THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE WORKERS' COMPENSATION COMMISSION
Aisha Taylor, Commissioner
Melody L. James, Commissioner
Avery B. Wilkerson, Commissioner

W.C.C. FILE NO.: 2001117

Appellate Case No. 2022-001595

TIMOTHY STARNES..... CLAIMANT, APPELLANT,

v.

MERITAGE ASSET MANAGEMENT, INC. D/B/A CENTURARY GLASS, EMPLOYER, and INSURANCE COMPANY OF THE WEST, CARRIER.....RESPONDENTS.

INITIAL BRIEF OF APPELLANT

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STATEMENT OF ISSUE ON APPEAL

1. Whether the Majority Opinion of the Full Commission Affirming the Single Commissioner's Decision and Order reducing Attorney Fees to $13,458.02 was an abuse of discretion and improperly based on speculation, surmise, and conjecture that ignored the preponderance of the evidence in the record.

STATEMENT OF THE CASE

This matter was before the Full Commission's En Banc Appellate Panel pursuant to Appellant's Form 30, requesting review of Single Commissioner Beck's (hereinafter "Single Commissioner") February 17, 2022 Decision and Order.. This matter was before the Single Commissioner on January 5, 2022 in Columbia, South Carolina pursuant to the Single Commissioner's own request to set a hearing to determine if attorney fees should be approved.

Claimant was involved in an accident arising out of and in the course and scope of his employment due to missing a step coming down a ladder on January 6, 2020. Claimant alleged he sustained injuries to his low back and right knee in the course and scope of his employment. Dr. Adam Schaaf released Claimant from care on December 21, 2020, with a 20% impairment rating to his right leg and recommended future care including "pt, injections, nsaids, topicals, and eventually an arthroplasty" (APA 1, p. 4). Defendants disputed the causal connection between the permanent impairment and treatment suggested for the work injury, and they exercised their right to obtain a second opinion concerning Claimant's impairment and the work-related injury. On April 1, 2021, Dr. Robert Lowery evaluated Claimant's right knee and found Claimant's knee condition was all preexisting and none of his impairment was attributable to his work-related injury (APA 3, pp. 6-7). For the low back, Dr. Alexander completed a Form 14B that gave a 5% impairment to the lumbar spine and opined that future medical treatment would include periodic injection therapy and medications as needed (APA 2, p. 5).

The parties entered into a Clincher Agreement and Final Release (hereinafter "Clincher") that was signed on July 8, 2021 and submitted to the South Carolina Workers' Compensation Commissioner (hereinafter "SCWCC") for approval. The SCWCC approved, processed, and mailed back the Clincher on July 12, 2021. Approximately one month later, the Single

Commissioner, for the first time, requested a breakdown concerning money set aside for future medical care. There was no specific amount or formal set aside in the Clincher for future medicals due to a dispute concerning entitlement to future medical benefits, which was clearly noted in the Clincher.

The Single Commissioner ultimately denied Claimant's Form 61 and set the matter for a hearing on September 8, 2021. Claimant's counsel was the only person to appear, and the Single Commissioner instructed him to figure out a solution to the Single Commissioner's issues with the Form 61. Claimant and his attorney attempted to file an Amended Form 61 setting aside a specific amount for future medical benefits per the Single Commissioner's demands. Upon receipt of the Amended Form 61, the Single Commissioner set a second hearing in Walterboro, SC on October 21, 2021. Despite the Claimant agreeing that he was aware of the terms of the Form 61 and did not initially care to dispute the matter further, the Single Commissioner continued the matter and advised Claimant to seek another attorney. Claimant made several attempts to seek another attorney to advise him regarding the settlement. (Exhibit A). After these attempts, the Single Commissioner reset the matter to be heard on January 5, 2022.

At the Single Commissioner's Hearing, Claimant took the position that he felt that he is entitled to more money for future medical care relying only on his feelings. There was no evidence submitted to substantiate these feelings. Claimant's counsel took the position that additional medical treatment was in dispute and not guaranteed, as was spelled out in the Clincher. Claimant's counsel relied on not only the Clincher but the medical evidence showing competing opinions concerning causation and future medical benefits. Regarding the breakdown of the settlement proceeds, Claimant's counsel relied on the Utica language included in the Clincher for the breakdown of the settlement. Finally, Claimant's counsel took the position that under S.C. Regs.

