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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM
South Carolina Workers' Compensation Commission
Appellate Panel

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Appellate Case No. 2024-000294

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Hector Lopez-Vasquez, …….. Claimant/Appellant,

v.

Ox Paper Tube & Core Carolina LLC, Employer, and Berkshire Hathaway Homestate Insurance, Carrier …… Respondents.

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# RECORD ON APPEAL (VOL. 2)

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Atrium Health

**AH Plastic & Reconstructive CLT**
1025 Morehead Medical Dr
Suite 200
Charlotte, NC 28204-

## Office/Clinic Visit Notes

DOCUMENT NAME: SURG - Plastic Surgery Visit Note

**AH PRS Follow up**

Patient: **LOPEZ VASQUEZ, HECTOR** **MRN: 8698563** **FIN:** [redacted]
Age: **48 years** Sex: **Male** DOB: [redacted]
Associated Diagnoses: **None**
Author: **DEGRASSI , AMANDA PA**

**Date of Service: 3/23/2022**

**Procedure**: Closed nasal reduction and application of Doyle splints

**Date of Procedure**: 2/24/2022

**Subjective**:
**3/23/2022**: Patient presents today with his wife for follow up after recent closed nasal reduction. He is Spanish speaking so an interpreter was used throughout our encounter. Patient had Doyle splints previously removec on 3/2/22 while still inpatient. He states he continues to have significant deviation to his nose and difficulty breathing through his nose. He has been diligently using saline nasal spray. He denies any subsequent injury to the area since discharge. His wife is asking if anything will be done today about his mouth. When asked what she means she states he has weakness to the right side of his face that makes it difficult for her to feed him and for him to eat. They are also inquiring what can be done for the teeth he lost during the initial injury.

**Physical Exam**:

A&O x3, NAD
Significant ongoing nasal deviation s/p closed nasal reduction
Some decreased patency to nasal passages
Ongoing right sided facial weakness
Multiple missing teeth

**Assessment and Plan**:
**3/23/2022**: Patient is s/p closed nasal reduction, but has ongoing issues with nasal deviation and difficulty breathing through his nose. I recommend continuing with saline nasal spray and ice to his nose. After discussing with Dr. Clavin, he recommends referral to CEENTA for evaluation for possible rhinoplasty/septoplasty. I also recommend dental referral for missing teeth. In regards to his ongoing facial weakness, he needs to follow up with ENT and neuro for recommendations and care. He is able to return to work from a plastic surgery standpoint. He will follow up on an as needed basis. This was also discussed with patient's workers compensation case manager. They all expressed understanding of our discussion and plan moving forward. They were encouraged to call if any questions or concerns arise

## Office/Clinic Visit Notes

DOCUMENT NAME: Physiatrist Visit Note

**LOPEZ VASQUEZ, HECTOR** **DOB:** [redacted] **MRN:** 0008783081
**Sex:** Male **FIN:** [redacted]

**Chief Complaint**
Hosp f/u
follow up rehab needs after TBI

**History of Present Illness**
PCP: Affinity Health Center
NSY: Dr Stetler
ENT: Dr O'Donnell
Plastics - pending
Needs Ophthalmology & Orthopedics
CCM: Stasia Hagerty

48-year-old male who presented on 2/18 after being struck by 5000 pound roll of paper. Initial GCS of 14-15 He was seen in the ED and underwent ATLS guidelines. Injuries included right SDH, subarachnoid hemorrhage, pneumocephalus, cribriform plate fracture, styloid fracture, right temporal bone fracture, LeFort II fracture. He was admitted to ICU for close monitoring. His repeat imaging was stable. EEG was completed and negative for seizure activity. He was noted to have right facial weakness; ENT was consulted and recommended steroids and follow up with their office. Plastics was consulted for his facial fractures and on 2/24 went to the OR for closed nasal reduction with application of Doyle splints.

Medical/Somatic:

Headaches:
· Location: starts at the neck and go up to the head and primarily the right side > left
· Frequency: constantly at night more so
· Intensity: 7-8/10
· Quality: stabbing, pulsating, no tingling, hands go numb with the headaches
· Improves with: oxycodone,
· Exacerbates with: light,
· Associated symptoms: nausea,
Medications - oxycodone once at night and Amitriptyline 25 mg, 650 mg of Tylenol 3-4x per day,
-Discussed rebound headache with Tylenol

Sleep:
Quality: 6-7 hours of sleep
Medications: none

Vestibular:
· Quality: dizziness with turning his head with associated nausea

Visual: right eye blurry vision
· Frequency: daily
· Improves with: closing the eye & massage

**Problem List/Past Medical History**
Ongoing
Diabetes mellitus
Fracture follow-up
Obesity
Historical
None

**Freetext Procedures**

**Date Procedure Description**
denies surgery

**Medications**
acetaminophen 325 mg oral tablet, 650 mg, 2 tablet, ORAL, q6h
amitriptyline 50 mg oral tablet, 50 mg, 1 tablet, ORAL, qHS (each night at bedtime)
atorvastatin 20 mg oral tablet, 20 mg, 1 tablet, ORAL, Daily
docusate sodium 10 mg/mL oral liquid, 100 mg, 10 mL, ORAL, BID (2 times a day)
gabapentin 300 mg oral capsule, 300 mg, 1 capsule, ORAL, q8h
Glucometer, See Instructions, Daily
Glucophage 1000 mg oral tablet, 1000 mg, 1 tablet, ORAL, BID (2 times a day), 1 refills
Lancets, See Instructions, Daily
Levemir FlexPen 100 units/mL subcutaneous solution, 16 units, SUBCUTANEOUS, qHS (each night at bedtime), 1 refills
metFORMIN, ORAL
methocarbamol 750 mg oral tablet, 750 mg, 1 tablet, ORAL, q8h
NovoLIN R PenFill 100 units/mL injectable solution, 10 units, SUBCUTANEOUS, TIDAC (3 times a day before meals), 1 refills
oxyCODONE 5 mg oral tablet, 5 mg, 1 tablet, ORAL, q4h, PRN
pioglitazone, ORAL, Daily
polyethylene glycol 3350 oral powder for reconstitution, 17 gm, ORAL, Daily
predniSONE 10 mg oral tablet, See Instructions
Senna 8.6 mg oral tablet, 8.6 mg, 1 tablet, ORAL, BID (2 times a day)
sodium chloride 0.65% nasal spray, 1 spray, NOSTRIL, EACH, PRN (As needed), PRN
Test Strips, See Instructions, Daily, 1 refills
Ultracet 37.5 mg-325 mg oral tablet, 1 tablet, ORAL, q6h, PRN, 2 refills

Cognitive:
Attention/Focus/Memory: patient notes no issues

Affective/Mood: wife worried about depression of spouse, crying
Medications: none but on Amitriptyline for headaches

Neurosurgery: healing well from most recent appointment, repeat CTH no bleeding, +aneurysm but not workers comp related, concerned right eye isn't closing (Dr Stetler)
ENT: last week on 3/8 and 3/9, perforated right ear drum, nose was cauterized
Plastics: pending next week 3/23
-Function: ambulating with RW very slowly
-Hearing: per ENT/Audiology notes - right sensorineural hearing loss and severe hearing loss of left hear
-Therapies: currently in home PT working on his right knee, home SLP, home OT, home RN visits,
-Ortho: small tibial cortical defect, still with pain, referred to Orthopedics
-DM2 - still taking steroids due to injury for inflammation for which his blood glucose remains elevated and therefore needs insulin for management of this given steroid induced hyperglycemia - duration of steroids needs to be clarified
-Bowel: continent
-Bladder: continent
-Swallow: soft diet due to lack of teeth/blended diet, pain with chewing

**Allergies**
tetracycline (rash)

**Social History**
Alcohol
Denies
Drug Abuse
Denies
Employment/School
Employed
Home/Environment
Marital Status: Single.
Tobacco
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day. Started at Age: 0 Years. Stopped at Age: 0 Years.
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day.
Vape/E-Cigarette
Use: Never.
Use: Never.

