BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

JAKARI NEWTON,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1477327
	)	
COMFORT KEEPERS,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE COMPENSATION DUE

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 ("Board") on June 12, 2019 in the hearing room of the Board in New Castle County, Delaware.

PRESENT:

MARK MUROWANY

MARY DANTZLER

Julie Pezzner, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Ran Ji, Attorney for the Employee

Joseph Andrews, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

On September 25, 2018, Ms. Jakari Newton ("Claimant") was picking up lunch for a patient during the course and scope of her employment at Comfort Keepers ("Employer") when she was involved in an automobile accident. A car ran through a red light and struck Claimant's car as she was driving through the intersectin. Claimant's average weekly wage at the time of the accident was $367.31 yielding a weekly compensation rate of $244.87. Employer offered a modified duty position with a temporary partial disability average weekly wage of $168.75 yielding a weekly compensation rate of $132.37. On November 8, 2018, Claimant filed an initial Petition to Determine Compensation Due in which she seeks: acknowledgement of injuries to her cervical spine, her thoracic spine, her lumbar spine, and her left upper extremity; payment of outstanding medical expenses; and payment of total disability benefits. Employer does not dispute the occurrence of the work accident but instead, disputes: the extent of Claimant's injuries; the reasonableness, necessity, and causal relationship of the medical treatment particularly with respect to Dr. Cary's treatment; and disputes the period of total disability.

A hearing was held on Claimant's petition on June 12, 2019. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Claimant testified on her own behalf. She had worked for Employer as a Home Health Aide for eight years. Her job entailed assisting patients with the activities of daily living. Such responsibilities could involve assisting with housekeeping, bathing, grocery shopping, laundry, cooking, transportation and companionship. One of her clients is wheelchair bound and requires bathing assistance and other physically demanding assistance. Claimant had never been disciplined regarding her job performance.

Claimant testified that when the car struck her car on September 25, 2018, Claimant's car went onto the sidewalk and started smoking. Her car was totaled. Someone had to help Claimant get out of the car.

Claimant sustained bruises on her chest from what she believed was the seatbelt. She experienced pains in her chest, her left arm, her neck and her back. An ambulance took her to St. Francis Hospital. St. Francis placed Claimant on three days of total disability.

Thereafter, Claimant went to her family doctor. On October 4, 2018, Claimant commenced treating with Dr. Cary because Claimant's family doctor did not treat for workers' compensation injuries. To Dr. Cary, Claimant complained of neck, of back and of left shoulder pain. Her left shoulder felt like it was on fire and she could barely raise her arm. She rated her pain at a ten on a ten-point pain scale.

Dr. Cary prescribed a seven-day, thirty pill prescription of 7.5 milligrams of Percocet that she started taking on an as-needed basis. He also prescribed a topical cream. He started her on massage therapy three times per week. He placed Claimant on total disability because her job requires frequent hand use and involves weights.

The next time Claimant treated with Dr. Cary, Dr. Cary extended the Percocet prescription to thirty days and prescribed ninety pills. At this visit, Claimant had pills remaining from the first prescription. Claimant has been treating with Dr. Cary monthly at which time he renews the Percocet prescription of ninety pills for thirty days. Claimant testified that she and Dr. Cary never discussed reducing the dosage of the Percocet.

In March 2019, Claimant asked Dr. Cary to release her to return to work because she needed the income. She and her husband had been having financial difficulty. Dr. Cary released her to return to full-time light duty work.

Claimant returned to Employer with her work release. She testified that she completed the training and had her fingerprints taken. She never heard back from Employer about having a position to which she could return. She thought she completed all the required training. She disputed there was one more training she had to complete before she could return to work at Employer.

Claimant testified that she benefitted from the massage therapy, from the medication and from the injection. She received the injection in early January 2019. The injection could reduce her pain level from a ten to a four on a ten-point pain scale while continuing to take the medication. The medication could reduce her pain from a ten to a six on a ten-point pain scale. She would like to have another injection.

Claimant testified that her work injuries have not fully resolved. She continues to have problems with her neck and with her left shoulder. She does not vacuum or help with groceries.

Claimant testified that she has been searching for a light duty home care job. She had an interview one week prior to the hearing. She was unable to take the job because she was not a certified nursing assistant.

Claimant acknowledged receiving a job offer from Employer by letter dated November 9, 2018. In the letter, Employer directed Claimant to provide the letter to her doctor to determine what type of work-related physical capabilities she had. Claimant testified that she provided the letter to Dr. Cary despite Dr. Cary's contention he never saw it.

During her testimony, Claimant reviewed a copy of a three-page letter handed to her by Employer's counsel. Claimant testified that she only remembered seeing the first two pages. She did not remember the third page but after looking at it at the hearing she verified the third page

identified the specific job Employer had offered her. She did not respond to such offer because Dr Cary had been continuing her total disability status.

