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

Maikol Zuniga, *Employee,* vs. Delaware Siding Co., *Employer.*	)))))))	I.A.B. No.: 1392207

ORDER

This matter came before the Board on a motion to dismiss a petition without prejudice because it was never properly served on the opposing party as required by law. On July 8, 2013 Delaware Siding Co. ("Employer") and Maikol Zuniga ("Employee") entered into an Agreement to recognize that the Employee sustained a left knee ACL tear from an industrial accident on November 12, 2012. No other injury was recognized by this Agreement. The Employee has now attempted to file a new petition on the grounds that an alleged back injury is causally related to the November 12, 2012 industrial accident as well. Employer has moved to dismiss on the ground that the Employee did not properly serve his petition upon the Employer via certified mail as required by 19 *Del. C.* § 2347.

Industrial Accident Board litigation revolves around Agreements. Terminology aside, the relief sought in any case will fall under one of three types of petitions: (1) an initial petition "upon failure to reach an agreement"; (2) a petition "to review an agreement"; or (3) a petition to commute compensation (which ultimately requires the parties to enter into an Agreement for commutation). Initial petitions are filed under 19 *Del. C.* § 2345 on the grounds that the parties have "failed to reach an agreement."[1] They essentially ask the Board to decide whether the parties should enter into an Agreement and, if so, its terms. 19 *Del. C.* § 2345 does not require petitioners to serve an initial petition on the opposing party via certified mail.

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[1] If the parties ultimately reach a settlement before the hearing, or if the Board issues a decision that is not appealed, then Board Rule 19, 19 Del. C. §§ 2344 and 2345 mandate that they document such in an Agreement to be approved by the Board.

After parties enter into an initial Agreement 19 *Del. C.* § 2347 allows either party to file a different type of petition to review that Agreement "on the ground that the incapacity of the injured employee has subsequently terminated, increased, diminished or recurred."[2] Yet, unlike with an initial petition, 19 *Del. C.* § 2347 explicitly mandates the following service of process:

> *No petition for review shall be accepted by the Department unless it is accompanied by proof that a copy of the petition for review has been served by certified mail upon the other party to the Agreement.*

Here, the parties entered into an Agreement to accept a left knee ACL tear. The Employee now attempts to file a petition for an alleged back injury to be accepted as well; thus, the grounds for his petition are that "the incapacity of the injured employee has… increased." The petition arises under 19 *Del. C.* § 2347, which prohibits the Department to accept this petition if it is not accompanied by proof that it was served by certified mail upon Employer. There is no proof that the petition was ever served via certified mail upon Employer or even its insurer. Therefore, the Department is statutorily prohibited to accept this petition at this time.

Employer's motion is GRANTED. The Employee's petition is DISMISSED at this time without prejudice for failure to provide proof that it was served via certified mail on Employer.

IT IS SO ORDERED this 25TH day of August, A.D. 2016.

INDUSTRIAL ACCIDENT BOARD

Robert J. Mitchell

Peter W. Hartnett

Brian Lutness, Esquire for Employee
Joseph Andrews, Esquire for Employer

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[2] Per 19 *Del. C.* § 2349 the Board also has the power to set aside voluntary compensation Agreements if it can be proven that the Agreement was obtained through fraud. *Lynch v. State*, No. 1328124 at *16 (Del. I.A.B. Oct. 7, 2010). This still requires a petition to review the Agreement. *Conner v. Boulden Buses, Inc.*, 1993 Del. Super. LEXIS 32 at *16-18 (Del. Super.).

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

MARION ALEXANDER,	:	
Claimant,	:	**I.A.B. No.: 1429645**
v.	:	
SEVERN MANAGEMENT d/b/a DUNBARTON VILLAGE ASSOC.,	:	
Employer.	:	

ORDER CONFIRMING NO PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE SEEKING EITHER DISFIGUREMENT OR PERMANENCY IS PENDING

Upon the Claimant's request for a legal hearing, the matter having come before the Board for hearing, the Board finds as follows:

1. On March 13, 2016, the Carrier filed a Petition for Review seeking to terminate the Claimant's temporary total disability benefits;

2. On Employer/Carrier's portion of a proposed Pre-Trial Memorandum (first received by the Claimant's counsel on August 12, 2016) in connection with the pending Petition for Review, an allegation as to the pendency of a Petition to Determine Disfigurement is made, as is an assertion that the extent of permanent impairment is at issue.

3. Claimant maintains that no petitions are currently pending seeking awards and/or determinations as to the extent of permanency and/or disfigurement.

4. In light of the above, and after consideration of the arguments presented by the parties, the Board finds as follows:

   A. No petitions are currently pending seeking awards and/or determinations as to the extent of permanency and/or disfigurement.
   B. A Petition to Determine Additional Compensation Due is a petition filed pursuant to 19 Del. C. §2326;
   C. A petition seeking an award of permanent impairment benefits is not a Petition for Review brought pursuant to 19 Del. C. §2347;
   D. This Hearing Officer is aware of the Order entered in Maikol Zuniga v. Delaware Siding Co., IAB No. 1392207, August 25, 2016 and respectfully, disagrees with its conclusions;
   E. Employer/Carrier cannot add a claim to establish permanency and/or disfigurement on a Pretrial Memorandum as, pursuant to Rule 26B, such claims require the filing of a separate petition; and

~~F. The Claimant is entitled to an award of attorney's fees in the amount of $_____ for the burden of presenting this motion.~~

SO ORDERED this 7th day of September, 2016.

Julie D B[illegible]
Hearing Officer

Andrea G. Green, Esquire for Claimant
Joseph Andrews, Esquire for Employer

JB
9-8-16

BEFORE THE INDUSTRIAL ACCIDENT BOARD OF THE STATE OF DELAWARE

GREGORY S. OTTER,

Employee,

v.

GREEN-LIGHT SOLUTIONS, LLC.,
EAST WIND ENTERPRISES, LLC.,
and NEIGHBORHOOD HOUSE, INC.

Employers.

Hearing Nos. 1385184, 1390163, and 1392097

DECISION ON PETITIONS 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 on April 26, 2013, in a Hearing Room of the Board, in New Castle County, Delaware.

PRESENT:

LOWELL L. GOUNDLAND

MARILYN J. DOTO

Eric D. Boyle, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:
Frederick S. Freibott, Attorney for the Employee
Keri L. Morris, Attorney for Green-Light Solutions, LLC.
Christian G. Heesters, Attorney for East Wind Enterprises, LLC.
Andrew J. Carmine, Attorney for Neighborhood House, Inc.

Section 2311 case: Due diligence includes making sure certificate of insurance covers work in Delaware

NATURE AND STAGE OF THE PROCEEDINGS

Gregory Otter ("Claimant") injured his left upper extremity while in the course and scope of his employment with Green-Light Solutions, LLC ("Greenlight") or East Wind Enterprises, LLC ("East Wind") in a compensable work accident on July 3, 2012. Claimant has filed Petitions to Determine Compensation Due against Greenlight (IAB#1385184) and East Wind (IAB#1390163). Both of these companies are incorporated in New Jersey. Initially Claimant filed a DCD petition solely against Greenlight; however a question of insurance coverage came up and ultimately the carrier, New Jersey Casualty Company, was dismissed following a legal hearing before the Board. *Gregory Scott Otter v. Greenlight Solutions, Inc.*, (Del. IAB) Hearing No. 1385184 (October 25, 2012). Subsequently, Claimant filed a DCD petition against a second potential employer, East Wind (IAB# 1390163), on November 14, 2012. Claimant then filed a third DCD Petition against Neighborhood House (IAB#1392097) on January 10, 2013. Claimant asserts that Neighborhood House is the general contractor and if the Claimant's employer(s) are uninsured, would provide insurance coverage pursuant to 19 *Del.C.* § 2311. There are two issues presented for the hearing on the merits; 1. Whether there is joint or concurrent employment of the Claimant between Greenlight and East Wind, and; 2. Whether Neighborhood House must provide worker's compensation insurance coverage pursuant to section 2311. In lieu of a stipulation of facts the Claimant with the consent of all parties submitted an Exhibit Book.[1] A hearing was held on the consolidated petitions on April 26, 2013. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Claimant, a thirty-three year old male, testified on his own behalf. The claimant has three children aged 14, two and 1/2 and 10 weeks old. He is a roofer by trade. He saw an ad for

[1] Hereinafter references to exhibits will be by their Exhibit tab number.

employment with Greenlight Solutions and sent in his resume. He met with both Steve Butler and Mike Nachurski. Their Delaware shop was in New Castle at 23 Parkway Drive. Both East wind and Greenlight shared space in that one shop. In the morning Claimant would go to the shop and there would be a board with the daily jobs listed and which employer was handling it. The business of both East Wind and Greenlight was to weatherize homes by installing insulation and air sealing attics. The foreman, which would be either Mr. Ford or Mr. Pietropaula would tell him which employer he was going to be working for on that day. He would then get a timesheet and circle which employer the job was for, and on any given day he could be working for East Wind or Greenlight. They usually had two crews going out, one for each employer, or both for one depending on the work orders. East wind is also known as Church's General Contracting.

The accident occurred when the ladder he was on sunk in soft ground and as a result tilted over. Claimant put his arm out to stop his fall and broke it. He had to have surgery on July 6, 2012. Following Claimant's fall Mr. Pietropaula took him to the emergency room. On the date of the accident, July 3, 2012, Claimant was working on a Greenlight job. He knew it was a Greenlight job because of the sign in board, which indicated which company he would be working for that day. He remembers the location of the accident, 11 Constitution Boulevard, because he specifically went back to the site to get the address after the accident. Claimant confirmed that his surgery was an open reduction procedure. Claimant has no doubt that Greenlight was his employer when the accident occurred.

On cross examination by counsel for Greenlight the Claimant confirmed that he began working for Greenlight/East Wind at the end of April 2012. He always received two separate paychecks, one from East Wind and one from Greenlight each week. He performed the same tasks or work duties for both East Wind and Greenlight. He did work with different crews under

the supervision of either Mr. Ford or Mr. Pietropaula. On cross examination by counsel for Neighborhood House Claimant admitted that the job advertisement he answered had nothing to do with Neighborhood House. The project was for Neighborhood House. On cross examination by counsel for East Wind Claimant admitted that the weatherization projects were for East Wind and Greenlight. If he was working on a Greenlight job it would be under Mr. Pietropaula who was the crew chief. Claimant confirmed that Steve Butler is the owner of Greenlight. If there was any problem on the job he would report it to his supervisor who would then tell Mr. Butler. If there was a problem on East Wind job he would tell the supervisor who would then tell Mike Nachurski who is the owner of East Wind. Claimant would complete one timesheet which had a spot for him to circle whether he was working for Greenlight or East Wind. Claimant confirmed that he had never heard of a firm called Greenview management at the time of the accident. He further confirmed that he was on a Greenlight job at the time the accident occurred.

Claimant was out of work for six months and he has unpaid medical expenses. Claimant further explained that there was an upstate crew any downstate crew. Mr. Pietropaula was his supervisor on both jobs. He described the shop as small office in front in a warehouse with all their equipment and trucks in the back. His understanding of the situation was that East Wind and Greenlight came together so that they could get this Delaware project.

Steven Pietropaula testified next on behalf of the Claimant. Mr. Pietropaula confirmed that he is employed by both East Wind and Greenlight and he worked out of their 23 Parkway Cir. office in New Castle Delaware. He confirmed that there was an office space of about 15 x 15 feet and behind that, there was a warehouse for their supplies. They also had two work trucks, one yellow and one white. The white truck usually went on Greenlight jobs. He confirmed that there was no overt signage on their business address or on their trucks. Employees would come

in the morning and wait in the back to load the trucks for the jobs on that day. He would have the work order. Mr. Pietropaula confirmed that he was a crew supervisor for both East Wind and Greenlight. The work order would state whether the job was for East Wind or Greenlight and they would never have a work order with both for the same job.

The work that they were involved in was sealing houses for energy efficiency. He agreed that East Wind and Greenlight were subcontractors for Neighborhood House. He confirmed that the work order for the job on which Claimant was injured listed Greenlight. (See Exhibits, Tab 11). Mr. Pietropaula dropped the claimant off at the site that morning and did not see the incident. He reviewed a payroll record and noted that it should state that the claimant was working for Greenlight on July 3 when the accident occurred. (Tab 4). He agreed that Greenlight was the employer on that day. He took the Claimant to the emergency room and described that he had a bump on his arm, and noted that it was swollen to double the size of his other arm.

On cross examination by counsel for Greenlight Mr. Pietropaula confirmed that Bill Ford is the other supervisor. He usually took one of the trucks and Mr. Ford took the other one. He works as a crew supervisor for both East Wind and Greenlight. Mr. Pietropaula reviewed payroll records for both East Wind and Greenlight listing both his name and the Claimant's for the week of the accident. (Tab 4, 5). Mr. Pietropaula is listed for hours on both the East wind and Greenlight payrolls for both days. He noted that he is a salaried employee, rather than hourly. On cross examination by counsel for Neighborhood House Mr. Pietropaula confirmed that he has nothing to do with the contracts. He thought that he was covered for workers compensation. He had not done any jobs in New Jersey since they got the Delaware contract with Neighborhood House. On cross examination by counsel for East Wind Mr. Pietropaula confirmed that he usually uses the yellow truck whereas Bill Ford usually uses the white truck. The insulation

machine in the white truck is owned by Mr. Butler from Greenlight solutions. Mr. Pietropaula has a routine when he comes in each day. He first checks the work order board to see who the job is for that day, then he gets the work order. His boss on a Greenlight job would be Steve Butler and his boss on East Wind job would be Mr. Nachurski. When the accident occurred Mr. Pietropaula first called Steve Butler to report it, however he could not reach Mr. Butler, so he then called Mr. Nachurski.

Mr. Pietropaula confirmed that all the work in Delaware that they received was from Neighborhood House for New Castle County jobs and First State for Sussex County jobs. He also confirmed that the Claimant did come to the shop after the accident, and he did see him. He noted that as soon as they saw the Claimant coming in the door, Mr. Butler jumped up and ran out the back door. This happened several times. His understanding is that Greenview Management is a company that was set up separately by Mr. Natchurski and Mr. Butler to oversee the Delaware operations of East Wind and Greenlight. Mr. Pietropaula also confirmed that a work order usually takes a whole day to complete.

Jack Sol-Church testified on behalf of Neighborhood House. He began working for Neighborhood House in September 2012 as their weatherization project manager. Prior to working for Neighborhood House Mr. Sol-Church worked for the State as a monitor on the weatherization project. The project is administered through the Department of Energy. He confirmed that the contract with East wind and Greenlight had been extended for six months after the initial period ended in March 2012. (Tab 6). The terms of the contract otherwise remained the same, with the standard extension language. There are three or four other subcontractors in the upstate project managed by Neighborhood House.

Mr. Sol-Church is now in charge of ensuring that they have the proper liability and workers compensation insurance certificates for their subcontractors. After this incident they now call the insurance agent listed on the certificates to verify coverage. He is not sure what Neighborhood House did prior to his assumption of these duties. His assumption is that they simply obtained the COI and reviewed it, but didn't follow up further to confirm coverage. On cross-examination by counsel for Greenlight Mr. Sol-Church indicated he was not aware of any other insurance certificates that they may have received beyond the initial ones from Greenlight and East Wind. They did have a COI effective on April 8, 2011, the contacting date. This COI had coverage running from 7/31/2010 to 7/31/2011. The original contracting period ran until March 2012 and was extended beyond that date.

On examination by counsel for Neighborhood House, Mr. Sol-Church confirmed that the contract here is typical for sub-contractors on this project. There is a paragraph in the contract on page 7 which indicates that the sub-contractors are responsible for safety and insurance coverage. (Tab 6). He confirmed that Neighborhood House never provided any insurance coverage for this contract. He referred to attachment C to the contract which indicates that the sub-contractor agrees to maintain worker's compensation insurance coverage. (Tab 6). This contract was signed by Stephen Butler for Greenlight and Veronica Oliver from neighborhood house. She is Mr. Sol-Church's supervisor. Both Neighborhood House and the State had no knowledge of the injury until they received correspondence from Claimant's counsel in January 2013. After receiving this correspondence they started checking on the insurance coverage in the contracts. He found out soon after receiving this letter that Greenlight had no workers compensation coverage. Mr. Sol-Church confirmed that when he gets a certificate of liability insurance he would look at the dates to ensure they matched up and whether worker's compensation coverage is included to

determine if it was a valid certificate. He then would assume it would provide coverage. Reviewing Greenlight's COI there is nothing on the certificate indicating that it only provided coverage in New Jersey. There were no exclusions listed. Mr. Sol-Church confirmed that he is not an insurance adjuster, and the people reviewing these documents generally do not have insurance experience. He was also not aware that Greenlight and East Wind were using Delaware employees.

Mr. Sol-Church stated that at the time of the initial contract his belief was that Neighborhood House employees would not have made an extra phone call after reviewing the COI. He's not sure exactly what they looked at since he was not an employee at that time. He confirmed that a valid COI would have the appropriate dates, the coverage amounts, and the type of insurance listed. After this incident they do verify the residence of the employees, and they call to double check on the COI. He agreed that they should get something in writing verifying a valid insurance certificate for Delaware.

Stephen Butler testified on behalf of Greenlight. Presently he is not working. He is the founder and a member of Green-light Solutions. The company's business address is in Plainfield New Jersey. His company was employed doing weatherization work. Greenlight is not operating now and only had three jobs in 2013. Beginning in 2008 the vast majority of their work was in New Jersey, until they obtained the Delaware contract with Neighborhood House. Once Greenlight and East Wind got the contract they put an advertisement through Craigslist for employees in Delaware, and then he and Mike Nachurski he would interview them. They did tell prospective employees that the job could mean work for either Greenlight or East Wind or both. They do tell employees that they might be working in New Jersey as well. He agreed that he may

have interviewed the Claimant; however they generally had a standard interview that was used for all employees.

Mr. Butler and Mr. Nachurski formed a third company called Greenview Management for the ultimate purpose of merging the Delaware contract work from East Wind and Greenlight into the third company. During the course of the contact with Neighborhood House Greenview management was used as a payroll management and accounting entity. All the funds that they receive from the contract would go into a Greenview Management account and then be distributed from there. They used a service called Paychecks and Mr. Nachurski would provide the written timesheets to Paychecks to issue payment to the employees. Expenses were also paid out of the Greenview account. He and Mike would take a draw from this account. Any profit, which was not very much, they would split 50-50. He thinks that Greenview was formed in 2012, probably around the time of the accident. After they started up in business in Delaware there was one pool of employees for both companies. He agreed that the pay stub showing Claimant working on July 2 instead of July 3 is a clerical error.

On cross examination by counsel for Neighborhood House Mr. Butler confirmed he signed the contract with Neighborhood House. He agreed that usually the subcontractors provide worker's compensation coverage. Sometimes in New Jersey a general contractor might provide coverage, however it was standard procedure to provide a COI to the contractor. He did have a telephone conversation with someone at Neighborhood House about putting them on the COI as an additional insured. He assumed that someone had reviewed the COI in order to make this call. Mr. Butler indicated that he had never had to deal with an injured worker before this accident. He only found out about the lack of coverage when the Claimant filed his claim. He filled out a report after the accident. He dealt with an insurance broker and he did follow up

about coverage in Delaware but received an ambiguous answer. They also received assurances that the East Wind policy was good in Delaware. After the incident he reviewed the insurance policy with the assistance of his broker and they determined that the policy did not cover his employees in Delaware. On cross examination by East Wind's counsel Mr. Butler confirmed that he was the sole member of Green-light Solutions. He maintained a separate account for Green-light Solutions. The money that they generated from the Neighborhood House contract was split and funneled through Greenview. He also confirmed that East Wind has a separate business address in New Jersey. He agreed that he did have some authority to sign certain documents like work orders on behalf of East Wind. Mr. Butler confirmed that the job that Claimant was on when he was injured was a Greenlight job. In 2013 he did have a workers comp policy for Greenview, however the process of merging the companies was never fully completed.

On cross examination by Claimant's counsel Mr. Butler agreed that the contract with Neighborhood House was extended in 2012 and continued in full force. He agreed that the contract specifies the local laws and regulations in Delaware apply. He agreed that he already had a worker's compensation policy in New Jersey and had never done work prior to this contract in Delaware. He made a couple of calls to his broker to find out if his policy in New Jersey would cover Delaware. He stopped doing business with his broker after this incident. Mr. Butler thought that his New Jersey policy covered residents of other states. Now he knows he needed a special rider to the insurance policy for coverage in Delaware. Initially the broker sent him to the Department of Labor website for coverage information. Mr. Butler noted that Neighborhood House would randomly determine who would get the jobs between East Wind and Greenlight. They would e-mail the job orders to them. He agreed that they were getting more work orders by having two separate companies. E-mails that came in with work orders were

addressed to both East Wind and Greenlight, but each work order would be separate by company. Mr. Butler noted that Neighborhood House was aware of the two company arrangement. He agreed also that both he and Mr. Nachurski would sign each other's work orders.

Michael Nachurski testified on behalf of East Wind. He is a general contractor and owner of East Wind Enterprises. He testified that there was never any merger into Greenview Management. He and Steve Butler where the management team but East Wind and Greenlight were to remain separate. Greenview was set up to handle the Delaware business only and the other two companies would continue as separate entities. They had limited authority to sign work orders on behalf of the other company, however when it came to contracts both he and Steve had to sign for themselves. Both companies also have separate bank accounts with no access by the other company. Both East Wind and Greenlight had separate business licenses. He confirmed that the employees could work for either East Wind or Greenlight.

On examination by counsel for Greenlight Mr. Nachurski confirmed that they had one office in Delaware. Each company had its own fax which was essentially an e-Fax that went to their e-mails through a New Jersey number. They did share a bookkeeper for Greenview Management for accounting purposes. When they hired Delaware employees it is accurate to say they could work for either Greenlight or East Wind. On examination by counsel for Neighborhood House he confirmed that East Wind also did work in Pennsylvania. Mr. Nachurski did find out that his New Jersey policy did not cover his work in Pennsylvania. He found out in December that he needed to get a specific Delaware policy. His agent initially told him in July that he would be covered for the Claimant's injury. Mr. Nachurski indicated that he stopped working in Delaware about two months ago because of a slowdown. They weren't making any

money to justify the continuing expenses. On examination by counsel for Claimant he confirmed that East Wind had Delaware employees at the time of the initial contract with Neighborhood House. When they got the contract he didn't have Delaware employees, so he didn't believe that Neighborhood House knew where his employees resided. On cross examination by counsel for Greenlight Mr. Nachurski confirmed that they obtained a new COI. He reviewed one for Greenview management but he only submitted one for East Wind. Greenview shut down after several payrolls in January of 2013. He confirmed that each company had handled its own taxes.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Delaware Workers' Compensation Act states that employees are entitled to compensation "for personal injury or death by accident arising out of and in the course of employment." DEL. CODE ANN. tit. 19, § 2304. Because Claimant has filed the current petitions, he has the burden of proof. DEL. CODE ANN. tit. 29, § 10125(c). There are two issues for the Board to consider in this matter. The first is whether Neighborhood House is liable to provide insurance coverage to the Claimant for his injury due to the uninsured status of the subcontractors, East Wind and Greenlight. *See,* 19 *Del.C.* § 2311(a)(5). The second issue is the employment relationship between Claimant and East Wind/Greenlight. In other words, who was Claimant's employer at the time of this accident, and whether there was any joint employment relationship between Claimant, East Wind and Greenlight. *See,* 19 *Del. C* § 2354.[2] Based on the applicable law and evidence presented the Board finds that Claimant was an employee of Greenlight when this accident occurred and that Claimant had a dual or concurrent employment relationship with Greenlight and East Wind. Further the Board finds that Neighborhood House

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[2] There is no dispute among the parties that Claimant was an employee of Greenlight and East Wind, rather the issue is limited to whether he was working as a joint or concurrent employee on the date of the accident.

failed to perform the due diligence required by section 2311 and must therefore provide worker's compensation insurance coverage to the Claimant for his injuries sustained in the accident on July 3, 2012.

Employment Relationship

The Workers' Compensation Act has established that an injured employee may be entitled to compensation by two or more employers. 19 *Del. C.* § 2354. Where more than one employment relationship is found to be responsible for a work injury, the multiple employers are all obligated to contribute to an injured worker's compensation. Such contribution would be in proportion to each employer's "wage liability to such employee, regardless of for whom such employee was actually working at the time of the injury." *Id.* To explore the potential of joint employment it is first necessary to define the term. According to Larson's treatise, Workmen's Compensation Law:

> Joint employment occurs when a single employee, under contract with two employers, and under the simultaneous control of both, simultaneously performs services for both employers, and when the service for each employer is the same as, or is closely related to, that for the other. In such a case, both employers are liable for workmen's compensation.

3 Larson's Workers' Compensation Law, § 68.01, (2000).

An employee can also be in the concurrent employ of two or more employers, however in that instance the employers do not share liability for worker's compensation benefits. These types of employment and section 2354 have been interpreted by the Delaware Supreme Court in the *Mazzetti* case, which is directly on point, and controls the Board's finding in this matter. *A. Mazzetti & Sons, Inc. v. Joseph Ruffin and First State Masonry, Inc.*, 437 A.2d 1120 (Del. 1981). The Court set forth three criteria to determine when a joint employment relationship exists;

(1) the employee is under the simultaneous control of both employers; and

(2) the employee performs the work simultaneously for both employers; and
(3) the services or work performed is the same or substantially similar.

Id. at 1123-1124. A dual or concurrent employment relationship exists when the employee's services are clearly severable between the employers. In other words the employers act independently and the employee performs work for one employer at a given time. The work time and services are clearly allocated to each employer. *Id.* The evidence presented in this case clearly demonstrates a concurrent employment relationship. The Claimant and several employer witnesses all testified that the job where the Claimant was injured was a Greenlight job. Claimant's supervisor on site, Mr. Pietropaula testified that he was working for Greenlight at the time. He also testified that the work orders from Neighborhood House would come in assigned to either Greenlight or East Wind. The work order submitted into evidence (Tab 11) clearly denotes Green-Light Solutions. The owners of these companies essentially confirmed that the jobs were separate, the pay roll was separate and the job on the day in question was a Green light job. Thus most, if not all, the evidence points to clearly separable, but concurrent employment in this case. Consequently, the Board finds that Claimant was an employee of Greenlight and not East Wind when this accident occurred.

Section 2311 liability

The Board already determined that Claimant's employer on the date of the accident, Greenlight, had no worker's compensation coverage for employees working in Delaware. *Gregory Scott Otter v. Greenlight Solutions, Inc.*, (Del. IAB) Hearing No. 1385184 (October 25, 2012). Greenlight had entered into a contract (Tab 6) with Neighborhood House to perform attic insulation projects. Neighborhood House as the general contractor on this project[3] is required pursuant to section 2311, to ensure that all their sub contractors carry valid worker's

[3] Neighborhood House fits the definition of a contractor pursuant to Chp. 25 Title 30 of the Delaware Code.

compensation coverage. 2311(a)(5). Failure to properly verify coverage may result in the general contractor providing insurance coverage for an employee of a sub contractor. Upon entering into the contract in question Greenlight submitted a COI that purported to show valid worker's compensation coverage for the dates in question. Neighborhood House contends that it fulfilled its' due diligence by obtaining a valid COI and therefore it should not be liable for coverage in this case. Several parties have cited the *Cordero* case, which essentially stands for the proposition that a contractor does not have a continuous duty to verify that proper coverage is in force during the contracting period. *Reuben Cordero v. Gulfstream Development Corp. and Delaware Siding Co.,* 2011 Del.Super. LEXIS 556 (November 30, 2011), *aff'd,* 2012 Del. LEXIS 599 (Del. November 20, 2012). The distinction with *Cordero* is that the initial COI was valid and the sub contractor let the coverage expire, whereas in this case the issue is whether the contractor conducted sufficient due diligence to ascertain the validity of the COI at the outset of the contract. The Court in *Cordero* does make the point that the general contractor does not have a duty beyond verifying that the COI is valid on its' face. *Cordero v. Gulfstream Development Corp. and Delaware Siding Co.*, 56 A3d 1030, 1038 (Del. 2012).

This brings us back to whether Neighborhood House verified that the COI provided by Greenlight was valid proof of coverage under the statute. Neighborhood House argues correctly that it has no further duty beyond verifying that the COI is valid on its face. *Id.* at 1038. Section 2311(a)(5) imposes a "good faith duty upon a contractor to "verify" its subcontractor's workers' compensation insurance coverage by exercising "due diligence."" *Cordero* at 1034. The Supreme Court pointed out, however, that the decision below did not define the scope of these requirements. *Id.* at 1034 (Fn 10). Claimant argues that on its' face the COI should have raised a concern because of the numerous connections to New Jersey, like the business address and the

carrier, New Jersey Casualty Company. As it turned out the COI is valid for coverage in NJ, but not in Delaware.[4] The statute provides that;

> "Any contracting entity shall obtain from [a] subcontractor ... a certification of insurance in force under this chapter. If the contracting entity shall fail to do so, the contracting entity ... shall be deemed to insure any workers' compensation claims arising under this chapter.

19 *Del.C.* § 2311(a)(5). The key for this case is that the COI must provide worker's compensation coverage under the Delaware statute. Consequently, the Board decision in *Estevam* is on point here. In that case the subcontractor had insurance coverage which was valid only in Pennsylvania and the Board ruled that the general contractor failed to verify valid coverage pursuant to 19 Del. Code Chp. 23 and had to step in and provide coverage to the claimant. *Estevam v. Marcelo Silva, d/b/a Girafa Construction and WM Company, Inc.*, (Del.IAB) Hearing No. 1342877 (January 7, 2010). *See also, McKirby v. A & J BUILDERS, INC.*, 2009 WL 713887 (Del.Super.). Consequently the Board finds that Neighborhood House failed to obtain a COI valid for coverage in Delaware and is required to provide insurance coverage for the Claimant in accordance with section 2311(a)(5).

In sum, the Board finds that Claimant sustained a compensable work injury while in the course and scope of his employment with Greenlight, an uninsured employer at the time of the accident. Further, Neighborhood House as the general contractor will provide workers compensation insurance coverage for the Claimant. The petitions against Greenlight and Neighborhood House are granted and the petition against East Wind is denied.

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[4] [illegible]

Attorney fees

A claimant who is awarded compensation 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). An award of compensation is defined as a change in position which is favorable to the Claimant and may be a non-monetary award. § 2320(10)(a), *See, Acme Markets, Inc. v. Fry,* 587 A.2d 454 (Table), 1991 WL 22370 (Del.Supr.), *citing, Willingham v. Kral Music, Inc.*, Del.Super., 505 A.2d 34, 36 (1985). At the hearing Claimant's counsel admitted that an attorney fee may not be due in this type of case, i.e.; determination of employment relationship and noted a recent Board decision on this issue where fees were not awarded. In the *McVeigh* case the Board held a legal evidentiary hearing to rule on the issue of employment relationship pursuant to section 2311. The Board ruled in the Claimant's favor and determined that the general contractor must provide coverage, much like this case; however an award of attorney fees was deferred to the hearing on the merits. *Cameron McVeigh v. ASI Construction, Inc., et.al.*, (Del.IAB.) Hearing Nos. 1375126, 1375415 and 1375416 (March 21, 2012). The procedural posture of the instant case is very different. Here the Board has ruled on the merits of the DCD Petitions and there is no future hearing. Consequently, an award of attorney fees is appropriate in this case.

In determining an award of attorney's fees, the trier of fact must consider the factors outlined in *General Motors Corp. v. Cox,* 304 A.2d 55, 57 (Del. 1973), such as the time involved in the presentations, fees customarily charged in the locality, the nature and length of the professional relationship with Claimant, and the attorney's experience/reputation. Claimant's counsel represents that his fee arrangement with Claimant is on a contingency basis. There has

been no indication that fees or expenses have been, or will be, received by Claimant from any other source. Claimant's counsel submitted an affidavit attesting that he spent approximately thirty five (35) hours preparing for the current hearing, which lasted approximately three (3) hours. While this case did not require the retention and testimony of expert witnesses, counsel's office prepared a notebook of pertinent exhibits to assist with lay witness testimony. Claimant's counsel indicated that his time on this case has precluded him from working on other cases in his office. Counsel has been admitted to the practice of law in Delaware since 1989 and is very experienced in workers' compensation, a specialized area of the law. His firm's association with Claimant began on July 10, 2012. The issue in this case was of above average complexity in nature. It does not appear that there were any unusual time limitations imposed by the Claimant or the circumstances surrounding the case. Claimant's counsel has also indicated that Employer has the ability to pay an award. Counsel's affidavit was submitted without objection.

Taking into consideration the fees customarily charged in this locality for such services as were rendered by Claimant's counsel and the factors set forth above, the Board finds that an attorney's fee in the amount of $6000.00 is appropriate. In the Board's estimation, this fee takes into account the value of obtaining worker's compensation insurance coverage for the Claimant following a prior ruling that the Employer, Green-Light Solutions, was uninsured.

STATEMENT OF THE DETERMINATION

For the reasons stated above, Claimant's Petition to Determine Compensation Due against Green-Light Solutions is hereby **GRANTED.** Claimant's Petition to Determine Compensation Due against Neighborhood House is **GRANTED.** Claimant's Petition to Determine Compensation Due against East Wind Enterprises is hereby **DENIED.**

IT IS SO ORDERED THIS 3 DAY OF JUNE, 2013.

INDUSTRIAL ACCIDENT BOARD

LOWELL L. GROUNDLAND

For MARILYN J. DOTO

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

Mailed Date: 6.5.13

OWC Staff

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

JULIO GARCIA TRUJILLO,	)	
	)	
Claimant,	)	
	)	
v.	)	Hearing No. 1419959
	)	
ATLANTIC BUILDING ASSOCIATES,	)	
	)	
	)	

JULIO GARCIA TRUJILLO,	)	
	)	
Claimant,	)	
	)	
v.	)	Hearing No. 1419958
	)	
GASTON SANTOS BAUTISTA,	)	
d/b/a SANTOS CONTRUCTION, LLC,	)	
	)	

DECISION ON PETITIONS TO DETERMINE COMPENSATION DUE

Pursuant to due notice of time and place of hearing served on all parties in interest, the above-stated cases came before the Industrial Accident Board on March 28, 2016, in a Hearing Room of the Board, in Kent County, Delaware. The Board required additional time to review the many exhibits, the parties' respective legal arguments, as well as the relevant case law. The Board's deliberations ultimately concluded on March 30, 2016.

PRESENT:

WILLIAM HARE

PATRICIA MAULL

Kimberly A. Wilson, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Tara E. Bustard, Attorney for the Employee

Andrew J. Carmine, Attorney for Atlantic Building Associates/Carrier

NATURE AND STAGE OF THE PROCEEDINGS

On August 10, 2015, Julio Garcia Trujillo ("Claimant") filed multiple Petitions to Determine Compensation Due ("DCD"), alleging that on April 9, 2014 he injured his low back while performing framing work on a construction site in Millville, Delaware. The accident allegedly occurred while Claimant was performing work for Gaston Santos Bautista d/b/a Santos Construction ("Santos");[1] Santos either worked directly for or was subcontracted to perform the work by WVM Construction ("WVM"), whom Atlantic Building Associates ("ABA") had initially subcontracted to do the framing.

A Petition for DCD was also filed against Santos, with IAB No. 1419958, which was duly noticed for hearing on March 28, 2016. Although Santos was timely noticed of the hearing date, time and location to the company's last known address, no one appeared on behalf of Santos, nor did Gaston Santos Bautista appear.

Claimant filed another Petition for DCD regarding this accident against ABA (IAB No. 1419959), which was also scheduled for a hearing on March 28, 2016. In relation to his petition, Claimant asserts that the insurance carrier for WVM (Liberty Mutual) denied coverage during the period of the alleged injury; therefore, Claimant maintains that ABA is liable for Claimant's workers' compensation injury under title 19 of the Delaware Code, section 2311. ABA contends that it satisfied section 2311 by obtaining a valid certificate of insurance ("COI") from WVM including the alleged date of injury. Claimant counters that ABA did not meet its statutory obligations because while the insurance coverage was valid, it only applied to workers and work

[1] A second Petition for DCD was filed against Santos, with IAB No. 1419958, and noticed for hearing on March 28, 2016. Although Santos was duly noticed of the hearing date, time and location to the company's last known address, no one appeared on behalf of Santos, nor did Gaston Santos Bautista appear. The Board notes that Claimant also filed Petitions against WVM, Melvin L. Joseph Construction and Miller & Smith; those petitions were not scheduled for March 28, 2016 and thus, did not receive proper notice of the instant hearing. Thus, due to a lack of notice, the Board makes no findings in relation to those parties.

accidents in the State of New Jersey. In this way, Claimant argues that ABA failed to use due diligence to research whether the coverage was actually valid in Delaware.

A hearing was held on Claimant's Petitions against Santos and ABA on March 28, 2016. The Board required additional time to review the many exhibits, the parties' respective legal arguments, as well as the relevant case law. The Board's deliberations ultimately concluded on March 30, 2016. This is the Board's decision on the merits of Claimant's Petitions.

SUMMARY OF THE EVIDENCE

Linda Garufi, a representative of ABA, was called to testify by Claimant. She confirmed that ABA had subcontracted WVM to provide some framing work at a construction job site in Millville, Delaware. In relation to the subcontract, AVS Insurance Agency (an insurance broker) provided ABA with a certificate of insurance indicating that WVM had valid workers' compensation insurance.

Mrs. Garufi admitted that she had not researched any further to make sure that WVM had workers' compensation coverage that specifically applied to work in Delaware. She explained that the COI form she received showed valid insurance coverage during the applicable period of time, with a valid policy number and amount of insurance coverage for workers' compensation purposes.[2] Mrs. Garufi admitted that the COI form did not state to which states the coverage extended or did not extend, however. She admitted that there is no mention of Delaware coverage, nor any other state, on the form. Mrs. Garufi explained that no COI form she has ever seen indicates on the form what states the coverage extends to, including this particular form. She also explained that frequently the insurance coverage is not limited to work in just one state; often there is an "all states" type of endorsement.

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[2] A packet of exhibits was marked into evidence as Joint Exhibit #1 by the parties. The COI form was located under a tab for "Exhibit G" within this exhibit.

Mrs. Garufi testified that she had never dealt with the AVS Insurance Agency ("AVS") broker before. She had no knowledge that the company's website indicates that it services New Jersey and Pennsylvania.[3]

Mrs. Garufi further admitted that she had not gone onto the Delaware Department of Labor ("DDOL") website to research whether WVM had insurance coverage specific to Delaware. She explained that she did not know about this tool. Mrs. Garufi testified that she did receive a copy of the Delaware business license for WVM Construction, however. This was received before WVM began performing work for ABA; ABA would not have allowed the company to work otherwise. The copy was located right on the State of Delaware's website. Mrs. Garufi testified that she asks for a copy of the business license from every subcontractor. She either looks it up or asks for a copy, but one must be received before work starts. She needs it in order to make deductions from the company's gross receipts.

Mrs. Garufi testified that she believes that a company who is a non-resident subcontractor must provide to the State of Delaware proof of workers' compensation insurance as well as a bond in order to work within the State of Delaware. Mrs. Garufi thought that by making sure that WVM had a Delaware business license, she also essentially made sure the business had proved to Delaware that it had workers' compensation insurance. She testified that she believed that if the proof provided by a subcontractor was good enough to pass these checks by the State of Delaware, it should also be good enough for her. Mrs. Garufi agreed that she believed that by making sure that WVM had a valid Delaware business license, this also meant that there was workers' compensation coverage as well. She reiterated that if Delaware received what it needed and then said that WVM could perform work in the State, she believes this to be sufficient. Mrs.

[3] A copy of this from the AVS website appears under Tab Exhibit I of Joint Exhibit #1.

Garufi denied seeing WVM's actual application for a Delaware business license, however.[4] She clarified that she does not believe that this application would be available to her.

Mrs. Garufi agreed that a person named Valtenir Pereira appears to have filled out the application form on behalf of WVM. She also admitted that while the application appears to be five pages long, it does not seem that the form was completely filled out by Mr. Pereira or that the State of Delaware had asked for the additional missing information. She admitted that, Mr. Pereira does not appear to have filled out the application's "Non-Resident Contractors" section. For example, he did not indicate whether or not he intended to subcontract, or give any information in regard to providing a bond, insurance contracts or insurance coverage.

Mrs. Garufi testified that ABA is located in Bishopsville, Maryland; because this is out of the State of Delaware, she testified that she can only go online and verify that there's a valid Delaware business license. That is all that she is able to find out. If she can find a valid Delaware business license and has a COI in hand, she goes no further in researching coverage. She reiterated that she knows by experience with subcontractors that in order to receive a business license to perform work in Delaware a bond and proof of workers' compensation coverage needs to first be supplied. Mrs. Garufi confirmed that a copy of WVM's business license for the year 2014 (a copy of which was included within the Joint Exhibit #1, at Tab Exhibit N) is the only evidence she personally viewed beyond the COI and contract itself, in terms of subcontracting WVM for the Millville project.

Mrs. Garufi testified that she has never met Mr. Pereira. She only dealt with Gaston Santos. She does not believe that she was actually introduced to him, however; most of the subcontractors that work for ABA are introduced to Mrs. Garufi's husband or her brother in law

[4] The application was under the "Exhibit J" tab of Joint Exhibit #1. A subpoena by Claimant's counsel directed to the State of Delaware for this application was included.

while they are working in the field. Mrs. Garufi never goes into the actual construction field. She believes that others from ABA probably met with Mr. Pereira in the field. Mrs. Garufi just writes the checks and gets the paperwork together. To Mrs. Garufi's knowledge, Mr. Pereira and Mr. Santos are cousins.

Mrs. Garufi agreed that Mr. Pereira, who is the owner of WVM, also signed the "Standard Agreement Between Contractor and Subcontractor" ("WVM Subcontractor Agreement") with ABA in March of 2014 that indicated that he must have Delaware insurance. Because he signed the contract, Mrs. Garufi presumed that Mr. Pereira was aware that if he would be working in Delaware, he needed to have insurance that covered Delaware work.[5]

Mrs. Garufi admitted that there was no mention of a specific "project location" in the WVM Subcontractor Agreement. She clarified that she had not hired WVM as a subcontractor for one particular location; ABA works with many builders within and outside of the State of Delaware. A certificate of insurance is not gotten for every specific job performed in Delaware. That is not something that is standard or normal practice in the industry.

Mrs. Garufi testified that she issued payments for work performed by check to WVM Construction or Valtenir Pereira d/b/a WVM Construction[6] and placed them in the hands of Gaston Santos, as an employee of WVM.

[5] Mrs. Garufi testified that she was not present when the contract was signed. Mr. Pereira signed the contract on behalf of WVM. This contract is under the Exhibit B Tab in Joint Exhibit #1. The relevant language is found on page 8 and reads:

> "19. **INSURANCE:** Until completion and final acceptance of the Work, Subcontractor shall carry public liability and property damage insurance in the minimum amounts required by the Contract Documents and State Law, and also such employer's liability or workmen's compensation insurance as may be necessary to insure the liability of the parties hereto for any injuries to the Subcontractor's employees...Subcontractor shall furnish Contractor certificates of the insurance required hereunder and a copy of each lost-time accident report made to Subcontractor's insurance carriers..."

[6] Mrs. Garufi testified that she initially issued the check to WVM Construction but was then told to issue checks in the future to Valdemir Pereira d/b/a WVM Construction. Checks were issued in this regard on April 10th, April 17th, April 25th, and April 28, 2014. Copies of these checks are located in Tab Exhibit A of Joint Exhibit #1.

As to how she learned of Claimant's alleged work accident, Mrs. Garufi testified that she recalled getting a medical bill that had been sent to ABA's office. She thought that he might have fallen off of a roof, but was unsure.

Mrs. Garufi explained that she hired WVM as a subcontractor on behalf of ABA. That is the only subcontractor she hired, though she conceded that Claimant had apparently performed work for the subcontractor. Once she received the medical bill, she called WVM's insurance company, Liberty Mutual. She advised Liberty Mutual that she was not sure if they knew of an incident, but that the primary coverage triggered would have been that of the employer of the person who fell. Mrs. Garufi testified that because she only hired WVM and not Claimant, she does not believe that ABA's insurance should be involved.

Mrs. Garufi denied ever telling Rebecca Colabaugh that she knew that WVM only had provided a New Jersey COI. She explained that she could not tell by looking at the COI provided to her to which state or states that the coverage extended. Likewise, she also is unsure which states WVM's Liberty Mutual policy covers. To Mrs. Garufi, the person located in New Jersey representing AVS who provided the COI to Mrs. Garufi in Bishopville, Maryland should have questioned or alerted that New Jersey coverage would not be sufficient, even if there was no knowledge that Delaware was even involved.