67-1204-1207 and SC Rule 1.5, he was entitled to a fee of 1/3 of the "total amount of compensation," which in this case was $85,000.00.

STANDARD OF REVIEW

The Administrative Procedures Act (APA) establishes the standard for judicial review of decisions of the Workers' Compensation Commission. Code 1976, § 1–23–380.

South Carolina Code Ann. § 1-23-380 establishes the "substantial evidence" rule as the standard of review for decisions of the Workers' Compensation Commission. *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 276 S.E.2d 304 (1981). Pursuant to that rule, a reviewing court may reverse or modify a decision of an administrative agency if the findings, inferences, conclusions, or decisions of that agency are clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. Code 1976, § 1–23–380(5)(e). Substantial evidence is defined as: "Such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. It must be enough to justify, if the trial went to a jury, refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury. This is something less than the weight of the evidence and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence." Workers' Compensation Commission. *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 276 S.E.2d 304 (1981) at 135-136, 276 S.E.2d at 307.

Appellate courts are not at liberty to substitute their view of the evidence for that rendered by the Commission. Rather, "[t]he Circuit Court's role is appellate only and is limited to deciding whether the Commission's decision is not supported by substantial evidence or is controlled by some error of law." *Rogers v. Kunja Knitting Mills Co.*, 312 S.C. 377, 440 S.E.2d 401 (Ct. App. 1994). When reviewing an appeal from the Workers' Compensation Commission, the appellate

court may not weigh the evidence or substitute its judgment for that of the Full Commission as to the weight of the evidence and questions of fact. *Therrell v. Jerry's, Inc.*, 370 S.C. 22, 26, 633 S.E.2d 893, 894-895 (2006).

Moreover, "the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence." *Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm'n*, 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984). In workers' compensation cases, the Appellate Panel is the ultimate finder of fact. *Shealy v. Aiken County*, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). When the evidence is conflicting over a factual issue, the findings of the Appellate Panel are conclusive. *Hargrove v. Titan Textile Co.*, 360 S.C. 276, 290, 599 S.E.2d 604, 611 (Ct. App. 2004). The final determination of witness credibility and the weight to be accorded evidence is reserved for the Appellate Panel. *Bass v. Kenco Group*, 366 S.C. 450, 458, 622 S.E.2d 577, 581 (Ct. App. 2005).

ARGUMENTS

I. The Majority of the Full Commission erred by affirming the Single Commissioner who found as fact and concluded as law that Counsel's fee was unreasonable because such findings and conclusions are an abuse of discretion and based on surmise, conjecture, and speculation.

In determining entitlement to and reasonableness of attorney fees, the Single Commissioner has authority pursuant to S.C. Code § 42-15-90 and S.C. Code Regs. 67-1204-1207. This authority is unquestioned by Claimant's counsel.

The Majority of the Full Commission erroneously affirmed the Single Commissioner's award of the entirety of the $44,218.12 based upon surmise, conjecture, speculation, and an assumption of Claimant's guarantee of future medical benefits. This award is based on

misstatements by the Single Commissioner concerning the facts of the case as well as errors of fact and law throughout the Decision and Order.

In what appears to be the overarching basis for awarding Claimant the entire $44,218.12 of the settlement, the Single Commissioner (and subsequently the Majority of the Full Commission) incorrectly wrote in the "Statement of the Case" that Claimant's settlement of $85,000.00 included $44,218.12 that was an "entitlement to [medical] benefits." (Decision and Order, p. 2). While Claimant was assigned a 20% permanent impairment to the leg by one doctor, a competing opinion found he had no causally related permanent impairment.

At the time of signing the Clincher in July 2021, no post-MMI medical benefits had been provided. Claimant was released at MMI by Dr. Schaaf on December 21, 2020 (APA 1). Furthermore, the approved Clincher clearly stated disputes had "arisen concerning Claimant's entitlement to further medical care and treatment, further temporary total disability compensation and the extent of causally related permanent disability, if any." (Clincher, p. 1). The Single Commissioner (and subsequently the Majority of the Full Commission) materially altered the language of the agreed upon and approved Clincher. What was a settlement amount based on denied and disputed treatment of body parts was changed into an entitlement to benefits that is not found in the Clincher, and it has led to the multitude of errors in the Single Commissioner's Decision and Order that was upheld by the Majority of the Full Commission.