Claimant admitted having failed a drug screen test. She explained that someone suggested taking a drug because it would alleviate her pain. She did not know what methamphetamine was at that time. This was a one-time event. She has never been charged with a crime involving drugs and has never received a speeding ticket.

At the visit Dr. Cary administered the drug screen test, Dr. Cary renewed Claimant's thirty-day Percocet prescription. After failing the drug screen test, Dr. Cary did not renew the Percocet prescription. Instead, he cut her off from the medication without any weaning off period. He gave Claimant ibuprofen and referred Claimant to pursue getting a medical marijuana card. She did not follow-up with obtaining a medical marijuana card.

Claimant acknowledged being involved in a work accident four or five years prior to the work accident, but the accident did not involve her neck or shoulder.

On cross-examination, Claimant denied telling Dr. Schwartz that she took sixty of the ninety prescribed Percocet pills each month. She denied having any remaining pills each month. She subsequently testified that she told Dr. Schwartz that if she had any pills remaining at the end of the month, she took them the following month.

Claimant verified that on May 19, 2019, she told Dr. Cary that she was still waiting for Employer to offer her a job. Claimant acknowledged that on May 5, 2019 she was denied unemployment. According to the written denial the reason was because Employer indicated that it continued to employ Claimant and that Employer could accommodate her full-time light duty work restrictions. Claimant acknowledged that by applying for unemployment, she was admitting she was physically capable of returning to work.

her application to unemployment acknowledged that at that time she was able to return to work.

Dr. Damon Cary who specializes in pain management and is a certified provider under the Delaware Workers' Compensation Healthcare Payment System testified by deposition to a reasonable degree of medical probability on behalf of Claimant. He commenced treating Claimant on October 4, 2018. Claimant was twenty-nine years old. He opined that as a result of the work accident, Claimant sustained cervical and thoracic strains and a left shoulder sprain with bursitis.

The medical services at issue include bills: from St. Francis Hospital; from Family Medical Associates; from Dr. Cary; from Delaware Open MRI; from Premier Orthopaedics; from National Medication Mang.; from US Lab Inc.; and from Emergency Physician Assoc. Dr. Cary opined that the medical treatment has been reasonable, necessary and causally related to the work accident. He additionally opined that the work accident rendered Claimant totally disabled from the day of the work accident until March 7, 2019. As of March 7, 2019, Claimant has been capable or working full-time light duty work.

Dr. Cary testified that Claimant's neck and left shoulder remain bothersome. Dr. Cary characterized Claimant's neck as guarded. Dr. Cary expects some improvement in Claimant's left shoulder. Dr. Cary testified that Claimant's upper mid back will resolve if it had not already. He expects some improvement with her left shoulder.

Dr. Cary testified that Claimant continues to require treatment. She should continue doing her home exercise program. She could be a candidate for an epidural injection into her cervical spine. She also could be a candidate for a cortisone injection into her left shoulder if she has a flare-up.

Dr. Cary was aware that Claimant worked as a Home Health Aide but did not know her specific job responsibilities. He presumed her job involved helping with basic activities of daily living. He recognized that some patients required more physically demanding assistance than others. Some patients might require manual lifting and using Hoyer lifts. Others might require doing laundry, cooking and running errands.

On October 4, 2018, Claimant's first visit with Dr. Cary, Claimant complained of neck pain, of upper back pain and of left shoulder pain. Upon physical examination, Claimant presented with restricted range of motion of the cervical and thoracic spines. She had muscle spasms over the trapezial muscles and thoracic paraspinal muscles bilaterally. She had restricted range of motion of the left shoulder with tenderness over the left shoulder. He diagnosed Claimant as sustaining strains of the cervical and thoracic spines and a sprain of the left shoulder.

Claimant disclosed having been involved in a motor vehicle accident six or seven years prior but that her symptoms had resolved.

Dr. Cary started Claimant on rehabilitation treatments three times per week, placed Claimant on total disability for four weeks and prescribed medication. The rehabilitation program was in Dr. Cary's office and involved soft modalities such as heat, electric stimulation, and massage therapy. The goals of the rehabilitation program were improving ranges of motion and of decreasing her pain and symptoms.

Dr. Cary started Claimant on 7.5 milligrams of Percocet for pain control and a compound cream for muscle spasm. He directed Claimant to take one tablet of Percocet as needed every six hours and to apply the cream to the affected areas as needed up to three times per day. His initial prescription was for thirty pills – an amount he anticipated would last one week to one-and-a-half weeks. He wanted to make sure the medication worked before issuing a thirty-day prescription of

ninety pills. He did not identify the specifics of his prescription in his medical notes but represented that such directions were written on the prescription containers.

Claimant underwent an MRI of the cervical spine and of the left shoulder on November 6, 2018. The MRI of the cervical spine did not demonstrate evidence of cervical pathology such as a disk herniation or disk bulge. Dr. Cary testified that the MRI did demonstrate a straightening of the normal cervical lordosis – a finding Dr. Cary represented was compatible with muscle spasm and was consistent with Claimant's complaints and physical examination findings. Dr. Cary recognized that Dr. Schwartz did not believe there was evidence of spasm on the MRI.

