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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
Workers' Compensation Commission Full Appellate Panel

Appellate Case No. 2022-000067

KYLE R. BAGLEY, Employee..... Appellant,

v.

JN FIBERS, INC., D/B/A SUN FIBER, LLC, Employer, and
GREAT AMERICAN INSURANCE COMPANY, Carrier..... Respondents.

FINAL BRIEF OF RESPONDENTS

C. Barrett Burley
M. Brooks Biediger
HOLDER PADGETT
LITTLEJOHN + PRICKETT, LLC
1201 Main Street, Suite 1430
Columbia, South Carolina 29021
Tel.: (803)335-1446
Fax: (803)708-7820

Attorneys for Respondents

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STATEMENT OF THE CASE

This is an appeal from the South Carolina Workers' Compensation Commission. Appellant alleges he sustained work related injuries to the back, head/brain, with affected body parts of "both legs (L>R), Left Arm and Radiculopathy down to back of his leg/scrotum and bottom of L-foot (L-foot drop as well)" from an accident on June 14, 2019. (R. p. 61). Respondents admitted the back injury was compensable, but denied the alleged head/brain injury and additional associated body parts. (R. p. 63).

On October 16, 2019, Appellant filed a Form 50 Employee's Request for Hearing in which he was primarily seeking determination of compensability for his alleged injuries and further medical treatment. On November 15, 2019, Respondents filed their Form 51 Answer in which they admitted Appellant sustained a minor compensable injury to his back, but denied the remainder of the alleged injuries and denied the extent of the disability alleged. Respondents also filed a Form 21 Employer's Request for Hearing in which they sought a determination that Appellant was at maximum medical improvement for the admitted back injury. (R. p. 60).

A hearing was held before the Honorable Gene McCaskill ("Single Commissioner") on September 28, 2020. In the Form 58 Pre-Hearing Brief (9/2/2020), Appellant was primarily seeking a determination of compensability for his alleged injuries, further medical treatment, as well as a determination of average weekly wage/compensation rate and whether Appellant "is entitled to underpaid/back-owed TTD as [Respondents] previously paid [Appellant] at a [compensation rate] lower than it should be." (R. p. 61-62). Respondents admitted Appellant

sustained a minor compensable injury to the back, but denied the remainder of the alleged injuries and denied the extent of the disability alleged. (R. p. 63). Respondents further sought a determination that Appellant was at maximum medical improvement pursuant to the medical evidence.

On May 13, 2021, the Single Commissioner issued a Decision and Order in which he found that Appellant had sustained a compensable head injury. (Single Commissioner Order, R. p. 19). The Single Commissioner also found that Respondents shall pay for the past causally related medical treatment and shall provide further causally-related medical care until Appellant reaches MMI or until further order of the Commission. (Single Commissioner Order, R. pp. 20-21). The Single Commissioner further ordered Respondents to provide a neurologist to treat Appellant's head/brain injury, as well as a provider for psychotherapy and "someone to treat the other 'non-neuro/psyche' injuries." (Single Commissioner Order, R. pp. 18-19).

On May 25, 2021, Respondents filed a Form 30 Request for Review by Appellate Panel of Full Commission ("Commission") contending generally that the Single Commissioner erred in finding Appellant met his burden in proving he sustained compensable injuries beyond his back, and in finding Appellant met his burden in proving he is entitled to temporary benefits and medical treatment. (R. p. 64). Oral arguments we heard before the Commission on August 30, 2021.

On December 21, 2021, the Commission issued its Decision and Order in which it reversed the findings of the Single Commissioner and determined the Appellant sustained a compensable injury to the back only. (Commission Order, R. pp. 35, 49). The Commission determined the Appellant failed to satisfy his burden of proving he sustained compensable injuries to his head, brain, left arm and hand, left foot, and psyche. (Commission Order, R. p. 49). Finally, the Commission determined the Appellant was at maximum medical improvement for his admitted

back injury, and awarded 10% permanent partial disability to the back. (Commission Order, R. pp. 49-50). This appeal follows.

STATEMENT OF THE FACTS

In the early morning hours of June 14, 2019, Appellant sustained an admitted work-related injury to his back when a large bale of fiber material rolled down a short ramp and knocked him backwards. Surveillance video from the Employer captured the incident in its entirety. (R. at Defendant's Exhibit 3, video of accident). In the video, the Appellant can be seen in a squatting position welding a repair onto a short roller ramp. (R. at Defendant's Exhibit 3, video of accident). The Appellant was pushed backwards by the bale, but he quickly stood up. (R. p. 184, line 25-p. 186, line 10; R. at Defendant's Exhibit 3, video of accident). During the accident and immediately thereafter, Appellant never lost consciousness. (R. at Defendant's Exhibit 3, video of accident).

After the accident, the Appellant walked around the area and left to report the injury to his supervisor. (R. p. 186, lines 14-23; R. at Defendant's Exhibit 3, video of accident). The supervisor asked if Appellant needed medical treatment, but he declined. (R. p. 189, line 9-p. 191, line 5). After reporting the accident, the Appellant continued working and completed his shift at 7:00 A.M. (R. p. 187, lines 6-15).