Mrs. Garufi agreed that ABA frequently deals with subcontractors that are not in Delaware. She admitted that she had not asked for something in writing from Mr. Pereira/WVM to verify that the subcontractor had valid Delaware workers' compensation insurance. She explained that she had never had an issue come up like this before; she now asks for this type of verification. Mrs. Garufi did not realize that a subcontractor would not have workers'

compensation insurance that is valid in a state in which they are performing work. Mrs. Garufi always now calls to verify this, in the interest of caution.

ABA's counsel next questioned Mrs. Garufi. ABA has been incorporated since 2005. The company performs both residential and commercial construction work within Maryland, Delaware, New York and New Jersey. The nature of the business is that work often crosses over state lines. At the project location where Claimant was allegedly injured, Miller & Smith were the builders of a community, and they subcontracted ABA, who then subcontracted WVM.

ABA has a steady stream of about 15 subcontractors throughout the year. It falls on Mrs. Garufi to make sure the paperwork is in order with the subcontractors, including routinely obtaining COIs, which is a common practice in the construction field when using subcontractors. Mrs. Garufi also makes sure to obtain a copy of the business license for ABA's potential subcontractors. She agreed that sometimes ABA acts as the subcontractor, when a general contractor hires the company for work.

Mrs. Garufi agreed that there is nothing on WVM's COI to specifically indicate Delaware coverage; however, this is the same in regard to ABA's COI. Further, beyond just listing the business address, to her knowledge, there is typically never coverage state(s) indicated on COIs. She confirmed that all of the COIs received by ABA between May 2013 and March 2015 do not appear to specify the states to which the insurance coverage extends or excludes.[7]

Since Mrs. Garufi has begun calling to make sure that the subcontractors are covered in the state where the work is being performed, if they are not covered in the proper state, she advised them that a policy needs to be gotten in the applicable state. Often, it takes a month or more for this to happen. Some other subcontractor is then likely be hired instead, because it is

[7] Twenty-seven COIs are contained in Joint Exhibit #1, Tab Exhibit H.

not practical to wait. The new subcontractor would also have to be properly vetted, however. It is a longer process.

Mrs. Garufi confirmed that the Subcontractor Agreement with WVM required that the subcontractor (WVM) provide insurance that complies with the governmental authority with jurisdiction over the work. She agreed that she believes that it would have been obvious to both Mr. Pereira and Mr. Santos that the work they were performing was in Delaware. No one had ever indicated any concern to her over whether there was valid Delaware workers' compensation coverage during the execution of the contract.

Mrs. Garufi testified that she did not see any red flags at all in regard to the COI. Since she had the COI and viewed the WVM's Delaware business license, she was comfortable that there was valid workers' compensation insurance to cover the subcontracted work. Further, she noted that she was writing checks to the company name as opposed to a person, which also made her feel at ease.

Mrs. Garufi admitted that, on the copy of the application for WVM's Delaware business license, it appears that Mr. Pereira checked "No" in response to a question asking "Will you have employees that work in Delaware, or withhold DE state income tax from DE residents that do not work in DE?"[8] She reiterated that she did not see this application and does not really know what the subcontractors tell the State of Delaware in order to get a Delaware business license. Mrs. Garufi reiterated that she is unsure whether the State of Delaware would provide her a copy of the actual application for a business license.

Mrs. Garufi denied telling Rebecca Colabaugh, Liberty Mutual's adjuster, that she knew that WVM only had provided a "New Jersey Certificate of Liability Insurance." She testified that there was no way she could have ever said that, as there is no such thing as only a New

[8] The application is marked as Tab Exhibit J under the Joint Exhibit #1.

Jersey COI. For example, ABA is covered in Maryland and Delaware in terms of workers' compensation insurance, but the COI does not actually say so. From her experience, one cannot look at a COI and see which state(s) are covered because coverage states are not listed on a COI. Further, Mrs. Garufi does not receive a copy of any insurance policies themselves.

Mrs. Garufi testified that her reason for speaking to Ms. Colabaugh was just to inform the insurance company that there had been an accident; she feared that the accident had not been reported when she received the bill. She could not recall if Ms. Colabaugh had told her that Liberty Mutual would not cover work accidents in Delaware.

The Board next questioned Mrs. Garufi. Mrs. Garufi agreed that she would not know if the subcontractor had lied in terms of having workers' compensation coverage or had misrepresented something in getting a Delaware business license.

She agreed that the COI she received appeared to be valid; it was sent directly to her from the insurance agent. Mrs. Garufi reiterated that because a New Jersey insurance broker sent the COI form to her in Maryland, she is not sure why the broker would not have questioned whether the work was to occur outside of New Jersey.

Claimant next testified on his own behalf.[9] He met Gaston Santos in April 2014 through of friend, Juan Carlos. Mr. Santos hired Claimant to perform framing work. The building Claimant was working on was in Delaware. Mr. Santos had not had Claimant complete any paperwork upon hire. Mr. Santos verbally advised Claimant he would pay him $12.00 hourly to perform framing work. He began working for Mr. Santos about two weeks prior to the work accident. Claimant only brought his own tools to the site.

Claimant described that on April 9, 2014, he was working for Santos on a very big construction site in Delaware. He had been working at this same site for approximately two

[9] Claimant testified with the assistance of a Spanish-language interpreter, Richard Lardi.

weeks. There were workers everywhere on the site. Claimant could recall seeing a truck that said "Atlantic Builders" on the side. On this day, Claimant was working on some headers above doors and windows of the building. He was cutting wood for Mr. Santos when he got a call from Juan Carlos. Juan Carlos told Claimant that he needed help installing some gable block. Claimant arrived to help and began working on the second floor of the building. At one point when Claimant went to grab the block, he stepped on a piece of plywood. The plywood slipped and broke, and Claimant ultimately ended up falling from the second floor to the ground while in a sitting position. He hit his rear end on the ground.

After the injury, Claimant thought that someone named "Ricky" called for an ambulance. Claimant was taken to a hospital in Lewes, Delaware. Once there, Claimant was informed that he had fractured his vertebrae and crushed two disks in the incident.

Claimant talked to Mr. Santos after the accident and he had assured Claimant he would help him out and pay all of his medical bills, but he has not paid for anything to date.

On cross examination, Claimant agreed that he had not asked Mr. Santos if he had workers' compensation insurance in Delaware prior to starting work for him. He explained that that is not something that is typically asked. Claimant had also not asked Mr. Santos about which town or state he would be working in prior to accepting the job. He just had wanted to work, was offered a job and took it. He was not considering the paperwork aspect of working.

The Board next questioned Claimant. Claimant reiterated he had not been given any forms to fill out when he began working for Mr. Santos. He was also paid only in cash.

On redirect examination, Claimant agreed that Mr. Santos had paid him for his first week of work. The work in question was performed at a construction site in Millville, Delaware.

Hyginus Delgado Diaz next testified on behalf of Claimant. Mr. Diaz was working on the same construction site as Claimant on April 9, 2014. He was also performing framing work. Mr. Diaz was employed by someone named "Antonio," and is unsure of Antonio's company name. Mr. Diaz could recall Mr. Santos's company working on the site that day. He did not know Claimant prior to working with him on this site. Claimant had been performing framing work on the house next door to the house that Mr. Diaz was working on at the time of the injury. Mr. Diaz had not witnessed the accident.

At one point, Mr. Diaz noticed that Claimant was lying on the ground, facedown. Since Mr. Diaz was the only one nearby who spoke a little English, he talked to Rick, the brother of the owner of the company. Mr. Diaz thought that Rick worked for ABA, but was unsure. Mr. Diaz told Rick that he thought that Claimant had fallen from the second floor and hurt his hip. Rick called 911. To Mr. Diaz's knowledge, Claimant had not returned to work at the site again after the accident. He thought that, despite the accident, the rest of Mr. Santos's crew had returned to work for one more day afterward.

On cross examination, Mr. Diaz testified that he did not think that the crew that was working with him had worked in Delaware prior to this job. He had not seen Mr. Santos working in Delaware prior to this, but had seen him and his truck before at a Delaware gas station.

Mr. Diaz worked with Claimant for about a week prior to the work accident.

The Board next questioned Mr. Diaz. He denied ever having worked for Gaston Santos Bautista or his company.

Rebecca Colabaugh, an adjuster from Liberty Mutual, testified by deposition on behalf of Claimant.[10] She has been employed by Liberty Mutual as a senior claims specialist for almost four years. Mrs. Colabaugh handles newer accidents and manages workers' compensation claims. She is involved in communicating with all of the parties.

Ms. Colabaugh testified that WVM had a contract for workers' compensation insurance coverage with Liberty Mutual that was effective in April of 2014. The policy coverage was applicable to the state of New Jersey only, however. Ms. Colabaugh is unaware of WVM ever having a Liberty Mutual policy for coverage extending into Delaware.

Ms. Colabaugh testified that on April 11, 2014, Linda Garufi contacted Liberty Mutual. Mrs. Garufi had apparently reported this claim to Liberty Mutual's screening unit. Before this, to Ms. Colabaugh's knowledge, no one had called in to verify that this insurance policy extended to the state of Delaware. Ms. Colabaugh had not spoken to Mrs. Garufi during the initial call; once she received the file, however, she called her directly a few times.

Mrs. Garufi advised Ms. Colabaugh that she had reported the claim to Liberty Mutual under the presumption that WVM was the owner. She also told of what she knew of the accident, essentially that Claimant had fallen to the ground while framing a house. Ms. Colabaugh requested a copy of the contract between WVM and ABA. Other than that, Mrs. Garufi had indicated that she had a COI showing coverage in New Jersey for WVM. Mrs. Garufi did not provide a copy of the COI and Ms. Colabaugh has never seen it. She is unsure how Mrs. Garufi went about obtaining the COI from AVS Insurance Agency, which was dated March 3, 2014, but knows that it can be gotten.

[10] Ms. Colabaugh's deposition was marked into evidence as Claimant's Exhibit #1.

Ms. Colabaugh conducted an internal investigation in regard to the incident involving WVM Construction and Claimant. This entailed reviewing information to determine if the New Jersey policy would apply to this Delaware accident.

The only information Ms. Colabaugh had in regard to who employed Claimant at the time of his accident was that Claimant was in contact with someone named Gaston Santos during his employment. She had received information, possibly from the general contractor (ABA) that Claimant was hired by Gaston Santos, who was employed in some capacity by WVM Construction. Ms. Colabaugh had never personally spoken with Mr. Santos. She did inquire with Mr. Pereira, the owner of WVM, by email. On April 30, 2014, he advised that he knew Gaston Santos, but that he was a "former employee." Mr. Pereira also indicated that it had been more than forty-five days since Mr. Santos worked for WVM. Ms. Colabaugh had no further contact with Mr. Pereira, as he failed to further respond to emails or phone calls.

Ms. Colabaugh also spoke with a representative from Westco Insurance in regard to this matter on April 15, 2014. The representative indicated that they had received a claim filed by ABA, but that they advised ABA that there would be no coverage for Claimant through ABA either. He was never an employee of theirs, so the claim would be denied.

That same day, April 15, 2014, Mr. Colabaugh contacted AVS Insurance Agency. She also questioned whether or not the company was aware of any Delaware policy for "this employer," and was told that AVS was not.

Based on the results of her investigation, Ms. Colabaugh concluded that WVM's New Jersey policy with Liberty Mutual would not extend to Delaware. Liberty Mutual thus denied workers' compensation coverage to WVM in terms of the Delaware accident involving Claimant.

On cross examination, Ms. Colabaugh agreed that a determination of whether there is specific insurance coverage requires looking at the actual policy. Further, Ms. Colabaugh agreed that Liberty Mutual insures businesses and employers all over the United States.

Ms. Colabaugh does not generally deal with COIs. She can obtain them from time to time, but she is not ever the one to create them. They are released primarily by the agents and brokers. Ms. Colabaugh admitted that she had never seen the COI that Mrs. Garufi referenced in regard to WVM.

When Ms. Colabaugh spoke with a representative from AVS Insurance, there was no indication that the person even knew of the accident.

Dr. Eric Schwartz, an orthopaedic surgeon, testified by deposition on behalf of ABA.[11] He evaluated Claimant on May 18, 2015 and reviewed the pertinent medical records.

On May 18, 2015, Dr. Schwartz noted that Claimant presented with an interpreter. At that time, Claimant indicated that on April 9, 2014, he was working on a second floor gable when he stepped onto a protruding piece of plywood and fell approximately ten feet to the ground. He was then transported to Beebe Medical Center.

Claimant began treating with Dr. Ganesh Balu on June 2, 2014 for neck, back and left shoulder pain. Dr. Balu diagnosed Claimant with a left shoulder strain/sprain, a neck strain/sprain and a fracture of the lumbar vertebra without a spinal cord injury in relation to the work accident. Dr. Schwartz concurred that these diagnoses causally relate to the April 9, 2014 accident.

In terms of treatment with Dr. Balu, Claimant had multiple injections on June 24, 2014, October 16, 2014, February 2, 2015 and February 3, 2015. Despite all of the treatment, Claimant indicated that his pain persisted. He had not returned to work for the contractor or the

[11] Dr. Schwartz's deposition was marked into evidence as ABA's Exhibit #1.

subcontractor that he had been working for at the time of the accident. However, Claimant indicated that he began working for a separate construction company, Doc Construction, in mid-November 2014. His work was in a full time, light duty capacity at the time Dr. Schwartz saw Claimant in May of 2015. Claimant's work reportedly included siding, trim, decks and railings.

In terms of the physical examination, Claimant had cervical tenderness midline as well as paracervical tenderness. His cervical range of motion was also restricted. The rest of the exam was normal, including the motor, sensory and reflex exam of the upper extremities. There was no evidence of any neurologic symptoms or cervical radiculopathy.

As for the shoulder, Claimant again had posterior left-sided paracervical discomfort and scapula pain. His shoulder exam was mildly limited in motion.

Regarding the low back and lower extremities, Claimant had midline lumbar/paralumbar musculature discomfort. His range of motion was limited. He had subjective complaints in the lower extremities.

Dr. Schwartz next reviewed Claimant's diagnostic studies. The CT scan showed a mild compression fracture of L2 without displacement or central canal narrowing.

Dr. Schwartz noted that as of December 2015, Claimant was having physical therapy. His pain was noted to be "daily," and his pain before therapy was noted to be a 7 on a pain scale from one to 10. After therapy, Claimant's pain was reportedly down to a 3 out of 10.

In Dr. Schwartz's opinion, Claimant's injuries, including a mild compression fracture and sprains and strains, should have resolved within three to six months. Dr. Schwartz further opined that the treatment leading up to the May 2015 exam was reasonable and necessary, but that Claimant did not require any further treatment after that time. This is because Dr. Schwartz felt

that Dr. Balu's notes failed to indicate functional gains for which to indicate any further therapeutic treatment.

As for Claimant's work capabilities, Dr. Schwartz concurred that Claimant could have returned to a light-duty position four hours per day in accordance with Dr. Balu's September 16, 2014 recommendation.

On cross examination, Dr. Schwartz agreed that he only examined Claimant once and that he saw no evidence of symptom magnification at that time.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

***Trujillo v. Atlantic Building Associates* (IAB #1419959)**

Normally, the fact that the parties admit that ABA was not Claimant's employer at the time of his April 9, 2014 accident would keep ABA from any liability regarding Claimant's injuries. However, this matter is not that simple. Pursuant to title 19, section 2311 of the Delaware Code, in cases involving contractors and subcontractors in the construction industry (*i.e.*, those who are or should be licensed under Chapter 25 of Title 30 of the Delaware Code), any "contracting entity" shall obtain from an independent contractor or subcontractor either a notice of exemption from the Workers' Compensation Act or "a certification of insurance in force under this chapter. If the contracting entity shall fail to do so, the contracting entity shall not be deemed the employer of any independent contractor or subcontractor or their employees but shall be deemed to insure any workers' compensation claims arising under this chapter." DEL. CODE ANN. tit. 19, § 2311(a)(5).

The Courts have recognized that by enacting section 2311, the "General Assembly put the onus on the general contractors to make sure that their subcontractors had coverage for

workers' compensation liability."[12] However, while the statute requires a general contractor to make the initial inquiry concerning insurance coverage, the Court has also found that the "statute does not impose any obligation on general contractors to follow up with their subcontractors to verify that the insurance remains in force."[13] A certificate of insurance is considered to be "in force" if it is "valid on its face at the time it is furnished to the contractor."[14]

This Board notes that the seminal case *Cordero*, while not squarely on point, still provides some direction. *Cordero* also involved a section 2311(a)(5) analysis; in that case, the initial COI that was provided was valid, though the subcontractor subsequently let the coverage lapse. In *Cordero*, the Court recognized that in seeking to protect employees of subcontractors, the General Assembly had undoubtedly intended that a certification "in force" remain effective throughout the entire coverage period. However, the Court recognized that the language of the statute itself did not provide for such an instance where the coverage was initially valid, yet lapsed before the end of the period denoted in the certification. While felt to be a regrettable and unfortunate result, the Court recognized that this issue could not be resolved except by the General Assembly, by actually rewriting the language of the statute itself.

In the instant case, this Board finds a similar problem. Here, while the COI reflected a facially valid insurance policy in place, WVM apparently did not have workers' compensation insurance coverage that was applicable to *Delaware* work, despite the fact that the work contracted for was always to be a Delaware project. As such, while WVM's voluminous policy contract itself with Liberty Mutual delineated clearly that only New Jersey work would be covered, the Board notes that the COI provided to ABA by AVS Insurance Agency on behalf of

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[12] *McKirby v. A&J Builders, Inc.*, Del. Super., C.A. No. 07A-08-005, Stokes, J., 2009 WL 713887 at *2 (March 18, 2009).
[13] *Cordero v. Gulfstream Development Corp.*, No. 11A-03-003, 2011 WL 6157487 at *3 (Del. Super. Ct., Nov. 30, 2011), *aff'd*, 56 A.3d 1030 (Del. 2012).
[14] *Cordero, id.* at 1037.

WVM failed to even suggest that there might be a coverage problem in terms of the state(s) covered or not covered.[15]

Significant for the Board's consideration here, the *Cordero* Court specifically pointed out that a general contractor does not have a duty beyond verifying that a COI is valid facially.[16] The Court pointed out that, in instances where a "contractor knows or has reason to believe the certification is false," it could not be supposed that the General Assembly intended to allow a contractor to rely on such a certification. Otherwise, the Court recognized narrow circumstances in which the facts of a certain case "may require liability to be imposed" where there is a finding of a "lack of due diligence by the general contractor."[17] Under the facts of *Cordero*, an example was given by the Court of a situation in which a "monitoring duty" might be implied where a contractor is aware that a subcontractor has a history of allowing its insurance coverage to lapse prior to the expiration of the coverage period.

Under the instant facts however, the Board carefully considered whether ABA acted in good faith and with proper due diligence in conjunction with the requirements of section 2311, and the Board felt strongly that it had. The Board considered that there was no evidence or indication of WVM having had a prior history of lapsing coverage or other insurance coverage issues, such as performing work in a state not covered by the workers' compensation policy in effect. Importantly, section 2311 essentially requires that a facially valid COI be obtained and retained for a period of three years, with little else delineated beyond that. Here, a COI that was technically valid on its face was turned over to ABA by AVS Insurance Agency on behalf of WVM.

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[15] This is despite the fact that AVS Insurance is apparently a New Jersey company and was clearly sending the policy to ABA's corporate office in Maryland. It is unclear whether or not it was asked by AVS (or revealed to AVS) that the project was actually located in Delaware.
[16] *Id.* at 1038.
[17] *Id.*

It is true that ABA presumed that there was Delaware coverage because the COI did not actually delineate which state(s) were covered or which states were excluded from coverage. However, the Board felt that, under the circumstances and based on the information contained on the COI, it was reasonable for ABA to have a good faith belief that WVM was covered in Delaware. ABA had a contract with WVM that reflected that WVM specifically agreed to ensure that there was workers' compensation insurance effective in the State in which the work was being performed. As the work was to be performed in Delaware, the Board felt that it was reasonable for ABA to presume that the COI ostensibly showed workers' compensation coverage applicable to Delaware.

Mrs. Garufi, on behalf of ABA, testified that beyond receipt of the COI, she actually went an extra step to confirm that WVM had a valid Delaware business license as well. The evidence presented shows that the State of Delaware requires a Workers Compensation Insurance Policy to be provided in order for a business to be licensed; Mrs. Garufi testified that she held this belief at the time the contract was entered and the COI was provided.[18] A copy of WVM's Delaware business license reflects that it was issued less than two months prior to the signing of the contract with ABA.[19] Mrs. Garufi also testified that, in her experience, the COIs do not usually indicate which states are included or excluded for purposes of coverage. She further testified that often, particularly with Liberty Mutual policies, the subcontractors tend to have "all states" policies, especially given the fact that contracting work in the area often overlaps between states. In support of this fact, ABA submitted the twenty-seven COIs that

[18] It is not clear whether WVM also provided the State of Delaware the COI that did not mention the applicable states of coverage; in any case, it was clear that as of the time of the accident, WVM did not have a workers' compensation policy applicable to Delaware.

[19] This copy was contained within Joint Exhibit #1, under Tab Exhibit N.

ABA had obtained in the timeframe between May 2013 and March 2015, and the Board noted that not one mentioned inclusions or exclusions in terms of state(s) coverage.[20]

Under these facts, and without further direction from the statute, the Board felt that ABA acted in good faith and satisfied any due diligence requirement under the statute. In so finding, the Board was convinced that ABA did not simply turn a blind eye or ignore any potential "red flags" that should have caused it to research the issue of actual Delaware coverage further. Claimant argued that because both the insurance broker, AVS Insurance, as well as WVM had New Jersey addresses listed on the COI, ABA should have been on notice that the coverage might only apply to New Jersey. However, counsel for ABA was persuasive that a company's corporate address almost always differs from the location of the actual construction project itself. For example, ABA's own corporate address was listed as Bishopville, Maryland, although the project at issue here was located in Millville, Delaware. Reviewing the corporate addresses on the COI itself, without more, would not have provided a definitive answer one way or another in terms of WVM's actual coverage.

Further, the Board also found Mrs. Garufi believable that not only does Liberty Mutual often provide "all states" policies in these type of circumstances, but the COIs that have been obtained by ABA more often than not (if at all) do not indicate the particular states that are included or excluded in terms of coverage. Thus, the Board did not feel that ABA simply received a piece of paper and "turned a blind eye" toward a lack of insurance coverage or otherwise ignore red flags as Claimant argues. The Board was convinced that ABA had good faith reasons to accept the facial validity of the COI that was provided on behalf of WVM.

If the facts here were different; for example, had ABA had knowledge of a propensity for WVM to not carry workers' compensation insurance applicable to the state in which work was to

[20] These COIs are contained at tab Exhibit H under Joint Exhibit #1.

be performed, despite signing a contract where this is required, the Board might have found that ABA is liable for Claimant's injury. In such a scenario, the Board would likely have determined that ABA should have delved deeper to ensure that the coverage actually extended to Delaware. However, as required by statute, the COI was valid on its face. The Board saw no red flags, beyond anything that is now seen in hindsight, for which ABA should have initially been put on notice that further research was necessary.

Cordero established that the statute only requires facial validity of a COI, and beyond that, only mentions that a contractor receive a COI "in force."[21] The statute, nor the relevant case law, offers any specific direction of additional steps for a contractor to take in order to confirm the facial validity of a COI under circumstances where there are no apparent "red flags." The *Cordero* Court was clear that under the right facts, where due diligence or a lack of good faith by a contractor exists, liability "may" need to be imposed.[22] After a thorough review of the evidence, and a finding that ABA acted in good faith and with sufficient due diligence under the statute, the Board felt strongly that such facts are not present here.

The Board notes that, because section 2311(a)(5) does little more than ask a contractor to obtain and retain for three years, a facially valid COI, if true that these COIs often do not contain information regarding the states where coverage is actually extended or excluded, this might become a recurring problem. Nonetheless, as the Superior Court in *Cordero* recognized, "[i]f additional responsibilities are to be placed on general contractors, that issue is one that calls for a legislative solution."[23]

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[21] As stated above, *Cordero* cited that "a certification of insurance is "in force" if it is valid on its face that the time it is furnished to the contractor." *Cordero, id.* at 1037.
[22] *Cordero,* 2011 WL 6157487 at *5.
[23] *Id.* at *3.

In sum, having found that ABA acted in good faith and with due diligence, based on the current language of section 2311(a)(5), the Board does not find that ABA is liable to insure Claimant's injuries under the Workers' Compensation Act in relation to the April 9, 2016 work accident.[24]

***Trujillo v. Gaston Santos Bautista d/b/a Santos Construction, LLC* (IAB# 1419958)**

Employment

In this case, the parties agreed that Claimant was not an employee of ABA. In terms of liability that Gaston Santos Bautista d/b/a Santos Construction ("Santos") might have in relation to Claimant's accident, the first issue to be considered is whether Claimant was an employee of Santos for purposes of the Workers' Compensation Act ("Act") at the time of the April 9, 2014 work accident.[25] After a review of the evidence presented, the Board finds that he was.

The starting point for the analysis is the statutory definition of "employee." The Act defines the term as meaning "every person in service of any corporation (private, public, municipal or quasi-public), association, firm or person, . . . under any contract of hire, express or implied, oral or written, or performing services for a valuable consideration."[26] This wording

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[24] However, Claimant potentially can pursue whatever legal remedies might be available to him under tort law.

[25] Gaston Santos Bautista d/b/a Santos Construction, LLC was sent timely notice of the hearing to its last known address. Despite proper notice, Mr. Santos Bautista failed to appear and no one else appeared on behalf of Santos Construction. The Board also notes that Claimant also filed a petition against WVM in regard to his accident. Post-hearing, it was discovered that WVM was not sent notice of the instant hearing, nor was the Petition against WVM placed on the Board's calendar for March 28, 2016. Apparently, an attorney previously represented WVA, but that attorney subsequently withdrew from the case. At that time, the case was removed from the Board's calendar, and for whatever reason, was not rescheduled for March 28, 2016. Thus, while WVM has the potential for liability in this case, because of this lack of notice, the Board makes no findings against WVM.

Therefore, while the Board finds Claimant to be an employee of Santos, there is also the possibility of liability against WVM, such as in a case of Joint Employment. If Claimant still wishes the Petition against WVM to be heard, Claimant likely needs to have that Petition, or any of the other Petitions filed in regard to Claimant's accident that were not heard on March 28, 2016, rescheduled for a future date.

[26] DEL. CODE ANN. tit. 19, § 2301(9).

provides two separate avenues by which a person may be found to be an employee (namely, under a "contract of hire" or "performing services for a valuable consideration").[27]

There is no substantial dispute that Claimant performed services for a valuable consideration for Santos. Claimant testified that Santos verbally offered him a job performing framing work at $12.00 per hour. Claimant brought nothing to the site but his own tools. Santos also personally paid Claimant in cash for the work he performed. Claimant was performing this work at the time of his injury. While no paperwork was formally provided or filled out, it was clear to the Board that Santos had hired Claimant to work, directed him on where to do the framing work he hired him for and paid him for his services. Claimant testified that Santos also offered to pay all of Claimant's medical expenses in relation to the April 9, 2014 accident, also suggestive that Claimant was working for Santos at the time of the injury.

For all of these reasons, the Board concludes that Claimant was an employee of Santos at the time he was injured on April 9, 2014, as defined by the Workers' Compensation Act.

Causation

The Delaware Workers' Compensation Act states that employees are entitled to compensation "for personal injury or death by accident arising out of and in the course of employment."[28] Because Claimant has filed the current petition, he has the burden of proof.[29] The primary issue in the case against Santos is whether an accident happened as Claimant describes and, if so, whether that accident resulted in compensable injuries. "The Claimant has

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[27] *See Barnard v. State*, 642 A.2d 808, 814 & 817 (Del. Super. 1992), *aff'd*, 637 A.2d 829 (Del. 1994).
[28] DEL. CODE ANN. tit. 19, § 2304.

[29] DEL. CODE ANN. tit. 29, § 10125(c).

the burden of proving causation not to a certainty but only by a preponderance of the evidence."[30]

When there has been a distinct, identifiable work accident, the "but for" standard is used "in fixing the relationship between an acknowledged industrial accident and its aftermath."[31] That is to say, if there has been an accident, the resulting injury is compensable if "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."[32] "A preexisting disease or infirmity, whether overt or latent, does not disqualify a claim for workers' compensation if the employment aggravated, accelerated, or in combination with the infirmity produced the disability."[33] After a thorough review of the evidence, the Board was persuaded that Claimant suffered a distinct, identifiable accident with resulting compensable injuries while working for Santos.

In so finding, the Board found Claimant credible that he had fallen from the second floor of a building on April 9, 2014 while employed by Santos. The Board believed Claimant that he was performing the framing work that Santos had hired him to perform at the time he was injured.

In finding for Claimant, the Board also relied on Dr. Schwartz's opinion, which was convincing and unopposed. Dr. Schwartz testified that he concurs with Dr. Balu's opinion that Claimant's diagnoses of a left shoulder strain/sprain, a neck strain/sprain and a fracture of the lumbar vertebra causally relate to the April 9, 2014 accident. Therefore, for the aforementioned

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[30] *Goicuria v. Kauffman's Furniture*, No. 97A-03-005, 1997 WL 817889 at *2 (Del. Super. Ct., Oct. 30, 1997), *aff'd*, 706 A.2d 26 (Del. 1998).

[31] *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. 1992).

[32] *Reese, id.* at 910.
[33] *Reese, id. See also State v. Steen*, 719 A.2d 930, 932 (Del. 1998).

reasons, the Board concludes that Claimant suffered compensable injuries in relation to the April 9, 2014 work accident.

Total Disability

As for Claimant's work capabilities, ABA and Claimant stipulated that Claimant was totally disabled from April 9, 2014 through September 16, 2014. Dr. Schwartz opined that he concurred with Dr. Balu that Claimant could have returned to a light-duty position four hours per day as of September 16, 2014. To Dr. Schwartz's knowledge, Claimant was working full time light duty for a new company as of mid-November 2014.[34]

Medical Expenses

Dr. Schwartz opined that Claimant's treatment leading up to his own May 18, 2015 exam was reasonable, necessary, and causally related to the April 9, 2014 accident. Dr. Schwartz, however, did opine that he believed that Claimant did not require any further treatment after May 18, 2015. As this was the only medical opinion presented to the Board, and the Board found Dr. Schwartz's opinion to be persuasive, the Board grants Claimant payment of his outstanding medical treatment expenses up through May 18, 2015. As such, those medical bills are to be paid by Santos in accordance with the fee schedule pursuant to 19 *Del. C.* § 2322B.

Attorney's Fee & Medical Witness Fee

A Claimant who is awarded compensation 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,

[34] The Board received limited information in this area, beyond the fact that ABA and Claimant stipulated that he earned $480.00 weekly at the time of his accident. With no other information available, it is presumed that Claimant is entitled to total disability at the compensation rate of $320.00 weekly (based on wages of $480.00 weekly at the time of the accident) for the period of time between April 9, 2014 and September 16, 2014. For the period from September 16, 2014 through when Claimant began working with Doc Construction, while he was apparently capable of working four hours per day, having no other information of light duty jobs available within the general labor market, Claimant is awarded partial disability benefits at his total disability compensation rate of $320.00 weekly.

whichever is smaller." DEL. CODE ANN. tit. 19, § 2320. At the current time, the maximum based on Delaware's average weekly wage calculates to $10,194.40. 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). Less than the maximum fee may be awarded and consideration of the *Cox* factors does not prevent the granting of a nominal or minimal fee in an appropriate case, so long as some fee is awarded.[35] A "reasonable" fee does not generally mean a generous fee.[36] Claimant, as the party seeking the award of the fee, bears the burden of proof in providing sufficient information to make the requisite calculation.

Claimant's counsel submitted an affidavit stating that 23 hours were spent preparing for this hearing. The hearing itself lasted about 3 hours. Claimant's counsel was admitted to the Delaware Bar in 2006, and is experienced in the area of workers' compensation litigation, a specialized area of the law. Claimant's first contact with counsel was in July of 2014, so counsel has represented Claimant for a little less than two years. This case was of above-average complexity. Counsel does not appear to have been subject to any unusual time limitations imposed by either Claimant or the circumstances, however. There is no evidence that accepting Claimant's case precluded counsel from other employment. Counsel's fee arrangement with Claimant is on a contingency basis. Counsel does not expect a fee from any other source. There is no evidence that Santos lacks the ability to pay a fee; although, because no one appeared on Santos' behalf, there is also no evidence that Santos is able to pay such a fee.

Taking into consideration the fees customarily charged in this locality for such services as were rendered by Claimant's counsel and the factors set forth above, the Board finds that an

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[35] *See Heil v. Nationwide Mutual Insurance Co.*, 371 A.2d 1077, 1078 (Del. 1977); *Ohrt v. Kentmere Home*, No. 96A-01-005, 1996 WL 527213 at *6 (Del. Super. Ct., August 9, 1996).

[36] *See Henlopen Hotel Corp. v. Aetna Insurance Co.*, 251 F. Supp. 189, 192 (D. Del. 1966).

attorney's fee in the amount of $6,500.00, or thirty percent of the total value of the award pursuant to this decision, whichever is less, is appropriate in this case.[37]

STATEMENT OF THE DETERMINATION

Accordingly, for the reasons stated above, the Board **DENIES** Claimant's petition against Atlantic Building Associates ("ABA") (IAB# 1419959) and finds that ABA is not liable to insure Claimant's injuries under section 2311(a)(5).

As for the petition against Gaston Santos Bautista d/b/a Santos Construction, LLC ("Santos"), IAB # 1419958, the Board **GRANTS** Claimant's petition.[38] In this regard, the Board finds that Claimant suffered a left shoulder strain/sprain, a neck strain/sprain and a fracture of the lumbar vertebra causally related to the work accident. The Board also awards Claimant total disability benefits from April 9, 2014 through September 16, 2014, at the established compensation rate of $320.00 weekly, based on wages of $480.00 weekly at the time of the accident. From September 16, 2014 until the date when Claimant began his work with Doc Construction (which is estimated to be mid-November 2014),[39] the Board further awards Claimant partial disability benefits at his total disability rate.

Additionally, the Board further awards Claimant payment of his related medical expenses, from the time of the accident through May 18, 2015, in accordance with the fee schedule pursuant to 19 *Del. C.* § 22322(b). Finally, the Board awards Claimant the payment of

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[37] The medical witness presented in this case was presented by ABA; thus, while Claimant has received an award against Santos, it does not appear that Claimant has yet incurred any medical witness fees.
[38] All of the awards made to Claimant pursuant to this decision are against Santos (and not ABA).
[39] The Board was not provided with a specific date when Claimant began working with Doc Construction.

a reasonable attorney's fee in the amount of $6,500.00, or thirty percent of the value of the total award pursuant to this decision, whichever is less.[40]

IT IS SO ORDERED this 13TH DAY OF APRIL, 2016.

INDUSTRIAL ACCIDENT BOARD

William Hare /sp
WILLIAM HARE

Patricia Maull /sp
PATRICIA MAULL

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

Mailed Date: 4-15-16

OWC Staff

[40] While ABA presented Dr. Schwartz, Claimant did not present a medical witness.

KeyCite Yellow Flag - Negative Treatment
Distinguished by Dixon v. Delaware Veterans Home, Del.Super., January 29, 2013

30 A.3d 775
Supreme Court of Delaware.

Eugene WATSON, Claimant Below, Appellant,
v.
WAL–MART ASSOCIATES, a Delaware Corporation, Employer Below, Appellee.

No. 442, 2010.
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Submitted: July 27, 2011.
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Decided: Oct. 21, 2011.
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Reargument Denied Nov. 4, 2011.

Synopsis
Background: Claimant sought judicial review of decision by Industrial Accident Board that he was not displaced worker entitled to total disability benefits, and which awarded him partial disability benefits. The Superior Court, Kent County, affirmed denial, and claimant appealed.

[Holding:] The Supreme Court, Berger, J., held that claimant whose reasonable job search was unsuccessful, was "displaced worker" eligible for total disability benefits under workers' compensation law.

Judgment of Superior Court reversed; judgment of Industrial Accident Board reversed; remanded to Superior Court for further action.

***777** Court Below: Superior Court of the State of Delaware, in and for Kent County, C.A. No. KO9A–11–001, IAB No. 1303174.
Upon appeal from the Superior Court. **REVERSED.**

Attorneys and Law Firms

Bayard J. Snyder, Esquire, Snyder & Associates, P.A., Wilmington, Delaware, for Appellant.

Christine P. O'Connor, Esquire, Tybout, Redfearn & Pell, Wilmington, Delaware for Appellee.

Before HOLLAND, BERGER, JACOBS and RIDGELY, Justices, and PARSONS, Vice Chancellor, * constituting the Court en Banc.

Opinion

BERGER, Justice:

In this appeal we consider the evidence required to prove and disprove that a claimant is a "displaced" worker under the workers' compensation law. A displaced worker is a partially disabled claimant who is deemed to be totally disabled because he is unable to work in the competitive labor market as a result of a work-related injury. A claimant who is not *prima facie* ***778** displaced, has the burden to prove that he made a reasonable job search, but was unable to obtain employment because of his disability. If a claimant satisfies that burden, the employer may rebut that evidence by showing that there are jobs available within the claimant's capabilities.

The Industrial Accident Board must use objective standards in deciding both of these issues. Where, as here, the claimant applied to at least a dozen jobs that were within his physical restrictions and were actually available, there was no basis to find that the search was unreasonable. Similarly, if the burden shifts to the employer to establish that there are jobs available within the claimant's limitations, a job survey will not automatically satisfy that burden. The employer must establish that the listed jobs actually are "available." If the claimant applied for most of the same jobs listed in the employer's survey without success, then the survey alone is insufficient evidence to satisfy the employer's burden. The Board found otherwise. Accordingly, we reverse.

FACTUAL AND PROCEDURAL BACKGROUND

Eugene Watson suffered a back injury in May 2007, while working at Wal–Mart Associates as a laborer. In August 2008, Watson underwent disc replacement surgery, which did not relieve his pain. After physical therapy, Watson's doctor limited him to sedentary or light work with a 20 pound lifting restriction. In December 2008, Wal–Mart filed a petition to terminate Watson's total disability

benefits. In October 2009, the Board issued its decision terminating Watson's total disability benefits. In June 2010, the Superior Court affirmed. This appeal followed.

The doctors all agreed that Watson suffered a permanent partial disability as a result of the 2007 accident. They also agreed that Watson's partial disability limits him to sedentary or light duty work, with no heavy lifting. The only issue before the Board was whether Watson is a displaced worker. Jessica Reno, a vocational case manager, testified that Watson has transferable skills and that there were 9 jobs available within his physical limitations, such as cashier, customer service representative, and debt collector. Reno spoke with the prospective employers and determined that each one would consider hiring someone with Watson's disabilities. Reno did not contact Wal–Mart because she did not see any ads for openings at any of the many Wal–Mart stores near Dover, Delaware.

Watson is a 56 year-old high school graduate who has no job skills other than his ability to follow instructions and to hold down a job. He worked as a janitor and an automobile assembly line worker, among other jobs, before working for Wal–Mart as a freight loader. After Wal–Mart filed its petition to terminate Watson's total disability benefits, he started a job search. Watson applied for 28 jobs without success. He applied online and in person, and always disclosed his disability on the applications. Watson received no response from the online applications. Two businesses that Watson applied to in person sent him letters saying that they could not hire him because of his disability. No other employer responded.

Watson acknowledged that some of the jobs he applied for were beyond his 20 pound lifting restriction. Watson also acknowledged that he did not ask any of the prospective employers whether any training would be required and he never asked what he would be paid. According to Reno, 12 of the 28 jobs required work outside Watson's restrictions, and that at least three of the remaining 16 jobs (all of which were listed on her labor market survey) had been filled by the time he applied for them.

***779** **[1]** The Board found that Watson's job search was not adequate and that he failed to prove that he was denied employment because of his disability. Accordingly, the Board granted Wal–Mart's petition to terminate Watson's total disability benefits. Based on Reno's testimony as to the average wages paid for the jobs listed in her labor market survey, the Board awarded Watson partial disability benefits. The Superior Court affirmed.

DISCUSSION

[2] **[3]** **[4]** The displaced worker doctrine recognizes that a worker who is not totally disabled nonetheless may be entitled to total disability benefits under Delaware's Workers' Compensation Law:

> [T]he determination of total disability requires consideration and weighing of not only the medical and physical facts but also such factors as the employee's age, education, general background, occupational and general experience, emotional stability, the nature of the work performable under the physical impairment, and the availability of such work. The proper balancing of the medical and wage-loss factors is the essence of the problem.... A workman may be totally disabled economically, and within the meaning of the Workmen's Compensation Law, although only partially disabled physically. In this connection, inability to secure work, if causally connected to the injury, is as important a factor as the inability to work. [1]

The claimant must demonstrate that he is a displaced worker, either by showing that he is a *prima facie* displaced worker, or that he "made reasonable efforts to secure suitable employment which have been unsuccessful because of the injury." [2] To rebut such a showing, the employer must establish "the availability of regular employment within the [claimant's] capabilities." [3]

[5] **[6]** **[7]** Claimants generally establish the reasonableness of their job searches through their own testimony, notes they kept during the job search, and any correspondence from prospective employers. Although the Board is the fact-finder, it is not free to ignore

this evidence if it is undisputed. The Board cannot find against the claimant simply because the claimant did not do everything he could have done. Its task is to determine whether the claimant's efforts were reasonable, not whether they were perfect. So, for example, if a claimant applied for a reasonable number of jobs that were available and within his physical limitations, it should not count against him if he also applied for jobs that were beyond his physical restrictions. Similarly, if a claimant applied for jobs listed on the employer's labor market survey, it should not count against him if one or more of those jobs were not available at the time of his application.

[8] **[9]** **[10]** **[11]** If the claimant shows that he conducted a reasonable job search and has been unsuccessful because of his work-related injury,[4] the burden shifts to the employer to rebut the claimant's showing. Typically, the employer relies on a vocational specialist who has prepared a labor ***780** market survey identifying jobs that the claimant is qualified to perform. But those surveys do not purport to establish that such jobs are available, only that they exist and were available at some point. "A proper application of the displaced worker doctrine can only be made by considering the contemporaneous availability of employment."[5] If the claimant has applied for most of the jobs on the survey, without success, the labor market survey's evidentiary value is significantly diminished. Without more, such a survey establishes only that the claimant might be able to find work, not that appropriate jobs are actually available. Under those circumstances, the labor market survey is insufficient to overcome the claimant's showing that he was unable to find work and, therefore, is a displaced worker.

Applying these principles to the facts of this case, the only conclusion that is supported by substantial evidence is that Watson is a displaced worker. He applied for 28 jobs, online and in person, including 6 of the 9 jobs identified in Reno's labor market survey. Watson had worked as a custodian for many years, and he applied for positions such as housekeeping, floor maintenance, and custodian, among others. Watson acknowledged that those were medium duty, not light duty, jobs and therefore, were beyond his restriction on lifting more than 20 pounds. But it was not unreasonable for him to think that an employer might want to hire him and modify his workload so as to conform to the weight lifting limitation. Moreover, Reno agreed that 16 of the 28 jobs Watson applied for were within his restrictions. Watson received only two responses to his applications. Both responding employers said that they could not hire him because of his partial disability.

From this evidence, the Board concluded that Watson did not conduct an adequate job search. It based that conclusion on the fact that Watson, "has not heard back from most of the jobs on his log, some jobs were not hiring, and other jobs were beyond his restrictions." But there is no evidence that employers contact prospective employees that they are not interested in hiring or that, in these circumstances, Watson should have contacted any employer again. Thus, the fact that Watson did not hear from most of the prospective employers has no probative value. As for Watson's 16 "appropriate" job applications, the Board made no finding that they were somehow inadequate, and nothing in the record would support such a finding. Accordingly, the Board's conclusion that Watson's job search was not reasonable must be reversed.

The Board also decided that Reno's survey and her testimony proved that Watson was not a displaced worker because the survey identified jobs that were within Watson's restrictions and "available in the open market." The Board was required to accept Watson's undisputed testimony that he applied for 28 jobs, including 6 of the jobs in Reno's survey, without success. Reno herself testified that 3 of her 9 jobs were *not* available when Watson applied for them. There was no evidence about the availability of the remaining 6 jobs. Wal–Mart did not find any job within its many, large retail stores that Watson could perform, and it apparently did nothing to assist Watson in finding a job elsewhere.

Wal–Mart's failure to rehire Watson is strong evidence that Watson is a displaced worker.[6] A small labor market survey indicating the *possible* availability of 6 jobs ***781** is not enough to overcome Wal–Mart's failure to rehire Watson, let alone Watson's unsuccessful job search. Wal–Mart had to demonstrate that appropriate jobs actually were available[7], and that the prospective employers would hire—not merely consider hiring—a person in Watson's position. Wal–Mart's evidence did not meet this standard.