The MRI of the left shoulder demonstrated mild joint effusion – a finding consistent with a bad sprain of the left shoulder. The left shoulder MRI also demonstrated moderate subcoracoid bursitis that Dr. Cary also attributed to the work accident whereas Dr. Schwartz did not. The MRI did not demonstrate evidence of a rotator cuff tear or of a labral tear.

Dr. Cary saw Claimant again on December 20, 2018, on January 3, 2019, and on January 31, 2019. At the January 31, 2019 visit, Claimant underwent a cortisone injection in the left shoulder. Dr. Cary renewed Claimant's prescription and started Claimant on a work conditioning program in lieu of the in-office rehabilitation program. He explained that the work conditioning program is more aggressive than the in-office rehabilitation program. Dr. Cary instructed Claimant to follow-up with him in five weeks.

The next visit was on March 7, 2019. In March, Claimant also reported having some insurance issues starting the work conditioning program. She had been doing home exercises. Dr. Cary decided it was time to try to return Claimant to work in a light duty capacity. He renewed Claimant's prescriptions. He also had Claimant undergo a drug screen test to be submitted to an

outside lab for the results. Dr. Cary testified that it normally takes approximately one week to receive the results.

Claimant failed the drug screen test. On April 4, 2019, Dr. Cary continued Claimant's home exercise program. He discussed the drug screen test results with Claimant and continued Claimant in a light duty work capacity. He discontinued the Percocet prescription due to the failed drug screen test results. He prescribed ibuprofen. He referred Claimant to Cannicare to pursue obtaining a medical marijuana card. To the best of Dr. Cary's knowledge, Claimant had not pursued having the consultation for medical marijuana.

Dr. Cary reviewed Dr. Schwartz's examination findings. Dr. Schwartz's examination findings were similar to Dr. Cary's examination findings. Such findings were consistent with Claimant's condition. Claimant had restricted range of motion of the cervical spine. She had weakness in the left upper extremity. Claimant reported to Dr. Schwartz that she had occasional numbness in the left upper extremity. Dr. Cary's diagnoses were the same as Dr. Schwartz's diagnoses other than that Dr. Cary did not believe that Claimant's upper back pain had improved by the time of the defense medical examination.

On cross-examination, Dr. Cary acknowledged that Section 18 of the Board of Medical Licensure identifies requirements related to the prescription of controlled substances to minimize deviation from the appropriate standard of care that could lead to abuse and diversion. Dr. Cary testified that since the time Claimant commenced treating with him, he has complied with the requirement of obtaining Claimant's medication history despite the fact he did not have any supporting documentation in his medical notes. He testified that he had entered Claimant's name into a computer system to obtain Claimant's history: of controlled substances with dosages; of the corresponding prescribing doctor; and of where the prescription was dispensed. The list dated

back to 2017. Such capability to access the necessary information *via* computer negated the need to query Claimant's prior medical physician to obtain the same information.

Dr. Cary testified that the reason the list was not in his file was because he shredded the list after reviewing it. He explained only doctors and pharmacists are allowed to view such information. It is not something he would produce to Employer even had he not shredded it regardless of Employer's subpoena.

Similarly, Dr. Cary testified that he also obtained an informed consent from Claimant but did not produce it to Employer. Dr. Cary testified that despite Employer's subpoena, Employer is not entitled to anything on the left side of his chart which includes: the patient's demographic sheets, the pain contracts, and all the other forms his patients complete when they enter his office.

Dr. Cary testified that he complied with the requirement of monitoring the treatment plan by identifying progress with respect to the goals of treatment. He acknowledged that in his records he repeated that the stated goals of the ongoing medical care were to decrease the patient's pain, to increase the level of function, and to improve the quality of life. Dr. Cary did not consider such statements to be vague or noncompliant with the Medical Practice Act.

Dr. Cary acknowledged that his medical notes from November 1, 2018 indicated that Claimant had full range of motion in her neck and in her thoracic spine despite pain complaints. He continued her thirty-day prescription of Percocet with baclofen cream. He did not issue a workers' compensation provider form because he issued one on the previous visit and under the Practice Guidelines, he does not have to issue another one unless her status has changed. He added that there is a thirty-dollar fee every time the physician submits that form. He gave her a disability slip but not on the workers' compensation certified form.

Dr. Cary recognized that St. Francis released Claimant to return to work without restrictions on September 28, 2018. On September 28, 2018, Dr. Layosa-Magat released Claimant to return to work without restrictions on October 5, 2018. When Dr. Cary saw Claimant on October 4, 2018, Dr. Cary placed Claimant on total disability because she needed rehabilitation therapy and needed better pain control.

Dr. Cary testified that usually cervical and shoulder sprains would resolve in three months, but he has seen circumstances such as Claimant's when they take longer to resolve. On November 29, 2018, Dr. Cary continued Claimant's total disability status. According to the medical notes from this visit, Claimant's thoracic spine/upper back had resolved. Her remaining injuries were cervical and left shoulder strains and bursitis.