Three days after the accident, Appellant first sought medical treatment at MUSC Health Chester Medical Center with complaints of acute, non-radiating pain in the posterior cervical, thoracic, and lumbar areas. (R. pp. 251-273). The record indicates the Appellant "was hit on forehead with a bale of fiber that knocked him onto his back on Friday, now hurting in his neck and entire back." (R. p. 252). On physical exam, the attending physician noted Appellant's motor function, sensory function, and deep tendon reflexes were normal, and that his gait was "steady, at a normal pace, without difficulty." (R. p. 253). CT scans of the cervical, thoracic, and lumbar

spine revealed no acute fractures, normal spinal alignment, normal vertebral discs, and no advanced canal stenosis. (R. pp. 257-258). Appellant was diagnosed with a contusion of his lower back and pelvis and discharged to follow up as needed with medication. (R. pp. 254-255). There was no notation of a left hand contracture or left foot drop in these records. (R. pp. 251-273)

Drewid Plyler Poulos, PA, Appellant's primary care provider, treated Appellant on June 25, 2019. (R. pp. 275-281). Appellant denied loss of consciousness during the accident, and complained of pain with radiculopathy in his neck and low back. (R. p. 275). Appellant denied "dizziness, light-headedness and headaches." (R. p. 276). There was no notation of a left hand contracture or left foot drop in these records. (R. pp. 275-281)

Dr. Matthew Brown, a neurosurgeon with Midlands Orthopaedics and Neurosurgery, first treated the Appellant on July 5, 2019, for complaints of neck pain radiating from the occiput up the vertex, as well as low back pain which "feels like glass," left-sided posterior buttock pain radiating to the thigh into the proximal calf, and left upper extremity pain radiating down to the left hand with a tingling sensation in the fingers with a flexed position of the whole left upper extremity. (R. pp. 295-298). On physical exam, Dr. Brown observed:

> His left shoulder, elbow joint, wrist joint, and all digits on the left hand are flexed and clenched at baseline, however, he is able to have normal range of motion when asked and as well as observed delayed later throughout the exam. The patient has 5/5 bilateral upper and bilateral lower extremity strength. Of note, the patient has good full strength in both the flexors as well as all extensors of his upper extremity and does not have poor oppositional tone.

(R. pp. 296-297). Dr. Brown opined Appellant's MRI of the cervical, thoracic, and lumbar spine (7/3/2019) revealed "no significant acute pathology," and that there was "no neurological structure impingement throughout his cervical, thoracic, or lumbar spine with no central canal stenosis or significant foraminal stenosis which would explain any of the patient's symptoms at this time."

(R. p. 297). Dr. Brown diagnosed Appellant with cervico-occipital neuralgia and a neck strain and recommended bilateral greater and lesser occipital nerve blocks. (R. p. 297).

On July 11, 2019, Dr. Brown performed the nerve block injections. (R. pp. 292-295). Dr. Brown then released Appellant at maximum medical improvement from a neurosurgical perspective and released Appellant back to the care of occupational medicine. (R. p. 294). Dr. Brown assigned a 0% whole person impairment for Appellant's lumbar and thoracic spine, plus a 5% whole person impairment for the cervical spine for "nonverifiable radicular complaints, and muscle tenderness, though no true muscle guarding was observed at the time of the visit." (R. p. 294).

On December 19, 2019, Dr. Brown sat for a deposition. (R. pp. 747-788). At his deposition, Dr. Brown confirmed his diagnosis of nonverifiable radiculopathy and occipital neuralgia and explained that a single occipital nerve block (an injection of a numbing medication and steroid) traditionally treats a vast majority of patients. (R. p. 757, line 18-p. 758, line 21, and p. 760, lines 7-9). Dr. Brown opined that he did not observe any surgical pathology, so he released Appellant for treatment of any non-surgical issues. (R. p. 760, line 20-p. 761, line 24). Given the nature of the injury, Dr. Brown testified he would not necessarily refer Appellant for neurology. (R. p. 769, lines 7-9). Dr. Brown also confirmed there was nothing structurally or mechanically wrong with Appellant's neck or back. (R. p. 785, lines 2-8).

Concerning Appellant's left sided foot drop, Dr. Brown opined that the symptoms were inconsistent with anatomic findings:

> When I evaluated him, it was the presentation of the multiple locations that don't fit an anatomic finding without significant issues. You can certainly have a very large injury, either a expanding hematoma or a very large contusion, which can affect both of those places, or potentially within the deep basal ganglia certainly can happen, but those would typically be presenting with other findings, which he did not have on exam.

(R. p. 770, lines 1-9).

Similarly, concerning Appellant's left upper extremity contracture, Dr. Brown opined that the presentation of symptoms was inconsistent with the known anatomical findings:

> [Appellant's left-hand contracture] is something that is difficult to explain from a anatomic and neurologic perspective because he did have very good oppositional tone. Typically, you'll have unopposed tone for -- lead -- lead to contractures. So, if you don't have the muscle input from the extensor muscles and/or the -- the nerves that control the extensor fibers, rather than the contracting and the flexion fibers, then you'll have unopposed tone and get a -- get a contraction. During my exam he had good, full strength in both sides, which made it very difficult to see that as a discreet, reliable finding.

(R. p. 770, line 15-p. 771, line 2).

Concerning Appellant's allegations of progressive weakness, Dr. Brown opined the timeline was inconsistent with how these symptoms develop following trauma:

> ...my expectation would be that a significant finding with a closed head injury would present early and then typically improve over time. If he had not had significant weakness at one month's time, I find it very unlikely that he would continue to develop weakness, which was not present even to a small degree at that point.

(R. p. 779, lines 16-23).

According to Dr. Brown, the problem attributing Appellant's alleged left foot drop and left upper extremity contracture was two-fold. First, there were no anatomic findings on the exam to corroborate the alleged symptoms. Secondly, given the spatial relationship in the brain between the neurons that control the arms and the neurons that control the legs, if a single traumatic lesion impacted both, that lesion would also have impacted other anatomical structures and create other problems which Appellant did not have. (R. p. 780, lines 2-23).

