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IN THE SUPREME COURT OF DELAWARE

HOWARD VANVLIET, Claimant Below-Appellant, v. D & B TRANSPORATION, Employer Below-Appellee.	No. 242, 2014 Court Below: The Superior Court of the State of Delaware, in and for Kent County, C.A. No. 13A-06-002 JTV

OPENING BRIEF OF CLAIMANT BELOW-APPELLANT

SCHMITTINGER AND RODRIGUEZ, P.A.

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DATED: July 2, 2014

Table of Contents

Table of Citations

Cases

Statutes

Nature of the Proceedings

This is Claimant's limited appeal of the Superior Court's decision dated April, 30, 2014, D & B Transportation v. VanVliet, 2014 Del. Super. LEXIS 211. The Superior Court's decision was rendered following a decision by the Industrial Accident Board (hereinafter "I.A.B." or "Board") dated May 15, 2013 in the case of Howard VanVliet v. D & B Transportation, I.A.B. Hearing No. 1184191 (May 15, 2013). The Board's decision was rendered following a remand hearing that was consolidated with Claimant's Petition for Additional Compensation Due seeking payment of ongoing pain management treatment. The Board held that Claimant's 2010 cervical spine surgery and pain management treatments were reasonable, necessary and related to the Claimant's work accident. VanVliet, at *18, 19. The Board awarded payment of Claimant's medical bills as well as payment of medical witness fees and attorney fees. VanVliet, at *21.

Thereafter, the Employer below-Appellant filed an appeal to the Superior Court of the State of Delaware, in and for Kent County.

The Superior Court reversed the Board's decision in part and affirmed it in part. The Superior Court reversed the Board's decision to award medical treatment by Dr. Sonti and affirmed the Board's decision awarding pain management treatment.

Thereafter, the Claimant below-Appellant filed the instant appeal to this Court. The Claimant's appeal is limited to the Court's reversal of the award for medical treatment provided by Dr. Sonti.

This is the Opening Brief of the Claimant below-Appellant.

Summary of the Arguments

1. The Superior Court erred as a matter of law when it determined that an out of state provider must comply with the Delaware Worker's Compensation Health Care Payment System.

Statement of Facts[1]

The Claimant below-Appellant is Howard VanVliet. The Employer below-Appellee is D & B Transportation.

The Claimant filed a Petition to Determine Additional Compensation Due seeking surgical authorization as well as medical expenses, transportation expenses, total disability and medical witness and attorney's fees on or about August 23, 2010. Trial was set for December 22, 2010.

On November 12, 2010, the Employer/Carrier requested a legal hearing seeking dismissal of Claimant's Petition, noting that Claimant received medical treatment by a healthcare provider that is not certified under Delaware law/healthcare regulations and that the Claimant did not seek pre-approval prior to having the surgery.

The Board held a legal hearing on December 8, 2010 to address Employer's Request for Dismissal. Employer alleged that Claimant failed to comply with 19 Del. C. § 2322D when he received medical treatment from an out of state, non-certified provider under Delaware's Worker's Compensation statute without receiving pre-authorization from the insurance carrier. Claimant argued that under Polk v. Green Acres Pavilion, I.A.B. Hearing No. 1253843

[1] As this appeal is limited to the issue of the Superior Court's failure to award medical treatment by Dr. Sonti, the Statement of Facts will be limited to those facts germane to that issue, along with such other information as is necessary to place the controversy in context.

(December 4, 2009), treatment by a non-certified, out of state provider does not foreclose the ability of an injured worker or treating physician to seek reimbursement for the care rendered; instead it simply removes the presumption and shifts the burden of proving reasonableness and necessity of the care to the worker or non-certified provider.

Following the legal hearing the Board dismissed the portion of Claimant's Petition that requested reimbursement for his surgery and related medical expenses, but found that "the mere fact that treatment is unauthorized (and, hence, not compensable under the Workers' Compensation Act) does not mean that it rises to the level of unreasonable treatment such as would break the chain of causation." VanVliet, at *8. The Board concluded that although the Claimant's surgery was not compensable, the Claimant "still had a viable claim for total disability as a result of that surgery." Id.

Following the Board's decision, the Employer/Carrier offered to pay Claimant temporary total disability benefits from the date of the surgery performed by Dr. Sonti through November 2, 2010. The Claimant accepted the offer, and as a result, benefits were paid and Agreements and Receipts were filed and approved by the Board.

On September 17, 2011, the Claimant appealed the Board's decision to dismiss a portion of his Petition to the Superior Court. Following briefing, the

Superior Court reversed and remanded the decision back to the Board on November 28, 2012. Shortly before the Superior Court issued the November 28, 2012 decision, Claimant filed another Petition to Determine Additional Compensation Due for additional medical bills on or about September 11, 2012. The issues on remand and the newly filed Petition were consolidated and heard by the Board on May 2, 2013.

Following that hearing, the Board held that Claimant's 2010 cervical spine surgery and pain management treatments were reasonable, necessary and related to the Claimant's work accident. VanVliet, at *18, 19. The Board awarded payment of Claimant's medical bills as well as payment of medical witness fees and attorney fees. VanVliet, at *21.

Thereafter, the Employer below-Appellant filed the instant appeal to the Superior Court of the State of Delaware, in and for Kent County in which it appealed the Board's decision in its entirety as well as the decision of the Superior Court dated November 28, 2012.

The Superior Court issued its decision on April 30, 2014, reversing the Board's decision in part and affirming it in part. D& B Transp., *supra.* The Superior Court reversed the Board's decision awarding medical treatment by Dr. Sonti finding that "the claimant cannot recover his medical expenses from his 2010 spinal surgery because Dr. Sonti was not certified nor preauthorized to

perform the treatment as required by 19 Del. C. § 2322D(a)(1)." Id. at *10. The Superior Court affirmed the Board's decision awarding payment of pain management treatment by Dr. Dickinson. Id. The Superior found that the Board's decision was "supported by substantial evidence and free from legal error." Id. That portion of the Court's decision is not being appealed.

On May 13, 2014, the Claimant appealed the Superior Court's decision to reverse the Board's award of Dr. Sonti's treatment to this Court.

This is Claimant's Opening Brief.

Argument

ISSUE 1: The Superior Court erred as a matter of law when it determined that an out of state provider must comply with the Delaware Worker's Compensation Health Care Payment System.

Questions Presented

Did the Superior Court err as a matter of law when it determined that an out of state doctor must comply with the Delaware Worker's Compensation Health Care Payment System?

The issue regarding Claimant's treatment with Dr. Sonti was presented to the Board during the hearing at Hearing Transcript 5 (hereinafter TR-___), A-10 and starting on page 4 of Claimant's Opening Brief below.

Scope of Review

In reviewing whether the Superior Court erred, this Court's review of questions of law, such as the construction of the worker's compensation statute, is *de novo*. Duvall v. Charles Connell Roofing, 564 A.2d 1132 (Del. 1989), Avila-Hernandez v. Timber Products, et. al., 2012 Del. Super. LEXIS 18, (January 6, 2012). Not only is the issue of construction of statutory law subject to plenary review by the Court but so is the application of that law to undisputed facts. Id., *citing* Pub. Water Supply co. v. DiPasquale, 735 A.2d 378, 381 (Del. 1999)(quoting Stoltz Mgmt. Co., Inc. v. Consumer Affairs Bd, 616 A.2d 1205,

1208 (Del. 1992). Thus, the Court may consider, but does not defer to, an agency's interpretation of a statute it administers even if the agency's interpretation is rational or not clearly erroneous. Id. at *7-8.

Merits of Argument

The issue in this case is whether a physician practicing outside of the State of Delaware can be compelled to comply with the Delaware Workers' Compensation Health Care Payment System when the provider has not chosen to become a certified provider within Delaware's system. In the present case, the Claimant's surgeon performed neck surgery on August 11, 2010. Claimant filed a Petition requesting first authorization and then ultimately payment of his medical bills in relation to the surgical procedure. The Superior Court held that the claimant cannot recover his medical expenses from his 2010 spinal surgery because Dr. Sonti, a Maryland physician, was not certified nor preauthorized to perform the treatment as required by 19 Del. C. § 2322D(a)(1).

When interpreting the Worker's Compensation Act, the Court engages in a liberal construction so as to accomplish the statute's purpose to compensate injured employees, resolving "any reasonable doubts in favor of the worker." Avila-Hernandez, *supra.* at *9, *citing* Lawhorn v. New Castle County, 2006 Del. Super. LEXIS 187 (Del. Super. May 1, 2006) *aff'd*, 913 A.2d 570 (Del. 2006). "[T]he Workers' Compensation Act specifically states that '[n]o agreement, rule,

regulation or other device shall in any manner operate to relieve any employer or employee in whole or in part from any liability created by this chapter, except as specified in this chapter.'" Id., *citing* 19 Del. C. § 2305. Additionally, the courts in Delaware "apply rules with a 'liberal construction because of the underlying public policy that favors' a litigant's right to a day in court as opposed to a judgment due to default." Id., *citing* Dishmon v. Fucci, 32 A.3d 338 (Del. 2011).

Title 19 Del. C. §2322(a) contains the following language:

> During the period of disability the employer *shall furnish* reasonable surgical, medical, dental, optometric, chiropractic and hospital services, medicine and supplies, including repairing damage to or replacing false dentures, false eyes or eye glasses and providing hearing aids, as and when needed, unless the employee refuses to allow them to be furnished by the employer. (emphasis added).

This statute is unambiguous and requires an employer to furnish reasonable surgical services during the employee's period of disability. Notably, the statute makes no distinction between treatment rendered within the state of Delaware versus outside the state. However, the Court reversed Board's award of medical treatment for Dr. Sonti because Dr. Sonti was not certified and did not obtain pre-authorized citing to 19 Del. C. 2322D(a)(1).

Nineteen Del. C. § 2322D(a)(1) imposes requirements on health care providers; importantly, it does not place any obligations upon Claimants[2]. In the present case, the provider who performed Claimant's surgery was not a certified provider under 19 Del. C. §2322C (a)(1); however, he was not required to be as he is a provider practicing in Maryland, not Delaware and thus not subject to Delaware law while outside the bounds of our State. If a person is not "present within the state, due process requires that he have certain minimum contacts with it to ensure that he has fair warning that a particular activity may subject him to jurisdiction in another state." Healthtrio v. Margules, 2007 Del. Super. LEXIS 34, 21 (January 16, 2007), *citing* International Shoe Co. v. Washington, 326 U.S. 310, 316, 66 S. Ct. 154, 90 L. Ed. 95 (1945). In order for the Courts of Delaware to have personal jurisdiction over Dr. Sonti it must be either general or specific jurisdiction. Title 10, Section 3104(c)(4) of the Delaware code provides in part:

> (c) As to a cause of action brought by any person arising from any of the acts enumerated in this section, a court may exercise personal jurisdiction over any non-resident or his personal representative, who in person or through an agent:

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[2] There is no requirement in 19 Del. C. §2322D or elsewhere that precludes Claimants from seeking treatment with providers outside the boundaries of the State of Delaware. The statute specifically states that "[c]ertification shall be required for a health care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health care provider first preauthorize each health care procedure, office visit or health care service to be provided to the employee with the employer or insurance carrier." 19 Del. C. § 2322D(a)(1). The statute goes on to list the requirements for certification, these are requirements for the providers to fulfill, not Claimants.

* * * *

> (4) Causes tortuous injury in the State or outside of the State by an act or omission outside the State if he regularly does or solicits business, engages in any other persistent course of conduct in the State or derives substantial revenue from services, or things used or consumed in the State.

In the present case, Dr. Sonti treated Claimant entirely within the state of Maryland, there was no evidence that any of Dr. Sonti's treatment occurred within Delaware or that Dr. Sonti had any contact whatsoever with the state of Delaware. Clearly there is no specific jurisdiction over Dr. Sonti as her treatment of Claimant took place entirely within the state of Maryland. "[W]hen a state exercises personal jurisdiction over a defendant in a suit not arising out of or related to the defendant's contact with the forum, the state has been said to be exercising 'general jurisdiction' over the defendant." Mayhall v. Ming Tar Factory Co., LTD., 1994 Del. Super. LEXIS 705, *citing* LaNuova D & B, S.p.A. v. Bowe Co., Inc., 513 A.2d 764, 768 (Del. 1986). The Superior Court has held that in order for Delaware courts to exercise general jurisdiction over a person the person's "activities in the forum must be continuous and substantial." Id. at *7. The Legislation's reach in enacting 19 Del. C. §2322C cannot extend any further than this Court's jurisdiction to apply same.

In this case the Claimant's treatment did not occur within the state of Delaware, so no specific jurisdiction can be exercised over Dr. Sonti's treatment. Additionally, there was no evidence presented to the Board to prove

that Dr. Sonti has continuous or substantial contacts with the state of Delaware such that the Delaware courts may exercise jurisdiction over her treatment. To subject out of state physicians to the rules and regulations of the states of each of their patients would be unduly burdensome to physicians. Requiring Dr. Sonti to follow the rules and regulations of the state of Delaware when she does not practice in Delaware and has not become a certified provider under Delaware's Worker's Compensation State would be a violation of her due process rights.

When a physician is certified per the Worker's Compensation Statute "the certification rules shall require that any health care provider to be certified agree to the following terms and conditions: a. Compliance with Delaware worker's compensation laws and rules. . ." 19 Del. C. § 2322D(a)(2). Accordingly, if a physician is certified under the worker's compensation statute then they must comply with the Delaware Fee Schedule and accept those amounts set forth in the statute. However, it is noteworthy that the Statute provides payment to out-of-state providers that are not licensed to practice in the State of Delaware separate from those providers who are licensed to practice medicine in the State of Delaware. The Statute provides a separate valuation for payment to physician's who are not licensed in Delaware. For those physicians, the carrier/employer must pay the greater of the fee schedule in place in the state in which the procedure takes place if one exists or the fee schedule in the Delaware

geozip in which the injury took place or where the employee is principally assigned. 19 Del. C. § 2322B(6). However, if a physician who is licensed to perform such a procedure in Delaware but performs the procedure outside Delaware, they are entitled to the amount set forth in the fee schedule. Id. If the Legislature intended for out-of-state providers to become certified prior to treating an injured worker then that provider would be bound by Delaware's Fee Schedule and there would be no need for the differentiation and the language that those providers receive the greater of the Fee Schedule in the State which the procedure is performed or Delaware's fee schedule.

This Court recently addressed this case in its Wyatt v. Rescare Home Care, 2013 Del. LEXIS 591. This Court held that 19 Del. C. § 2322D requires providers be either certified or preauthorize their care for treatment of injured workers. Id. at *20. However, the present case is readily distinguishable from the Wyatt case. Whereas Wyatt involved a Delaware physician who was not certified, in the present case the provider was not a licensed physician in Delaware and did not practice medicine in Delaware. All of the Claimant's treatment was performed entirely out of the state of Delaware.