**Review of Systems**
10 point review of systems is negative unless as stated above in the history of present illness

**Physical Exam**

Vitals & Measurements

| Time | HR | BP | Temp |
|---|---|---|---|
| 13:05 | 75(peri) | 106/72 | 97.6 (oral) |

**HT:** 172.72 cm
Concussion Exam

Cervical Exam:
ROM: full ROM with all plane but has to do it very slowly
Palpation: + right trap pain and ROM painful to the right

Ocular Movements:
Smooth pursuits - WNL
worsening blurry vision with horizontal or vertical saccades
Convergence: impaired

VOR:
Horizontal: mild dizziness
Vertical: no dizzy but blurriness worsens and uncomfortable

Memory Exam
Immediate and Delayed Memory Recall : 3/3 objects recalled at 5 minutes
Reverse Week: able to perform correctly

Gait: slow cadence with RW with step through gait

Constitutional: sitting in a chair in no acute distress
Ears,Nose, Mouth, Throat: mucous membranes moist, ears and nose with no abnormality
Eyes: Non-icteric sclera. Normal conjunctiva. Right eye can't close completely, Right eye convergence deficits, right eye esotropia
Cardiovascular: No cyanosis, extremities well perfused
Respiratory: No increased respiratory effort. Equal chest rise bilaterally
GI: Abdomen non-distended
Musculoskeletal: Normal muscle bulk. At least antigravity strength in bilateral upper limbs
Skin: No obvious rashes. Skin warm and dry
Neuro: Following commands appropriately. Verbal. Answers questions appropriately, Right facial weakness with CN VII palsy
Psych: Appropriate mood and affect.

**Assessment/Plan**

1. Traumatic subdural hematoma with loss of consciousness
   Stable - per Neurosurgery note resolved bleed

Facial Fractures - pending Plastics appt next week and wound benefit from Nutrition Consultation for which referral placed as he has been losing weight due to being on a soft diet and his food is blended per wife.
Would benefit from outpatient SLP therapy to work on dysphagia once Plastics determine further course of action

LE pain - referral to Orthopedics for his right lateral proximal tibial cortical defect

All referrals given to Workers Comp CCM today at visit and would NOT recommend return to work at this time

DM2: still taking steroids due to injury for inflammation for which his blood glucose remains elevated and therefore needs insulin for management of this given steroid induced hyperglycemia - duration of steroids needs to be clarified

Mood: increase of Amitriptyline should also help mood as wife concerned that patient is depressed

Ordered:
Patient Visit STAT - 49029
Referral
Referral
Referral
Referral
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology

2. Migraine headache
Patient with migraine + cervicogenic component along with right facial paralysis which also could be contributing to his headaches

Will increase his Amitriptyline to 50 mg at bedtime - new prescription sent

Would also benefit from headache (neurology) specialist for this - referral placed

Discussed to cut back on Tylenol due to rebound headache concern and oxycodone as well as narcotics are not standard of care for management of headaches

Ordered:
Referral
Referral
Referral
Referral
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology

3. Vestibular dizziness
Has a temporal lobe bone fracture - likely with untreated vestibular deficits - would benefit from Vestibular eval and therapy - referral placed

Ordered:
Referral
Referral
Referral
Referral
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology

4. Blurry vision, right eye
Needs to see Neuro-Ophthalmology - referral placed - ideally could be seen at CEENTA where patient sees ENT as significant blurry vision of the right eye as well -

Would also benefit from Vision Therapy - OT consult placed to determine if patching would be helpful as well

Given dry eye - recommended Artificial Tears 1 drop BID to right eye and to tape right eye at night as his right eye does not completely close due to CN VII palsy

Ordered:
Referral
Referral
Referral
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology

## Office/Clinic Visit Notes

5. Oropharyngeal dysphagia
Has had significant weight loss from his injury due to soft food diet - pending Plastics appointment but would benefit from Nutrition consultation to evaluate weight loss and find foods that are high caloric and high protein for weight gain
Ordered:
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology
Referral - OT/PT/Speech/Audiology

6. Esotropia, right eye
Referral to Ophthalmology for further evaluation of his right eye due to significant facial fractures

7. Sensorineural hearing loss
Hearing Loss - right sensorineural hearing loss per ENT and severe hearing loss of left ear Continue to follow up with ENT

RTC in 2 months

**Patient Education**
Traumatic Brain Injury: Long-term Care

**Attestation and Time**
90 minutes spent reviewing prior visit notes, performing history and examination, education on TBI recovery, vision, headaches, ordering additional referrals, and medication adjustments

**Electronically Signed By: DESAI, SIMA AJIT MD**
**03/17/2022 04:39 PM**

## Immunizations

| | | | |
|---|---|---|---|
| **Vaccine**<br>influenza virus vaccine,inactivated | **Date Given**<br>2/21/2022 13:30 EST | | **Age**<br>48 years |
| **Admin Person**<br>BENFIELD ,SAVANNA STUDENT NURSE | **Facility:**<br>CMC | | **Data Source**<br>PowerChart |
| **Site**<br>Deltoid, Left | **Route**<br>IM (INTRAMUSCULAR) | **Amount**<br>0.5mL | **Manufacturer**<br>ID Biomedical Corp |
| **Expiration Date**<br>6/30/2022 | **Lot Number**<br>AD49D | **Funding Source:** | **Vaccine For Children Status:** |
| **Vaccine Information Statement:**<br>Influenza (IIV) (English) | **Vaccine Information Statement Published Date:**<br>8/15/2019 | | **Vaccine Information Statement Date Given:**<br>2/21/2022 |

MEDICAL QUESTIONNAIRE
RE: HECTOR L. VASQUEZ

Pg. 1 of 2

1. It is my opinion, most probably and to a reasonable degree of medical certainty, that Mr. Vasquez has required 24-hour attendant care, 7 days a week since he was discharged home from the hospital?

✓ YES _____ NO

2. It is my opinion, most probably and to a reasonable degree of medical certainty, that Mr. Vasquez will require 24 hour attendant care, 7 days a week on an ongoing basis for the foreseeable future?

✓ YES _____ NO

3. It is my opinion, most probably and to a reasonable degree of medical certainty, that Mr. Vasquez significant other, Ms. Julianna Roldan-Dimas, is capable of providing the required 24-hour attendant care to Mr. Vasquez.

✓ YES _____ NO



PAGE 3/4 * RCVD AT 4/5/2022 9:57:55 AM [Eastern Daylight Time] * SVR:DCR-RFCDT-MC-04/42 * DNIS:7043554442 * CSID:+17043554442 * ANI:8033247545 * DURATION (mm-ss):01-21

MEDICAL QUESTIONNAIRE
RE: HECTOR L. VASQUEZ



4. In your opinion, most probably and to a reasonable degree of medical certainty, did Mr. Vasquez' traumatic injuries - - to include traumatic brain injury – and his subsequent treatment medications worsen is pre-existing diabetic condition causing Mr. Vasquez to become a Type 1 – Insulin Dependent Diabetic?

√
YES

NO

Sima Desai, M.D.
Neurorehabilitation
Carolinas Rehabilitation – Charlotte

4/6/22
Date



PAGE 4/4 * RCVD AT 4/5/2022 9:57:55 AM [Eastern Daylight Time] * SVR:DCR-RFCDT-MS-01/42 * DNIS:7043554442 * CSID:+17043554442 * ANI:8033247545 * DURATION (mm-ss):01-21

MR#8783081

CHARLOTTE EYE
EAR NOSE & THROAT
ASSOCIATES, P.A.