Dr. Cary testified that he was unaware that Employer offered Claimant a modified duty job and that Claimant was supposed to present the job offer to Dr. Cary for his approval and for his identification of necessary work restrictions. Dr. Cary thought it was unusual that Employer did not fax the job offer directly to him. He typically does not receive such forms from the patient. Dr. Cary remarked that regardless of whether he saw the job offer, he would not have approved it because he opined that Claimant remained totally disabled at that time. Dr. Cary acknowledged that he never placed restrictions on Claimant's driving or on Claimant's activities of daily living.

Dr. Cary testified that his treatment was compliant with the Practice Guidelines yet he was treating acute injuries and the Practice Guidelines address chronic pain. Dr. Cary added that Claimant reported having benefitted from the injection even up until the most recent time Dr. Cary saw Claimant.

Dr. Eric Schwartz who is board certified in orthopedic surgery testified by deposition to a reasonable degree of medical probability on behalf of Employer. He reviewed pertinent medical records. He examined Claimant on January 28, 2019. He questioned the extent of Claimant's work injuries.

Giving Claimant the benefit of the doubt, Dr. Schwartz opined that Claimant sustained sprains and strains of the neck and the left shoulder that resolved by the time of the defense medical examination. He remarked that usually strains and sprains resolve in eight to ten weeks. Claimant may have had chest and low back issues, but they also resolved before the defense medical examination. He recognized that Claimant had a CAT scan of the chest when she treated at the hospital on September 25, 2018. Dr. Schwartz opined that Claimant would have been capable of returning to full-time light duty work as of October 5, 2018 when her family doctor had released her to return to work.

Dr. Schwartz testified that also by the time of the defense medical examination, Claimant had reached maximum medical improvement. Although Dr. Schwartz did not believe Claimant would benefit from a shoulder injection, he testified that he would not oppose the reasonableness or necessity of a shoulder injection being a treatment option given her subjective complaints.

Dr. Schwartz questioned the veracity of Claimant's subjective complaints. He explained that Claimant's symptoms were out of proportion to the objective studies and to the physical examination findings. On November 6, 2018, Claimant underwent MRIs of the cervical spine and of the left shoulder. Prior to undergoing the MRIs, Claimant completed a patient questionnaire on which she reported having neck pain extending into the left shoulder and down her arm into her hands. She reported having throbbing aching pain and tingling in the hand. She indicated on the form she was taking Percocet 7.5.

Dr. Schwartz reviewed the MRI films of both the cervical spine and of the left shoulder. Dr. Schwartz represented that the MRI of the cervical spine was essentially normal. There was no disk herniation, no disk bulge, and no facet disease. Based on the MRI findings, Claimant's cervical complaints were non-verifiable.

The MRI of the left shoulder only demonstrated mild subcoracoid bursitis but otherwise, the MRI was essentially normal. The rotator cuff was normal. There was no evidence of a rotator cuff tear or of a labral tear. Dr. Schwartz represented that the mild subcoracoid bursitis did not relate to the work accident. Dr. Schwartz concluded that there were no acute findings on either MRI nor were there any findings on either MRI that would justify the need for the treatment Dr. Cary was providing.

At the defense medical examination, Claimant reported that her chest pain completely resolved. She denied having any low back pain. She complained of neck and of left shoulder pain. She rated her neck pain and her shoulder pain on average at a four to a five on a ten-point pain scale. She stated that her pain could reach a ten on a ten-point pain scale. She had pain with activities of daily living but was able to perform all such activities. She stated that Dr. Cary was prescribing ninety pills per month of Percocet that she was taking twice per day. She had pills remaining at the end of the month. Claimant was not interested in pursuing cervical injections or surgery.

Upon physical examination, Claimant's muscle examination was normal. There was no evidence of motor weakness in the upper extremities. Her reflexes were normal. She had no sensory deficiencies. She reported some occasional numbness in a nonspecific pattern in her left upper extremity but in general her upper extremity had a normal neurologic examination with normal motor strength and reflexes. Range of motion of her shoulder was restricted to one hundred

thirty degrees actively and one hundred sixty degrees passively. She had global nonspecific weakness in the left upper extremity.

Dr. Schwartz concluded that there were no objective findings on physical examination to verify any pathology. The defense medical examination was essentially normal. The MRIs of the cervical spine and of the shoulder were essentially normal.

Claimant was not forthcoming to Dr. Schwartz about her medical history. Claimant denied any prior treatment to her neck or to her left shoulder, but from Dr. Schwartz's review of the medical records, he learned that Claimant treated for neck complaints in the emergency room on September 13, 2011 after being involved in a motor vehicle accident. Dr. Schwartz admitted that there did not appear to be any follow-up visits pursuant to this motor vehicle accident.

