:

> The court may order an appeal dismissed, *sua sponte*, or upon a motion to dismiss by any party. Dismissal may be ordered for untimely filing of an appeal, for appealing an unappealable interlocutory order, for failure of a party to diligently prosecute the appeal, for failure to comply with any rule, statute, or order of the Court, or for any other reason deemed by the court as appropriate.

---

7 *Olney*, 425 A.2d at 614.

8 *Person-Gaines v. Pepco Holdings, Inc.*, 981 A.2d 1159, 1161 (Del. 2009).

This remedy is discretionary, not mandatory. The Court must balance the technical violation against the interests of justice inherent in a particular case.[9] As the violation becomes more egregious, the presumption tilts in favor of granting the dismissal.[10]

Here, the Claimant's Opening Brief was due on September 7, 2012, but was not filed until September 15, 2012. In the context of this case, an eight-day delay does not rise to the level of egregiousness necessary to overcome the interest of justice in deciding this matter on its merits. Accordingly, RPC's request to dismiss this matter for a violation of Superior Court Rule 72(i) must be denied.

Waiver

Employer also argues that this matter should be dismissed upon a theory of waiver by Claimant. Employer contends that Claimant raised entirely new arguments on appeal and failed to initially present them to the Board. Specifically, Employer takes issues with Claimant's argument that 19 *Del. C.* § 2322(h) has supplanted the "feeling of compulsion" doctrine. By failing to raise this argument before the Board, Employer contends that the Claimant has waived this issue and should be barred from raising it now.

---

[9] *See OperaDelaware v. Kerchner*, 2000 WL 302652, at *1 (Del. Super.) (refusing to dismiss appeal when the opening brief was filed three days late).

[10] *See Air Prods. & Chems. v. McDougall*, 1999 WL 1611273, at *2 (Del. Super.) (granting dismissal where appellant failed to file an appeal within thirty days).

Because the Court will resolve this appeal on other grounds, the Court need not address Employer's waiver argument.

Claimant's Low Back Injury Was Not Work-Related

The Board denied Claimant's Petition to Determine Additional Compensation Due as to his low back symptoms, finding that this complaint was not related to Claimant's work-related knee injury. In reaching this conclusion, the Board rejected the testimony of Dr. Sugarman, noting conflicting reports by the Claimant as to when the low back pain began and what event precipitated the pain. According to the Board, Dr. Sugarman's diagnosis was based primarily on Claimant's report that his complaints began following the fall on the stairs. Further, the Board noted that onset of Claimant's low back complaints began approximately one month after the fall on the stairs, and immediately following the time that Claimant fell on leaves while "scouting" for deer.

Dr. Sugarman opined that the fall on the stairs caused acute disc herniation in Claimant's low back. According to Dr. Sugarman, Claimant reported no back symptoms prior to the fall, followed by the progression of symptoms necessitating surgery and physical therapy. Dr. Sugarman reviewed hand-written notes prepared by Dr. Pollner, Claimant's primary care physician. Although Dr. Sugarman found the

majority of the notes illegible, he was able to identify a portion of the notes that referred to an incident where Claimant "slipped on leaves."

Dr. Case reviewed Claimant's medical records. Dr. Case considered Claimant's failure to disclose any back injury to Dr. Manifold when Claimant was initially examined, and Claimant's failure to initially notify Dr. Sugarman or Dr. Pollner of the fall on the stairs during the course of their examinations of the Claimant. Dr. Case opined that Claimant's low back injury was unrelated to the fall on the stairs. Dr. Case also found it significant that Claimant never received treatment for the low back injury prior to the end of 2009. Further, Claimant's medical records failed to mention any fall on stairs.

The Court finds that the Board's determination—that Claimant's low back complaint was not work-related—is supported by substantial evidence. The Board was presented with conflicting medical testimony. As the trier of fact, the Board is free to accept one expert opinion and reject the other.[11] Therefore, the Board's conclusion—that the low back injury is not compensable—is hereby affirmed.