The IAB has drawn two different conclusions regarding treatment by out-of-state providers who are not certified under Delaware's Worker's Compensation Statute. In one instance the Board declined to dismiss Claimant's

Petition seeking payment of medical bills from an out-of-state physician (North Carolina) who was not a certified provider. Bertha Polk v. Green Acres Pavillion, I.A.B. Hearing No. 1253843 (December 9, 2009). In Polk the Board determined that "where out of state medical providers are concerned, the Board and the State of Delaware can only compel compliance with the Delaware Worker's Compensation Health Care Payment System (HCPS) if the provider chooses to become a certified provider in our system." Id. at *3. However, the Board reached the opposite conclusion when faced with treatment by a non-certified out of state physician within close proximity to Delaware. Suzanne M. Shay v. Christiana Care Health Services/Visiting Nurses Association, I.A.B. Hearing No. 1090250 (May 25, 2010). In Shay the Board dismissed the Claimant's petition for medical treatment expenses incurred from an out of state physician (Maryland). The Board seems to make a distinction between states in close proximity to Delaware and those that are not. However, if the State of Delaware cannot reach beyond its borders to "compel compliance with the Delaware Worker's Compensation Health Care Payment System" than there must be no distinction between a state that borders Delaware and one that is farther away. Delaware cannot impose its laws upon physicians that are not within its jurisdiction and therefore Dr. Sonti was not required to seek pre-

authorization prior to treatment of the Claimant. The decision by the Superior Court should be reversed.

The Claimant in this case has done exactly what is contemplated by the Board's decision in Polk: he filed a Petition seeking authorization and subsequently payment of his medical treatment provided by an out of state, non-certified provider. The Board determined that the treatment provided by Dr. Sonti was in fact reasonable, necessary and related and subsequently awarded payment of her medical bills. The Superior Court reversed that decision noting that the provider was not certified and did not seek preauthorization. As the Board determined in Polk, treatment by a non-certified, out of state provider is not forever barred by the Worker's Compensation statute, but instead such treatment is not "presumed reasonable" and Claimant must file a Petition and prove that his treatment is reasonable and thus compensable under 19 Del. C. § 2322. The Court erred as a matter of law when it determined that Claimant's treatment was "not compensable under the Worker's Compensation Act" and the decision must be reversed and remanded for a finding consistent with the Statute.

Notably, the insurance carrier is not left without recourse to challenge the payment of medical treatment provided by an out of state provider who is not certified under Delaware's Statute. Indeed the "payor would follow the previous

practice of denying payment and the injured worker (or non-certified health care provider as an 'assignee') would have to file an appropriate petition with the Board seeking payment for the services rendered". Polk, *supra* at *3. The Board has held that "in order for the non-certified provider to get payment for disputed treatments that were not pre-authorized by the relevant insurance carrier, a petition would have to be filed with the Board and the treatment would have to be found reasonable and necessary." Id.

A finding that the statute forever bars a Claimant from seeking reimbursement for treatment provided by an out of state, non-certified provider would conflict with the intended purpose of the Worker's Compensation Statute - "to compensate injured employees resolving 'any reasonable doubts in favor of the worker.'" Avila-Hernandez, *supra.* at *9, *citing* Lawhorn, *supra.* The Employee in this case would be deprived of compensation for treatment that has in fact be found to be reasonable. The ruling by the Court allows the carrier to be absolved of payment for otherwise compensable treatment on a technicality--no request for authorization prior to proceeding with treatment by an out of state provider (who is not subject to the laws and regulations of the State of Delaware), even if such treatment would ultimately meet the definition of reasonable and necessary. Delaware Courts "apply rules with a 'liberal construction because of the underlying public policy that favors' a litigant's right

to a day in court as opposed to a judgment due to default.'" Id., *citing* Dishmon, *supra.* The Court should reverse the Superior Court's ruling in this case and remand the matter for a finding consistent with the Statute.

Conclusion

WHEREFORE, based on the foregoing, the Claimant Below Appellant, Howard VanVliet, by and through his attorneys, Schmittinger & Rodgriguez, P.A., hereby respectfully requests that the Court reverse the decision of the Superior Court as to the reversal of the Board's award for Dr. Sonti's treatment, and remand this matter for an award of worker's compensation benefits consistent with the statutes and case law referenced above.

Respectfully submitted,

SCHMITTINGER AND RODRIGUEZ, P.A.

BY: _____

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DATED: July 2, 2014

Certificate of Service

I hereby certify that I have caused copies of the foregoing:

OPENING BRIEF OF CLAIMANT-BELOW, APPELLANT

to be served upon:

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Via electronic service on July 2, 2014.

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BY:

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DATED: July 2, 2014

Service: **Get by LEXSEE®**
Citation: **2014 Del. Super. LEXIS 211**

*2014 Del. Super. LEXIS 211, **

D & B TRANSPORTATION, Employer-Below, Appellant, v. HOWARD VANVLIET, , Employee-Below, Appellee.

C.A. No. 13A-06-002 JTV

SUPERIOR COURT OF DELAWARE, KENT

2014 Del. Super. LEXIS 211

January 14, 2014, Submitted
April 30, 2014, Decided

NOTICE:

THIS OPINION HAS NOT BEEN RELEASED FOR PUBLICATION. UNTIL RELEASED, IT IS SUBJECT TO REVISION OR WITHDRAWAL.

PRIOR HISTORY: [*1]
Upon Consideration of Appellant's Appeal From Decision of the Industrial Accident Board. Vanvliet v. D & B Transp., 2012 Del. Super. LEXIS 510 (Del. Super. Ct., Nov. 28, 2012)

DISPOSITION: REVERSED IN PART. AFFIRMED IN PART.

CASE SUMMARY

OVERVIEW: HOLDINGS: [1]-The Board erred in awarding the claimant compensation for the spinal surgery performed by the physician because the physician was not certified under the Delaware Workers' Compensation Act nor preauthorized to perform the treatment as required by Del. Code Ann. tit. 19, § 2322D(a)(1); [2]-The evidence supported the Board's decision regarding the compensability of the pain management treatment because that doctor was certified and the pain management treatment was reasonable and necessary under Del. Code Ann. tit. 19, § 2322C(6); the Board heard evidence that the treatment was connected to the original work-related incident.

OUTCOME: Affirmed in part and reversed in part.

CORE TERMS: claimant's, surgery, pain, spinal, preauthorization, medical expenses, work-related,

medical treatment, provider, medical provider, preauthorized, doctor, Compensation Act, administered, compensable, substantial evidence, legal error, care provider, statutory exception, preformed, uncertified, treating, preform, evidence to support, disability benefits, health care, provide treatment, insurance carrier, compensability, presumed

LEXISNEXIS® HEADNOTES

Hide

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN1 See Del. Code Ann. tit. 19, § 2322D(a)(1).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN2 See Del. Code Ann. tit. 19, § 2322C(6).

Administrative Law > Judicial Review > Reviewability > Jurisdiction & Venue

Administrative Law > Judicial Review > Standards of Review > Substantial Evidence

Administrative Law > Judicial Review > Standards of Review > De Novo Review

HN3 A court has appellate jurisdiction over final agency decisions pursuant to Del. Code Ann. tit. 29, § 10142. On appeal from a decision of an administrative board, a court must determine whether the board's decision is supported by substantial evidence to support the board's findings of facts and conclusions of law and free from legal error. Substantial evidence is defined as such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. The court reviews legal issues de novo. More Like This Headnote

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN4 The Delaware Supreme Court holds that Del. Code Ann. tit. 19, § 2322D unambiguously requires that providers either be certified or preauthorized and that the treatments provided are reasonable and necessary to treat a work-related injury, and that when a provider is neither certified nor preauthorized, compensation for medical treatment is generally not available. More Like This Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Evidence > Witnesses

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN5 When the Delaware Industrial Accident Board adopts one medical opinion over another, the opinion by the Board constitutes substantial evidence for purposes of appellate review. More Like This Headnote

COUNSEL: Cheryl Ann Ward, Esq., Franklin & Prokopik, Wilmington, Delaware, Attorney for Appellant.

Walt F. Schmittinger, Esq., and Kristi N. Vitola, Esq., Schmittinger & Rodriguez, Dover,

Delaware, Attorneys for Appellee.

JUDGES: James T. Vaughn, Jr., President Judge.

OPINION BY: James T. Vaughn, Jr.

OPINION

VAUGHN, President Judge

This is an appeal from a decision of the Industrial Accident Board granting the claimant's petition to Determine Additional Compensation relating to a 2010 spinal surgery and subsequent pain management treatment. For the reasons which follow, I conclude that the medical expenses relating to the claimant's spinal surgery are not recoverable under 19 *Del. C.* § 2322.[1] I also conclude that the Board's decision that the claimant's pain management treatment was preformed by a certified medical provider, was reasonable and necessary, and was related to the claimant's work-related accident is support by substantial evidence and is free from legal error.

FACTS

In February 2001, the claimant suffered a work-related neck injury. As a result of the work-related injury, the claimant underwent **[*2]** spinal surgery in 2001 and received disability benefits. On August 11, 2010, Dr. Sonti, a Maryland surgeon, preformed a second spinal surgery on the claimant, allegedly relating to the claimant's 2001 work accident. Although other doctors in Dr. Sonti's medical practice firm were certified, Dr. Sonti was not certified under 19 *Del. C.* § 2322D(a)(1) at the time he performed the claimant's surgery.

FOOTNOTES

1 Two sections of Section 2322 apply to the compensation of medical expenses administered by a medical professional. 19 *Del. C.* § 2322D(a)(1) states:

> *HN1*Certification shall be required for a health care provider to provide treatment to an employee pursuant to this chapter, without the requirement that the health care provider first preauthorize each health care procedure, office visit or heath care service to be provided to the employee with the employer or insurance carrier.

19 *Del. C.* § 2322C(6) states:

> *HN2*Services rendered by any health care provider certified to provide treatment services for employees shall be presumed in the absence of contrary evidence, to be reasonable and necessary if such services conform to the most current version of the Delaware health care practices guidelines. Services **[*3]** provided by heath care providers that are not certified shall not be presumed reasonable and necessary unless such services are preauthorized by the employer or insurance carrier, subject to the exceptions set forth in § 2322D(b) of this title.

On August 23, 2010, the claimant filed two petitions for Determination of Additional Compensation. The first petition sought retroactive preauthorization for the cervical spine surgery preformed by Dr. Sonti almost two weeks earlier. The second petition demanded total disability benefits and compensation for medical expenses relating to the claimant's 2010 spinal surgery. The two petitions were consolidated. On November 12, 2010, the employer moved to dismiss the claimant's petition because Dr. Sonti was not certified under the Delaware Workers' Compensation Act and lacked preauthorization to preform the spinal surgery. The Board held a hearing on December 22, 2010 to evaluate the merits of the employer's motion to dismiss.

At the hearing, the employer argued that Dr. Sonti was not certified nor had preauthorization to preform the surgery and, thus, the claimant's claims for Dr. Sonti's medical expenses should be dismissed. The claimant argued **[*4]** that a treating doctor did not need to be certified or preauthorized to preform the medical treatment so long as the treatment was "reasonable, necessary, and related to the work injury." Additionally, the claimant argued that the preauthorization should relate back to before the surgery because delaying surgery for preauthorization would promote "unreasonable form over substance."

On December 21, 2010, the Board dismissed the claimant's claim for Dr. Sonti's medical expenses because, as the Board determined, the statute requires that if the claimant resides in Delaware and/or uses a Delaware provider, the provider must be certified or receive preauthorization to be reimbursed for expenses under the Delaware Worker's Compensation Act. The Board also concluded that retroactive preauthorization was insufficient under the circumstances. On September 15, 2011, the claimant appealed the Board's decision to this Court.

On November 28, 2012, this Court held that 19 *Del. C.* § 2322C(6) did not operate as a complete bar to compensation recovery when medical services were preformed by an uncertified medical provider.[2] This Court found that the statute was ambiguous and that where the medical provider **[*5]** is not certified nor has obtained preauthorization, that the presumption of "reasonable and necessary" falls away and a claimant must show that the medical expenses were reasonable and necessary to treat the work-related injury.[3] This Court remanded the case to the Board to determine whether the claimant's 2010 spinal surgery was reasonable and necessary.[4]

FOOTNOTES

2 *Vanvliet v. D & B Transp.*, 2012 Del. Super. LEXIS 510, 2012 WL 5964392 (Del. Super. Nov. 28, 2012).

3 2012 Del. Super. LEXIS 510, [WL] at *4.

4 2012 Del. Super. LEXIS 510, [WL] at *5.

On September 11, 2012, the claimant filed a petition to Determine Additional Compensation demanding compensation for the medical expenses associated with his ongoing pain management. Following the claimant's 2010 spinal surgery, Dr. Sonti referred the claimant to Dr. Dickinson for pain management treatment. Dr. Dickinson began treating the claimant on May 19, 2011 for his persistent and chronic back pain. Dr. Dickinson is certified under the Delaware Workers' Compensation Act.

On May 2, 2013, the Board heard the remand and evaluated the claimant's September 2012 petition for ongoing pain management. The Board accepted numerous medical providers' opinions regarding the reasonableness and necessity of the claimant's 2010 spinal surgery and pain **[*6]** management administered by Dr. Dickinson. Ultimately, the Board concluded that the surgery and the following pain management treatment was reasonable, necessary and related to the claimant's work-related

accident and, therefore, compensable.

On June 11, 2013, the employer filed an appeal with this Court, appealing the Board's May 2013 decision and asking that this Court revisit its November 2012 remand decision.

PARTIES' CONTENTIONS

The employer contends that the Board erred in awarding compensability of the claimant's spinal su rgery, pain medical treatment, and attorneys' and medical witness' fees. The employer contends that 19 *Del. C.* § 2322D bars compensation for medical expenses when the medical provider is not certified and has not received preauthorization for the medical treatment, thus barring compensation for the claimant's 2010 spinal surgery; that the claimant experienced new injury, unrelated to the work-related incident, which caused his symptomology necessitating pain management; and that the Board's decision to accept one physician's opinion over another was against the great weight of the evidence. Furthermore, the employer contends that this Court erred in reversing **[*7]** and remanding the Board's December 2010 decision because 19 *Del. C.* § 2322D allows compensation only when the medical treatment is administered by a certified medical provider or a provider who has preauthorization for the medical treatment.

The claimant contends that the Board's decision granting compensation for his 2010 spinal surgery and continued pain management is free from legal error and is based on substantial evidence from multiple credible medical providers. The claimant also argues that this Court does not have jurisdiction to hear an appeal of its own decision, and thus cannot evaluate the merits of this Court's November 2012 decision regarding 19 *Del. C.* § 2322D.

STANDARD OF REVIEW

HN3 This Court has appellate jurisdiction over final agency decisions pursuant to 29 *Del. C.* § 10142. On appeal from a decision of an administrative board, this Court must determine whether the board's decision is supported by substantial evidence to support the board's findings of facts and conclusions of law and free from legal error.[5] Substantial evidence is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[6] On appeal, this Court reviews **[*8]** legal issues *de novo.* [7]

FOOTNOTES

5 *Olney v. Cooch*, 425 A.2d 610, 613 (Del. 1981).

6 *Id.* at 614.