[12] The purpose of the displaced worker doctrine is to provide full workers' compensation benefits for those who

are partially disabled but unable to find work because of the disability. Unskilled laborers, like Watson, are the people most likely to fall into this category.[8] They do not have resumes or well developed interviewing skills. Their attorneys tell them that they must conscientiously look for work, and that they should keep a log of their efforts. When they follow those instructions, and do not find work, they should not be denied full benefits unless it is clear that appropriate jobs are truly available.

CONCLUSION

Based on the foregoing, the decision of the Superior Court is reversed, and the decision of the Industrial Accident Board is reversed. This matter is remanded to the Superior Court for further action in accordance with this opinion.

All Citations

30 A.3d 775

Footnotes

* Sitting by designation pursuant to art. IV, § 12 of the Delaware Constitution and Supreme Court Rules 2 and 4(a) to fill up the quorum as required.

1 *Ham v. Chrysler Corporation,* 231 A.2d 258, 261 (Del.1967).

2 *Franklin Fabricators v. Irwin,* 306 A.2d 734, 737 (Del.1973).

3 *Ham v. Chrysler Corporation,* 231 A.2d at 262.

4 If the claimant advises prospective employers that he has a physical limitation, and he does not get the job, there is an inference that employer turned the claimant down because of the partial disability. *Keeler v. Metal Masters Foodservice Equipment Co.,* 712 A.2d 1004, 1005 (Del.1998).

5 *Adams v. Shore Disposal, Inc.,* 720 A.2d 272, 273 (Del.1998).

6 *Chrysler Corporation v. Duff,* 314 A.2d 915, 918 (Del.1973) (citing Larson's Workmens' Compensation Law, § 57.62).

7 A job opening that generates a long line of applicants the day that it is posted cannot reasonably be considered an available job. Common sense tells us that an employer is going to hire a person with no disabilities for an entry level unskilled job that is in demand.

8 "It is a well-known fact of modern economic life that the demand for unskilled and semiskilled labor has been rapidly declining ... and that the great bulk of the persistent hard-core unemployment in the United States is in these categories." Larson's Workers' Compensation Law, § 84.01(3).

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2016 WL 355002
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Delaware.

Re: Roos Foods
v.
Magdalena Guardado.

C.A. No.: S15A-05-002-ESB
|
January 26, 2016

Attorneys and Law Firms

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Opinion

E. SCOTT BRADLEY, JUDGE

***1** Dear Counsel:
This is my decision on Roos Foods' appeal of the Industrial Accident Board's denial of its Petition for Termination of Benefits for Magdelena Guardado. Guardado worked for Roos Foods for approximately five years. Guardado performed a variety of tasks for Roos Foods, but spent most of her time operating a machine that made cream. Guardado was involved in a compensable work-related accident on June 22, 2010. Guardado injured her left wrist when she slipped on the floor at work. Guardado was in and out of work until the summer of 2013 when she was placed on total disability. Dr. Richard P. DuShuttle surgically fused Guardado's wrist on June 18,2014. Dr. DuShuttle released Guardado to light-duty, one-handed work on August 7, 2014. Notwithstanding that, Guardado has not been able to find a job. Guardado is 38–years–old. Guardado was born in El Salvador and came to the United States in 2004. Guardado earned the equivalent of a high school degree in El Salvador, but has no other skills or training and her work history consists of just the five years she spent at Roos Foods. Guardado only speaks Spanish and is not able to work legally in the United States.

Roos Foods filed a Petition for Termination of Benefits on November 7, 2014, arguing that Guardado was no longer totally disabled and was physically able to return to work. The Board held a hearing on March 24, 2015. The Board denied Roos Foods' Petition for Termination of Benefits on April 7, 2015, concluding that Guardado was a *prima facie* displaced worker and that Roos Foods had not shown that there was work available for Guardado given her capabilities and limitations. Roos Foods then filed this appeal. I have concluded that the Board's decision is supported by substantial evidence and free from legal error.

STANDARD OF REVIEW

The Supreme Court and this Court repeatedly have emphasized the limited appellate review of the factual findings of an administrative agency. The function of the Superior Court on appeal from a decision of the Industrial Accident Board is to determine whether the agency's decision is supported by substantial evidence and whether the agency made any errors of law. [1] Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. [2] The appellate court does not weigh the evidence, determine questions of credibility, or make its own factual findings. [3] It merely determines if the evidence is legally adequate to support the agency's factual findings. [4] We review errors of law *de novo*. [5] Absent an error of law, the Board's decision will not be disturbed where there is substantial evidence to support its conclusions. [6]

DISCUSSION

***2** Normally, in a total disability case, the employer is initially required to show that the claimant is not totally incapacitated (i.e., demonstrate "medical

employability").[7] The claimant is then required to rebut that showing, by showing that he or she is a *prima facie* displaced worker, or submit evidence of reasonable, yet unsuccessful, efforts to secure employment which have been unsuccessful because of the injury (i.e., "actual displacement").[8] As a rebuttal, the employer may then present evidence showing that there are regular employment opportunities within the claimant's capabilities.[9]

The Workers' Compensation Act provides that employees who have suffered a loss in earning power following a workplace injury are entitled to benefits, and this inquiry requires consideration of the employee's individual circumstances. The Board made three findings in reaching its decision denying Roos Foods' Petition for Termination of Benefits. First, the Board found that Roos Foods met its initial burden by showing that Guardado was medically employable. Second, the Board found that Guardado rebutted that presumption by showing that she was *prima facie* displaced based upon her individual circumstances. Third, the Board found that Roos Foods did not present evidence showing that there were regular employment opportunities within Guardado's capabilities and limitations. Roos Foods argues that the Board erred 1) in relying on Guardado's undocumented worker status to conclude that she is *a prima facie* displaced worker, 2) in applying the *Campos*[10] decision to the *prima facie* displaced worker analysis, and 3) in not requiring Guardado's displacement to be casually related to her accident at work, but instead basing it on her citizenship status.

I. Medically Employable

The Board's finding that Guardado is medically employable is based upon substantial evidence and free from legal error. In a stipulation of facts, signed by the parties, both Dr. DuShuttle and Dr. Eric T. Schwartz concluded that Guardado is physically capable of returning to work with restrictions. Both doctors agree that Guardado can do one-handed light-duty work with her right hand and use her injured left hand as an "assistance hand." This evidence is uncontradicted and clearly established that Guardado is medically employable.

II. Displaced Worker

The Board's finding the Guardado is a *prima facie* displaced worker is based upon substantial evidence and free from legal error. "A worker is displaced if she is so handicapped by a compensable injury that [s]he will no longer be employed regularly in any well known branch of the competitive labor market and will require a specially-created job if [s]he is to be steadily employed."[11] An injured worker can be considered displaced either on a *prima facie* basis or through showing "actual" displacement. The Board found that because Guardado only applied for a few jobs there was no basis to find "actual" displacement. Therefore, the Board had to consider whether Guardado was displaced on a *prima facie* basis. The critical elements to be considered in finding *prima facie* displacement are a person's age, mental capacity, education, and training.[12] Under normal circumstances, to qualify as a *prima facie* displaced worker, one must have only worked as an unskilled laborer in the general labor field.[13] Guardado's job at Roos Foods was classified as an unskilled job in production assembly.

***3** The undisputed testimony before the Board established that Guardado 1) is 38–years–old, 2) is unskilled, 3) only speaks Spanish, 4) has the equivalent of a high school diploma from El Salvador, 5) can only use her right hand for light-duty work and left hand as an "assistance hand," 6) has only worked for five years, and 7) is an undocumented worker unable to work legally in the United States. The Board recited these facts in its written opinion with the primary focus being on the fact that Guardado was an undocumented worker. Even without Guardado's undocumented status, the evidence certainly supports the Board's finding that she fits into the *prima facie* displaced category. Guardado is almost middle-aged and has no education beyond high school in El Salvador. Guardado has no real workplace training, very little work experience, does not speak English, is unskilled in the labor market, and has work restrictions that limit her to light-duty work with one hand. These undisputed facts certainly portray a woman disqualified from regular employment in any well-known branch of the competitive labor market. When you add in the fact that she can not work legally in this country, then her difficulties in obtaining work become even greater. There is no doubt that Guardado, with her capabilities and limitations, is going to have a very difficult time finding a job.

III. Availability of Regular Employment

The Board's finding that Roos Foods failed to provide a labor market survey showing that there were jobs available to Guardado that took into consideration all of her capabilities and limitations is based upon substantial evidence and free from legal error. "If the evidence of degree of obvious physical impairment, coupled with other factors such as the injured employee's mental capacity, education, training, or age, places the employee prima facie in the "odd-lot" category, as defined in *Hartnett* and *Ham,* the burden is on the employer, seeking to terminate total disability compensation, to show the availability to the employee of regular employment with the employee's capabilities."–[14] As the Superior Court stated in *Abex,* "Common sense and everyday experience tells us that a person with given physical disabilities may be physically capable of performing certain "available" work, but because of [her] disability may be unacceptable to an employer and thus unable to secure such work ... Jobs must be realistically "within reach" of the disabled person ... A showing of physical ability to perform certain appropriate jobs and general availability of such jobs is ... an insufficient showing of the availability of said jobs to a particular claimant."[15]

Ellen Lock, a vocational rehabilitation witness for Roos Foods, performed a labor market survey. Lock testified that the survey was a representative sample of positions available to Guardado. Lock was aware of Guardado's job history, her inability to speak English, educational history, and her physical limitations. Lock identified eight potential positions in her labor market survey that she claimed were suitable for Guardado. Lock acknowledged that two of the jobs that Dr. Schwartz took issue with were probably not suitable for Guardado. Lock was not aware of Guardado's legal inability to work in the United States. Lock stated it would be relevant to employers, but she did not ask them if they would hire an undocumented worker. Therefore, there is no evidence in the record that there are jobs are available to Guardado with her qualifications and limitations.

The Board found that while Guardado was medically able to work with restrictions, she belonged in the "odd-lot" category because of her individual circumstances, thus shifting the burden to Roos Foods to show the availability of regular employment. The Board found that Roos Foods could not carry its burden to show that work was available to Guardado with her qualifications and limitations because Roos Foods' own witness could not testify that there was any work available for Guardado in light of her undocumented status.

Roos Foods argues that the Board's consideration of Guardado's immigration status was inappropriate and unrelated to her accident at work. The Delaware Supreme Court in *Campos,* a total disability case, addressed this, stating that federal restrictions that prevent employers from hiring undocumented workers may make it more difficult for an employer to prove job availability, but any difficulty is appropriately borne by the employer, who must take the employee as it hired [her].[16] Guardado was an undocumented worker when she was hired by Roos Foods. Roos Foods could have prevented the problems it now complains of if it had only checked Guardado's immigration status before it hired her. Roos Foods, as the Supreme Court ruled in *Campos,* must take Guardado as it hired her. The fact that Guardado may have difficulty getting another job because of her age, low education level, lack of skills and work experience, physical limitations and immigration status is something that Roos Foods must accept.

CONCLUSION

***4** The Board's finding that 1) Guardado was medically able to work with restrictions, 2) was a *prima facie* displaced worker, and 3) Roos Foods did not establish that work was available to Guardado within her restrictions and qualifications is based upon substantial evidence in the record and free from legal error.

The Industrial Accident Board's decision is **AFFIRMED.**

IT IS SO ORDERED.

All Citations

Not Reported in A.3d, 2016 WL 355002

Footnotes

1 *General Motors v. McNemar,* 202 A.2d 803, 805 (Del.1964); *General Motors v. Freeman,* 164 A.2d 686 (Del.1960).

2 *Oceanport Ind. v. Wilmington Stevedores,* 636 A.2d 892, 899 (Del.1994); *Battista v. Chrysler Corp.,* 517 A.2d 295, 297 (Del.Super.1986), *app. dism.,* 515 A.2d 397 (Del.1986)(TABLE).

3 *Johnson v. Chrysler Corp.,* 213 A.2d 64, 66 (Del.1965).

4 29 *Del.C.* § 10142(d).

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

6 *Dallachiesa v. General Motors Corp.,* 140 A.2d 137 (Del.Super.1958).

7 *Howell v. Supermarkets General Corp.,* 340 A.2d 833, 835 (Del.1975).

8 *Id.*

9 *Id.*

10 *Campos v. Daisy Construction Company*, 107 A.3d 570 (Del.2014).

11 *Torres v. Allen Family Foods,* 672 A.2d 26, 30 (Del.1996) citing *Ham v. Chrsyler Corp.* 231 A.2d 258, 261 (Del.1967).

12 *Chrysler Corp., v. Duff,* 314 A.2d 915, 916 (Del.1973).

13 See *Vasquez v. Abex Corp.,* 618 A.2d 91 (Del.1992)(TABLE), 1992 WL 397454, at *2 (Del. Nov. 5, 1992).

14 *Chrysler Corporation v. Duff* 314 A.2d 915, 916–17 (Del.1973).

15 *Campos v. Daisy Construction Company,* 107 A.3d 570, 576 (Del.2014) citing *Abex v. Brinkley*, 252 A.2d 552, 553 (Del.Super.1969).

16 *Campos v. Daisy Construction Company*, 107 A.3d 570, 572 (Del.2014).

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BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

MARY McKINNEY, Claimant, vs. LABOR READY, Employer, and ESIS, INC., Insurance Carrier, Defendants.	File No. 5005302 ALTERNATE MEDICAL CARE DECISION Headnote No. 2701

STATEMENT OF THE CASE

This is a contested case proceeding under Iowa Code chapters 85 and 17A. Claimant, Mary McKinney, sustained a stipulated work injury in the employ of defendant Labor Ready on July 11, 2000. In this action, she seeks an award of alternate medical care under Iowa Code section 85.27 and 876 Iowa Administrative Code 4.48.

The cause was heard by telephone conference call and fully submitted on November 13, 2002. The record consists of McKinney's testimony and exhibits 1-5. The entire hearing was recorded via audiotape, which constitutes the official record of proceedings.

Pursuant to a standing order of delegation of authority by the workers' compensation commissioner pursuant to Iowa Code section 86.3, the undersigned enters this decision for the workers' compensation commissioner. There is no right of appeal of this decision to the workers' compensation commissioner. Appeal of this decision, if any, would be by judicial review pursuant to Iowa Code section 17A.19.

ISSUES

At hearing, defendants agreed to responsibility for certain unpaid medical expenses. The sole issue presented for resolution is whether defendants are liable for

the expense of medical marijuana prescribed by the authorized treating physician for pain relief.

FINDINGS OF FACT

Mary McKinney sustained a left fibula fracture and crush injury to the tibial plafond when she was run over by a forklift truck on July 11, 2000. She has subsequently been diagnosed with complex regional pain syndrome, a condition sometimes referred to by physicians as "causalgia" or "reflex sympathetic dystrophy." Severe and intractable pain is the result. McKinney credibly testified that she is essentially limited to moving on hands and knees as the result of severe, constant and sharp pain.

McKinney has received a variety of treatment modalities without relief. These include administration of nonsteroidal anti-inflammatories, sympathetic blocks, and several opiates.

McKinney is currently a resident of the state of Oregon. Her authorized treating physician, Stuart Rosenblum, M.D., a physician duly licensed to practice medicine in Oregon, has recommended the use of medical marijuana, which he feels may mitigate McKinney's symptoms, described as:

Patient with intractable neuropathic pain, not readily relieved with opioid therapy. (Exhibit 2)

Dr. Rosenblum's statement was made as part of an "attending physician's statement" on a form pursuant to the Oregon Medical Marijuana Program. The parties agree and stipulate that the state of Oregon maintains a program for state-sanctioned use of medical marijuana.

CONCLUSIONS OF LAW

An application for alternate medical care is not automatically sustained because claimant is dissatisfied with the care he has been receiving. Mere dissatisfaction with the medical care is not ample grounds for granting an application for alternate medical care. Rather, the claimant must show that the care was not offered promptly, was not reasonably suited to treat the injury, or that the care was unduly inconvenient for the claimant. Long v. Roberts Dairy Company, 528 N.W.2d 122 (Iowa 1995).

The employer shall furnish reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services, and supplies for all conditions compensable under the workers' compensation law. The employer shall also allow reasonable and necessary transportation expenses incurred for those services. The employer has the right to choose the provider of care, except where the employer has denied liability for the injury. Section 85.27. Holbert v. Townsend Engineering Co., Thirty-second Biennial Rep. of the Industrial Comm'r, 78 (Review-reopen October 16,1975).

Defendants are not permitted to substitute their decisions as to proper care for that of their authorized treating doctor. See Kreisel v. Indian Hills Care Center, File No. 1185544, (Alt Care, July 27, 1999).

This agency has frequently been called upon in alternate medical care claims to require employers and insurance carriers to honor the treatment recommendations of their own authorized physicians. Orders granting such relief have been routinely forthcoming. This case is no different except that the treatment modality recommended is not readily available in the state of Iowa. However, Iowa Code sections 124.205(7) and 124.206(7) do offer controlled substance exclusions for marijuana "used for medicinal purposes pursuant to rules of the board of pharmacy examiners."

Irrespective of what relief might be available in Iowa, McKinney is a resident of Oregon. Dr. Rosenblum is a physician licensed to practice in the state of Oregon. The state of Oregon provides for the use of medical marijuana through a state-sanctioned program. Dr. Rosenblum's recommendation is pursuant to that program.

Defendants also contend that Dr. Rosenblum "has not shown" that the recommended treatment would be effective. No authority is offered for the proposition that an authorized physician must guarantee a successful result for every treatment modality recommended. Symptomatic treatment of severe and intractable pain is entirely appropriate and, in this case, reasonable and necessary within the meaning of section 85.27. McKinney is entitled to the relief she seeks.

ORDER

THEREFORE, IT IS ORDERED:

McKinney's petition for alternate medical care is granted. Defendants are liable for expenses related to the use of medical marijuana recommended by Dr. Rosenblum under the Oregon Medical Marijuana Act Program.

Signed and filed this ____14th____ day of November, 2002.

DAVID RASEY
DEPUTY WORKERS'
COMPENSATION COMMISSIONER

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Cited
As of: September 23, 2016 2:30 PM EDT

Maez v. Riley Indus.

Court of Appeals of New Mexico

January 13, 2015, Filed

Docket No. 33,154

Reporter
2015-NMCA-049; 347 P.3d 732; 2015 N.M. App. LEXIS 7

MIGUEL MAEZ, Worker-Appellant, v. RILEY INDUSTRIAL and CHARTIS, Employer/Insurer-Appellees.

Subsequent History: Released For Publication May 12, 2015.

Prior History: **[***1]** APPEAL FROM THE WORKERS' COMPENSATION ADMINISTRATION. David L. Skinner, Workers' Compensation Judge.

Disposition: Compensation order reversed.

Core Terms

medical marijuana, medical care, marijuana, patients, certification, cannabis, pain management, treatment plan, prescribe, workers' compensation, recommend, license, pain, substantial evidence, medical treatment, deposition, medical report, prescription, requires

Case Summary

Overview

HOLDINGS: [1]-The workers' compensation judge (WCJ) erred in denying a worker's claim for reimbursement because no substantial evidence supported the WCJ's conclusion that medical marijuana used pursuant to the Lynn and Erin Compassionate Use Act, N.M. Stat. Ann. §§ 26-2B-1 to 26-2B-7 (2007), was not reasonable and necessary medical care for the worker under the Workers' Compensation Act, N.M. Stat. Ann. § 52-1-49(A); [2]-Regardless of whether the worker requested treatment with medical marijuana, his health care provider (HCP) had treated him with traditional pain management that had failed and adopted a treatment plan based on medical marijuana, and he would not have done so if it were an unreasonable medical treatment; [3]-The HCP adopted a treatment plan that called for medical marijuana, and by the very nature of such treatment, medical marijuana was a necessary component.

Outcome

Compensation order reversed.

LexisNexis® Headnotes

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

HN1 The Workers' Compensation Act, N.M. Stat. Ann. §§ 52-1-1 to 52-1-70 (1929, as amended through 2013), authorizes reimbursement for medical marijuana used pursuant to the Lynn and Erin Compassionate Use Act, N.M. Stat. Ann. §§ 26-2B-1 to 26-2B-7 (2007).

Workers' Compensation & SSDI > Coverage > Actions Against Employers > Statutory Requirements for Adequate Coverage

HN2 The Workers' Compensation Act requires an employer to provide a worker reasonable and necessary health care services from a health care provider. N.M. Stat. Ann. § 52-1-49(A) (1929, as amended through 2013). Conversely, an employer need not provide a worker with health care that is not reasonable and necessary. The employer's obligation is limited by § 52-1-49(A) to paying for reasonable and necessary' health care services.

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

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

HN3 Under a whole record standard of review, the court of appeals determines whether substantial evidence in the record as a whole supports the workers' compensation judge's (WCJ) conclusion. Substantial

evidence is credible evidence in light of the whole record that is sufficient for a reasonable mind to accept as adequate to support the conclusion. The court of appeals gives deference to the WCJ as factfinder and views the evidence in the light most favorable to the decision without disregarding contravening evidence.

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

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

HN4 While the court of appeals generally may not weigh the evidence, even under whole record review, such review allows the reviewing court greater latitude to determine whether a finding of fact was reasonable based on the evidence. Moreover, its review has even greater latitude when reviewing an issue for which the evidence is documentary in nature. When all or substantially all of the evidence on a material issue is documentary or by deposition, an appellate court may examine and weigh it. In review for substantial evidence of such a record from a district court proceeding, the appellate court must then give some weight to the findings of the trial judge on such issue and not disturb such findings based on conflicting evidence unless such findings are manifestly wrong or clearly opposed to the evidence.

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

HN5 The court of appeals will not disturb the workers' compensation judge's findings unless they are manifestly wrong or clearly opposed to the evidence.

Workers' Compensation & SSDI > ... > Judicial Review > Standards of Review > General Overview

HN6 The court of appeals applies a de novo standard to the workers' compensation judge's application of law to the facts.

Governments > Agriculture & Food > General Overview

Healthcare Law > Medical Treatment > General Overview

HN7 The Lynn and Erin Compassionate Use Act requires for enrollment that a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act provide a written certification that the patient has a debilitating medical condition and that the person certifying believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient. N.M. Stat. Ann. § 26-2B-3(E), (H) (2007).

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

Governments > Agriculture & Food > General Overview

Healthcare Law > Medical Treatment > General Overview

HN8 The Workers' Compensation Administration regulations adopted pursuant to the Workers' Compensation Act, N.M. Stat. Ann. § 52-4-5 (1993) and N.M. Stat. Ann. § 52-5-4 (2003), define "prescription drug" as a drug requiring a written order from an authorized health care provider (HCP) for dispensing by a licensed pharmacist or authorized HCP. N.M. Code R. 11.4.7.7(OO) (2011).authorized treating health care provider (HCP) But, medical marijuana is not a prescription drug. The certification required under the Lynn and Erin Compassionate Use Act by a person licensed in New Mexico to prescribe and administer controlled substances is the functional equivalent of a prescription. N.M. Stat. Ann. § 26-2B-3(E), (H) (2007).

Workers' Compensation & SSDI > Administrative Proceedings > Evidence > Burdens of Proof

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

HN9 The worker has the burden of proving that his or her medical expenses were reasonably necessary.

Governments > Agriculture & Food > General Overview

Healthcare Law > Healthcare Litigation > Actions Against Healthcare Workers > Doctors & Physicians

HN10 The Lynn and Erin Compassionate Use Act, N.M. Stat. Ann. § 26-2B-4(E) (2007), states that a practitioner may not be subject to arrest, prosecution, or penalty for distributing medical marijuana under the Compassionate Use Act.

Healthcare Law > Medical Treatment > General Overview

Governments > Agriculture & Food > General Overview

HN11 See the Lynn and Erin Compassionate Use Act, N.M. Stat. Ann. § 26-2B-2 (2007).

Workers' Compensation & SSDI > Administrative Proceedings > Judicial Review > General Overview

HN12 The court of appeals will affirm the decision of a workers' compensation order if it is right for any reason.

Counsel: Titus & Murphy Law Firm, Victor A. Titus, Farmington, NM, for Appellant.

Hoffman Kelley Lopez LLP, Lori A. Martinez, Albuquerque, NM, for Appellees.

Judges: JAMES J. WECHSLER, Judge. WE CONCUR: CYNTHIA A. FRY, Judge, MICHAEL E. VIGIL, Judge.

Opinion by: JAMES J. WECHSLER

Opinion

[732] WECHSLER, Judge.**

[*1] In *Vialpando v. Ben's Automotive Services, 2014-NMCA-084, ¶ 1, 331 P.3d 975*, *cert. denied*, *331 P.3d 924 (2014)*, this Court held that ***HN1*** the Workers' Compensation Act, *NMSA 1978, §§ 52-1-1 to -70* (1929, as amended through 2013), authorizes reimbursement for medical marijuana used pursuant to the Lynn and Erin Compassionate Use Act (Compassionate Use Act), *NMSA 1978, §§ 26-2B-1 to -7* (2007). The workers' **[**733]** compensation judge in *Vialpando* had found that the worker was qualified to participate in the Department of Health Medical Cannabis Program authorized by the Compassionate Use Act and that such treatment would be reasonable and necessary medical care. *2014-NMCA-084, ¶ 1*.

[*2] In this appeal, the workers' compensation judge (WCJ) found that the worker's authorized treating health care provider (HCP) did not prescribe medical marijuana and concluded that medical marijuana was not reasonable and necessary medical care. Worker ***Miguel Maez*** argues that the WCJ erred in this conclusion because Worker **[***2]** had proven that medical marijuana was reasonable and necessary medical care, particularly based on the evidence that the HCP's treatment plan for Worker included medical marijuana, and the HCP and another doctor had certified Worker's use of medical marijuana as required by the Compassionate Use Act.

[*3] Because there is not substantial evidence supporting the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care for Worker, we reverse the WCJ's compensation order.

I. BACKGROUND

[*4] Worker suffered two compensable injuries to his lumbar spine in the course and scope of his employment with Riley Industrial on February 14, 2011 and March 4, 2011. Riley Industrial was insured by Chartis (both referred to as Employer herein). Worker was entitled to payment of temporary disability until the date of maximum medical improvement and permanent partial disability thereafter based on a seven percent whole body impairment for the balance of the 500-week benefit period. He was also entitled to ongoing reasonable and necessary medical care. His authorized HCP was Dr. Anthony Reeve.

[*5] The WCJ found that "Dr. Reeve did not prescribe medical marijuana to Worker" and concluded that **[***3]** "[m]edical marijuana is not reasonable and necessary medical care from an authorized HCP" that would require payment by Employer. Worker appeals from the WCJ's compensation order to the extent that the WCJ did not award medical benefits for Worker's use of medical marijuana for pain management.

II. REASONABLE AND NECESSARY MEDICAL CARE

A. Issue on Appeal

[*6] On appeal, Worker initially makes arguments concerning the interrelationship of the Workers' Compensation Act and the Compassionate Use Act that are similar to those we decided in *Vialpando*. In *Vialpando*, filed after Worker filed his brief-in-chief in this case, we determined that medical marijuana treatment approved under the Compassionate Use Act that the WCJ found to be reasonable and necessary medical care qualifies for reimbursement under the Workers' Compensation Act. *Vialpando, 2014-NMCA-084, ¶ 1*.

[*7] The WCJ in this case did not find Worker's medical marijuana treatment to be reasonable and necessary medical care. To the contrary, the WCJ specifically concluded that "[m]edical marijuana is not reasonable and necessary medical care from an authorized HCP." Worker argues that the WCJ erred in reaching this conclusion because the evidence indicated that medical marijuana is reasonable **[***4]** care for Worker's chronic low back pain and because the WCJ incorrectly found that medical marijuana was not "prescribed" by Dr. Reeve.

[*8] ***HN2*** The Workers' Compensation Act requires an employer to provide a worker "reasonable and necessary health care services from a health care provider." *Section 52-1-49(A)*. Conversely, an employer need not provide a worker with health care that is not

reasonable and necessary. *See* Vargas v. City of Albuquerque, 1993-NMCA-136, ¶ 8, 116 N.M. 664, 866 P.2d 392 ("[T]he employer's obligation is limited by Section 52-1-49(A) to paying for 'reasonable and necessary' health care services"). Thus, the pivotal question in Worker's appeal is whether the evidence supports the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care.

[**734] B. Standard of Review

[*9] We address this question ***HN3*** under a whole record standard of review by determining whether substantial evidence in the record as a whole supports the WCJ's conclusion. *Dewitt v. Rent-A-Center, Inc., 2009-NMSC-032, ¶ 12, 146 N.M. 453, 212 P.3d 341*. Substantial evidence is credible evidence in light of the whole record "that is sufficient for a reasonable mind to accept as adequate to support the conclusion[.]" *Id.* (internal quotation marks and citation omitted). We give deference to the WCJ as factfinder and view the evidence in the light most favorable to the decision without disregarding **[***5]** contravening evidence. *Id.*

[*10] ***HN4*** While we generally may not weigh the evidence, even under whole record review, such review "allows the reviewing court greater latitude to determine whether a finding of fact was reasonable based on the evidence[.]" *Herman v. Miners' Hosp., 1991-NMSC-021, ¶ 10, 111 N.M. 550, 807 P.2d 734*. Moreover, our review has even greater latitude when reviewing an issue for which the evidence is documentary in nature. As in this case, when "all or substantially all of the evidence on a material issue is documentary or by deposition," an appellate court may "examine and weigh it[.]" *United Nuclear Corp. v. Gen. Atomic Co., 1979-NMSC-036, ¶ 62, 93 N.M. 105, 597 P.2d 290* (internal quotation marks and citation omitted). In review for substantial evidence of such a record from a district court proceeding, the appellate court must then give "some weight to the findings of the trial judge on such issue" and not disturb such findings based on conflicting evidence "unless such findings are manifestly wrong or clearly opposed to the evidence." *Id.* (internal quotation marks and citation omitted). In this case, in which we are applying whole record review, we must similarly give weight to the WCJ's findings and consider contravening evidence. *Dewitt, 2009-NMSC-032, ¶ 12*. Following *United Nuclear*, ***HN5*** we will not disturb the WCJ's findings unless they are manifestly **[***6]** wrong or clearly opposed to the evidence. *1979-NMSC-036, ¶ 69*.

[*11] ***HN6*** We apply a de novo standard to the WCJ's application of law to the facts. *Vialpando, 2014-NMCA-084, ¶ 5*.

C. Review of the Evidence

[*12] Dr. Reeve provided the evidence concerning the issue of whether medical marijuana constituted reasonable and necessary medical care. He testified by deposition. He made detailed medical reports of each of Worker's visits, and the reports were included as exhibits to his deposition.

[*13] Dr. Reeve began treating Worker on June 13, 2011. He testified that his diagnosis of Worker included chronic back pain and that he treated Worker with medication for pain management. Over the course of Worker's treatment, Dr. Reeve had injected Worker with Toradol and had prescribed Soma, Ultram, Sprix, Percocet, Lortab (oxycodone), and hydrocodone for Worker's pain. Dr. Reeve also referred Worker to another doctor for spinal injections. During one test required for pain management patients, Worker tested positive for marijuana. Dr. Reeve informed Worker that if Worker was going to take marijuana, he needed to have a license for Dr. Reeve to continue administering other narcotics, and further, even if Worker had a license, he would probably consider only additional **[***7]** nonnarcotic pain medication.

[*14] On February 28, 2012, Dr. Reeve first saw Worker for a medical marijuana evaluation. In his medical report, Dr. Reeve states that Worker has had spinal injections and chronic pain management and that Worker "has failed traditional pain management and is a candidate for the cannabis program." At that time, Dr. Reeve was treating Worker with hydrocodone. His report concludes with the following:

> **IMPRESSION**
>
> 1. Lumbar radiculopathy.
> 2. Chronic low back pain.
> 3. Failed traditional management.
>
> **REHABILITATION MANAGEMENT AND SUGGESTIONS**
>
> I have reviewed the records and examined the patient. The history, radiographic and **[**735]** physical findings are consistent at this time. I will recommend authorization of medical marijuana as a trial. Authorization is good for

one year and the patient will need to show symptomatic progress upon reauthorization.

TREATMENT PLAN

Authorization for medical marijuana for one year.

[*15] Dr. Reeve re-authorized Worker for the medical marijuana program after an evaluation on April 3, 2013. Similarly, Dr. Reeve again stated in his report that Worker had "failed traditional pain management and is a candidate for the cannabis program." He stated the same "IMPRESSION" **[***8]** and "REHABILITATION MANAGEMENT AND SUGGESTIONS" as he had on February 28, 2012. His "TREATMENT PLAN" stated "Reauthorization for medical marijuana for one year."

[*16] ***HN7*** The Compassionate Use Act requires for enrollment that "a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act" provide a "written certification" that "the patient has a debilitating medical condition" and that the person certifying "believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient." *Section 26-2B-3(E)*, *(H)*. Dr. Reeve signed the certification for Worker to qualify for the Compassionate Use Act medical marijuana program. The original certification is not part of the record on appeal. Dr. Reeve also signed the certification re-enrolling Worker in the program. In that certification, in addition to the statutory requirements stated above, Dr. Reeve further certified that Worker "has current unrelieved symptoms that have failed other medical therapies."

[*17] At his deposition, Dr. Reeve was asked: "And because you signed for [medical marijuana], do you believe that it is an appropriate medical treatment for [Worker's] **[***9]** herniated disk?" Dr. Reeve responded:

> Well, I think I need to be really clear on this issue. What happens is patients are going to use the cannabis [marijuana] either one way or the other. He already tested positive for it. And so I explain to patients, "If you're going to use cannabis, you should probably have a license for it because people will suspect you of using it ultimately, and you can always pass a preemployment screen or other tests if you have a license for it." And if patients request that I sign it, I will sign for them, but I'm not recommending or distributing or in any way advocating for the use of medical cannabis.

1. Necessity of a Prescription

[*18] Worker contends that the WCJ erred in his conclusion that medical marijuana does not constitute reasonable and necessary medical care because Dr. Reeve did not "prescribe" medical marijuana for Worker. The WCJ found that Dr. Reeve did not prescribe medical marijuana to Worker and further found that "Employer is not liable for the purchase of medical marijuana based on the fact that the medical marijuana is not being prescribed by the authorized HCP, Dr. Reeve." ***HN8*** The Workers' Compensation Administration regulations adopted pursuant **[***10]** to *NMSA 1978, Section 52-4-5* (1993) and *NMSA 1978, Section 52-5-4* (2003) applicable at the time Worker filed his application defined "prescription drug" as a drug requiring "a written order from an authorized HCP for dispensing by a licensed pharmacist or authorized HCP." *11.4.7.7(OO) NMAC* (12/31/2011). But, as we stated in *Vialpando*, medical marijuana is not a prescription drug. *2014-NMCA-084, ¶ 11*. Moreover, as we further stated in *Vialpando*, the certification required under the Compassionate Use Act by a person licensed in New Mexico to prescribe and administer controlled substances is the functional equivalent of a prescription. *Id. ¶ 12*; see *§ 26-2B-3(E)*, *(H)*. We thus agree with Worker that the fact that Dr. Reeve did not provide Worker a prescription as defined in the regulations does not support the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care for Worker.

2. Conclusion Regarding Reasonable Medical Care

[*19] As we have stated, to the extent that the WCJ based his conclusion that medical **[**736]** marijuana was not reasonable and necessary medical care on his finding that Dr. Reeve did not prescribe medical marijuana for Worker, the WCJ's conclusion is based on a faulty premise. Employer argues that the evidence in the record nevertheless supports the **[***11]** WCJ's conclusion. We therefore turn to the other evidence to determine whether it supports the conclusion that medical marijuana was not reasonable and necessary medical care for Worker.

[*20] We discuss the two aspects of the WCJ's conclusion separately. With regard to whether medical marijuana was reasonable medical care for Worker, we have little difficulty concluding that the evidence as a whole does not support the WCJ's conclusion. Regardless of whether Worker requested treatment with medical marijuana, Dr. Reeve had treated Worker with traditional pain management that had failed. He adopted a treatment plan based on medical marijuana. He would

not have done so if it were an unreasonable medical treatment. The evidence does not support a conclusion that Dr. Reeve did not believe medical marijuana to be a reasonable treatment for Worker.

3. Conclusion Regarding Necessary Medical Care

[*21] The aspect concerning necessary medical care is more difficult. Dr. Reeve did not testify that the medical marijuana treatment was necessary for Worker's care. Rather, when asked in his deposition whether he believed it was appropriate medical treatment because he had signed for it, Dr. Reeve stated that **[***12]** Worker was using marijuana, that such patients need a license for such use, and that he will sign for them if he is requested. He specified that in doing so he was not recommending marijuana use. He also considered the medical marijuana program to be a patient's decision "as it's private and voluntary and it's not overseen by a physician."

[*22] The WCJ decided from this evidence that medical marijuana was not necessary medical care for Worker. The question before us is whether there was substantial evidence for the WCJ to reach this conclusion. Under our standard of review, we must defer to the finder of fact and view the evidence in the most favorable light to the decision without disregarding contravening evidence.

[*23] Worker had the burden to establish that medical marijuana was a necessary medical treatment. *See Di Matteo v. Doña Ana Cnty., 1985-NMCA-099, ¶ 26, 104 N.M. 599, 725 P.2d 575* (stating under previous version of Workers' Compensation Act that ***HN9*** the worker had the burden of proving that his medical expenses were reasonably necessary). The evidence indicates that Dr. Reeve considered traditional pain management to have failed and planned to treat Worker with medical marijuana. Dr. Reeve also testified, however, that medical marijuana treatment is a patient's **[***13]** decision and that he will adopt it on a patient's request. The question before us distills to whether, considering all the evidence, the WCJ could reasonably have concluded that medical marijuana was not necessary medical care because Dr. Reeve merely acceded to Worker's choice and adopted medical marijuana as his treatment plan because Worker had begun to use it on his own.

[*24] We begin with the contravening evidence. Dr. Reeve's medical reports clearly state that he had treated Worker with traditional pain management and that such treatment had failed. The medical reports further state that Dr. Reeve was adopting medical marijuana as his treatment plan and would recommend its use for Worker. Dr. Reeve did so, certifying in Worker's re-enrollment form that Worker had "unrelieved symptoms that have failed other medical therapies." We consider this evidence to clearly establish that medical marijuana was necessary for Worker's treatment because (1) traditional pain management had failed and (2) it would not be possible for Dr. Reeve to institute or carry out his treatment plan without medical marijuana.

[*25] To support the WCJ's conclusion and to consider the evidence in the light most favorable **[***14]** to the WCJ's conclusion, we must be able to infer from Dr. Reeve's deposition testimony, as argued by Employer, that medical marijuana treatment was entirely Worker's **[**737]** choice and that Dr. Reeve certified Worker for the medical marijuana program only because Worker intended to use it regardless and asked Dr. Reeve for the certification. In this regard, Dr. Reeve testified that Worker had tested positive for marijuana, that patients use marijuana "either one way or the other[,]" and that he will sign for patients if requested. He further stated that he was "not recommending or distributing or in any way advocating for the use of medical cannabis."

[*26] But, even reading this evidence in the light most favorable to the WCJ's decision, we do not consider this testimony to be inconsistent with Dr. Reeve's medical records. There is no conflict in the evidence that Dr. Reeve addressed medical marijuana as a treatment for Worker because Worker had used marijuana and tested positive for it. Nor do we question that Dr. Reeve pursued medical marijuana as a treatment plan because Worker requested it. Dr. Reeve's testimony also indicates that, in adopting his treatment plan, he did not recommend medical **[***15]** marijuana to Worker or advocate its use. Dr. Reeve did not distribute medical marijuana to Worker. See *Section 26-2B-4(E)* (***HN10*** stating that a practitioner may not be subject to arrest, prosecution, or penalty for distributing medical marijuana under the Compassionate Use Act).

[*27] We must focus on the question at issue—whether medical marijuana was necessary medical care for Worker. The facts that Dr. Reeve did not initiate or recommend to Worker such care are not dispositive. Regardless of whether he took such action or was merely "passive," as Employer contends, Dr. Reeve adopted a treatment plan that called for medical marijuana. By the very nature of such treatment, medical marijuana was a necessary component. Dr.

Reeve then recommended Worker for receipt of medical marijuana by his certification. He did so, even though at Worker's request, because traditional pain management was not successful for Worker.

[*28] Perhaps most significantly, we cannot accept the contention, albeit implied, that Dr. Reeve would certify Worker for medical marijuana use solely on Worker's request regardless of whether it was appropriate for Worker's medical care. Marijuana is a controlled substance. The Compassionate Use Act makes **[***16]** an exception to the contraband use of marijuana only when necessary for medical treatment. *See* § 26-2B-2 (***HN11*** "The purpose of the [Compassionate Use Act] is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments."). Of course, a patient must wish to participate in the Compassionate Use Act program, but that law does not contemplate that individuals who wish to receive marijuana may do so merely upon request; it requires the certification by a professional. Nor does it contemplate that this professional certification will be issued in an irresponsible fashion. Dr. Reeve was familiar with the Compassionate Use Act program and testified that he was "one of only two doctors that I know of in the state that will sign for the medical cannabis[.]" We cannot infer from Dr. Reeve's testimony that he would certify Worker for the Compassionate Use Act program without exercising his medical judgment. Indeed, to the contrary, his medical records describe in detail the basis for his exercise of his medical judgment.

[*29] We additionally note that Dr. Reeve re-examined Worker on April 3, 2013 and reauthorized **[***17]** Worker for the Compassionate Use Act program. Dr. Reeve certified at that time that Worker continued to meet the eligibility requirements for the program and that Worker "has current unrelieved symptoms that have failed other medical therapies." This certification underscores Worker's need for medical marijuana therapy.

[*30] We thus read the evidence in the record as a whole as failing to support and as clearly opposed to the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care.

III. WORKER'S REFUSAL OF REASONABLE AND NECESSARY MEDICAL CARE

[*31] Employer also argues that, if medical marijuana is reasonable and necessary medical care, Employer should not be responsible **[**738]** to reimburse it because Worker refused the reasonable and necessary medical care that Dr. Reeve was providing to him. We address this argument because, if Employer is correct, we could affirm the WCJ's compensation order because it is right for a reason that it does not address. *See Davis v. Los Alamos Nat'l Lab., 1989-NMCA-023, ¶ 18, 108 N.M. 587, 775 P.2d 1304* (stating that ***HN12*** we will affirm the decision of a workers' compensation order if it is right for any reason).

[*32] However, we do not agree with Employer. Employer's argument is premised on its position that:

> It was Worker's **[***18]** own choice, and not Dr. Reeve's professional judgment of what constituted reasonable and necessary care, that first motivated the medical use of marijuana. Dr. Reeve's rationale for signing for the medical cannabis was not that he wasn't providing reasonable and necessary care, but rather that Worker was going to use marijuana regardless of whether Worker was taking narcotic pain medication.

[*33] As we have discussed, however, the substantial evidence in the record as a whole does not support the proposition that Dr. Reeve certified Worker for medical marijuana treatment merely because Worker had made that choice. The record, which includes Dr. Reeve's medical reports, does not support a conclusion that traditional pain medication was the sole reasonable and necessary treatment, precluding any other.

IV. CONCLUSION

[*34] Substantial evidence in the record as a whole does not support the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care. We therefore reverse the WCJ's compensation order.

[*35] IT IS SO ORDERED.

JAMES J. WECHSLER, Judge

WE CONCUR:

CYNTHIA A. FRY, Judge

MICHAEL E. VIGIL, Judge

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<u>*2016 ME Wrk. Comp. LEXIS 30*</u>

State of Maine Workers Compensation Board Appellate Division

August 23, 2016

Case No. App. Div. 15-0022; Decision No. 16-26

Reporter
2016 ME Wrk. Comp. LEXIS 30

GAETAN H. BOURGOIN

(Appellee)

v.

TWIN RIVERS PAPER CO., LLC,

(Appellant)

and

SEDGWICK CMS,

Disposition: affirmed

Notice:
[*1]

Any party in interest may request an appeal to the Maine Law Court by filing a copy of this decision with the clerk of the Law Court within twenty days of receipt of this decision and by filing a petition seeking appellate review within twenty days thereafter. *39-A M.R.S.A. § 322 (Supp. 2015)*.

Core Terms

medical marijuana, pain, marijuana, twin, narcotic, medical findings, clear and convincing evidence, medical treatment, chronic pain, side effect, reimbursement

Counsel

Attorney for Appellant: Anne-Marie L. Storey, Esq., John K. Hamer, Esq., Attorney for Appellee: Norman G. Trask, Esq.