As it pertains to the Single Commissioner's Finding of Fact 9, there is no evidence in the record of Claimant's counsel's negotiations with Defendants in this matter, and I do not believe any such evidence is admissible in this matter. It is true that, as is required under the law of this State, Mr. Alexander represented his client diligently and tirelessly in pursuit of the best result possible in the underlying claim. However, Claimant's counsel did not "reverse course" during

this fee petition hearing as found as fact by the Single Commissioner (Finding of Fact 9). The Single Commissioner put Claimant's counsel in the unfortunate and awkward position of having to denigrate his client's case and defend their decision to amend the Form 61 as Claimant and his counsel agreed. During such defense, Claimant's counsel attempted to explain why only $1,000.00 was set aside in the Amended Form 61, and it is true and accurate that the future medical benefits recommended by the doctors were opinions and not awards or orders that guarantees Claimant anything. As such, Claimant's counsel was required to put forth the position as if he was the Defendants working against his client. To find Claimant's counsel "reversed course" is improper and prejudicial to use as a basis for reducing the attorney fees.

In his Finding of Fact 12, the Single Commissioner found, in direct contravention of his Finding of Fact 11 (and the actual language of the Clincher), that the Clincher allocated $44,218.12 for future medical treatment. The Clincher clearly expressed, as was stated in the Single Commissioner's Finding of Fact 11, that the remaining balance was "in exchange for the Clincher and future medical treatment." (Clincher, p. 2). The first sentence of Finding of Fact 12 is simply inaccurate. Furthermore, the Single Commissioner found these calculations "indicate an unusual scenario." There is no evidence in the record to support such a finding of an unusual scenario.

Moreover, the Single Commissioner assumed, and created a fiction in his Decision and Order, that there was more money paid for ONLY future medical care than for indemnity. He ignored the language of the Clincher stating this money was also for a clincher of the claim, and he ignored Claimant's counsel's argument concerning the value to Defendants for being able to clincher this claim and avoid additional exposure for increased permanent disability, additional TTD, or potential permanent and total disability. The Majority of the Full Commission adopted the Single Commissioner's findings of fact as their own, and in so doing, committed the same

error.

The Single Commissioner's Finding of Fact 15 improperly made prior e-mail correspondence with the Commissioner's assistant part of the record for this fee petition. Claimant's counsel was never made aware during the hearing that this correspondence would be a part of the file nor was anything about these emails discussed at the fee petition hearing. Furthermore, the cursory recounting of what was in those emails is not only inaccurate but misleading. It is true that there was no formal set aside for medicals, which is clear from the language of the Clincher. Additionally, to avoid any confusion about what exactly was sent to the Single Commissioner's assistant, I have pasted the emails below:

From: Chip Alexander <chip@leekelaw.com>
Sent: Thursday, July 29, 2021 10:23:43 AM
To: DeBruhl, Shawn <sdebruhl@wcc.sc.gov>
Subject: Re: [secure] Tim Starnes 2001117 Fee Petition

Hi Shawnee,

Can you point me to where or why we can't take a fee off the full amount? SC Regs 67-1204-1207 don't make any mention of medicals and 67-1205 says we can take up to 1/3 "of the total amount of compensation," which in this case, was $85,000.00. There also isn't anything in SC Rule 1.5 regarding this. Additionally, there isn't an MSA or any formal set-aside for medicals.

- Chip

From: Chip Alexander <chip@leekelaw.com>
Sent: Thursday, July 29, 2021 3:05:45 PM
To: DeBruhl, Shawn <sdebruhl@wcc.sc.gov>
Cc: bfreeman@wjcblaw.com <bfreeman@wjcblaw.com>
Subject: Re: [secure] Tim Starnes 2001117 Fee Petition

Hi Shawnee,

I'm sorry and don't mean to be argumentative, but I still don't understand. 42-1-100 says, "compensation is the money allowance payable to an employee…." Reg 67-1205(c) says an attorney may charge up to 1/3 "of the total amount of compensation." None of the exceptions to 1205(c) apply to this settlement and my taking a fee of the entirety of the settlement. Again, the total amount of compensation in this case was $85,000, and any future care was denied by the defendants, so there wasn't a number specified by myself and defense counsel. I have copied Trapper on here if you need confirmation. Additionally, I'm not sure how 42-15-60 has any bearing on my fee, as this claim is clinchered, defendants are not providing any benefits under this statute, and this is not an order from a commissioner.