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

DISCUSSION

In November 2013, *HN4* the Delaware Supreme Court held that 19 *Del. C.* § 2322D unambiguously "requires that providers either be certified or preauthorized and that the treatments provided are reasonable and necessary to treat a work-related injury," and that when "the provider is neither certified nor preauthorized, compensation for medical treatment is generally not available."[8] In *Wyatt*, a worker, who was experiencing lower back pain and severe lower extremity numbness at work, went to see Dr. Venkataramana, a doctor she knew did not handle workers' compensation cases and withheld that her injuries were work-related.[9] Following a hearing, the Board determined that the claimant could not be compensated for her medical expenses associated with Dr. Venkataramana

because the treating provider was an instate provider who was not certified and did not obtain preauthorization for the claimant's treatment.[10] The Superior Court held that the Board erred in concluding that there was any compensable work-related injury, but did not rule **[*9]** on any other grounds.[11] On appeal from the Superior Court, the Delaware Supreme Court concluded, as a matter of statutory interpretation, that medical treatment administered by an uncertified provider who has not been granted preauthorization is not compensable, unless it meets a statutory exception.[12] Ultimately, the Supreme Court held that the employer was exempted by statute from having to pay for medical treatment provided by Dr. Venataramana, with the exception of one treatment that fell within a statutory exception.

FOOTNOTES

8 *Wyatt v. Rescare Home Care*, 81 A.3d 1253, 1263 (Del. 2013). There are two narrow statutory exception to allow compensation for non-certified nor preauthorized medical treatment. Section 2322D(b) specifically allows compensation for the first visit to an uncertified, non-preauthorized provider only when services are reasonable and necessary and the provider has a good faith belief that the injury was work-related and for care provided in a hospital or pre-hospital's emergency unit.

9 *Id.* at 1256 - 57.

10 *Id.* at 1258. The Board concluded that the claimant's other medical expenses would be compensable pending the submission of "clean claims." *Id.*

11 *Id.*

12 *Id.* at 1263.

In the **[*10]** instant case, the Board found that Dr. Sonti was not certified under Delaware's Workers' Compensation Act nor obtained preauthorization for the spinal surgery. I now follow the Supreme Court's holding in *Wyatt*, and find that the claimant cannot recover his medical expenses from his 2010 spinal surgery because Dr. Sonti was not certified nor preauthorized to perform the treatment as required by 19 *Del. C.* § 2322D(a)(1).[13]

FOOTNOTES

13 The claimant has not asserted to this Court or to the Board that Dr. Sonti's medical treatment qualified under any statutory exception.

The claimant also filed a petition for reimbursement of medical expenses relating to pain management treatment with Dr. Dickinson. The Board found that Dr. Dickinson is certified under the Delaware Workers' Compensation Act and that the treatment was reasonable, necessary and related to the claimant's work-related injury. I find that the Board's decision is supported by substantial evidence and is free from legal error. At the Board's hearing all of the doctors that testified agreed that Dr. Dickinson was certified and the pain management treatment was reasonable and necessary. While one doctor opined that the treatment was related **[*11]** to a new incident, the Board heard evidence from several other doctors who testified that the treatment was connected to the original work-related incident. HN5 "When the Board adopts one medical opinion over another, the opinion by the Board constitutes substantial evidence for purposes of appellate review."[14] I conclude that there is substantial record evidence to support the Board's decision regarding compensability of the pain

management treatment.

FOOTNOTES

14 *Munyan v. Daimler Chrysler Corp.*, 909 A.2d 133, 136 (Del. 2006).

Therefore, the Board's decision on remand awarding compensation for the services performed by Dr. Sonti is **reversed** and the Board's determination that Dr. Dickinson was certified and the treatment was reasonable and necessary is **affirmed**. Accordingly, only the expenses related to the claimant's pain management administered by Dr. Dickinson are compensable pursuant to 19 *Del. C.* § 2322D.

IT IS SO ORDERED.

/s/ James T. Vaughn, Jr.

President Judge

Service: **Get by LEXSEE®**
Citation: **2014 Del. Super. LEXIS 211**
View: Full
Date/Time: Friday, June 27, 2014 - 3:04 PM EDT

02841 IAB

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

DEC 28 2010

HOWARD VANVLIET,	)	
	)	
Employee	)	
	)	Hearing No. 1184191
v.	)	
	)	
D AND B TRANSPORTATION,	)	
	)	
Employer.	)	

ORDER

Pursuant to due notice of time and place of hearing served on all parties in interest, on December 8, 2010, the Board heard a Motion filed by Employer, D and B Transportation, against Claimant, Howard Vanvliet, seeking dismissal of Claimant's current pending Petition to Determine Additional Compensation Due. The issue underlying Claimant's pending petition is Claimant's request for payment of compensation for total disability as well as medical expenses related to an August 11, 2010 neck surgery. The petition was filed on August 23, 2010.

Employer alleges that Claimant failed to comply with title 19, Delaware Code section 2322D inasmuch as he received medical treatment from an out of state, non-certified provider (non-certified in the context of Delaware's Worker's Compensation statutory scheme) without obtaining pre-authorization from the insurance carrier. Employer maintains that this unauthorized medical care is not compensable given the mandatory provisions of title 19 Delaware Code section 2322D.

Claimant argues that the rationale outlined in *Bertha Polk v. Green Acres Pavilion* should control. In this regard, Claimant asserts that treatment rendered by non-

certified, out of state providers does not foreclose the ability of an injured worker or treating physician to seek reimbursement for the care rendered but instead simply removes the presumption and shifts the burden of proving reasonableness and necessity of the care to the worker or non-certified provider.[1] Claimant further argues that the currently pending Petition to Determine Additional Compensation Due seeks authorization as well as payment for the treatment that Claimant received and thus any favorable decision issued by the Board would relate back to the time of the petition's filing.

In response, Employer asserts that the *Polk* case is distinguishable from the case at hand in that the injured worker in that case had relocated a significant distance from the state of Delaware and therefore had little to no access to certified Delaware providers. The Claimant in the case at bar continues to be a Delaware resident with complete access to certified Delaware providers. In fact, argues Employer, Claimant obtained treatment from a medical practice just over the Delaware line in Salisbury, Maryland, where virtually every physician, excepting the one Claimant received treatment from, is a certified Delaware provider.[2]

After hearing the arguments of the parties and considering the relevant statutes and case law, the Board finds that dismissal is appropriate with respect to the portion of Claimant's petition pertaining to the medical treatment provided by a non-certified provider for which there was no preauthorization, but there is no legal basis for dismissal of Claimant's petition with respect to his claim for total disability benefits.

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[1] *See Bertha Polk v. Green Acres Pavilion*, Del. IAB Hearing No. 1253843 (December 4, 2009).
[2] *See Claimant's Exhibit 1.*

Since issuance of the *Polk* decision, the Board has had occasion to consider a number of variations on the *Polk* facts in light of the language and intent of the Workers' Compensation Act. These examinations have yielded a thoughtful and consistent application of the law that seemingly strives to protect both the rights of injured workers as well as the original intent of the legislation. This balance has been reached in the Board's appreciation of the difficulty inherent for those who have relocated from our state as opposed to those who continue to reside in and enjoy the benefits of availing themselves of certified Delaware providers. An analysis of the evolution of the Board's interpretation of the Worker's Compensation Act, therefore, as it relates to treatment with certified and non-certified providers is essential to the Board's current finding.

The *Polk* case is an excellent point of reference to begin the examination. In *Polk*, Claimant was injured while living and working in the state of Delaware. Some time later, Claimant relocated to North Carolina to reside with her elderly mother. Claimant was unable to find a certified Delaware provider to treat her in North Carolina. The efforts made by the North Carolina providers to get preauthorization for Claimant's care was unclear though ultimately Claimant proceeded forward receiving care in North Carolina from a number of non-certified providers. Claimant then filed a Petition to Determine Additional Compensation Due seeking both authorization for the care she had received as well as payment of the medical expenses already accrued without authorization. The Board, in refusing to dismiss Claimant's pending petition as being in violation of title 19 Delaware Code section 2322D found that, "where out of state medical providers are concerned, the Board and the State of Delaware can only compel compliance with the Delaware Workers' Compensation Health Care Payment System

(HCPS) if the provider chooses to become a certified provider in our system."[3] Moreover, the Board found that in circumstances like those found in *Polk*, "in order for the non-certified provider to get payment for disputed treatments that were not pre-authorized by the relevant insurance carrier, a petition would have to be filed with the Board and the treatment would have to be found reasonable and necessary."[4] The Board in reaching this outcome cited title 19, Delaware Code section 2322C(6) which provides in relevant part that "[s]ervices provided by health care providers that are not certified *shall not be presumed reasonable and necessary* unless such services are preauthorized by the employer or insurance carrier, subject to the exception set forth in § 2322D(b) of this title." DEL. CODE ANN. tit. 19, § 2322C(6) (emphasis added).[5] The Board refused to find that such services are *per se* not compensable.

Very close in time to the issuance of the *Polk* Decision, the Board issued a Decision in the matter of *Kathleen Mason v. State of Delaware*, Del. IAB Hearing No. 1198102 (January 15, 2010). In *Mason*, both the injured worker (Claimant) and the medical provider whose treatment was in question were located in Delaware. The care that Claimant received was not preauthorized nor was the provider certified pursuant to the Delaware Workers' Compensation Act. In making the finding that Claimant's medical treatment with the uncertified Delaware provider was not compensable, the Board cited title 19 section 2322(D)(a)(1) of the Workers' Compensation Act which provides: "Certification shall be required for a health care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health care provider first preauthorize each health care procedure, office visit or health care service

[3] *Id.* at 3.
[4] *Id.*
[5] *Id.* at 3-4.

to be provided to the employee with the employer or insurance carrier." (Emphasis added.) The Board interpreted this statutory langue to mean that medical providers had to either be certified or seek preauthorization prior to rendering treatment leaving only the limited exceptions of one time or emergency care as outlined in title 19 sections 2322D(b) and 2322B(8)c. The Board distinguished the facts of *Mason* from those of *Polk* noting that the injured employee in *Mason* continued to live and treat in Delaware with a provider who was licensed in Delaware and should have been aware of the requirements of the Delaware Worker's Compensation Act. The Board, in extending this rationale and citing section 13 of the synopsis for Senate Bill 1 of the 144th Delaware General Assembly,[6] ultimately held that "at least in the case of providers over which the State can assert jurisdiction, the Board interprets the mandatory language of Section 2322D to reflect a legislative intent that medical providers be certified or obtain pre-authorization if they want to pursue payment under the workers' compensation act."[7]

Thereafter, the Board's Decision in the matter of *Suzanne M. Shay v. Christiana Care Health Services/Visiting Nurses Association*, Del. IAB Hearing No. 1090250 (May 25, 2010) seemingly extended the logic of *Mason*. In *Shay*, the injured worker/Claimant was a Delaware resident who sought and obtained unauthorized medical treatment from an out of state (Baltimore, Maryland), uncertified provider. Claimant argued that title 19 section 2322D should not apply to her because her provider was outside of Delaware's

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[6] Section 13 of the synopsis states that Section 2322D "provides for the development of certification standards for health care providers treating employees in the workers' compensation system. *Certification will require such providers to commit to certain standards in order to treat employees without pre-authorization.* Such certification shall not be required for an employee's first treatment by a professional or for treatment by emergency personnel." (Emphasis added.) Thus, it is clear that the legislative intent was that, with only limited exceptions for emergency treatment or a first visit, a provider was either to become a certified provider under the HCPS, or the treatment needs to be preauthorized.

[7] *Mason* at 12-13. *See also Andrea Tullock Grulke v. Amazon.Com*, Del. IAB Hearing No. 1334951 (July 8, 2010).

jurisdiction and that to apply the preauthorization requirement to her treatment would deprive her of her statutory right to pick a doctor of her own choosing.[8] The Board again distinguished the facts in *Shay* from those in Polk noting that in *Polk*, Claimant resided in another state and sought the care of a physician local to her residence. Claimant in the *Shay* case, however, continued to be a Delaware resident but chose to leave the boundaries of our state to travel to Baltimore, Maryland for the sole purpose of seeking treatment. The Board held that while title 19 Delaware Code section 2322 permits Claimant to choose her own doctor, it does not relieve her of the responsibility of complying with title 19 Delaware Code section 2322D(a)(1) whereby non-certified providers must seek preauthorization before rendering care to an injured worker.[9]

Acknowledging the need for reconciliation in reading the relevant workers' compensation statutes as a whole, the Board in the case at bar is satisfied that the lines have been fairly and appropriately drawn as it relates to application of these statutes to injured workers and certified or non-certified providers; if an injured worker resides in and/or treats with Delaware providers, those providers must either be certified or receive preauthorization for the treatment to be rendered to the extent that future reimbursement will be sought under the Worker's Compensation Act (excepting only the first time visit or emergency medical care noted above). This is not an unduly burdensome requirement. Indeed, it appears that virtually every other physician in the Maryland practice apart from Claimant's own doctor had become certified providers under the HCPS.[10] While Claimant's doctor is not compelled to become a certified provider, under Delaware law if

[8] *Shay* at 2.
[9] *Shay* at 2-3.
[10] The requirements of the certification process for a provider can readily be found on-line. *See* http://www.delawareworks.com/industrialaffairs/provider.certification.shtml

certification is not obtained and the doctor wishes Claimant's employer to pay for those services, then the doctor and Claimant need to first get preauthorization for the proposed treatment. That did not happen in this case.

Claimant raises the argument that the petition itself seeks authorization for the medical treatment. However, as discussed above, the statutory provisions are clear that a medical provider needs to seek *preauthorization* for the treatment. In this case, Claimant did not seek authorization for this medical treatment until after that treatment was already provided. In no way can this be interpreted as a request for preauthorization.[11]

Accordingly, based upon this analysis, the Board finds that Employer's Motion to Dismiss must be GRANTED with respect to that portion of the petition that pertains to medical treatment provided by a non-certified provider for which no preauthorization was obtained. Under the applicable statutory provisions, such treatment is simply not compensable under the Workers' Compensation Act.

However, a portion of Claimant's petition pertains to a period of total disability following the surgery. The mere fact the surgery itself is not compensable because of Claimant's failure to follow the statutory requirements does not necessarily mean that the resulting period of total disability is not compensable. If the surgery was causally related to a compensable work injury and if, because of that surgery, Claimant was rendered totally disabled, that period of disability may well be compensable. It has been recognized that if a claimant undergoes *unreasonable* medical treatment and that treatment results in a worsening of the claimant's condition, that improper treatment can

[11] As noted above, the surgery was performed on August 11. The petition was filed on August 23. There is no indication that Employer was given any fair opportunity to review or preauthorize the treatment before it was an accomplished fact. Claimant and his doctor simply did not seek preauthorization, contrary to the requirements of Delaware law.

constitute an intervening event that breaks the chain of causation from the original work injury at least with regard to any worsening of the condition.[12] However, the mere fact that treatment is unauthorized (and, hence, not compensable under the Workers' Compensation Act) does not mean that it rises to the level of unreasonable treatment such as would break the chain of causation.[13] Accordingly, while the surgery was unauthorized and therefore not compensable, Claimant still has a viable claim for total disability as a result of that surgery.