Dr. S. Taylor Jarrell, a neurosurgeon at Carolina Neurosurgery and Spine, treated the Appellant on August 22, 2019, following a referral from Appellant's primary care physician. (R.

pp. 391-396). Dr. Jarrell agreed with Dr. Brown that Appellant did not require any surgery. (R. p. 394). However, given the alleged headaches, Dr. Jarrell referred Appellant for a CT Scan of the head. (R. p. 394).

On September 5, 2019, Dr. Jarrell reviewed the CT scan of the head and noted that "[a]ll of his neuro imaging is normal." (R. p. 399). For further treatment, Dr. Jarrell opined Appellant "would probably benefit from a referral to orthopedics," but that Dr. Jarrell did "not have anything to offer at this point." (R. p. 399).

Dr. David DuPuy, a general orthopedic surgeon with OrthoCarolina, first treated Appellant on September 12, 2019. (R. pp. 407-409). Given Appellant's symptoms of left-hand contracture and left foot drop, Dr. DuPuy opined that these symptoms were "coming from the brain, as opposed to the spinal cord, either cervical, thoracic, or lumbar." (R. p. 900, line 23-p. 902, line 2). On this first visit, Dr. DuPuy referred Appellant for an MRI of the brain. (R. p. 408). According to Dr. DuPuy, the "only abnormality" on the MRI was a small "hot spot" which he could not say was causing Appellant's alleged symptoms. (R. p. 913, lines 6-17).

On September 26, 2019, Dr. DuPuy referred Appellant for a nerve study. (R. p. 417). According to Dr. DuPuy, the nerve study "pretty much ruled out the neck and the back" as the cause of Appellant's alleged left hand and left foot symptoms. (R. p. 912, lines 20-22).

At his deposition on April 29, 2020, Dr. DuPuy opined that from an orthopedic standpoint, there was nothing structurally or mechanically wrong with Appellant's head or brain:

> Q: Yeah. From an orthopaedic standpoint, is there anything structurally or mechanically wrong with Mr. Bagley's head or brain, from what you can tell?
>
> A: No. That's a surprise to me that those scans are essentially normal. The -- but it doesn't mean that an injury can't have occurred at the cellular, microscopic level. But he didn't have a -- a subdural hematoma, and he doesn't have an area in the brain by MRI where it's just dark, where the brain tissue has died and the body has carried kind of cleaned it up. He doesn't have that.

> And so that, to me this is an – an irregular presentation and, of course, that's why I defer it to Dr. Rao and the – the neurology subspecialist.
> But from an orthopaedic standpoint, I do not think that there is an injury to the cervical nerves from the neck, shoulder, arm, out to the hand.

(R. p. 931, line 18-p. 932, line 11). Dr. DuPuy testified he would defer to neurology in the evaluation of Appellant's brain:

> . . . I have nothing from an orthopaedic standpoint to say this has anything to do with a neck injury or an arm injury or a back injury or a leg and foot injury. And if they say it's not coming from the brain, then I do not know why he is in that fixed position. And as I said, the fact that he was able to continue working and then presented to the workers' comp the next day, the CT scan was normal, that part doesn't make sense with this syndrome either. But, of course … But, I mean, that's what I'm saying: It is what it is.

(R. p. 936, line 20-p. 937, line 20).

On the issue of scope of evaluation and his opinion, Dr. DuPuy testified:

Q Okay. And so, at least from -- from an orthopaedic standpoint, you can't say what's causing – what underlying pathology is causing Mr. Bagley's symptoms; is that fair to say?
A That is exactly what I say. Yes.
Q And then, of course, your -- your -- the scope of your evaluation is limited to the orthopaedic side of things?
A Yes. It is. My expertise is limited to the orthopaedic arms and legs part, not inside the brain.

(R. p. 938, line 17-p. 939, line 2).

Dr. T. Hermanth Rao, a neurologist at The Neurological Institute, first treated the Appellant on October 31, 2019, for left upper extremity held in flexion, left foot held in inversion, and decreased muscle strength in the left upper and lower extremities with left foot drop, as well as various cognitive issues including headaches, loss of memory, dizziness, irritability, and depression. (R. pp. 431-434). In the records, Dr. Rao provided a differential diagnosis of closed head injury versus spine injury and referred Appellant for an EEG. (R. p. 433).

On November 19, 2019, Appellant had a follow up visit with Dr. Rao. (R. pp. 435-438). According to Dr. Rao, Appellant's EEG revealed "regular" findings. (R. p. 437). Dr. Rao then recommended Appellant for a 96-hour video EEG and an outpatient brain injury program. (R. p. 437).

Dr. Rao sat for a deposition on February 14, 2020. (R. pp. 789-887). Concerning his diagnosis, Dr. Rao opined:

> Well, I thought he had a closed-head injury, you know, given the temporal relationship of the injury and the symptoms when they began. And along with that he had a postconcussive syndrome. The issue was also could there have been a spinal injury. You know, in looking at that impact directly to the top of his head, that force can -- is also transmitted down into the spine. So with his left-sided weakness, the other possible location was not just the head injury, but also could there also have been a spinal injury.

(R. p. 798, lines 8-18).

Concerning the results Appellant's EEG study, Dr. Rao testified Appellant "seemed to have some slowing. It was intermittent in left frontal area. And that could be a sign of a head injury." (R. p. 800, lines 21-23). Appellant's father provided a medical history which motivated Dr. Rao to ultimately recommend a 96-hour EEG to investigate "episodes" which might be seizures or symptoms of a mild traumatic brain injury. (R. p. 802, lines 12-21).