Board's Decision on Reargument

The Board denied Claimant's Motion for Reargument. The Board held:

> Based on the available evidence, the Board concludes that the payment of low back-related medical bills was not compelled by a belief that the

[11] *Opalach v. Diagnostic Imaging, P.A.*, 2007 WL 2758773, at *4 (Del. Super.).

> low-back injury had been accepted as compensable by the carrier. Henlon may have felt compelled to pay the bills under compulsion of the Act, but only in relation to the accepted injury to the right knee, not in relation to the low back. This is not enough for the Board to imply an agreement as to compensation for the low back. The Board believes that Henlon showed, at a minimum, a lack of diligence and care in performing her job as a claims adjuster; however, even gross negligence in Henlon's performance of her job would not be enough to place liability for the underlying low-back injury on the Employer. To invoke an "implied agreement" as to compensation, the payments had to have been made under the feeling o[f] compulsion that the Act required Henlon to do so because the low-back injury was related to the work accident. *See Tenaglia-Evans v. St. Francis Hospital*, [] 2006 WL 3590385 (Del. Dec. 11, 2006) (finding no implied agreement where carrier paid for two surgeries to cervical spine without any formal agreement that recognized a cervical spine injury, citing the earlier acceptance of a low back injury in the case and the testimony from the adjuster that the payment had been carelessly authorized). The Board believes this case to be comparable to *Tenaglia-Evans* and similarly concludes that the payments were not made under the necessary feeling of compulsion. Therefore, the Board finds no implied agreement to accept the low back bills as compensable.

The Board explained its conclusion:

> After considering the additional evidence offered at the hearing on reargument, the Board finds that the Employer/[C]arrier paid the low back-related bills by mistake and not under a feeling of compulsion under the Workers' Compensation Act. The Board accepts [] Henlon's testimony that she paid the low back bills because the claim was marked as "Accepted" when she viewed the individual bills on her computer. She explained that she was aware of the previously accepted claim for a right knee injury, and she never actually read the bills or accompanying medical records before paying the bills. She acknowledged that the text of the bills, the medical records, and the names of the providers were readily available to her online; however, she would just see the "A" for "Accepted" on the bills and pay them.

> She insisted that she cannot review every medical bill she receives because of the volume of bills and the pressure to get payments out quickly. Currently, she has 150 Delaware workers' compensation cases assigned to her. Some of Henlon's testimony is difficult to believe, especially given her 25 years experience as an insurance adjuster. Nonetheless, Claimant did not offer any explicit evidence to show an intent or promise by the [C]arrier to accept compensability for the low back at any point, though the [C]arrier may have been considering doing this before Dr. Case conducted his DME. Claimant himself appears to have assumed the Employer/[C]arrier was disputing compensability of the low back claim, since Claimant filed a DACD in August 2010 and pursued it through to a hearing in December 2010.

The Board relied on *Tenaglia-Evans v. St. Francis Hospital*[12] in support of its position that a payment made by an employer or an employer's insurance carrier to an employee, paid by mistake rather than under a feeling of compulsion, does not create an implied agreement. In *Tenaglia-Evans*, the Supreme Court held that, when an insurance adjuster, who carelessly approved every claim, authorized payment for claimant's surgery, such payment was solely a result of the "poor performance" of the insurance adjuster.[13] Such payments were made by mistake, and not as a result of a feeling of compulsion on the part of the employer.[14]

19 **Del. C.** *§ 2322(h) Does Not Create Liability as a Result of Mistaken Payments*

---

12 2006 WL 3590385, at *3 (Del.)