IT IS SO ORDERED THIS 21 DAY OF DECEMBER, 2010.

INDUSTRIAL ACCIDENT BOARD

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HAROLD B. BARBER

Victor R. Epolito Jr.
VICTOR R. EPOLITO JR

I, Angela M. Fowler, Hearing Officer, hereby certify that the foregoing is a true and correct decision of the Industrial Accident Board.

Angela Fowler
OWC Staff

Mailed Date: 12-21-10

Walt Schmittinger, Esquire, for Claimant

William Rimmer, Esquire, for Employer

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[12] *See Klenk v. The Medical Center of Delaware*, Del. Super., 2008 WL 250548 at *4-*5 (January 30, 2008). *See also Bullock v. K-Mart Corporation*, Del. Super., 1995 WL 339025 at *3 (May 5, 1995)("[i]f a physician directs a patient to undergo treatment which turns out not to be reasonable or necessary to treat a compensable injury, . . . there is nothing in the statute which requires the employer to pay the cost. If the converse were true, the door to all sorts of abuses would be opened.") The employer, of course, would remain liable for those problems unaltered by the unreasonable treatment and remain causally related to the original injury. In addition, the chain of causation would not be broken if treatment that was otherwise reasonable was negligently performed. Such fault on the part of the physician is insufficient to break the causal chain. *See Stevenson v. Haveg Industries*, Del. Super., 1985 WL 188996 at *2, Taylor, J. (April 15, 1985).

[13] *See Klenk*, 2008 WL 250548 at *6 (citing with approval *Pacific Employers Ins. Co. v. Industrial Comm'n of Arizona*, 652 P.2d 147 (Ariz. App. 1982) for the proposition that unauthorized treatment did not break the chain of causation so long as the employee's decision to have the surgery was reasonable).

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

HOWARD VAN VLIET,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1184191
	)	
D AND B TRANSPORTATION,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE AND ON REMAND FROM SUPERIOR COURT

Pursuant to due notice of time and place of hearing served on all parties in interest, the above-stated cause came before the Industrial Accident Board on May 2, 2013, in the Hearing Room of the Board, Milford, Delaware.

PRESENT:

MARY DANTZLER

WILLIAM HARE

Julie G. Bucklin, Workers' Compensation Hearing Officer

APPEARANCES:

Kristi N. Vitola, Attorney for the Claimant

Cheryl A. Ward, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDING

On February 14, 2001, Howard Van Vliet ("Claimant") was injured in a compensable industrial accident while employed by D and B Transportation ("D&B"). On September 11, 2012, Claimant filed a Petition to Determine Additional Compensation Due seeking payment of medical bills for pain management treatment. On November 28, 2012, the Superior Court issued its decision regarding the Board's previous dismissal of Claimant's Petition to Determine Additional Compensation Due regarding payment of medical bills for cervical spine surgery. The Superior Court reversed and remanded the case back to the Board, so the matter was combined with the Petition regarding pain management treatment.[1] D&B acknowledged Claimant's industrial accident and paid for Claimant's workers' compensation benefits, including total disability benefits following surgery in 2010, but argues that the cervical spine surgery and pain management treatment were not related to the industrial accident. On May 2, 2013, the Board conducted a hearing on Claimant's Petitions and this is the Board's decision.

SUMMARY OF THE EVIDENCE

Claimant testified about his industrial accident and medical treatment. Claimant was loading pallets of frozen chicken on February 14, 2001, when a pallet broke and fell on his neck. He underwent cervical spine surgery with Dr. Matthew Eppley and felt about fifty to sixty percent better, but still had stiffness and nerve damage.

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[1] The current Board consists of different Board Members than had sat on the dismissal of Claimant's petition in December of 2010. However, that prior Board did not reach the underlying merits of Claimant's petition concerning the reasonableness, necessity and causal relation of the medical treatment. That prior Board dismissed the petition as a matter of law based on what the Board thought was a clear violation of the statutory prohibition contained in 19 *Del. C.* § 2322D(a)(1). Thus, the issue that was presented to the prior Board is not implicated in the current hearing and the issues to be presented at the current hearing were not implicated in the prior hearing. As such, there is no need to have identity of Board Members in this case. In any event, at least one of the prior Board Members is no longer with the Board.

Claimant continued to undergo treatment after the accident and surgery until 2005. There was no gap in Claimant's treatment after 2005 because he saw his primary care physician, Dr. Rosa, for pain medication. Dr. Rosa's records indicate that Claimant had two heart attacks, high blood pressure, trouble swallowing since the cervical spine surgery, and other ailments.

Claimant returned to work in 2007 as a truck driver for D&B, but he could not tolerate the drive from Delaware to Florida and Louisiana, so he switched jobs around 2009 and started driving a route between New Jersey and New York for Tangier Transportation. Claimant did not have any other accidents since the 2001 industrial accident. There was one day when Claimant was cranking down the landing gear when he felt a bad burning sensation in his neck and dizziness and then he fell to the ground. He always had neck pain and pain down his arm and left leg since the accident, but it gradually increased and he started treating with Dr. Gayatri Sonti because he was having so much pain.

Between 2001 and 2007, Claimant received total disability benefits from D&B, as well as Social Security Disability benefits, and his wife works. He returned to work in 2007 because he had lost his car and everything else, so he had to work in order to pay his bills. Claimant passed the commercial driver's license ("CDL") physical examination before he started working for Tangier Transportation and the owner of the company was aware of Claimant's physical condition and that he could not drive long distances.

Dr. Sonti performed cervical spine surgery in 2010 and then sent Claimant to pain management with Dr. Eva Dickinson. Claimant has not returned to work since the 2010 surgery. Claimant lives with his wife. He spends his days watching television, but he does not do much else. Between 2003 and 2007, he did not do much at all.

Claimant saw Dr. Ronald Sabbagh for a defense medical examination in October 2012 and Dr. Sabbagh noted that Claimant injured his neck when he fell in 2011. Claimant explained to the Board that Dr. Sabbagh was wrong and that he must have been referring to the incident when he was cranking the loading gear, which occurred before the 2010 surgery. Claimant did not hit his head while getting out of his truck or injure his neck at any time after the industrial accident and he never told Dr. Dickinson or anyone at her office that he hit his head.

Claimant continued to have neck pain after the industrial accident and first cervical spine surgery that gradually worsened. He continues to have pain after both surgeries and his pain level stays around a seven out of ten on the pain scale. He currently takes fifteen milligrams of oxycodone every six hours, but it does not help. He is still seeking pain management treatment, but with Dr. Edward Babigumira, rather than Dr. Dickinson. He switched providers because he was not satisfied with Dr. Dickinson's treatment.

Claimant presented a medical bills exhibit[2] to the Board with the bills totaling $31,172.36. The exhibit indicates that the surgery with Dr. Sonti cost $22,049.00 and pain management with Dr. Dickinson's office cost $9,123.36.

Gayatri Sonti, M.D., a board-certified neurosurgeon, testified by deposition on behalf of Claimant. Dr. Sonti began treating Claimant on August 2, 2010. Her office is located in Salisbury, Maryland and she only practices medicine in Maryland. She was not certified under the Delaware Worker's Compensation Guidelines when she performed the surgery for Claimant and the surgery was not preauthorized. She believes that the cervical spine surgery was reasonable, necessary and causally related to Claimant's industrial accident.

[2] Claimant's Exhibit 1.

Claimant's chief complaints were neck pain and pain down the left arm; the arm pain was worse than the neck pain. He had weakness and persistent pain in the left arm, but no symptoms on the right side or in the legs or any other evidence of problems with cord compression. He reported that any lifting, straining or head turning made his left arm pain worse. Claimant reported that the pain had been gradually worsening over the past four years. He did not indicate that there was any accident or injury that took place at that time to cause the symptoms.

Dr. Sonti reviewed Claimant's diagnostic studies. The cervical spine MRI showed the previous fusion from C5 to C7, as well as compression at the adjacent level of C4-5 mostly from the back along the nerve root on the left side. With Claimant's complaints mostly involving the left arm, it indicates compression on the nerve roots. The MRI findings also suggest compression on the spinal cord and nerves, mostly at the adjacent level from his previous fusion surgery. It is not uncommon for an adjacent level to be affected after a fusion. There is no specific timeframe for the adjacent level to be affected; it could occur within a year or two, or it is not unusual to see it happen five to ten years later.

Claimant's fusion surgery took place in 2001; everything went well and his nerves were adequately decompressed. Typically, he should not have had symptoms for many years because the stress on the adjacent levels is a slow process that takes years to build up. Claimant mentioned that his symptoms started about four years earlier, which would have been around 2006 and the symptoms gradually worsened. Dr. Sonti did not find anything unusual about that time period for the onset and progression of Claimant's symptoms.

Claimant tried conservative treatment before coming to Dr. Sonti's office. He tried physical therapy, epidural injections, and pain management. He had recently undergone two sets of three epidural injections, which is usually the maximum amount of injections for someone to

get in about six months. The injections did not help him, which means that there is a significant compression around the nerve root. Dr. Sonti did not know which physician performed those injections or the exact timeframe of the injections when she testified, but the description of the injections from Claimant sounded like the injections were appropriate.

The significant findings on physical examination included limited strength in the left arm, as well as some atrophy in the left arm. Claimant had decreased sensation in the left thumb, index finger and middle finger. The pain distribution in the upper arm is from the C5 nerve.

Dr. Sonti's plan was to decompress the nerve because of the significant compression. She performed the surgery on August 11, 2010. During surgery, she found that there was even more nerve root compression than expected based on what she saw on the scans. The objective findings during surgery correlated with the subjective complaints and the diagnostic studies.

Claimant was taken out of work following surgery. He was taking medication following surgery, including a muscle relaxant called Diclofenac and the pain medication was oxycodone. Claimant followed up with Dr. Sonti on August 27th and he still had some neck pain, which is expected, but his arm pain had improved. On October 14th, Claimant continued to improve, but he still had some neck pain. By December 8th, he had improved significantly, but his neck pain had not resolved completely and he had very mild residual symptoms. By February 8, 2011, Claimant was progressing as expected. He had significant improvement in the neck pain and even more improvement in the left arm pain, but he still had some residual pain that required medication off and on.

Dr. Sonti last saw Claimant on October 18, 2011 and he continued to report improvement. Dr. Sonti released Claimant from her care and referred him to pain management to handle his pain medication. Adjacent level pathology can persist and is not something that

will completely improve and never happen again. Dr. Sonti will not be surprised if Claimant has further continuation of the adjacent level disease because of the nature of the spine and degeneration. A flare-up is expected.

Dr. Sonti testified that the surgery that she performed was reasonable, necessary and related to Claimant's industrial accident and the 2001 fusion surgery, but that the degeneration could have progressed even without the 2001 surgery. Claimant was off of work following the surgery and Dr. Sonti does not know of any other reason for him to have been off of work at that time. The credibility of Claimant's complaints was part of the basis for her opinion regarding the causal relationship of the surgery to the industrial accident.

Dr. Bruce Grossinger, M.D., board-certified in neurology, pain management and EMG, testified by deposition on behalf of Claimant. Dr. Grossinger performed defense medical examinations of Claimant on March 17, 2005 and November 2, 2010 on behalf of D&B. He is a certified provider under the Delaware Worker's Compensation Guidelines. Dr. Grossinger believes that the cervical spine surgery with Dr. Sonti was reasonable, necessary and causally related to Claimant's industrial accident.

Dr. Grossinger was aware of Claimant's 2001 industrial accident. Claimant was unloading a truck and developed radiating neck pain. He was found to have disc protrusions at C5-6 and C6-7 and underwent a C5-6 and C6-7 laminectomy, discectomy and fusion surgery with Dr. Eppley. Claimant had an excellent response to the surgery and returned back to normal by the time of the 2005 examination. Dr. Grossinger agreed that the surgery was related to the 2001 industrial accident. He also agreed that it was reasonable for Claimant to take medications, including Neurontin, Bextra and oxycodone, but that Claimant was no longer taking those medications in 2005.

When Dr. Grossinger saw Claimant again in November 2010, it was regarding the same 2001 industrial accident. He obtained an updated history at the second examination. Claimant continued to experience neck pain and stiffness, radiating into his left shoulder and arm, with tingling and numbness in the left hand. Dr. Grossinger explained that since Claimant had a two-level fusion, it naturally causes stress above and below the fusion levels. There came a time, nine years after the industrial accident and first surgery when a different spine surgeon evaluated Claimant and noted structural problems at C4-5, which is one level above the fusion site, and the surgeon determined that another surgery was necessary. Dr. Sonti performed the surgery in 2010 and there was some residual neck pain and stiffness, although the surgery was successful and the radicular symptoms improved.

When Dr. Grossinger saw Claimant in November 2010, he had an excellent response to the 2010 surgery and was back to normal, except for the restricted neck mobility. Both surgeries appeared to be very successful. Since Dr. Grossinger has not seen any records of any subsequent industrial injuries and given the natural history of neck injuries and the propensity for problems above and below the fusion levels, it is logical and reasonable to determine and reaffirm that the second surgery at one level above the original fusion site "was indeed referable to the work accident of 2001."[3] Dr. Grossinger also testified that "were there no work accident in 2001, no prior surgery, there would not reasonably be a need for the second surgery."[4] Dr. Grossinger agreed that the 2010 surgery was reasonable and necessary.

Claimant was working three hours per day on a limited duty truck driving position until about January 2010. The fact that Claimant was working in that capacity does not change Dr.

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[3] Dr. Grossinger's April 3, 2013 deposition at page 9, lines 11-12.
[4] *Id.* at lines 13-15.

Grossinger's opinion regarding the causal relationship of the 2010 surgery to the original 2001 industrial accident.

Dr. Grossinger agreed that the reemergence of problems above and below the fusion level can occur years later, but the timeframe is highly variable. It is not unusual for the symptoms to surface years later. Even though it was nine years later, Claimant did not lose the right to excellent medical care and, in fact, received great medical care from both surgeons. Dr. Grossinger opined that Claimant was totally disabled from the date of the surgery in August 2010 until his evaluation on November 2, 2010, following which Claimant was limited to lifting no more than twenty pounds. The total disability period was directly related to the 2010 surgery. Dr. Grossinger also agreed that the postoperative care, including physical therapy, medications and office visits, was reasonable, necessary and causally related to the 2001 industrial accident. He thought that monthly follow-up visits for medication refills and adjustments were reasonable.

Dr. Grossinger agreed that he might not have had any of Claimant's medical records from 2003 through 2010. His opinion regarding causation is based on the hypothetical that Claimant did not have any additional injuries or accidents since neither party to this litigation has brought any additional injuries to his attention. If there was another significant work injury that was documented that he did not know about, it could change his opinion.

Dr. Grossinger agreed that if Claimant was seen eighteen times in one calendar year for just medication follow-up visits, it would be excessive and not within the Delaware practice guidelines, but he did not have those records in his possession so it was difficult for him to speculate. For a patient who does not have any indications of misusing drugs, a drug screening should be performed at least once a year for oxycodone. Some of the good pain management

physicians in Delaware order the urine toxicology screens on a monthly basis and the Drug Enforcement Agency does not seem to quarrel with over-analyzation.