April 8, 2022

Sima Desai, MD
1100 Blythe Blvd
Charlotte NC 28203

Patient: **Hector Lopez Vasquez**
Date of Birth: [redacted]
Date of Visit: **4/8/2022**

Dear Sima Desai, MD,

Thank you for referring Hector Lopez Vasquez to me for evaluation. Here is my assessment and plan of care:

**Assessment/Plan:**
**1. Visual disturbance, bilateral**
Following closed head injury per patient/wife via interpretor. Blurry vision OD>OS per patient. Exam showed right-sided facial nerve paralysis (facial nerve palsy) involving upper and lower face. ENT records from Atrium reviewed - report comminuted petrous temporal bone fracture. Eye eye exam showed no ocular trauma OU. He does have secondary exposure keratitis/keratoconjunctivitis sicca from the poor eyelid closure/blink.

- Automated Visual Field, Extended - OU - Both Eyes (92083) obtained today - low patient reliability OS, borderline reliability OD. Some non-specific field defects OS>OD but suspect artifact. No segment field defects present, no field constriction OU.

Reassurance given. See further discussion below. F/U prn if symptoms worsen or other problems develop.

**2. Facial paralysis on right side**
Facial nerve palsy, upper and lower face. Poor eyelid closure with lagophthalmos in right eye secondary to the facial nerve palsy/paralysis. Suspect related to the previous head trauma.
Recommended aggressive lubrication to the right eye. Recommended f/u with neurology services or neuro-ophthalmology services for further evaluation and management. Per patient's case worker he is scheduled to see neurology services in the future. Discussed having patient see neuro-ophthalmology services. They wished to proceed with this. Will refer.

**3. Exposure keratitis, right eye**
See above. Recommended aggressive lubrication with Refresh PM or Gelteal Gel to right eye at least 3 to 4 times a day and as needed. Recommended taping eyelids of right eye closed at night. Advised patient not to rub or wipe at the eye(s). F/U prn if symptoms worsen or other problems develop.

If symptoms worsen may need to see oculo-plastics services for possible gold weight insertion or tarsorrhaphy.

**4. Diabetes mellitus type 2 without retinopathy (CMS/HCC)**
No diabetic retinopathy seen in either eye. Recommended observation for now. The risks of diabetic

Lopez Vasquez, Hector
DOB: [redacted]

retinopathy (including bleeding, swelling, abnormal blood vessel growth and potential vision loss) were discussed at length. Tight blood sugar control and annual exams recommended. Recheck in 12 months with dilated exam - sooner prn if any problems or vision changes. Letter to PCP.

**5. Closed head injury**
See above. Outside records showed subdural and subarachnoid hemorrhages. He is scheduled to see neurology services in follow-up per caseworker. Recommended he keep this appointment.

Eye exam otherwise WNL OU - no other ocular pathology seen OU. Reassurance given.

*CEENTA COVID practice guidelines were followed during the care of this patient.*

Below you will find my full exam findings. If you have questions, please do not hesitate to call me. I look forward to following Hector along with you.

Sincerely,

Ernest Bhend, MD

CC: Brian White, MD

Lopez Vasquez, Hector
DOB: [redacted]

## Base Eye Exam

### Visual Acuity (Snellen - Linear)

| | Right | Left |
|---|---|---|
| Dist sc | 20/60 -2 | 20/30 -1 |

### Tonometry (Icare, 10:28 AM)

| | Right | Left |
|---|---|---|
| Pressure | 13 | 15 |

### Pupils

| | Dark | Light | Shape | React | APD |
|---|---|---|---|---|---|
| Right | 5 | 3.5 | Round | Sluggish | None |
| Left | 6 | 4 | Round | Sluggish | None |

### Visual Fields

| Left | Right |
|---|---|
| Full | |

Blurry right eye. See Humphrey Visual Fields

### Extraocular Movement

| Right | Left |
|---|---|
| Full, Ortho | Full, Ortho |

With attempted closure right eye moves up and in (Bell's phenomenon). No strabismus. Full range of motion OU. Gaze otherwise orthophoric in all fields

### Neuro/Psych

Oriented x3: Yes
Mood/Affect: Normal

### Dilation

Both eyes: 1.0% Tropicamide, 2.5% Phenylephrine @ 11:29 AM

## Slit Lamp and Fundus Exam

### External Exam

| | Right | Left |
|---|---|---|
| External | total right facial paralysis (upper and lower) | Normal |

### Slit Lamp Exam

| | Right | Left |
|---|---|---|
| Lids/Lashes | poor closure with blink or forced closing of eyes, lagophthalmos, good Bell's phenomenon, skin intact | Normal - good closure with blink, skin intact |
| Conjunctiva/Sclera | 1 to 2+ bulbar injection, conjunctiva otherwise intact, tear film clear | White and quiet, tear film clear |
| Cornea | very dry on surface, small dellen infero-temporal (peri-limbal aspect 7:00 position), diffuse SPK inferior 1/2, epithelium otherwise intact, no ulcers or breakdown, cornea clear | Clear, epithelium intact |
| Anterior Chamber | Deep and quiet | Deep and quiet |
| Iris | Round and reactive, iris intact | Round and reactive, iris intact |

Lopez Vasquez, Hector
DOB: [redacted]

| | | |
|---|---|---|
| Lens | Clear | Clear |
| Vitreous | Normal/clear - no hemorrhage | Normal/clear - no hemorrhage |

Fundus Exam

| | Right | Left |
|---|---|---|
| Disc | Normal - flat/pink with good neural rim | Normal - flat/pink with good neural rim |
| C/D Ratio | 0.3 | 0.3 |
| Macula | Normal/flat - no edema or hemorrhage | Normal/flat - no edema or hemorrhage |
| Vessels | Normal caliber and appearance - no retinopathy or hemorrhage | Normal caliber and appearance - no retinopathy or hemorrhage |
| Periphery | Normal - flat/attached 360 degrees, no holes or tears, no hemorrhages | Normal - flat/attached 360 degrees, no holes or tears, no hemorrhages |

## Refraction

Manifest Refraction

| | Sphere | Cylinder | Axis | Dist VA |
|---|---|---|---|---|
| Right | -1.00 | +0.50 | 030 | 20/25 |
| Left | -0.50 | Sphere | | 20/25 |

| | | | |
|---|---|---|---|
| GROUP # | : | GROUP # | : |
| POL/SS # | : | POL/SS # | : |
| INSURED | : , | INSURED | : , |
| REL TO INS | : | REL TO INS | : |
| MAIL TO | : , | MAIL TO | : , |
| ADDRESS #1 | : | ADDRESS #1 | : |
| ADDRESS #2 | : | ADDRESS #2 | : |
| CITY/ST/ZIP | : | CITY/ST/ZIP | : |
| PHONE | : EXT: | PHONE | : EXT: |
| APPROV/REF | : | APPROV/REF | : |
| COMMENT | : | COMMENT | : |

## Office/Clinic Visit Notes

DOCUMENT NAME: Physiatrist Visit Note

**Addendum by DESAI , SIMA AJIT MD on May 04, 2022 17:00:29 EDT**

ATTENDING ATTESTATION:

*I have personally seen and examined the patient this morning concurrently with the fellow. I agree with the history, findings, assessment, medical decision making, and plan as written by the fellow physician. Chart and therapy progress reviewed.*

*-Headaches are still persistent - stop Amitriptyline as this is not helping - start Sumatriptan PRN for Abortive headaches, Start Gabapentin 300 mg TID x 10 days - if no improvement, can increase to 600 mg TID if needed - pending neurology input for further headache management as patient may benefit from occipital block injection*
*-Discussed to stop using Motrin as this is contributing to rebound headaches*
*-Sleep - difficulty sleeping due to frequent interruption in his breathing - pending rhinoplasty/septoplasty by Plastics/ENT*
*-Caregiver Support - wife completing 12 weeks of FMLA but patient requires 24/7 help at home and would continue to need a caregiver at home - discussed to fax paperwork here and I can fill out for her*
*-Pending Neuro-Ophthalmology, Pending Dental procedure to fix his teeth, Pending Ortho appointment for tibial cortical defect, Pending starting outpatient PT/OT/SLP at Pineville, Pending date for Neurology*
*-No longer need nutrition follow up as patient is gaining weight and eating well*
*-Patient should not work at this time given TBI and polytrauma injuries*

55 minutes spent reviewing prior visit notes, performing history and examination, education on headache management, rebound headaches, and medication refills.