Panel: PANEL MEMBERS: ADMINISTRATIVE LAW JUDGES JEROME, ELWIN, AND STOVALL; BY: ADMINISTRATIVE LAW JUDGE JEROME

Opinion

Oral Argument: December 9, 2015

Twin Rivers Paper Co. appeals from a decision of a Workers' Compensation Board administrative law judge (*Pelletier, ALJ*) granting Gaeton H. Bourgoin's Petition for Payment of Medical and Related Services regarding a March 3, 1989, work injury. The ALJ, rejecting the medical findings of an independent medical examiner (IME) appointed pursuant to 39-A M.R.S.A. § 312 (Supp. 2015), concluded that in this case, the use of medical marijuana constituted reasonable and proper medical treatment under 39-A M.R.S.A. § 206 (Supp. 2015), [1] and ordered Twin Rivers to reimburse **[*2]** Mr. Bourgoin for costs associated with its use.

Twin Rivers contends the ALJ erred because (1) the use of marijuana contravenes the federal Controlled Substances Act, 21 U.S.C. § 801 et seq.; (2) the order violates the restriction barring private health insurers from paying for medical marijuana set forth in the Maine Medical Use of Marijuana Act (MMUMA), 22 M.R.S.A. § 2426(2)(A) (Supp. 2015); and (3) there is insufficient clear and convincing evidence to contradict the IME's medical findings. We affirm the ALJ's decision.

I. BACKGROUND

Gaeton Bourgoin began working at Twin Rivers' paper mill (formerly owned by Fraser Paper) in Madawaska in 1980. On March 3, 1989, he suffered a work-related back injury. He went out of work in 1989 or early 1990, and has received total incapacity benefits from that time forward. Since 1993, Mr. Bourgoin has suffered from severe chronic pain syndrome. He experiences pain and muscle spasms in his back, legs, arms, and chest. He was diagnosed in the early 1990s with reflex sympathetic dystrophy (RSD), which causes him burning pain, mostly in his legs. He also suffers from psychological sequela of his back injury and related **[*3]** RSD.

Through the years, Mr. Bourgoin has tried many different treatments for his pain. He has traveled to the New England Medical Center in Boston, the Yale New Haven Pain Clinic in Connecticut, the Mayo Clinic in Minnesota, and to a neurologist in Florida. He is not a suitable candidate for surgery. He has been to pain management specialists and has tried numerous medications, including narcotics. He developed dependence on narcotic medications in the early 1990s.

For the last several years, Mr. Bourgoin has been treated for pain management by Dr. Sirdorczuk, a local general practitioner. Dr. Sirdorczuk, in consultation with Dr. Herland, a Bangor pain management specialist, prescribed a series of combinations of narcotic pain medications, none of which worked for Mr. Bourgoin, and caused side effects that included abdominal pain, nausea, and problems with sleep and urination. Dr. Sirdorczuk then prescribed non-narcotic medications, including suboxone, which were less effective for his pain and also caused side effects. Mr. Bourgoin was subsequently admitted to a psychiatric facility for chronic pain with insomnia and suicidal ideation.

After Mr. Bourgoin's hospitalization, Dr. **[*4]** Sirdorczuk, in consultation with Mr. Bourgoin's psychiatrist, recommended a trial of medical marijuana consistent with the MMUMA. [2] In January of 2012, Mr. Bourgoin obtained a medical marijuana program physician certification from Dr. Joseph Starkman, who works in the practice known as Integr8 Health, LLC, with Dr. Dustin Sulak in Falmouth, Maine. Such a certification contains a statement that in the physician's medical opinion, the medical marijuana will be used to treat "a patient's debilitating medical condition." 22 M.R.S.A. § 2423-B.

Mr. Bourgoin has been using medical marijuana for his pain since that time. He testified that his quality of life has improved, that he experiences significantly less pain, and he sleeps better. He no longer takes opioid pain medications or other narcotic drugs.

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[1] Title 39-A M.R.S.A. § 206 provides that " [a]n employee sustaining a personal injury arising out of and in the course of employment or disabled by occupational disease is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer."

[2] The Legislature enacted MMUMA to permit, conditionally, the use, possession, cultivation, and furnishing of marijuana for medicinal purposes, specifically for the purpose of treating a patient's debilitating medical condition, including chronic pain. 22 M.R.S.A. §§ 2423-A, 2423-B.

Mr. Bourgoin filed his Petition for Payment of Medical and Related Services, seeking reimbursement for costs associated with his use of medical marijuana. Twin Rivers argued that (1) treatment with medical marijuana cannot be considered reasonable and proper under section 206 because marijuana use is punishable by federal law; and (2) the **[*5]** board cannot require it to pay for medical marijuana pursuant to section 2426(2)(A) of MMUMA. Mr. Bourgoin underwent an independent medical examination with Dr. Renato Medrano. *39-A M.R.S.A. § 312*. Dr. Medrano opined that medical marijuana is not a reasonable and proper medical treatment under section 206 of the Workers' Compensation Act.

The ALJ considered and rejected Twin Rivers' arguments, found clear and convincing evidence in the record to contradict the IME's medical findings, and granted Mr. Bourgoin's petition. Twin Rivers filed a Motion for Additional Findings of Fact and Conclusions of Law, which the ALJ denied. Twin Rivers then filed this appeal.

II. DISCUSSION

I. Does Reimbursement for Medical Marijuana Violate the Federal Controlled Substances Act or Maine Medical Use of Marijuana Act?

Twin Rivers contends that the ALJ's decision is inconsistent with (1) the federal Controlled Substances Act, *21 U.S.C. § 801 et seq.*, which classifies marijuana as a Schedule I drug and makes the manufacturing, possession, distribution, and dispensing of marijuana a federal crime; and (2) section 2426(2)(A) of the MMUMA, which authorizes the use, possession, **[*6]** cultivation, and furnishing of marijuana for medicinal purposes, but protects public insurance programs and private health insurers from being required to pay for medical marijuana. For the reasons set forth in *Noll v. Lepage Bakeries, Me. W.C.B. No. 16-25, 2016 ME Wrk. Comp. LEXIS 29 (App. Div. en banc 2016)*, we reject Twin Rivers' arguments on these issues and affirm the ALJ's decision. [3]

II. Does the Record Contain Clear and Convincing Evidence to Support the ALJ's Determination that Medical Marijuana is Reasonable and Proper Medical Treatment?

Twin Rivers next contends that the ALJ's decision rejecting the IME's medical findings is not supported by clear and convincing evidence. We disagree.

In the course of this litigation, Mr. Bourgoin underwent an independent medical examination performed by Dr. Medrano. Dr. Medrano opined that treatment with marijuana is not reasonable and proper because marijuana is a Schedule I drug with no currently accepted medical use and a high potential for abuse. He also opined that there is no medical consensus regarding marijuana use, and there is inadequate scientific and medical research supporting the use of marijuana **[*7]** for medical purposes. He recommended continued use of strong narcotic medications for Mr. Bourgoin.

An administrative law judge is required to adopt the medical findings of an IME absent clear and convincing evidence to the contrary in the record. [4] *39-A M.R.S.A. § 312(7)*. "For purposes of section 312, this means that we determine whether the [ALJ] could have been reasonably persuaded by the contrary medical evidence that it was highly probable that the record did not support the IME's medical findings." *Dubois v. Madison Paper Co., 2002 ME 1, P 14, 795 A.2d 696*.

The ALJ rejected Dr. Medrano's opinion based on evidence that included medical records showing that Dr. Medrano's suggestion that "strong narcotic medications" be utilized to treat Mr. Bourgoin's pain had already been tried and had failed "miserably." The ALJ also relied upon evidence establishing that Mr. Bourgoin had been found to be dependent on or addicted to narcotics as far back as the early 1990's, and that previous efforts to stop the

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[3] Twin Rivers also asserts that ordering reimbursement for medical marijuana is not reasonable and proper because, due to the nature of medical marijuana dispensaries, receipts are not required to appear on the same billing forms as other treatments compensable under the Act. Thus, it contends, there can be no control or oversight over the billing, and the system lacks accountability and is ripe for fraud.

[4] Title 39-A M.R.S.A. § 312(7) provides:

opioids had resulted in side effects followed by psychiatric hospitalization with suicidal ideation. Further, he **[*8]** cited to evidence that treatment with other non-narcotic pain medications, such as suboxone, had either caused side effects which were problematic, or were inadequate to control his pain.

In addition, the ALJ relied on Dr. Sulak's testimony that opioid medications, while useful for acute or post-surgical pain, are not nearly as useful in treating chronic pain because of issues of tolerance, sensitization, and the need for dose escalation, as well as the potentially lethal side effects of large doses of narcotics. The ALJ also cited Dr. Sulak's testimony regarding the analgesic effects of marijuana, and medical records supporting Mr. Bourgoin's testimony that he had experienced significant benefit from using medical marijuana while treatment with opioids had been a failure. [5]

The evidence explicitly relied on by the ALJ shows that after a long history of unsuccessful treatment for pain with conventional pain control methods, medical marijuana has provided Mr. Bourgoin with some relief. Based on that evidence, the ALJ could have been reasonably persuaded that it was highly probable that the record did not support Dr. Medrano's medical **[*9]** findings on the issue of whether the use of medical marijuana is reasonable, proper, and necessary medical treatment for Mr. Bourgoin under *39-A M.R.S.A. § 206*. [6]

III. CONCLUSION

We conclude that the ALJ's decision, ordering Twin Rivers to reimburse Mr. Bourgoin for the costs associated with medical marijuana use, does not contravene any identified provision of the Federal Controlled Substances Act or section 2426(2) of the Maine Medical Use of Marijuana Act. We further conclude that the ALJ did not err in rejecting the IME's findings and concluding that the use of medical marijuana was reasonable, proper, and necessary medical treatment in this case.

The entry is:

The administrative law judge's decision is affirmed.

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5 Twin Rivers asserts that the ALJ improperly relied on Dr. Sulak's testimony as part of the clear and convincing evidentiary case against the IME's medical findings, because " [c]ontrary evidence [may] not include medical evidence not considered by the independent medical examiner. " 39-A M.R.S.A. § 312(7). Dr. Sulak's deposition was taken after the IME issued his report pursuant to section 312. However, Dr. Medrano was given a copy of Dr. Sulak's deposition transcript and reviewed that transcript before his own deposition; he was questioned about Dr. Sulak's medical opinion; and he articulated his points of disagreement with Dr. Sulak. Therefore, Dr. Sulak's testimony was considered by the IME, and the ALJ did not err when citing Dr. Sulak's testimony as part of the evidence required to meet the clear and convincing standard.

6 Research has disclosed only three appellate decisions, all from New Mexico, in which the courts ruled that legislatively-authorized medical marijuana use could be considered "reasonable and necessary" medical care under that state's Workers' Compensation Act. *Lewis v. American General Media* , 355 P.3d 850 (N.M. App. 2015); *Mayez v. Riley Industrial* , 347 P.3d 732 (N.M App. 2015); *Vialpando v. Ben's Automotive Servs.* , 331 P.3d 975 (N.M. App. 2014). Professor Larson suggests that these courts may have been disinclined to discontinue treatment that was providing some relief to the injured workers, who suffered from chronic pain and had been unsuccessfully treated with narcotic medications. 8 ARTHUR LARSON, LEX K. LARSON & THOMAS A. ROBINSON, LARSON'S WORKERS' COMPENSATION LAW § 94.06 (Matthew Bender, Rev. Ed. 2016).

2016 ME Wrk. Comp. LEXIS 29

State of Maine Workers Compensation Board Appellate Division

August 23, 2016

Case No. App. Div. 15-0061; Decision No. 16-25

Reporter
2016 ME Wrk. Comp. LEXIS 29

GARY A. NOLL

(Appellee)

v.

LEPAGE BAKERIES, INC.

(Appellant)

and

CANNON COCHRAN MANAGEMENT SERVICES, INC.

Prior History:

Noll v. Lepage Bakeries, Inc., 2015 ME Wrk. Comp. LEXIS 145 (2015)

Disposition: affirmed

Notice:
[*1]

Any party in interest may request an appeal to the Maine Law Court by filing a copy of this decision with the clerk of the Law Court within twenty days of receipt of this decision and by filing a petition seeking appellate review within twenty days thereafter. 39-A M.R.S.A. § 322 (Supp. 2015).

Core Terms

workers' compensation, reimburse, medical marijuana, self-insured, federal law, marijuana, private health, casualty, pain, insurance company, coverage, medical treatment, injured employee, disability, medicinal, medical use of marijuana, health insurance, carrier

Counsel

Attorney for Appellant: Elizabeth Knox Peck, Esq., Attorney for Appellee: David A. Chase, Esq.

Panel: EN BANC PANEL MEMBERS: ADMINISTRATIVE LAW JUDGES STOVALL, COLLIER, ELWIN, GOODNOUGH, JEROME, KNOPF, AND PELLETIER; BY: Administrative Law Judge Jerome

JAMES DONOVAN

Opinion

Argued: June 10, 2016

At issue in this case is whether an employer who is self-insured for purposes of workers' compensation may be ordered to reimburse an injured worker for costs associated with the reasonable and proper use of medicinal marijuana authorized by the Maine Medical Use of Marijuana Act. 22 M.R.S.A §§ 2421-2430-B (Supp. 2015) (MMUMA).

Lepage Bakeries, Inc., appeals from a decision of a Workers' Compensation Board administrative law judge (*Hirtle, ALJ*) granting Gary A. Noll's Petition for Payment of Medical and Related Services regarding a February 9, 2012, work injury. The ALJ ordered Lepage to reimburse **[*2]** Mr. Noll the cost of obtaining a medical marijuana certificate, medical marijuana, and a vaporizer to administer medical marijuana. Lepage contends that ordering it to reimburse Mr. Noll for medical marijuana and related expenses contravenes (1) federal law and puts it at risk of prosecution because the purchase, sale, and possession of marijuana, even for medical purposes, remains illegal under the Controlled Substances Act, 21 U.S.C.A. §§ 801-904; and (2) section 2426(2) of the MMUMA, which provides that a "private health insurer" cannot be required to reimburse a person for the costs associated with the medical use of marijuana. We affirm the ALJ's decision.

I. BACKGROUND

This case was decided on stipulated facts, which are reproduced here in full:

1. The employee sustained a low back injury on February 9, 2012 while making a delivery for Lepage Bakeries, Inc.

2. The employer paid the employee's lost time and medical benefits on a voluntary basis through January 1, 2015, when it filed a Notice of Controversy.

3. The January 2015 Notice of Controversy was filed to contest a specific medical treatment the employee requested reimbursement for: expenses **[*3]** associated with his use of medical marijuana.

4. The grounds for the employer's denial of the requested reimbursement are that medical marijuana is classified as a Schedule I drug under the Controlled Substances Act and is illegal under U.S. federal law.

5. The employee used prescription pain medications for his back pain, but had difficulty tolerating their side effects; whereupon his treating physiatrist, Dr. Ross, recommended he obtain a medical marijuana assessment.

6. Kevin Kenerson, D.O. assessed the employee and found him qualified for use of medical marijuana and a vaporizer in late 2014.

7. The employer selected a doctor to examine the employee in early 2015. The employer's Section 207 medical examiner, Dr. Peter Esponnette, stated in his report that the employee is "one of the exceptionally few people who have noncancerous pain, non-Aids related pain, etc. for whom medical marijuana is an excellent choice." He further stated he strongly advocates for the employee to use medical marijuana to treat his low back pain, especially as he has been able to discontinue his use of three other medications through his use of marijuana.

8. Based on the clear conflict between the **[*4]** current federal and state law as to the legality of the use of marijuana, the employer has refused to grant the employee's request for reimbursement of his medical marijuana expenses.

Based on these facts, the ALJ initially determined that despite Lepage's arguments, the risk of prosecution under federal law for reimbursing the employee was not sufficiently realistic to warrant denial of Mr. Noll's Petition for Payment of Medical and Related Services. Moreover, Lepage failed to identify any provision of the Controlled Substances Act that would render the conduct at issue illegal.

Nonetheless, the ALJ denied the petition on the ground that Mr. Noll did not meet his burden to establish that a self-insured employer like Lepage is not a "private health insurer" within the meaning of the MMUMA, 22 M.R.S.A. § 2426(2), and is therefore subject to Mr. Noll's requested relief.

Upon Mr. Noll's Motion for Additional Findings of Fact and Conclusions of Law, however, the ALJ granted the petition, determining that Lepage was not a private health insurer under the MMUMA and therefore could be required to reimburse Mr. Noll. The ALJ reasoned that the Workers' Compensation Act defines the term **[*5]** "employer" to include the self-insured employer, but excludes self-insured employers from the definitions of "insurance company," citing 39-A M.R.S.A. § 102(12), (14) (Supp. 2015). Thus, a self-insured employer is excluded from the meaning of "private health *insurer* ." (Emphasis added.)

The ALJ further reasoned:

[T]he Workers' Compensation Act defines an "insurance company" as "any casualty insurance company" that otherwise meets the requirements under Title 39-A M.R.S.A. § 102(14). The Maine Insurance Code defines health insurance and casualty insurance differently and names coverage under the Workers' Compensation Act as "casualty insurance" distinct from "health insurance. " 24-A M.R.S.A. §§ 704, 707. The distinction in Title 24-A is consistent with Title 39-A and the Workers' Compensation Act's definition [of] "insurance company" as "any casualty insurance company[.]" 39-A M.R.S.A. § 102(14). The definition of workers' compensation insurance as "casualty" instead of "health" insurance in multiple relevant sources excludes the Employer in this case from the meaning of a "private health insurer" as used in 22 M.R.S.A. § 2426(2)(A).

(Footnotes omitted.)

Finding no **[*6]** federal or Maine statutory bar to ordering reimbursement, the ALJ concluded that under the stipulated facts, medical marijuana constitutes "reasonable and proper" medical care for Mr. Noll pursuant to 39-A M.R.S.A. § 206, and granted the petition. Lepage filed this timely appeal. The executive director determined that the issues presented on appeal warranted consideration by the Appellate Division en banc. *See* Me. W.C.B. Rule, ch. 13, § 2(3).

II. DISCUSSION

A. Standard of Review

The role of the Appellate Division is "limited to assuring that the [ALJ's] factual findings are supported by competent evidence, that [the] decision involved no misconception of applicable law and that the application of the law to the facts was neither arbitrary nor without rational foundation." Pomerleau v. United Parcel Serv., 464 A.2d 206, 209 (Me. 1983) (quotation marks omitted).

"When construing provisions of the Workers' Compensation Act, our purpose is to give effect to the Legislature's intent." Hanson v. S.D. Warren Co., 2010 ME 51, P 12, 997 A.2d 730. "In so doing, we first look to the plain meaning of the statutory language, and construe that **[*7]** language to avoid absurd, illogical, or inconsistent results." *Id.* We also consider "the whole statutory scheme of which the section at issue forms a part so that a harmonious result, presumably the intent of the Legislature, may be achieved." Davis v. Scott Paper Co., 507 A.2d 581, 583 (Me. 1986); *see also* Graves v. Brockway Smith Co., 2012 ME 128, P 9, 55 A.3d 456.

B. Reimbursement for Medical Marijuana and Associated Costs

"An employee sustaining a personal injury arising out of and in the course of employment or disabled by occupational disease is entitled to reasonable and proper medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids, as needed, paid for by the employer." 39-A M.R.S.A. § 206 (Supp. 2015). The Legislature enacted MMUMA to permit, conditionally, the use, possession, cultivation, and furnishing of marijuana for medicinal purposes, specifically, for the purpose of treating or alleviating a patient's debilitating medical condition, including intractable pain. 22 M.R.S.A. §§ 2422(2), 2423-A, 2423-B. The ALJ concluded, and the

parties do not dispute on appeal, that Mr. Noll's use of medical **[*8]** marijuana constitutes reasonable and proper medical treatment, and reimbursement is not expressly prohibited by any provision of the Workers' Compensation Act. [1]

1. Conflict with Federal Law

Although Maine law allows for the medicinal use of marijuana, federal law does not. Under the Controlled Substances Act, 21 U.S.C.A. § 812(c), marijuana remains classified as a Schedule I drug; manufacturing, possession, distribution, and dispensing of marijuana remain a federal crime. 21 U.S.C.A. § 841(a)(1); *see also* Savage v. Me. Pretrial Servs., 2013 ME 9, P 17, 58 A.3d 1138 (stating that MMUMA authorizes conduct that would be otherwise illegal under federal law) . Because the federal government's authority to prosecute drug offenses supersedes state law authorizing use or possession of marijuana, *see* Gonzales v. Raich, 545 U.S. 1, 32-33, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005), Lepage contends that requiring reimbursement would make it complicit in the commission of a federal crime. Moreover, Lepage contends that the risk of prosecution under federal law presents a strong policy reason militating **[*9]** against reimbursement.

Research has disclosed only one appellate-level decision regarding payment for medical marijuana under workers' compensation laws that addresses the potential conflict with federal law, Vialpando v. Ben's Automotive Servs., 2014- NMCA 084, 331 P.3d 975 (N.M. App. 2014), *cert denied*, 331 P.3d 924, (N.M. 2014). [2] In *Vialpando*, the employer challenged a Workers' Compensation Judge's order requiring an employer to reimburse an injured employee for costs associated with the medicinal use of marijuana obtained pursuant to that state's Compassionate Use Act, N.M. Stat. Ann. §§ 26-2B-1 to 2B-7 (2007). Id. at 976. The employer contended that compelling reimbursement would require it to violate the federal Controlled Substances Act and the public policy reflected therein. Id. at 979. The New Mexico Court of Appeals affirmed the Workers' Compensation Judge's decision based on the employer's failure to identify any particular provision of the Controlled Substances Act that would be violated by reimbursement, and it declined to search for such a statute. Id. at 979-80. **[*10]** Further, the court found the expressions of public policy in federal law to be equivocal at best, noting that although marijuana remains illegal under the Controlled Substances Act, the Justice Department has indicated that interfering with state medical marijuana laws is not one of its enforcement priorities. Id. at 980. The court finally noted that New Mexico's public policy is clear and embodied in its Compassionate Care Act: "to allow the beneficial use of cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments." *Id.*

Citing Vialpando, the ALJ rejected Lepage's arguments, reasoning that "[t]he language of the Controlled Substances Act relied upon by [Lepage] makes no mention of the facts presented in this case and [Lepage] cites no persuasive authority for its argument that reimbursing a medical marijuana patient falls within the conduct prohibited by federal law. " The ALJ also cited to a Justice Department Memorandum articulating a policy of noninterference with states' rights regarding medical marijuana, further weakening Lepage's argument that reimbursement would place it at **[*11]** risk of prosecution for violating federal law. *See* Memorandum, James M.

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1 Although it was not an issue in controversy in this case, we note that three New Mexico Court of Appeals panels have held, in similar cases in which the employee had first unsuccessfully sought relief from significant pain through traditional treatment with opioids, that legislatively-authorized medical marijuana use could be considered "reasonable and necessary" medical care under that state's Workers' Compensation Act. *Lewis v. American General Media* , 355 P.3d 850 (N.M. App. 2015); *Mayez v. Riley Industrial* , 347 P.3d 732 (N.M App. 2015); *Vialpando v. Ben's Automotive Servs.* , 331 P.3d 975 (N.M. App. 2014). Professor Larson suggests that these courts may have been disinclined to discontinue treatment that was providing some relief to the injured workers. 8 ARTHUR LARSON, LEX K. LARSON & THOMAS A. ROBINSON, LARSON'S WORKERS' COMPENSATION LAW § 94.06 (Matthew Bender, Rev. Ed. 2016).

2 In Maine, Workers' Compensation Board Administrative Law Judges have approved the reimbursement of injured employees for costs associated with medical marijuana use in three additional cases. *Crandall Univ. of Me. System* , W.C.B. No. 08-00-3314 (July 15, 2015); *Doten v. Domtar Inds., Inc.* , W.C.B. No. 09-02-37-96 (July 8, 2015); *Bourgoin v. Twin Rivers Paper Co.* , W.C.B. No. 89-01-36-55 (March 16, 2015).

Cole, Deputy Attorney General, United States Dep't of Justice, *Guidance Regarding Marijuana Enforcement* (August 29, 2013). [3]

We agree with the ALJ's reasoning. The decision involved no misconception of applicable law or misapplication of the law to the facts, and it was neither arbitrary nor without rational foundation. Pomerleau, 464 A.2d at 209. We find no basis in federal law or policy identified by the parties that would preclude a self-insured employer from reimbursing an injured employee for costs associated with medical marijuana use pursuant to the MMUMA and the Workers' Compensation Act.

2. Private Health Insurer

We next decide whether section 2426(2)(A) of the MMUMA restricts the board from requiring Lepage to reimburse Mr. Noll for costs associated with medical use of marijuana. Title 22 M.R.S.A. § 2426(2)(A), provides:

This chapter may not be construed to require:

A. A government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana [.]

It is **[*12]** undisputed that Lepage is a self-insured employer for purposes of workers' compensation. Lepage contends that as such, it fits within the scope of the term "private health insurer" as that term is used in section 2426(2)(A). Lepage asserts that the ALJ's decision, resting on the Maine Insurance Code's distinction between casualty and health insurance (with workers' compensation being designated as casualty insurance) and the Workers' Compensation Act's definition of "insurance company," which does not specifically include the self-insured employer, fails to consider the overall purpose and practical application of the Act. It contends that the self-insured employer's obligation under the Workers' Compensation Act is the same as that of a private health insurer: when an employee obtains medical services as a result of a work-related injury, it is the self-insured employer's duty to promptly pay for those services either directly or by reimbursing the employee. 39-A M.R.S.A. § 206(7).

In support of its arguments, Lepage cites to Nichols v. S.D. Warren/Sappi, 2007 ME 103, 928 A.2d 732 (overruled in part by statute on other grounds). In that case, the Law Court had to **[*13]** decide whether a lump sum disability payment received by the employee pursuant to a permanent and total disability feature in an employer-funded life insurance policy constituted a payment "under a disability insurance policy," and was thus subject to offset under 39-A M.R.S.A. § 221(3)(A)(2). *Id. P 1*. The Court allowed the offset, determining that the "plain meaning of the term 'disability insurance policy' includes a payment pursuant to a disability feature in a policy that provides multiple coverages. " *Id. P 15*. The Court reasoned that "[t]he definitions of different types of insurance coverage are not mutually exclusive, and 'the inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which such coverage is likewise reasonably includable.' 24-A M.R.S. § 701 (2006)." *Id. P 12*.

We find the case of Deabay v. St. Regis Paper Co., 442 A.2d 963 (Me. 1981), to be more closely on point. In *Deabay*, the Law Court held that payments made by a health insurer could not be construed as payments made by the employer or its workers' compensation insurer for purposes of tolling the statute **[*14]** of limitations because the health insurer was not synonymous with the employer or the workers' compensation insurer. *Id. at 964*. The Court reasoned that the term "insurer" in the statute of limitations clearly contemplated workers' compensation carriers; payments made by the health insurer were not made pursuant to requirements of the Workers' Compensation Act; and the health insurer's liability was entirely independent from whatever liability the employer incurred under the Act. *Id.*

Accordingly, despite Lepage's arguments, we conclude that the plain meaning of "private health insurer" in 22 M.R.S.A. § 2426(2)(A) does not include an employer who is self-insured for purposes of workers' compensation.

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[3] Additionally, Professor Larson has observed:

"Private health insurer" is not defined in the MMUMA, nor elsewhere in Maine statutory law. As the ALJ noted, and looking at the broader statutory scheme, the Worker's Compensation Act includes "self-insurer" within the definition of "employer," not within the definition of "insurance company," 39-A M.R.S.A. § 102(12), (14); and Workers' Compensation insurance is characterized by statute as casualty insurance, not health insurance, *compare* 24-A M.R.S.A. § 707 **[*15]** *with* 24-A M.R.S.A. § 704.

Moreover, although both private health insurers and workers' compensation carriers are required to provide coverage for medical treatment, the Workers' Compensation Act is also a substitute for, and shields employers from, civil liability. 39-A M.R.S.A. §§ 103, 401 (2001 & Supp. 2015). As part of the "Grand Bargain," under the Act, employees lose their right to sue but gain the right to compensation for lost wages and reasonable and necessary medical care. In contrast, private health insurance is a benefit governed by a variety of state and federal laws. Those laws allow insurers and employers (within certain parameters) the right to limit medical treatment by excluding coverage for certain types of care and to require copayments or coinsurance. *See, e.g.*, 24-A M.R.S.A. §§ 4301-4320 (2015 & 2015 Supp.). The Workers' Compensation Act subjects employers and carriers to an entirely different set of legal and regulatory obligations with respect to liability for medical treatment. *See Deabay, 442 A.2d at 964*.

Finally, had the Legislature intended, it could have explicitly exempted workers' compensation insurance carriers and self-insured **[*16]** employers from the obligation to reimburse injured employees for costs associated with medical marijuana claims under the Workers' Compensation Act. [4] It did not.

III. CONCLUSION

We conclude that (1) no identified provision of federal law would preclude requiring a self-insured employer to reimburse an injured employee for the costs associated with the reasonable and proper medicinal use of marijuana pursuant to the MMUMA or the Workers' Compensation Act; and, (2) consistent with the statute's plain meaning, section 2426(2)(A) of the MMUMA does bar the board from requiring a self-insured employer to reimburse an injured employee for those costs.

The entry is:

The ALJ's decision is affirmed.

End of Document

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[4] As the ALJ noted, the Arizona Legislature has explicitly exempted workers' compensation carriers from reimbursing costs associated with the medical use of marijuana. Ariz. Rev. Stat. Ann. § 36-2814(A)(1) (2015).

Neutral
As of: September 23, 2016 3:03 PM EDT

United States v. McIntosh

United States Court of Appeals for the Ninth Circuit

December 7, 2015; August 16, 2016, Filed

No. 15-10117, No. 15-10122, No. 15-10127, No. 15-10132, No. 15-10137, No. 15-30098, No. 15-71158, No. 15-71174, No. 15-71179, No. 15-71225

Reporter
2016 U.S. App. LEXIS 15029

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STEVE MCINTOSH, Defendant-Appellant. UNITED STATES OF AMERICA, Plaintiff-Appellee, v. IANE LOVAN, Defendant-Appellant. UNITED STATES OF AMERICA, Plaintiff-Appellee, v. SOMPHANE MALATHONG, Defendant-Appellant.UNITED STATES OF AMERICA, Plaintiff-Appellee, v. VONG SOUTHY, Defendant-Appellant. UNITED STATES OF AMERICA, Plaintiff-Appellee, v. KHAMPHOU KHOUTHONG, Defendant-Appellant. UNITED STATES OF AMERICA, Plaintiff-Appellee, v. JERAD JOHN KYNASTON, AKA Jared J. Kynaston, AKA Jerad J. Kynaston; SAMUEL MICHAEL DOYLE, AKA Samuel M. Doyle; BRICE CHRISTIAN DAVIS, AKA Brice C. Davis; JAYDE DILLON EVANS, AKA Jayde D. Evans; TYLER SCOTT MCKINLEY, AKA Tyler S. McKinley, Defendants-Appellants. IN RE IANE LOVAN, IANE LOVAN, Petitioner, v. UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA, FRESNO, Respondent, UNITED STATES OF AMERICA, Real Party in Interest. IN RE SOMPHANE MALATHONG, SOMPHANE MALATHONG, Petitioner, v. UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA, FRESNO, Respondent, UNITED STATES OF AMERICA, Real Party in Interest. IN RE VONG SOUTHY, VONG SOUTHY, Petitioner, v. UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA, FRESNO, Respondent, UNITED STATES OF AMERICA, Real Party in Interest. IN RE KHAMPHOU KHOUTHONG, KHAMPHOU KHOUTHONG, Petitioner, v. UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF CALIFORNIA, FRESNO, Respondent, UNITED STATES OF AMERICA, Real Party in Interest.

Prior History: **[*1]** Appeal from the United States District Court for the Northern District of California. D.C. No. 3:14-cr-00016-MMC-3. Maxine M. Chesney, Senior District Judge, Presiding.

Appeals from the United States District Court for the Eastern District of California. D.C. No. 1:13-cr-00294-LJO-SKO-1, D.C. No. 1:13-cr-00294-LJO-SKO-2, D.C. No. 1:13-cr-00294-LJO-SKO-3, D.C. No. 1:13-cr-00294-LJO-SKO-4. Lawrence J. O'Neill, District Judge, Presiding.

Appeal from the United States District Court for the Eastern District of Washington. D.C. No. 2:12-cr-00016-WFN-1 Wm. Fremming Nielsen, Senior District Judge, Presiding.

Petitions for Writ of Mandamus. D.C. No. 1:13-cr-00294-LJO-SKO-1, D.C. No. 1:13-cr-00294-LJO-SKO-3, D.C. No. 1:13-cr-00294-LJO-SKO-2, D.C. No. 1:13-cr-00294-LJO-SKO-4.
United States v. Kynaston, 534 Fed. Appx. 624, 2013 U.S. App. LEXIS 15035 (9th Cir. Wash., 2013)

Disposition: VACATED AND REMANDED WITH INSTRUCTIONS.

Core Terms

medical marijuana, appropriations, prosecutions, funds, state law, district court, cultivation, authorize, marijuana, rider, individuals, prohibits, injunction, cases, injunctive relief, spending, implementing, manufacture, appeals, enjoin, marijuana plants, practical effect, orders, Dictionary, spending money, direct denial, federal court, separation-of-powers, requirements, principles

Case Summary

Overview

ISSUE: Whether criminal defendants may avoid prosecution for various federal marijuana offenses on the basis of a congressional appropriations rider that prohibits the U.S. Department of Justice (DOJ) from spending funds to prevent states' implementation of

their own medical marijuana laws. HOLDINGS: [1]-Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), prohibits the DOJ from spending money on actions that prevent the Medical Marijuana States giving practical effect to their state laws that authorize the use, distribution, possession, or cultivation of medical marijuana; [2]-At a minimum, § 542 prohibits DOJ from spending funds from relevant appropriations acts for the prosecution of individuals who engaged in conduct permitted by the State Medical Marijuana Laws and who fully complied with such laws.

Outcome

The court vacated the orders of the district courts and remanded with instructions to conduct an evidentiary hearing to determine whether defendants had complied with state law.

LexisNexis® Headnotes

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Authority of Appellate Court

HN1 Federal courts are courts of limited subject-matter jurisdiction, possessing only that power authorized both by the Constitution and by Congress. Before proceeding to the merits of a dispute, the court must assure itself that it has jurisdiction.

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Final Judgment Rule

HN2 The court of appeals' jurisdiction is typically limited to final decisions of the district court. In criminal cases, this prohibits appellate review until after conviction and imposition of sentence.

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Interlocutory Appeals

HN3 Under *28 U.S.C.S. § 1292(a)*, the courts of appeals shall have jurisdiction of appeals from: (1) Interlocutory orders of the district courts of the United States granting, continuing, modifying, refusing or dissolving injunctions, except where a direct review may be had in the Supreme Court. By its terms, *§ 1292(a)(1)* requires only an interlocutory order refusing an injunction.

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Interlocutory Appeals

HN4 While *28 U.S.C.S. § 1292(a)(1)* must be narrowly construed in order to avoid piecemeal litigation, it does permit appeals from orders that have the "practical effect" of denying an injunction, provided that the would-be appellant shows that the order "might have a serious, perhaps irreparable, consequence." The U.S. Court of Appeals for the Ninth Circuit finds nothing in Carson to suggest that the requirement of irreparable injury applies to appeals from orders specifically denying injunctions. Carson merely expanded the scope of appeals that do not fall within the meaning of the statute. Thus, Carson's requirements do not apply to appeals from the "direct denial of a request for an injunction."

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Interlocutory Appeals

HN5 In almost all federal criminal prosecutions, injunctive relief and interlocutory appeals will not be appropriate. Federal courts traditionally have refused, except in rare instances, to enjoin federal criminal prosecutions. An order by a federal court that relates only to the conduct or progress of litigation before that court ordinarily is not considered an injunction and therefore is not appealable under *28 U.S.C.S. § 1292(a)(1)*. Thus, in almost all circumstances, federal criminal defendants cannot obtain injunctions of their ongoing prosecutions, and orders by district courts relating solely to requests to stay ongoing federal prosecutions will not constitute appealable orders under *§ 1292(a)(1)*.

Criminal Law & Procedure > Appeals > Appellate Jurisdiction > Interlocutory Appeals

Constitutional Law > Congressional Duties & Powers > Spending & Taxation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN6 It is emphatically the exclusive province of the Congress not only to formulate legislative policies and mandate programs and projects, but also to establish their relative priority for the Nation. Once Congress, exercising its delegated powers, has decided the order of priorities in a given area, it is for the courts to enforce them when enforcement is sought. A court sitting in equity cannot ignore the judgment of Congress, deliberately expressed in legislation. When Congress has enacted a legislative restriction like the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), that expressly prohibits the Department of Justice from spending funds on certain actions, federal criminal

defendants may seek to enjoin the expenditure of those funds, and the court of appeals may exercise jurisdiction over a district court's direct denial of a request for such injunctive relief.

Criminal Law & Procedure > Jurisdiction & Venue > Jurisdiction

HN7 District courts in criminal cases have ancillary jurisdiction, which is the power of a court to adjudicate and determine matters incidental to the exercise of its primary jurisdiction over a cause under review.

Constitutional Law > The Judiciary > Case or Controversy > Standing

HN8 The doctrine of standing asks whether a litigant is entitled to have a federal court resolve his grievance. A court has an independent obligation to examine its own jurisdiction, and standing is perhaps the most important of the jurisdictional doctrines.

Constitutional Law > The Judiciary > Case or Controversy > Standing

Criminal Law & Procedure > Appeals > Appellate Jurisdiction

HN9 Constitutional limits on the court's jurisdiction are established by U.S. Const. art. III, which limits the jurisdiction of federal courts to "Cases" and "Controversies." U.S. Const. art. III, § 2. It demands that an "actual controversy" persist throughout all stages of litigation. That means that standing must be met by persons seeking appellate review. To have U.S. Const. art. III standing, a litigant must have suffered or be imminently threatened with a concrete and particularized "injury in fact" that is fairly traceable to the challenged action and likely to be redressed by a favorable judicial decision.

Constitutional Law > The Judiciary > Case or Controversy > Standing

HN10 One who seeks to initiate or continue proceedings in federal court must demonstrate, among other requirements, both standing to obtain the relief requested, and, in addition, an ongoing interest in the dispute on the part of the opposing party that is sufficient to establish concrete adverseness. When those conditions are met, U.S. Const. art. III does not restrict the opposing party's ability to object to relief being sought at its expense.

Constitutional Law > The Judiciary > Case or Controversy > Standing

HN11 Threatened prosecution may give rise to standing.

Constitutional Law > The Judiciary > Case or Controversy > Standing

Constitutional Law > Separation of Powers

HN12 The Bond decision concluded that, "if the constitutional structure of our Government that protects individual liberty is compromised, individuals who suffer otherwise justiciable injury may object." The U.S. Supreme Court explained that both federalism and separation-of-powers constraints in the Constitution serve to protect individual liberty, and a litigant in a proper case can invoke such constraints "when government acts in excess of its lawful powers." The Court gave numerous examples of cases in which private parties, rather than government departments, were able to rely on separation-of-powers principles in otherwise jusiticiable cases or controversies. In another decision, the Court recognized, of course, that the separation of powers can serve to safeguard individual liberty and that it is the duty of the judicial department--in a separation-of-powers case as in any other--to say what the law is.

Constitutional Law > Congressional Duties & Powers > Spending & Taxation

HN13 The Appropriations Clause of the Constitution, refer to *U.S. Const. art. I, § 9, cl. 7*, provides that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law."). This straightforward and explicit command means simply that no money can be paid out of the Treasury unless it has been appropriated by an act of Congress. Money may be paid out only through an appropriation made by law; in other words, the payment of money from the Treasury must be authorized by a statute.

Constitutional Law > Congressional Duties & Powers > Spending & Taxation

Constitutional Law > Separation of Powers

HN14 The Appropriations Clause plays a critical role in the Constitution's separation of powers among the three branches of government and the checks and balances between them. Any exercise of a power granted by the Constitution to one of the other branches of Government is limited by a valid reservation of congressional control over funds in the Treasury. The Clause has a

fundamental and comprehensive purpose to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good and not according to the individual favor of Government agents. Without it, Justice Story explained, the executive would possess an unbounded power over the public purse of the nation; and might apply all its moneyed resources at his pleasure.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN15 None of the funds made available in this Act to the Department of Justice may be used, with respect to Medical Marijuana States to prevent any of them from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015).

Governments > Legislation > Interpretation

Governments > Legislation > Effect & Operation

HN16 It is a fundamental canon of statutory construction that, unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning. Regarding the plain meaning of "prevent any of the Medical Marijuana States from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana"--the pronoun "them" refers back to the Medical Marijuana States, and "their own laws" refers to the state laws of the Medical Marijuana States. And "implement" means: To "carry out, accomplish; esp.: to give practical effect to and ensure of actual fulfillment by concrete measure." Implement, Merriam-Webster's Collegiate Dictionary (11th ed. 2003); "To put into practical effect; carry out." Implement, American Heritage Dictionary of the English Language (5th ed. 2011); and "To complete, perform, carry into effect (a contract, agreement, etc.); to fulfil (an engagement or promise)." Implement, Oxford English Dictionary, www.oed.com. The court may follow the common practice of consulting dictionaries to determine ordinary meaning.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN17 In sum, Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), prohibits the Department of Justice from spending money on actions that prevent the Medical Marijuana States giving practical effect to their state laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

Governments > Legislation > Interpretation

Criminal Law & Procedure > Criminal Offenses > Controlled Substances > Delivery, Distribution & Sale

Criminal Law & Procedure > Criminal Offenses > Controlled Substances > Possession

HN18 Statutory language cannot be construed in a vacuum. It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme. The court must read the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), with a view to its place in the overall statutory scheme for marijuana regulation, namely the Controlled Substances Act (CSA) and the State Medical Marijuana Laws. The CSA prohibits the use, distribution, possession, or cultivation of any marijuana. *21 U.S.C.S. §§ 841(a)*, *844(a)*. The State Medical Marijuana Laws are those state laws that authorize the use, distribution, possession, or cultivation of medical marijuana. Thus, the CSA prohibits what the State Medical Marijuana Laws permit.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN19 In light of the ordinary meaning of the terms of Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), and the relationship between the relevant federal and state laws, the court considers whether a superior authority, which prohibits certain conduct, can prevent a subordinate authority from implementing a rule that officially permits such conduct by punishing individuals who are engaged in the conduct officially permitted by the lower authority. The court concludes that it can.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN20 At a minimum, Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), prohibits the Department of Justice from spending funds from relevant appropriations acts for the

prosecution of individuals who engaged in conduct permitted by the State Medical Marijuana Laws and who fully complied with such laws.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN21 "Law" has many different meanings, including the following definitions that appear most relevant to Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015): "The aggregate of legislation, judicial precedents, and accepted legal principles; the body of authoritative grounds of judicial and administrative action; esp., the body of rules, standards, and principles that the courts of a particular jurisdiction apply in deciding controversies brought before them." "The set of rules or principles dealing with a specific area of a legal system." Law, Black's Law Dictionary (10th ed. 2014); and: "1. a. The body of rules, whether proceeding from formal enactment or from custom, which a particular state or community recognizes as binding on its members or subjects. (In this sense usually the law.)." "One of the individual rules which constitute the 'law' (sense 1) of a state or polity. The plural has often a collective sense. approaching sense 1." Law, Oxford English Dictionary, www.oed.com. The relative pronoun "that" restricts "laws" to those laws authorizing the use, distribution, possession, or cultivation of medical marijuana.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN22 In sum, the ordinary meaning of Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), prohibits the Department of Justice from preventing the implementation of the Medical Marijuana States' laws or sets of rules and only those rules that authorize medical marijuana use.

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN23 Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), prohibits the federal government only from preventing the implementation of those specific rules of state law that authorize the use, distribution, possession, or cultivation of medical marijuana. DOJ does not prevent the implementation of rules authorizing conduct when it prosecutes individuals who engage in conduct unauthorized under state medical marijuana laws. Individuals who do not strictly comply with all state-law conditions regarding the use, distribution, possession, and cultivation of medical marijuana have engaged in conduct that is unauthorized, and prosecuting such individuals does not violate § 542. Congress could easily have drafted § 542 to prohibit interference with laws that address medical marijuana or those that regulate medical marijuana, but it did not. Instead, it chose to proscribe preventing states from implementing laws that authorize the use, distribution, possession, and cultivation of medical marijuana.

Governments > Legislation > Effect & Operation

Governments > Legislation > Interpretation

HN24 It is a fundamental principle of appropriations law that the court may only consider the text of an appropriations rider, not expressions of intent in legislative history. An agency's discretion to spend appropriated funds is cabined only by the text of the appropriation, not by Congress' expectations of how the funds will be spent, as might be reflected by legislative history. As the U.S. Supreme Court has said (in a case involving precisely the issue of Executive compliance with appropriation laws, although the principle is one of general applicability): "legislative intention, without more, is not legislation."