Dr. Eva Dickinson, M.D., board-certified in emergency medicine and addiction medicine and is certificate-in-waiting in chronic pain management and interventional pain management, testified by deposition on behalf of Claimant. Dr. Dickinson began treating Claimant on May 19, 2011 and she is certified under the Delaware Worker's Compensation Guidelines. She believes that the pain management treatment has been reasonable, necessary and causally related to Claimant's industrial accident.

Dr. Sonti referred Claimant to Dr. Dickinson for his 2001 work-related injury because his whole spine hurt. He said that he was lifting something off of a truck and had pain in her shoulder and hand, which developed into his neck and then into his thoracic spine and lumbar spine. He underwent cervical spine surgery, but had persistent pain and his primary care physician was writing his prescriptions for pain medication, so Dr. Sonti referred Claimant to Dr. Dickinson for care of his chronic pain.

When Claimant initially presented to Dr. Dickinson's office, he complained of pain from his neck down to the lower back. He also complained of diffuse muscle pain, some palpitations, a lot of headaches, insomnia, night sweats, and nausea. His pain level was a seven out of ten on the pain scale, but Claimant thought that it would be a ten out of ten without any medication. The physical examination showed that he had limited extension of his neck with tenderness in the facets, but no actual facet loading nor palpable muscle spasms. He had a negative Adson's test and a negative Spurling's test. He had decreased lateral rotation bilaterally, as well as decreased extension and flexion in the cervical spine.

Claimant was already taking ten milligrams of oxycodone every four hours, as well as "handfuls" of ibuprofen for the neck and low back when he started treating with Dr. Dickinson. She started Claimant on fifteen-milligrams of oxycodone with a limit of five a day to be taken every four to six hours as needed for pain. She also started Claimant on four milligrams of Zanaflex every eight hours for some muscle spasms in the neck and fifteen milligrams of Mobic once a day to get Claimant off of the "handfuls" of ibuprofen.

Dr. Dickinson last treated Claimant on June 25, 2012. Claimant was seen in Dr. Dickinson's office fairly regularly between May 2011 and June 25, 2012. Claimant's medications required monthly visits. Dr. Dickinson also performed diagnostic studies in her office, including an ANSAR test that looks at autonomic function.

The February 2012 cervical spine MRI showed new changes, including a new herniated disc. The MRI showed that the fusion was still in place, but Claimant had significant osteophytic overgrowth, bulging at C4-5 with left-sided foraminal narrowing, a left foraminal far lateral disc herniation, and moderate canal stenosis. Those were all new changes as compared to the May 2011 MRI. Dr. Dickinson explained that when there is a fusion, there is additional pressure on the levels above and below the fusion site, so Claimant had certain changes at C5-6 and C6-7 and in 2012 there were new changes and pressure at C3-4 and C4-5.

Dr. Dickinson believes that the treatment that her office provided to Claimant from May 2011 through June 2012 was reasonable, necessary and causally related to the 2001 industrial accident and the subsequent surgery performed in 2010. Claimant had pressure and pushing on the nerve in the cervical spine, so he had radicular pain right before the 2010 surgery that was pretty significant and also severe neck pain. Whenever Claimant moved, he got spasms in the neck, which went up into his head and caused headaches. The injury and the surgery accelerated

arthritis in the area due to the cytokines and other factors that have been produced in that area and when arthritis accelerates, the pain accelerates in the area of the fusion.

Given Claimant's chronic condition, Dr. Dickinson expects him to have flare-ups in the future. She also expects to see a progression of the problem in his cervical spine due to the acceleration process. Dr. Dickinson agreed that her notes from May 19, 2011 indicate that Claimant went back to work in December 2010 and bumped his head getting out of the truck and pain started again. She also noted that Claimant is retired.

Dr. Dickinson explained that she saw Claimant twenty-one times in thirteen months because of two positive drug screens, which then required weekly appointments until she felt that he would adhere to the pain medication agreement. She agreed that her office performed eighteen drug tests on Claimant. She is not aware of who Claimant is treating with currently, but he stopped treating with her because he did not want any treatment other than medication.

Ronald Sabbagh, M.D., a board-certified orthopedic surgeon and certified under the Delaware Worker's Compensation Guidelines, testified by deposition on behalf of D&B. Dr. Sabbagh evaluated Claimant on October 11, 2012 and reviewed his medical records in conjunction with that examination. He believes that Claimant's surgery and pain management treatment were reasonable and necessary, but not causally related to the industrial accident.

Claimant told Dr. Sabbagh about his 2001 industrial accident when boxes of chicken fell on him while unloading a truck. He underwent a discectomy and fusion surgery with Dr. Eppley in 2001 and had done well following that surgery. He returned to work full-time and then he had increased neck pain. He had a subsequent surgery in 2010 for a C4-5 level disc osteophyte and he recovered well from that surgery. Dr. Sabbagh agreed that the 2001 surgery was related to the industrial accident.

Dr. Sabbagh explained that there was a significant gap in Claimant's treatment. Claimant went back to work a few years after the 2001 accident and surgery and then about five years passed before he had any other treatment for the neck pain. The five-year gap indicates that, most likely, Claimant did not have any symptoms and, therefore, did not have any pain and he was able to function at a normal level. Dr. Sabbagh believes that at that point, the treatment with regard to the industrial accident had ceased.

Claimant's specific complaints involved the neck, shoulders, arms, left leg, and low back with sharp pain, numbness, tingling, pain in his brain and headaches. He basically described chronic neck, shoulder and arm pain that was mainly on the left. Dr. Sabbagh diagnosed Claimant with a stable cervical spine fusion at C5 to C7 from the 2001 industrial accident and a stable left C4-5 posterior laminectomy.

Dr. Sabbagh believes that the 2010 surgery was reasonable and appropriate, but that it was not related to the 2001 industrial accident. Claimant had an injury in 2001 and underwent surgery that addressed the injuries at that time. Claimant healed well and returned to full-time work; he had an excellent initial result from surgery. Claimant went on to have a fairly pain-free period for years, which indicates to Dr. Sabbagh that he recovered from the industrial accident. The fact that Claimant had symptoms and surgery approximately ten years later indicates that there is more than likely a progression of the natural process and disease rather than the specific event in 2001. For someone of Claimant's age, the need for the surgery that was performed in 2010 could have arisen without a specific incident or event.

Dr. Sabbagh reviewed Dr. Sonti's records and when Dr. Sonti first saw Claimant in 2010, he reported that his pain began about four years earlier, which would be around 2006. That information does not change Dr. Sabbagh's opinion regarding causation because that is still five

years after Claimant's 2001 industrial accident and initial surgery. He does not know about any further injury or accident that correlates with the onset of the symptoms that started in 2006. Dr. Sabbagh is not aware of anyone else ascribing the need for the 2010 surgery to an intervening accident or injury.

There is research regarding adjacent level problems and disease and Dr. Sabbagh agrees that it is not uncommon, but he explained that it is still more common to have an adjacent level disease from a natural progression of symptoms rather than from the fusion surgery itself. Approximately one-third of patients that have fusion surgery may go on to have an adjacent level disease, which means that two-thirds do not. According to Dr. Sonti's records, Claimant was recovering and had significant improvement following the 2010 surgery. Claimant's pain increased in 2011 after he fell and hit his head. Dr. Sabbagh agreed that Claimant's 2010 surgery was due to adjacent disc disease, but believes that it is more likely due to a natural progression of changes rather than due to the 2001 surgery based on the research data at this point. He conceded that he could not know in any individual case whether the adjacent level disease is due to the fusion surgery or natural progression independent of surgery, but given the odds, it is more likely to be due to a natural progression rather than to the prior fusion surgery. He agreed that his opinion is based on general statistics and his clinical practice rather than connecting the statistics to Claimant specifically.

Claimant started pain management treatment with Dr. Dickinson in May 2011 and indicated that he hit his head getting out of a truck in December 2010, which correlates with his increased symptomatology. Even if the Board finds that the 2010 surgery is related to the industrial accident, Dr. Sabbagh believes that the pain management treatment that began in 2011 is not related to the industrial accident, but rather, is related to the December 2010 incident when

Claimant hit his head. Patients do not usually need ongoing pain management after the type of surgery that Claimant underwent in 2010. Dr. Sabbagh agreed that Claimant's pain complaints are chronic at this point and that it is reasonable for him to continue seeking pain management treatment, including medication and office visits with Dr. Dickinson or another pain management physician. Dr. Sabbagh did not take issue with the treatment that Dr. Dickinson's office provided for Claimant's chronic pain.

Dr. Sabbagh understood that Claimant was working full-time in an unrestricted capacity as a truck driver before he started treating with Dr. Sonti for the additional symptoms. Dr. Sabbagh recalled from Claimant's history that Claimant bumped his head getting out of the truck in December 2010, but Dr. Sabbagh cannot recall whether Claimant sought medical treatment urgently following that event. Claimant did not start treating with Dr. Dickinson until May 2011 and that is when he first reported the incident. Claimant was still treating with Dr. Sonti in December 2010, but she did not record any history of such an event in her records in December 2010 or February 2011.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant bears the burden of proving that the cervical spine surgery and pain management treatment have been reasonable, necessary, and causally related to the industrial injury. D&B accepted compensability of Claimant's industrial accident and has paid for Claimant's workers' compensation benefits. It argues, however, that Claimant's surgery in 2010 and pain management treatment beginning in 2011 were not related to the industrial accident and, therefore, are not compensable. For the following reasons, the Board finds that Claimant has met his burden of proof for both issues.

Cervical Spine Surgery

- Procedural History

Claimant initially filed the Petition to Determine Additional Compensation Due regarding the payment for surgery on August 23, 2010. D&B filed a Motion to Dismiss the petition because Dr. Sonti was not certified under the Delaware Worker's Compensation Guidelines and did not get preauthorization for the surgery. The Board granted the dismissal in its December 21, 2010 Order ("Order"). Claimant appealed the Board's Order and the Superior Court issued its decision on November 28, 2012.[5]

The Board explained in its Order that it dismissed Claimant's Petition because 19 *Del. C.* § 2322D ("the statute") requires the physician to be certified under the Delaware Worker's Compensation Guidelines or to obtain preauthorization for treatment in order for the treatment to be compensable. Section 2322D(a)(1) specifically states: "Certification *shall be required* for a health care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health care provider first preauthorize each health care procedure, office visit or health care service to be provided to the employee with the employer or insurance carrier." (Emphasis added.) Dr. Sonti was not certified and failed to obtain preauthorization for the surgery, so the Board found that it had to dismiss the Petition based on the statute.

The Superior Court held that § 2322D is ambiguous and interpreted it to mean that the treatment is not *assumed* to be compensable when the physician is not certified and did not obtain preauthorization, but that the Board could still entertain the Petition and determine whether the treatment was reasonable, necessary and causally related. The case was reversed and remanded back to the Board. Accordingly, the issue now presented to the Board is whether,

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[5] *Howard VanVliet v. D & B Transportation*, Del. Super. Ct., C.A. No. 11A-09-003-JTV, Vaughn, J. (November 28, 2012).

despite the fact that Dr. Sonti had neither the required certification nor the required preauthorization contemplated by § 2322D(a)(1), the treatment is still compensable as reasonable and necessary medical treatment causally related to a work injury.

- Analysis of the Issue

The Board accepts Claimant's testimony about his industrial accident and medical treatment. Claimant was not involved in any subsequent accidents and did not sustain any other injuries after the 2001 industrial accident. He improved after the 2001 surgery, but then the symptoms gradually returned and worsened beginning in 2006. He obtained pain medications through Dr. Rosa when needed until he finally sought treatment with Dr. Sonti in 2010. Even though Claimant was able to return to work as a truck driver in 2007, he had difficulty with the long distance drives, so he switched employers to a company that accommodated his injury and restrictions, as Dr. Grossinger indicated.

When there is a conflict in the medical testimony, the Board must decide which physician is more credible. *General Motors Corp. v. McNemar*, 202 A.2d 803 (Del. 1964). As long as there is substantial evidence to support its decision, the Board may accept the testimony of one physician over another. *Standard Distributing Co. v. Nally*, 630 A.2d 640, 646 (Del. 1993). In the case at hand, the doctors agree that Claimant's cervical spine surgery was reasonable and necessary; they just disagree as to whether it is causally related to the industrial accident. The Board accepts the opinions of Drs. Sonti and Grossinger over Dr. Sabbagh's opinion. The Board finds that the opinions of Drs. Sonti and Grossinger are more persuasive as they are consistent with the facts of this case and Claimant's overall condition.

The Board finds that Dr. Sabbagh's opinion is not persuasive. Dr. Sabbagh agreed that Claimant's 2010 surgery was reasonable and necessary, but that it was not related to the

industrial accident. He agreed that Claimant had adjacent level disc disease, but assumed that it was due to the natural progression of the degenerative condition rather than from the industrial accident or 2001 fusion surgery. However, Dr. Sabbagh could not say within a reasonable degree of medical probability whether Claimant's adjacent level disease was related to the natural progression or related to the 2001 fusion surgery in this particular case.

The Board accepts Dr. Sonti's opinion that the cervical spine surgery was reasonable, necessary and causally related to the industrial accident. Even Dr. Grossinger, who examined Claimant on behalf of D&B, indicated that the cervical spine surgery was reasonable, necessary and causally related to the industrial accident. Both Drs. Sonti and Grossinger explained that the previous two-level fusion likely caused the adjacent level disc problems that led to the 2010 surgery. They explained that it takes years for the problems to develop and that even though it was nine years after the first surgery, that it was still within a reasonable timeframe for the adjacent level disease to be related to the fusion surgery. The symptoms started in 2006 and gradually worsened until Claimant sought treatment with Dr. Sonti in 2010, which is not an unusual presentation for this condition. Dr. Grossinger's opinion is particularly persuasive in this case since he was the defense medical examining physician rather than the treating physician and he still agreed that the 2010 surgery was reasonable, necessary and causally related to the 2001 industrial accident and 2001 fusion surgery.

The Board finds that Claimant's industrial accident and fusion surgery are causally related to the adjacent level degenerative condition that led to surgery in 2010 and, therefore, the 2010 cervical spine surgery is compensable. *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. 1992). Based on the foregoing, the Board finds that Claimant has met his burden of proof. The Board finds that the 2010 cervical spine surgery with Dr. Sonti was reasonable, necessary

and causally related to the industrial accident and, therefore, it is compensable. The medical bills for the surgery should be paid within the framework of the Delaware Workers' Compensation Fee Schedule.

Pain Management Treatment

The Board accepts Claimant's testimony about his condition and pain management treatment. Dr. Sonti referred Claimant to pain management with Dr. Dickinson after Dr. Sonti released him from her care because he had ongoing symptoms. All of the doctors agreed that the pain management treatment was reasonable and necessary; even Dr. Sabbagh had no issues with the treatment that Dr. Dickinson provided to Claimant. Dr. Sabbagh just opined that the treatment was not related to the industrial accident. He thought that the pain management treatment beginning in 2011 was related to a new incident, such as the incident when Claimant was tightening the landing gear, but Claimant explained that the landing gear incident occurred before the 2010 surgery.