**Electronically Signed By: DESAI, SIMA AJIT MD**
**05/04/2022 05:06 PM**

**VASQUEZ, HECTOR LOPEZ** **DOB:** [redacted] **MRN:** 0008783081
**Sex:** Male **FIN:** 6525083669

**Diagnostic Results**
No new images.

**Chief Complaint**
2 mo FU WC
F/u after TBI

**Lab Results**
No new labs.

**History of Present Illness**
PCP: Affinity Health Center
NSY: Dr Stetler
ENT: Dr O'Donnell
Plastics: Dr Clavin
CCM: Stasia Hagerty

**Problem List/Past Medical History**
Ongoing
Diabetes mellitus
Fracture follow-up
Obesity
Historical
None

48-year-old male who presented on 2/18/22 after being struck by 5000 pound

roll of paper. Initial GCS of 14-15. Injuries included right SDH, subarachnoid hemorrhage, pneumocephalus, cribriform plate fracture, styloid fracture, right temporal bone fracture, LeFort II fracture. He was admitted to ICU for close monitoring. His repeat imaging was stable. EEG was completed and negative for seizure activity. He was noted to have right facial weakness; ENT was consulted and recommended steroids and follow up with their office. Plastics was consulted for his facial fractures and on 2/24 went to the OR for closed nasal reduction with application of Doyle splints.

Last visit 3/17. At that time, referred to nutrition, orthopedics, Neurology, vestibular PT, CEENTA, vision therapy. Increased amitriptyline.

Today patient presents with CCM, wife, and in-person interpreter.

-Medical: did have ED visit on 4/3 for HA but discharged home
-ENT: per ENT/Audiology notes - right sensorineural hearing loss and severe hearing loss of left ear
-Plastics: saw AH Plastics (Dr. Calvin) 3/23 who recommended referral to CEENTA for possible rhinoplasty/septoplasty, has upcoming appt
-Ophtho: saw Ophtho at CEENTA (Dr. Bhend) and diagnosed with R>L blurry vision in setting of R CN VII lesion and exposure keratitis, did get procedure on R eye to assist with lid closure and noted improvement, also referred to Dr. White Neuro-ophtho
-Function: ambulating with RW very slowly
-Therapies: approved for PT, OT, SLP from 3/17 visit, waiting to start
-Ortho: small tibial cortical defect, still with pain, referred to Orthopedics on 3/17 and has appt in May
-Bowel: continent
-Bladder: continent
-Diet: was referred to nutrition on 3/17 but diet has improved with help from wife and has gained weight

Headaches:
· Location: starts at the neck and go up to the head and face
· Frequency: constant
· Intensity: 7-8/10
· Quality: stabbing, pulsating
· Improves with: oxycodone
· Exacerbates with: light, area is sensitive to touch
· Associated symptoms: nausea
· Medications - Amitriptyline 50 (increased 3/17 visit) and no change in sx, now taking Motrin Q6H for about 1 mo
· Referred to Neuro, awaiting appt

Sleep:
· Interrupted sleep in setting of pain and difficulty breathing with facial fractures pending possible rhino/septoplasty

Vestibular:
· Quality: dizziness with turning his head and bending forward, referred to PT as mentioned above

Cognitive:
Attention/Focus/Memory: patient notes no issues

**Freetext Procedures**

**Date Procedure Description**
denies surgery

**Medications**
atorvastatin 20 mg oral tablet, 20 mg, 1 tablet, ORAL, Daily
gabapentin 300 mg oral capsule, 300 mg, 1 capsule, ORAL, q8h
gabapentin 300 mg oral capsule, See Instructions, 2 refills
Glucometer, See Instructions, Daily
Glucophage 1000 mg oral tablet, 1000 mg, 1 tablet, ORAL, BID (2 times a day), 1 refills
Lancets, See Instructions, Daily
Levemir FlexPen 100 units/mL subcutaneous solution, 16 units, SUBCUTANEOUS, qHS (each night at bedtime), 1 refills
metFORMIN, ORAL
NovoLIN R PenFill 100 units/mL injectable solution, 10 units, SUBCUTANEOUS, TIDAC (3 times a day before meals), 1 refills
oxyCODONE 5 mg oral tablet, 5 mg, 1 tablet, ORAL, q4h, PRN
pioglitazone, ORAL, Daily
sodium chloride 0.65% nasal spray, 1 spray, NOSTRIL, EACH, PRN (As needed), PRN
SUMAtriptan 25 mg oral tablet, 25 mg, 1 tablet, ORAL, PRN (As needed), PRN, 1 refills
Test Strips, See Instructions, Daily, 1 refills
Ultracet 37.5 mg-325 mg oral tablet, 1 tablet, ORAL, q6h, PRN, 2 refills

**Allergies**
tetracycline (rash)

**Social History**
Alcohol
Denies
Drug Abuse
Denies
Employment/School
Employed
Home/Environment
Marital Status: Single.
Tobacco
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day.
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day. Started at Age: 0 Years. Stopped at Age: 0 Years.
Vape/E-Cigarette
Use: Never.

Use: Never.

Affective/Mood: wife worried about depression of spouse, crying

Past medical history, social history, and family history: reviewed with the patient and unchanged since last visit or otherwise noted in the HPI.

**Review of Systems**
10-point review of systems negative except as mentioned above in subjective.

**Physical Exam**

Vitals & Measurements

| Time | HR | BP | Temp |
|---|---|---|---|
| 12:10 | 99(peri) | 108/79 | 97.5 (oral) |

**HT:** 172.72 cm
Constitutional: sitting on EOB in no acute distress
Ears,Nose, Mouth, Throat: mucous membranes moist, trachea midline
Eyes: Incomplete closure of R eye, improved after procedure
Cardiovascular: No cyanosis, extremities well perfused
Respiratory: No increased respiratory effort. Equal chest rise bilaterally
GI: Abdomen non-distended
Musculoskeletal: Normal muscle bulk. At least antigravity strength in bilateral upper limbs
Skin: No obvious rashes. Skin warm and dry
Neuro: Awake and alert, answering questions appropriately. Fluent speech in Spanish. R CN VII palsy.
Psych: Appropriate mood and affect.

**Assessment/Plan**
1. Traumatic subdural hematoma with loss of consciousness of 30 minutes or less
2. Migraine headache without aura
3. Vestibular dizziness involving both inner ears
4. Blurry vision
5. Sensorineural hearing loss
Temporal bone fracture

48-year-old male who presented on 2/18/22 after being struck by 5000 pound roll of paper. Initial GCS of 14-15. Injuries included right SDH, subarachnoid hemorrhage, pneumocephalus, cribriform plate fracture, styloid fracture, right temporal bone fracture, LeFort II fracture.

#TBI:
-Therapies: referrals to PT, OT, SLP placed at 3/17 visit and they were approved but have not started yet
-Headaches: **discontinued amitriptyline** since no improvement at all, patient has taken **gabapentin** in the past and will restart given description of pain as neuropathic in nature (start 300 TID with instructions to increase to 600 TID if needed). Again provided education on rebound headaches. Also new Rx for **sumatriptan PRN. Pending Neurology** appt for additional management.
-Sleep: interrupted in setting of headaches and difficulty breathing, will attempt

## Office/Clinic Visit Notes

to treat HA as above and patient meeting with ENT soon regarding possible rhino/septoplasty
-Caregiver support: wife had FMLA x12 weeks set to expire soon and was wondering about extending, she was instructed to contact her work to see if there is other paperwork that she needs completed by us
-Specialty care: Nutrition consult no longer needed since PO intake and weight has improved. Ortho appt in May. CEENTA for rhinoplasty/septoplasty and Dr. White Neuro-ophtho upcoming. Waiting to hear back from Neuro for scheduling.