- Chip

From: sdebruhl@wcc.sc.gov <sdebruhl@wcc.sc.gov>
Sent: Thursday, July 29, 2021 2:29:31 PM
To: chip@leekelaw.com <chip@leekelaw.com>
Subject: Re: [secure] Tim Starnes 2001117 Fee Petition

Guidance regarding future medical can be found in Reg. 67-1205(c), Section 42-1-100 and 42-15-60.

Thanks

The Single Commissioner's Finding of Fact 15 misstated Mr. Alexander's e-mails, as he was referencing the mention of S.C. Code § 42-15-60 by the Commissioners' assistant and

clarifying that it refers to medical care that has been ordered by a Commissioner, which was not the case in the underlying claim. Additionally, Defendants were not providing any medical benefits under this statute. The Majority of the Full Commission adopted the Single Commissioner's findings of fact as their own, and in so doing, committed the same error.

In his Finding of Fact 17, the Single Commissioner stated that Claimant's counsel didn't provide any rationale for setting aside $1,000.00 for future medicals. First, it is untrue that no rationale was given, as Finding of Fact 9 notes I made clear that none of the medical benefits suggested by the physicians were guaranteed (and were not ordered by a commissioner). Further, the Single Commissioner asked for attorney-client privileged information, which clearly put Claimant's Counsel in the awkward position of having to divulge confidential information concerning the agreement between himself and a client. To ask for such privileged information, and then hold that against Claimant's Counsel, is prejudicial.

Additionally, at the first hearing in Yemassee, the Single Commissioner advised Claimant's Counsel to seek a resolution of the issue of no money being set aside for future medical care. As such, Claimant's Counsel attempted to have Defendants amend the Clincher to clarify this issue, but considering it had already been processed and approved two months earlier, they were unwilling. Because of this, Claimant and his counsel met again to discuss setting aside money for medical benefits per the Single Commissioner's request, and we agreed to file an Amended Form 61 setting aside an amount to satisfy the Single Commissioner.

The Single Commissioner's Finding of Fact 17 further incorrectly assumes that any evidence must be offered to explain how the amount Claimant and his counsel agreed to set aside was reached. Again, the Single Commissioner speculated that Claimant would be guaranteed ANY additional medical benefits, and he ignored the bona fide dispute regarding future medical benefits,

as is clearly stated in the Clincher. (Clincher, p. 1). The Single Commissioner treated opinions in the record as evidence to make a finding concerning entitlement to additional medical treatment, when no such finding is allowable, as it is in direct contravention of the approved Clincher, which states, "[t]he parties acknowledge that the opinions stated by physicians regarding the nature and extent of Claimant's medical condition and disability are opinions, not facts, and that, to the extent they are relying on those opinions, they are doing so with the knowledge that such opinions may be incorrect." (Clincher, p. 4). Additionally, there was no evidence put forth to substantiate the Single Commissioner awarding all $44,218.12 to Claimant and not accounting for the value to Defendants to clincher this claim. The Majority of the Full Commission adopted the Single Commissioner's findings of fact as their own, and in so doing, committed the same error.

In his Conclusion of Law 1, the Single Commissioner provided no basis in the law for how "compensation" does not include funds paid for future medical care. S.C. Code § 42-1-100 states, "[t]he term 'compensation' means the money allowance payable to an employee or to his dependents as provided for in this Title and includes funeral benefits provided in this Title." The "money allowance payable to an employee" in this case was $85,000.00, which is the total amount of compensation. As such, under S.C. Code Reg 67-1205B, Claimant's counsel should be entitled to an attorney fee of $28,33.33, or 1/3 of the total amount of compensation.

Regardless, to avoid the very scenario we have now found ourselves in, Claimant and his counsel agreed to set aside $1,000.00 to account for the non-guaranteed future medical benefits. An Amended Form 61 was filed requesting an attorney fee of $28,000, or 1/3 of the remaining $84,000.00, which should be considered reasonable under S.C. Code Reg 67-1205B. The Single Commissioner should have relied on the agreement between Claimant and his counsel since no future care had been ordered by a commissioner and no medical benefits were guaranteed. To find

Claimant is "entitled" to any amount for future medical benefits (that is not specified in the Clincher), is based purely on surmise, conjecture, and speculation. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

While there is no error in the Single Commissioner's Conclusion of Law 4, I mention this here only to note that all aspects of this Conclusion of Law were met by Claimant and his counsel, especially with the filing of the Amended Form 61. The parties agreed to a contingency fee of 1/3, the fee agreement was fully explained to Claimant, the dollar amount of the fee that would be deducted from client's benefits was explained, and Claimant signed the Amended Form 61. There is no evidence these actions were not done.