Governments > Legislation > Effect & Operation

Criminal Law & Procedure > Criminal Offenses > Controlled Substances

Criminal Law & Procedure > Commencement of Criminal Proceedings

HN25 To be clear, Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015), does not provide immunity from prosecution for federal marijuana offenses.

Civil Procedure > Remedies > Writs > All Writs Act

Civil Procedure > ... > Writs > Common Law Writs > Mandamus

HN26 The court has jurisdiction under the All Writs Act, 28 U.S.C.S. § 1651, to "issue all writs necessary or appropriate in aid of our jurisdiction and agreeable to the usages and principles of law." 28 U.S.C.S. § 1651. The writ of mandamus is a drastic and extraordinary

remedy reserved for really extraordinary causes.

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Judges: Before: Diarmuid F. O'Scannlain, Barry G. Silverman, and Carlos T. Bea, Circuit Judges. Opinion by Judge O'Scannlain.

Opinion by: Diarmuid F. O'Scannlain

Opinion

O'SCANNLAIN, Circuit Judge:

We are asked to decide whether criminal defendants may avoid prosecution for various **[*5]** federal marijuana offenses on the basis of a congressional appropriations rider that prohibits the United States Department of Justice from spending funds to prevent states' implementation of their own medical marijuana laws.

I

A

These ten cases are consolidated interlocutory appeals and petitions for writs of mandamus arising out of orders entered by three district courts in two states within our circuit.[1] All Appellants have been indicted for various infractions of the Controlled Substances Act (CSA). They have moved to dismiss their indictments or to enjoin their prosecutions on the grounds that the Department of Justice (DOJ) is prohibited from spending funds to prosecute them.

In *McIntosh*, five codefendants allegedly **[*6]** ran four marijuana stores in the Los Angeles area known as Hollywood Compassionate Care (HCC) and Happy Days, and nine indoor marijuana grow sites in the San Francisco and Los Angeles areas. These codefendants were indicted for conspiracy to manufacture, to possess with intent to distribute, and to distribute more than 1000 marijuana plants in violation of 21 U.S.C. §§ 846, 841(a)(1), 841(b)(1)(A). The government sought forfeiture derived from such violations under 21 U.S.C. § 853.

In *Lovan*, the U.S. Drug Enforcement Agency and Fresno County Sheriff's Office executed a federal

[1] Appellants filed one appeal in *United States v. McIntosh*, No. 15-10117, arising out of the Northern District of California; one appeal in *United States v. Kynaston*, No. 15-30098, arising out of the Eastern District of Washington; and four appeals with four corresponding petitions for mandamus—Nos. 15-10122, 15-10127, 15-10132, 15-10137, 15-71158, 15-71174, 15-71179, 15-71225, which we shall address as *United States v. Lovan*—arising out of the Eastern District of California.

search warrant on 60 acres of land located on North Zedicker Road in Sanger, California. Officials allegedly located more than 30,000 marijuana plants on this property. Four codefendants were indicted for manufacturing 1000 or more marijuana plants and for conspiracy to manufacture 1000 or more marijuana plants in violation of 21 U.S.C. §§ 841(a)(1), 846.

In *Kynaston*, five codefendants face charges that arose out of the execution of a Washington State search warrant related to an investigation into violations of Washington's Controlled Substances Act. Allegedly, a total of 562 "growing marijuana plants," along with another 677 pots, some of which appeared to have the root structures of **[*7]** suspected harvested marijuana plants, were found. The codefendants were indicted for conspiring to manufacture 1000 or more marijuana plants, manufacturing 1000 or more marijuana plants, possessing with intent to distribute 100 or more marijuana plants, possessing a firearm in furtherance of a Title 21 offense, maintaining a drug-involved premise, and being felons in possession of a firearm in violation of 18 U.S.C. §§ 922(g)(1), 924(c)(1)(A)(i) and 21 U.S.C. §§ 841, 856(a)(1).

B

In December 2014, Congress enacted the following rider in an omnibus appropriations bill funding the government through September 30, 2015:

> None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

Consolidated and **[*8]** Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 538, 128 Stat. 2130, 2217 (2014). Various short-term measures extended the appropriations and the rider through December 22, 2015. On December 18, 2015, Congress enacted a new appropriations act, which appropriates funds through the fiscal year ending September 30, 2016, and includes essentially the same rider in § 542. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015) (adding Guam and Puerto Rico and changing "prevent such States from implementing their own State laws" to "prevent any of them from implementing their own laws").

Appellants in *McIntosh, Lovan*, and *Kynaston* filed motions to dismiss or to enjoin on the basis of the rider. The motions were denied from the bench in hearings in *McIntosh* and *Lovan*, while the court in *Kynaston* filed a short written order denying the motion after a hearing. In *McIntosh* and *Kynaston*, the court concluded that defendants had failed to carry their burden to demonstrate their compliance with state medical marijuana laws. In *Lovan*, the court concluded that the determination of compliance with state law would depend on facts found by the jury in a federal prosecution, and thus it would revisit the defendants' motion after the trial.

Appellants in all **[*9]** three cases filed interlocutory appeals, and Appellants in *McIntosh* and *Lovan* ask us to consider issuing writs of mandamus if we do not assume jurisdiction over the appeals.

II

HN1 Federal courts are courts of limited subject-matter jurisdiction, possessing only that power authorized both by the Constitution and by Congress. *See* Gunn v. Minton, 133 S. Ct. 1059, 1064, 185 L. Ed. 2d 72 (2013). Before proceeding to the merits of this dispute, we must assure ourselves that we have jurisdiction. *See* Steel Co. v. Citizens for a Better Env't, 523 U.S. 83, 95, 118 S. Ct. 1003, 140 L. Ed. 2d 210 (1998).

A

The parties dispute whether Congress has authorized us to exercise jurisdiction over these interlocutory appeals. ***HN2*** "Our jurisdiction is typically limited to final decisions of the district court." United States v. Romero-Ochoa, 554 F.3d 833, 835 (9th Cir. 2009). "In criminal cases, this prohibits appellate review until after conviction and imposition of sentence." Midland Asphalt Corp. v. United States, 489 U.S. 794, 798, 109 S. Ct. 1494, 103 L. Ed. 2d 879 (1989). In the cases before us, no Appellants have been convicted or sentenced. Therefore, unless some exception to the general rule applies, we should not reach the merits of this dispute. Appellants invoke three possible avenues for reaching the merits: jurisdiction over an order refusing an injunction, jurisdiction under the collateral order doctrine, and the writ of mandamus. We address the

first of these three avenues.

1

HN3 Under 28 U.S.C. § 1292(a), "the courts of appeals shall have **[*10]** jurisdiction of appeals from: (1) Interlocutory orders of the district courts of the United States . . . granting, continuing, modifying, *refusing* or dissolving *injunctions*, . . . except where a direct review may be had in the Supreme Court." (emphasis added). By its terms, § 1292(a)(1) requires only an interlocutory order refusing an injunction. Nonetheless, relying on *Carson v. American Brands, Inc.*, 450 U.S. 79, 84, 101 S. Ct. 993, 67 L. Ed. 2d 59 (1981), the government argues that § 1292(a)(1) requires Appellants to show that the interlocutory order (1) has the effect of refusing an injunction; (2) has a serious, perhaps irreparable, consequence; and (3) can be effectually challenged only by immediate appeal.

The government's reliance on *Carson* is misplaced in light of our precedent interpreting that case. In *Shee Atika v. Sealaska Corp.*, we explained:

> In *Carson*, the Supreme Court considered whether section 1292(a)(1) permitted appeal from an order denying the parties' joint motion for approval of a consent decree that contained an injunction as one of its provisions. Because the order did not, on its face, deny an injunction, an appeal from the order did not fall precisely within the language of section 1292(a)(1). The Court nevertheless permitted the appeal. The Court stated that, ***HN4*** while section 1292(a)(1) must be narrowly construed in order **[*11]** to avoid piecemeal litigation, it does permit appeals from orders that have the "practical effect" of denying an injunction, provided that the would-be appellant shows that the order "might have a serious, perhaps irreparable, consequence."
>
> We find nothing in *Carson* to suggest that the requirement of irreparable injury applies to appeals from orders specifically denying injunctions. *Carson* merely expanded the scope of appeals that do not fall within the meaning of the statute. Sealaska appeals from the direct denial of a request for an injunction. *Carson*, therefore, is simply irrelevant.

39 F.3d 247, 249 (9th Cir. 1994) (citations omitted); *accord* Paige v. California, 102 F.3d 1035, 1038 (9th Cir. 1996); *see also* Shee Atika, 39 F.3d at 249 n.2 (noting that its conclusion was consistent with "the overwhelming majority of courts of appeals that have considered the issue" and collecting cases). Thus, Carson's requirements do not apply to appeals from the "direct denial of a request for an injunction." Shee Atika, 39 F.3d at 249.

2

In the cases before us, the district courts issued direct denials of requests for injunctions. Lovan, for instance, requested injunctive relief in the conclusion of his opening brief: "Therefore, the Court should dismiss all counts against Mr. Lovan based upon alleged violations of 21 U.S.C. § 841 and/or enjoin the Department **[*12]** of Justice from taking any further action against the defendants in this case unless and until the Department can show such action does not involve the expenditure of any funds in violation of the Appropriations Act." At the hearing, Lovan's counsel made exceptionally clear that his motion sought injunctive relief in the alternative:

> THE COURT: But remember, your remedy is not because you are upset that the Department of Justice is spending taxpayer money. Your remedy is a dismissal, which is what you are seeking now, is it not?
>
> MR. FARKAS: And your Honor, as an alternative in our motion, we ask for a stay of these proceedings, asked this Court to enjoin the Department of Justice from spending any funds to prosecute Mr. Lovan if this Court finds he is in conformity with the California Compassionate Use Act. So it is a motion to dismiss or, alternatively, a motion to enjoin until Congress designates funds for that purpose.

Shortly thereafter, Lovan's counsel reiterated: "[W]e would ask either for a dismissal or to enjoin the government from spending any funds that were not appropriated under the Appropriations Act." At the close of the hearing, Lovan's counsel even explicitly argued that the **[*13]** district court's denial of injunctive relief would be appealable immediately: "I believe this might be the type of collateral order that is appealable to the Ninth Circuit immediately. As I said, we are asking for an injunction." The district court denied Lovan's motion, which clearly requested injunctive relief.

Similarly, in *Kynaston*, the opening brief in support of the motion began and ended with explicit requests for injunctive relief. Subsequent filings by other defendants in that case referenced the injunctive relief sought, and one discussed at length how courts of equity should exercise their jurisdiction. The district court denied the motion, which clearly sought injunctive relief.

In *McIntosh*, the defendant requested injunctive relief in

his moving papers, and he mentioned his request for injunctive relief three times in his reply brief. At the hearing, the question of injunctive relief did not arise, and the district court said simply that it was denying the motion. Although McIntosh could have emphasized the equitable component of his request more, we conclude that he raised the issue sufficiently for the denial of his motion to constitute a direct denial of a request for **[*14]** an injunction.

Therefore, we have jurisdiction under 28 U.S.C. § 1292(a)(1) to consider the interlocutory appeals from these direct denials of requests for injunctions.

3

We note the unusual circumstances presented by these cases. ***HN5*** In almost all federal criminal prosecutions, injunctive relief and interlocutory appeals will not be appropriate. Federal courts traditionally have refused, except in rare instances, to enjoin federal criminal prosecutions. *See* Ackerman v. Int'l Longshoremen's Union, 187 F.2d 860, 868 (9th Cir. 1951); Argonaut Mining Co. v. McPike, 78 F.2d 584, 586 (9th Cir. 1935); Stolt-Nielsen, S.A. v. United States, 442 F.3d 177, 185 (3d Cir. 2006); Deaver v. Seymour, 822 F.2d 66, 69, 261 U.S. App. D.C. 334 (D.C. Cir. 1987). "An order by a federal court that relates only to the conduct or progress of litigation before that court ordinarily is not considered an injunction and therefore is not appealable under § 1292(a)(1)." Gulfstream Aerospace Corp. v. Mayacamas Corp., 485 U.S. 271, 279, 108 S. Ct. 1133, 99 L. Ed. 2d 296 (1988). Thus, in almost all circumstances, federal criminal defendants cannot obtain injunctions of their ongoing prosecutions, and orders by district courts relating solely to requests to stay ongoing federal prosecutions will not constitute appealable orders under § 1292(a)(1).

Here, however, Congress has enacted an appropriations rider that specifically restricts DOJ from spending money to pursue certain activities. ***HN6*** It is "emphatically . . . the exclusive province of the Congress not only to formulate legislative policies and mandate programs and projects, but also to establish **[*15]** their relative priority for the Nation. Once Congress, exercising its delegated powers, has decided the order of priorities in a given area, it is for . . . the courts to enforce them when enforcement is sought." Tenn. Valley Auth. v. Hill, 437 U.S. 153, 194, 98 S. Ct. 2279, 57 L. Ed. 2d 117 (1978); *accord* United States v. Oakland Cannabis Buyers' Co-op., 532 U.S. 483, 497, 121 S. Ct. 1711, 149 L. Ed. 2d 722 (2001). A "court sitting in equity cannot 'ignore the judgment of Congress, deliberately expressed in legislation.'" Oakland Cannabis, 532 U.S. at 497 (quoting Virginian Ry. Co. v. Sys. Fed'n No. 40, 300 U.S. 515, 551, 57 S. Ct. 592, 81 L. Ed. 789 (1937)). Even if Appellants cannot obtain injunctions of their prosecutions themselves, they can seek—and have sought—to enjoin DOJ from *spending funds* from the relevant appropriations acts on such prosecutions.[2] When Congress has enacted a legislative restriction like § 542 that expressly prohibits DOJ from spending funds on certain actions, federal criminal defendants may seek to enjoin the expenditure of those funds, and we may exercise jurisdiction over a district court's direct denial of a request for such injunctive relief.

B

1

As part of our jurisdictional inquiry, we must consider whether Appellants have standing to complain that DOJ is spending money that has not been appropriated by Congress. ***HN8*** "The doctrine of standing asks whether a litigant is entitled to have a federal court resolve his grievance." Kowalski v. Tesmer, 543 U.S. 125, 128, 125 S. Ct. 564, 160 L. Ed. 2d 519 (2004). Although the government concedes that Appellants have standing, we have an "independent obligation to examine [our] own jurisdiction, and standing is perhaps the most important of the jurisdictional doctrines." United States v. Hays, 515 U.S. 737, 742, 115 S. Ct. 2431, 132 L. Ed. 2d 635 (1995) (internal quotation marks and alterations omitted).

HN9 Constitutional limits on our jurisdiction are established by Article III, which limits the jurisdiction of federal courts to "Cases" and "Controversies." U.S. Const. art. III, § 2. It "demands that an 'actual controversy' persist throughout all stages of litigation. That means that standing 'must be met by persons

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[2] We need not decide in the first instance exactly how the district courts should resolve claims that DOJ is spending money to prosecute a defendant in violation of an appropriations rider. We therefore take no view on the precise relief required and leave that issue to the district courts in the first instance. We note that ***HN7*** district courts **[*16]** in criminal cases have ancillary jurisdiction, which "is the power of a court to adjudicate and determine matters incidental to the exercise of its primary jurisdiction over a cause under review." United States v. Sumner, 226 F.3d 1005, 1013-15 (9th Cir. 2000); *see* Kokkonen v. Guardian Life Ins. Co. of Am., 511 U.S. 375, 378-80, 114 S. Ct. 1673, 128 L. Ed. 2d 391 (1994); Garcia v. Teitler, 443 F.3d 202, 206-10 (2d Cir. 2006).

seeking appellate review . . . .'" Hollingsworth v. Perry, 133 S. Ct. 2652, 2661, 186 L. Ed. 2d 768 (2013) (citations omitted). To have Article III standing, a litigant "must have suffered or be imminently threatened with a concrete **[*17]** and particularized 'injury in fact' that is fairly traceable to the challenged action . . . and likely to be redressed by a favorable judicial decision." Lexmark Int'l, Inc. v. Static Control Components, Inc., 134 S. Ct. 1377, 1386, 188 L. Ed. 2d 392 (2014).

In *Bond v. United States*, the Supreme Court addressed a situation similar to the cases before us. 564 U.S. 211, 131 S. Ct. 2355, 180 L. Ed. 2d 269 (2011). There, the Third Circuit had concluded that the criminal defendant lacked "standing to challenge a federal statute on grounds that the measure interferes with the powers reserved to States," and the Supreme Court reversed. Id. at 216, 226.

The Court explained that ***HN10*** "[o]ne who seeks to initiate or continue proceedings in federal court must demonstrate, among other requirements, both standing to obtain the relief requested, and, in addition, an 'ongoing interest in the dispute' on the part of the opposing party that is sufficient to establish 'concrete adverseness.'" Id. at 217 (citations omitted). "When those conditions are met, Article III does not restrict the opposing party's ability to object to relief being sought at its expense." *Id.* "The requirement of Article III standing thus had no bearing upon [the defendant's] capacity to assert defenses in the District Court." *Id.*

Applying those principles to the defendant's standing to appeal, the Court concluded that **[*18]** it was "clear Article III's prerequisites are met. Bond's challenge to her conviction and sentence 'satisfies the case-or-controversy requirement, because the incarceration . . . constitutes a concrete injury, caused by the conviction and redressable by invalidation of the conviction.'" *Id.* Here, Appellants have not yet been deprived of liberty via a conviction, but their indictments imminently threaten such a deprivation. *Cf.* Susan B. Anthony List v. Driehaus, 134 S. Ct. 2334, 2342-47, 189 L. Ed. 2d 246 (2014) ***HN11*** (threatened prosecution may give rise to standing). They clearly had Article III standing to pursue their challenges below because they were merely objecting to relief sought at their expense. And they have standing on appeal because their potential convictions constitute concrete, particularized, and imminent injuries, which are caused by their prosecutions and redressable by injunction or dismissal of such prosecutions. *See* Bond, 564 U.S. at 217.

After addressing Article III standing, ***HN12*** the *Bond* Court concluded that, "[i]f the constitutional structure of our Government that protects individual liberty is compromised, individuals who suffer otherwise justiciable injury may object." Id. at 223. The Court explained that both federalism and separation-of-powers constraints in the Constitution serve **[*19]** to protect individual liberty, and a litigant in a proper case can invoke such constraints "[w]hen government acts in excess of its lawful powers." Id. at 220-24. The Court gave numerous examples of cases in which private parties, rather than government departments, were able to rely on separation-of-powers principles in otherwise jusiticiable cases or controversies. *See* id. at 223 (citing Free Enter. Fund v. Pub. Co. Accounting Oversight Bd., 561 U.S. 477, 130 S. Ct. 3138, 177 L. Ed. 2d 706 (2010); Clinton v. City of New York, 524 U.S. 417, 433-36, 118 S. Ct. 2091, 141 L. Ed. 2d 393 (1998); Plaut v. Spendthrift Farm, Inc., 514 U.S. 211, 115 S. Ct. 1447, 131 L. Ed. 2d 328 (1995); Bowsher v. Synar, 478 U.S. 714, 106 S. Ct. 3181, 92 L. Ed. 2d 583 (1986); INS v. Chadha, 462 U.S. 919, 103 S. Ct. 2764, 77 L. Ed. 2d 317 (1983); N. Pipeline Constr. Co. v. Marathon Pipe Line Co., 458 U.S. 50, 102 S. Ct. 2858, 73 L. Ed. 2d 598 (1982); Youngstown Sheet & Tube Co. v. Sawyer, 343 U.S. 579, 72 S. Ct. 863, 96 L. Ed. 1153, 62 Ohio Law Abs. 417 (1952); A.L.A. Schechter Poultry Corp. v. United States, 295 U.S. 495, 55 S. Ct. 837, 79 L. Ed. 1570 (1935)).

The Court reiterated this principle in NLRB v. Noel Canning, 134 S. Ct. 2550, 189 L. Ed. 2d 538 (2014). There, the Court granted relief to a private party challenging an order against it on the basis that certain members of the National Labor Relations Board had been appointed in excess of presidential authority under the Recess Appointments Clause, another separation-of-powers constraint. Id. at 2557. The Court "recognize[d], of course, that the separation of powers can serve to safeguard individual liberty and that it is the 'duty of the judicial department'—in a separation-of-powers case as in any other—'to say what the law is.'" Id. at 2559-60 (citing Clinton, 524 U.S. at 449-50 (Kennedy, J., concurring), and quoting Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177, 2 L. Ed. 60 (1803)); *see also* id. at 2592-94 (Scalia, J., concurring in the judgment) (discussing at great length how the separation of powers protects individual liberty).

Thus, Appellants have standing to invoke separation-of-powers provisions of the Constitution to challenge **[*20]** their criminal prosecutions.

2

Here, Appellants complain that DOJ is spending funds that have not been appropriated by Congress in violation of ***HN13*** the Appropriations Clause of the Constitution. *See* U.S. Const. art. I, § 9, cl. 7 ("No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . . ."). This "straightforward and explicit command . . . means simply that no money can be paid out of the Treasury unless it has been appropriated by an act of Congress." Office of Pers. Mgmt. v. Richmond, 496 U.S. 414, 424, 110 S. Ct. 2465, 110 L. Ed. 2d 387 (1990) (citation omitted). "Money may be paid out only through an appropriation made by law; in other words, the payment of money from the Treasury must be authorized by a statute." *Id.*

HN14 The Appropriations Clause plays a critical role in the Constitution's separation of powers among the three branches of government and the checks and balances between them. "Any exercise of a power granted by the Constitution to one of the other branches of Government is limited by a valid reservation of congressional control over funds in the Treasury." *Id. at 425*. The Clause has a "fundamental and comprehensive purpose . . . to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good and not according to the individual favor of Government agents." *Id. at 427-28*. Without it, Justice **[*21]** Story explained, "the executive would possess an unbounded power over the public purse of the nation; and might apply all its moneyed resources at his pleasure." *Id. at 427* (quoting 2 Joseph Story, *Commentaries on the Constitution of the United States* § 1348 (3d ed. 1858)).

Thus, if DOJ were spending money in violation of § 542, it would be drawing funds from the Treasury without authorization by statute and thus violating the Appropriations Clause. That Clause constitutes a separation-of-powers limitation that Appellants can invoke to challenge their prosecutions.

III

The parties dispute whether the government's spending money on their prosecutions violates § 542.

A

We focus, as we must, on the statutory text. Section 542 provides that ***HN15*** "[n]one of the funds made available in this Act to the Department of Justice may be used, with respect to [Medical Marijuana States[3]] to prevent any of them from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana." Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015). Unfortunately, the rider is not a model of clarity.

1

HN16 "It is a 'fundamental canon of statutory construction' that, 'unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning.'" Sandifer v. U.S. Steel Corp., 134 S. Ct. 870, 876, 187 L. Ed. 2d 729 (2014) (quoting Perrin v. United States, 444 U.S. 37, 42, 100 S. Ct. 311, 62 L. Ed. 2d 199 (1979)). Thus, in order to decide whether the prosecutions of Appellants violate § 542, we must determine the plain meaning of "prevent any of [the Medical Marijuana States] from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana." The pronoun "them" refers **[*23]** back to the Medical Marijuana States, and "their own laws" refers to the state laws of the Medical Marijuana States. And "implement" means:

> To "carry out, accomplish; *esp.*: to give practical effect to and ensure of actual fulfillment by concrete measure." *Implement, Merriam-Webster's Collegiate Dictionary* (11th ed. 2003);
>
> "To put into practical effect; carry out." *Implement, American Heritage Dictionary of the English Language* (5th ed. 2011); and
>
> "To complete, perform, carry into effect (a contract, agreement, etc.); to fulfil (an engagement or promise)." *Implement, Oxford English Dictionary*, www.oed.com.

See Sanford v. MemberWorks, Inc., 625 F.3d 550, 559

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[3] To avoid repeating the names of all 43 jurisdictions listed, we refer to Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, **[*22]** Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming, the District of Columbia, Guam, and Puerto Rico as the "Medical Marijuana States" and their laws authorizing "the use, distribution, possession, or cultivation of medical marijuana" as the "State Medical Marijuana Laws." While recognizing that the list includes three non-states, we will refer to the listed jurisdictions as states and their laws as state laws without further qualification.

(9th Cir. 2010) (We "may follow the common practice of consulting dictionaries to determine" ordinary meaning.); Sandifer, 134 S. Ct. at 876. ***HN17*** In sum, § 542 prohibits DOJ from spending money on actions that prevent the Medical Marijuana States' giving practical effect to their state laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

2

DOJ argues that it does not prevent the Medical Marijuana States from giving practical effect to their medical marijuana laws by prosecuting private individuals, rather than taking legal action against the state. We are not persuaded.

Importantly, the ***HN18*** "[s]tatutory language **[*24]** cannot be construed in a vacuum. It is [another] fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." Sturgeon v. Frost, 136 S. Ct. 1061, 1070, 194 L. Ed. 2d 108 (2016) (internal quotation marks omitted). Here, we must read § 542 with a view to its place in the overall statutory scheme for marijuana regulation, namely the CSA and the State Medical Marijuana Laws. The CSA prohibits the use, distribution, possession, or cultivation of any marijuana. *See* 21 U.S.C. §§ 841(a), 844(a).[4] The State Medical Marijuana Laws are those state laws that authorize the use, distribution, possession, or cultivation of medical marijuana. Thus, the CSA prohibits what the State Medical Marijuana Laws permit.

HN19 In light of the ordinary meaning of the terms of § 542 and the relationship between the relevant federal **[*25]** and state laws, we consider whether a superior authority, which prohibits certain conduct, can prevent a subordinate authority from implementing a rule that officially permits such conduct by punishing individuals who are engaged in the conduct officially permitted by the lower authority. We conclude that it can.

DOJ, without taking any legal action against the Medical Marijuana States, prevents them from implementing their laws that authorize the use, distribution, possession, or cultivation of medical marijuana by prosecuting individuals for use, distribution, possession, or cultivation of medical marijuana that is authorized by such laws. By officially permitting certain conduct, state law provides for non-prosecution of individuals who engage in such conduct. If the federal government prosecutes such individuals, it has prevented the state from giving practical effect to its law providing for non-prosecution of individuals who engage in the permitted conduct.

We therefore conclude that, ***HN20*** at a minimum, § 542 prohibits DOJ from spending funds from relevant appropriations acts for the prosecution of individuals who engaged in conduct permitted by the State Medical Marijuana Laws and who fully **[*26]** complied with such laws.

3

Appellants in *McIntosh* and *Kynaston* argue for a more expansive interpretation of § 542. They contend that the rider prohibits DOJ from bringing federal marijuana charges against anyone licensed or authorized under a state medical marijuana law for activity occurring within that state, including licensees who had failed to comply fully with state law.

For instance, Appellants in *Kynaston* argue that "implementation of laws necessarily involves all aspects of putting the law into practical effect, including interpretation of the law, means of application and enforcement, and procedures and processes for determining the outcome of individual cases." Under this view, if the federal government prosecutes individuals who are not strictly compliant with state law, it will prevent the states from implementing the *entirety* of their laws that authorize medical marijuana by preventing them from giving practical effect to the penalties and enforcement mechanisms for engaging in unauthorized conduct. Thus, argue the *Kynaston* Appellants, the Department of Justice must refrain from prosecuting "unless a person's activities are so clearly outside the scope of a state's medical marijuana **[*27]** laws that reasonable debate is not possible."

To determine whether such construction is correct, we must decide whether the phrase "laws that authorize" includes not only the rules authorizing certain conduct but also the rules delineating penalties and enforcement mechanisms for engaging in unauthorized conduct. In

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[4] This requires a slight caveat. Under the CSA, "the manufacture, distribution, or possession of marijuana [is] a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration preapproved research study." Gonzales v. Raich, 545 U.S. 1, 14, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005); *see* 21 U.S.C. §§ 812(c), 823(f), **841(a)(1)**, 844(a). Thus, except as part of "a strictly controlled research project," federal law "designates marijuana as contraband for *any* purpose." Raich, 545 U.S. at 24, 27.

answering that question, we consider the ordinary meaning of "laws that authorize the use, distribution, possession, or cultivation of medical marijuana." "***HN21*** Law" has many different meanings, including the following definitions that appear most relevant to § 542:

> "The aggregate of legislation, judicial precedents, and accepted legal principles; the body of authoritative grounds of judicial and administrative action; esp., the body of rules, standards, and principles that the courts of a particular jurisdiction apply in deciding controversies brought before them."
>
> "The set of rules or principles dealing with a specific area of a legal system <copyright law>."

Law, Black's Law Dictionary (10th ed. 2014); and:

> "1. a. The body of rules, whether proceeding from formal enactment or from custom, which a particular state or community recognizes as binding on its members or subjects. (In this **[*28]** sense usually *the law.)*."
>
> "One of the individual rules which constitute the 'law' (sense 1) of a state or polity. . . . The plural has often a collective sense . . . approaching sense 1."

Law, Oxford English Dictionary, www.oed.com . The relative pronoun "that" restricts "laws" to those laws authorizing the use, distribution, possession, or cultivation of medical marijuana. *See* Bryan A. Garner, *Garner's Dictionary of Legal Usage* 887-89 (3d ed. 2011). ***HN22*** In sum, the ordinary meaning of § 542 prohibits the Department of Justice from preventing the implementation of the Medical Marijuana States' laws or sets of rules and only those rules that authorize medical marijuana use.

We also consider the context of § 542. The rider prohibits DOJ from preventing forty states, the District of Columbia, and two territories from implementing their medical marijuana laws. Not only are such laws varied in composition but they also are changing as new statutes are enacted, new regulations are promulgated, and new administrative and judicial decisions interpret such statutes and regulations. Thus, § 542 applies to a wide variety of laws that are in flux.

Given this context and the restriction of the relevant laws to those **[*29]** that authorize conduct, we conclude that ***HN23*** § 542 prohibits the federal government only from preventing the implementation of those specific rules of state law that authorize the use, distribution, possession, or cultivation of medical marijuana. DOJ does not prevent the implementation of rules authorizing conduct when it prosecutes individuals who engage in conduct unauthorized under state medical marijuana laws. Individuals who do not strictly comply with all state-law conditions regarding the use, distribution, possession, and cultivation of medical marijuana have engaged in conduct that is unauthorized, and prosecuting such individuals does not violate § 542. Congress could easily have drafted § 542 to prohibit interference with laws that address medical marijuana or those that regulate medical marijuana, but it did not. Instead, it chose to proscribe preventing states from implementing laws that authorize the use, distribution, possession, and cultivation of medical marijuana.

B

The parties cite various pieces of legislative history to support their arguments regarding the meaning of § 542.

We cannot consider such sources. ***HN24*** It is a fundamental principle of appropriations law that we may only consider the **[*30]** text of an appropriations rider, not expressions of intent in legislative history. "An agency's discretion to spend appropriated funds is cabined only by the 'text of the appropriation,' not by Congress' expectations of how the funds will be spent, as might be reflected by legislative history." Salazar v. Ramah Navajo Chapter, 132 S. Ct. 2181, 2194-95, 183 L. Ed. 2d 186 (2012) (quoting Int'l Union, UAW v. Donovan, 746 F.2d 855, 860-61, 241 U.S. App. D.C. 122 (D.C. Cir. 1984) (Scalia, J.)). In *International Union*, then-Judge Scalia explained:

> As the Supreme Court has said (in a case involving precisely the issue of Executive compliance with appropriation laws, although the principle is one of general applicability): "legislative intention, without more, is not legislation." The issue here is not how Congress expected or intended the Secretary to behave, but how it *required* him to behave, through the only means by which it can (as far as the courts are concerned, at least) require anything—the enactment of legislation. Our focus, in other words, must be upon the text of the appropriation.

746 F.2d at 860-61 (quoting Train v. City of New York, 420 U.S. 35, 45, 95 S. Ct. 839, 43 L. Ed. 2d 1 (1975)); *see also* Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631, 646, 125 S. Ct. 1172, 161 L. Ed. 2d 66 (2005)

("The relevant case law makes clear that restrictive language contained in Committee Reports is not legally binding."); Lincoln v. Vigil, 508 U.S. 182, 192, 113 S. Ct. 2024, 124 L. Ed. 2d 101 (1993) ("'[I]ndicia in committee reports and other legislative history as to how the funds should or are expected to be spent do not establish any **[*31]** legal requirements on' the agency." (citation omitted)).

We recognize that some members of Congress may have desired a more expansive construction of the rider, while others may have preferred a more limited interpretation. However, we must consider only the text of the rider. If Congress intends to prohibit a wider or narrower range of DOJ actions, it certainly may express such intention, hopefully with greater clarity, in the text of any future rider.

IV

We therefore must remand to the district courts. If DOJ wishes to continue these prosecutions, Appellants are entitled to evidentiary hearings to determine whether their conduct was completely authorized by state law, by which we mean that they strictly complied with all relevant conditions imposed by state law on the use, distribution, possession, and cultivation of medical marijuana. We leave to the district courts to determine, in the first instance and in each case, the precise remedy that would be appropriate.

We note the temporal nature of the problem with these prosecutions. The government had authority to initiate criminal proceedings, and it merely lost funds to continue them. DOJ is currently prohibited from spending funds **[*32]** from specific appropriations acts for prosecutions of those who complied with state law. But Congress could appropriate funds for such prosecutions tomorrow. Conversely, this temporary lack of funds could become a more permanent lack of funds if Congress continues to include the same rider in future appropriations bills. In determining the appropriate remedy for any violation of § 542, the district courts should consider the temporal nature of the lack of funds along with Appellants' rights to a speedy trial under the Sixth Amendment and the Speedy Trial Act, 18 U.S.C. § 3161.[5]

V

For the foregoing reasons, we vacate the orders of the district courts and remand with instructions to conduct an evidentiary hearing to determine whether Appellants have complied with state law.[6]

VACATED AND REMANDED WITH INSTRUCTIONS.

[5] The prior observation should also serve as a warning. ***HN25*** To be clear, **§ 542** does not provide immunity from prosecution for federal marijuana offenses. The CSA prohibits the manufacture, distribution, and possession of marijuana. Anyone in any state who possesses, distributes, or manufactures marijuana for medical or recreational purposes (or attempts or conspires to do so) is committing a federal crime. The federal government can prosecute such offenses for up to five years after they occur. *See* 18 U.S.C. § 3282. Congress currently restricts the government from spending certain funds to prosecute certain individuals. But Congress could restore funding tomorrow, a year **[*33]** from now, or four years from now, and the government could then prosecute individuals who committed offenses while the government lacked funding. Moreover, a new president will be elected soon, and a new administration could shift enforcement priorities to place greater emphasis on prosecuting marijuana offenses.

Nor does any state law "legalize" possession, distribution, or manufacture of marijuana. Under the Supremacy Clause of the Constitution, state laws cannot permit what federal law prohibits. U.S. Const. art VI, cl. 2. Thus, while the CSA remains in effect, states cannot actually authorize the manufacture, distribution, or possession of marijuana. Such activity remains prohibited by federal law.

[6] ***HN26*** We have jurisdiction under the All Writs Act to "issue all writs necessary or appropriate in aid of [our] jurisdiction[] and agreeable to the usages and principles of law." 28 U.S.C. § 1651. The writ of mandamus "is a drastic and extraordinary remedy reserved for really extraordinary causes." United States v. Guerrero, 693 F.3d 990, 999 (9th Cir. 2012) (quoting Cheney v. U.S. Dist. Court, 542 U.S. 367, 380, 124 S. Ct. 2576, 159 L. Ed. 2d 459 (2004)). We **DENY** the petitions for the writ of mandamus because the petitioners **[*34]** have other means to obtain their desired relief and because the district courts' orders were not clearly erroneous as a matter of law. *See id.* (citing Bauman v. U.S. Dist. Ct., 557 F.2d 650, 654-55 (9th Cir. 2010)). In addition, we **GRANT** the motion for leave to file an oversize reply brief, ECF No. 47-2; **DENY** the motion to strike, ECF No. 52; and **DENY** the motion for judicial notice, ECF No. 53.

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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Delaware.

CHRYSLER CORPORATION, Employer/Appellant,
v.
Frank KASCHALK, Employee/Appellee.

No. Civ.A. 98A-03-006-JOH.
|
June 16, 1999.

Appeal from a Decision of the Industrial Accident Board-Affirmed.

Attorneys and Law Firms

Timothy A. Casey, of Marshall, Dennehey, Warner, Coleman & Goggin, for employer/appellant.

Robert P. LoBue, of Wilmington, Delaware, for employee/appellee.

MEMORANDUM OPINION

HERLIHY, J.

***1** Chrysler Corporation appeals a decision of the Industrial Accident Board awarding Frank Kaschalk partial disability benefits. [1] Kaschalk had suffered several compensatory, job-related injuries in his thirty-year employment with Chrysler. He was on lighter duty in April 1994 when he retired claiming that he could no longer put up with the back pain. Several months later, he obtained a new, different job with another employer. That job was part-time.

The Board held that Kaschalk left his job because of his physical condition and that he did not retire and was eligible for benefits. Chrysler, however, claims there is insufficient evidence to sustain that holding and that Kaschalk, instead, retired disqualifying him from benefits. The Court has determined that substantial evidence exists to support the Board's factual decision and its legal reasoning is free from error.

FACTUAL BACKGROUND

Kaschalk worked for Chrysler from 1964 until his retirement in April 1994 at age 54. During that period, Kaschalk injured his back at least twice: once in 1970 while lifting a 600-pound barrel, and again in September 1993 when he slipped and fell on the floor of Chrysler's automobile assembly plant. During the 1970's and 1980's, Kaschalk had many surgical procedures for his back condition, but remained on the production line. At some time in the early 1990's, Kaschalk stopped working on the assembly line and, instead, began driving cars from one area of the plant to a staging area. During this period of time, Kaschalk reported to his superiors that his work was causing back pain. He testified that during the Autumn and Winter of 1993, he missed a few days of work due to his back. He was treated by his physician, Dr. Pierre LeRoy, but released to return to light-duty work with limited bending and lifting as overall restrictions. At the end of March 1994, Dr. LeRoy found that Kaschalk's injury and pain were exacerbated by his work and placed additional motion restrictions on him. On various occasions in March and April, Dr. LeRoy issued temporary "disability slips" for Kaschalk.

On April 24, 1994, Kaschalk retired from Chrysler but he did not do so on doctor's orders or in consultation with Dr. LeRoy. Several years later, Dr. LeRoy testified in his deposition that it was his medical opinion that, with the development of his symptoms by Spring of 1994, Kaschalk was no longer able to work-the job was beyond his physical capabilities. Dr. LeRoy stated that, as of April or May of 1994, he *would have* reduced Kaschalk to approximately 35 hours of sedentary duty, again without bending, standing or running. Kaschalk told the Board that he would have worked at Chrysler until he was 60 but for his medical condition. He sought employment after his retirement but remained unemployed for three months until he began working twenty hours per week as a clerk at an Acme supermarket. As of December 1997, Dr. LeRoy said, he would have reduced from 35 to 20 the hours Kaschalk could work.

***2** In March 1997, Kaschalk filed a petition to determine additional compensation due for partial disability. After a hearing, the Board found that, but for his injury, Kaschalk could have worked a 35-hour work week from April 1994

through December 1997 and that he could have worked a 20-hour work week from January 1998 into the future and was compensated accordingly for those periods. The Board also made the following findings:

1. That retirement has no impact on an employee's ability to receive benefits, unless the employer can prove that the employee has taken himself out of the labor market entirely. Kaschalk retired only because of circumstances surrounding his back, had intended to work until age 60 and put himself back into the labor market within three months of his retirement. Therefore, he did not retire, voluntarily or otherwise, in the traditional sense of intentionally removing himself from the working world. Consequently, his retirement did not impact on his ability to receive benefits.

2. That Kaschalk suffered a loss of earning power as a result of his 1993 fall, after which he was unable to meet new duties required of him by Chrysler. While Kaschalk's medical provider, Dr. LeRoy, "*would have* reduced Claimant's work schedule to 35 hours per week," and "*would have* recommended a more sedentary type position" in 1994, the fact that he did not actually issue these restrictions was irrelevant and Kaschalk did not have to be "specifically incapacitated" in order to be compensated, as long as he lost wages due to his injury.

3. That when, in December 1997, Dr. LeRoy reduced Kaschalk's work schedule to 20 hours per week, he suffered another loss of earning power also traceable to his previous industrial accident.

STANDARD OF REVIEW

The role of this Court on an appeal from the Board is to determine whether the Board's decision is supported by substantial evidence and is free from legal error.[2] Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.[3] This Court does not sit as a trier of fact with authority to weigh the evidence, determine issues of credibility and make its own factual findings.[4]

DISCUSSION

Kaschalk's departure from Chrysler in April 1994 raises two distinct but interrelated issues. Chrysler argues that there was not substantial evidence for the Board to determine that he left his job due to his back pain. It also contends that Kaschalk retired voluntarily making him ineligible, as a matter of law, for worker's compensation benefits.

Chrysler's attack on the Board's decision that Kaschalk left his job in April 1994 is premised on criticisms of Dr. LeRoy's testimony and the medical record. In March and April 1994, Dr. LeRoy gave Kaschalk several temporary disability slips but never advised him to cease work altogether. Kaschalk, instead, left Chrysler without consulting with Dr. LeRoy.

***3** In March 1994, Dr. LeRoy noted a worsening in Kaschalk's back pain and added a restriction: no running. Apparently, Kaschalk's work duties had been increased and Dr. LeRoy was issuing brief, temporary disability slips in March and April. Several years later, however, Dr. LeRoy testified that he would have restricted Kaschalk even more. He would have recommended a sedentary job, not even the light-duty driving job Kaschalk had, and would have reduced his hours to 35 per week. There was no evidence such a job existed, although Kaschalk testified he asked for one and Chrysler turned him down. Chrysler argues Dr. LeRoy's later rationalization, as it sees it, for Kaschalk's decision to leave his job is inconsistent with his temporary slips in 1994 and means Dr. LeRoy's testimony supporting the decision to leave should have been disregarded.

Kaschalk described how his job of driving cars caused his back pain to worsen to the point of intolerance. While stating he wanted to work there until he was 60, he testified he could no longer perform his job. Chrysler challenges his credibility by noting that since he had worked for it for thirty years and was eligible to retire, his professed desire to work for it for six more years was not credible.

The Board found that Kaschalk did not retire in the traditional sense because his back condition rendered him incapable of continuing to perform his job. While not a model of clarity in how it picked and chose the conflicting evidence to reach this decision, there is substantial evidence to support it.

First, it must be kept in mind that it is the Board which decides issues of credibility, not the courts.[5] While Chrysler presented medical testimony differing, in part, from Dr. LeRoy's about Kaschalk's back condition, the Board is entitled to reject one witness' testimony over another's.[6] Accepting Dr. LeRoy's testimony, as it obviously did, means, in this case, that there was substantial evidence to support the Board's determination that Kaschalk's back pain prompted his decision to leave his job.[7] Further examination of the record demonstrates that the Board's decision is sustainable. Chrysler's attack on Dr. LeRoy's credibility overlooks the frequency with which in March and April 1994 he was finding Kaschalk unable to do his job, even if for one or several days.

Retirement can disqualify an employee from receiving worker's compensation benefits.[8] Chrysler argues that Kaschalk retired. He was eligible to do so and left on his own without contemporaneous direction from any physician. The premise of Chrysler's argument, however, is whether the Board found Kaschalk retired, not because of back problems but because he was eligible at 54 with thirty years at Chrysler. Had the Board found his retirement was in the "traditional" sense, Chrysler's argument would have validity and the Board would have committed an error of law in awarding him benefits. A reading of the Board's decision, however, indicates that the Board was aware that "traditional" retirement meant disqualification from benefits.

*4 In addition to Dr. LeRoy's testimony and Kaschalk's testimony of his condition when he retired, the Board had other evidence that Kaschalk intended to remain in the labor force to the extent his physical condition allowed. First was his own testimony which the Board was free to accept or reject.[9] Second, Chrysler declined to give a janitorial job to him before Kaschalk left its employ. Third, several months after leaving Chrysler, Kaschalk applied for several positions and eventually obtained a job consistent with his back situation and limitations. Dr. LeRoy concurred that as of December 20, 1997, Kaschalk's job was appropriate and with his limited hours (20) of employment. In short, there was substantial evidence to support the Board's finding that Kaschalk had not removed himself from the job market and had not "retired" in a way which would disqualify him from benefits. Where substantial evidence exists, the Board's decision must be affirmed.[10] Further, this Court finds no legal error in the Board's rulings.[11]

CONCLUSION

For the reasons stated herein, the decision of the Industrial Accident Board awarding Frank Kaschalk partial disability benefits is AFFIRMED.