RTC 2 months

The patient was seen and discussed with Dr. Desai.

Rachel Teranishi MD
Brain Injury Medicine Fellow

**Electronically Signed By: TERANISHI, RACHEL MD**
**05/04/2022 02:11 PM**

## Immunizations

| | | | |
|---|---|---|---|
| **Vaccine**<br>influenza virus vaccine,inactivated | **Date Given**<br>2/21/2022 13:30 EST | | **Age**<br>48 years |
| **Admin Person**<br>BENFIELD ,SAVANNA STUDENT NURSE | **Facility:**<br>CMC | | **Data Source**<br>PowerChart |
| **Site**<br>Deltoid, Left | **Route**<br>IM (INTRAMUSCULAR) | **Amount**<br>0.5mL | **Manufacturer**<br>ID Biomedical Corp |
| **Expiration Date**<br>6/30/2022 | **Lot Number**<br>AD49D | **Funding Source:** | **Vaccine For Children Status:** |
| **Vaccine Information Statement:**<br>Influenza (IIV) (English) | **Vaccine Information Statement Published Date:**<br>8/15/2019 | | **Vaccine Information Statement Date Given:**<br>2/21/2022 |

Atrium Health

CMG REHABILITATION ASSOCIATES
1100 BLYTH BLVD
CHARLOTTE, NC 28203

HECTOR VASQUEZ
302 CHARLOTTE ST
YORK, SC 29745

May 12, 2022

To Whom It May Concern,

Mr. Hector Lopez Vasquez was admitted to CMC from 2/18/2022 to 3/2/2022. Mr. Vasquez was involved in an accident at work and subsequently have a traumatic brain injury along with several polytrauma injuries. As a result of his injuries, his wife will be required to care for him at home as his caregiver 24 hours a day/7 days per week as the patient can not be left alone at this time.

Please reach out with any questions or concerns.

Sincerely,
Sima A. Desai, MD
Carolinas Rehabilitation
Phone:704-355-7073, Fax: 704-355-4442

| | | | |
|---|---|---|---|
| GROUP # | : | GROUP # | : |
| POL/SS # | : | POL/SS # | : |
| INSURED | : , | INSURED | : , |
| REL TO INS | : | REL TO INS | : |
| MAIL TO | : , | MAIL TO | : , |
| ADDRESS #1 | : | ADDRESS #1 | : |
| ADDRESS #2 | : | ADDRESS #2 | : |
| CITY/ST/ZIP | : | CITY/ST/ZIP | : |
| PHONE | : EXT: | PHONE | : EXT: |
| APPROV/REF | : | APPROV/REF | : |
| COMMENT | : | COMMENT | : |

## Office/Clinic Visit Notes

DOCUMENT NAME: Physiatrist Visit Note

**VASQUEZ, HECTOR LOPEZ** **DOB:** [redacted] **MRN:** 0008783081
**Sex:** Male **FIN:** [redacted]

**Chief Complaint**
f/u appt
follow up rehab needs after TBI

**History of Present Illness**
PCP: Affinity Health Center
NSY: Dr Stetler
ENT: Dr Rao, Dr O'Connell
Plastics: Dr Clavin
Ortho: Dr Rentz
Neuro Ophthalm: Dr White
Neurology: Dr Jalali

CCM: Stasia Hagerty + In person spanish interpreter present today

49-year-old male who presented on 2/18/22 after being struck by 5000 pound roll of paper. Initial GCS of 14-15. Injuries included right SDH, subarachnoid hemorrhage, pneumocephalus, cribriform plate fracture, styloid fracture, right temporal bone fracture, LeFort II fracture. He was admitted to ICU for close monitoring. His repeat imaging was stable. EEG was completed and negative for seizure activity. He was noted to have right facial weakness; ENT was consulted and recommended steroids and follow up with their office. Plastics was consulted for his facial fractures and on 2/24 went to the OR for closed nasal reduction with application of Doyle splints.

Last visit 5/22- at that time he was started on Gabapentin for his headaches while he awaited Neurology appt for headache management.

Today patient presents with CCM, wife, and in-person interpreter.

-Medical: no ED visits or hospitalizations
-Function: ADLs are improving and wife just supervision, progressing from OT/PT/SLP, ambulating with RW
-Cognition: in SLP & making progress towards goals
-Therapies: In PT/OT/SLP
-ENT: will see back in February, right sensorineural hearing loss and severe

**Problem List/Past Medical History**
Ongoing
Diabetes mellitus
Fracture follow-up
Historical
Obesity

**Freetext Procedures**

**Date Procedure Description**
denies surgery

**Medications**
atorvastatin 20 mg oral tablet, 20 mg, 1 tablet, ORAL, Daily
gabapentin 300 mg oral capsule, See Instructions, 2 refills
Glucometer, See Instructions, Daily
Glucophage 1000 mg oral tablet, 1000 mg, 1 tablet, ORAL. BID (2 times a day), 1 refills
Lancets, See Instructions, Daily
Levemir FlexPen 100 units/mL subcutaneous solution, 16 units, SUBCUTANEOUS, qHS (each night at bedtime), 1 refills
metFORMIN, ORAL
NovoLIN R PenFill 100 units/mL injectable solution, 10 units, SUBCUTANEOUS, TIDAC (3 times a day before meals), 1 refills
pioglitazone, ORAL, Daily
sodium chloride 0.65% nasal spray, 1 spray, NOSTRIL, EACH, PRN (As needed), PRN
SUMAtriptan 25 mg oral tablet, 25 mg, 1 tablet, ORAL, PRN (As needed), PRN, 1 refills
Test Strips, See Instructions, Daily, 1 refills

**Allergies**
tetracycline (rash)

hearing loss of left ear, Dr O'Connell to address surgery vs hearing aid in 2023
-Rhinoplasty: with Dr Rao from CEENTA, August 2nd
-Ophtho: saw Ophtho at CEENTA (Dr. Bhend) and diagnosed with R>L blurry vision in setting of R CN VII lesion and exposure keratitis, did get procedure on R eye to assist with lid closure and noted improvement,
-Neuro Ophthal: Dr White - hard palate (enlarged ridge) noticed, vision and movement of right eye is stable, happy with movement with Right CN VII lesion but starting to see some regeneration. Recommended Oral Maxillofacial Specialist
-Dental: needs a bridge done and Dr Rao to determine course of timing of bridge and whether he needs to see oral surgery
-Odynophagia: noticed with SLP, Dr Rao (ENT) will see on 7/22 and evaluate, even with salvia, hurts his palate and with swallow,
-Ortho: has medial meniscus tear - Dr Rentz following - will need to determine when appropriate date of surgery
-Bowel: continent
-Bladder: continent
-Diet: pureed diet still,
-Dizziness: when he goes from sitting to standing, bending gets dizzy, lying down (gets spinning sensation), working on that with PT, improving but still present

Headaches:
· Location: starts at the neck & jaw as well as around right mastoid, twisting to right or left hurts as well,
· Frequency: daily
· Quality: pulling sensation from inside the head
· Improves with: gabapentin
· Exacerbates with: light, area is sensitive to touch and hard to lie his head on the pillow
· Associated symptoms: nausea
· Medications - Gabapentin, Nortriptyline 30 mg at bedtime, Magnesium, and Riboflavin
· Dr Jalali - was seen by Neurology (June 23rd)

Sleep:
· Interrupted sleep in setting of pain and difficulty breathing with facial fractures pending possible rhino/septoplasty

**Review of Systems**
10 point review of systems is negative unless as stated above in the history of present illness

**Physical Exam**

Vitals & Measurements

| Time | HR | BP | Temp |
|---|---|---|---|
| 11:55 | 80(peri) | 109/76 | 97.1 (oral) |

**HT:** 172.72 cm
Constitutional: sitting in a chair in no acute distress
Ears,Nose, Mouth, Throat: mucous membranes moist, ears and nose with no abnormality
Eyes: Non-icteric sclera. Normal conjunctiva.
Cardiovascular: No cyanosis, extremities well perfused

**Social History**
Alcohol
Denies
Drug Abuse
Denies
Employment/School
Employed
Home/Environment
Marital Status: Single.
Tobacco
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day.
Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day. Started at Age: 0 Years. Stopped at Age: 0 Years.
Vape/E-Cigarette
Use: Never.
Use: Never.