13 *Id.*

14 *Id.*

Claimant contends that 19 *Del. C.* § 2322(h), enacted by the General Assembly shortly after the Supreme Court's *Tenaglia-Evans* decision was issued, creates an exclusive method by which an employer or its insurance carrier can make payments to an employee without admitting to liability. If an employer or its insurance carrier fails to follow the statutory procedures, Claimant contends, it has effectively conceded payment liability, and is thereafter obligated to the employee. As neither the Employer nor Carrier in the present matter followed the statutory procedures outlined in Section 2322(h), Claimant alleges that Employer or Carrier has conceded liability to Claimant.

Section 2322(h) provides:

> (h) An employer or insurance carrier may pay any health care invoice or indemnity benefit without prejudice to the employer's or insurance carrier's right to contest the compensability of the underlying claim or the appropriateness of future payments of health care or indemnity benefits. In order for any provision or payment of health care services to constitute a payment without prejudice, the employer or insurance carrier shall provide to the health care provider and the employee a clear and concise explanation of the payment, including the specific expenses that are being paid, the date on which such charges are paid, and the following statement, which shall be conspicuously displayed on the explanation in at least 14-point type:
>
> > This claim is IN DISPUTE and payment is being made without prejudice to the Employer's right to dispute the compensability of the workers' compensation claim generally or the Employer's obligation to pay this bill in particular.

> (1) Partial payment of the uncontested portion of a partially contested health care invoice shall be considered a payment without prejudice to the right to contest the unpaid portion of a health care invoice, provided the above notice requirements are met.
>
> (2) No payment without prejudice made under a reservation of rights pursuant to this subsection shall be subject to return, recapture or offset, absent a showing that the claim for payment was fraudulent.
>
> (3) No payment without prejudice that complies with the above is admissible as evidence to establish that the claim is compensable.
>
> (4) No payment without prejudice that complies with the above shall extend the statute of limitations unless the claim is otherwise determined by agreement or the Board to be compensable.

Section 2322(h) provides a mechanism by which an employer or its insurance carrier is permitted to make a payment of medical expenses to an employee while reserving the right to later dispute liability. Section 2322(h) does not disturb the Supreme Court's holding in *Tenaglia-Evans*. The *Tenaglia-Evans* Court ruled that a payment made by an employer or its insurance carrier to an employee by mistake, and without a feeling of compulsion, does not create an implied agreement as to liability.

The "feeling of compulsion" doctrine only applies when the payment of expenses is accompanied by a "'compulsion' on the part of the employer or its insurance carrier to pay the expenses."[15] A payment of expenses by mistake lacks

[15] *Tenaglia-Evans*, 913 A.2d 570.

this compulsion. Therefore a mistake cannot form the basis for an implied agreement to pay additional medical bills.[16]

Because Section 2322(h) became effective only one month following the Supreme Court's decision in *Tenaglia-Evans*, it appears that Section 2322(h) was not enacted in response to *Tenaglia-Evans*. Claimant cites to no authority suggesting that the General Assembly enacted Section 2322(h) for the purpose of superseding the *Tenaglia-Evans* holding.

The Board determined that Carrier paid Claimant's low back-related medical expenses by mistake. This finding is supported by substantial evidence, and the Court will not disturb that finding. Making the payments by mistake, Carrier lacked a "feeling of compulsion" required to create an implied agreement to make additional payments. Therefore, the Board's determination – that Employer is not liable for Claimant's low back injury – must be affirmed.

---

[16] *Id.*

CONCLUSION

Substantial evidence supports the Board's determination that Carrier paid the medical expenses relating to Claimant's low back injury by mistake, and not under a feeling of compulsion. Thus, no implied agreement to make additional payments exists. The Board correctly determined that that Employer is not liable for medical expenses relating to Claimant's low back injury, and that 10 *Del. C.* § 2322(h) does not apply to payments made by mistake.

THEREFORE, the Decisions of the Industrial Accident Board dated January 21, 2011 and March 14, 2012 are hereby **AFFIRMED**.

IT IS SO ORDERED.

/s/ *Mary M. Johnston*

The Honorable Mary M. Johnston