All Citations

Not Reported in A.2d, 1999 WL 458792

Footnotes

1 The Board denied Kaschalk's petition asking for benefits for permanent sexual disfunction. He has not cross-appealed that decision.

2 *Histed v. E.I. duPont De Nemours & Co.*, Del.Supr., 621 A.2d 340, 342 (1993).

3 *State v. Cephas*, Del.Supr., 637 A.2d 20, 23 (1994).

4 *Keeler v. Metal Masters Food Service Equipment Co., Inc.*, Del.Supr., 712 A.2d 1004, 1006 (1998).

5 *Air Mod Corp. v. Newton*, Del.Super., 215 A.2d 434, 438 (1965).

6 *Delaware Tire Center v. Fox*, Del.Super., 401 A.2d 97, 100 (1979); *aff'd.*, Del.Supr., 411 A.2d 606 (1980).

7 *General Motors Corp. v. Veasey*, Del.Supr. 371 A.2d 1074, 1076 (1977).

8 *Sharpe v. W.L. Gore and Associates*, Del.Super., C.A.No. 97A-10-017, Silverman, J. (May 29, 1998).

9 *Standard Distributing Co. v. Nally*, Del.Supr., 630 A.2d 640, 646 (1993).

10 *M.A. Hartnett, Inc. v. Coleman*, Del.Supr., 226 A.2d 910 (1967).

11 *Buckley v. Delaware Valley Rehabilitation Services, Inc.*, Del.Supr., 711 A.2d 789, 792 (1998).

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GENERAL MOTORS CORP.
v.
Edward H. WILLIS and the Industrial Accident Board

No. 99A-12-008-JEB.
|
Submitted April 26, 2000.
|
Decided Sept. 5, 2000.

Letter Opinion and Order on Employer/Appellant's Appeal from a Decision of the Industrial Accident Board-Affirmed.

Gentlemen:

Opinion

BABIARZ, J.

*1 This is the Court's Letter Opinion and Order on General Motors Corporation's ("GM") appeal of a decision of the Industrial Accident Board ("IAB" or "Board"). For the reasons stated herein, the decision of the Board is AFFIRMED.

FACTS

Claimant/Appellee Edward Willis began working as an assembly line worker for GM in January of 1968. He worked on the line until December of 1992 when he was injured. Thereafter, Mr. Willis required three back surgeries, the first occurring in January of 1993.

Mr. Willis received temporary total disability and accident benefits from GM until September 28, 1998. For five and one half years after his original injury, GM never located a job for Mr. Willis that he could perform at the plant. But, in September of 1998, GM returned Mr. Willis to work on the United Way campaign. He received full pay while he was working on the campaign and did not received disability benefits during that time. Mr. Willis returned to receiving total disability benefits after the campaign ended. Mr. Willis was again called to work in November of 1998 to sell 50/50 tickets to raise money for needy families. Following these two short stints returning to work at GM, Mr. Willis informed GM that he would be retiring from his position in January of 1999. At that point, Mr. Willis had 30 years service with GM. It is undisputed that Mr. Willis' retirement was a voluntary one from GM and not a disability retirement. [1] Thereafter, Mr. Willis began to collect pension benefits from GM, which he was entitled to get because of his years of service with the company. [2]

It was Mr. Willis' expectation that he would work at a different job after he retired, so it was (and is) his position that because he was going to continue working, he should receive partial disability benefits stemming from his loss of earning capacity from his industrial accident. [3] GM asserted that because Mr. Willis retired voluntarily, he was not entitled to partial disability benefits. GM also asserted that if Mr. Wills was entitled to partial disability, those payments should be offset by Mr. Willis' employer funded pension. GM filed a petition to terminate partial disability benefits with the IAB, claiming that because Mr. Willis had retired and took advantage of the GM pension, he could no longer receive partial disability benefits.

In September of 1999, a hearing was held before an IAB hearing officer. The IAB hearing officer determined that while retirement may disqualify an employee from receiving workers compensation benefits in certain instances, because Mr. Willis had not taken himself out of the labor market, he was entitled to ongoing partial disability. Mr. Willis was awarded the difference between 66 2/3% of the wages received before the injury and his earning capacity of $7.80 an hour thereafter.

GM then filed a Motion for rehearing or reargument with the Board, arguing that the Claimant is not entitled to double recovery for a single loss where both sources of recovery emanate from a single employer. GM also argued that it is entitled to an offset of amounts paid in the form of retirement pensions, and that pensions should be considered as actual earned wages for the purposes of calculating the Claimant's earning capacity. The hearing officer held that any payment received under the pension is wholly unrelated to the Claimant's basis for receiving

partial disability benefits under workers' compensation, and therefore, there is no element of double recovery. IAB Dec. at 4 (Dec. 3, 1999).

***2** GM has appealed the ruling of the IAB to this Court, claiming that the hearing officer erred as a matter of law in determining that Mr. Willis was entitled to receive partial disability benefits after he voluntarily retired from GM and began receiving employer funded pension benefits. GM also argues that the Board erred in failing to consider Mr. Willis' employer funded pension benefits as wages.

Mr. Willis argues that the has a right to receive a service pension after 30 years of service and the fact that he was partially disabled due to a work injury at GM should not operate as a forfeiture of his right to a pension because he did not retire in a traditional sense.

STANDARD OF REVIEW

The Supreme Court and this Court have repeatedly emphasized the limited review of the factual findings of an administrative agency. *Carpenter v. Mattes Electric,* C.A. No. 96A-07-005, Quillen, J. (April 9, 1997). The function of the reviewing Court is to determine whether the agency's decision is supported by substantial evidence and free from legal error. *General Motors Corp. v. Freeman,* Del.Supr., 3 Storey 74, 164 A.2d 686, 688 (1960); *Johnson v. Chrysler Corp.,* Del.Supr., 9 Storey 48, 213 A.2d 64, 66-67 (1965). Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Oceanport Ind. Inc. v. Wilmington Stevedores Inc.,* Del.Supr., 636 A.2d 892, 899 (1994); *Battista v. Chrysler Corp.,* Del.Super., 517 A.2d 295, 297 (1986), app. dism., Del.Supr., 515 A.2d 397 (1986). On appeal from the Board, the Superior Court does not sit as a trier of fact with authority to weigh the evidence, determine questions of credibility, and make its own factual findings and conclusions. *Johnson,* 213 A.2d at 66. It merely determines if the evidence is legally adequate to support the agency's factual findings. 29 *Del. C.* § 10142(d).

DECISION

Retirement, in a traditional sense, can disqualify an disqualify an employee from receiving worker's compensation benefits. *Chrysler Corp. v. Kaschalk,* Del.Super., C.A. No. 98A-03-006, Herlihy, J. (June 16, 1999). This is especially true where an employee does not look for work after his retirement and where the Claimant is content with his or her retirement lifestyle. *Brown v. James Julian, Inc.,* Del.Super., C.A. No. 97A-07-006, Barron, J. (Oct. 6, 1997). The workers compensation act, however, does not expressly preclude the receipt of certain duplicative benefits. *State v. Calhoun,* Del.Supr., 634 A.2d 335, 337 (1993). Where an employee voluntarily takes retirement but does not intend to remove himself or herself from the job market, the employee can collect partial disability benefits stemming from a pre-retirement industrial accident and simultaneously collect a pension. *See Chrysler Corp. v. Kaschalk,* Del.Super., C.A. No. 98A-03-006, Herlihy, J. (June 16, 1999).

GM's general statement that an employee cannot secure double recovery for a single loss where both sources of recovery emanate from the employer, is true. *See Calhoun,* 634 A.2d at 338; *Guy Johnson Transp. Co. v. Dunkle,* Del.Supr., 541 A.2d 551 (1988).[4] Generally, however, pensions rights become vested when the requirements for the pensions have been met. *See City of Wilmington v. Miller,* Del.Supr., 293 A.2d 574 (1972). Pensions are part of the compensation of the employee to which he is as much entitled, upon qualification, as he is to wages for work performed. *See id.* Also, receipt of pension benefits does not generally bar or reduce a Claimant's right to worker's compensation benefits in the absence of a specific statutory provision stating otherwise. *Bramble v. Bd. of Pension Trustees,* Del.Super., 579 A.2d 1131, 1136 (1989).[5]

***3** The Board found, in a carefully written and well crafted Opinion, that the Claimant was eligible to receive a retirement pension independently of the work accident after fulfilling the requirement of thirty years service. Because the pension was wholly unrelated to the Claimant's basis for receiving partial disability under worker's compensation act, the Board held that the Claimant should also receive partial disability benefits for his reduced earning capacity stemming from his industrial accident.

The Board considered several factors in determining that Mr. Willis was entitled to partial disability benefits and pension benefits. The Board noted that the Claimant is 55 years old which is significantly below the usual retirement

age of 65. Mr. Willis sought employment and actually attained employment prior to the hearing date. He is no longer capable of working at his previous job at GM and he has experienced a loss of earning capacity as a result of his work injury. He also has a right to his pension due to his years of service. Indeed, a witness for GM testified that there are employees who work at GM currently who also collect a pension while still working because GM cannot force those employees to retire. IAB Dec. at 4 (Sept. 21, 1999).

Taking those factors into consideration, the Board correctly opined that simply because an individual takes a voluntary retirement does not automatically preclude receipt of partial disability benefits if an employee wishes to continue working and actively seeks, and obtains, employment after retirement. While the Court is sympathetic to GM's argument that Mr. Willis' pension and partial disability payments will now total more than his original salary, if Mr. Willis had not been injured, he could have retired from GM, collected his pension, and made even more money. The partial disability section of the worker's compensation act is designed to reimburse the employee for lost earnings stemming from an industrial accident. *See Chrysler Corp. v. Chambers,* Del.Super., 288 A.2d 450, 452 (1972), *aff'd,* Del.Supr., 299 A.2d 431 (1972). Here, Mr. Willis is entitled to pension benefits and his partial disability should not be offset by his pension. Simply, retirement pensions are not earnings under the statute and the Board should continue to evaluate whether an individual is entitled to pension and partial disability benefits on a case by case basis.

For the foregoing reasons, the decision of the IAB is *AFFIRMED.*

IT IS SO ORDERED.

All Citations

Not Reported in A.2d, 2000 WL 1611067

Footnotes

1 The IAB hearing officer found that Mr. Willis knew that the did not have to retire when the did. IAB Op. 107671, Sept 21, 1999 at 8.

2 It appears that the pension received by the Claimant was a service pension that the did not contribute to as part of his salary.

3 In fact, two days prior to the IAB hearing, Mr. Willis was hired by Lackawanna Security Services.

4 *Johnson* involved an injured employee's attempt to recover medical expenses pursuant to 19 *Del. C.* § 2322(a) after those expenses had been paid by the employer. *Id.* The Supreme Court did not allow the employee to recover for expenses which he had not, in fact, sustained. *Id.*

5 The Court notes that both *Miller* and *Bramble* are cases decided that deal with one's right to receive pension benefits under State law and are only used for guidance. Here, the basis for the Claimant's pension is contractual in nature and the Board did not find any contractual or statutory language that would reduce a Claimant's right to pension benefits.

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2011 WL 141164
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Delaware,
Kent County.

Sally JACKSON, Claimant Below-Appellant,
v.
GENESIS HEALTH VENTURES,
Employer Below-Appellee.

C.A. No. 09A-09-001 (RBY).
|
Submitted: Oct. 12, 2010.
|
Decided: Jan. 6, 2011.
|
Jan. 6, 2011.

Upon Consideration of Claimant's Appeal from the Decision of the Industrial Accident Board. **AFFIRMED**

Attorneys and Law Firms

Walt F. Schmittinger, Esq., Schmittinger & Rodriguez, P.A., Dover, Delaware, for Claimant Below-Appellant.

R. Stokes Nolte, Esq., Reilly, Janiczek & McDevitt, P.A., Wilmington, Delaware, for Employer Below-Appellee.

OPINION AND ORDER

YOUNG, J.

SUMMARY

*1 Sally Jackson appeals from a decision of the Industrial Accident Board denying her claim for total disability benefits. Because the Board's decision is supported by substantial evidence, Jackson's appeal is **DENIED.**

FACTS

Sally Jackson ("Jackson") was employed as a nurse by Genesis Health Ventures ("Genesis") in 1994. That October, Jackson's supervisor asked her to unpack a newly delivered crate containing a wire frame that, once assembled, would be used to store the facility's medical waste. Jackson objected, protesting that the frame was too heavy for her to move safely. Jackson's supervisor disagreed, and again requested that Jackson unpack the crate. Jackson finally acquiesced, and promptly tore the meniscus in her right knee.

Jackson underwent arthroscopic surgery later that month, and Genesis paid Jackson benefits including compensation for medical expenses, total disability, and permanency. Regrettably, the surgery evidently did not eliminate Jackson's pain. Hence, Jackson visited numerous doctors over the next several years in search of additional treatment. Jackson's recovery was hindered by the effect of her allergies and diabetes, which appear to have eliminated conventional anti-inflammatory medications and injections as possible sources of treatment. Instead, Jackson relied on a combination of ice and Tylenol to combat her right knee pain for more than a decade.

Jackson returned to work as a nurse in 1996, and continued to work in that capacity until retiring in 1999. Although Jackson gave conflicting testimony on this point, the record supports the conclusion that Jackson's only significant work experience after 1999 was a brief stint in staff development at a nursing home in 2005. Jackson quit after five weeks primarily due, according to her, to pain associated with a preexisting back injury. Aside from this, Jackson spent retired life assisting her husband's occasional work in providing music and entertainment to local senior centers.

By 2007, Jackson's knee pain had worsened, and in September she fell in her garage. This accident precipitated yet another series of medical visits, culminating in a total knee replacement surgery in April 2008. The operation was considered a success, although Jackson was readmitted to the hospital in May, where she spent four days recovering from multiple pulmonary embolisms.

On June 23, 2008, Jackson filed a petition with the Industrial Accident Board (the "Board") seeking compensation for the cost of her knee replacement surgery, as well as the cost of her subsequent pulmonary

embolism treatment. Jackson also requested total disability compensation from April 29, 2008 to June 9, 2008 to cover the time she spent recuperating in the hospital as a result of her knee operation. In her petition before the Board, Jackson argued that her medical treatment was causally related to her 1994 work accident, and therefore compensable by Genesis.

In its September 1, 2009 decision, the Board found that Jackson's 2008 accident was the direct and natural result of her 1994 accident, and ordered Genesis to pay for the cost of Jackson's 2008 knee replacement surgery and subsequent hospitalization for her pulmonary embolisms. The Board, however, denied Jackson's request for total disability benefits, because Jackson had voluntarily removed herself from the workforce, and so did not qualify for total disability compensation. Jackson has filed an appeal with this Court on the sole ground that the Board's decision disqualifying her from receiving total disability compensation was in error.

DISCUSSION

***2** The review of an Industrial Accident Board's decision is limited to an examination of the record for errors of law and a determination of whether substantial evidence exists to support the Board's findings of fact and conclusions of law. [1] Substantial evidence equates to "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." [2] This Court will not weigh the evidence, determine questions of credibility, or make its own factual findings. [3] Errors of law are reviewed *de novo.* [4] Absent errors of law, the standard of review for a Board's decision is abuse of discretion.

Worker's Compensation law has a two-fold purpose: 1) it provides compensation for work-related injuries, and 2) it relieves employers and their employees of the expenses associated with civil litigation . [5] When determining if a legitimate claim for compensation exists, the relevant inquiry is whether there was a work-connected injury. [6] Once the existence of a work-related injury has been established, the next step is to ascertain the type of benefits due the employee. "Benefits for physical injury ... are of two kinds: wage-loss payments based on the concept of disability; and payment of hospital and medical expenses occasioned by any work-connected injury, regardless of wage loss or disability." [7] When a workrelated injury results in total disability, the employer must pay during the continuance of the total disability compensation equal to 66 2/3% of the injured employee's wages. [8]

The dispute in this case centers on Jackson's claim for wage-loss payments stemming from the time she spent recovering after her April 2008 surgery. As noted above, Delaware's workers' compensation law provides for lost wage benefits during any period where a claimant is totally disabled from working. [9] " 'Total disability' means a disability which prevents an employee from obtaining employment commensurate with [her] qualifications and training." [10] To establish a claim for total disability benefits, the claimant must show that he or she was actually incapacitated from earning wages. [11] A determination of total disability requires a consideration and weighing of not only the medical and physical facts but also such factors as the employee's age, education, general background, occupational and general experience, emotional stability, the nature of the work performable under the physical impairment, and the availability of such work. [12] The finder of fact must take into consideration not only the medical testimony but also the facts and circumstances that may relate to the claimant as a 'unit of labor' in his handicapped condition. [13]

The facts and circumstances of Jackson's injury form the genesis of this appeal. The parties do not dispute that Jackson was unable to work following her total knee replacement surgery. What the parties do dispute is whether Jackson's inability to work constitutes a 'total disability' in light of Jackson's prior retirement.

***3** Unlike many other jurisdictions, Delaware's Workers' Compensation Statute does not contain any express provision making injuries compensable after retirement. [14] This is not to say that a worker's retirement constitutes an absolute bar to recovering disability benefits. Voluntary retirement is simply one factor to consider when determining whether an employee is entitled to disability benefits under Delaware law. [15] Still, a worker's voluntary retirement, and the reasons therefore, are important considerations in the analysis. Delaware case law has frequently noted that voluntary retirement from the workplace may disqualify an employee from receiving disability benefits. [16] This is

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especially true where an employee does not look for work after his retirement, and where the employee is content with his or her retirement lifestyle.[17]

Here, the Board found that Jackson retired in 1999 due to the pain associated with an unrelated back injury. In making this finding, the Board discredited Jackson's statement that she retired due to her knee pain. The Board also found that because Jackson told her treating physician that she was retired, the possibility of her returning to work was never discussed at any time before or after her surgery.

The Board's finding that Jackson voluntarily retired in 1999 is not dispositive. However, when combined with the Board's other findings, which indicate that Jackson had removed herself from the workforce, that her retirement was not due to her work-related injury, and that she never discussed or even attempted to look for work during treatment, it is abundantly clear that the Board's decision is supported by substantial evidence and must be upheld.

This Court's review of the record confirms the Board's analysis. The record discloses that Jackson has not looked for work in the health care industry since 2005. In 2007 she told her treating physician that she was retired from nursing, and thus asked no questions about, and made no arrangements to resume working with restrictions. Jackson's surgery may have left her temporarily unable to work, but, as the Board found, Jackson had no intention of working, because of the pain associated with an unrelated and non-compensable injury. That Jackson has not sought employment of any kind following her successful knee surgery is also instructive.

Taken together, these facts provide substantial evidence for the Board's finding that Jackson was not entitled to total disability benefits following her 2008 knee replacement surgery, and accordingly, Jackson's appeal is denied.

CONCLUSION

Based on the foregoing, the decision of the Industrial Accident Board is **AFFIRMED.**

SO ORDERED.

All Citations

Not Reported in A.3d, 2011 WL 141164

Footnotes

1 *Histed v. E.I. Dupont de Nemours & Co.,* 621 A.2d 340, 342 (Del.1993); *Willis v. Plastic Materials,* 2003 WL 164292 (Del.Super.Ct. Jan. 13, 2003); *Robinson v. Metal Masters, Inc.,* 2000 WL 1211508 (Del.Super.Ct. July 14, 2000).

2 *Olney v. Cooch,* 425 A.2d 610, 614 (Del.1981) (quoting *Consolo v. Federal Mar. Comm'n* 383 U.S. 607, 620 (1966)).

3 *Collins v. Giant Food, Inc.,* 1999 WL 1442024 (Del.Super.Ct. Oct. 13, 1999) (quoting *Johnson v. Chrysler Corp.,* 213 A.2d 64, 66-67 (Del.1965)).

4 *Anchor Motor Freight v. Ciabattoni,* 716 A.2d 154 (Del.1998).

5 *State v. Brown,* 2000 WL 33225298 (Del.Super.Ct. Aug. 7, 2000) *aff'd sub nom. Brown v. State Dept. Of Corr.,* 768 A.2d 467 (Del.2001); *Lord v. Souder,* 748 A.2d 393 (Del.2002); *Guy J. Johnson Transportation Co. v. Dunkle,* 541 A.2d 551, 552 (1988).

6 1 Larson's Workmen's Compensation Law § 1.03 (1999).

7 4 Larson's Workmen's Compensation Law § 57.10 (1999).

8 19 *Del. C.* § 2324.

9 *Id.*

10 *M.A. Hartnett, Inc. v. Coleman,* 226 A.2d 910, 913 (Del.1967).

11 *Id.* at 913.

12 *Ham v. Chrysler Corp.,* 231 A.2d 258, 261 (Del.1967).

13 *Id.* at 261.

14 *See generally* 75 A.L.R. 5th 339 (originally published in 2000) Eligibility for Unemployment Compensation of Employee who Retires Voluntarily.

15 *See General Motors Corp. v. Willis,* 2000 WL 1611067 (Del.Super.Ct. Sept. 5, 2000); *Chrysler corp. v. Kaschalk,* 1999 WL 458792 (Del.Super. Ct. June 16, 1999); *Sharp v. W.L. Gore & Assocs.,* 1998 WL 438796 (Del.Super.Ct. May 29, 1998).

16 *Hirneisen v. Champlain Cable Corp.*, 892 A.2d 1056 (Del.2006).

17 *Brown v. James Julian, Inc.*, (Del.Super.Ct. Jan. 23, 1997).

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BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

LAURIE POPKEN,)
)
Employee,)
)
v.) Hearing No. 1266150
)
STATE OF DELAWARE,)
)
Employer.)

Recurrence denied - claimant voluntarily removed herself from work force

DECISION ON PETITION TO DETERMINE ADDITIONAL 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 ("the Board") on August 18, 2011 in the Hearing Room of the Board, in New Castle County, Delaware.

PRESENT:

JOHN DANIELLO

MARILYN DOTO

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

APPEARANCES:

Jessica Welch, Attorney for the Employee

Robert Greenberg, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

Ms. Laurie Popken ("Claimant") injured herself during a compensable work injury on March 21, 2005. As a result of the injury she underwent two surgeries on her right knee and three surgeries on her left knee. The most recent surgery occurred on January 11, 2011 at which time she has been placed on total disability. On March 15, 2011, Claimant filed a Petition to Determine Additional Compensation Due on which she alleges that she is entitled to receive total disability benefits resulting from the January 11, 2011 surgery. The State of Delaware ("Employer") does not dispute the compensability of the surgery and has paid the medical expenses. Employer, however, disputes that Claimant is entitled to total disability benefits because it contends that Claimant voluntarily removed herself from the workforce.

A hearing was held on Claimant's petition on August 18, 2011. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Claimant testified on her own behalf. She is forty-nine years old and is a high school graduate. She worked part-time for Employer for approximately five years before she injured herself during the course and scope of her employment. She explained that she worked part-time to enable her to be home when her daughter was not in school. Employer terminated her position in 2006.

Claimant testified that as a result of her injury, she had surgeries on her right knee in 2005 and in 2006.[1] She had surgeries on her left knee in 2007 and 2008.[2] On November 7, 2008, Employer filed a Petition for Review in which it alleged that Claimant was no longer totally disabled. Prior to the hearing on Employer's Petition, Claimant and Employer stipulated

[1] The surgery in 2006 was a total knee replacement surgery.
[2] The surgery in 2008 was a total knee replacement surgery.

that Claimant was no longer totally disabled as of March 12, 2009. On April 24, 2009, in accordance with 19 *Del.C.* §2301B(a)(4) by stipulation of the parties, a Hearing Officer entered an Order granting Employer's Petition for Review according to the terms identified in the stipulation. Claimant continued treating with Dr. Leitman who had placed Claimant on light duty status. Claimant acknowledged that Dr. Leitman placed work restrictions on her but the only work restrictions she could recall were no bending or placing weight on her knees.

Claimant testified that despite the fact she was released to return to work, she continued to consider herself totally disabled because of the pain. Claimant stated that she shared such opinion with Dr. Leitman but Dr. Leitman did not take her complaints seriously and maintained her work status. In September 2010, Claimant treated with Dr. Evan Crain. Dr. Crain referred her to Dr. Bodenstab. On January 11, 2011, Dr. Bodenstab performed surgery on her left knee and placed Claimant on total disability as of the date of surgery.

Claimant acknowledged that she has not worked after March 12, 2009 – the day she stipulated that she was no longer totally disabled. Initially she testified that between March 12, 2009 and January 11, 2011, her job search consisted of going to the Department of Labor on one occasion. On cross examination, she represented that she made two visits to the Department of Labor. Claimant generally stated that she talked with friends about employment but did not cite any other efforts such as looking in the classified section of the newspaper to find employment. Claimant admitted that she did not apply for any jobs.

Claimant denied voluntarily removing herself from the workforce. She explained that because of her significant knee pain, she did not believe she was capable of working nor did she

believe her bilateral knee condition enabled her to be employable.[3] She did not consider herself retired; she did not indicate to anyone including her doctors that she considered herself as retired. She did not consider herself to be a housewife. Claimant stated that she wants to return to work and has every intention of returning to work once her knees sufficiently improve. She feels useless not being able to work.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Delaware law is established that if an employee retires thereby voluntarily removing himself or herself from the workforce, such retirement can disqualify the employee from receiving workers' compensation benefits. *Sharp v. W.L. Gore and Associates*, Del. Super., C.A. No. 97A-10-017, Silverman, J. (May 29, 1998). "This is especially true where an employee does not look for work after his [or her] retirement, and where the employee is content with his or her retirement lifestyle." *Jackson v. Genesis Health Ventures*, Del. Super., C.A. No. 09A-09-001, Young, J. (Jan. 6, 2011).

In the case before the Board, Claimant did not accept a retirement package or buyout package. Claimant is currently unemployed. The issue before the Board is whether Claimant's unemployment status constitutes a voluntary removal from the workforce for the purposes of the Workers' Compensation Statute.

Claimant contends that she did not voluntarily remove herself from the workforce. She is forty-nine years old, an age remarkably younger than a typical retirement age of sixty-five. Claimant testified that she does not consider herself retired. She did not intend to remove herself from the workforce; she believes that it is only her work injury that prevents her from being physically capable of returning to work in any capacity. She added that she would like to return

[3] Claimant acknowledged medically treating after the work accident for conditions unrelated to the work injury. She maintained that such conditions did not and do not prevent her from returning to work. She stated that only the work injury prevents her from working.

to work and intends to return to work as soon as her bilateral knee condition sufficiently improves.

Despite the reasons supporting Claimant's contention, the Board finds that Claimant did in fact voluntarily remove herself from the workforce. The fact remains that Claimant admitted by stipulation that on March 12, 2009 she became capable of returning to work and was no longer totally disabled. Her doctor, Dr. Leitman, placed Claimant on light duty work status; Claimant was medically cleared to return to work.

Claimant continued to medically treat for her work injury. It was not until Claimant had surgery on January 11, 2011 that a doctor placed Claimant on total disability. In other words, between March 12, 2009 and January 11, 2011 – a period of nearly two years - Claimant was medically cleared for returning to some form of employment even if it she could not return to her former job. Such clearance was determined in lieu of Claimant's need to continue treatment and in lieu of the seriousness of her injury.

In light of the fact that Claimant was not totally disabled, between March 12, 2009 and January 11, 2011[4], Claimant had a duty to actively seek employment during the interim. Giving Claimant the benefit of the doubt, Claimant's actions to seek employment in a span of twenty-one months was limited to having general discussions with friends about employment and to visiting the Department of Labor one or two times with no follow-up. Claimant's testimony was vague regarding how she spent her time while she was at the Department of Labor. She could not state with specificity what her job efforts were during her visits at the Department of Labor. Furthermore, Claimant could not specifically identify her work restrictions during the interim and did not identify any type of job for which she would consider applying. Claimant admittedly

[4] The Board accepts and finds that Claimant was not totally disabled during such time and that Claimant was physically capable of returning to work.

did not search the classified section of the newspaper or search online to conduct a job search. She could not cite to any other job search efforts when asked at the hearing. Claimant admittedly did not apply for any jobs. Her lack of effort to pursue employment while she was medically cleared to return to work does not at all constitute a reasonable job search. Instead Claimant voluntarily chose not to pursue employment; such choice constitutes a voluntary removal from the workforce. Therefore, Claimant has no wages that are lost as a result of her surgery on January 11, 2011. To order Employer to pay total disability benefits in this situation would be inequitable. The Board denies Claimant's Petition for Additional Compensation Due.

STATEMENT OF THE DETERMINATION

For the reasons stated above, the Board denies Claimant's Petition to Determine Additional Compensation Due and finds that Claimant is not entitled to receive total disability benefits.

IT IS SO ORDERED THIS 25th DAY OF AUGUST, 2011.

INDUSTRIAL ACCIDENT BOARD

JOHN DANIELLO

MARILYN DOTO

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

Mail Date: 8-25-11

Karen Miller
OWC Staff

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

DOROTHEA CALE,	)	
Employee,	)	
v.	)	Hearing No. 1278553
KRAFT FOODS, INC.,	)	
Employer.	)	

Increase in TPD denied & claimant has a retirement lifestyle

DECISION ON PETITION TO DETERMINE ADDITIONAL 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 on April 27, 2012, in the Hearing Room of the Board, in Milford, Delaware.

PRESENT:

HAROLD B. BARBER
Board Member

VICTOR EPOLITO JR
Board Member

Angela M. Fowler, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Robert Lobue, Attorney for the Employee

Francis Nardo, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

Dorothea Cale ("Claimant") suffered a compensable injury to her neck while at work for her employer, Kraft Foods, Inc. ("Employer") on December 7, 2005, when she struck her head during the operation of a piece of equipment. As a result of this compensable injury, Claimant received, among other things, compensation for periods of lost earning capacity. In fact, Claimant presently receives compensation for a partial loss of earnings at the rate of $142.81 per week.[1]

On December 7, 2011, Claimant filed a Petition to Determine Additional Compensation Due alleging an increase in her entitlement to partial disability compensation effective December 17, 2009. Employer opposes such an award maintaining that there has been no change in Claimant's circumstances since the Board's July 10, 2007 Decision terminating Claimant's total disability benefits and setting the rate for partial disability under which Claimant continues to be compensated at present.

A hearing was held on Claimant's petition on April 27, 2012. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Dr. Kartik Swaminathan, M.D., a board certified physical medicine and rehabilitation physician and Claimant's treating doctor, testified by deposition on Claimant's behalf. Dr. Swaminathan opined that Claimant is not capable of medium-duty work as was previously found by the Board and can, at best, work in a part-time sedentary capacity.

Dr. Swaminathan testified that he began treating Claimant on July 6, 2007, when she was referred to him by her primary care physician. Claimant initially presented with complaints of chronic neck pain, significant upper and lower extremity tingling, numbness and weakness as

well as low back pain; all of which Claimant attributed to her December 7, 2005 work accident. In terms of treatment pre-dating Dr. Swaminathan, he indicated that Claimant was treated at Kent General Hospital, then by her primary care physician, Dr. Varipapa (a neurologist), and Dr. Hermanton (a surgeon). After a failed attempt at physical therapy, an MRI of Claimant's cervical spine revealed multiple level disc bulges including degenerative disc disease and desiccation at C3-4, C4-5 and C5-6. Dr. Hermanton performed a three level cervical fusion to address these issues but Claimant continued to have symptoms which resulted in her referral to Dr. Swaminathan.

Once assessed by Dr. Swaminathan, Claimant was diagnosed with cervical myelopathy,[2] post-laminectomy syndrome, closed-head injury with mild post-concussive syndrome, gait dysfunction and neurogenic bladder. Claimant was placed on several medications for spasticity and kept out of work since she could not return to her former employment. In the intervening four and a half years, Dr. Swaminathan has continued to see Claimant on roughly two to three month intervals primarily for medication management and management of flare-ups in her pain. Dr. Swaminathan confirmed that the bulk of Claimant's present symptoms, as was the case when she initially presented to him, relate to the accident induced myelopathy which is a permanent condition that will not improve. In fact, Dr. Swaminathan most recently saw Claimant on February 21, 2012, at which time her physical examination findings continued to be consistent with what she has presented with over the last several years including chronic neck and back pain, bilateral upper and lower extremity spasticity, tenderness and spasm in the cervical

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[1] *See* Joint Exhibit 1 (Stipulation of Facts).

[2] Dr. Swaminathan explained that the acute flexion type of injury that Claimant had when she struck her head at work reduced the amount of space for the spinal cord to move. This injury to the spinal cord, while aided by the decompression surgery performed by Dr. Hermanton, left Claimant's functioning in a slowed down capacity. According to Dr. Swaminathan Claimant's stretch reflexes in her hands, the ligaments, the muscles and the joints become hyperactive causing stiffness and limited movement. Reflexes are more exaggerated and repetitive tasks cause the hand(s) to shake.

paraspinal muscles, trapezius muscles, upper back and thoracic paraspinal muscles as well as hyperflexia in all four limbs and patchy hypothesia in both upper and lower extremities.

Dr. Swaminathan confirmed that as of February 2012, he continued to restrict Claimant's ability to work to part-time (no more than four hours a day) sedentary work allowing a maximum of 30 minutes sitting at a time for a total of no more than two hours a day, standing, walking and driving up to one hour with frequent breaks and only occasional use of her arms, particularly above her shoulders. Furthermore, Dr. Swaminathan indicated that Claimant cannot lift more than ten pounds, contrary to the Board's 2007 Decision wherein Claimant was found to be capable of medium-duty work, lifting up to 40 pounds occasionally and 20 pounds regularly. Dr. Swaminathan explained that Claimant has a difficult time walking from the parking lot to his office given her gait and balance issues. As such, lifting up to 40 pounds would be out of the question. While the present defense medical examiner, Dr. Andrew Gelman, opined most recently that Claimant could work full-time sedentary to light duty, Dr. Swaminathan maintained that Claimant is not capable of full-time work or lifting in excess of the ten pounds permitted for sedentary duty. Dr. Swaminathan further confirmed that former defense medical examiner, Dr. Michael Mattern, after evaluating Claimant in 2009 and later in October 2010, issued work restrictions for Claimant similar to those which Dr. Swaminathan has currently proposed. According to Dr. Swaminathan, while Claimant has enjoyed some relief in regards to her spasticity and corresponding improvement in her physical findings, she has not otherwise experienced any significant changes in recent years and thus these restrictions are permanent.

On cross examination, Dr. Swaminathan confirmed that Claimant had the three level neck fusion in July 2006, approximately one year before he assumed her care. As such, by July 2007 when he began seeing Claimant, the fusion had formed solidly and was in good condition. It was

his opinion that the surgery was, in fact, successful in relieving some of Claimant's complaints in her extremities and neck. Dr. Swaminathan maintained, however, that while the surgery seemingly prevented further injury or further deterioration in Claimant's case, the spinal cord injury had already occurred and was irreversible.

Dr. Swaminathan confirmed that from the time of his clinical examination of Claimant on July 6, 2007, Claimant's condition has not changed and fortunately has not gotten worse. Follow-up MRI's of Claimant's cervical spine in 2008 and again two in 2011 all showed no significant change. A subsequent EMG was also normal. As such, Dr. Swaminathan confirmed that Claimant's condition is and has been stable.

While Dr. Swaminathan admitted that he has no notes reflecting an appreciation of what kinds of activities Claimant undertakes on a daily basis, he indicated that he totally disabled Claimant from any and all work in July 2007 and never modified that restriction until February 2012 when he indicated that Claimant could work in a part-time sedentary capacity. Dr. Swaminathan clarified that for the first two years of this period, his total disability opinion was based predominantly on Claimant's inability to return to her job with Employer. His present opinion, however, reflects his view of her ability to work in any kind of job and was prompted in February 2012 by Claimant's attorney.

Dr. Swaminathan confirmed that the Board accepted the opinion of Dr. Scott Rushton, defense medical examiner, over that of Claimant's treating surgeon, Dr. Hermanton, as part of its 2007 Decision finding that Claimant could work in a full-time medium-duty capacity. Dr. Swaminathan admitted, in this context, that Claimant's condition has not deteriorated since the Board rendered that Decision. Furthermore, despite even his own release of Claimant to part-time sedentary work, Dr. Swaminathan is unaware of any efforts on Claimant's part to return to

work outside of some volunteer work that she does for her church. In fact, he indicated his belief that Claimant is retired.

During brief re-direct examination, Dr. Swaminathan confirmed his opinion that Claimant reached maximum medical improvement sometime approximately two years after her cervical fusion or sometime in the summer of 2008. It is Dr. Swaminathan's opinion that at least that far back it was clear that Claimant would not be able to do medium-duty work.

Claimant testified that she is 58 years old. She worked for Employer for just over 30 years leading up to her December 7, 2005 work accident during which she was jolted while operating a piece of equipment and hit her head. As a result of this accident, Claimant suffered injury to her neck, hands, legs, lower back and forehead. Prior to the accident, Claimant worked in a utility position performing cleaning and maintenance around the plant. Claimant indicated that this required heavy lifting of up to 75 pounds at a time; work that she was able to do despite her then slight frame of five foot, three inches tall and 130 pounds. Claimant considered herself a model employee who assumed leadership roles for Employer. She indicated that she never had any other work-related injuries and never suffered absenteeism from the job.

Immediately following the 2005 industrial accident, Claimant began experiencing heaviness in her hands and legs, the sensation of pins and needles in her extremities, tingling numbness, incontinence and exhaustion. The July 2006 fusion surgery with Dr. Hermanton relieved much of her pain but left her with the feelings of heaviness, muscle spasm and exhaustion. Claimant indicated that it is her understanding that these remaining symptoms are the result of nerve damage (myelopathy) suffered during the accident. She testified that the symptoms impact her on a daily basis and have not improved over the years, so much so that Claimant has not even attempted to lift anything over 15 to 20 pounds in years.

On cross examination, Claimant confirmed that after being treated at the hospital on the day of her injury she was released and advised that the sensation issues she was having in her extremities would resolve. When this did not occur, Claimant eventually went to surgery with Dr. Hermanton. Thereafter, Dr. Hermanton post-surgically gave Claimant a release to return to work in a sedentary capacity but she did not attempt that as she hoped to be able to return to the more physically demanding work she had done for Employer. Subsequently in 2007, unable to return to her former position with Employer, Claimant retired from Employer, receiving the benefit of her pension. Claimant indicated that it was her dream upon retirement to work full-time as an artist in her at-home studio. This dream has faltered in the years since the accident, however, as she finds it difficult to paint given the lingering issues with her hands. Instead, Claimant volunteers in her church and hopes to become a part of the church's ministry if so called upon. Claimant has not otherwise looked for any work in the labor market.

Claimant testified that she lives alone in a single story modular home. Her 74 year old mother and other family members assist her with things around the home that she finds difficult to do on her own. Claimant indicated that she does shop, cook and drive but indicated that most activities are very difficult and draining to her. At this point, Claimant does not intend to return to the work force because she does not think that she is capable of being a dedicated employee. Claimant receives a pension from her retirement from Employer as well as social security benefits which became effective approximately six months after the work accident.

Dr. Andrew Gelman, M.D., a board certified orthopedic surgeon, testified by deposition on Employer's behalf. Dr. Gelman, having examined Claimant in addition to conducting a review of her relevant medical records opined that Claimant's condition has not changed since the Board's finding that she could perform medium-duty work in 2007. While Dr. Gelman

indicated that Claimant's age and other factors may lend themselves to less strenuous work, the injuries that Claimant sustained in the work accident do not so limit her.

Dr. Gelman testified that he examined Claimant on February 9, 2012. Both Claimant and her medical records confirm the nature of the 2005 industrial accident wherein she was jolted on a piece of equipment and struck her head. Hospital records immediately following the accident fail to document total paraesthesias but a related cervical MRI did confirm Claimant's known, preexisting history of degenerative cervical spine disease.[3] Thereafter Claimant followed up with her primary care physician, Dr. Patel, who documented complaint of pain in Claimant's low back as well as tingling in both of Claimant's upper extremities. Dr. Patel also noted bruising peripheral to Claimant's face and eyes but otherwise indicated a normal neurological examination, normal gait, intact reflexes and no spinal tenderness or spasm. Claimant was evaluated by a neurologist, Dr. Varipapa, and ultimately by Dr. Hermanton who performed a three level fusion on her neck in 2006. Claimant enjoyed success following the surgery to include a solid fusion with good positioning.

Dr. Gelman testified that he is aware that following Claimant's surgery a Board hearing was held regarding her ability to work. He has reviewed the Board's Decision related to that July hearing and is familiar with the Board's finding that Claimant is capable of working in up to a medium-duty capacity.

Dr. Gelman indicated that after the Board's hearing, Claimant again followed up with Dr. Varipapa who noted symptoms similar to those documented in the 2005 timeframe. Dr. Varipapa found Claimant to have intact reflexes, strength and sensation. MRI's of Claimant's

[3] Dr. Gelman later specified that Claimant had symptomatic cervical spine problems dating back to at least 2003. Claimant had imaging studies performed at that time which showed multilevel degenerative disease, similar if not identical, to the disease appreciated in the 2005 timeframe following the work accident. Claimant received care for these cervical issues that included both consultations with her primary care physician, Dr. Patel, as well as orthopedic surgeon, Dr. Eric Schwartz in April 2003.

neck and back during this time showed the stable cervical fusion and only mild degenerative changes. Dr. Varipapa noted no deterioration in Claimant's condition or even in her subjective complaints. Claimant also simultaneously continued her care with Dr. Swaminathan who ordered updated cervical MRIs in March and August 2011; both of which showed no significant change(s). Similarly the two EMGs performed of Claimant's upper and lower extremities, the most recent in 2011, were both normal. Thus, given this history and Claimant's presentation, Dr. Gelman diagnosed Claimant as having been treated for cervical spondyloses with records supporting a myelopathy.

Dr. Gelman indicated his agreement with Dr. Swaminathan's opinion that Claimant's condition has not deteriorated since July 2007. As such, Dr. Gelman testified that he found nothing in the records or his own physical examination of Claimant related to injuries sustained in the 2005 industrial accident that would have warranted a change in Claimant's work capability from medium-duty as found by the Board in 2007 to something less. While Dr. Gelman acknowledged that looking at Claimant as a human being, given her age and overall physical condition, Claimant may admittedly be more amenable to light-duty work, he emphasized that this level of restriction is unrelated to Claimant's industrial injuries. In fact, in the context of her industrial injuries Dr. Gelman insisted that Claimant is capable of working full-time. Specifically, Dr. Gelman testified that not only did he not find any objective evidence of ongoing injury related to Claimant's industrial accident, but he found no clinical evidence to support any worsening of Claimant's condition since July 2007.

In comparing his own work recommendations for Claimant to those of former defense medical examiner, Dr. Michael Mattern, Dr. Gelman indicated that Dr. Mattern's records reflect few, if any, objective findings and document little to no progressive change or deterioration in

Claimant's condition particularly in regard to the myelopathy. Furthermore, while Dr. Mattern recommended work restrictions similar to those offered by Dr. Swaminathan at present, Dr. Gelman indicated that he is not sure what issues Dr. Mattern took into consideration when offering that opinion. Specifically, he is unsure of whether or not Dr. Mattern limited his work opinion of Claimant to the injuries she sustained in the industrial accident or if he allowed for nonrelated injuries and/or issues including Claimant's age and general health. Dr. Gelman noted, however, that Drs. Mattern, Varipapa and Swaminathan all confirmed that Claimant's condition has remained stable and has not worsened. Dr. Gelman testified that the solidly healed fusion that Claimant achieved after her 2006 surgery is not susceptible to injury if lifting of 50 pounds is involved. According to Dr. Gelman, while the symptoms related to Claimant's myelopathy, which have existed since the 2005 work accident, may cause her some issue with the performance of certain tasks, it is strictly non-work related issues that make it less attractive for Claimant to attempt medium-duty work at this time in her life.

Dr. Gelman testified that Claimant reported to him that she had not pursued employment of any kind since her injury. Nevertheless, Dr. Gelman reviewed the Labor Market Survey created by Coventry on Employer's behalf in this matter and approved all 15 jobs identified therein as being compatible with Claimant's physical abilities.[4]

During cross examination, while recognizing that Claimant has been treated for cervical degenerative process with what he characterized as chronically stable features of myelopathy, Dr. Gelman acknowledged that considering Claimant as a whole he felt that she could work full-time sedentary to light-duty. Dr. Gelman acknowledged that stability does not mean that Claimant does not experience symptoms though he indicated that different physicians have appreciated varying degrees of those symptoms. Dr. Gelman confirmed that medium-duty work

is defined as work that requires exerting 20 to 50 pounds of force occasionally and/or 10 to 25 pounds of force frequently and admitted that if Claimant were his patient he would not advise that she work at that level.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Title 19, section 2347 of the Delaware Code provides in relevant part:

> On the application of any party in interest on *the ground that the incapacity of the injured employee has subsequently terminated, increased, diminished or recurred* ..., the Board may, at any time, but not oftener than once in 6 months, review any agreement or award.
>
> On such review, *the Board may make an award ending, diminishing, increasing or renewing the compensation previously agreed upon or awarded,* and designating the persons entitled thereto, subject to this chapter, and shall state its conclusions of facts and rulings of law. (emphasis added).