Dr. Schwartz added that he became aware that on November 9, 2018, Employer offered Claimant a modified job. According to Dr. Cary's medical notes from May 7, 2019, Claimant reported to Dr. Cary that she was still waiting to get work from Employer.

Dr. Schwartz recognized that on the day of the work accident, September 25, 2018, Claimant treated at St. Francis Hospital where she was examined by Dr. Janice Balas. Dr. Balas released Claimant to return to work on September 28, 2018 without work restrictions. Claimant treated with her family doctor, Dr. Anna Layosa-Magat, on September 28, 2018 who issued a no work note that released Claimant to return to work with no restrictions on October 5, 2018. Claimant commenced treating with Dr. Cary on October 4, 2018 who continued Claimant's total disability status through Claimant's March 7, 2019 visit with Dr. Cary. Dr. Schwartz testified that Dr. Cary's examination from October 4, 2018 did not show any evidence of cervical radiculopathy or other findings that would justify total disability status.

At Claimant's March 7, 2019 visit with Dr. Cary, Dr. Cary released Claimant to return to full-time light duty work. However, Dr. Cary's medical notes did not identify any improvement, or any changes to substantiate the change in work status. Dr. Cary also administered a drug screen test at this visit. Claimant tested one hundred percent positive for d-Methamphetamine and zero percent positive for 1-Methamphetamine. Such result indicated illicit drug use.

On April 4, 2019, Claimant's next visit with Dr. Cary, Dr. Cary indicated that having reviewed the urinalysis, he discontinued Claimant's Percocet prescription and he indicated he was going to prescribe medicinal marijuana.

Dr. Schwartz opined that the narcotics Dr. Cary was prescribing from Claimant's initial visit with Dr. Cary was not reasonable or necessary. Such prescription was not consistent with the CDC Guidelines the Practice Guidelines or with Medicare Part D. According to Section 18 of the Delaware Regulated Professions and Occupations Code, "

> [T]he use of opioid analgesics for other than legitimate medical purposes can pose a threat to the individual and society and the inappropriate prescribing of controlled substances including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use.

(Schwartz Depo., 6/3/2019, 29:10-17). Delaware adopted such regulations to mandate that licensed practitioners incorporate certain safeguards into their practices to minimize the potential for abuse and diversion of controlled substances. Some of the requirements include: providing and documenting a written treatment plan; identifying the goals and objectives to be used to determine treatment success; and addressing the necessity of continuing treatment modalities.

Dr. Cary did not document the above-stated requirements. Dr. Cary did not document how the treatment was helping Claimant, if it was helping at all. Dr. Cary's notes consistently referenced ongoing medical care goals of decreasing Claimant's pain, increasing Claimant's

function level, and improving Claimant's quality of life. However, Dr. Cary did not identify in any of the medical notes if Claimant was achieving any of the goals.

Dr. Cary did not document strict time, quantity or limitations with respect to the prescription as required by the Practice Guidelines. In other words, Dr. Cary did not document the number of prescribed pills or document a targeted end point of the Percocet prescription. Dr. Cary did not document a pill count, yet Claimant reported to Dr. Schwartz that she was not taking all her medication. She had pills remaining at the end of the month. Dr. Schwartz questioned what Claimant was doing with the pills she was not taking.

Section 9.5 of the Delaware Uniform Controlled Substances Act states that when issuing a prescription for an opioid analgesic to an adult patient for outpatient use for the first time for an acute pain episode, a practitioner may not issue a prescription for more than a seven-day supply. Dr. Schwartz testified that Dr. Cary did not identify the duration of the initial prescription. Based on Claimant's report to Dr. Schwartz, it appeared the first prescription was for thirty days as opposed to seven.

According to Section 9.6 of the Uniform Controlled Substances Act, prior to issuing a subsequent prescription for an opioid analgesic for acute pain, the practitioner must perform an appropriate evaluation of the patient's medical history and condition including the following: query the prescription monitoring program; administer a fluid drug screen test; obtain an informed consent signed by the patient; and schedule and undertake periodic follow-up visits.

Dr. Schwartz commented that while Dr. Cary was seeing Claimant on a periodic basis, Dr. Cary did not appear from the medical notes to assess the medication or to document if and how the medications were helping or improving function. Dr. Cary may have noted that Claimant's pain rating was lower in May than it was in January, a pain scale does not constitute increased function

level or improved quality of life. Furthermore, there is no indication that Dr. Cary obtained the required informed consent from Claimant.

Dr. Schwartz acknowledged that a doctor can treat pain with narcotics, but such prescriptions should be for a brief duration. Dr. Schwartz remarked that generally, no one needs more than three to six weeks of narcotics. Taking narcotics more than three to four months dramatically increases the likelihood of narcotic and opioid abuse. Dr. Schwartz speculated that Dr. Cary would have continued Claimant's narcotic prescription indefinitely had she not failed the drug screen test.