At his deposition, Dr. Rao was questioned about his involvement in alleged Medicare fraud brought by the U.S. Department of Justice in 2013. Dr. Rao denied that he was ever charged with fraud, but instead testified there was a technical issue which led to a business decision to "go ahead and pay back" the federal government. (R. p. 819, line 15-p. 820, line 2). Concerning the press release from the USDOJ in which the prosecutor states "Dr. Rao's actions not only compromised the integrity of the Medicare program, but exposed his patients to potential danger," and "Dr. Rao allowed his staff to practice a potentially hazardous procedure on Medicare patients, without his

supervision, then blatantly charge taxpayers," Dr. Rao confirmed he was the neurologist that was the subject of the press release, but he denied there was a fraud allegation. (R. p. 820, lines 3-23; R. p. 854). Dr. Rao denied misrepresenting to Medicare that he was present for procedures and then billing Medicare because he was "within a 12-second time period." (R. p. 822, lines 17-22). Dr. Rao admitted entering into a Settlement Agreement (R. pp. 856-878) and a corporate integrity agreement with the USDOJ for a judgment against him in the amount of $2,000,000, which he argued was an overpayment not a fine. (R. p. 822, line 17-p. 826, line 4).

Dr. Rao was also asked about whether he was delinquent in his board certification with the American Board of Psychiatry and Neurology. Concerning the notation of "MOC Status: Not meeting MOS requirements" on his board certification, Dr. Rao testified this involved continuing medical education credits which he had not yet submitted to the board. (R. p. 826, line 5-p. 827, line 18).

Dr. Brett Gunter, a neurosurgeon at the Lexington Brain and Spine Institute, first treated Appellant on March 10, 2020. (R. pp. 621-624). Dr. Gunter reviewed an updated MRI of the lumbar spine (2/27/2020) and opined it showed no evidence of acute injury. (R. p. 623). Dr. Gunter diagnosed Appellant with lumbar myofascial syndrome. (R. p. 623). Dr. Gunter further opined Appellant had no mechanical restriction on his ability to return to work. (R. p. 623).

On July 8, 2020, Dr. Gunter reviewed an updated MRI of the brain (6/9/2020), which he opined was normal. (R. p. 629). Dr. Gunter further reviewed an updated MRI of the cervical spine, which demonstrated "cervical spondylosis with some canal stenosis and foraminal stenosis but without significant cord or nerve root compression. The stenosis appears largely congenital." (R. p. 629). As such, Dr. Gunter opined he was "unable to identify either significant cervical spinal disease or intracranial ... disease to explain his current condition." (R. p. 629). Dr. Gunter opined

Appellant needed continued rehabilitation, but gave no indication for surgical intervention. (R. p. 629).

On September 8, 2020, Dr. Gunter sat for a deposition. (R. pp. 943-982). For the brain, Dr. Gunter testified he reviewed Appellant's CT Scan of the head (8/29/2019), MRI of the brain (9/24/2019), and second MRI of the Brain (6/9/2020), and none of these tests revealed any evidence of acute injury. (R. p. 951, line 21-p. 952, line 22).

For the cervical spine, Dr. Gunter testified he reviewed Appellant's CT Scan of the neck (6/17/2019), MRI of the neck (7/3/2019), second MRI of the neck (6/9/2020), and none of these tests revealed any evidence of acute injury. (R. p. 953, line 11-p. 954, line 6). For the lumbar spine, Dr. Gunter testified he reviewed Appellant's CT Scan of the lumbar spine (6/17/2019), MRI of the lumbar spine (7/3/2019), second MRI of the lumbar spine (2/27/2020), and none of these tests revealed any evidence of acute injury. (R. p. 954, lines 12-23). Dr. Gunter further opined there was no evidence of acute injury on Appellant's EMG nerve study. (R. p. 955, lines 12-17).

Like Dr. Brown, Dr. Gunter explained that the Appellant's symptoms were inconsistent with the anatomical layout of the brain. According to Dr. Gunter, the part of the brain that controls leg function is located on the motor cortex and is interhemispheric (situated along the center between the two halves of the brain). (R. p. 968, line 25-p. 969, line 3). The part of the brain that controls arm function is on the surface of the motor cortex next to the face, in a geographically different part of the brain. (R. p. 969, lines 4-14).

In order to prove Appellant sustained a brain injury which causes his current left arm and left leg symptoms, Dr. Gunter opined there would have to be distinct lesions on these separate portions of the brain. (R. p. 969, lines 10-14). Further, the singular traumatic event would have

had to damage these separate parts of the brain while sparing the parts of the brain on either side. (R. p. 976, lines 18-22).

According to Dr. Gunter, if Appellant sustained a closed head injury to the motor cortex, it should have been visible on an initial CT scan as a contusion, and in the follow-up MRIs of the brain as an alteration of the anatomy of the motor cortex, but that is not the case with Appellant. (R. p. 968, lines 14-21). Dr. Gunter was emphatic on the point, testifying the diagnostic imaging "... would pick this up. This would be big." (R. p. 970, lines 3-5).

Dr. Gunter summarized his opinions:

> He doesn't have an acute injury of his cervical spine or his spinal cord or his nerve roots, because there's no evidence of that. And he doesn't have an injury to his brain, at least based on the evidence. And he doesn't have an injury to his lumbar spine, based on evidence.

(R. p. 972, lines 16-21).

Concerning post-concussive syndrome, Dr. Gunter opined that Appellant's symptoms of contractures and alteration in muscle tone without radiographic evidence of injury were not indicative of post-concussive syndrome. (R. p. 975, lines 12-16).

