BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

FRANCISCO IRIZARRY,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1294065
	)	
	)	
	)	
CHRISTIANA CARE HEALTH SERVICES,	)	
	)	
	)	
Employer.	)	

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 June 30, 2009, in the Hearing Room of the Board, in New Castle County, Delaware.

PRESENT:

LOWELL L. GROUNDLAND

ALICE M. MITCHELL

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

APPEARANCES:

Gary S. Nitsche, Attorney for the Employee

Anthony M. Frabizzio, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

On August 15, 2006, Francisco Irizarry ("Claimant") sustained a compensable low back injury while employed with Christiana Care Health Services ("Employer" or "Christiana Care"). On September 25, 2008, Claimant filed a Petition to Determine Additional Compensation Due, seeking to appeal a non-certification of certain medical treatment by utilization review ("UR") pursuant to Title 19 of the Delaware Code, section 2322F(j).[1] Employer disputes that the treatment in issue was consistent with the Practice Guidelines ("Practice Guidelines") or, in the alternative, argues that the treatment was not reasonable, necessary or causally related to the work injury.

A hearing was held on Claimant's petition on June 30, 2009. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Dr. Peter Bandera, a physician board certified in physical medicine and rehabilitation, testified by deposition on behalf of Claimant. He first treated Claimant in November of 2006. At that time, Claimant's MRI of the low back was significant in that he had a T12 compression fracture and an L4-5 disk herniation. In November of 2006, Claimant displayed diffuse spasm in the midline and tenderness in the low back. He had a positive right straight leg raising sign which was suggestive of nerve irritation perhaps as a result of a disk herniation or severe stenosis. Claimant had significant pain when transferring from sit to stand and some right gluteus weakness, indicative of an L5

[1] Title 19 Del. C. §2322F(j) gives either the moving or non-moving party recourse for appealing the result of the utilization review and provides for *de novo* review of the decision by the Industrial Accident Board.

innervated muscle. He had a high degree of pain and spasm as well as inflammation in the back. Dr. Bandera's impression was that Claimant had a traumatic expression of chronic compression fracture at T12, intervertebral disk dysfunction with L4-5 disk herniation with extrusion, radiculopathy and associated strain and sprain. Because Claimant was very symptomatic, he needed a surgical consultation, physical therapy, medication and remained out of work. His condition was causally related to his work injury.

When Claimant saw Dr. Rudin, the L4-5 disk involvement was identified and Claimant received a L4-5 diskectomy and L4 and L5 nerve root decompression. Following the surgery, Claimant still had radiating pain, continued spasm and limited range of motion. Dr. Bandera began a post-operative therapy program with medication support and continued Claimant on his out of work status. Claimant ultimately had another low back surgery in February of 2008. The surgery was a L3-4, L4-5 fusion as well as an L3-4 laminectomy. His diagnosis at that time was facet fracture at L4-5 and degenerative disk disease from L4 to S1. Again, Claimant was started on a post-operative therapy program following the surgery. His condition was improved in that there was a negative straight leg raising sign, but he still reported pain on transferring from a sit to stand position. Because the therapy was following a second surgery, Dr. Bandera opted for a conservative and evenly paced program consisting of progressive mobilization, strengthening, joint conservation and ergonomics. Additionally, Claimant was afflicted with comorbidity of the lower thoracic spine compression fracture, which

required more delicate and slow-paced treatment.[2] The physical therapy treatment from March of 2008 to the end of August 2008 consisted of modalities inclusive of heat, ice, electrical stimulation, intersegmental traction, hydromassage, and various ultrasound interventions. These were in addition to progressive exercises and an adjustment program. The progressive stretch, strengthening and joint conservation program was because Claimant had already had two complex surgeries, including a fusion procedure with a comorbidity of a thoracic spine fracture. The duration of the therapy was impacted by the extent of three complex diagnoses (two surgeries to the back and thoracic fracture) as well as Claimant's inability to receive certain treatments. Part of the therapy was specifically designed to be an alternative to an injection program or full medication trials, which would have been reasonable, necessary and sanctioned by the Practice Guidelines. Dr. Bandera testified that the number of Claimant's physical therapy visits were within the Practice Guidelines, although there is some leeway allowed for post-surgical therapy visits. In the Practice Guidelines, post-surgical therapy and pre-surgical therapy are distinct. Additionally, there is flexibility allowed when a patient has multiple diagnoses or unavailability of recommended medical treatments. Here, Claimant had two surgeries to the low back and a thoracic fracture involved and was not able to participate in a needed injection and medication trial program. An EMG of August of 2008 was consistent with chronic low grade bilateral L5 and right L4 radiculopathy. Compared to the December 2007 study, the EMG showed more chronic features of a radiculopathy