Dr. Schwartz added that even if Dr. Cary's prescriptions were compliant with the Practice Guidelines, such prescription would not be reasonable or necessary from the beginning. The number one rule when prescribing narcotics is to start with low dosages. Although Dr. Schwartz disagreed with the prescription, Dr. Cary should have started Claimant on five milligrams twice daily to be taken in conjunction with a muscle relaxer and an anti-inflammatory. Dr. Schwartz added that it was worth noting, Dr. Cary abruptly stopped the narcotic prescription without decreasing it over time.

Ms. Jamie Ramage, the owner and president of Employer since September 1, 2014, testified on Employer's behalf. She purchased the business after Claimant commenced working there. She was familiar with Claimant. Claimant reported to her office to address matters such as scheduling, time off, training, and picking up paperwork. Ms. Ramage agreed with how Claimant described Claimant's job responsibilities.

Claimant attempted to return to work during the March 2019 timeframe. Employer offered Claimant a light duty job for which Claimant had to undergo training. Claimant completed the necessary online phone skills class but did not complete the training on how to log into the software

program. Ms. Ramage did not know if anyone on Employer's behalf contacted Claimant to remind Claimant to complete the software program training.

Ms. Ramage considered Claimant to be a good employee. People called Employer to compliment Claimant. Ms. Ramage never received a complaint about Claimant. Claimant's job has since been terminated.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In order to be compensable, the injury must arise out of or be in the course of employment. 19 *Del. C.* § 2304. As this is the Claimant's Petition, Claimant has the burden to prove by a preponderance of the evidence that the injury was caused by the work accident. *Goicuria v. Kauffman's Furniture*, Del. Super., C.A. No. 97A-03-005, Terry, J., 1997 WL 817889 at *2 (Oct. 30, 1997), *aff'd*, 706 A.2d 26 (Del. 1998). The "but for" definition of proximate cause that is used in the area of tort law is the applicable standard for causation. *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. Supr.1992). Hence, the Claimant must prove that "the injury would not have occurred but for the accident. The accident need not be the sole cause or even a substantial cause of the injury. If the accident provides the 'setting' or 'trigger', causation is satisfied for purposes of compensability." *Reese*, 619 A.2d at 910.

When an employee has suffered a compensable injury, the employer is required to pay for reasonable and necessary medical services/treatment causally related to that injury. 19 *Del. C.* § 2322. What constitutes "reasonable medical services" for purposes of Section 2322 is determined by the Board on a case-by-case basis. *See Willey v. State*, Del. Super., C.A. No. 85A-AP-16, Bifferato, J., 1985 WL 189319 at *2 (November 26, 1985). "Whether medical services are necessary and reasonable or whether the expenses are incurred to treat a condition causally related

to an industrial accident are purely factual issues within the purview of the Board." *Bullock v. K-Mart Corporation*, Del. Super., C.A. No. 94A-02-002, 1995 WL 339025 at *3 (May 5, 1995).

It is undisputed Claimant was involved in a work accident. Claimant contends that as a result of the work accident, she injured her cervical spine, her thoracic spine, her lumbar spine and her left upper extremity. She also contends that as a result of the work accident, she was totally disabled from September 25, 2018 through March 6, 2019.

Based on the totality of the evidence, the Board finds that Claimant injured her cervical spine and her left upper extremity as a result of the work accident.[1] The Board accepts the opinions of Dr. Schwartz over the opinions of Dr. Cary. Dr. Schwartz presented credibly. Dr, Schwartz opined that Claimant sustained strains and strains of the cervical spine and of the left shoulder. Dr. Cary made similar diagnoses with respect to the cervical spine and the left shoulder although Dr. Cary included a bursitis diagnosis that Dr. Schwartz did not causally relate to the work accident. By accepting Dr. Schwartz's testimony, the Board does not find that the bursitis is causally related to the work accident.

When Dr. Schwartz examined Claimant, Claimant did not present with thoracic spine complaints or with lumbar spine complaints. Claimant specifically stated that her chest pain resolved. The chest is different from the thoracic spine. It is not clear from the evidence what were the exact body parts or injuries requiring treatment at St. Francis Hospital or at Dr. Layosa-Magat's office. Claimant has the burden to prove such injuries. Claimant relies on Dr. Cary to prove a thoracic spine injury. As will be discussed below, Dr. Cary did not present credibly. Dr. Cary appeared to overstate and overtreat Claimant's alleged injuries. His testimony regarding

[1] Claimant might have additionally temporarily injured her chest. Claimant testified that she had bruises on her chest. Dr. Schwartz testified that Claimant underwent a CAT scan of her chest when she treated at the emergency room. However, the Board makes no finding with respect to the chest as it was not an alleged injury in the Stipulation of Facts.

Claimant's thoracic spine injury was inconsistent. When discussing Claimant's current prognosis, Dr. Cary testified that Claimant's upper mid back (thoracic spine) will resolve if it had not already. He also testified that he did not believe Claimant's thoracic spine injury resolved by the time of the defense medical examination. However, on November 29, 2018, Dr. Cary in his medical notes documented that Claimant's thoracic spine/upper back had resolved and her remaining injuries were cervical and left shoulder strains and bursitis. Accepting Dr. Schwartz's testimony, the Board limits Claimant's injures to sprains and sprains of the cervical spine and the left shoulder. The Board does not find compensable any injuries to the thoracic spine or to the lumbar spine.