While we do not necessarily agree, and it is unclear if Conclusion of Law 6 misstated the law, as was done previously in his Decision and Order, the Single Commissioner changed the facts of this case to find Claimant is "entitled to medical care" when every piece of evidence contradicts such a finding. As discussed above, future medical benefits (and even permanent impairment) were disputed in this case and had not been ordered by a commissioner. Claimant's counsel worked his hardest to secure a settlement that he and Claimant agreed was favorable considering the dispute. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

In his Conclusion of Law 7, the Single Commissioner relied on en banc orders that should not control in this case. While we could debate whether this is binding precedent (or whether there is any basis for not allowing a fee off the entirety of this settlement), that is not necessary in the case at hand because the Amended Form 61 does not attempt to charge a contingency fee against benefits provided to an injured worker for medical treatment. First, the benefits referenced were

never provided. Second, the money paid in settlement was clearly provided with the understanding that there was a dispute as to future medical benefits. While the Clincher unfortunately was not clear as to what amount was specifically for future medical benefits, this is why Claimant and his counsel filed the Amended Form 61 to set aside a number per the Single Commissioner's request.

Single Commissioner Conclusion of Law 9 is flat out wrong and based on speculation. Claimant's Counsel vehemently rejects any notion that he did not adequately advise his client of what he was signing. It could not be clearer that Claimant agreed to the fee Counsel purports to charge, as Claimant signed not only the original Form 61 but an Amended Form 61, which, in plain language, states, "I agree to pay my attorney the fee and costs stated. I understand the fee and costs are paid out of my **compensation** and I understand how much money I will receive after I pay my attorney." (Form 61, Amended Form 61).

Additionally, without debating the law on sums allocated for future medical and reliance on en banc orders, Claimant and his attorney did in fact set aside $1,000.00 for future medical care on the Amended Form 61, which Claimant's counsel is not attempting to take a fee off at this time. The Single Commissioner essentially decided a merits issue regarding compensability of an injury and entitlement to treatment. He relied on one opinion that recommended a future knee surgery to conclude that Claimant, in fact, would be entitled to this surgery, when such a conclusion is not supported by the language of the Clincher, is directly contradicted by other medical evidence, and was never ordered previously by a commissioner. The Single Commissioner has taken it upon himself to entitle Claimant to medical benefits that were disputed. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

The Single Commissioner's Conclusion of Law 10 is setting a dangerous precedent for the

Commission as to what evidence may be relied upon in finding injuries compensable and entitlement to future medical care. The Single Commissioner explicitly stated that he relied on Claimant's testimony that he THINKS he will require a knee replacement in the future. If the Commission would like to set this standard going forward, I am happy to forego this additional fee to know that medical evidence stated to a reasonable degree of certainty is no longer necessary in determining compensability or entitlement to future medical care. Considering that is impossible under our current law, it should also be considered an error of law for the Single Commissioner in this case to rely on lay testimony of a Claimant's thoughts to find he should be entitled to additional benefits. Additionally, there was not an incorrect calculation provided in the original Form 61 or Amended Form 61, which were both explained to Claimant. There is no evidence either breakdown of the total amount of compensation "further complicat[ed]" Claimant's understanding of the settlement terms. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

Single Commissioner Conclusion of Law 11 stated Counsel incorrectly included sums intended for future medical treatment. This conclusion is based upon surmise, conjecture, and speculation, especially with the submission of the Amended Form 61. As previously stated, the Single Commissioner found as fact and concluded as law that Claimant is entitled to medical benefits, which were very much disputed and not guaranteed to Claimant. Further, and without evidence to support such a conclusion, the Single Commissioner speculated as to what amount Claimant may need for future medical care, and it is improper to award anything more than what Claimant and his counsel agreed to, which is $1,000.00. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

Conclusion of Law 12 does not definitively state but implies the Single Commissioner found that the authorized treating physician's recommendations for future medical treatment are controlling in this case. Again, this would set a dangerous precedent that in any future case, the opinion of the authorized treating physician will always be given favor over a competing opinion. In this scenario, claimants would suffer abject prejudice from the outset in any case simply because they do not get to direct their own care. An opinion of the authorized treating physician could be completely contradictory to the preponderance of the medical evidence, but in this scenario, it is still given deference simply because it was the authorized treating physician.