[2] Some of the therapy appointments (13) predated the Workers' Compensation Practice Guidelines ("Practice Guidelines") but the bulk of them (23) post-dated the May 23, 2008 effective date. The therapy visits in issue range from March 26, 2008 to August 28, 2008.

process—a long term inflammatory pattern involving the low back. In August of 2008, Dr. Bandera noted that Claimant was progressing slowly in therapy and that he was still ambulating with a cane. He was also taking Percocet, Lyrica, Oxycodone and prescription Ibuprofen. These prescriptions were used for chronic pain and to help with the complex nature of Claimant's two surgeries and his thoracic fracture.

In September of 2008, Dr. Bandera recommended moving Claimant into a functional work hardening/work conditioning program with gait training and neuromuscular reach education. The goal was to get Claimant into more task activities to be able to deal with basic activities of daily living and into the future to be reprogrammed into work-type activities. This program began September 3, 2008 and lasted until March 11, 2009 and consisted of twenty-four different visits. It was within the Practice Guidelines because the guides allow for the duration of post-surgical therapy to be modified based on the availability of other services. Claimant's therapy was longer in duration in order to supplant other usual and customary remedies that he could not receive. After the conditioning program ended in March of 2009, a follow-up injection was planned that was ultimately not approved.

Claimant did obtain relief from the therapy program and from the one injection he received in February of 2009. The injection gave Claimant beyond fifty percent function and improvement. However, Claimant was unable to get any further injections. His current prognosis is guarded. Currently, he is working on a home exercise program with medication to support him. He has failed back surgeries that require narcotic painkillers. He does not have access to other medication trials.

The utilization reviewer did not distinguish the different types of rehabilitation intervention offered to Claimant. The reviewer also did not distinguish the fact that there are complex multiple comorbidities of two surgeries to the low back and the thoracic spine fracture. Additionally, the UR report states that the reviewer did not see the physical therapy notes and ignored the clinical notes that state that Claimant began a functional work hardening program as of August of 2008 and that he did not have access to other services. The guides specifically state that "the duration will be impacted by the availability of services" in terms of treatment parameters. The fact that there are no guides regarding the thoracic spine despite Claimant's fracture was also ignored. The reviewer, however, did certify a total of twenty-four physical therapy sessions. Dr. Kalamchi also testified that a four to six month program of physical therapy is reasonable after a second surgery such as Claimant's, consisting of about thirty-six to forty sessions, followed by a work hardening program. That is exactly what happened here. And although Dr. Kalamchi disagrees that a patient should continue with narcotic medications more than six months following surgery, there exists a body of patients who require narcotic medications on more of a long-term basis. Claimant has been totally disabled from all forms of employment since his surgery.

At the time of Dr. Bandera's deposition, the outstanding medical bills were $16,013.00 up through and including October 22, 2008.

On cross examination, Dr. Bandera clarified that the therapy following the second surgery employed similar modalities to those following the first surgery, although the latter was longer in duration. He admitted that Claimant had the same modalities for

almost a year, up until the second surgery. Dr. Bandera also admitted that Claimant is getting relief and a better ability to function from the modalities he is receiving, however it is not an ideal situation because of the lack of injections and expanded medication program. He agreed that Claimant also received some passive modalities after the second surgery and for approximately a year, but clarified that they helped Claimant to function in lieu of access to the full services he required. The work conditioning/functioning program has helped Claimant with basic improvement in material handling skills, safety and ergonomics. But he still is unable to work and it can take up to six months of work conditioning to get Claimant back to work. Work conditioning precedes a work hardening program. Without the intervention that Claimant has had, he would be in a much worse situation. Dr. Bandera clarified that the utilization reviewer did not acknowledge that there was a work conditioning program following the initial therapy program.