Dr. Gunter opined "there is no relationship between [Appellant's] injuries and the development of those contractures, physically." (R. p. 980, lines 1-6). Dr. Gunter explained that if Appellant had a brain injury leading to a muscle contracture, his first symptom should have been paralysis of the extremity, followed by spasticity, followed by alteration of tone and contractures, which Appellant did not have. (R. p. 975, line 23-p. 924, line 2). Concerning the Appellant's alleged seizures, Dr. Gunter testified "relating a seizure disorder to this trauma would be impossible." (R. p. 970, lines 8-10). Finally, having proven there was no physical explanation for Appellant' symptoms, Dr. Gunter opined there might be a psychological/behavior component,

which he would not comment on as they are outside the scope of his expertise. (R. p. 978, lines 10-14).

Dr. Gunter noted other medical evidence to indicate Appellant did not sustain a brain injury on June 14, 2019. Concerning Appellant's motor strength, Dr. Gunter opined that acute brain injury would produce an immediate loss of motor strength that improves over time. (R. p. 958, lines 10-19). However, Appellant had full strength in his early visits with Dr. Brown, but deteriorated over time, which was inconsistent with the typical timeline of a brain injury.

Another factor referenced by Dr. Gunter involved the loss of consciousness. According to Dr. Gunter, loss of consciousness is a typical symptom of severe head injury with long-term neurologic dysfunction:

> [Appellant] says he did not get knocked out. And so you would not anticipate a severe closed head injury if that patient failed to have loss of consciousness. Now, that doesn't mean you can't get post-concussive symptoms, which are different. You can get post-concussive symptoms either with or without loss of consciousness. But severe closed head injury symptoms, like neurologic decline, neurologic, dysfunction as a result of the head injuries, you would expect to have loss of consciousness.

(R. p. 967, lines 15-24).

STANDARD OF REVIEW

The South Carolina Administrative Procedures Act ("APA") sets forth the standard for judicial review of decisions of the Workers' Compensation Commission. *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 276 S.E.2d 304 (1981).

Pursuant to the APA:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
>
> . . .
>
> (d) affected by other error of law;

> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. CODE ANN. § 1-23-380.

"'Substantial evidence' is not a mere scintilla of evidence . . . [but] is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached . . . ." *Lark*, 276 S.C. at 135, 276 S.E.2d at 306. Substantial evidence 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. *Ellis v. Spartan Mills*, 276 S.C. 216, 218, 277 S.E.2d 590, 591 (1981). "[A] judgment upon which reasonable men might differ will not be set aside." *Lark*, 276 S.C. at 136, 276 S.E.2d at 307.

Pursuant to this scope of review, the Court may not substitute its judgment for that of the appellate panel as to the weight of the evidence on questions of fact. *Gadson v. Mikasa Corp.*, 368 S.C. 214, 220, 628 S.E.2d 262, 266 (2006). "The findings of an administrative agency are presumed correct and will be set aside only if unsupported by substantial evidence." *Id.* at 222, 628 S.E.2d at 266.

"The Appellate Panel is the ultimate fact finder in Workers' Compensation cases, and it is not bound by the single commissioner's findings of fact." *Bass v. Isochem*, 365 S.C. 454, 468, 617 S.E.2d 369, 376 (Ct. App. 2005). The ultimate determination of a witness' credibility and the weight of such evidence is reserved to the Commission. *Shealy v. Aiken County*, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). The existence of inconsistent conclusions that may be drawn from the evidence does not preclude the administrative agency's findings from being based on substantial evidence. *DuRant v. South Carolina Dep't of Health & Envtl. Control*, 361 S.C. 416,

420 604 S.E.2d 704, 707 (Ct. App. 2004). "Where there are conflicts in the evidence over a factual issue, the findings of the Commission are conclusive." *Etheredge v. Monsanto Co.*, 349 S.C. 451, 455, 562 S.E.2d 679, 681 (Ct. App. 2002).

ARGUMENT

I. THE SUBSTANTIAL EVIDENCE SUPPORTS THE COMMISSION'S DETERMINATION THAT APPELLANT FAILED TO PROVE A COMPENSABLE INJURY TO HIS BRAIN.

Appellant argues he sustained a brain injury during the accident which caused him to suffer specific functional symptoms in his extremities (left hand contracture and a left foot drop). To support this argument, Appellant essentially argues that the Commission should have afforded more weight to Dr. DuPuy and Dr. Rao.

As a threshold matter, each of Appellant's arguments goes to the weight of the evidence on questions of fact. For instance, the first two arguments make it apparent that the evidence from Dr. DuPuy and Dr. Rao was favorable to the Appellant, and that the evidence from Dr. Brown and Dr. Gunter was favorable to the Respondents. Appellant argues the Commission should have afforded more weight to Dr. DuPuy and Dr. Rao over Dr. Brown and Dr. Gunter. The Appellant further argues that Dr. Brown's opinion should be discounted based upon a "cursory" medical examination, which also tainted the opinions of Dr. Gunter.

However, in drawing the parallel between the expert opinions, the Appellant has implicitly acknowledged that there is conflicting evidence over a factual issue in dispute. "Where there are conflicts in the evidence over a factual issue, the findings of the Commission are conclusive." *Id.* "[E]ven sharply contradicted evidence of injury can constitute substantial evidence for purposes of review." *Pack v. S.C. DOT*, 381 S.C. 526, 537, 673 S.E.2d 461, 467 (Ct. App. 2009).