Accordingly, in order for Claimant in the instant action to establish an increase in the amount of partial disability that she is entitled to receive subsequent to the Board's 2007 Decision on the matter, Claimant must show that there has been a change in her condition between the issuance of that Decision and the period to which she now claims there should be a retroactive modification.[5] This requires Claimant prove by a preponderance of the evidence that her condition has changed for the worse since the now controlling Decision was issued. Looking at this burden of proof much as one would a claim for recurrence of total disability, the Board is

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[4] *See* Exhibit 1 attached to Dr. Andrew Gelman's March 23, 2012 Deposition (Labor Market Survey).

[5] The Board issued the controlling Decision on July 19, 2007. There is no dispute that this Decision was not appealed. In fact, Claimant admitted that while the myelopathy now argued to be at the heart of her reduced abilities existed at the time of that Decision, there was an assessment made on Claimant's behalf that there was little room for a successful appeal of the Board's Decision and thus the Decision was accepted as written.

Given these undisputed facts, the Board is satisfied that to the extent that Claimant is situated exactly as she was at the time of the last Board hearing and subsequent Decision, the question becomes whether or not there is anything

satisfied that the worsened condition that Claimant has to demonstrate must be more then a slight change in impairment.[6] Given these applicable legal standards, the Board finds that Claimant in the instant action has not met her burden of demonstrating that her condition has changed such as to cause her additional lost earning capacity.

Factually speaking, Claimant provided no evidence of a worsening in her condition. To the contrary, all of the medical professionals involved including Dr. Varipapa, Dr. Mattern, Dr. Gelman and Dr. Swaminathan seem to agree that Claimant's condition has remained stable. The decompression and fusion surgery that Claimant underwent in 2006 with Dr. Hermanton was a success and has apparently thwarted the likelihood of progression of Claimant's injury and/or the symptoms that she has experienced as a result of the myelopathy. In fact, Dr. Swaminathan testified that, if anything, Claimant has experienced a reduction in her pain complaints and some increased mobility.

Claimant has argued that Dr. Swaminathan's opinion that she reached maximum medical improvement sometime in the summer of 2008 which led to a change in his return to work assessment for her is sufficient to meet her underlying burden by showing a change in Claimant's circumstances. This testimony and accompanying argument, however, does little more than clarify that the total disability status that Dr. Swaminathan originally had Claimant on for more than a year of his treatment of her was based very narrowly on the premise that the only work subject to consideration was Claimant's former job. For all intents and purposes Dr. Swaminathan admits that he was not assessing Claimant's work capabilities with any eye towards anything else. While his view changed as of August 2008 or so, there is no evidence

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new to evaluate or decide that would warrant disturbing the Board's prior decision. *See Delhaize America, Inc., v. Baker*, 2005 WL 2090774 at *2 (Del. February 28, 2005).

[6] *Cullen v. State*, 2007 WL 1241841, at *2. "Because a slight change in impairment does not support a finding of recurrence, neither does a continuation of impairment." *Chubb*, at 536.

that this modified opinion was related to a deterioration in Claimant's condition. Again, if anything, it is suggestive of the fact that Claimant was improved at least to the extent that Dr. Swaminathan indicated he was willing to take Claimant from a total disability restriction at that point to a light to sedentary duty restriction.

The Board is similarly not persuaded by the argument that other physicians including former defense medical examiner, Dr. Mattern, and current defense medical examiner, Dr. Gelman, readily admit that Claimant is best suited for sedentary to light duty work. As noted by Dr. Gelman in support of his own opinion, there is insufficient information to know that Dr. Mattern's opinion was specifically related to Claimant's work-related disability. Dr. Gelman himself indicated that at Claimant's age and in light of her other non-accident related conditions, medium duty work would not be his first choice for her. Nevertheless, his testimony was that the basis for shying away from medium duty work for Claimant has nothing to do with her work-related injuries or the myelopathy which, according to all of the medical professionals, was in existence and causing similar symptoms back in 2007 when last the Board considered these issues. As such, there is no credible basis to find that any change in Claimant's work abilities is related to her work accident or that her work-related injuries and/or condition is the cause for such a change.

Moreover, it seems clear that Claimant has, for all intents and purposes, removed herself from the labor market through retirement. Delaware law has long since recognized that a traditional retirement can disqualify an employee from receiving certain workers' compensation benefits.[7] That having been said, however, not every retirement terminates the right to receive wage replacement benefits. The retirement must be voluntary and not motivated by the work

[7] *General Motors Corp. v. Willis*, Del. Super., C.A. No. 99A-12-008, Babiarz, J., 2000 WL 1611067 at *2 (September 5, 2000); *Chrysler Corporation v. Kaschalk*, Del. Super., C.A. No. 98A-03-006, Herlihy, J., 1999 WL 458792 at * 3 (June 16, 1999).

injury.[8] Furthermore, an employee may retire from one employer with the intent of remaining in the job market with another employer and remain eligible for benefits.[9] The Court in *Willis*, however, clarified that retirement can disqualify a claimant from receiving worker's compensation benefits if the claimant has not looked for work after retirement and is content with the retirement lifestyle.

In Claimant's case, Claimant testified that she retired from Employer having worked more than 30 years and now receives a corresponding pension. Claimant also confirmed that she has been receiving social security benefits since shortly after the work accident. While these are not determinative facts, they are strong evidence that Claimant is content with the retirement lifestyle when considered in light of the rest and remainder of Claimant's testimony. Specifically, Claimant admitted that she has not looked for any work, despite her own treating physician advising her that she is cleared to work in a part-time, sedentary capacity. In fact Claimant admitted that in terms of work, her only aspirations at this time are to serve in the ministry at her church and volunteer her time. As such, while the Board is satisfied that Claimant has fallen short of showing that her condition has worsened such that she might otherwise be entitled to additional compensation for lost earning capacity, Claimant's own testimony about her retirement would likely prohibit such an increase even had the Board found differently on the issue of Claimant's alleged change in circumstances.

Accordingly, Claimant's request for additional compensation for lost wages is denied.

Attorney's Fee and Medical Witness Fees

A claimant who is awarded compensation 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

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[8] *See Sharpe v. W. L. Gore & Assocs.*, Del. Super., C.A. No. 97A-10-017, Silverman, J., 1998 WL 438796 at *1 (May 29, 1998)(claimant told he had to retire or his employment would be terminated).
[9] *See Willis*, 2000 WL 1611067 at *2; *Kaschalk*, 1999 WL 458792 at * 4.

weekly wage in Delaware as announced by the Secretary of Labor at the time of the award, whichever is smaller." DEL. CODE ANN. tit. 19, § 2320. At the current time, the maximum based on Delaware's average weekly wage calculates to $9,330.80.

In this case, however, Claimant has not achieved any sort of award and so, she is not entitled to the payment of attorney's fees. Likewise, because there is no award, Claimant is not entitled to payment of her medical witness fees under title 19, section 2322(e) of the Delaware Code.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, the Board finds that Claimant's Petition is DENIED.

IT IS SO ORDERED THIS 3rd DAY OF MAY, 2012.

INDUSTRIAL ACCIDENT BOARD

FOR: HAROLD B. BARBER

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, Esquire
Hearing Officer

Mailed Date: 5-3-12

Karen Miller
OWC Staff

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

SHELINA KIRKLAND,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1419447
	)	
	)	
SMCS TERMINIX,	)	
	)	
Employer.	)	

ORDER

1. Employer filed a Petition to for Review of Benefits on December 11, 2014. Accordingly, based on Dr. Kalamchi's opinion, Employer alleges that Claimant's condition has fully resolved and, as a result, she is physically able to return to work.

2. After due notice of time and place of hearing was served on all parties in interest, the above-stated case did come before the Board on May 15, 2015.

3. At that time, the parties presented a signed Stipulation and Order that Claimant's total disability benefits should be terminated as of the date of filing of Employer's petition, December 12, 2014.

4. Despite this, Employer's counsel argued that a hearing was still necessary in order to litigate the issue of whether Claimant's condition has, in fact, fully resolved. Employer maintained that it was only informed that Claimant planned to concede that she is no longer totally disabled about four or five days prior to the hearing.

5. Claimant objected to Employer's request that the hearing go forward on the issue of whether Claimant's condition has fully resolved, citing that the only issue to be determined in

regard to Employer's petition was whether Claimant was physically capable of working. Claimant argued that the presentation of the Stipulation which would terminate her total disability benefits negated the need for a hearing on the merits of Employer's petition. Claimant pointed to I.A.B. Rule 26 and argued that the rule reads that Employer must file a new petition in order to litigate that issue.

5. At the time of the hearing, the Board did not agree with Claimant's reading of Rule 26 and ruled in favor of Employer that Employer could proceed on the Petition for Review in regard to the issue of whether Claimant's condition has fully resolved, consistent with Dr. Kalamchi's opinion. However, for some reason, Claimant had not yet deposed a medical expert in relation to Employer's petition. Employer conceded that if the Board were to proceed with the hearing, it had no objection to keeping the record open to allow Claimant time to later supplement the record with a deposition from her own medical expert. Claimant maintained her earlier objection.

6. The Board's inclination was to proceed with the hearing and allow Claimant to later supplement the record. Unfortunately, the Board soon realized that Board member Shannon's impending retirement would undoubtedly be effective before Claimant would be able to supplement the record with her own doctor's deposition. Thus, as a result, if the hearing were to have proceeded, the parties would not be able to have this Board hear the full presentation of their respective positions.

7. This Board has the power to grant a continuance for good cause in circumstances which would prevent a party from having a full and fair hearing. The Board is satisfied that a continuance is appropriate in these circumstances. A new hearing date shall be scheduled within sixty (60) days.

IT IS SO ORDERED THIS 15th DAY OF MAY, 2015.

INDUSTRIAL ACCIDENT BOARD

LOWELL L. GROUNDLAND

Terrence M. Shannon

For TERRENCE M. SHANNON

5.27.15

xc: Joseph Weik, Esq., Attorney for Claimant
John Ellis, Esq., Attorney for Employer/Carrier

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BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

SHELINA KIRKLAND,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1419447
	)	
TERMINIX,	)	
	)	
Employer.	)	

DECISION ON PETITION TO TERMINATE BENEFITS

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 Monday July 6, 2015, in the Hearing Room of the Board, in New Castle County, Delaware.

PRESENT:

LOWELL L. GROUNDLAND

MARILYN J. DOTO

Eric D. Boyle, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Joseph W. Weik, Esquire, Attorney for the Employee

John J. Ellis, Esquire, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

Shelina Kirkand ("Claimant") was injured on April 29, 2013 while in the course and scope of her employment with Terminix. ("Employer"). Claimant sustained injuries to her low back and neck. The injury was recognized as compensable and Claimant received certain workers' compensation benefits, including total disability. Claimant has been receiving total disability benefits at the rate of $407.99 per week, based on her wage at the time of the injury of $611.98 per week. On December 12, 2014, Employer filed a Petition for Review seeking to terminate Claimant's receipt of total disability benefits. A hearing was scheduled for May 15, 2015, however prior to the hearing Claimant conceded that she was no longer totally disabled and the parties signed a stipulation and order to that effect. Employer did not then withdraw the pending petition stating that the case would still proceed on the issue of whether Claimant's injuries had fully resolved. Claimant objected to the hearing going forward citing that this was not an issue for the pending petition. Consequently a motion hearing was held on the original hearing date. Claimant argued that Industrial Accident Board Rule 26 required Employer to file a new petition to litigate this issue. The Board disagreed and allowed Employer to argue whether Claimant's injuries had resolved on the pending petition. Since Claimant, in reliance on the concession regarding the total disability, had not scheduled expert medical testimony to oppose Employer's claim the Board granted a continuance to allow for the scheduling of Claimant's expert testimony. *Shelina Kirkland v. Terminix,* Del. IAB Hearing No. 1419447 (May 27, 2015) ORDER. The hearing on the issue of whether Claimant's injuries have fully resolved was rescheduled and was held on July 6, 2015. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Claimant was called by Employer to testify in its' case in chief. Claimant lives in Bear Delaware. Claimant testified that he she is always honest with her providers and admitted that she had prior injuries. Claimant denied any ongoing pain complaints. Her back and neck are mostly pain free. Claimant agreed she lived in Tennessee in 2000. Claimant did not recall treating for back pain while she lived in Tennessee. She did have a primary care doctor while she lived there. In 2005 Claimant did not recall treating with Diamond State Chiropractic and Dr. Goldstein. In 2005 she was going to Glasgow Family Practice for medical treatment. A January 31, 2005 note from Diamond State Chiropractic indicates that Claimant had an insidious onset of low back pain and provided them with a chronic history of low back pain as well. A January 14 note from Glasgow Family Practice indicated that she had low back pain complaints and was diagnosed with scoliosis. She told them that she could not climb stairs due to her low back pain.

Claimant was in a motor vehicle accident in February of 2007. She had complaints of 10 out of 10 back pain in the emergency room and followed up with a Dr. Sheehan who is a chiropractor at Glasgow Family Practice. The records indicated that Claimant had numerous complaints of severe neck and back pain. Claimant was asked whether she remembers treating with Dr. Patil between 2007 and 2010. She felt that the name was familiar and the practice name, Delaware Neurological, rings a bell. The notes from Dr. Patil in 2008 indicated he was concerned that her back injury had become chronic. Claimant agreed that in 2010 she was treating with Dr. Patil for injuries incurred in the 2007 motor vehicle accident. Claimant reviewed a note relating to treatment for a motor vehicle accident that occurred on May 26 2010. Following that accident she was treated at the Rappahannock hospital emergency room (ER). The ER records indicated that Claimant was rear-ended and injured her neck, back and left

shoulder. She had 9/10 pain complaints. Claimant conceded that past medical history was recorded as negative. The doctor's notes on the ER record specifically mentioned that Claimant was laughing and joking with her companion and not evidencing any pain behaviors. Claimant testified that her back pain from the 2007 accident was gone by the time of the 2010 motor vehicle accident. Claimant reviewed a note dated July 29, 2010 from Dr. Patil which indicated that she had continuing complaints of intermittent low back pain from the 2007 incident. Claimant reiterated that she did not have further low back pain at that time.

Claimant admitted that she had chronic neck and back pain following the 2010 motor vehicle accident. Dr. Gregory Adams was her primary doctor and she started treating with Dr. Xing on a monthly basis in between 2010 and 2013. Claimant conceded that every now and then she had some low back pain by the time of the work related accident. A February 2013 note from Dr. Xing indicated that Claimant had continuing low back and neck pain complaints. Claimant testified that this pain was not the same as after the accident. Claimant was prescribed Percocet and naproxen. Claimant told Dr. Xing at the February visit that on a trip to Memphis she had to stop many times due to the pain and back spasms. Work was causing increasing pain to the point where her pain was an 8/10. Claimant admitted that she did not go to the ER following the 2013 work accident; rather she returned from Dover and went to Concentra. Claimant conceded that October 17, 2013 was her last visit with Dr. Xing, who had discharged her for filing multiple prescriptions for narcotic medications from different doctors. Claimant denied abusing her Percocet prescription. Claimant believes that she started seeing Dr. Dietrich in 2010.

Claimant also had a consult with Dr. Rastogi on March 12, 2014 who noted that her symptoms started on April 29th 2013. Claimant believed she did inform Dr. Rastogi about her prior accidents and issues. She admitted however that his note only reflects unrelated health

issues not the prior motor vehicle accidents. Claimant treated with Dynamic Physical Therapy after the work injury. She also felt that the name of Dr. Patil sounded familiar. On the April 14, 2014 intake form she listed low back pain and neck pain lasting one year, but did not complete the space for her past medical history.

On examination by her own attorney Claimant testified that she worked for Terminix as a termite inspector for two years. She testified that this was physical work as she would have to crawl around in tight spaces. On April 29, 2013 her back and neck were feeling fine. She was able to do her job without restrictions, which was a physically demanding job. She only took her medication as needed for off and on pain complaints. Claimant was sitting at a red light when she was rear-ended. She felt immediate pain in her neck, back and left ankle. Her manager told her to bring the truck back and go to Concentra. They provided treatment and restricted her to office work. After the accident she saw Dr. Xing and Terminix sent her to see Dr. Cucuzella. Initially Dr. Xing discharged her and told her she needed to go see the Employer's doctors. Dr. Cucuzella gave Claimant her three injections into her low back. Claimant did get injections in 2010 with Dr. Xing as well.

Dr. Cucuzella also performed ablation treatments and prescribed medication. Claimant stated her back was now worse and she has difficulty walking up stairs. Her chiropractor,r Dr. Dietrich, is associated with Dr. Adams. As of September 13, 2013 she was no longer working for Terminix. Currently Claimant is working for Tri-State Pooper Scoopers on a part time basis. Claimant testified that she has not recovered from the April 29, 2013 accident. She could no longer perform the Terminix job or work in her garden. The chiropractic treatment helps and she takes her medications occasionally because of back pain. Claimant could not recall whether Dr. Kalamchi asked about her past medical history. In three examinations he did not touch her neck

or back. Each exam lasted perhaps 5 minutes. Claimant denied telling Dr. Kalamchi that she was fully recovered from the April 29, 2013 accident. Claimant testified that when she saw Dr. Rastogi in 2014 it was the first time she had consulted with a neurosurgeon about surgery. She confirmed that Dr. Patil was treating her for the 2007 and 2010 accidents.

On redirect Claimant testified that her function prior to the 2013 accident was better. Claimant reviewed a note from Dr. Dietrich from September 2012 in which she detailed the limitations on her activities of daily living. She had to stay-at-home because of her back pain and change positions frequently. She could only walk slowly and was unable to do jobs around the house. She had to lie down often and could only stand for short amount of time. She could only walk short distances. She had to avoid heavy lifting. She had to move slowly to walk upstairs and found that she had a bad temper. Claimant testified that Dr. Xing didn't give her a chance to tell her story about the prescriptions before discharging her in October 2013. At that time Claimant's low back pain was a 5/10 without meds and a 1/10 with medications. In February of 2013 Claimant's back pain was an 8/10 without meds and a 1/10 with medication and rest. Through her last medical visit Claimant was taking medications as needed which included Percocet and muscle relaxers prescribed by Dr. Xing. Now she is taking Advil and Aleve. Her pain level is a 6/10 without medication and 2/10 with Advil. Claimant is now able to deal with her pain unless she has a bad day. Claimant is looking for a full-time job. Prior to 2013 she had on and off low back pain which increased with activities. Without a lot of activities her back pain would be at 2/10.

Dr. Ali Kalamchi, a physician board certified in orthopedic surgery, testified by deposition on behalf of the Employer. Dr. Kalamchi examined Claimant on three occasions, August 6, 2013, June 10, 2014 and February 27, 2015. In conjunction with his exams Dr.

Kalamchi has reviewed a voluminous amount of medical records. Claimant reported a history of injuries as a result of a work related motor vehicle accident (MVA) on April 29, 2013. Claimant was rear ended, but did not recall hitting her head or chest. The accident occurred in Dover and she drove back to Wilmington and went to Concentra. Claimant had neck, low back and left ankle pain. She started therapy with Dr. Nalda at Concentra and the symptoms in her neck and ankle improved. By the time Dr. Kalamchi saw her four months later Claimant's neck pain was limited to occasional aches during damp weather. Claimant reported that her low back was improved with no pain most of the time. She had occasional central back pain and no radiation down the legs. Dr. Kalamchi asked Claimant about her past medical history and she denied prior low back pain other than aching from her scoliosis, although she had no specific treatment for it. Dr. Kalamchi agreed that this history was not accurate.

Claimant told Dr. Kalamchi that she was on light duty for a while and initially had more pain on return to full duty. By the time of the first exam she was back to her regular job. Claimant was still having therapy 2 times per week and took occasional Motrin and Flexeril. On physical exam Dr. Kalamchi noted the features of scoliosis and the rest of the exam was normal except for mild subjective pain in the low back. The diagnostic studies revealed findings consistent with the scoliosis with some disc desiccation at the L5-S1 level with annular tear. There were no protrusions. Dr. Kalamchi diagnosed resolved cervical and lumbar strain related to the accident. He felt Claimant had reached MMI with respect to formal treatment. Claimant was doing her regular activities without limitation and only had minimal subjective complaints. At the next visit Claimant told Dr. Kalamchi that she stopped working in September 2013 because of her intense symptoms. Her treatment, which included injections and chiropractic modalities, continued with more providers entering the picture. Dr. Cucuzzella had given her

injections and released her PRN. She was referred to Dr. Dietrich for chiropractic treatment and to Dr. Onyewu for medication management. Claimant had a consult with Dr. Rastogi who recommended a discogram and discussed surgery. Claimant told Dr. Rastogi that she was not interested in surgery.

In June 2014 Claimant had mild left sided neck pain and tightness in the low back without radiation. At this visit Claimant recalled a 2010 MVA that resulted in neck pain and treatment with Dr. Xing. Claimant had treatment for the lumbar spine as well. Claimant was out of work under doctor's orders and not looking for work. Evaluation of the cervical spine was normal other than mild upper extremity guarding. Claimant had limited forward flexion in the lumbar spine. She had no radiation and straight leg raising was negative. Claimant had trouble with lateral bending and had to hold her knees to steady herself. Dr. Kalamchi commented that a year ago Claimant was much better with normal range of motion but now after all the treatment she was complaining more and guarded. Dr. Kalamchi testified that Claimant had elements of Waddell signs, including facial grimacing and excessive verbalization of pain. Claimant was showing a non-organic presentation out of proportion to the clinical examination. Claimant had degenerative findings on MRI scan. Dr. Kalamchi felt that Claimant had a lumbar spine sprain related to the MVA, but when he saw her he would describe non-specific cervical and lumbar pain. He agreed that Claimant's symptoms were not in line with the diagnostic studies.

Dr. Kalamchi felt that Claimant had a "sick role attitude", in that initially she was doing better and then after seeing doctors who told her she had something wrong and they could treat her she now believed something was wrong and she needed the treatment. Dr. Kalamchi agreed that he noted that Claimant's presentation was consistent with psychosomatic and emotional overlay. Everyone was willing to provide treatment, but in his opinion there is nothing to treat.

Based on her subjective complaints she would have a slight limitation to medium duty and treatment would be home exercises. Dr. Kalamchi also noted that Claimant exhibited signs of symptom magnification. At the final exam in February 2015 Claimant presented worse than before coming in with a cane for support and noting that her son drove her to the appointment. Claimant told Dr. Kalamchi that she lived with her mother and son who do everything for her. He agreed this was different than her first presentation. Claimant was still seeing the chiropractor every two weeks for treatment. Claimant was "fidgety" during the exam getting up and changing positions, stretching, and walking around. Dr. Kalamchi testified that when you have been doing exams for a long time you know that this is all a show. Claimant was leaning forward, but there was no spasm detected. Claimant continued with lumbar discomfort and active range of motion was limited by guarding. Claimant had a normal neurological examination and straight leg raising was negative. Claimant was not complaining of neck pain.

Dr. Kalamchi reviewed updated medical records. He reviewed a lumbar MRI from 2007 which showed an annular tear with degenerative changes at L5-S1 as well as a bulge and possible tear at L4-5. Dr. Kalamchi concluded that the findings on the subsequent MRI had been there all along. Claimant had not told Dr. Kalamchi that she had low back treatment at that time. Dr. Kalamchi concluded that Claimant had subjective low back pain, sick role and a nonorganic presentation. He felt that her presentation was not in line with the benign studies and exams. Dr. Kalamchi agreed that in his opinion any injury Claimant sustained as a result of the 2013 accident had resolved by August 2013. Dr. Kalamchi summarized records that he had recently received of Claimant's treatment prior to the 2013 accident. Claimant treated at Methodist hospital for low back and left sided radiating pain complaints between 2001 and 2003. In 2005 she treated at Glasgow Family Practice and was given medications and a handicap parking

sticker for her back limitations. The records on March 8, 2007 referenced an MVA and Claimant was treated for back and neck pain. She continued to treat and on December 30, 2010 obtained a renewal on her parking sticker. The emergency room records in February 2007 diagnosed headaches and low back strain. Claimant had 8/10 pain. Claimant treated with Dr. Kishor Patil between 2007 and 2010 for injuries to her neck and back. Claimant's low back pain and radiation into the left was the worse. Claimant denied prior injuries to Dr. Patil on April 2007. An EMG revealed acute left L5-S1 radiculopathy. Dr. Patil concluded that Claimant's injuries were chronic. Claimant was again treating with Dr. Patil in 2010 with regard to a May 26, 2010 MVA with complaints of low back pain and headaches. Claimant admitted to ongoing, intermittent back pain. Another EMG revealed acute left sided lumbar radiculopathy. Dr. Kalamchi reviewed the emergency room records from Rappahannock General Hospital with reference to the 5/26/10 MVA. Claimant denied any past medical history. The doctor in the ER noted that Claimant was laughing and joking with her companion and was not guarding her neck or back. According to the records she was complaining of 8/10 pain at that time.

Claimant also treated regularly with Dr. Xing from 2010 through 2013 with complaints of severe back and neck pain. On January 8, 2013 she had complaints of 8/10 neck and back pain. Dr. Xing noted that Claimant could not do anything, her whole body was sore and her workload was causing too much pain. Dr. Xing also noted that Claimant's auto accident case was settling. Dr. Kalamchi reviewed Dr. Xing's note dated October 17, 2013. The note referenced that Claimant had been discovered filling prescriptions for narcotics from multiple providers at the same time. Dr. Xing would no longer prescribe controlled substances. Claimant stated that she wasted $40 and would just follow up with Dr. Cucuzzella. Dr. Xing noted in the record that Claimant was high risk for substance abuse and other abnormal behavior. Claimant has treated

with various chiropractors, including Dr. Dettrich from 2011 through 2015 for a number of diagnosis. Claimant's family physician also noted back pain with degenerative joint disease and arthritis in 2011. Dr. Kalamchi agreed that Claimant had a pattern of not telling providers of her past medical history. He also agreed that Claimant had reported low back pain since 2001 and has had near constant neck and low back treatment and complaints since 2010. Dr. Kalamchi agreed with Dr. Xing that Claimant was high risk for narcotics abuse. In his opinion Claimant's injuries from the 2013 work accident had resolved by August 6, 2013. He also reviewed a labor market survey with sedentary jobs and noted that Claimant could do much more than that level listed.

On cross examination Dr. Kalamchi confirmed that his opinion was that Claimant's injuries related to the April 29, 2013 work accident had completely resolved. He agreed that none of the treating doctors had come to that conclusion. Dr. Kalamchi agreed that he noted in his conclusion on August 6, 2013 that the diagnosis was resolved cervical and lumbar sprain. He agreed that Claimant still had pain and was treating at that time. Dr. Kalamchi testified that the continuing treatment was one of the problems in this case and at that time the pain was mild. Claimant was working as well. On his last examination Dr. Kalamchi diagnosed chronic low back pain. He admitted that his diagnosis changed but that was based on her subjective complaints which she has had for two years. Dr. Kalamchi can't say 100% whether she actually has pain, but he noted there are things in the record and on her presentation that make her pain unbelievable. There is no reason in the record why Claimant should have a worse presentation now two years later without objective evidence of injury.

Dr. Kalamchi agreed that he is not a psychiatrist or psychologist nor did he administer a Global Assessment of Functioning (GAF) test on Claimant. While he did not do any personality

assessments, Dr. Kalamchi testified that he has seen thousands of patients and he can tell which ones have spinal issues and which ones are playing him. Claimant is in the latter group. Dr. Kalamchi admitted he did not test for depression or anxiety, nor is he an expert on interpretation of psychometric tests. Dr. Kalamchi agreed that chronic pain can lead to depression. Dr. Kalamchi testified that "sick role status" is not the same as malingering. In this case providers are willing to treat her and provided medication, stating that she needs all of it, and then her condition gets worse. Dr. Kalamchi felt that the Waddell test is sufficient for spine disorders and in this case Claimant came in the first time feeling good and back to work, the second time symptoms are worse and the third time she is totally disabled, can't drive and is using a cane, so it doesn't take a genius to figure out something is wrong psychologically. He did admit that he did not put in his report that Claimant was laughing and feeling good on the first visit. He admitted that Claimant was still having neck, back and ankle pain, abet with no underlying pathology. Dr. Kalamchi agreed that the Waddell signs were created to determine if there is a non-organic component to low back pain. It is not a malingering test. There are a number of variations on Waddell tests you could do in a particular case. He agreed there are seven standard tests. Dr. Kalamchi admitted that most of his opinion was based on observations, so there were some tests he did not do, and in fact he administered only one of the official tests. Dr. Kalamchi testified that when he was in Toronto he worked on studies of these signs and symptoms even before Waddell came in, so he is very experienced with these issues. Gordon Waddell came and did a fellowship in Toronto with doctors who were studying non-organic presentation in workers compensation patients. Dr. Kalamchi agreed that Waddell was critical of the use of these signs in litigation. He agreed that the tests are used to determine if a patient needs a psychological referral and in this case none of the treating doctors made such a referral. Dr. Kalamchi noted

that whatever the treating physicians did, it did not help Claimant. He was not aware of any referrals, but Claimant was treating with Dr. Xing who will treat anybody for pain management, but even she ended up discharging her. Dr. Kalamchi was willing to give Claimant the benefit of the doubt that she had some soft tissue sprain which required initial treatment, but beyond that there was no indication for further treatment.

Dr. Kalamchi agreed that Dr. Cucuzzella is a pain management physician and provided injections and ablation treatment to Claimant. He still felt that this treatment was unnecessary in his opinion. Dr. Kalamchi wouldn't have recommended these procedures in his opinion. Dr. Cucuzella could certainly give her an ablation for changes related to the scoliosis, but that would not be related to the work accident. His opinion is different from that of Dr. Cucuzella. Dr. Kalamchi has done facet injections in the past, which he indicated is the same thing as an ablation. He has not done this procedure in the past ten (10) years. Dr. Kalamchi agreed that someone could have a normal orthopedic and neurologic examination and still have back pain. With a normal MRI the back pain would be more postural or muscular rather than spine related. Claimant had an annular tear on the 2007 MRI and Dr. Kalamchi noted was still there in 2013. An annular tear does not heal because it is avascular. Dr. Kalamchi did not think the pain was from the tear, which is why he gave the sprain diagnosis. While painful a sprain diagnosis does not last forever, it gets better. Dr. Kalamchi noted in the AMA Guides they don't give permanent impairment for a sprain, but here in Delaware patients are often rated with 3-5% impairment for chronic low back pain related to a sprain/strain injury.

Dr. Kalamchi confirmed that he thought Claimant had a soft tissue injury from the work accident and that is the type of injury that typically resolves. Dr. Kalamchi agreed that there is no record that Claimant's chronic back and neck problems from 2007-2010 ever resolved. Part of an

orthopedic surgeons practice is to assess a patient's emotional and psychological stability because it could affect the treatment they could offer. It is critical for a surgeon to determine if a patients complaints are credible because they need to ensure the abnormality being operated on is the source of the pain. Dr. Kalamchi testified that Claimant's chronic pain in 2015 is based on her subjective symptoms which he questions. He confirmed that Claimant's ongoing complaint is of low back pain and not radiculopathy as diagnosed by Dr. Patil in 2010.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Termination

This matter is not the typical Petition for Review in that Claimant has already conceded that she is no longer totally disabled and signed a stipulation to that effect. The sole issue for the Board's determination is whether the injuries Claimant sustained in the April 29, 2013 work accident have completely resolved. Claimant advances several procedural arguments favoring a dismissal of the Petition in light of the fact that she has conceded to the termination of her total disability benefits. Claimant argues that Industrial Accident Board Rule 26 requires a separate petition to be filed asking for the Board to consider a resolution of the entire case. This is because the current Petition sought only a review of Claimant's receipt of total disability benefits. Further the request for a determination on the resolution of Claimant's injuries was not noted on the Pre-trial Memorandum; essentially Claimant was not put on notice of this request. Claimant also argues that Employer is attempting to shut down the entire case which amounts to an impermissible commutation of all benefits.

The Board previously addressed these issues in the motion hearing and ruled in favor of the Employer, determining that the hearing could proceed on the pending Petition. *Shelina Kirkland v. Terminix,* Del. IAB Hearing No. 1419447 (May 27, 2015) ORDER. In fairness to

Claimant the Board also continued the case and allowed Claimant the opportunity to present expert testimony from her treating physicians on the instant issue, thus remedying the notice issue. *Id.* Claimant next argued that the law favors her position against a total shut down of her case. Claimant cited to the *Davis v. Christiana Care Health Services* case where the Superior Court had reversed the Board's dismissal of a case on similar grounds as the present matter. In *Davis* Employer presented a motion to the Board to dismiss Claimant's petition to determine additional compensation due on the basis that Claimant had settled his entire case by agreement between the parties. The Board found that the Claimant's petition for permanent impairment should be dismissed due to the earlier agreement. The Agreement as to Compensation filed in the case contained the language; "lumbar spine contusion-resolved". In an e-mail confirming settlement employer's counsel used similar language, however claimant's counsel merely stated that the agreement would resolve the issues presently pending before the Board. The Court noted that the issues then before the Board were whether Claimant had "suffered a compensable work related injury and whether his medical bills were reasonable and causally related to the work accident." *Davis v. Christiana Care Health Services,* Del.Super. 2015 WL 899599 at *5. The Court further stated that the Board's legal conclusion that Claimant was not entitled to permanent impairment "without more" was erroneous. *Id.* at *4. The Court also dismissed the argument that the settlement agreement barred further benefits on the basis of *res judicata.* The agreement specifically only resolved the then pending dispute and the permanency issue had never been litigated nor had claimant knowingly waived future benefits. *Id.* at *5.

The Board finds the *Davis* case to be distinguishable from the instant matter. Here the Board is being specifically asked to determine on the merits whether Claimant's injuries have resolved, or whether she is back to her baseline condition prior to the work accident. In *Davis*

there was never any determination by the Board on the merits, merely a legal ruling on the meaning of language on a purported settlement agreement. The Court in *Davis* did note that employer could use the agreement and the medical opinion it was apparently based on as a defense against the petition filed for permanent impairment. *Id.* at*5. The Board as the trier of fact has the discretion to make a determination, based on substantial evidence that a claimant's injury has completely resolved. *Cottman v. Burris Fence Construction,* Del.Super. 2006 WL 2242729, *aff'd,* Del. 918 A2d. 338 (2006). (no recurrence possible when injury had completely resolved). *See also, Schreffler v. Heavy Equipment Metals,* Del.Super. 2011 WL 1848896.

In this case the Board finds that Claimant's injuries from the April 29, 2013 injury have resolved or returned to baseline condition prior to the accident with respect to her low back pain, although as noted below the Board has reason to be skeptical of Claimant's pain complaints. In finding that Claimant's injuries have resolved, the Board relies on the testimony of Dr. Kalamchi, the sole medical expert to testify in this case. Claimant argues that Dr. Kalamchi's testimony is inconsistent and should not be relied upon. Claimant points out that despite his initial opinion that the injuries resolved in August 2013, in 2014 Dr. Kalamchi diagnosed her with continued strain and in 2015 with chronic low back pain. Claimant was also placed on an open agreement for total disability in January 2015. The Board disagrees and finds that Dr. Kalamchi's opinion about Claimant and her diagnosis remained the same despite the altered semantics. Dr. Kalamchi testified that in his opinion Claimant's injuries related to the accident resolved by the time of his first examination in August 2013. He noted that Claimant had chronic low back pain based on her subjective complaints and her prior medical history. Dr. Kalamchi also made it clear that he did not believe Claimant's ongoing subjective complaints. He further noted that Claimant has a pattern of failing to tell medical providers about her past medical

history. He testified that the annular tear which was found on the MRI done prior to the accident and had not changed, and was not the cause of her pain. He diagnosed a strain injury which typically resolves. Dr. Kalamchi did concede that a permanent impairment rating can be given for a strain/sprain with ongoing subjective complaints.

Dr. Kalamchi was suspect of Claimant's pain complaints because Claimant initially had mild residual symptoms at his first exam, but then she got progressively worse for no apparent organic reason. By the time of his last exam he noted Claimant was using a cane and had to be driven to the appointment. It was at this visit when her pain behavior was most magnified. Dr. Kalamchi termed her issue as a "sick role syndrome", when an otherwise recovered patient is offered more and more treatment by medical providers willing to treat her and find additional problems she didn't know she had. He testified that Claimant had an inorganic presentation and was a symptom magnifier. Dr. Kalamchi even noted that after treating patients for many years he can often tell when someone has spinal issues or whether they are trying to pull the wool over his eyes, and he feels Claimant is in the latter group. Claimant also initially denied a history of back injuries, but subsequently Dr. Kalamchi reviewed a great deal of records from her prior accidents including low back injuries. Additionally, he noted this denial was a consistent pattern over several of her accidents with multiple providers.

The Board agrees with Dr. Kalamchi and finds Claimant's testimony unreliable and not credible. The Board finds that Claimant's complete lack of credibility even calls into question her complaints of pain relating back to her prior accidents. Claimant repeatedly denied a history of back problems on medical records in addition to the denials on examination with Dr. Kalamchi. In fact on Claimant's first treatment with Concentra following this accident she denied a history of back pain or problems and yet she had just seen Dr. Xing several months

prior complaining of back pain at an 8/10 level. Another damning piece of evidence is the emergency room record following her May 2010 motor vehicle accident in Virginia. The ER doctor took the time to note that Claimant was laughing and carrying on with her companion as if nothing was wrong. Then on treatment with Dr. Xing shortly thereafter she has complaints of severe neck and back pain. Not only is Claimant's testimony inconsistent with the medical records, the evidence points to the fact that she is misrepresenting her medical history and overstating her complaints, to put it mildly. She claimed that her back pain stemming from the 2007 accident was gone by the time of the 2010 accident; however under cross examination the medical records reflected that she continued with pain complaints. Claimant did admit to having back pain every now and then before the 2013 work accident; however Dr. Xing's records in February reveal that Claimant cited 8/10 back pain and she was taking Percocet and Naproxen. She went on a trip to Memphis and had to stop multiple times because of back pain. Her job duties were also causing an increase in her pain. Claimant also told Dr. Kalamchi that after the 2013 accident she had trouble climbing stairs because of her back pain. However the medical records reflected that Claimant had this functional limitation back in 2005, however she failed to enlighten the doctor as to this history. Interestingly Claimant testified that when she was discharged by Dr. Xing in October 2013 her pain levels were 1/10 with medication and 5/10 without medication, whereas her pain levels in February 2013 prior to the accident were 1/10 with medication and 8/10 without medication. [1] This testimony would seem to confirm Dr. Kalamchi's opinion, keeping in mind that the Board believes there is an element of symptom magnification by the Claimant.

In summary Employer has met its' burden to prove by a preponderance of the evidence that Claimant's injuries as a result of the April 2013 accident have resolved. Dr. Kalamchi

[1] Dr. Xing discharged Claimant because she was obtaining narcotic medications from several different providers.

testified that Claimant's injuries resolved as of August 6, 2013 when he examined Claimant. At a minimum Claimant was back to her pre-accident condition by the time of her discharge by Dr. Xing in October 2013. It is important to note that at his initial examination Dr. Kalamchi had little knowledge of Claimant's extensive past medical history and he based his opinion on Claimant's then current complaints and his physical examination. Since that exam records came to light which cast doubt on the veracity of Claimant's ongoing complaints. Based on the foregoing evidence the Claimant's injuries have resolved and the Employer's Petition will be granted.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, the Board finds that Claimant's injuries related to the April 29, 2013 accident resolved as of August 6, 2013. Employer's Petition for Review is hereby **GRANTED.**

IT IS SO ORDERED THIS 17th DAY OF AUGUST 2015.

INDUSTRIAL ACCIDENT BOARD

Marilyn J. Doto

MARILYN DOTO

for/ John Daniello

~~JOHN D. DANIELLO~~ Lowell W. Groundland

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

Mailed Date: 8-19-15

Karen Snider

OWC Staff

EFiled: Jun 17 2016 09:03AM EDT
Transaction ID 59159556
Case No. N15A-08-003 AML

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

SHELINA KIRKLAND,	)	
	)	
Claimant-below/Appellant,	)	
	)	
v.	)	C.A. N15A-08-003 AML
	)	
TERMINIX,	)	
	)	
Employer-below/Appellee.	)	
	)	

Submitted: March 8, 2016
Decided: June 17, 2016

ORDER

On appeal from a decision of the Industrial Accident Board: AFFIRMED.

This is Shelina Kirkland's appeal from an August 17, 2015 decision of the Industrial Accident Board (the "Board"). After a hearing, the Board granted Terminix's Petition for Review, terminating Kirkland's benefits, based on the Board's determination that Kirkland's injuries had resolved fully as of August 6, 2013.

Background and Procedural History

On April 29, 2013, Shelina Kirkland injured her low back and neck while working for Terminix. Her injuries were acknowledged as compensable, and she received workers' compensation benefits, including total disability benefits.

On December 12, 2014, Terminix filed with the Board a Petition for Review (the "Petition") to terminate Kirkland's receipt of total disability benefits. A hearing on the Petition was scheduled for May 15, 2015. In accordance with Board Rule 9,[1] the parties filed a pre-trial memorandum with the Board on February 24, 2015. Terminix's medical expert, Dr. Kalamchi, was deposed on May 12, 2015. Kirkland did not depose any of her experts listed on the pre-trial memorandum before the May 2015 hearing.

On May 15, 2015, the date of the Board hearing, the parties signed a stipulation in which Kirkland conceded her "disability has ended" and she "no longer opposes [Terminix's] Petition to Terminate her disability benefits."[2] Terminix, however, wanted to proceed on the Petition, alleging Kirkland's work injuries had resolved fully.[3] Kirkland contended that Terminix needed to file a second petition "terminating medical benefits" in order for the Board to consider that issue.[4]

Following argument from both sides, the Board decided that the issue of whether Kirkland's work injuries had resolved properly was before them.[5]

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[1] State of Delaware Industrial Accident Board Rules, attached as Ex. B to Terminix's App. to Answering Br. (hereinafter cited as "Board Rule(s)" or "Rule(s)").
[2] Termination Stip. & Order, attached as Ex. A-18 to Appellant's App. to Opening Br.
[3] Tr. 4:6–9, May 15, 2015 hearing, attached as Ex. 9 to Appellant's App. to Opening Br.
[4] *Id.* 7:12–17.
[5] *Kirkland v. Terminix*, No. 1419447, at 14 (Del. I.A.B. Aug. 17, 2015) (Decision on Petition to Terminate Benefits) (hereinafter cited as "I.A.B. Decision, Aug, 17, 2015").

Specifically, the Board stated:

> "[T]he petition that was filed is the appropriate measure to have the issue of whether [Kirkland's] condition has resolved. This is the proper vehicle to have that issue resolved and just the fact that there is now a concession . . . a late concession that [Kirkland] is no longer totally disabled, [Terminix] should still have a chance to litigate that issue of whether the condition has been fully resolved."[6]

The Board did, however, continue the case for 60 days to allow Kirkland "a chance to depose her own doctor on [the] issue"[7] of whether she recovered from her work injuries.[8] Although Kirkland scheduled her treating chiropractor's deposition for June 15, 2015,[9] Terminix's counsel was informed on June 14, 2015 that "they had elected to cancel the deposition."[10]

On July 6, 2015, the parties reconvened to litigate whether Kirkland's injuries had resolved fully. At that hearing, Terminix submitted Dr. Kalamchi's deposition transcript. Kirkland relied on her own testimony.

On August 17, 2015, the Board issued its decision and concluded the only issue to decide was "whether the injuries Claimant sustained in the April 29, 2013 work accident have completely resolved."[11] Based on the record, the Board granted Terminix's Petition, determining that Kirkland's work-related injuries had

[6] Tr. 9:4–12, May 15, 2015 hearing, attached as Ex. 9 to Appellant's App. to Opening Br.
[7] *Id.* 9:16–19.
[8] I.A.B. Decision, Aug, 17, 2015, at 15.
[9] Tr. 5:19–20, July 6, 2015 hearing, attached as Ex. 10 to Appellant's App. to Opening Br.
[10] Terminix's Answering Br. 2.
[11] I.A.B. Decision, Aug, 17, 2015, at 14.

resolved fully as of August 6, 2013.[12] Kirkland appealed the Board's decision on August 24, 2015.