Respiratory: No increased respiratory effort. Equal chest rise bilaterally
GI: Abdomen non-distended
Musculoskeletal: Normal muscle bulk. At least antigravity strength in bilateral upper limbs & lower limbs
Skin: No obvious rashes. Skin warm and dry
Neuro: Following commands appropriately. Verbal. Answers questions appropriately, Oriented to date, CN VII palsy improving (right face), Memory 3/3 at 5 minutes, negative VOR testing
Gait - step to gait with RW
Psych: Appropriate mood and affect.

**Assessment/Plan**

1. Traumatic subdural hematoma with loss of consciousness of 30 minutes or less
   Therapies: continue PT, OT, and SLP therapies - making progress in all domains
   Sleep: to be assessed by ENT in relation to need for rhinoplasty

   Speciality Care
   ENT: hearing, will see in 2023 to determine hearing aid vs surgery
   ENT: Dr Rao - to determine which procedures he needs in what order given his poly-facial fractures, mandible fractures,
   Odynophagia: Dr Rao ENT to evaluate on 7/22 and determine course
   Dental: will need dental work done and will need Dr Rao to determine if he needs to see oral maxillofacial surgery given his extensive facial injuries
   Ortho: pending medial meniscus repair
   Work: patient should not return to work at this time and continues to need extensive medical appointments and therapy to help optimize his function
Ordered:
Referral

2. Migraine headache without aura
   Continue Gabapentin, Nortriptyline, Magnesium, and Riboflavin per Neurology
Ordered:
Referral

3. Vestibular dizziness involving both inner ears
   Continue PT
Ordered:
Referral

4. Blurry vision
   Seeing Dr White with Neuro-Ophthalmology
Ordered:
Referral

5. Cranial nerve VII palsy
   Slowly improving

**Patient Education**

Dizziness

## Office/Clinic Visit Notes

**Attestation and Time**
55 minutes spent reviewing prior visit notes, performing history and examination, education on poly-specialist involvement with his care to optimize his recovery.

**Electronically Signed By: DESAI, SIMA AJIT MD**
**07/20/2022 06:09 PM**

## Immunizations

| | | | |
|---|---|---|---|
| **Vaccine**<br>influenza virus vaccine,inactivated | **Date Given**<br>2/21/2022 13:30 EST | | **Age**<br>48 years |
| **Admin Person**<br>BENFIELD ,SAVANNA STUDENT NURSE | **Facility:**<br>CMC | | **Data Source**<br>PowerChart |
| **Site**<br>Deltoid, Left | **Route**<br>IM (INTRAMUSCULAR) | **Amount**<br>0.5mL | **Manufacturer**<br>ID Biomedical Corp |
| **Expiration Date**<br>6/30/2022 | **Lot Number**<br>AD49D | **Funding Source:** | **Vaccine For Children Status:** |
| **Vaccine Information Statement:**<br>Influenza (IIV) (English) | **Vaccine Information Statement Published Date:**<br>8/15/2019 | | **Vaccine Information Statement Date Given:**<br>2/21/2022 |

The Shae Group, LLC

A Vocational Consulting Firm

**Celena Earl, MRC, CRC**
Vocational Consultant
PO Box 3331
Lancaster, SC 29721
803-286-9994
Shaegroup@comporium.net

**Andrew Creech, Esq.**
Elrod Pope Law Firm
212 E. Black St.
Rock Hill, SC 29730

Date: 04/28/2022

PLAINITIFF: Hector Lopez Vazquez
DATE OF BIRTH: [redacted], age 48

## WAGE ANALYSIS

### INTRODUCTION:

The above captioned file was referred on 04/21/2022 for a wage analysis, regarding Mr. Vazquez's home health needs and his fiancé, Ms. Juliana Roldan Dimas providing that care. Medical records were provided by the referral source and included records from Carolinas Medical Center and Sima Desai, MD.

### MEDICAL SUMMARY:

According to the medical records reviewed, Mr. Vazquez had a work-related injury on 02/18/2022. Mr. Vazquez was diagnosed with multiple facial fractures and a Traumatic Brain Injury.

On 04/06/2022, Sima Desai, MD opined that Mr. Vazquez would need 24-hour care, 7 days per week. He noted that Ms. Juliana Roldan Dimas, his fiancé, would be capable of providing this care.

### EARNING CAPACITY:

According to Dr. Desai, Ms. Juliana Roldan Dimas can provide 24 hour, 7 days a week home health care to Mr. Vazquez. Ms. Roldan-Dimas has been providing this care since Mr. Vazquez's arrival home from the hospital. She is currently on FMLA from her position at Black and Decker. Once her FMLA is exhausted, she will continue to stay home and provide Mr. Vazquez round-the-clock care. His care needs consist of assistance with eating, bathing,

using the bathroom, movement about the home and medication management. Since the work- related accident Mr. Vazquez's diabetes has become uncontrolled and needs constant monitoring.

Ms. Roldan-Dimas and Mr. Vazquez live in a home with Ms. Roldan-Dimas's daughter and multiple other members of their family. The family feels more comfortable with Ms. Roldan-Dimas providing his round-the-clock care than a third-party caretaker. The possibility of a language barrier also plays into their level of comfort with a third-party caretaker.

According to the Bureau of Labor & Statistics May 2021 data for the metropolitan area of Charlotte-Concord-Gastonia, NC-SC, the following are wages for this position:

| | Unskilled Wages |
|---|---|
| Home Health and Personal Care Aides | $14.07 per hour |

According to Salary.com the average rate of pay is $15.00 per hour for an unskilled Home Health Aide.

The following are representative examples of the current job openings for unskilled Home Health Aides and the corresponding wages for Charlotte-Concord-Gastonia, NC-SC:

| | Unskilled Hourly Wages |
|---|---|
| Always Best Care | $14 to $16 |
| Right at Home | $13 to $16 |
| Blue Dot Cares | $11 to $15 |

Based on these wages, the earning capacity is $14.41 to keep in line with the average earnings for this occupation/role.

**CONCLUSIONS:**

As a result of the accident, Ms. Juliana Roldan-Dimas has become the full-time caregiver for Mr. Vazquez. She has the earning potential of $14.41 per hour to provide Mr. Vazquez his round-the-clock care.

I reserve the right to modify my opinion should additional information become available.

Sincerely,

**Celena Earl, MRC, CRC**

Atrium Health

AH Musculoskeletal Inst Fort Mill
1690 Highway 160 West
Fort Mill, SC 29708-
Phone: 803-548-2424 Fax: 803-548-6808

## Office/Clinic Visit Notes

DOCUMENT NAME: Orthopaedic Visit Note

**Ortho office note-proced**

Patient: **VASQUEZ, HECTOR LOPEZ** **MRN: 8698563** **FIN:** [redacted]
Age: **48 years** Sex: **Male** DOB: [redacted]
Associated Diagnoses: **None**
Author: **RENTZ JR, JAMES N MD**

**Visit Information**
**Primary Care Provider**

**Chief Complaint**
**5/12/2022 9:53 EDT** **WC--NP w/ right knee and left ankle injury; DOI 2-18-22 (Modified)**

**History of Present Illness**
_He comes for a Worker's Comp. injury of his right knee and left ankle. He says the knee hurts the most. He speaks limited English so the entire visit was done with the video interpreter. He was working and a pallet that was holding multiple large rolls of paper gave way and the rolls fell over onto him knocking him to the floor. He was knocked out and does not really recall details of what happened. His right knee hurts mostly over the lateral aspect. The left ankle hurts over the anterolateral aspect. He had a few visits of home health physical therapy but has not had any others. He did have some other injuries and is being treated for those but they are not an orthopedic. He ambulates with a walker because of the knee pain but also because of dizziness from his other injuries.