In the present case, the Commission considered this conflicting evidence and determined that greater weight should be given to the opinions of Dr. Brown and Dr. Gunter. (Finding of Fact

No. 52; R. p. 46). In support of this finding, the Commission cited an extensive list of evidence from these experts. (Findings of Fact 5-72; R. pp. 35-50). As the ultimate finder of fact, the decision to give greater weight to Dr. Brown and Dr. Gunter is reserved to the Commission and supports the determination that Appellant failed to prove a brain injury.

As will be discussed in more detail below, the Commission's determinations are supported by the substantial evidence. Therefore, the Commission's determination that Appellant did not sustain a brain injury should be affirmed.

A. APPELLANT'S ALLEGED SYMPTOMS ARE ANATOMICALLY INCONSISTENT WITH THE MECHANISM OF INJURY.

Appellant asserts "[t]here is simply no evidence of record to support the decision of the [Commission], much less substantial evidence." (Appellant's Brief, p. 15). The Appellant argues the Commission used an improper standard by requiring "objective evidence in the form of [diagnostic] imaging." (Appellant's Brief, p.16). However, this argument overlooks the fact that most of the Commission's findings were not based on the diagnostic imaging. Instead, these findings are based upon medical testimony of how the Appellant's symptoms were inconsistent with the known medical progression of brain injuries. (Findings of Fact 42, 43, 46-50, 57-61, 64, 65; R. pp. 44-49).

Based upon the testimony of Dr. Brown and Dr. Gunter, the Commission determined it was essentially physically impossible for the accident to have caused the Appellant's alleged symptoms. Specifically, the Commission determined that the Appellant's "alleged symptoms of a left hand contracture and left foot drop – without functional impairment to any other body part – are essentially impossible based upon the [Appellant's] known mechanism of injury and the anatomical layout of the brain." (Finding of Fact 61; R. p. 48).

To understand why this accident was not capable of producing Appellant's specific symptoms, Dr. Brown and Dr. Gunter explained the motor function of body parts can be traced back to certain parts of the brain. (Dr. Brown Dep., R. p. 780, lines 2-23; Dr. Gunter Dep., R. p. 968, line 3-p. 969, line 14; p. 976, lines 10-17). If a brain injury caused functional symptoms in the left foot and left hand, these symptoms could be traced to damage to the motor neuron signals that go to these areas of the body. (Dr. Brown Dep., R. p. 780, lines 2-23; Dr. Gunter Dep., R. p. 968, lines 22-25).

For the Appellant's left foot symptoms, leg function is associated with the interhemispheric motor cortex of the brain. (Dr. Gunter Dep., R. p. 968, line 25-p. 969, line 3). This area is "in-between the two halves of the brain, which is uncommonly injured because it's fairly well protected in the interhemispheric sulcus." (Dr. Gunter Dep., R. p. 968, line 25-p. 969, line 3).

For the left hand symptoms, arm function is associated with the precentral gyrus, which is located "out ... over the hemisphere" of the brain. (Dr. Gunter Dep., R. p. 969, lines 4-14).

Dr. Brown and Dr. Gunter explained that the part of the brain that controls the leg and the arm are geographically separate from each other. (Dr. Brown Dep., R. p. 780, lines 16-23; Dr. Gunter Dep., R. p. 968, line 22-p. 969, line 14).

This area of brain between the interhemispheric cortex (leg) and precentral gyrus (arm) is associated with other motor functions. (Dr. Gunter Dep., R. p. 976, lines 10-22). For example, the precentral gyrus (arm) is adjacent to the area that controls the face, so an injury to the brain impacting the arm "but not the face would be unusual, because they're geographically, immediately adjacent." (Dr. Gunter Dep., R. p. 969, lines 4-9). As such, a single hit to the head that impacted both leg and arm would necessarily manifest in symptoms to other motor functions as well.

The problem with the Appellant's argument is that he is alleging a single hit to the head manifesting in symptoms to the left foot and left hand *only*. Because the interhemispheric cortex (leg) and precentral gyrus (arm) are located in separate areas of the brain, it is impossible for a single hit to the head to injure both areas without also damaging the area in between and causing functional problems in other body parts. Therefore, as explained by Dr. Brown and Dr. Gunter, the Appellant's alleged symptoms are inconsistent with the anatomical layout of the brain because a single brain injury would have necessarily caused additional functional symptoms beyond those alleged.

The Appellant bears the burden of proving he sustained a brain injury that caused his alleged left foot and left hand symptoms. Therefore, because the substantial evidence proved these specific symptoms were inconsistent with the anatomical layout of the brain, the Commission correctly determined the Appellant failed to satisfy his burden of proving an injury to the brain.

B. THE OBJECTIVE DIAGNOSTIC IMAGING PROVES THE APPELLANT DID NOT SUSTAIN A BRAIN INJURY.

Appellant alleges that the Commission's determination was inappropriately based upon the "absence of imaging." (Appellant's Brief, p. 10). Although the Commission did not rely exclusively on the diagnostic imaging in their decision, it should first be noted that there is no "absence of imaging" in this case. Over a dozen diagnostic imaging studies were performed on the Appellant, including studies for his brain (one CT scan and two MRIs), neck (two CT scans and two MRIs), thoracic spine (one CT scan and one MRI), and lumbar spine (one CT scan and two MRIs). Far from speculation or conjecture, these imaging studies are diagnostic tools that – unlike self-reported symptoms – produce objective evidence of any potential pathology which is incapable of manipulation by the patient.

Based upon the Appellant's alleged symptoms, Dr. Gunter testified that any brain injury capable of causing these symptoms *should have* been visible on diagnostic imaging:

> . . . in order to produce a contracture due to injury to the motor strip, you need to have an injury that you can see. You need to have a bruise in there, or a more intracerebral hemorrhage in there, that actually produces cortico damage to permanently reduce the motor function in the affected extremity.