The Board accepts the opinions of Drs. Dickinson, Sonti and Grossinger regarding the pain management treatment that Dr. Dickinson provided. Since the Board finds that the surgery was causally related to the industrial accident and the doctors agree that the treatment was reasonable and necessary following the surgery, the Board also finds that the pain management treatment was causally related to the industrial accident. Claimant had lingering symptoms following the 2010 surgery and it was appropriate for him to seek treatment.

D&B argued that the pain management treatment was excessive; however, even Dr. Sabbagh agreed that the treatment that Dr. Dickinson provided was appropriate. Furthermore, the Board accepts Dr. Dickinson's explanation that there were more than the typical number of

visits in this case because Claimant had a couple of positive drug screens, which led to additional appointments and drug screens until he was in compliance again with the medication agreement.

Based on the foregoing, the Board finds that Claimant has met his burden of proof. The Board finds that the pain management treatment with Dr. Dickinson was reasonable, necessary and causally related to the industrial accident and, therefore, it is compensable. The medical expenses should be paid within the framework of the Delaware Workers' Compensation Fee Schedule.

Attorney's Fee and Medical Witness Fees

Having received an award, Claimant is entitled to a reasonable attorney's fee assessed as costs against D&B in an amount not to exceed thirty percent of the award or ten times the average weekly wage, whichever is smaller. *Del. Code Ann.* tit. 19, § 2320. Claimant's counsel submitted an affidavit attesting to 59.2 hours of preparation for this two and a half-hour hearing. This case was not novel or difficult, nor did it require exceptional legal skills to try properly. It was argued that acceptance of this case precluded other employment by Claimant's counsel. The Board considered the fees customarily charged in this locality for similar legal services, the amounts involved and the results obtained. The Board also considered the argument that this case posed time limitations upon Claimant's counsel, the date of initial contact on September 4, 2002, and the relative experience, reputation, and ability of Claimant's counsel. It was argued that the fee was contingent, that Claimant's counsel does not expect to receive compensation from any other source, and that the employer is able to pay an award. *General Motors Corp. v. Cox*, 304 A.2d 55, 57 (Del. 1973).

The Board must consider the ten factors enumerated in *Cox* when considering an attorney's fee award or else it would be an abuse of discretion. *Thomason v. Temp Control*, Del.

Super. Ct., C.A. No. 01A-07-009, Witham, J., slip.op. at 5-7 (May 30, 2002). Claimant bears the burden of establishing entitlement to an attorney's fee award and must address the *Cox* factors in the application for an attorney's fee. Failure to address the *Cox* factors deprives the Board of the facts needed to properly assess the claim. The *Cox* factors were addressed in the Affidavit Regarding Attorney's Fees.

In the case at hand, based on the results obtained, information presented and D&B's failure to argue that an attorney's fee award is not appropriate, the Board finds that one attorney's fee in the amount of $6,614.70 (which is thirty-percent of the surgical bills) and one attorney's fee in the amount of $2,737.01 (which is thirty-percent of Dr. Dickinson's bills) is reasonable for the two issues presented. *Del. Code Ann.* tit. 19, § 2320. The award is reasonable given Claimant's counsel's level of experience and the nature of the legal task. In accordance with §2320(10)a, the attorney's fee awarded shall act as an offset against fees that would otherwise be charged by counsel to Claimant under their fee agreement.

As there is an award, medical witness fees are taxed as costs against D&B. *Del. Code Ann.* tit. 19, § 2322(e).

STATEMENT OF THE DETERMINATION

Based on the foregoing reasons, Claimant's Petitions to Determine Additional Compensation Due are GRANTED as to the 2010 cervical spine surgery and the pain management treatment. The medical bills should be paid within the framework of the Delaware Workers' Compensation Fee Schedule. In addition, Claimant is entitled to payment of medical witness fees and two attorney's fees in the amount of thirty-percent of each award for a total attorney's fee award of $9,351.71.

IT IS SO ORDERED THIS 15th DAY OF MAY 2013.

INDUSTRIAL ACCIDENT BOARD

/s/ Mary Dantzler

/s/ William Hare

I hereby certify that the above is a true and correct decision of the Industrial Accident Board.

Julie G. Bucklin
Workers' Compensation Hearing Officer

Mailed Date: 5/15/2013

OWC Staff

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

BERTHA POLK,	)	
	)	
Employee	)	
	)	Hearing No. 1253843
v.	)	
	)	
GREEN ACRES PAVILION,	)	
	)	
Employer.	)	

ORDER

Pursuant to due notice of time and place of hearing served on all parties in interest, on December 2, 2009, the Board heard a Motion filed by Employer, Green Acres Pavilion, against Claimant, Bertha Polk, seeking dismissal of several alleged medical expenses underlying Claimant's current pending Petition to Determine Additional Compensation Due, scheduled to be heard March 1, 2010.[1] Employer alleges that Claimant failed to comply with title 19, Delaware Code section 2322D inasmuch as she received medical treatment from out of state, non-certified providers (non-certified in the context of Delaware's Worker's Compensation statutory scheme) without obtaining pre-authorization from the insurance carrier. Employer maintains that these unauthorized treatments are not compensable and are not properly before the Board. Furthermore, the Employer argues that to allow Claimant to pursue out of state treatment conducted by

[1] By letter dated November 9, 2009, Claimant provided a list of nine (9) separate outstanding expenses allegedly owing to Claimant by the carrier. Item one (1) on this list references unpaid bills for prescription medications, prescribed by Delaware physicians, Dr.'s Rowe or Villabona, during a period from August 2007 through September 2008 while items two (2) through nine (9) all relate to treatment that Claimant received out of state by non-certified providers without prior authorization. Employer seeks dismissal of all claims related to prescriptions issued after May 2008 when the Health Care Guidelines were instituted as well as all out of state, unauthorized medical treatment.

non-certified medical providers deprives the insurance carrier of the ability to utilize the Utilization Review ("UR") process.

Claimant argues that UR is an option that Employer has available to use if claims are going to be denied. It is not a required precursor to litigation. Claimant further argues that the currently pending Petition to Determine Additional Compensation Due seeks authorization as well as payment for the treatments that Claimant has received from her out of state providers. Claimant argues that she has relocated from the State of Delaware to North Carolina wherein there are no Delaware certified providers and no incentive for providers to become so certified. She maintains that it is an inconsistent reading of the statutes to suggest that an individual in her circumstances could be forced to go without treatment because she is no longer a resident of the State of Delaware and can't find a doctor inclined to indulge Delaware's Worker's Compensation certification process. Claimant further argues that authorization, if granted by the Board in the upcoming hearing on the merits, would relate back to the treatment that she has already received.

Both Claimant and Employer acknowledge that neither is factually certain what procedure the North Carolina medical providers used to try and get pre-authorization for the treatments rendered Claimant or if they even made such an attempt. Employer further acknowledges that, at present, there is no evidence one way or the other regarding whether or not Claimant's treating physicians or pharmacy provided the medical bills to the carrier prior to the filing of the underlying petition.

After hearing the arguments of the parties and considering the relevant statutes and regulations, the Board agrees with Claimant that dismissal is inappropriate.

The Board is satisfied that title 19, section 2322D(a)(1), as referenced by Employer, does not preclude the potential payment of expenses related to medical treatment provided by non-certified providers for whom no prior authorization was sought or obtained. Specifically, where out of state medical providers are concerned, the Board and the State of Delaware can only compel compliance with the Delaware Workers' Compensation Health Care Payment System (HCPS) if the provider chooses to become a certified provider in our system. If a provider becomes Delaware certified, the provider agrees to comply with the law(s) and regulations of the Delaware HCPS.

In this same vein, insurance carriers or other payors can avail themselves of the UR process for all in-state and out-of-state certified health care providers, if they want to deny payment because they believe the certified health care provider's treatment did not adhere to one of the six (6) practice guidelines now in effect.

However, if the treatment at issue does not apply to a practice guideline or the out-of-state provider is not certified, then the payor would follow the previous practice of denying payment and the injured worker (or non-certified health care provider as an "assignee") would have to file an appropriate petition with the Board seeking payment for the services rendered. Specifically, in circumstances like those found in the instant case, in order for the non-certified provider to get payment for disputed treatments that were not pre-authorized by the relevant insurance carrier, a petition would have to be filed with the Board and the treatment would have to be found reasonable and necessary.

This reading of the statutes is further supported by the language of title 19, Delaware Code section 2322C(6) which provides in relevant part that ,"[s]ervices provided by health care providers that are not certified *shall not be presumed reasonable*

and necessary unless such services are preauthorized by the employer or insurance carrier, subject to the exception set forth in § 2322D(b) of this title." DEL. CODE ANN. tit. 19, § 2322C(6) (emphasis added). This does not state that such services are ineligible for payment—merely that they will not be "presumed reasonable." However, if they are subsequently found to be reasonable, they are subject to being paid by the employer or carrier pursuant to the requirements of title 19, section 2322 of the Delaware Code.

As such, the Board is satisfied that neither preauthorization nor Delaware certification are requirements to have treatment paid by an employer or carrier. Instead, the Board finds that certification of a provider creates a presumption that the treatments rendered by that provider are reasonable if they are within the Health Care Practice Guidelines. *See* DEL. CODE ANN. tit. 19, § 2322C(6) (treatment by a certified health care provider that conforms with the Health Care Practice Guidelines is "presumed, in the absence of contrary evidence, to be reasonable and necessary"). If an Employer or insurance carrier wants to deny payment for or dispute the reasonableness of a medical procedure administered by a certified provider, the UR process is an appropriate avenue to pursue. Otherwise, the employer can deny the unauthorized treatments provided by a non-certified provider and the burden shifts to the Claimant and/or physicians both to file a petition seeking payment and to prove the reasonableness of the treatments.

In the instant case, Claimant sought and obtained care from non-certified providers without prior authorization from the insurance carrier. As such, at the time of Claimant's hearing on the merits of her claim to have these expenses compensated by Employer, Claimant will not have the benefit of a presumption that the treatments were reasonable but will instead have the burden of demonstrating that the treatments were

reasonable, necessary and causally related to her compensable work injury.[2] She is not foreclosed, however, from the opportunity to make that showing.

Accordingly, the Board finds that Employer's Motion to Dismiss all or part of Claimant's underlying Petition to Determine Additional Compensation Due must be DENIED.

IT IS SO ORDERED THIS 4th DAY OF DECEMBER, 2009.

INDUSTRIAL ACCIDENT BOARD

VICTOR EPOLITO JR

MARY DANTZLER

I, Angela M. Fowler, Hearing Officer, hereby certify that the foregoing is a true and correct decision of the Industrial Accident Board.

OWC Staff

Mailed Date: 12/4/09

Walt Schmittinger, Esquire, for Claimant

Natalie Palladino, Esquire, for Employer

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[2] This is different than what had previously been the case. Prior to the adoption of the Health Care Practice Guidelines, case law had indicated that, when causation was not in issue, a claimant could succeed on the merits of the petition just by producing evidence concerning the medical services rendered and the amounts charged for such services. If claimant did this, the burden then shifted to the employer to show that the treatment and/or charges were unreasonable. *General Motors Corp. v. English*, Del. Super., C.A. No. 90A-10-2, Goldstein, J., 1991 WL 89812 at *2 (May 10, 1991), *aff'd*, 608 A.2d 727 (Del. 1992). *See also Guy J. Johnson Transportation Co. v. Dunkle*, 541 A.2d 551, 553 (Del. 1988)(to prevail, claimant "must present evidence that (a) he has incurred medical expenses, (b) such expenses are attributable to a work-related injury and (c) the employer has not paid such expenses as required by 19 *Del. C.* § 2322"). In short, under the old law, there had always been a presumption that medical treatment received by a claimant was reasonable unless proven otherwise. That presumption no longer applies unless the treatment is by a certified provider and within the Health Care Practice Guidelines.

BEFORE THE INDUSTRIAL ACCIDENT BOARD OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

SUZANNE M. SHAY,	)	
	)	
Claimant,	)	
	)	
v.	)	
	)	IAB No: 1090250
CHRISTIANA CARE HEALTH SERVICES/ VISITING NURSES ASSOCIATION,	)	
	)	
	)	
Employer.	)	

STIPULATION AND ORDER

This matter is before the Industrial Accident Board upon a Petition to Determine Additional Compensation Due filed by Suzanne M. Shay ("Claimant") alleging certain transportation and medical expenses as well as a limited period of total disability, with the hearing on this petition being scheduled for June 2, 2010 at 1:00p.m.

The medical treatment in issue was obtained by Claimant from a non-certified health care provider and the claimant neither sought nor obtained preauthorization for the treatment. In connection with the settlement of an earlier petition, Christiana Care Health Services ("CCHS") had previously authorized Claimant to undergo a single injection treatment from an out-of-state provider (Dr. Myerson), reserving the right to review and further preauthorize any additional treatment. Claimant did undergo a single Synvisc injection on December 14, 2009, in accordance with the pre-authorization/settlement and the corresponding expenses and mileage were paid. However, Claimant then proceeded to have two further injections, administered on December 21 and December 28, 2009, with associated follow-up visits, for which Claimant neither requested nor received preauthorization. It is these injections that are the subject of the current petition.

CCHS seeks to have the medical treatment portion of the petition dismissed for failure to follow the requirements of title 19, section 2322D of the Delaware Code.[1] This section provides that "[c]ertification *shall* be required for a health care provider to provide treatment to an employee, pursuant to this chapter, *without the requirement that the health care provider first preauthorize each health care procedure...*" DEL. CODE ANN. tit. 19, § 2322D(a)(1) (emphasis added).

Claimant asserts that the requirements of this section do not pertain to her because the medical provider in question is located in Baltimore and not subject to the jurisdiction of Delaware. The doctor in question refuses to become certified under Delaware's health care payment system. Claimant asserts that to apply the preauthorization requirement to her treatment would deprive her of her statutory right to pick a doctor of her own choosing for her treatment. *See* DEL. CODE ANN. tit. 19, § 2323..

The Board agrees with CCHS. This is not a case like *Polk v. Green Acres Pavilion*, Del. IAB, Hearing No. 1253843 (December 4, 2009)(ORDER), where the claimant lived in another state (North Carolina) and sought treatment from a local doctor. Claimant in this case lives in Delaware and chose to travel to another state for the sole purpose of seeking treatment. While, pursuant to section 2323, Claimant is permitted to choose her own doctor, this does not relieve her of the responsibility of complying with section 2322D(a)(1). Under that section, if Claimant chooses to go to a doctor who is not a certified provider, the requirement is to obtain preauthorization before receiving treatment. Claimant was aware of this requirement because of the settlement of the prior petition in which CCHS did expressly preauthorize one injection only.

[1] Initially, CCHS sought to have the entire petition dismissed, but counsel agreed with Claimant's counsel that the portion of the petition pertaining to the total disability claim is not connected to the two unauthorized injections that she received.

Claimant was on notice that further injections would need preauthorization and neither she nor her doctor sought it.