**Review of Systems**
**Constitutional**: Negative.
**Respiratory**: Negative.
**Gastrointestinal**: Negative.
**Immunologic**: Negative.
**Musculoskeletal**: Negative except as stated in HPI.
**Integumentary**: Negative.
**Neurologic**: Negative.
**Psychiatric**: Negative.

**Health Status**
**Allergies**:
Allergic Reactions (Selected)
*Severity Not Documented*
Tetracycline- Rash.

Atrium Health

**AH Musculoskeletal Inst Fort Mill**
**1690 Highway 160 West**
**Fort Mill, SC 29708-**
**Phone: 803-548-2424 Fax: 803-548-6808**

## Office/Clinic Visit Notes

**Current medications**: (Selected)

Prescriptions

*Prescribed*

Glucometer: See Instructions, Daily, Duration of need--99--Lifetime. E11.9 once per year, 1 Each, 0 Refill(s)
Glucophage 1000 mg oral tablet: 1,000 mg, 1 tablet, ORAL, BID (2 times a day), 60 tablet, 1 Refill(s)
Lancets: See Instructions, Daily, Duration of need--99--Lifetime. E11.9 4 times daily, 9 Each, 0 Refill(s)
Levemir FlexPen 100 units/mL subcutaneous solution: 16 units, SUBCUTANEOUS, qHS (each night at bedtime), Take 16 units at night before bed., 15 mL, 1 Refill(s)
NovoLIN R PenFill 100 units/mL injectable solution: 10 units, SUBCUTANEOUS, TIDAC (3 times a day before meals), Take 10 units with meals; do not take if blood sugar less than 140, 15 mL, 1 Refill(s)
SUMAtriptan 25 mg oral tablet: 25 mg, 1 tablet, ORAL, PRN (As needed), for 30 day(s), may repeat dose in 2 hours if needed, PRN: Headache, 18 tablet, 1 Refill(s)
Test Strips: See Instructions, Daily, Duration of need--99--Lifetime. E10.9 4 times daily, 99 Each, 1 Refill(s)
gabapentin 300 mg oral capsule: 300 mg, 1 capsule, ORAL, q8h, 90 capsule, 0 Refill(s)
gabapentin 300 mg oral capsule: See Instructions, 1-2 capsule ORAL TID (3 times a day) 30 day(s) -Start by taking 1 capsule TID - if still having headaches after 10 days can increase to 2 capsules TID, 180 capsule, 2 Refill(s)
sodium chloride 0.65% nasal spray: 1 spray, NOSTRIL, EACH, PRN (As needed), PRN: Dry Nasal Passages, 1 Each, 0 Refill(s)

Documented Medications

*Documented*

atorvastatin 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily
metFORMIN: ORAL, 0 Refill(s)
pioglitazone: ORAL, Daily, 0 Refill(s)

**Problem list**:

All Problems

Diabetes mellitus / SNOMED CT 121589010 / Confirmed
Fracture follow-up / SNOMED CT 283788016 / Confirmed

**Histories**

**Family History**:

No family history items have been selected or recorded.

**Social History**

**Social & Psychosocial Habits**

**Provider: RENTZ JR,JAMES N MD**
**Date of Service:** 5/12/2022
**Visit #:** 6531725674

**Pt Name: VASQUEZ, HECTOR LOPEZ**
**Org MRN#:** 8698563
**DOB:** [redacted] **Sex:** Male

**Printed:** 5/19/2022 09:00 EDT

**Print ID:** 551033850

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1690 Highway 160 West
Fort Mill, SC 29708-
Phone: 803-548-2424 Fax: 803-548-6808

## Office/Clinic Visit Notes

**Home/Environment**
12/07/2020 **Marital Status:** Single

**Alcohol**
12/07/2020 **Use:** Denies

**Drug Abuse**
12/07/2020 **Use:** Denies

**Employment/School**
12/07/2020 **Status:** Employed

**Tobacco**
02/18/2022 **SHX Smokeless Tobacco Use** Never
**Smoking Status:** Never smoker
**# Years Active Cigarette Smoker:** 0
**Current or Former Smoking History - Avg # Packs/Day (20 cigs** 0
**Started at age:** 0 Years
**Stopped at age:** 0 Years

05/04/2022 **SHX Smokeless Tobacco Use** Never
**Smoking Status:** Never smoker
**# Years Active Cigarette Smoker:** 0
**Current or Former Smoking History - Avg # Packs/Day (20 cigs** 0

**Vape/E-Cigarette**
02/18/2022 **Vape/E-Cigarette Use:** Never

05/04/2022 **Vape/E-Cigarette Use:** Never

**Physical Examination**
**VS/Measurements**
Measurements from flowsheet : Measurements - Standard

| | | |
|---|---|---|
| 5/12/2022 9:53 EDT | Height (inches) | 68 inch |
| | Clinical Weight Contributor (lb) | 159.6 lb |

, BMI : Body Mass Index

Atrium Health

AH Musculoskeletal Inst Fort Mill
1690 Highway 160 West
Fort Mill, SC 29708-
Phone: 803-548-2424 Fax: 803-548-6808

## Office/Clinic Visit Notes

5/12/2022 9:53 EDT Body Mass Index 24.27 kg/m2

**General**: Alert and oriented, No acute distress.
Ambulation status: Assistive devices ( Walker ).
Appearance: Within normal limits.
Behavior: Appropriate.
Skin: Within normal limits.
**HENT**: Normocephalic.
**Neck**: Supple, Non-tender.
**Respiratory**: Respirations are non-labored.
**Cardiovascular**: Good pulses equal in all extremities.
**Musculoskeletal**: He has no swelling of the right knee. There is no varus or valgus instability or pain with stressing. Lachman appears stable. Flexion is about 110 degrees and extension is full. He has mild tenderness over the lateral joint line. No pain medially. No pain with McMurray's. The left ankle shows no swelling. He has no instability with anterior drawer testing. He has full active motion with no evidence of pain. No point tenderness to palpation other than around the region of the anterior talofibular ligament..
**Integumentary**: Warm, Dry.
**Neurologic**: Alert, Oriented, Normal sensory, Normal motor function.
**Cognition and Speech**: Oriented, Speech clear and coherent.
**Psychiatric**: Cooperative, Appropriate mood & affect.

**Review / Management**

**Radiology results**

X-ray, X-rays from the time of his injury show a small avulsion fracture off the lateral tibial plateau but no other abnormality other than very mild DJD with some sclerosis of the medial and lateral tibial plateau. X-rays today of the right knee show no new findings. X-rays today of the left ankle are normal

**Impression and Plan**

IMP: _Sprain of the right knee and left ankle with an avulsion fracture off the lateral tibial plateau. This fracture does not appear to be structurally significant. He when I ask him what hurts more he says the knee. I do not think anything further is needed for the ankle. We are going to schedule an MRI for the knee and I will see him back after that. His work status orthopedically is sitdown work only until I see him back. The impression and plan was also discussed in the presence of his nurse case manager.