Claimant testified on his own behalf. He had surgery for his work injury in both January of 2007 and February of 2008, neither of which helped his condition. Currently, Claimant suffers low back pain and leg numbness and tingling. His leg feels as if it is falling asleep. Claimant has to use a cane as a result. He also cannot bend down. Claimant's right foot also has an electric shock feeling at times. The second surgery did not improve the right foot condition. His pain is almost every day. He takes Percocet three to four times per day, nerve pain medication (Lyrica) two to three times per day and muscle relaxants two times per day. Claimant had to recently pay for some of these out of pocket, though he did get some reimbursement for them.

After Claimant's second surgery, Dr. Rudin advised him he could not help him further. Claimant currently treats with Dr. Peter Bandera for his leg and back. The treatment consists of machines, hydrotherapy, lifting/carrying boxes, and stretches. The mode of therapy has changed a little as it has progressed. It has helped relieve Claimant's pain some but has not helped with activities of daily living. Claimant also continues to suffer problems with sleep. Dr. Bandera also performed some injection therapy with Claimant, but he only had relief for about a week and then the pain returned.

At home, Claimant performs some exercises he learned in physical therapy which sometimes helps with his legs. He started a functional capacity evaluation ("FCE"), but it had to be stopped because he had high blood pressure. The FCE has not yet been rescheduled.

All of the mileage documentation that Claimant provided for his appointments with Dr. Bandera and Christiana Care for imaging is accurate.

On cross examination, Claimant clarified that immediately after the work injury he had low back pain that traveled down his right leg. His pain was about an eight or nine out of ten. After his first surgery, his pain was the same and possibly even worse. He had physical therapy for about a year with Dr. Bandera after the first surgery. His treatment consisted of heat and ice therapy, electrical stimulation, traction, hydromassage, exercise and ultrasound. This treatment helped alleviate his pain a little but did not improve his function. A cane was suggested after Claimant's first surgery, but Claimant has only used a cane ever since his second surgery. Claimant was

prescribed Percocet after his first surgery, but the dosage went up from 5mg to 10mg after his second surgery. It has helped his pain.

Claimant's condition is worse following his second surgery. He has the same areas of pain, but can now hardly bend down, has to move more and has worse pain than before. Claimant had physical therapy following the second surgery that helped to relieve pain a little. He would have relief for a couple days but not to the extent he could stop taking his Percocet. Claimant's abilities are the same now as they were following the work injury. He still has a gait problem and is still using his cane.

Claimant began a work hardening/functioning program with Dr. Bandera in September of 2008. It consisted of working with walking, picking up boxes, moving them and putting them back down. Additionally, other different machines were used to strengthen his legs, including a treadmill. Claimant had electrical stimulation and other modalities in January and February of 2009. This helped with his pain but he still had to take his prescriptions. He was only able to proceed with the program for about six months before he had to stop due to lack of insurance reimbursement. Since March of 2009 when Claimant stopped the work hardening program, Claimant has only had check-up visits.

Claimant's average day consists of being at home, resting and watching television. His mother has to put his shoes on for him. Claimant will drive sometimes or ride with someone else instead.

Dr. Ali Kalamchi, an orthopedic surgeon, testified by deposition on behalf of Employer. He examined Claimant In January, May and November of 2007, in October

of 2008 and June of 2009. When Dr. Kalamchi first examined Claimant in January of 2007, his diagnosis after a physical examination and review of an MRI was that Claimant had an L4-5 herniation with right radiculopathy. Claimant had a microdiskectomy at L4-5 afterward with only minimal improvement in his condition. When Dr. Kalamchi examined Claimant again in May of 2007, Claimant's complaints were very similar to his previous examination—low back and leg pain. Not only was Claimant's pain the same as before the surgery, he now complained of pain in the left leg. Dr. Kalamchi also noted some signs of symptom magnification in that Claimant was guarding most of his ranges of motion and exaggerated his pain even upon simple touching. Claimant's clinical examination also did not evidence a residual radiculopathy in that multiple tests were negative as to both legs. At that point, Dr. Kalamchi opined that Claimant's post-operative management was prolonged. He recommended a work hardening program and an FCE.