The Parties' Contentions

Kirkland contends that the issue of whether her work-related injuries had resolved fully was not properly before the Board and that the Board's ultimate decision on that issue therefore "constitutes reversible error because the Board decided an issue that was not properly placed before it" in violation of its own Rules[13] – specifically, Board Rule 26. That Rule states: "When a petition is pending before the Board, . . . a party wishing to [*inter alia*, request to review an open compensation agreement] must file a formal petition."[14]

Kirkland argues that Terminix's pending Petition alleged only that "Claimant is physically able to return to work," and, therefore, the sole issue on which the Board could render a determination was whether Kirkland physically was able to return to work after her April 29, 2013 work injuries.[15] She contends that, under Rule 26, the Board could not consider whether her injuries had resolved fully unless and until Terminix filed a second petition specifically raising that

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[12] *Id.* at 19.
[13] Appellant's Opening Br. 7.
[14] *Id.* at 7-8 (citing Board Rule 26:

> When a petition is pending before the Board, either party may assert an additional issue but a party wishing to assert one or more of the following issues must file a formal petition . . .
> (1) A request to review an open compensation agreement . . . .).

[15] Appellant's Opening Br. 8.

issue. Because no such petition was filed, Kirkland argues the Board erred in determining Kirkland's injuries resolved as of August 6, 2013.[16]

Kirkland also argues that whether she received notice of the July 6, 2015 hearing's subject-matter "sufficiently in advance" of the hearing is irrelevant because Rule 26 conclusively requires a petition to be filed.[17] Nonetheless, Kirkland contends that if notice was relevant, her counsel was not "properly notified by the [Board] that there would be a hearing on the issue of whether . . . [her] work related injuries had fully resolved."[18] Relying on *Phillips v. Delhaize America, Inc.*,[19] Kirkland argues that the "Board's proceedings are governed by both the requirements of due process and the [Administrative Procedures Act (the 'APA')]."[20] Accordingly, the Board must "inform the party of the time, place, and date of the hearing and the subject matter of the proceedings."[21] In *Phillips*, this Court determined the Board failed to comply with "either due process or the APA's notice requirements [since] [t]he Board did not send any notice at all to [the parties] about what [the Board] intended [to] address at the legal hearing."[22]

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[16] *Id.*
[17] Appellant's Reply Br. 2.
[18] Appellant's Opening Br. 9.
[19] 2007 WL 2122139, at *2 (Del. Super. July 20, 2007) (citing 19 *Del. C.*§ 2301A (d) and 29 *Del. C.* § 10161).
[20] Appellant's Opening Br. 8.
[21] *Id.* (citing *Phillips*, 2007 WL 2122139, at *2 (citing *J.L.B. Corp. v. Delaware A.B.C.C.*, 1985 WL 189008, at *2 (Del. Super. June 7, 1985))).
[22] Appellant's Opening Br. 9 (citing *Phillips*, 2007 WL 2122139 at 2).

Kirkland further contends that the pre-trial memorandum was not sufficient notice because Terminix checked off the box indicating that "Claimant's continued injuries are not causally related to the accident," which, Kirkland argues, is not the same as alleging her injuries "completely resolved."[23] Lastly, Kirkland argues she was prejudiced by the Board's decision because, had she known the Board was going to consider whether her condition had resolved, her cross-examination of Terminix's medical expert "would have been far different and more focused on that issue."[24]

Terminix responds that Rule 26 does not require Terminix "to file a second Petition for Review in order to have the Board address whether [Kirkland's] work injuries have resolved."[25] Rather, the "relevant standard is whether an issue has been raised sufficiently in advance of [the] hearing to provide parties notice and an opportunity to be heard."[26] Citing *Jepsen v. University of Delaware*, Terminix contends: "An issue is properly before the Board if it is the subject of a petition or included on the Pre-Trial Memorandum."[27] Moreover, Terminix argues: "Even if [Kirkland's] interpretation of Rule 26 was debatable, the courts generally 'will not

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[23] Appellant's Reply Br. 3.
[24] Appellant's Opening Br. 10.
[25] Terminix's Answering Br. 17.
[26] *Id.* at 18.
[27] *Id.* (citing *Jepsen v. Univ. of Del.*, 2003 WL 22139774, at *3 (Del. Super. Aug. 28, 2003).

force the Board to impose a literal and hyper[-]technical interpretation of the rules where the Board itself has chosen not to do so.'"[28]

Terminix asserts that the Board agreed that the pending Petition encompassed the issue of whether Kirkland's work injuries fully had resolved. The Board's decision was reasonable, Terminix contends, given that Kirkland was on notice that Terminix intended to terminate her benefits based on the medical expert opinion that her work injuries had resolved.[29] For example, in August 2013, Dr. Kalamchi opined that Kirkland's work-related related cervical and lumbar strains had "resolved."[30] Moreover, at the May 15, 2015 hearing, the Board specifically told Kirkland that the next hearing would address the fully-resolved issue. Therefore, even if Kirkland was unaware of the issue until the hearing, she was not prejudiced because, at the very latest, Kirkland was notified by the Board on May 15, 2015 that there would be a hearing in 60 days.[31]

Terminix further argues that "Delaware courts have many times in the past affirmed Board [d]ecisions finding that a [c]laimant's condition has returned to baseline and that the employer is no longer responsible for current problems."[32]

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[28] Terminix's Answering Br. 18 (citing *Yellow Freight Sys., Inc.*, 1999 WL 167780, at *4 (Del. Super. Mar. 5, 1999)).
[29] Terminix's Answering Br. 18-19.
[30] Kalamchi Dep. 10:24.
[31] Terminix's Answering Br. 19.
[32] *Id.* at 15 (citing *Schreffler v. Heavy Equip. Rentals*, 2011 WL 1848896, at *6 (Del. Super. Apr. 26, 2011) ("The Board's decision . . . is supported by substantial evidence that Claimant's ongoing symptoms are related solely to his pre-existing condition.")); *Cottman v. Burris Fence*

Terminix contends that Kirkland offered no medical evidence to rebut the fact that she had a "pre-existing and symptomatic degenerative back condition,"[33] and that "Dr. Kalamchi's testimony constituted substantial evidence for the Board to rely on"[34] in finding that Kirkland's work injuries fully resolved. Accordingly, Terminix posits, the Board's decision should be affirmed.

Standard

This Court repeatedly has emphasized its limited role in reviewing the Industrial Accident Board's decisions: the Court must determine if the Board's factual findings are supported by substantial evidence in the record[35] and whether its decision legally was correct.[36]

"Substantial evidence" is less than a preponderance of the evidence but more than a "mere scintilla."[37] It is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[38] The Court must review the record to determine if the evidence is legally adequate to support the Board's factual findings. In so doing, the Court evaluates the record in the light most favorable to

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Constr., 918 A.2d 338 (Del. 2006) (TABLE) (affirming decision that sprain from work injury had resolved and any further symptoms were the result of an underlying chronic condition)); *see also Paynter v. Allen Family Foods*, C.A. No. S10A-12-003, at 12 (Del. Super. June 14, 2011) ("Employer does not carry the burden for the cost of treatment due to a degenerative condition unrelated to the workplace injury.").

[33] Terminix's Answering Br. 15-16.

[34] *Id.* at 13.

[35] *Histed v. E.I. duPont de Nemours & Co.*, 621 A.2d 340, 342 (Del. 1993).

[36] *Johnson v. Chrysler Corp.*, 213 A.2d 64, 66 (Del. 1965).

[37] *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

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

the prevailing party to determine whether substantial evidence existed reasonably to support the Board's conclusion.[39] The Court does not "weigh evidence, determine questions of credibility or make its own factual findings."[40]

Moreover, "an administrative agency's interpretation of its rules [is] presumptively correct."[41] Generally, judicial deference is given to "an administrative agency's construction of its own rules in recognition of its expertise in a given field."[42] Accordingly, "an administrative agency's interpretation of its rules will not be reversed unless 'clearly wrong.'"[43] On appeal, the Court reviews legal issues *de novo*.[44]

Analysis

Kirkland has not challenged the validity of the Board's decision that her work injuries had resolved. The limited issue currently before this Court is whether that issue properly was before the Board in the first place. For the reasons set forth below, I find that the Board was within its discretion to determine whether Kirkland's work injuries had resolved.

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[39] *Burmudez v. PTFE Compounds, Inc.*, 2006 WL 2382793, at *3 (Del. Super. Aug. 16, 2006).
[40] *Olney*, 425 A.2d at 614.
[41] *Div. of Soc. Servs. v. Burns*, 438 A.2d 1227, 1229 (Del. 1981).
[42] *Id.* (citing *Diebold, Inc. v. Marshall*, 585 F.2d 1327 (6th Cir. 1978)).
[43] *Burns*, 438 A.2d at 1229 (citing *Peterson v. Hall*, 421 A.2d 1350, 1353 (Del. Super. 1980)).
[44] *Person-Gaines v. Pepco Holdings, Inc.*, 981 A.2d 1159, 1161 (Del. 2009).

The Board Rules applicable here are sufficiently vague so as to require interpretation by the Board. That interpretation is given great weight[45] and unless "clearly wrong," will not be reversed.[46] In this case, the Board determined on two separate dates, and after a change in composition,[47] that the pending Petition, along with the pre-trial memorandum, sufficiently raised the issue of whether Kirkland's work injuries had resolved fully.[48] I cannot say that the Board's interpretation of its Rules clearly is wrong.

Rule 26 states, in pertinent part, that:

> When a petition is pending before the Board, either party may assert an additional issue but a party wishing to assert one or more of the following issues must file a formal petition . . .
>
> (1) A request to review an open compensation agreement.

For its part, Rule 9 requires that parties complete a pre-trial memorandum before a Board hearing, which includes a "complete statement of what the petitioner seeks and alleges."[49] The pre-trial memorandum may be amended up to 30 days prior to

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[45] *Riley v. Chrysler Corp.*, 1987 WL 8273, at *1 (Del. Super. Mar. 6, 1987) ("The Board's interpretation of its own rule is entitled to great weight."); *see also Goldsborough v. New Castle County*, 2011 WL 51736 (Del. Super. Jan. 5, 2011).
[46] *Burns*, 438 A.2d at 1229.
[47] Board member Terrence Shannon retired shortly after the May 27, 2015 hearing.
[48] *See Kirkland v. SMCS Terminix*, No. 1419447, at 2 (Del. I.A.B. May 27, 2015) (ORDER); I.A.B. Decision, Aug. 17, 2015, at 14.
[49] Rule 9(B)(5)(b).

the hearing.[50] Terminix's Petition alleged Kirkland physically was able to return to work.[51] The pre-trial memorandum further clarified the issues Terminix was raising, namely whether Kirkland's continuing injuries were work-related.[52] That contention reasonably can be read as Terminix asserting Kirkland's work injuries fully had resolved. The Board's determination that Terminix satisfied Rules 9 and 26 therefore was not clearly erroneous.

Even if I concluded the Board's interpretation of its Rules was erroneous, Kirkland's appeal nevertheless would fail because any error of the Board was remedied by the 60-day extension to allow additional discovery. It is "settled in Delaware that before the Board can consider an issue, the issue must be raised sufficiently in advance of the hearing to provide the parties notice and an opportunity to be heard."[53] This Court has held that: "An issue is before the Board if it is the subject of a petition submitted to the Board ***or*** is appropriately noticed at the Pretrial Hearing."[54] Conversely, if a party is not given proper notice of an issue before the hearing, that issue is not properly before the Board.[55]

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[50] Rule 9(B)(6)(a).
[51] Terminix's App. to Answering Br. Ex. A.
[52] *Id.* Ex. C.
[53] *Murphy Steel, Inc. v. Brady*, 1989 WL 124934, at *2 (Del. Super. Oct. 3, 1989); *see also* Rule 8(C): "No order involving a matter submitted under this Rule shall be issued by the Board against the non-moving party until the non-moving party has been given an opportunity to be heard on the issue."
[54] *Jepsen*, 2003 WL 22139774, at *3 (emphasis added).
[55] *Id.*

For example, in *Murphy Steele, Inc. v. Brady*, an employer sought to terminate a claimant's total disability benefits. The employer's intentions were reflected in both the pre-trial memorandum and the petition for review. The claimant, however, neither petitioned the Board for partial disability benefits, nor "directly indicate[d] in the Pre-Trial Memorandum that he was entitled to partial disability benefits."[56] This Court held that the "first mention of this [partial disability benefits] issue in the opening statement was not sufficient notice," to the employer and remanded the matter to the Board "so that the Employer is given the opportunity to disprove partial disability."[57]

On the other hand, "[i]n proceedings before the Board, it can hardly be expected that technical niceties of pleading will be observed and, where the informality thereof works no substantial injustice to the other party, it should not be allowed to defeat an otherwise meritorious claim."[58] For example, in *Yellow Freight System, Inc. v. Berns*,[59] an employer argued that a claimant failed to mention a certain defense in the pre-trial memorandum. The Board, however, not

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[56] *Murphy Steel, Inc.*, 1989 WL 124934, at *3.
[57] *Id.*
[58] *Gen. Motors Corp. v. Socorso*, 105 A.2d 641, 644 (Del. Super. 1953) (citing Larson's Workmen's Compensation Law 252); *see also Conner v. Boulden Buses, Inc.*, 1993 WL 54493, at *6 (Del. Super. Feb. 19, 1993) ("[A]n informal tribunal such as the Board may, in appropriate circumstances, rule on different legal grounds than those presented by the parties if neither party is clearly prejudiced.").
[59] 1999 WL 167780 (Del. Super. Mar. 5, 1999).

only "chose to hear and consider Claimant's position," but relied on it.[60] This Court rejected the employer's argument, holding that "[w]hile the Board's procedural rules are promulgated for 'more efficient administration of justice,' this Court will not force the Board to impose a literal and hyper-technical interpretation of the rules where the Board itself has chosen not to do so."[61]

Kirkland's appeal elevates form over substance. Kirkland was not "harmed or misled by any defect in [the] form of the petition."[62] The informality here, if there was any, cannot defeat an otherwise meritorious claim, especially where Kirkland elected not to present her case at a later date.

In sum, I find Kirkland suffered no prejudice by the Board's hearing the issue on July 6, 2015. Here – unlike in *Phillips* where the Board sent no notice at all to the parties or *Murphy Steele* where the first mention of the issue was in opening statements – the Board informed Kirkland of exactly what issue was going to be contested at the July 6, 2015 hearing, giving her time to depose her expert on the issue. Kirkland, therefore, was given adequate notice that whether her work injuries fully had resolved would be addressed at the July 6, 2015 hearing. Although she argues she would have questioned Dr. Kalamchi in a different manner had she been aware that the issue of full recovery was going to be heard by

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[60] *Id.* at *4.

[61] *Id.*; *see also Socorso*, 105 A.2d at 644.

[62] *Socorso*, 105 A.2d at 644; *see also Conner*, 1993 WL 54493.

the Board, she did not seek to re-depose the doctor in the 60-day window before the hearing. Moreover, Kirkland offers no explanation for why she presented no medical expert of her own at the July 6, 2015 hearing.[63]

Based on the foregoing, I find the Board's interpretation of their Rules was not clearly erroneous and the Board was within its discretion in relying on Dr. Kalamchi's opinion and finding that Kirkland fully recovered from her April 29, 2013 accident. The Board's August 17, 2015 Decision therefore is **AFFIRMED**.

IT IS SO ORDERED.

Abigail M. LeGrow, Judge

Original to Prothonotary
cc: John J. Ellis, Esquire
Joseph W. Weik, Esquire

[63] Appellant's Opening Br. 6 ("Claimant's counsel opted not to depose an expert witness prior to the July 6, 2015 new hearing date.").

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

MICHELLE CURTIS-HOWETT,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1072218
	)	
TECOT ELECTRIC,	)	
	)	
Employer.	)	

ORDER

This matter came before the Board on August 28, 2014, on a motion by Tecot Electric ("Employer"), through Delaware Insurance Guaranty Association ("DIGA"), seeking a finding that DIGA is not responsible for payment of medical expenses incurred by Michelle Curtis-Howett ("Claimant") that are allegedly reasonable, necessary and causally related to Claimant's December 1995 work accident.

Background: Claimant was injured in a compensable work accident on December 27, 1995. Employer's workers' compensation insurance carrier for that date of injury was Reliance Insurance Company. In 2001, Reliance Insurance Company was declared insolvent and liquidated. Pursuant to the Delaware Insurance Guaranty Association Act (chapter 42 of title 18 of the Delaware Code), the existence of an "insolvent insurer" triggered coverage by DIGA. Part of the purpose of DIGA is to provide "for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer." DEL. CODE ANN. tit. 18, § 4202. However, the law makes provisions to prevent duplicative recoveries:

> (a) Any person having a claim covered under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim shall be required

> to first exhaust the rights under such policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such insurance policy.
>
> (b) Any person having a claim which may be recovered under more than 1 insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, such person shall seek recovery first from the association of the location of the property, and, if it is a workers' compensation claim, such person shall seek recovery first from the association of the residence of the claimant. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.
>
> (c) Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim shall be required to exhaust the rights under such program prior to recovery under this chapter. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such program.

DEL. CODE ANN. tit. 18, § 4212.

Following the insolvency of Reliance Insurance Company, Claimant had healthcare coverage under her husband's healthcare policy with his employer. However, in March of 2014, Claimant's husband lost his job and, subsequently, his healthcare coverage. Claimant seeks to have DIGA cover her reasonable and necessary medical expenses causally related to her workers' compensation injury.

Argument: Employer/DIGA argues that, under the federal Patient Protection and Affordable Care Act, 42 U.S.C. ch. 157 ("ACA"), Claimant has an "affirmative obligation" to obtain healthcare insurance coverage and that the mechanism for obtaining affordable insurance set up under the ACA is the equivalent of a "governmental insurance or guaranty program" such that Claimant must exhaust her rights to coverage under such a program before DIGA becomes responsible for payment of medical expenses.

Claimant argues that ACA does not mandate that she obtain coverage. She also notes that, at the time that her husband lost his job, the open enrollment period for obtaining coverage under a health insurance exchange under the ACA had ended.

Issues: Multiple questions are raised by this motion. The Board lacks sufficient legal input from the parties to properly determine the matter. These issues include:

First, whether the Board even has jurisdiction to determine the matter. The question posed concerns, specifically, the scope of DIGA's responsibilities under the Delaware Insurance Guaranty Association Act and the ACA. Neither of those Acts is within the Board's normal jurisdiction, which is limited to issues arising out of chapter 23 of title 19 of the Delaware Code, *i.e.*, the Workers' Compensation Act. *See* DEL. CODE ANN. tit. 19, § 2301A. There is, therefore, a question of whether the Board has jurisdiction to resolve this issue. *See, generally, Delaware Insurance Guaranty Association v. Pickering*, Del. Super., C.A. No. 04C-09-240, Johnston, J., 2006 WL 1067317 (April 10, 2006).

Second, if the Board has jurisdiction, the next issue concerns the scope of the ACA. The Board is not familiar with all the provisions of that Act. What specific statutory provision or provisions establish that Claimant either has or does not have an affirmative obligation to obtain healthcare insurance? Is it, as Claimant argues, optional provided a person is willing to pay the assessed fee for not having coverage; or does the ACA actually mandate that coverage be obtained?

Third, what effect does the closing of the open enrollment period have on this? When a person is suddenly deprived of insurance after the close of an open enrollment period, is there a mechanism under the ACA to obtain insurance immediately, or must that person wait until the next open enrollment period?

Fourth, if DIGA is not responsible to pay for medical expenses if a person has other healthcare insurance and if the ACA requires all to have such insurance, then under what set of circumstances would DIGA ever be liable to pay medical expenses? In other words, is it DIGA's position that the effect of the ACA is to completely absolve it of paying medical benefits under chapter 42 of title 18, and if not under what circumstances would any person be considered as not "having a claim or legal right of recovery under any governmental insurance or guaranty program"? DEL. CODE ANN. tit. 18, § 4212(c).

Fifth, regardless of the effect of ACA, if a person has healthcare insurance that, under title 18, section 4212(a), would otherwise need to be exhausted before DIGA became responsible for benefits, can that person voluntarily drop that coverage (and thus be relieved of paying premiums for it) and have DIGA assume coverage or does some provision of the Delaware Insurance Guaranty Association Act or caselaw associated with it prohibit such action?

These issues all involve statutory enactments that the Board has little familiarity. As such, the Board finds that it needs proper legal briefing of the issue before it can make an informed decision. Accordingly, the Board orders that briefing be done by the parties addressing the issues raised above. The Board requests that the parties propose a suitable briefing schedule within one week of the receipt of this order. If the parties are unable to agree on a briefing schedule, then either party may request that the Board impose one.

IT IS SO ORDERED this 18th. day of September, 2014.

INDUSTRIAL ACCIDENT BOARD

TERRENCE M. SHANNON

OTTO R. MEDINILLA, SR.

Mailed Date: 9. 22. 14

OWC Staff

Christopher F. Baum, Hearing Officer for the Board
Michael B. Galbraith, Attorney for Claimant
John J. Klusman, Jr., Attorney for Employer

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BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

MICHELLE CURTIS-HOWETT,	)	
Employee,	)	
v.	)	Hearing No. 1072218
TECOT ELECTRIC,	)	
Employer.	)	

ORDER

This matter first came before the Board on August 28, 2014, on a motion by Tecot Electric ("Tecot"), through Delaware Insurance Guaranty Association ("DIGA"), seeking a finding that DIGA is not responsible for payment of medical expenses incurred by Michelle Curtis-Howett ("Claimant") that are allegedly reasonable, necessary and causally related to Claimant's December 1995 work accident. After hearing the presentation of the parties, the Board requested additional briefing on several issues. *See Curtis-Howett v. Tecot Electric*, Del. IAB, Hearing No. 1072218 (September 18, 2014)(ORDER). This briefing was completed on January 9, 2015.

Background: Claimant was injured in a compensable work accident on December 27, 1995. Tecot's workers' compensation insurance carrier for that date of injury was Reliance Insurance Company ("Reliance"). In 2001, Reliance was declared insolvent and liquidated. Pursuant to the Delaware Insurance Guaranty Association Act (chapter 42 of title 18 of the Delaware Code), the existence of an "insolvent insurer" triggered coverage by DIGA. Part of the purpose of DIGA is to provide "for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or

policyholders because of the insolvency of an insurer." DEL. CODE ANN. tit. 18, § 4202. However, the law makes provisions to prevent duplicative recoveries:

> (a) Any person having a claim covered under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim shall be required to first exhaust the rights under such policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such insurance policy.
>
> * * *
>
> (c) Any person having a claim or legal right of recovery under any governmental insurance or guaranty program which is also a covered claim shall be required to exhaust the rights under such program prior to recovery under this chapter. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such program.

DEL. CODE ANN. tit. 18, § 4212.

Following the insolvency of Reliance, Claimant had healthcare coverage under her husband's healthcare policy with his employer. However, in March of 2014, Claimant's husband lost his job and, subsequently, his healthcare coverage. Claimant, now without healthcare coverage, seeks to have DIGA cover her reasonable and necessary medical expenses causally related to her workers' compensation injury.

DIGA argues that, under the federal Patient Protection and Affordable Care Act, 42 U.S.C. ch. 157 ("ACA"), Claimant has an "affirmative obligation" to obtain healthcare insurance coverage and that the mechanism for obtaining affordable insurance set up under the ACA is the equivalent of a "governmental insurance or guaranty program" such that, under section 4212(c) of title 18 of the Delaware Code, Claimant must exhaust her rights to coverage under such a program before DIGA becomes responsible for payment of medical expenses. Claimant argues that ACA does not mandate that she obtain coverage.

Jurisdiction: The first issue that the Board requested the parties to address was whether this Board even has jurisdiction to resolve this matter.

> The question posed concerns, specifically, the scope of DIGA's responsibilities under the Delaware Insurance Guaranty Association Act and the ACA. Neither of those Acts is within the Board's normal jurisdiction, which is limited to issues arising out of chapter 23 of title 19 of the Delaware Code, *i.e.*, the Workers' Compensation Act. *See* DEL. CODE ANN. tit. 19, § 2301A. There is, therefore, a question of whether the Board has jurisdiction to resolve this issue. *See, generally, Delaware Insurance Guaranty Association v. Pickering*, Del. Super., C.A. No. 04C-09-240, Johnston, J., 2006 WL 1067317 (April 10, 2006).

Curtis-Howett v. Tecot Electric, Del. IAB, Hearing No. 1072218 (September 18, 2014)(ORDER).

DIGA argues that the basic issue is one of insurance coverage for a work injury. The Board's jurisdiction applies to all issues arising under the Workers' Compensation Act, including insurance coverage issues. *See Silva-Garcia v. City Window Cleaning*, Del. IAB, Hearing No. 1348611, at 3-4 (November 23, 2010)(ORDER). *See also Liberty Mutual Ins. Co. v. Silva-Garcia*, Del. Super., C.A. No. 13A-01-002, Young, J., 2013 WL 4507847 (August 22, 2013) (affirming Board's determination that the employer had workers' compensation insurance coverage on the date of loss), *aff'd sub nom.*, LM Insurance Corp. v. Silva-Garcia, 93 A.3d 654 (Del. 2014). In this case, the issue is whether DIGA is obligated to provide coverage for medical expenses submitted under a compensable workers' compensation claim (*i.e.*, a dispute over compensation to be paid under the Workers' Compensation Act). As such, DIGA argues that the issue is well within the scope of the Board's jurisdiction.

Claimant does not dispute that the Board generally has the power to hear disputes concerning compensation to be paid under the Workers' Compensation Act. However, Claimant argues that, in this case, the Board is being requested to engage in statutory interpretation of a

federal law (the ACA), namely to determine whether the ACA creates a "governmental insurance or guaranty program" that would effectively relieve DIGA of the obligation to pay workers' compensation benefits to Claimant. Claimant argues that the Board, as a state administrative board (albeit one exercising a quasi-judicial function), is not vested with the authority to apply federal law or engage in federal statutory interpretation.

DIGA argues that the Board is not being asked to enforce or apply the ACA, merely to recognize its existence as a source of available healthcare coverage. The Board has frequently been required to consider issues raised by the effect of federal statutes and regulation on the operation of the Workers' Compensation Act. For example, the Board has considered whether an employer was entitled to an offset of compensable medical expenses because of payments made by Medicare. *See Porter v. Insignia Management Group*, Del. Super., C.A. No. 02A-06-004, Witham, J., 2003 WL 22455316, at *4 (Sept. 26, 2003). Likewise, the Board has held that a disability ruling by the Social Security Administration is not relevant to a Board determination of disability because the Workers' Compensation Act employs a different standard for "total disability" than the Social Security Administration. *See Jarman v. Willow Grove Meats*, Del. Super., C.A. No. 93A-07-001, Steele, J., 1994 WL 146031, at *8 (March 30, 1994), *aff'd*, 650 A.2d 1306 (Del. 1994). More recently, the Board engaged in a detailed analysis of the federal Immigration Reform Control Act ("IRCA") to consider what effect, if any, IRCA had on the receipt of benefits under Delaware's Workers' Compensation Act. *See Ramirez v. Delaware Valley Field Services*, Del. IAB, Hearing No. 1363724, at 10-16 (December 19, 2011). This decision was subsequently affirmed by the appellate courts. *See Delaware Valley Field Services v. Ramirez*, Del. Super., C.A. No. 12A-01-007, Herlihy, J., 2012 WL 8261599 (September 13, 2012), *aff'd*, 61 A.3d 617 (Del. 2013).

Considering these arguments, the Board agrees with DIGA that it does have jurisdiction of this issue. As will be discussed in more detail below, a crucial consideration in this case actually concerns the provisions of the Workers' Compensation Act, particularly the statutory language about who should be primarily responsible for payment of reasonable and necessary medical expenses causally related to a work accident.

Scope of ACA: The second issue that the Board requested briefing on is the scope of the federal ACA, specifically addressing the issue of whether it creates an affirmative obligation on the part of Claimant to obtain healthcare insurance.

DIGA argues that "minimum essential" healthcare coverage is "available" and "readily accessible" to Claimant through the operation of the ACA. DIGA argues that this equates to Claimant having "a claim or legal right of recovery" under a "governmental insurance or guaranty program," as contemplated by section 4212(c) of title 18 of the Delaware Code. DIGA further argues that Claimant's "voluntary inaction" in not obtaining insurance coverage under the ACA means that DIGA's legal responsibility to pay the medical expense claims of the insolvent insurer is not triggered. More specifically, DIGA argues that a plain reading of ACA makes it clear that Congress' intent was that every qualified individual is required to procure a minimum level of essential healthcare coverage. *See, e.g.,* 26 U.S.C. § 5000A (2012) (setting forth a "requirement" of minimum essential coverage that applicable individuals "shall" obtain or face paying a "penalty").

Claimant responds that the U.S. Supreme Court has already ruled on this issue. In *National Federation of Independent Businesses v. Sebelius*, 132 S.Ct. 2566 (2012), the Supreme Court held that

> [w]hile the individual mandate clearly aims to induce the purchase of health insurance, it need not be read to declare that

> failing to do so is unlawful. *Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS.*

Sebelius, 132 S.Ct. at 2596-97 (emphasis added). As such, the Supreme Court concluded that, despite the ACA using the term "penalty," making a payment to the IRS in lieu of getting insurance was not a true penalty but was, rather, a tax. *See Sebelius*, 132 S.Ct. at 2595-96.

DIGA does not dispute this holding, but argues that the mere fact that Claimant would not be violating any law if she did not seek other health insurance (choosing to pay a tax instead) does not change the basic point that she has "a claim or legal right of recovery under [a] governmental insurance or guaranty program," namely the ACA, which she is "required to exhaust" before recovering anything from DIGA. *See* DEL. CODE ANN. tit. 18, § 4212(c).

Essentially, DIGA is arguing that Claimant is required to seek other insurance in order to exhaust it before DIGA's obligations are triggered under the Delaware Insurance Guaranty Association Act.

The Board disagrees. If the ACA made it mandatory for Claimant to obtain insurance, the argument might possibly have some validity (although, as will be discussed later, this is not certain once one factors in that this is a compensable injury under the Workers' Compensation Act). However, the U.S. Supreme Court's ruling in *Sebelius* makes it clear that neither the ACA nor any other law imposes a negative legal consequence to not buying health insurance beyond a tax payment to the IRS. *Sebelius*, 132 S.Ct. at 2597.[1]

At most, then, all the ACA does is make insurance available to Claimant. It does not compel Claimant to try to obtain it. DIGA's argument that the Delaware Insurance Guaranty

[1] Because of the Board's ruling on this, the issue of the effect of the closing of the open enrollment period in Claimant's case, *see Curtis-Howett*, *supra*, at 3, becomes moot. It does not matter whether Claimant was able to enroll or not. Similarly, the Board's question concerning under what circumstances DIGA would ever pay if the ACA required everybody to purchase insurance, *see id.* at 4, is moot.

Association Act does compel Claimant to seek other insurance does not hold up to analysis. A requirement to "exhaust" a policy or benefits under a program that a person has is not a requirement for that person to obtain a new policy just for the purpose of exhausting it.

This point is clearer if we first consider the matter outside the framework of a workers' compensation claim. Suppose Claimant in this case was the person who directly paid for health insurance from Reliance and then Reliance became insolvent. According to DIGA, because of the ACA, Claimant would have to take advantage of the availability of insurance under the ACA and buy new insurance to exhaust before DIGA would step in. This is directly contrary to the intent of the Delaware Insurance Guaranty Association Act, which is to protect the insured from the insolvency of an insurer. It is hardly a protection to tell the insured that they have to go out and buy new insurance.

The Scope of the Workers' Compensation Act: The issue becomes even clearer when one factors in that this is a claim under the Workers' Compensation Act. One of the primary purposes of this Act is to relieve an injured employee from paying expenses for medical treatment necessitated by a compensable work injury.

The Workers' Compensation Act was designed so that:

> [e]very employer and employee, adult and minor, except as expressly excluded in this chapter, shall be bound by this chapter respectively to pay and to accept compensation for personal injury or death by accident arising out of and in the course of employment, regardless of the question of negligence and to the exclusion of all other rights and remedies.

DEL. CODE ANN. tit. 19, § 2304

The important thing for this analysis is that the compensation relationship created by the Workers' Compensation Act is between the *employer* and the *employee*. While an employer may be expected to obtain insurance to cover its liabilities under the Workers' Compensation

Act, *see* DEL. CODE ANN. tit. 19, § 2371, this does not change the fact that the employer remains primarily liable to pay benefits to an injured worker. An uninsured employer is still liable for the payment of benefits to an injured worker.

The Workers' Compensation Act further provides, with respect to medical treatment:

> (a) During the period of disability *the employer* shall furnish reasonable surgical, medical, dental, optometric, chiropractic and hospital services, medicine and supplies . . . as and when needed unless the employee refuses to allow them to be furnished by the employer.
>
> (b) If *the employer*, upon application made to the employer, refuses to furnish the services, medicines and supplies mentioned in subsection (a) . . ., the employee may procure the same and shall receive *from the employer* the reasonable cost thereof within the above limitations.
>
> (c) Upon application made to the Board by the injured employee . . ., the Board may, at its discretion, require *the employer* to furnish additional services, medicines and supplies of the kind mentioned in subsection (a) . . . as and when needed, for such further period as it shall deem right and proper. The charges for such additional services, medicines and supplies shall not exceed the rates regularly charged to other individuals for like services and supplies, provided, however, that the Board shall at all times have jurisdiction to determine and shall determine the character of services and supplies to be furnished.

DEL. CODE ANN. tit. 19, § 2322 (emphases added). Thus, Claimant's primary resource for paying medical expenses for reasonable and necessary medical treatment related to a work injury is *the employer*. Once again, an employer might insure itself for the payment of such obligations, but that does not change the fact that under the Workers' Compensation Act it is the employer who is ultimately responsible for paying benefits to an injured worker.

In this case, while Tecot's workers' compensation insurance carrier has gone insolvent, it is the Board's understanding that Tecot itself is not insolvent or bankrupt. As such, Tecot itself

would, by statute, still be responsible for paying Claimant's related medical expenses. In other words, while Claimant was the beneficiary of the insurance policy that Tecot had with Reliance, the party that was actually insured was Tecot, who would otherwise be directly responsible to pay Claimant's medical expenses. Thus, the "insured" party that the Delaware Insurance Guaranty Association Act was designed to protect would, in this particular case, be Tecot, not Claimant.

The Superior Court has held that "[t]he policies creating Guaranty Associations do not envision plaintiffs losing their rights to compensation nor do they envision shifting of tort liability from one party to another party." *Tri-State Motor Transit Co. v. Intermodal Transportation, Inc.*, Del. Super., C.A. No. 88C-JN-135, Gebelein, J., at 23 (May 14, 1991)(quoted in *Process Industries, Inc. v. Delaware Ins. Guaranty Assoc.*, Del. Super., C.A. No. 92C-11-7, Herlihy, J., 1994 WL 318965 at *12 (May 25, 1994)). The same can be said with respect to claimants losing their rights to compensation under the Workers' Compensation Act. To accept DIGA's argument would be to deprive Claimant of the benefit and protection of the Workers' Compensation Act, making her pay for her own medical expenses related to her work accident instead of her employer, who is statutorily required to pay those expenses. DIGA's argument, if accepted, would, in fact, shift Tecot's liability for paying Claimant's medical expenses on to Claimant in contravention of the express terms of the Workers' Compensation Act.

The Board rejects the argument that the exhaustion requirement in the Delaware Insurance Guaranty Association Act has or was ever intended to have such an effect. Neither it nor the ACA supplants or preempts the protections of the Workers' Compensation Act. Claimant's right to medical benefits under the Workers' Compensation Act is not voided simply

because her employer's chosen insurance carrier became insolvent. Rather, in this situation, the insured party that DIGA might require to exhaust all other insurance would be Tecot, not Claimant. It is Tecot who, in the absence of insurance, would be directly liable to Claimant for benefits under the Workers' Compensation Act. There is no indication that Tecot has any other insurance to turn to or exhaust in order to pay Claimant's compensable medical expenses. Under those circumstances, DIGA is responsible to step into the shoes of Tecot's insolvent insurer and pay Claimant's medical expenses on behalf of Tecot. This is precisely the protective function that the Delaware Insurance Guaranty Association Act was meant to have.

Conclusion: For these reasons, DIGA's motion seeking a finding that it is not responsible for payment of Claimant's reasonable and necessary medical expenses causally related to her work accident is denied.[2]

IT IS SO ORDERED this 6th day of March, 2015.

INDUSTRIAL ACCIDENT BOARD

FOR:
TERRENCE M. SHANNON

OTTO R. MEDINILLA, SR.

Mailed Date: 3.11.15

OWC Staff

Christopher F. Baum, Hearing Officer for the Board
Gary S. Nitsche & Kiadii S. Harmon, Attorneys for Claimant
John J. Klusman, Jr., Attorney for Employer

[2] In its prior order, the Board also questioned whether a person who has healthcare insurance that would otherwise need to be exhausted before DIGA became responsible to pay benefits could voluntarily drop that coverage. *See Curtis-Howell, supra*, at 4. In retrospect, this question is also moot because it does not reflect the facts in this case.

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Case No. N15A-04-001 JAP

IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

TECOT ELECTRIC, Employer-Appellant, v. MICHELLE CURTIS-HOWETT, Employee-Appellee.	)	C.A. No.: N15A-04-001 JAP

FILED
PROTHONOTARY
CIVIL COUNTER
2015 NOV 16 AM 11: 19

ORDER

For the reasons stated on the record at the November 16, 2015 hearing, the Industrial Accident Board's judgment of March 6, 2015 is **AFFIRMED**.

It is **SO ORDERED**.

November 16, 2015

John A. Parkins, Jr.
Superior Court Judge

oc: Prothonotary

cc: John J. Klusman, Jr., Esquire, Benjamin K. Durstein, Esquire, Tybout, Redfearn & Pell, Wilmington, Delaware
Gary S. Nitsche, Esquire, Michael B. Galbraith, Esquire, Weik, Nitsche, Dougherty & Galbraith, Wilmington, Delaware

BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

PHYLLIS S. EURE,	)	
	)	
Claimant,	)	
	)	
v.	)	Hearing No. 1125400
	)	
DELAWARE PARK,	)	
	)	
Employer.	)	

ORDER

On May 31, 2016, Delaware Park ("Employer") filed a Petition for Commutation seeking to commute the workers' compensation benefits of Phyllis S. Eure with respect to a compensable work injury that she sustained on May 15, 1998. The hearing on the merits of this petition is currently scheduled for September 29, 2016.[1] On July 15, 2016, Claimant filed a motion seeking dismissal of the petition. On September 2, 2016, Employer filed a motion to compel Claimant's attendance at mediation. These two motions were heard by the Board on September 8, 2016.

Dismissal: Claimant acknowledged that the parties had entered into negotiations for a possible commutation of Claimant's benefits. However, Claimant has since informed her counsel that she has no interest in having a commutation at this time. Claimant argues that, because a commutation is only to be granted if it is in the Claimant's best interest, and because she does not wish to have a commutation at this time, Employer's petition should be dismissed.

The Board disagrees. The Board's authority to commute workers' compensation benefits is conferred by statute, namely section 2358 of title 19. This section specifically states that a request for commutation can be considered by the Board "[u]pon application of either party." DEL. CODE ANN. tit. 19, § 2358(a). This provision goes on to state:

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[1] By separate motion, the parties stipulated to a continuance of this hearing.

> Such commutation may be allowed if it appears that it will be for the best interest of the employee or the dependents of the deceased employee, or that it will avoid undue expense or hardship to either party, or that such employee or dependent has removed or is about to remove from the United States or that the employer has sold or otherwise disposed of the whole or the greater part of the injured employee's or the dependents of a deceased employee's business or assets.

DEL. CODE ANN. tit. 19, § 2358(a).[2] Thus, while the best interest of the injured employee is certainly a significant consideration in determining whether to grant a commutation, by statute it is not the only consideration.[3] A commutation can be granted to "avoid undue expense or hardship to either party" or because the injured employee is leaving the country or because the employer is going out of business. In any event, "[w]hether commutation is in the best interest of the claimant or will avoid undue hardship and expense to either party depends on the totality of circumstances in each case." *General Foods Corp. v. Meekins*, Del. Super., C.A. No. 86A-AU-1, Ridgely, J., 1988 WL 15335 at *2 (February 11, 1988).

Thus, the mere fact that Claimant does not want a commutation is not the final word. While the totality of the circumstances is to be considered, there are certain common factors that should be reviewed. The Board must keep in mind that the primary purpose of the Workers' Compensation Act is to provide an injured employee with periodical payments "to preclude any possibility of an imprudent employee . . . wasting the means provided for his support and thereby becoming a charge on society." *Molitor v. Wilder*, 195 A.2d 549, 552 (Del. Super.), *aff'd*, 196 A.2d 214 (Del. 1963). As such, commutations (particularly when one of the parties opposes it)

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[2] The last clause is apparently a codification error, as it should probably read that the employer has sold or disposed of the *employer's* business or assets. It is a moot question in this case.

[3] Indeed, under certain circumstances, the best interest of the recipient of benefits is not even considered. An employer "may at any time commute all future installments of compensation payable to alien dependents not resident of the United States by paying to such alien dependents the then value thereof, calculated in accordance with § 2358 of this title." DEL. CODE ANN. tit. 19, § 2333(a).

are not favored and should only be granted after a showing of "unusual circumstances" where the reasons are "sound and convincing." *Molitor*, 195 A.2d at 552. One factor to be considered is whether the claimant's medical condition is expected to change significantly for the better or the worse. *See Kandravi v. Beebe Hospital*, Del. Super., C.A. No. 94A-10-005, Ridgely, J., 1995 WL 411736 at *4 (May 26, 1995). Similarly, the Board needs to weigh the commutation amount offered versus the reasonable likelihood of future benefits to the claimant and the prospect of future litigation over entitlement to such benefits. Another common factor to consider is whether there would be financial hardship to the claimant if the commutation is not granted. "Where the claimant is not experiencing financial hardship which would warrant commutation on that grounds, the IAB is under no obligation to grant commutation based upon an economic analysis showing that she will receive more money overall through commutation than through periodic payments." *Boney-Nearhos v. Southland Corporation*, Del. Super., C.A. No. 001-07-005, Vaughn, J., 2001 WL 1482937 at * 3 (July 31, 2001).

Clearly, then, there is a high burden of proof on the part of a petitioner in the case of a disputed commutation. However, that the burden of proof is high does not mean that it cannot be met. As such, Claimant's motion to dismiss is denied.

Mediation: Employer asserts that it has requested mediation pursuant to section 2348A(a). Claimant has stated that she also does not want to participate in mediation. Employer argues that, under the statute, "either party" may request mediation and that, having done so, the mediation "shall" be conducted. *See* DEL. CODE ANN. tit. 19, § 2348A(a). Employer argues that the use of the word "shall" makes the mediation mandatory and that Claimant should be compelled to participate in it, in good faith.

Reviewing the mediation section in its entirety, the Board disagrees with Employer's conclusion. Unlike an arbitration, under which an arbitrator renders an opinion as to the merits of a case, in mediation the function of a mediator is to facilitate the parties in reaching a mutually acceptable resolution of a dispute. When one of the parties has no interest in mediating, there is no basis to reach a mutually acceptable resolution. At a minimum, for the mediation process to succeed, there must at least be mutual agreement to participate.

The statute specifies that any mediation under section 2348A "shall be nonbinding," DEL. CODE ANN. tit. 19, § 2348A(b),[4] and, in "any hearing before the Board, no evidence shall be permitted regarding the mediation," DEL. CODE ANN. tit. 19, § 2348A(d). Under these provisions, the Board does not see how any party can be compelled to participate in a section 2348A mediation. Even if the Board entered an order compelling Claimant to participate and if Claimant did not do so in good faith, evidence of such non-participation could not come before the Board because of section 2348A(d) and, even if it did, there is nothing that the Board could do about it because the mediation process, by law, is nonbinding anyway under section 2348A(b).

For these reasons, Employer's motion to compel mediation under section 2348A is denied.

Conclusion: Employer is within its rights to have a hearing on the merits of its petition to commute Claimant's benefits, but it does not have the right to compel Claimant to engage in mediation of that dispute if Claimant does not wish to participate. As such, Claimant's motion to dismiss and Employer's motion to compel are both denied.

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[4] To clarify, if the parties did reach a settlement, it would be reduced to writing and signed by the parties, their counsel and the mediator. Such a "signed mediation agreement" is binding even if the mediation itself is not. *See* DEL. CODE ANN. tit. 19, § 2348A(c).

IT IS SO ORDERED this 13th day of September, 2016.

INDUSTRIAL ACCIDENT BOARD

JOHN D. DANIELLO

Jemma Buckley for
PETER W. HARTRANFT

OWC Staff

Mailed Date: 9-14-16

Christopher F. Baum, Hearing Officer for the Board
William R. Stewart, III, Esquire, for Claimant
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