(Dr. Gunter Dep., R. p. 975, lines 17-22). Dr. Gunter explained what to look for on diagnostic imaging to corroborate these specific symptoms:

> So with a closed head injury you would need to produce an injury to the motor cortex. And it should be visible immediately. And it should be ... seen at least as a bruise or a contusion on the early CAT scan that he had, which he did not. And it should be seen as an alteration in the anatomy of the motor cortex on the subsequent MRIs, but it did not, as those MRIs, were read as normal.

(Dr. Gunter Dep., R. p. 916, lines 14-21). Dr. Gunter was emphatic on the point:

> Q. Now, isn't it true that MRIs and CTs don't always pick up certain things like that.
> A. But they would pick this up. This would be big.

(Dr. Gunter Dep., R. p. 970, lines 3-5).

Despite the exhaustive diagnostic imaging, there was no evidence of injury to Appellant's brain. The first imaging study of the Appellant's brain was a CT scan on August 28, 2019. This scan was ordered by Dr. Jarrell who opined that "[a]ll of his neuro imaging is normal." (R. p. 399). Dr. Gunter and Dr. DuPuy also confirmed this CT scan did not show any brain injury. (Dr. Gunter Dep., R. p. 952, lines 8-10; Dr. DuPuy Dep., R. p. 900, lines 7-9, p. 924, lines 8-12).

The second imaging study on the Appellant's brain was an MRI on September 24, 2019, ordered by Dr. DuPuy. According to Dr. DuPuy, the "only abnormality" on the MRI was a small "hot spot" which he couldn't say was causing Appellant's alleged symptoms. (Dr. DuPuy Dep., R. p. 913, lines 6-17). Dr. DuPuy confirmed there was nothing he could point to as mechanically or structurally wrong with the Appellant's head or brain, and was surprised to see "that those scans

are essentially normal." (Dr. DuPuy Dep., R. p. 931, line 18-p. 932, line 3). Dr. Gunter also opined there was no evidence of a brain injury on this MRI. (Dr. Gunter Dep., R. p. 952, lines 11-15).

The third imaging study on the Appellant's brain was a repeat MRI on June 9, 2020, ordered by Dr. Gunter. (R. p. 629). Since the Appellant's prior brain imaging had all been negative, Dr. Gunter ordered the repeat MRI "to ensure that we hadn't missed something." (Dr. Gunter Dep., R. p. 973, lines 5-8). However, like the prior neuro imaging, Dr. Gunter opined the second brain MRI showed no brain injury. (Dr. Gunter Dep., R. p. 952, lines 16-22).

Therefore, based upon the Appellant's specific symptoms, there should have been some evidence of brain injury on the three diagnostic imaging scans. However, as confirmed by Dr. Jarrell, Dr. DuPuy, and Dr. Gunter, the neuro imaging of Appellant's brain was all normal, with no diagnostic evidence of injury. Accordingly, Appellant also failed to carry his burden of proving a brain injury because the exhaustive diagnostic imaging found there was nothing wrong with his brain.

C. APPELLANT'S ALLEGED TIMELINE OF SYMPTOMS IS INCONSISTENT WITH A BRAIN INJURY.

Beyond the anatomical inconsistency and the normal diagnostic imaging, the Commission further supported its determinations with expert testimony that the Appellant's reported symptoms were inconsistent with medical science of closed head injuries.

The first inconsistent symptom was the fact that the Appellant did not lose consciousness during the accident. Dr. Gunter opined that in a brain injury capable of producing persistent functional deficits in the hands or feet, the accident should have caused severe loss of consciousness or a coma. (Dr. Gunter Dep., R. p. 967, lines 15-24, p. 976, line 9-p. 977, line 6). However, as can be seen on the surveillance footage of the incident, the Appellant never lost consciousness and certainly never fell into a coma. (R. at Defendant's Exhibit 3, video of accident).

Dr. Gunter testified that because the Appellant did not lose consciousness, he would not have expected the Appellant to have long term functional deficits as alleged. (Dr. Gunter Dep., R. p. 967, lines 6-24).

The second inconsistency is the timeline of the Appellant's alleged loss of motor strength. According to Dr. Brown and Dr. Gunter, an acute brain injury would produce an *immediate* loss of motor strength that *improves* over time. (Dr. Brown Dep., R. p. 779, lines 16-23; Dr. Gunter Dep., R. p. 958, lines 10-19). However, the Appellant had full strength in his early visits with Dr. Brown, but allegedly worsened over time, which was inconsistent with the timeline of motor strength loss from a brain injury. (Dr. Brown Dep., R. p. 779, lines 16-23).

The third inconsistency is the timeline of the Appellant's alleged muscle contractions. Dr. Gunter testified that when a brain injury produces a muscle contracture, the first symptom is paralysis of the extremity, followed by spasticity, then lastly followed by alteration of tone and contractures. (Dr. Gunter Dep., R. p. 975, line 23-p. 976, line 2). However, the Appellant did not have any of these symptoms preceding his alleged muscle contracture. As such, Appellant's development of symptoms (including progressive weakness and contracture without prior spasticity) was clinically inconsistent with the progression of long term functional symptoms from a severe closed head injury. (Dr. Gunter Dep., R. p. 958, lines 10-19).

Dr. Brown also testified that the Appellant's presentation on physical exam was inconsistent with the typical presentation of muscle contractions:

> [The left hand contracture] is something that is difficult to explain from a anatomic and neurologic perspective because he did have very good oppositional tone. Typically, you'll have unopposed tone for -- lead -- lead to contractures. So, if you don't have the muscle input from the extensor muscles and/or the – the nerves that control the extensor fibers, rather than the contracting and the flexion fibers, then you'll have unopposed tone and get a -- get a contraction. During my exam he had good, full strength in both sides, which made it very difficult to see that as a discreet, reliable finding.