The extent of Claimant's purported injuries was not credible. Dr. Schwartz questioned the veracity of Claimant's complaints because they were disproportionate to the examination findings and to the diagnostic tests. Dr. Schwartz testified that there were no objective findings on his physical examination or in the MRIs to verify any pathology about which Claimant complained. The defense medical examination was essentially normal other than limited range of motion and subjective complaints. Range of motion has a subjective component – it is limited by subjective reports of pain. The MRIs of the cervical spine and of the shoulder were essentially normal. There was no evidence of acute injuries. The Board accepts Dr. Schwartz's testimony that there were no findings in either MRI to support Claimant's subjective complaints. Claimant's complaints were unverified. The Board accepts Dr. Schwartz's opinion that Claimant's injuries resolved by the time of the defense examination, January 28, 2019.

On January 31, 2019 Claimant underwent a cortisone injection into the left shoulder. The injection occurred after January 28, 2019. Dr. Schwartz opined such injection was not causally related to the work accident but rather was causally related to the bursitis. The Board does not causally relate such injection to the work accident.

The Board does not find that Dr. Cary's treatment was reasonable or necessary. His treatment of Claimant including his lack of documentation was unprofessional and concerning. Dr. Cary failed to comply with the Medical Practice Act, the CDC Guidelines, the Practice Guidelines or with Medicare Part D. He failed to comply with the requirements relating to prescribing narcotics. Dr. Cary failed to document the required information about his prescription for Percocet. He did not indicate in his records the duration of his initial prescription or the number of pills prescribed. Dr. Schwartz testified that Claimant told him the initial prescription was for thirty days. Dr. Cary and Claimant testified the initial prescription was for seven days. Of note, Dr. Cary also testified upon prescribing the medication at the first visit, October 4, 2018, he directed Claimant to follow-up with him in four weeks - not seven days.

Although Dr. Schwartz did not believe Claimant's condition required narcotics, Dr. Schwartz testified that when starting a patient on narcotics, the initial prescription should be a lower dosage than what Dr. Cary prescribed. The dosage should be five milligrams to be taken twice daily. Dr. Cary started Claimant at 7.5 milligrams to be taken every six hours. The fact that Dr. Cary eventually stopped the Percocet prescription without any weaning off period or without discussion with Claimant about the potential need for a weaning off period raises questions about the reasonableness of the prescription and how it was used.

Dr. Cary did not document if and if so, how Claimant was benefitting from treatment. To simply repeatedly cite general goals of reducing pain, of increasing function, and of increasing quality of life without documenting evidence of how any of such goals are being achieved is insufficient. Dr. Cary did not make any documentations to serve as a comparison basis from visit to visit except for two visits when Dr. Cary documented a pain rating.

Dr. Cary testified that he obtained an informed consent from Claimant but chose not to produce it despite the subpoena. If a doctor intends to provide medical care to patients in workers' compensation cases, part of the doctor's professional duty to the patients is to cooperate with the workers' compensation legal process. *Hudson v. Templeo USA, Inc.*, Del. IAB, Hearing No. 1166137, at 2 (May 19, 2004)(ORDER). Employer properly issued a *subpoena duces tecum* to Dr. Cary. It is inexcusable for Dr. Cary to refuse to comply. If there is a question of the relevancy of evidence with respect to production, such issue should be brought before the Board to determine. Instead, Dr. Cary failed to cooperate with the workers' compensation legal process and placed Employer at a disadvantage. Dr. Cary placed Employer at a further disadvantage by not disclosing that he allegedly had documents in his possession that he was not producing. Instead, Dr. Cary led Employer to believe that he never obtained an informed consent.

Similarly, Dr. Cary testified that he obtained a list of Claimant's prescription history from a computer database but immediately after his review, he shredded the list. Dr. Cary stated that even had he not shredded the list, he would have refused to produce it to Employer. Dr. Cary did not disclose to Employer that he reviewed a list of Claimant's medication history. The Board acknowledges the possibility that Dr. Cary never obtained an informed consent or obtained a prescription history, in which case he would not have such documentation to produce.

Dr. Schwartz emphasized that Dr. Cary failed to document evidence to support how Claimant's function improved to justify releasing Claimant to return to work in terms of Dr. Cary previously maintaining Claimant's work status. In light of the above, the Board does not find Dr. Cary's treatment reasonable or necessary.

With respect to Claimant's work status, Dr. Balas placed Claimant on total disability from September 25, 2018 through September 27, 2018. Dr. Layosa-Magat placed Claimant on total

disability from September 28, 2018 through October 4, 2018. Dr. Layosa-Magat released Claimant to return to full-time work with no restrictions beginning October 5, 2018. Dr. Schwartz testified that Dr. Cary's examination from October 4, 2018 did not show any evidence of cervical radiculopathy or other findings that would justify total disability status. Dr. Schwartz opined that Claimant could have returned to full-time light duty work as of October 5, 2018.