Additionally, this would render second opinions futile. As has been mentioned throughout, the Single Commissioner relied on one opinion that indicates Claimant may need a future knee surgery to conclude that Claimant, in fact, would be entitled to this surgery, when such a conclusion is not supported by the language of the Clincher and was never ordered previously by a commissioner. Furthermore, the issue of entitlement future medical benefits was not an issue before the Single Commissioner with the fee petition. The Single Commissioner has taken it upon himself to entitle Claimant to medical benefits that were disputed. Finally, no evidence exists in the record to support concluding that a right knee arthroplasty is the most expensive portion of this physician's recommended treatment and was purely speculative to conclude. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

The Single Commissioner's Conclusion of Law 13 stated that the Clincher is not binding on the issue of attorney fees and reasonableness thereof. This is a misstatement of the argument put forth by Claimant's Counsel at the hearing. Counsel was simply pointing to the *Utica* language as the only definitive breakdown of the total settlement. While the Single Commissioner does have

to ensure the reasonableness of attorney fees, it is quite clear under S.C. Code Reg 67-1205B that 1/3 of the total amount of compensation is reasonable. Additionally, the Single Commissioner erroneously found an "injustice" with no evidence to support such an accusation. He concluded Claimant MAY require expensive future medical treatment. First, there is no evidence concerning potential costs for any of the treatment one doctor recommended. Second, to conclude Claimant MAY need future care does not meet the standard of more likely than not. Furthermore, it is speculation to not only say Claimant will have such treatment but how it will be paid for in the future. Moreover, as has been stated ad nauseum, NONE of this recommended medical treatment was guaranteed or had been ordered by a commissioner. Lastly, this Conclusion of Law erroneously determined that more than half of the settlement was dedicated to future medical treatment when no such evidence supports such a finding, and the settlement funds were also for the value to clincher the claim and any conclusion but this is speculation, surmise, and conjecture. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

The Single Commissioner's Conclusion of Law 14 (similarly to Finding of Fact 9) relied on non-existent evidence in the record of Claimant's counsel's negotiations with Defendants in this matter, and I do not believe any such evidence is admissible in this matter. It is true that, as is required under the law of this State, Mr. Alexander represented Claimant diligently and tirelessly in pursuit of the best result possible in the underlying claim. However, Claimant's counsel did not "reverse course" during this fee petition hearing. As previously mentioned, the Single Commissioner put Claimant's counsel in the unfortunate and awkward position of having to denigrate his client and defend their decision to amend the Form 61, as Claimant and his counsel agreed to do. During such defense, Claimant's counsel attempted to explain why only $1,000.00

was set aside in the Amended Form 61, and it is true and accurate that the future medical treatment identified by the doctors were opinions and not awards or orders that guarantee Claimant anything. As such, Claimant's counsel was required to put forth the position as if he was the Defendants working against his client. To find Claimant's counsel "reversed course" is improper and prejudicial to use as a basis for reducing the attorney fees.

Furthermore, Claimant's Counsel attempted explain how the value of a clincher in this claim was worth more than zero dollars and how it would be valued as the majority of the remaining money for Defendants to avoid exposure for additional TTD, change in condition, or potential permanent and total disability. The Single Commissioner simply dismissed any argument regarding this from Claimant's Counsel. The Majority of the Full Commission adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

Single Commissioner Conclusion of Law 15 clearly shows the Single Commissioner was only left to speculate on future medical treatment, which he did in awarding the entirety of the $44,218.12 to Claimant and not accounting for the value of the clincher to Defendants. For the Single Commissioner to conclude that because he cannot speculate on one end of the calculation only leads to the solution of awarding all funds is purely speculation. This matter concerning future care was agreed upon and decided by Claimant and his Counsel, which is evidenced by the Amended Form 61. The only thing that is NOT speculation, surmise, and conjecture is that Claimant and his Counsel agreed to set aside this amount and both parties were aware of how much they were getting, as evidenced by the signing of the Amended Form 61. The Majority of the Full Commission likewise speculated when they adopted the Single Commissioner's conclusions of law as their own, and in so doing, committed the same error.

