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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In The SUPREME COURT

APPEAL FROM THE
SOUTH CAROLINA WORKER'S COMPENSATION COMMISSION

Gene McCaskill, Commissioner
R. Michael Campbell, II, Commissioner
T. Scott Beck, Commissioner

SCWCC File No. 1508995

Appellate Case No. 2022-001095

Samuel Paulino, Claimant

Petitioner,

v.

Diversified Coatings, Inc.,
Employer, and AmGuard Ins.
Co., Carrier

Respondents.

RESPONDENTS BRIEF

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STATEMENT OF THE ISSUES ON APPEAL

- I. Did the Court of Appeals properly reverse the Commission’s award of permanent and total disability based on an undetermined loss of use of the back greater than 50% when such award is contrary to the “medical evidence” and is otherwise unsupported by substantial evidence?**

STATEMENT OF THE CASE

Samuel Paulino (“Petitioner”) was involved in successive accidents in the course of his employment with Diversified Coating Systems (“Diversified”) on or about November 22, 2014 and/or February 7, 2015. Petitioner alleged he sustained injuries to his lower back in these accidents. Diversified denied his claim for benefits under the South Carolina Workers Compensation Act (“Act”) on grounds that he did not sustain an “injury” in either accident per S.C. Code § 42-1-60, as evidenced by inconsistent histories in the medical records and equivocal witness testimonies. In the alternative, Diversified asserted that Petitioner failed to timely report his alleged work injuries, thereby barring his entitlement to benefits under S.C. Code § 42-15-20.

By Order dated January 13, 2017, Commissioner Mike Campbell found, *inter alia*, that Petitioner failed to meet his burden of proving that he sustained “injury” due to either accident. In addition, he found that Petitioner failed to timely provide notice to Diversified that he had sustained injury in either incident. His claim for benefits under the Act was denied in full. Petitioner thereafter appealed to the Full Commission Appellate Panel, which REVERSED via Order dated July 19, 2017. The Full Commission ordered Defendants to pay all outstanding causally related medical bills, found that Petitioner had reached maximum medical improvement (“MMI”) as of April 22, 2016 and ordered payment of temporary total disability benefits (TTD) for a finite period between July 15, 2015 (stipulated date disability began) and April 22, 2016 (date of MMI).

Diversified thereafter filed a Form 21 for a determination of Petitioner's entitlement to permanent partial disability compensation (PPD).

At the permanency Hearing before Commissioner Wilkerson, Petitioner argued that he was permanently and totally disabled based on a greater than 50% loss of use of his back pursuant to S.C. Code § 42-9-30 (21) even though his medical impairment ratings were only 13% to the *whole person* from the treating neurosurgeon, Dr. McHenry, and 12% to the *lumbar spine* from the pain management provider, Dr. Math. Diversified countered that those medical impairment ratings for a minimally invasive single level microdiscectomy do not support a finding of greater than 50% loss of use of the back. By Order dated April 13, 2018, Commissioner Wilkerson found that Claimant sustained a "greater than 50% loss of use of his back." The Commissioner never made a specific finding of what Petitioner's actual impairment or loss of use of the back was. He nevertheless awarded Petitioner permanent and total disability benefits under S.C. Code § 42-9-30 (21), finding that Diversified failed to rebut the statutory presumption of total disability under S.C. Code § 42-9-10 (B). The Full Commission Appellate Panel ("Full Commission") affirmed.

Thereafter, Diversified appealed to the S.C. Court of Appeals, arguing, *inter alia*, that: 1) "medical evidence," as defined by the Act, does not support the Full Commission's finding that Petitioner sustained greater than 50% loss of use of his back as a matter of law; and 2) there is no other substantial evidence in the record regarding the character and nature of Claimant's injury supporting the Full Commission's award. The Court of Appeals REVERSED the Full Commission Order and REMANDED the case for further proceedings.

EVIDENCE OF THE CASE

Petitioner underwent an L3-4 microdiscectomy performed by Dr. McHenry on July 30, 2015 [p. 147]. Following an unremarkable post-surgical rehabilitation and recovery, Dr. McHenry ultimately released Petitioner at MMI on April 22, 2016 and assigned a 13% impairment rating to the whole person pursuant to DRE lumbar category III of the *AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 5TH EDITION* (“*AMA Guides*”). [APPENDIX pp. 128-130].

Thereafter, Dr. McHenry referred the Petitioner to Dr. Math for pain medication management and possible injections. Dr. Math prescribed and adjusted Tramadol and other medications for Petitioner. In March 2017, Dr. Math referred Petitioner back to Dr. McHenry for an updated assessment of additional surgery. Dr. McHenry ordered another MRI to assess his post-surgical status. On April 12, 2017, Dr. McHenry stated the following: “I reviewed images from the most recent MRI lumbar scan and compared with his previous post-op and the pre-op MRI. The disc herniation at L3-4 is no longer present. He has persistent degenerative changes but no focal impingement that correlates with his persistent radicular leg symptoms. I do not think he would benefit from further surgical intervention.” [emphasis added] [APPENDIX p. 131]. Petitioner returned to Dr. Math in June 2017 and she ordered a functional capacity exam (FCE).