Claimant argues that if preauthorization were denied, it would be burdensome to have to file a petition with the Board to seek preauthorization because that would delay treatment. However, Claimant did not even attempt to receive preauthorization. It is not appropriate for Claimant to just assume CCHS would deny preauthorization. Secondly, to the extent a denial would have come and caused a burden to Claimant, that is a burden that she chose to put on herself by seeking care from a non-certified provider. Claimant's right to have a doctor of her own choosing does not relieve her of the consequences of that choice.[2]

Accordingly, Claimant's petition is dismissed to the extent that it pertains to the medical treatment expenses incurred from a non-certified provider without preauthorization. The remainder of the petition is still set for hearing on June 2.

IT IS SO ORDERED THIS 25 DAY OF MAY, 2010.

INDUSTRIAL ACCIDENT BOARD

LOWELL L. GROUNDLAND

ALICE M. MITCHELL

Mailed Date:

OWC Staff

Christopher F. Baum, Hearing Officer for the Board

Kenneth F. Carmine, Esquire, for Claimant
William D. Rimmer, Esquire, for CCHS

[2] For example, if a claimant were to choose a doctor who practices a form of alternative medicine that is not recognized as reasonable treatment, it is no defense that the claimant had the right to choose that doctor. The treatment would still be unreasonable.

*81 A.3d 1253, *; 2013 Del. LEXIS 591, **

AMANDA WYATT, Employee Below, Appellant, v. RESCARE HOME CARE, Employer Below, Appellee.

No. 112, 2013

SUPREME COURT OF DELAWARE

81 A.3d 1253; 2013 Del. LEXIS 591

October 23, 2013, Submitted
November 20, 2013, Decided

SUBSEQUENT HISTORY: Case Closed December 6, 2013.

PRIOR HISTORY: [1]**
Court Below — Superior Court of the State of Delaware, in and for Sussex County. C.A. No. S12A-06-004.
Rescare Home Care v. Wyatt, 2013 Del. Super. LEXIS 222 (Del. Super. Ct., Mar. 6, 2013)

DISPOSITION: REVERSED and REMANDED.

CASE SUMMARY

OVERVIEW: HOLDINGS: [1]-The superior court erred in reversing the Industrial Accident Board's decision that the claimant's injury was caused by a work-related accident where the Board found the treating physician's account more credible, and a reviewing physician had agreed that if the claimant's account of the injury events were true, the work event likely caused the injury; [2]-The Board correctly concluded that Del. Code Ann. tit. 19, § 2322B(8)(b) did not apply to the treating physician's services as the medical treatment the claimant received was not provided in an emergency room or performed in a prehospital setting by ambulance attendants or paramedics; [3]-The Board properly concluded that Del. Code Ann. tit. 19, § 2322D(a)(1) exempted the employer from having to pay for medical treatment provided by the treating physician, apart from the care provided during the claimant's first visit.

OUTCOME: Superior court's judgment reversed. Board's judgment affirmed in part and reversed in part.

CORE TERMS: claimant, provider, emergency, compensable, pain, work-related, care provider,

preauthorization, medical experts, medical expenses, health care, surgery, lifting, preauthorized, deposition, medical testimony, medical history, medical treatment, uncertified, healthcare, presumed, sufficient evidence, causation, credible, medical bills, office visit, unambiguous, persuasive, industrial accident, syndrome

LEXISNEXIS® HEADNOTES

Hide

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN1 On appeal from the Industrial Accident Board, the superior court and the Supreme Court of Delaware must determine, whether the Board ruling is supported by substantial evidence and free from legal error. Substantial evidence is that relevant evidence that a reasonable mind might accept as adequate to support a conclusion. The superior court and the Supreme Court must view the record in the light most favorable to the prevailing party below. More Like This Headnote | *Shepardize:* Restrict By Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN2 Both the Supreme Court of Delaware and the superior court may only overturn a factual finding of the Industrial Accident Board when there is no satisfactory proof in favor of such a determination. However, an award cannot stand on medical testimony alone, if the medical testimony shows nothing more than a mere possibility that the injury is related to the accident. Nevertheless, such medical testimony can be supplemented by other credible evidence tending to show that the injury occurred directly after the trauma and without interruption, such evidence would be sufficient to sustain an award. More Like This Headnote | *Shepardize:* Restrict By Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN3 In case law, the Supreme Court of Delaware held that a decision of the Industrial Accident Board was based on sufficient evidence where medical testimony was supported by credible lay testimony. More Like This Headnote | *Shepardize:* Restrict By Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN4 The Supreme Court of Delaware emphasized that the Industrial Accident Board is entrusted to find the facts in any given case, and its findings of fact must be affirmed if supported by any evidence, even if the reviewing court thinks the evidence points the other way. More Like This Headnote | *Shepardize:* Restrict By Headnote

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > Standards of Review > Substantial Evidence

HN5 The Supreme Court of Delaware held that there was no factual foundation for a medical expert's testimony where the medical expert's testimony was based on an inaccurate medical history. More Like This Headnote

Civil Procedure > Appeals > Standards of Review > De Novo Review

Governments > Legislation > Interpretation

HN6 The Supreme Court of Delaware reviews statutory interpretation undertaken by boards and trial courts de novo. When so doing, the court's goal is to, determine and give effect to the legislative intent. More Like This Headnote | *Shepardize:* Restrict By Headnote

Governments > Legislation > Interpretation

HN7 Undefined words in a statute are given their ordinary, common meaning, and words should not be construed as surplus if a reasonable construction will give them meaning. More Like This Headnote

Governments > Legislation > Interpretation

HN8 When the statute is clear on its face and is fairly susceptible to only one reading, the unambiguous text will be construed accordingly, unless the result is an absurdity that cannot be attributed to the legislature. Where the text of a statute is ambiguous, however, the Supreme Court of Delaware ill resort to other sources [of the statute's apparent purpose, including relevant public policy. More Like This Headnote

Governments > Legislation > Interpretation

HN9 In interpreting the statute, the Supreme Court of Delaware will read all sections of the statute in light of all the others to produce a harmonious whole. More Like This Headnote

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

HN10 See Del. Code Ann. tit. 19, § 2322B(8)(b).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN11 See Del. Code Ann. tit. 19, § 2322D(a)(1).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > General Overview

HN12 See Del. Code Ann. tit. 19, § 2322C(6).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > General Overview

HN13 See Del. Code Ann. tit. 19, § 2322B(1).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN14 See Del. Code Ann. tit. 19, § 2322D(b).

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN15 Del. Code Ann. tit. 19, § 2322D(b) specifically allows compensation for the first visit to an uncertified, non-preauthorized provider, but only where services are reasonable and necessary and where the provider believes, in good faith, that the injury was work-related. More Like This Headnote

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN16 The Supreme Court of Delaware holds that the statutory framework is unambiguous when all of the provisions are read in pari materia. Del. Code Ann. tit. 19, § 2322D requires that providers be either certified or preauthorized and that the treatments provided are reasonable and necessary to treat a work-related injury. When the provider is either certified or preauthorized, the claimant is entitled to the presumption that treatments provided were both reasonable and necessary. This presumption is rebuttable, however, meaning that an employer could attempt to rebut it by showing evidence to the contrary. More Like This Headnote

Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Authorized Treatment

HN17 Where the provider is neither certified nor preauthorized as required by Del. Code Ann. tit. 19, § 2322D, compensation for medical treatment is generally not available, with narrow exceptions for care provided on the first visit to the provider and for care provided in the emergency unit of a hospital or in a pre-hospital setting. More Like This Headnote

COUNSEL: Kenneth F. Carmine , Esquire (argued) and Tiffany M. Shrenk, Esquire, Potter, Carmine & Associates, P.A., Wilmington, Delaware, for appellant.

Linda Wilson , Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Wilmington, Delaware, for appellee.

JUDGES: Before HOLLAND , BERGER and RIDGELY , Justices.

OPINION BY: HOLLAND

OPINION

[*1256] HOLLAND , Justice:

The claimant-appellee and cross-appellant-appellant, Amanda Wyatt ("Wyatt" or the "Claimant"), appeals from a Superior Court judgment reversing an Industrial Accident Board (the "Board") finding that she had a compensable, work-related injury. The employer-appellant and cross-appellee-appellee is Wyatt's former employer, Rescare Home Care ("Rescare"). Wyatt raises two claims on appeal. First, she contends the Superior Court erred in reversing the Board's decision that her injury was a compensable industrial accident, since the Board's decision was based upon substantial evidence. Second, she submits that the Board erred in denying the medical expenses for her emergency back surgery.

We have concluded that the Superior Court erred in reversing the Board's **[**2]** decision that the Claimant had a compensable work related injury. We have also concluded that the Board properly determined that her back surgery was not compensable. Therefore, the judgment of the Superior Court is reversed.

Facts

The facts as found by the Board are as follows. The Claimant worked for Rescare as a certified

nursing assistant for four to five years before she was injured. She primarily worked with a five-year-old boy, Isaac, who was completely dependent upon her. In addition to other duties, Claimant was charged with bathing, feeding, and transferring Isaac from his chair to his stand or to the floor and back, all without assistance. The Claimant would perform transfers of Isaac throughout the day while attending to him at school, as well as at Isaac's home three days per week. **[*1257]** Isaac weighed about fifty-five pounds at the time of the accident.

The Claimant began experiencing lower back pain on October 21, 2010 when she bent over to pick to something up in her home. After trying to work through the pain, she was eventually forced to go to the emergency room. She was diagnosed with a pulled muscle and given a prescription for both muscle relaxers and pain medication. No **[**3]** tests were ordered, and the Claimant did not attempt to seek further treatment at that time.

On Friday, December 10, 2010, the Claimant began experiencing lower back pain again. She thought it was simply the result of frequent work. She did not work that weekend, and took off an additional day on Monday, December 13, 2010 to rest.

On Wednesday, December 15, 2010, the Claimant met Isaac at his school in order to resume her work duties, though her lower back pain continued. When she transferred Isaac for lunch, the Claimant's back pain ceased, but her leg went numb and she felt the urgency to urinate. She headed immediately for a restroom, and was witnessed by a school physical therapist to be dragging her left foot, which was numb. Her whole perineal area was numb when using the restroom.

The Claimant called her mother, who works for a general surgeon's office. The Claimant's mother relayed the above symptoms to Dr. Tatineni, one of the surgeons for whom the Claimant's mother works. Dr. Tatineni said that the Claimant needed to see Dr. Balapur Venkataramana ("Dr. Venkatarama"), who is a neurosurgeon, right away. When an appointment could not be had before Monday, December 20, 2010, Dr. **[**4]** Tatieni called Dr. Venkataramana directly, and Dr. Venkataramana agreed to see the Claimant on Friday, December 17, 2010.

While in Dr. Venkataramana's waiting room on Friday, December 17, 2010, Dr. Venkataramana's receptionist overheard the Claimant speaking to her mother about work, and informed the Claimant and her mother that Dr. Venkataramana does not take workers' compensation cases. She also informed the Claimant that if her case was a workers' compensation claim, she would have to go elsewhere for treatment. The Claimant, fearful that she would not be able to be seen immediately by another doctor, told Dr. Venkataramana that the numbness began when she woke up, rather than when lifting Isaac, in order to receive treatment.

Dr. Venkataramana sent the Claimant to have an MRI, x-rays, and blood work in the same building and told her not to leave. Subsequently, he told the Claimant to meet him the next morning, Saturday, December 18, 2010, at Beebe hospital so that he could read the MRI. During that visit, Dr. Venkataramana informed the Claimant that she needed to have surgery the next day. Dr. Venkataramana performed spinal surgery on Sunday, December 19, 2010.

After the surgery, **[**5]** the Claimant told Dr. Venkataramana that the onset of the numbness actually occurred while lifting Isaac at school. After reviewing the Claimant's medical history and records, including the medical examination performed by defense expert, Dr. Kevin Hanley, Dr. Venkataramana testified during his deposition that the type of work that the Claimant does caused the disc herniation, and that cauda equina syndrome was the result. Dr. Venkataramana also testified that the Claimant could not have had the disc herniation and cauda equina syndrome before December 15, 2010, because she would not have been able to work **[*1258]** through the pain associated with the type of injury sustained that day.

The Claimant submitted to an examination by Dr. Hanley, an expert medical witness for the defense.

Dr. Hanley agreed that lifting Isaac could have caused the Claimant's injury, and also agreed that if the Claimant's testimony regarding the lifting incident on December 15, 2010 is taken as true, then a work accident caused her herniated disc rupture. Because the Claimant initially did not tell Dr. Venkataramana about the incident, however, Dr. Hanley opined that her injury was more likely caused by gradual onset **[**6]** due to sneezing, standing up, or bending over at home. Furthermore, Dr. Hanley denied that the Claimant had cauda equina syndrome, since her pain was mainly on the left side of her lower back.

Procedural History

The Claimant filed a Petition to Determine Compensation Due seeking acknowledgement that her lower back injury was a compensable industrial injury on June 10, 2011. The Board issued its decision on the merits on February 3, 2012, which: 1) made its findings of fact; 2) granted the Claimant's petition; and 3) awarded her payment of medical bills, payment of total disability benefits from December 15, 2010 to February 1, 2011 at $364.33 per week, and attorney's fees in the amount of $8,000.

Rescare filed a Motion for Reargument on the award of medical bills, on the basis that Dr. Venkataramana cannot be compensated under title 19, section 2322D of the Delaware Code because he is an in-state provider who is not certified under the Health Care Payment system and did not obtain preauthorization for the treatments he provided. The Board agreed with Rescare, finding that the "emergency exception" to title 19, section 2322D of the Delaware Code did not apply, and that Dr. Venkataramana's **[**7]** services were not compensable. Nevertheless, the Board found that the Claimant's other medical expenses would be compensable pending the submission of "clean claims."

The Claimant and Rescare filed cross-appeals with the Delaware Superior Court. The Superior Court held that the Board erred when it found causation, i.e., that the Claimant's injury was a compensable industrial accident, because there was not sufficient evidence in the record to support such a finding. The Superior Court placed particular emphasis on the fact that, in its view, Dr. Venkataramana was not aware at the time that he rendered his expert opinion that the Claimant's injury occurred while lifting Isaac. As a result of that emphasis, the Superior Court held, "[t]he Board's decision is simply not rationally related to or based on Dr. Venkataramana's opinion." The Superior Court did not rule on the other grounds raised in the cross-appeals. We address those issues in the interest of justice and judicial economy.

Standard of Review

HN1 On appeal from the Board, the Superior Court — and this Court — must determine, "whether the [Board] ruling is supported by substantial evidence and free from legal error."[1] Substantial evidence **[**8]** is that "relevant evidence that a reasonable mind might accept as adequate to support a conclusion."[2] The Superior Court and this Court must view the record **[*1259]** in the light most favorable to the prevailing party below.[3]

FOOTNOTES

1 *Diamond Fuel Oil v. O'Neal*, 734 A.2d 1060, 1062 (Del. 1999) (quoting *Stoltz Management Co., Inc. v. Consumer Affairs Bd.*, 616 A.2d 1205, 1208 (Del. 1992)).