The Majority of the Full Commission found as fact in Finding of Fact 2 that the

defendants accepted the claim and provided treatment. No such evidence exists in the record to substantiate this claim was accepted, and to rely "generally" on the Clincher is speculative at best. It is improper to find a claim has been accepted simply because some treatment has been provided, and the Clincher made it very clear that there was a dispute regarding entitlement to future medical care, which clearly shows they had not accepted the claim.

The Majority of the Full Commission's Finding of Fact 5 is wholly inaccurate and directly contradicts the Single Commissioner hearing transcript, as it pertains to Claimant's Counsel. As was stated to the Full Commission in a brief and oral arguments, a rationale was provided to the Single Commissioner for why more was paid to clincher the claim than was paid for indemnity (Single Commissioner Hr. Tr. P. 6, l. 1 : P. 7, l. 16).

The Majority of the Full Commission's Finding of Fact 7 is wholly inaccurate and directly contradicts the Single Commissioner hearing transcript. Again, for the Single Commissioner or Majority to disagree with a rationale is one thing, but to find as fact that no rationale was put forth is wholly inaccurate and contradicts the record. When asked why $1,000.00 was set aside, Counsel explained to the Single Commissioner that there was a chance the knee was found not compensable and the medical treatment was not guaranteed (Single Commissioner Hr. Tr. P. 9, ll. 9-17; P. 10, l. 12 : P. 12, l. 16). Furthermore, it is Counsel's position that there is not a requirement under the Act that he provide a rationale for valuing future medical care, especially when it was not a guaranteed benefit or entitlement to Claimant.

The Majority of the Full Commission's Conclusion of Law 1 affirms the Single Commissioner's calculation of attorney fees. They concluded that "Counsel is not entitled to take a fee on sums paid for future medical treatment pursuant to the Act and Commission Regulations." First, the Majority only generally references the Act and regulations here and

provided no specific law or regulation under the Act, which clearly appears to be based on their arbitrary and capricious opinions and not the law. Second, Counsel and Claimant filed an Amended Form 61 that specifically set aside an amount for medical treatment that Counsel is NOT attempting to take a fee on. As such, this conclusion is erroneous since Counsel ultimately only requested a fee from the $84,000.00 in compensation that was not specifically set aside by him and his client on the Amended Form 61. If the Majority is now saying Counsel is not entitled to a reasonable fee of 1/3 of the $84,000.00, it is our position this is also a clear error of law, as Regulation 67-1205 allows for such a fee amount.

The Majority of the Full Commission's Conclusion of Law 2 is not debated insofar as it pertains to the Commissioner's authority to approve the attorney's fee. The Majority is missing the point of our appeal in that we disagree, and believe it is a clear error of law, that the Single Commissioner is allowed to materially change the terms of a settlement and Clincher agreement between the parties.

Conclusion of Law 3 from the Majority incorrectly concludes as law that the claim for the right knee was admitted simply because some of treatment has been provided. It is erroneous to conclude that any time defendants provide medical treatment subjects them to admitting a claim. Such a conclusion is not only prejudicial to defendants but would also lead to future prejudice against claimants by defendants refusing to provide treatment so that they are not found to have admitted a claim they may later choose to deny after exercising their rights under the Act. To make such a conclusion would never allow defendants to raise a defense such as preexisting condition (or any other defense) that they would clearly not know about until they have already started providing treatment.

The Majority of the Full Commission's Conclusion of Law of 4 is also inaccurate. The

Single Commissioner specifically ordered an award for medical costs, and it is inexplicable that the Majority would conclude otherwise. He found as fact and concluded as law that Claimant was "entitled" to medical treatment, which was in dispute in the underlying claim. To conclude that he only found the attorney fee is unreasonable while ignoring that he found Claimant was entitled to medical treatment clearly ignores parts of the Single Commissioner's Decision and Order. Additionally, to conclude that no additional award of benefits other than what was agreed to by the parties is also inaccurate, as the parties agreed in the Clincher on specific amounts, and Claimant and his Counsel agreed to a specific amount in the Form 61 and Amended Form 61. The Single Commissioner clearly awarded more to Claimant than the parties agreed to, otherwise this appeal would not have happened.