Petitioner performed the FCE with Elite Physical Therapy on November 20, 2017. Significant findings from the FCE include the following: 1) consistent effort without high pain focus; 2) overall MEDIUM duty lifting capacity with OCCASIONAL maximum lift of 50 pounds and FREQUENT lift capacity of 15 pounds; 3) CONSTANT level (greater than 40 minutes/hour) for sitting, walking, and standing; 4) FREQUENT level (20-40 minutes/hour) for lumbar flexion and rotation; and OCCASIONAL level (less than 20 minutes per hour) for kneeling, squatting, and

overhead lifting. [APPENDIX p. 359]. Dr. Math ultimately assigned Petitioner a 12% impairment to the *lumbar spine* pursuant to the 6th Edition of the *AMA Guides*. [APPENDIX p. 33 and p. 288].

ARGUMENTS

I. THE COURT OF APPEALS PROPERLY HELD AS A MATTER OF LAW THAT THE COMMISSION’S FINDING OF GREATER THAN 50% LOSS OF USE OF THE BACK WAS NOT SUPPORTED BY “MEDICAL EVIDENCE” IN THE RECORD.

Relying on Clemmons v. Lowe’s Home Centers, Inc., 420 S.C. 282, 803 S.E.2d 268 (2017), the Court of Appeals held “the Commission erred in affirming the single commissioner’s determination that Petitioner’s back is impaired greater than fifty percent because “there is no *medical evidence* in the record that supported” that finding. Paulino v. Diversified Coatings, Inc., Unpublished Op. No. 2022-UP-096 at p. 2. “Medical evidence” is defined under the Act as “expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider.” S.C. Code §42-1-160 (G).

Clemmons holds that “medical evidence” of impairment is virtually outcome determinative of a claimant’s entitlement to PPD compensation under § 42-9-30 (21). 803 S.E.2d 268 at p. 271. In that case, the claimant had a multi-level cervical fusion and was assigned a 25% whole person impairment rating by the authorized treating physician. That rating converted to a 71% regional impairment to the cervical spine per the *AMA Guides*. The Commission awarded claimant PPD benefits based on 48% loss of use of the back. Despite evidence in the record confirming claimant returned to full duty work as a cashier at Lowes performing tasks indicative of *less than* fifty-percent loss of use of his back, the Supreme Court reversed the Commission’s award, finding “there is *no* evidence in the record that Clemmons suffered anything less than a fifty percent impairment to his back. Every doctor and medical professional who assigned an *AMA Guides*

impairment rating indicated Clemmons lost more than seventy percent of the use of his back.”
(emphasis added).

In the instant case, the Court of Appeals correctly noted that the undisputed “medical evidence” confirms whole person impairment ratings of only 13% from Dr. McHenry and 12% from Dr. Math. These impairments are obviously significantly less than 50%. Even if the medical impairment rating alone is not outcome determinative of PPD compensation under § 42-9-30 (21), the medical impairment rating opined by a doctor is clearly the paramount factor for the Commission’s consideration in light of this Court’s reference to the term “medical evidence” on no less than four occasions throughout its opinion in Clemmons. As such, Diversified submits that the Commission clearly erred as a matter of law by ignoring the primacy of the medical impairment rating commanded by Clemmons by finding Petitioner sustained loss of use of the back **OVER FOR TIMES GREATER** than the medical impairments.

Further, the Court of Appeals correctly rejected the Commission’s finding that the impairment ratings in the instant case were “low based on a poor surgical result” as being unsupported by competent “medical evidence.” See Burnette v. City of Greenville, 401 S.C. 417, 428-429, 737 S.E 2d 200, 206-207 (Ct. App. 2012)(a commission finding regarding a medical issue that does not originate from a medical provider is not supported by substantial evidence as a matter of law). Petitioner’s appeal to the primacy of Commission’s “administrative expertise” [Pet. For Writ of Cert. p. 8] in medical matters is a red herring argument. The Court of Appeals correctly recognized that general administrative expertise cannot usurp the actual “medical evidence” presented in any given case. For these reasons, the Court of Appeals properly held that the medical impairment ratings in this case are unrefuted; thus, the Commission’s award of total disability based on greater than 50% loss of use of the back was unfounded based on the “medical evidence.” An award from

the Commission not in accord with the medical impairment ratings from a doctor is the result this Court categorically rejected in Clemmons.

It can be fairly questioned what “medical evidence” other than the medical impairment rating, *if any*, justifies a scheduled disability award higher than the medical impairment rating denotes. An appellate court must affirm the findings made by the Commission if they are supported by substantial evidence, in this case “medical evidence.” *See Clemmons supra*. However, “[a]n appellate court can reverse or modify the Commission's decision if it is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record.” Pierre v. Seaside Farms, 386 S.C. at 540, 689 S.E.2d at 618. Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence [that], considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action. Taylor v. S.C. Dept of Motor Vehicles, 368 S.C. 33, 36, 627 S.E.2d 751, 752 (Ct. App. 2006).