2 *Steppi v. Conti Elec., Inc.*, 991 A.2d 19 (Del. 2010) (TABLE) (citing, *Scheers v. Indep. Newspapers*, 832 A.2d 1244, 1246 (Del. 2003)).

3 *Id.* (citing *General Motors Corp. v. Guy*, 1991 Del. Super. LEXIS 347, 1991 WL 190491, at *3 (Del. Super. Ct. Aug. 16, 1991)).

HN2 Both this Court and the Superior Court may only overturn a factual finding of the Board when there is no satisfactory proof in favor of such a determination.[4] However, "an award cannot stand on medical testimony alone, if the medical testimony shows nothing more than a mere possibility that the injury is related to the accident."[5] Nevertheless, such medical testimony can be supplemented by "other credible evidence tending to show that the injury occurred directly after the trauma and without interruption, . . . such evidence would be sufficient to sustain an award."[6]

FOOTNOTES

4 *Id.* (citing *Johnson v. Chrysler Corp.*, 59 Del. 48, 213 A.2d 64, 66-67, 9 Storey 48 (Del. 1965)).

5 *General Motors Corp. v. Freeman*, 53 Del. 74, 164 A.2d 686, 688, 3 Storey 74 (Del. 1960).

6 *Id.*

Sufficient [9] Evidence Precedents**

HN3 In *General Motors Corp. v. Freeman*,[7] this Court held that a decision of the Board was based on sufficient evidence where medical testimony was supported by credible lay testimony.[8] In that case, a worker began to suffer pain immediately after being affected by a foreign body entering his eye while dealing with a fire.[9] Although he was later diagnosed with a detached retina, testifying experts could not say with a medical certainty that the condition was caused directly by the work incident, although they each testified that it was a possibility.[10] In that case, the Board found that the injured worker's credible testimony regarding the timeline of events supported the "weak" medical testimony and was sufficient to show causation.[11] Both the Superior Court and this Court affirmed that determination by the Board.[12]

FOOTNOTES

7 *Id.* at 686.

8 *Id.* at 689.

9 *Id.* at 687.

10 *Id.*

11 *Id.* at 689.

12 *Id.*

In *Steppi v. Conti Elec., Inc.*,[13] this Court reversed a Superior Court judgment which overturned the Board's finding that the claimant had shown causation.[14] In that case, where the claimant's exposure to hydrogen sulfide gas at an oil refinery led to his disability, the Board found the testimony of **[**10]** two medical experts in support of claimant to be more persuasive than other evidence to the contrary, including testimony by a defense medical expert.[15] The Superior Court reversed, concluding that there was no evidence of a gas leak and no causal connection between the claimant's injury and the incident.[16] This Court held that "[t]he decision of the Board was supported by the minimum

quantum of evidence required and should have been affirmed."[17] In *Steppi*, HN4 this Court emphasized that the Board is entrusted to find the facts in any given case, and its findings of fact "must be affirmed if supported by any evidence, **[*1260]** even if the reviewing court thinks the evidence points the other way."[18]

FOOTNOTES

13 *Steppi v. Conti Elec., Inc.*, 991 A.2d 19 (Del. 2010) (TABLE).

14 *Id.*

15 *Id.*

16 *Id.*

17 *Id.*

18 *Id.* (quoting 8 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* § 130.01[3] (2009)).

Conversely, in *Perry v. Berkley*,[19] HN5 this Court held that there was no factual foundation for a medical expert's testimony where the medical expert's testimony was based on an inaccurate medical history.[20] In that case, the medical expert was never asked at a subsequent deposition to update his testimony based upon a corrected **[**11]** medical history.[21] This Court held that because the medical expert's testimony was based upon an incorrect medical history, it was inadmissible under of D.R.E. 702 and *Daubert v. Merrell Dow Pharms.*., 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993).[22]

FOOTNOTES

19 *Perry v. Berkley*, 996 A.2d 1262 (Del. 2010).

20 *Id.* at 1270.

21 *Id.*

22 *Id.* at 1270-71.

Sufficient Evidence Presented

In this case, the Board found that the Claimant's injury was caused on December 15, 2010 when the Claimant lifted Isaac in the course of her work duties. The Board here, like the Board in *Freeman*, relied upon Claimant's testimony about the timing of her injury to supplement the medical evidence provided by Dr. Venkataramana when it determined causation. Furthermore, the Board here, much like the Board in *Steppi*, found Dr. Venkataramana's testimony, supported by the testimony provided by the lay witnesses, more persuasive and credible than Dr. Kevin Hanley's testimony that the Claimant's injury could not be traced to a work-related incident to a medical certainty.

In this case, the Superior Court relied heavily on the fact that at the time of his diagnosis of the Claimant's injury, Dr. Venkataramana was unaware of the December 15, 2010 lifting incident.

[12]** Unlike in *Perry*, however, it is clear from the transcript of Dr. Venkataramana's deposition that he knew of the Claimant's differing accounts of her injury's origin at the time of his deposition was taken. It was during his deposition that he rendered the expert medical opinion on which the Board relied. Furthermore, there is sufficient other evidence in the record to support the Board's finding. Specifically, Dr. Hanley agreed that if the Claimant's account of the events relating to her injury are true, that the event likely caused the injury.

The record reflects that the Board's findings of fact are sufficient to support its conclusion that the Claimant's injury was caused by a work-related accident. Therefore, the Superior Court's judgment to the contrary must be reversed.

Statutory Review Standard

HN6 This Court reviews statutory interpretation undertaken by boards and trial courts *de novo*.[23] When so doing, this Court's goal is to, "determine and give effect to [the] legislative intent."[24] ***HN7*** Undefined words are given their ordinary, common meaning, and words should not be construed as surplus if a reasonable construction will give them meaning.[25] ***HN8*** When the statute is "clear on its face and **[**13]** is fairly susceptible to only one reading, the unambiguous text will be construed accordingly," unless the result is an absurdity "that **[*1261]** cannot be attributed to the legislature."[26] Where the text of a statute is ambiguous, however, this Court, "will resort to other sources [of the statute's apparent purpose], including relevant public policy."[27] ***HN9*** In interpreting the statute, this Court will read all sections of the statute, "in light of all the others to produce a harmonious whole."[28]

FOOTNOTES

23 *Progressive N. Ins. Co. v. Mohr*, 47 A.3d 492, 495 (Del. 2012) (citations omitted).

24 *Id.* (quoting *Le Van v. Independence Mall, Inc.*, 940 A.2d 929, 932 (Del. 2007)).

25 *Id.*

26 *Id.* at 496 (citing *CML V, LLC v. Bax*, 28 A.3d 1037, 1040 (Del. 2011)).

27 *Id.* (citing *PHL Variable Ins. Co. v. Price Dawe 2006 Ins Trust, ex rel. Christiana Bank and Trust Co.*, 28 A.3d 1059, 1070 (Del. 2011)).

28 *Id.* (quoting *CML V, LLC v. Bax*, 28 A.3d 1037, 1040 (Del. 2011)).

Emergency Exception Inapplicable

Title 19, section 2322B(8)(b) of the Delaware Code states:

> ***HN10*** Healthcare provider services provided *in an emergency department of a hospital, or any other facility subject to the Federal Emergency Medical Treatment and Active Labor Act*, 42 U.S.C. § 1395dd, **[**14]** and any emergency medical services *provided in a prehospital setting by ambulance attendants and/or paramedics*, shall be exempt from the healthcare payment system and shall not be subject to the requirement that a healthcare provider be certified pursuant to § 2322D of this title, requirements for preauthorization of services, or the healthcare practice guidelines adopted pursuant to § 2322C of this title.[29]

FOOTNOTES

29 Del. Code Ann. tit. 19, § 2322B (emphasis added).

The Claimant argues that, ". . . it is clear that the 'emergency exception' provided by section 2322B(8)[(b)] applies in all situations where urgent care is needed," and cites numerous extrajurisdictional cases that support her point. Those cases are, however, at best persuasive authority, and, given the unambiguous nature of the Delaware statutory language, inapplicable in this case.

We hold that the Board correctly concluded the emergency exception of title 19, section 2322B(8)(b) does not apply to the facts of the Claimant's case because the medical treatment she received from Dr. Venkataramana was not provided in the emergency room of a hospital or other similar facility, nor was it performed in a prehospital setting by ambulance **[**15]** attendants or paramedics. Therefore, the emergency exception under title 19, section 2322B(8)(b) does not apply to the facts of the instant case and cannot be grounds for the recovery of medical expenses related to the surgery performed by Dr. Venkataramana.

Preauthorization Was Necessary

Title 19, section 2322D(a)(1) of the Delaware Code states:

> ***HN11*** *Certification shall be required for a health care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health care provider first preauthorize* each health care procedure, office visit or health care service to be provided to the employee with the employer or insurance carrier.[30]

FOOTNOTES

30 Del. Code Ann. tit. 19, §2322D(a)(1) (emphasis added).

Read alone, such a provision would seem to limit reimbursement for medical expenses only to those cases in which either the provider was certified under the statute or the provider is uncertified *and* obtains a prior authorization. However, title 19, section 2322C(6) states:

> **[*1262]** ***HN12*** Services rendered by any health care *provider certified* to provide treatment services for employees *shall be presumed*, in the absence of contrary evidence, *to be reasonable and necessary* if such **[**16]** services conform to the most current version of the Delaware health care practice guidelines. *Services provided by health care providers that are not certified shall not be presumed reasonable and necessary unless such services are preauthorized* by the employer or insurance carrier, subject to the exception set forth in § 2322D(b) of this title.[31]

Furthermore, title 19, section 2322B(1) of the Delaware Code states:

> ***HN13*** *The intent of the General Assembly in authorizing a health care payment system* is

> not to establish a "push down" system, but is instead to establish a system that eliminates outlier charges and streamlines payments by *creating a presumption of acceptability of charges implemented through a transparent process*, involving relevant interested parties, that prospectively responds to the cost of maintaining a health care practice . . .[32]

FOOTNOTES

31 Del. Code Ann. tit.19, §2322C(6) (emphasis added).

32 Del. Code Ann. tit. 19, §2322B(1) (emphasis added).

In *Vanvliet v. D & B Transp.*,[33] the Superior Court engaged in an analysis of the foregoing statutory provisions in a case concerning whether health care provided by a non-certified practitioner who failed to obtain preauthorization for the care **[**17]** provided was unrecoverable.[34] In that case the court found that the statute was ambiguous with regard to the compensability of such claims and interpreted the statute to allow for the compensation of such claims where medical expenses are "reasonable and necessary," to treat a work-related injury.[35]

FOOTNOTES

33 *Vanvliet v. D&B Transp.*, 2012 Del. Super. LEXIS 510, 2012 WL 5964392 (Del. Super. Ct. Nov. 28, 2012).

34 2012 Del. Super. LEXIS 510, [WL] at *3.

35 2012 Del. Super. LEXIS 510, [WL] at *4.

In *Vanvliet*, the Superior Court relied upon the fact that nowhere in the statute does the legislature expressly exempt employers from paying medical bills where the provider is uncertified and failed to obtain preauthorization.[36] Furthermore, the court found that the presence of the word "presumed" is key to the proper interpretation of the statute.[37] The court reasoned that a statutory interpretation that prohibits compensation where a provider is not certified and does not obtain preauthorization would fail to give effect to the term "presumed" in title 19, section 2322C(6), and that it would fail to effect the express intent of the General Assembly to create a legal presumption in favor of certified or preauthorized providers as announced in title 19, section 2322B(1).[38] As a result, where **[**18]** the medical provider is not certified and does not obtain preauthorization, the court in *Vanvliet* held the presumption in favor of the treatment being "reasonable and necessary" falls away, and the Claimant must show the reasonableness and necessity of the course of action taken for the treatment of the Claimant's work-related injuries.[39]

FOOTNOTES

36 *Id.*

37 *Id.*

38 *Id.*

39 *Id.*

The interpretation by the Superior Court in *Vanvliet* does not address the entire statutory framework. The statutes **[*1263]** relied upon by the court in *Vanvliet* must be read *in pari materia* with title 19, section 2322D(b), which provides:

> ***HN14*** Notwithstanding the provisions of this section, *any health care provider may provide services during 1 office visit . . . without first having obtained prior authorization*, and receive reimbursement for *reasonable and necessary services directly related to the employee's injury* . . . . The provisions of this subsection are *limited to the occasion of the employee's first contact* with any health care provider for treatment of the injury, and *further limited* to instances *when the health care provider believes in good faith, after inquiry, that the injury or occupational disease was suffered in the course of* **[**19]** *the employee's employment*.[40]

FOOTNOTES

40 Del. Code Ann. tit. 19, §2322D(b) (emphasis added).

An interpretation of the statute which makes section 2322D(b) a nullity does not read all sections of the statute, "in light of all the others to produce a harmonious whole."[41] ***HN15*** Section 2322D(b) specifically allows compensation for the *first visit* to an uncertified, non-preauthorized provider, but only where services are *reasonable and necessary* and where the provider believes, in good faith, that the injury was work-related. Such an exception would be superfluous if the statute were intended to function as the court in *Vanvliet* determined. Under that court's analysis, any uncertified, non-preauthorized provider could be compensated for *all* expenses that the Claimant shows, by a preponderance of the evidence, to have been "reasonable and necessary" to the treatment of a work-related injury. Situations like those covered in section 2322D(b) would be subsumed by that analysis, and an exception for the first office visit would be unnecessary, rendering the provision meaningless.

FOOTNOTES

41 *Progressive N. Ins. Co. v. Mohr*, 47 A.3d 492, 495 (Del. 2012) (citations omitted).

HN16 We hold that the statutory framework is unambiguous **[**20]** when all of the provisions are read *in pari materia*. The statute requires that providers be either certified or preauthorized and that the treatments provided are reasonable and necessary to treat a work-related injury. When the provider is either certified or preauthorized, the claimant is entitled to the *presumption* that treatments provided were both "reasonable and necessary." This presumption is rebuttable, however, meaning that an employer could attempt to rebut it by showing evidence to the contrary.

HN17 Where, however, the provider is neither certified nor preauthorized, compensation for medical treatment is generally not available, with narrow exceptions for care provided on the first visit to the provider[42] and for care provided in the emergency unit of a hospital or in a pre-hospital setting.[43] Accordingly, the Board properly concluded that title 19, section 2322D(a)(1) exempted the employer

from having to pay for medical treatment provided by Dr. Venkataramana, apart from the care provided during the Claimant's first visit with him.

FOOTNOTES

42 Del. Code Ann. tit. 19, § 2322B.

43 Del. Code Ann. tit. 19, § 2322D(b).

Conclusion

The judgment of the Superior Court is reversed. The judgment of the **[**21]** Board is affirmed in part and reversed in part as to the compensability of the Claimant's "other medical expenses." Only the expenses related to the Claimant's first visit to Dr. Venkataramana are compensable pursuant **[*1264]** to section 2322D(b) and the other sections in the entire statutory scheme. This matter is remanded for further proceeding in accordance with this opinion.

Certificate of Service

I hereby certify that I have caused copies of the foregoing:

Opening Brief of Appellant

Appendix to Appellant's Opening Brief

to be served upon: Cheryl Ward, Esquire
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via electronic service on June 27, 2014.

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