After his November of 2007 evaluation, Dr. Kalamchi diagnosed Claimant with chronic residual lower back and right leg pain post microdiskectomy. He also noted moderate symptom exaggeration to the diagnosis. This was about a year after the surgery and Claimant was still using a cane despite the fact that he had a normal clinical examination.

Dr. Kalamchi's next examination in October of 2008 was after Claimant's second surgery, a fusion, which had occurred in February of 2008. The fusion was at L4-5 with stabilization at L3-4. Claimant stated that the surgery had not been helpful. He was still using a cane and complaining of low back and leg pain. In Dr. Kalamchi's opinion,

Claimant only needed a routine post-operative program followed by a work hardening program and possibly an FCE. He also felt an aquatic exercise program may have helped.

The most recent examination was in June of 2009. Claimant was still using his cane at that time. He was not undergoing any active treatment and was seeing Dr. Bandera monthly for prescription renewals. In Dr. Kalamchi's opinion, Claimant did not require any further therapeutic modalities. It was a year and a half after surgery and he would not benefit from further treatment. It is reasonable about six weeks after surgery to begin aquatic exercises. After three months, if progress is good, land and strengthening exercises are reasonable about three times per week. About six weeks after that, Dr. Kalamchi evaluates a patient's ability to return to work. If the patient is not doing well, he will add a work hardening program and refer him or her for an FCE. After six months, he does not recommend treatment. Between a period of aquatic exercises, land exercises and work hardening, it is reasonable to have about thirty to forty sessions in total.

The PG's stress a limitation of passive modalities that include electrical stimulation, iontophoresis, manipulation, massage, mobilization, heat/cold therapy, traction, TENS and ultrasound. Additionally, there is a focus on documentation of objective functional gain through therapy. When utilized, the Practice Guidelines state that passive modalities should also be done with active exercises. Dr. Bandera's notes do not state any objective gains or changes and only talk of the patient's continued symptoms and pain medications ordered. It is clear that Claimant's condition is still the

same as before the therapy. He continues to take narcotics. In Dr. Kalamchi's opinion, no patient should be on Percocet after three months.

On cross examination, Dr. Kalamchi admitted that the EMG from August of 2008 no longer showed the acute features that were present in the December 2007 EMG. He agreed that his October of 2008 report noted that Claimant could not reasonably return to work. He also agreed that the Practice Guidelines limit non-operative therapeutic activities for the low back but do not prescribe a maximum number for therapeutic treatment to the low back post-operatively.

Beth Taylor, a workers' compensation claim adjuster assigned to Claimant's case testified on behalf of Employer. She reviewed the medical bills from Claimant's treatment with Dr. Bandera. Claimant's physical therapy continued after the first surgery up until the second surgery. The same modalities were apparently employed every visit. After Dr. Kalamchi opined that treatment was unreasonable after six months post-surgery, Claimant's claims were denied. The carrier paid for physical therapy from February 7, 2007 through December 27, 2007. Beginning with January 3, 2008, the claims regarding physical therapy were denied. After the second surgery, some medical bills were again paid including surgical costs, mileage and diagnostic testing.[3] Eleven visits in total were unpaid; eighty-nine treatments were paid.

[3] The surgery was ultimately covered by the insurance carrier although Dr. Kalamchi had opined it was unreasonable as it would not be beneficial to Claimant.

Claimant began physical therapy on March 26, 2008 following his second surgery.[4] The same modalities were employed as were utilized prior to the second surgery. There was no way to tell if Claimant had any improvement from physical therapy as it was not noted by Dr. Bandera. A request was made to UR to review Dr. Bandera's treatment on February 18, 2009.[5] All of the records that Dr. Bandera had provided to the carrier were sent to UR.[6] These included office notes and hand written notes from the physical therapy. Dr. Bandera sent itemized charges with codes for treatment along with notes to explain the charges. All medical records and doctor's notes were included.