A valid functional capacity evaluation (FCE) arguably constitutes other medical evidence that the Commission may properly consider for awarding PPD compensation for injury to the back. In this case, Petitioner’s FCE was highlighted by the following capabilities: 1) MEDIUM duty lifting capacity with OCCASIONAL maximum lift of 50 pounds and FREQUENT lift capacity of 15 pounds; 2) CONSTANT level (greater than 40 minutes/hour) for sitting, walking, and standing; 3) FREQUENT level (20-40 minutes/hour) for lumbar flexion and rotation; and 4) OCCASIONAL level (less than 20 minutes per hour) for kneeling, squatting, and overhead lifting. [APPENDIX p. 359]. These functional capacities, coupled with the 12% lumbar spine and 13% whole person impairment ratings from the treating physicians do not logically equate to greater than 50% loss of use of the back.

In sum, for the sound reasons cited in its Opinion, the Court of Appeals correctly determined there was no other sufficient “medical evidence” in the Record supporting the Commission’s award of greater than 50% loss of use of the back. “Reasonable minds” simply cannot justify an award of total disability based on a finding of greater than 50% loss of use of the back that is over FOUR TIMES GREATER than the medical impairment ratings when there is no other medical evidence to the contrary.

II. THE COURT OF APPEALS PROPERLY HELD THERE IS NO OTHER SUBSTANTIAL EVIDENCE IN THE RECORD REGARDING THE “CHARACTER” OF CLAIMANT’S INJURY SUPPORTING THE COMMISSION’S FINDING OF GREATER THAN 50% LOSS OF USE OF HIS BACK.

Under the “medical model” of compensation per § 42-9-30, the nature and character of the injury to a scheduled member controls the award to a statutorily presumed period of disability. *See Stephenson v. Rice Services*, 323 S.C. 113, 473 S.E.2d 699 (SC 1996) (with scheduled disability injuries the compensation depends on the “character of the injury” rather than loss of earnings). Moreover, a permanent disability award pursuant to S.C. Code § 42-9-30 “need not be shown with mathematical exactness,” but it still must only be founded on evidence of sufficient substance to afford a reasonably determinable basis for it. *See Bundrick v. Powell’s Garage and Wrecker Service*, 248 S.C. 496, 151 S.E.2d 437 (SC 1966) (the award may not rest on surmise, conjecture or speculation; it must be founded on evidence of sufficient substance to afford a reasonable basis for it).

In the instant case, the Court of Appeals correctly noted that Petitioner presented only sparse testimony regarding the nature and extent of his physical injuries. There is no testimony or other subjective evidence that refutes the objective “medical evidence” confirming impairment of less than 50% loss of use of the back. As such, the speculative nature of the Commission’s finding

that Petitioner sustained a greater than 50% loss of use of the back is self-evident. The Commission never even determined what Petitioner’s actual loss of use of his back was; it merely found the impairment was some **unknown factor** over four times greater than the impairment ratings. This is clearly erroneous because there is no evidence of “sufficient substance” to support it. See Bundrick supra.

Although this Court in Clemmons found there was no evidence of impairment *less* than 50%, this Court still nevertheless remanded the case to the Commission with instructions to determine the actual impairment. Clemmons, 420 S.C. at pp. 489-490. A finding of the actual impairment is clearly required. Otherwise, the award is nothing more than speculation, surmise, and conjecture and cannot stand. See Bundrick supra. For these reasons, the Court of Appeals correctly reversed the Commission’s generic finding that Claimant’s impairment is simply greater than the threshold for a presumption of total disability.

Finally, if the medical impairment rating must be the paramount factor for purposes of awarding PPD under the “medical model” of compensation as this Court clearly holds in Clemmons, then other non-medical or lay evidence regarding the character of the injury cannot logically supersede the proportion the impairment rating bears to the Commission’s ultimate total loss of use award under S.C. Code § 42-9-30 (21). Although the award need not be shown with “mathematical exactness,” the Commission’s award of permanent and total disability based on an undetermined loss of use of the back over **FOUR TIMES GREATER than the medical impairment ratings**, and unsupported by other medical evidence and/or lay testimony regarding the character of the injury, stretches the limits of that premise beyond any useful application. The Commission’s “administrative expertise” and discretion is not a license to render permanent disability awards contrary to medical and other evidence presented in a particular case. Although

an award of permanent disability may not be definable with mathematical precision, it must make some modicum of sense based on the evidence as a whole. The Court of Appeals correctly noted that the Commission's award in this case fails miserably in that regard.

CONCLUSION

For all the aforementioned reasons, the Court of Appeals correctly REVERSED the Full Commission's permanent and total disability award. This Court must AFFIRM and REMAND the case back to the Full Commission with instructions to render an appropriate PPD award in accordance with evidentiary Record.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "George D. Gallagher", is written over a horizontal line. The signature is fluid and cursive.

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