(Dr. Brown Dep., R. p. 770, line 15-p. 771, line 2).

Therefore, the substantial evidence proved these specific symptoms were inconsistent with the medical science of brain injuries, and the Commission correctly determined the Appellant failed to satisfy his burden of proving an injury to the brain.

D. APPELLANT FAILED TO PROVE AN AGGRAVATION OF HIS PRE-EXISTING PSYCHOLOGICAL ISSUES.

Appellant is asking the Court to reverse the Commission's finding that Appellant failed to prove he sustained an aggravation of a pre-existing psychological condition. While the Appellant admits that "the record is limited," the Appellant bears the burden of proving the injury as alleged. *Riley v. South Carolina Ports Authority*, 253 S.C. 621, 172 S.E.2d 657 (1970). If the record was too limited for the Commission to determine an aggravation, the Appellant has not met his burden of proof.

The Appellant has failed to prove by substantial evidence that his pre-existing psychological issue have been aggravated by the accident. There is no dispute the Appellant had psychological issues that pre-dated the accident. However, there is no evidence that his current physical symptoms are associated with the accident, and therefore there is no evidence of psychological issues from these alleged symptoms and no evidence of aggravation of his pre-existing psychological issues. It is well established that workers' compensation awards must not be based on surmise, conjecture or speculation. *Kennedy v. Williamsburg County*, 242 S.C. 477, 480, 131 S.E.2d 512, 513 (1963). Since the Court cannot determine there has been an aggravation of the Appellant's pre-existing psychological issues without resorting to speculation from the limited record, Respondents respectfully request the Commission's determination be affirmed in this regard.

II. THE COMMISSION CORRECTLY DETERMINED THE APPELLANT WAS AT MAXIMUM MEDICAL IMPROVEMENT FOR HIS ADMITTED BACK INJURY.

The Appellant alleges that the Commission should not have found him to be at maximum medical improvement. However, the Appellant's argument conflates his back injury (which is at maximum medical improvement) with the alleged brain injury (which was rejected by the Commission). For the following reasons, the Commission's determination on maximum medical improvement is supported by the substantial evidence and should be affirmed.

Maximum medical improvement "is a term used to indicate that a person has reached such a plateau that in the physician's opinion there is no further medical care or treatment which will lessen the degree of impairment." *O'Banner v. Westinghouse Elec. Corp.*, 319 S.C. 24, 28, 459 S.E.2d 324, 327 (Ct. App. 1995). Maximum medical improvement "is a factual determination made by the Appellate Panel that will be upheld unless not supported by substantial evidence." *Hamilton v. Martin Color-Fi, Inc.*, 405 S.C. 478, 485, 748 S.E.2d 76, 80 (Ct. App. 2013).

The Commission's determination of maximum medical improvement is supported by the medical opinion of Dr. Brown. On August 28, 2019, Dr. Brown executed a Form 14B in which he released Appellant at maximum medical improvement from a neurosurgical perspective and released Appellant back to the care of occupational medicine. Dr. Brown assigned a 0% whole person impairment for Appellant's lumbar and thoracic spine, plus a 5% whole person impairment for the cervical spine for "nonverifiable radicular complaints, and muscle tenderness, though no true muscle guarding was observed at the time of the visit." (R. p. 294, 314).

At his deposition (12/12/2019), Dr. Brown confirmed his opinions from the Form 14B. (Dr. Brown Dep., R. p. 786, lines 14-18). Accordingly, the Commission's determination that the

Appellant is at maximum medical improvement is supported by the substantial evidence and should be affirmed in this regard.

CONCLUSION

For the foregoing reasons, the Respondents respectfully request this Court affirm the Decision and Order the pursuant to the S.C. Workers' Compensation Act and the applicable case law. Each of Appellant's arguments concern the weight and credibility of evidence which are questions reserved for the Commission as factfinder. Further, the Commission's determinations are supported by the substantial evidence and there is no evidence of reversable error.

Respectfully submitted,

HOLDER PADGETT
LITTLEJOHN & PRICKETT, LLC

C. Barrett Burley, S.C. Bar No. 77490
bburley@hplplaw.com
M. Brooks Biediger , S.C. Bar No. 77658
bbiediger@hplplaw.com
1201 Main Street, Suite 1430
Columbia, SC 29201
Phone: (803)335-1446
Fax: (803)708-7820
ATTORNEYS FOR RESPONDENTS

Columbia, South Carolina
January 17, 2023

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
Workers' Compensation Commission Full Appellate Panel

Appellate Case No. 2022-000067

KYLE R. BAGLEY, Employee..... Appellant,

v.

JN FIBERS, INC., D/B/A SUN FIBER, LLC, Employer, and
GREAT AMERICAN INSURANCE COMPANY, Carrier..... Respondents.

CERTIFICATE OF COUNSEL

Respondents, by and through their undersigned counsel, certify that the Final Brief of Respondents complies with Rule 211(b), SCACR.

HOLDER PADGETT
LITTLEJOHN & PRICKETT, LLC

C. Barrett Burley, S.C. Bar No. 77490
bburley@hplplaw.com
M. Brooks Biediger , S.C. Bar No. 77658
bbiediger@hplplaw.com
1201 Main Street, Suite 1430
Columbia, SC 29201
Phone: (803)335-1446
Fax: (803)708-7820
ATTORNEYS FOR RESPONDENTS

Columbia, South Carolina
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