The Board reiterates that it does not appear that there was an improvement in condition to justify a change in work status on March 7, 2019 from October 4, 2018. Instead, Claimant admitted that on March 7, 2019, she requested Dr. Cary release her to return to work because of her financial hardship. Dr. Cary complied. The Board does not find that Claimant was totally disabled at any time during Dr. Cary's treatment. The Board accepts Dr. Schwartz's opinion that Claimant was no longer totally disabled and could have returned to light duty work as of October 5, 2018.

Employer offered Claimant a modified duty job on November 9, 2018. It is established under Delaware law that when a treating physician has placed a claimant on total disability and instructed the claimant to stay out of work that the claimant is entitled to rely on the doctor's orders until such time that the Board determines otherwise. *Gilliard-Belfast v. Wendy's, Inc.*, 754 A.2d 251, 254 (Del. Supr. 2000). Applying the holding in *Gilliard-Belfast v. Wendy's, Inc.*, 754 A.2d 251 (Del. Supr. 2000), the Board finds that Claimant's total disability ends as of March 7, 2018.

To summarize, the Board grants Claimant's petition in part. It finds that Claimant sustained sprains and strains to her cervical spine and her left shoulder as a result of the work accident that resolved by January 29, 2019, the date of the defense medical examination. The Board finds that the medical treatment excluding the Percocet prescription until January 28, 2019 was reasonable, was necessary, and was causally related to the work accident. The Board awards

total disability benefits from September 25, 2018 until March 7, 2019 as a result of applying the holding in *Gilliard-Belfast v. Wendy's, Inc.*

Medical Witness Fees and Attorney's Fee

Under 19 *Del. C.* § 2322(e), the employer shall pay for Claimant's medical expert's fees in the event Claimant receives an award. In light of the fact that Claimant's Petition to Determine Compensation Due is granted in part, the Board awards Claimant payment of her medical expert witnesses' fees.

A claimant who is awarded compensation generally is entitled to payment of "a reasonable attorney's fee in an amount not to exceed thirty percent of the award or ten times the average weekly wage in Delaware as announced by the Secretary of Labor at the time of the award, whichever is smaller...." 19 *Del.C.* § 2320(10)(a). Attorney's fees are not awarded, however, if, thirty days prior to the hearing date, the employer gives a written settlement offer to the claimant that is "equal to or greater than the amount ultimately awarded by the Board." DEL. CODE ANN. tit. 19, § 2320. Employer tendered a settlement, but the Board finds that the value of its award is greater than the settlement offer.

At the current time, based on Delaware's average weekly wage, the maximum calculates to $10,704.80. The factors that must be considered in assessing a fee are set forth in *General Motors Corp. v. Cox*, 304 A.2d 55 (Del. 1973). The Board is permitted to award less than the maximum fee. So long as the Board awards some fee and considers the *Cox* factors, the Board may grant a nominal or minimal fee in an appropriate case. *See Heil v. Nationwide Mutual Insurance Co.*, 371 A.2d 1077, 1078 (Del. 1977); *Ohrt v. Kentmere Home*, Del. Super., C.A. No. 96A-01-005, Cooch, J., 1996 WL 527213 at *6 (August 9, 1996). A "reasonable" fee does not generally mean a generous fee. *See Henlopen Hotel Corp. v. Aetna Insurance Co.*, 251 F. Supp.

189, 192 (D. Del. 1966). Claimant, as the party seeking the award of the fee, bears the burden of proof in providing sufficient evidence to make the necessary calculation.

Claimant's counsel submitted an Affidavit and a copy of the retention agreement to enable the Board to consider the necessary *Cox* factors. Claimant's counsel who presented at the hearing spent eight hours preparing for the hearing. However, Claimant's co-counsel spent twenty-five hours preparing for the hearing. The hearing lasted approximately one hour and forty-five minutes. After such consideration, the Board awards an attorney's fee of $4,700 to be paid by Employer. This amount does not exceed thirty percent of the value of the award.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, Claimant's Petition to Determine Compensation Due is hereby GRANTED IN PART. The Board awards Claimant: acknowledgement of a cervical sprain and strain injury and a left shoulder sprain and strain injury that resolved by January 28, 2019. The Board awards: payment of outstanding medical bills until January 28, 2019 excluding any bill relating to the Percocet/narcotic prescription; payment of total disability benefits from September 25, 2018 until March 7, 2019; payment her medical expert witness' fees; and payment of a reasonable attorney's fee.

IT IS SO ORDERED THIS 17th DAY OF SEPTEMBER 2019.

INDUSTRIAL ACCIDENT BOARD

Mark Murowany /bs
MARK MUROWANY

Mary Dantzler /bs
MARY DANTZLER

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

Mail Date: 9/19/19

TP
OWC Staff