The Majority's Conclusion of Law 5 is correct in what the Single Commissioner decided, but the Majority is again missing the point of this appeal. The claimant was not "entitled" to medical care, as no such benefit had been awarded by a commissioner. The need for and entitlement to additional medical care was very much in dispute, as is specified in the Clincher.

The Majority of the Full Commission's Conclusion of Law of 6 is clearly arbitrary and capricious as it states, ". . . the future treatment valuation in this case is speculative **considering the other facts and circumstances.**" The Majority failed to specify what the other facts and circumstances are that made the future treatment valuation speculative. Further, as discussed above, Counsel did provide a rationale for how the $1,000.00 was reached.

The Majority of the Full Commission's Conclusion of Law of 7 says the fee is unreasonable because it is not a fee customarily charged in the locality for similar services and implies it does not meet S.C. Code Regs 67-1205B and Rules of Professional Conduct 1.5(a)(3). This is a further abuse of discretion, as the Majority has provided no explanation for how a 1/3 fee does not comport

with the referenced laws and regulations, nor have they provided any basis for how this fee, which is exactly what is stated as reasonable under the Act and Regulations, is not customarily charged in the locality for similar services. Additionally, the Majority's Decision and Order is the FIRST time there was any mention of the *Glasscock* factors. During the oral arguments before the Full Commission, NONE of the commissioners hearing the appeal raised any of these six factors or requested any information that would substantiate now using these against Counsel in disapproving the Amended Form 61.

The Majority of the Full Commission's Conclusion of Law 8 stated there is no basis in the Act for awarding Mr. Alexander mileage. Admittedly, Mr. Alexander was unable to voice the statute at the time. However, while this is only a minor issue in this case, we do want to note now there is foundation in the Act for awarding mileage. It is our position that S.C. Code 42-3-130 provides for mileage reimbursement for Mr. Alexander since the Single Commissioner summoned him to appear at three separate locations (Yemassee, Walterboro, and Columbia), none of which were the jurisdictions of this claim. Additionally, the Single Commissioner made the odd decision to swear in Mr. Alexander as if he is witness, which we believe brings him under the purview of S.C. Code 42-3-130 (Hr. Tr. P. 5, ll. 17-23).

CONCLUSION

For the reasons set forth above, Claimant's Counsel respectfully requests that the Order of the Full Commission be reversed with regards to the Findings of Fact and Conclusions of Law concerning the Amended Form 61 Fee Petition, and the Court find the preponderance of the evidence supports finding Claimant's Counsel's petition for a 1/3 fee on the remaining $84,000.00 is reasonable under the Act and Rules of Professional Conduct. Furthermore,

Claimant's Counsel requests reimbursement for mileage for the three hearings the Single Commissioner summoned him to in accordance with S.C. Code 42-3-130.

Respectfully submitted,

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Attorney for Claimant

December 30, 2022
North Charleston, South Carolina

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Dec 30 2022
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE WORKERS COMPENSATION COMMISSION

Gene McCaskill, Commissioner
R. Michael Campbell, II, Commissioner
Avery B. Wilkerson, Jr., Commissioner

Appellate Case No. 2022-001595

TIMOTHY STARNES..... CLAIMANT, APPELLANT,

v.

MERITAGE ASSET MANAGEMENT, INC. D/B/A CENTURARY GLASS, EMPLOYER, and INSURANCE COMPANY OF THE WEST, CARRIER.....RESPONDENTS.

PROOF OF SERVICE

The undersigned hereby certifies that on December 30, 2022 he served Claimant and Counsel for the Respondent with a copy of the *Initial Brief of Appellant* by mailing copies of the same by United States Mail postage prepaid to the following address:

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December 30, 2022

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December 30, 2022

Via Electronic Mail
Jenny Abbott Kitchings, Clerk of Court
SC Court of Appeals
P.O. Box 11629
Columbia, SC 29211

RE: ***Timothy Starnes v. Meritage Asset Management, Inc.***
Appellate Case No.: 2022-001595

Dear Honorable Kitchings:

Enclosed for filing is the original and one (1) copy of the Initial Brief of Appellant in the above-referenced matter. I have also enclosed proof of service upon Claimant and Counsel for Respondents.

Thank you for your attention to this matter. If you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

Richard C. Alexander
Attorney at Law

RCA/ca

cc: Christopher T. Hourihan, Esq.
Timothy Starnes