Ms. Taylor next received the UR decision.[7] The decision was that only twenty-four post-surgical visits were reasonable. The UR found that Dr. Bandera gave the same treatment over and over without indication of change of modalities or improvement in Claimant's condition. The UR ultimately non-certified thirty of Claimant's treatment visits with Dr. Bandera. The timeframe certified was from March 26, 2008 to include twenty-four visits.

Ms. Taylor was aware that Claimant had physical therapy but was not aware whether or not Dr. Bandera's treatment became a work hardening program. Though Dr.

[4] The Practice Guidelines were not effective until May 23, 2008. Ms. Taylor testified that all of the treatment bills were paid in full for treatment rendered before May 23, 2008.
[5] The period of Claimant's treatment with Dr. Bandera reviewed by UR was from March 26, 2008 to October 21, 2008 and from November 26, 2008 and ongoing.
[6] Claimant objected to the packet of Dr. Bandera's records that Ms. Taylor referred to, citing that he was not aware of this packet until Dr. Bandera's deposition. Employer responded that the packet contains all of the records that were already provided to Claimant; the only part that may not have been sent was the cover page—which consisted of a typed cover page letter requesting UR of the records. The Board overruled the objection as the records contained in the packet had been provided to Claimant already and the one part that may not have been provided was a cover sheet that was not prejudicial to Claimant. Clearly, Claimant realized that a request for UR had been made in some format by Employer far in advance of the hearing.
[7] The UR decision was issued March 10, 2009.

Bandera indicated that he had Claimant on a "work functioning program" all of the treatment was almost identical to that received prior to that time. She was not aware of having denied any aquatic therapy or medication claims for Claimant.

On cross examination, Ms. Taylor admitted that the UR report states that Dr. Bandera's physical therapy notes were not a part of the UR review. She also agreed that she did not ask for clarification from Dr. Bandera what he meant by a work functioning program. Ms. Taylor agreed that she was not aware of whether or not the Practice Guidelines limit post-surgical treatment. She admitted that some of what Dr. Bandera describes as work functioning modalities were different from the physical therapy; these include climbing, treadmill and work with boxes.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On his Petition to Determine Additional Compensation Due, Claimant carries the burden of proof and must demonstrate by a preponderance of the evidence that his post-surgical related medical treatment with Dr. Bandera was reasonable, necessary and causally related to the work accident.[8] "Whether medical services are necessary and reasonable or whether the expenses are incurred to treat a condition causally related to an industrial accident are purely factual issues within the purview of the Board." *Bullock v. K-Mart Corporation*, Del. Super., C.A. No. 94A-02-002, 1995 WL 339025, at **3 (May 5, 1995); *see Keil's Wholesale Tire v. Marion*, Del. Supr., No. 174, 1986, Moore, J. (October 27, 1986)(Order). When the medical testimony is in conflict, the Board or

[8] Title 19 of the Delaware Code section 2322F(j) states that "[i]f a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for *de novo* review."

hearing officer, in the role as the finder of fact, must resolve the conflict. *General Motors Corp. v. McNemar*, 202 A.2d 803 (Del. 1964). As long as substantial evidence is found, the Board may accept the testimony of one expert over another. *Standard Distributing Company v. Nally*, 630 A.2d 640, 646 (Del. 1993). Thus, the Board accepts Dr. Bandera's testimony in conjunction with the plain language of the Practice Guidelines as more persuasive than that of Dr. Kalamchi and hereby finds that Dr. Bandera's treatment was reasonable, necessary and causally related to the work injury.

First, the Board notes that the Practice Guidelines regarding low back treatment preliminarily concede that services rendered outside of the Guidelines "may still represent acceptable medical care, be considered reasonable and necessary treatment and be determined to be compensable."[9] Further, the Guidelines provide that they are only meant to apply to the first six months after a course of treatment begins, with day one referring to the first date of treatment.[10] In this case, Claimant underwent his second surgery in February of 2008. The course of treatment in issue began on March 26, 2008. Thus, the six month timeframe would extend to approximately September 26, 2008. The Board recognizes that Dr. Kalamchi contests any treatment Claimant received over thirty to forty sessions as unreasonable. Employer points to the Practice Guidelines which mention that "[t]he majority of injured workers with low back pain will often achieve resolution of their condition within 8 to 24 [physical therapy] visits, with most not

[9] Practice Guidelines, Part D, § 1.0.
[10] Practice Guidelines, Part D, § 2.1.

requiring the maximum number allowed."[11] However, the Board finds that this same section prefaces this language by stating:

> Obviously, duration will be impacted by patient compliance, as well as comorbidities and availability of services. Clinical judgment may substantiate the need to modify...the total number of visits discussed in this document.[12]

Dr. Bandera stressed that the duration and quality of the treatment that he has provided to Claimant has been prolonged and not as effective because Claimant's condition is more complex following two surgeries and the fact that he has additional thoracic problems (comorbidities). Additionally, Dr. Bandera repeatedly stressed that Claimant has been limited in his availability to receive certain medical services, such as additional injection therapy and medicine trials. The Board notes that the Practice Guidelines further provide that:

> On occasion, specific diagnoses and post-surgical conditions may warrant durations of treatment beyond those listed as "maximum." Factors such as exacerbation of symptoms, re-injury, interrupted continuity of care and comorbidities may also extend durations of care.[13]

Again, the Board finds that the duration of Claimant's treatment with Dr. Bandera was affected by the combination of his two low back surgeries and thoracic condition as well as the unavailability of certain services that Dr. Bandera opined would be more effective

[11] Practice Guidelines, Part D, § 2.1 referencing *Guide to Physical Therapy Practice*—Second Edition.
[12] Id.
[13] Id.

treatment tools.[14] However, even more dispositive in resolution of this issue is the plain language of the Guidelines themselves which specifically state that "[t]he non-surgical rehab guidelines...do not apply to post-operative rehabilitation and work conditioning."[15] Dr. Kalamchi conceded that per the Guidelines, the twenty-four visit guideline for non-surgical treatment does not apply to post-surgical low back treatment. The utilization reviewer only partially non-certified the disputed treatments, citing that only twenty-four visits were reasonable under the Guidelines. The Board does not agree and hereby finds that the duration of treatment by Dr. Bandera was reasonable, necessary and causally related to the work injury.

However, Employer further argues that Claimant's receipt of passive modalities in treatment extended beyond what was reasonable according to the Practice Guidelines. Employer refers to the low back treatment section of the Guidelines that reference the necessity of "specific goals with objectively measured functional improvement" in order to justify an extended duration of care.[16] First, the Board was troubled by the fact that the utilization reviewer questioned this in the absence of review of the physical therapy notes that were clearly necessary to clarify the issue. Additionally, the reviewer also failed to acknowledge that a portion of the sessions in question were part of a work functioning program, likely due to this lack of review of the physical therapy notes. In any case, however, the Guidelines for low back treatment preliminarily state that the guidelines that

[14] Employer also argued that Dr. Bandera's treatment was largely repeated from that which was administered prior to the second surgery. However, the Board notes that the Guidelines state that with post-operative therapy, there frequently is a necessity for repetition of visits previously ordered prior to surgery. Practice Guidelines, Part D, § 6.4.4. The section also cites "uncomplicated post-surgical cases" to which Dr. Bandera has also opined that Claimant's is a more complex surgical case.

[15] The non-surgical rehabilitation guidelines limit treatment to twenty-four visits.

[16] Practice Guidelines, Part D, § 5.10.

limit treatment are not meant to apply to post-operative rehabilitation and work conditioning. Dr. Bandera testified that he began Claimant on a work conditioning program in September of 2008 that extended into March of 2009. The Board accepts Dr. Bandera's testimony that this occurred. While Employer argued that the modalities employed by Dr. Bandera were the same as prior to the work conditioning program's inception, the Board accepts Dr. Bandera's and Claimant's testimony as persuasive that some of the modalities were similar but there was the addition of other modalities with the hope of strengthening Claimant to return him to work. Additionally, the utilization reviewer notes that "PT notes are not provided for review to identify the components of the provided PT program." Regardless of why the reviewer was not privy to the physical therapy notes, it is clear that he was unable to make an informed decision without review of these notes as to the quality of the physical therapy modalities employed, as to whether the treatment changed to a work conditioning program, or whether Dr. Bandera noted functional changes in Claimant's condition. The reviewer deemed Dr. Bandera's treatment as repetitive yet admitted that he had no access to exactly what modalities were employed in each session and was apparently unaware that Dr. Bandera placed Claimant into a work conditioning program in September of 2008. While the utilization reviewer also noted that Dr. Bandera showed "no effort to consider alternative treatment plans with failure to progress as expected," the Board accepts Dr. Bandera's testimony he did begin Claimant on a work conditioning program and did consider alternative treatments such as injections and medication trials but was limited in what he could offer Claimant in that

regard.[17] The Board was persuaded that while Claimant's improvement was not exponential, the disputed treatment was still reasonable and objectively (in Dr. Bandera's opinion) improved Claimant's functionality. The Guidelines specifically recognize that "3 to 10% of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care." The Board finds that this is the case with Claimant's treatment, especially in light of the testimony regarding the fact he was unable to receive alternative treatments which Dr. Bandera deemed optimal for Claimant's condition.[18] In sum, the Board finds that Dr. Bandera's treatment and related medical expenses (including mileage), although not optimal in terms of the availability of all modalities, was reasonable, necessary and causally related to the work injury.

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, whichever is smaller." DEL. CODE ANN. tit. 19, § 2320. At the current time, the maximum based on Delaware's average weekly wage calculates to $9,160.00. 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 Board from granting a nominal or

[17] Employer disagreed that the carrier had declined any requests for injection therapy for Claimant or alternative medication trials. Though it is not imperative to resolve this dispute, the Board found Dr. Bandera and Claimant credible that although Dr. Bandera had recommended both of these alternatives, they believed that they had been declined by the carrier.

[18] Practice Guidelines, Part D, § 2.10.

minimal fee in an appropriate case, so long as some fee is awarded. *See Heil v. Nationwide Mutual Insurance Co.*, 371 A.2d 1077, 1078 (Del. 1977); *Ohrt v. Kentmere Home*, Del. Super., C.A. No. 96A-01-005, Cooch, J., 1996 WL 527213 at *6 (August 9, 1996). A "reasonable" fee does not generally mean a generous fee. *See Henlopen Hotel Corp. v. Aetna Insurance Co.*, 251 F. Supp. 189, 192 (D. Del. 1966). Claimant, as the party seeking the award of the fee, bears the burden of proof in providing sufficient information to make the requisite calculation.

Claimant has achieved a finding that his treatment and related medical expenses following a February 2008 surgery was reasonable, necessary and causally related to his work injury. Claimant's counsel submitted an affidavit stating that his firm spent approximately twelve hours preparing for this hearing, which lasted just under three hours. Claimant's counsel was admitted to the Delaware Bar in 1988 and is very experienced in workers' compensation litigation, a specialized area of law. His firm's initial contact with Claimant was in November of 2006, so he has been representing Claimant for almost three years. The issues before the Board were above average to complex in nature, given the more novel nature of UR appeals. However, it does not appear that there were any unusual time limitations imposed by the Claimant or the circumstances surrounding the case. 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 the employer lacks the ability to pay 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 attorney's award of thirty percent of the total value of the award, or $5,000.00, whichever is less, to be reasonable.

Medical witness fees for testimony on behalf of Claimant are also awarded, in accordance with title 19, section 2322(e) of the Delaware Code.

STATEMENT OF THE DETERMINATION

Based on the foregoing, the Board **GRANTS** Claimant's Petition to Determine Additional Compensation Due and finds that the treatment and related medical expenses (including mileage expenses) that Claimant received/incurred following his February 2008 surgery are reasonable, necessary and causally related to his work injury. Therefore, Claimant is awarded a reasonable attorney's fee of $5,000.00, or thirty percent of the total value of his award, whichever is less, and his medical witness fee.

IT IS SO ORDERED this 14th day of OCTOBER, 2009.

INDUSTRIAL ACCIDENT BOARD

LOWELL L. GROUNDLAND

ALICE M. MITCHELL

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

Mailed Date: 10-19-09

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OWC Staff