**Dx/Order Association Plan**:

Diagnosis: **1**. Right knee sprain

**Provider: RENTZ JR,JAMES N MD**
**Date of Service:** 5/12/2022
**Visit #:** 6531725674

**Pt Name: VASQUEZ, HECTOR LOPEZ**
**Org MRN#:** 8698563
**DOB:** [redacted] **Sex:** Male

**Printed:** 5/19/2022 09:00 EDT

**Print ID:** 551033850

Atrium Health

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1690 Highway 160 West
Fort Mill, SC 29708-
Phone: 803-548-2424 Fax: 803-548-6808

## Office/Clinic Visit Notes

Comment:
Other status: New OV Level 3; Low MDM or 30-44 Mins - 99203; 05/12/22 11:02:00 EDT, Right knee sprain | Left ankle sprain (Completed)

Diagnosis: **2**. Left ankle sprain
Comment:
Other status: New OV Level 3; Low MDM or 30-44 Mins - 99203; 05/12/22 11:02:00 EDT, Right knee sprain | Left ankle sprain (Completed)

Diagnosis: Pain in right knee
Comment:

**End of Orders**

**Electronically Signed By: RENTZ, JAMES N MD**
**05/12/2022 11:06 AM**

**Provider:** RENTZ JR,JAMES N MD
**Date of Service:** 5/12/2022
**Visit #:** 6531725674

**Pt Name:** VASQUEZ, HECTOR LOPEZ
**Org MRN#:** 8698563
**DOB:** [redacted] **Sex:** Male

**Printed:** 5/19/2022 09:00 EDT
**Print ID:** 551033850

Atrium Health

## Ambulatory Work/School Release

AH Musculoskeletal Inst Fort Mill
1690 Highway 160 West

Fort Mill, SC, 29708
803-548-2424

Patient Name: VASQUEZ, HECTOR LOPEZ
DOB: [redacted]
Encounter Date: 05/12/2022
Attending MD: RENTZ JR, JAMES N MD

## Work/School Release

**Date of Exam:**
05/12/2022
**Date of Injury:**
02/18/2022
**Provider Seen Today:**
RENTZ JR, JAMES N MD
**Please Excuse:**
Patient
**From:**
Work
**Comments:**
Sit down work only until follow-up appointment

**Signature (If Required By Employer or School)**

# D/C Instructions and Med. Rec - Post-Op (ophth)

**Medication Administration**

| Set # | Medication | Lot # | Dose | Dose Unit of Measure | Site/Side/Route | Time | Administered by | Med Check | Confirmed |
|---|---|---|---|---|---|---|---|---|---|

**Discharge Instructions**

**DIET**

- You may eat and drink as tolerated, unless otherwise directed by your physician.

- Begin with clear liquids and slowly advance your diet to food as you feel more comfortable. It is best to avoid any greasy, spicy, or heavy foods for 24-hours after receiving anesthesia to prevent nausea.

- Drink at least 5 glasses of water per day.

**ANESTHESIA**

- If you have received general or local anesthesia with sedation, please pay particular attention to the following instructions:

  - The patient should drink plenty of fluids to help the body metabolize the medications used during surgery.

  - Do NOT drink alcoholic beverages including beer until tomorrow. Alcohol enhances the effects of anesthesia and sedation.

  - Do NOT drive a motor vehicle, operate machinery or power tools until tomorrow. If a child, no bicycle riding, skate boards, gym sets, etc. for 24 hours.

  - Do NOT make any important decisions or sign legal documents until tomorrow.

  - You may experience light headedness, dizziness and sleepiness following surgery. Please **do NOT stay alone**. A responsible adult should be with you for 24 hours.

  - Rest at home with moderate activity as tolerated. It may not be necessary to go to bed; however, it is important to rest for 24 hours following general anesthesia.

  - Do NOT climb stairs without assistance for the first 24 hours.

**POST-OPERATIVE PHONE CALL**

- You will receive a phone call from a Charlotte Surgery Center representative a few days after surgery. This a routine call to find out how you are progressing after your surgery.


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**CUITE**

- DO NOT rub the eye vigorously.

- When you rest or sleep, use 2-3 pillows to prop yourself up for the first week.

- For the next 3-4 days, use cool ice compresses as necessary to prevent swelling and pain to the eyelids. Leave the ice compresses on 20 minutes and then 5 minutes off while awake.

- Use given ointment, if applicable, 2 times a day for 3 days directly on the wound. Take about a 1/4-inch ribbon of the ointment (pea-sized amount) and spread over the wound site with a Q-tip or clean finger.

  - If the wound site is red or itching, please call our office at 704-295-3000. You may be having an allergic reaction to the ointment.

  - Your vision may be blurred and out of focus from the ointment. This will only last while using the ointment.

- Some swelling and bruising is to be expected and this may migrate to the lower face over time. This is maximal after surgery and gradually subsides over the following 10-14 days.

- Avoid excess sunlight; even a mild sunburn may cause prolonged swelling or irritation of the healing incisions.

- Fever, localized swelling, redness and tenderness may signify a developing infection and should be reported to the office.

**MEDICATIONS AFTER EYE SURGERY- DR. CUITE**

- Resume home medications unless otherwise directed.

- Resume your normal medication routine. If taking coumadin, resume day of surgery. If taking Aspirin, Plavix, Ibuprofen, resume 24 hours after surgery. If taking Xarelto or Eliquis resume two days after surgery.

- Use an over-the-counter pain medication such as Tylenol. Advil is okay after 24-48 hours. If you have anything more than mild pain and discomfort, please call the office.

- If you feel nauseated and/or have vomiting, avoid food and drink. Take only 2-3 ounces of clear liquids at hourly intervals. Discontinue pain medication until nausea passes. If these symptoms persist for anti-nausea medication.

**SMOKING AND ALCOHOL**

- Smoking should be strictly avoided because it interferes with the blood supply to the healing tissues and hinders healing.

- Alcohol consumption should be eliminated because this may act as an anticoagulant and result in bleeding.

**ACTIVITIES AFTER EYE SURGERY - DR. CUITE**

- Restrict yourself to bed rest with bathroom privileges for the first 24 hours. Then, limit your a activity sharply over the first week after surgery. You are encouraged to walk around the house, but avoid bending over at the


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Charlotte Surgery Center
2825 Randolph Rd , CHARLOTTE, NC 28211
704-377-1647
HECTOR LOPEZ VASQUEZ ID#: 246051 Physician: CATHERINE CUITE DOS: 05/20/2022

| Resume | Medication | Dose | Frequency | Last Dose | Signed |
|---|---|---|---|---|---|
| Today | **gabapentin 300 MG Oral Capsule** | 300 MG Oral Capsule | Three Times a Day | 05/19/2022 | ☑ |
| | Signed By: CATHERINE CUITE, MD [05/20/2022 06:49] | | | | |
| Today | **Levemir 100 UNT/ML in 3 ML Pen Injector** | 100 UNT/ML Prefilled Syringe | At Noon | 05/19/2022 | ☑ |
| | Signed By: CATHERINE CUITE, MD [05/20/2022 06:49] | | | | |
| Today | **Metformin Hydrochloride 1,000mg Oral tablet** | 1000 MG Oral tablet | Twice a Day | 05/19/2022 | ☑ |
| | Admission Notes: Head injury | | | | |
| | Signed By: CATHERINE CUITE, MD [05/20/2022 06:49] | | | | |
| Today | **NovoLIN R 100 UNT/ML Injectable Solution** | 10 mg - milligrams Injectable Solution | Three Times a Day | 05/19/2022 | ☑ |
| | Admission Notes: type 2 diabetes | | | | |
| | Signed By: CATHERINE CUITE, MD [05/20/2022 06:49] | | | | |
| Today | **SUMAtriptan succinate 25 MG Oral Tablet** | 25 MG Oral Tablet | As Needed | 05/19/2022 | ☑ |
| | Admission Notes: headache | | | | |
| | Signed By: CATHERINE CUITE, MD [05/20/2022 06:49] | | | | |

☑ Patient was NOT given prescriptions upon discharge from this center


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# MRI HEAD WO W IV CONTRAST

NOVANT HEALTH

**Lopez Vasquez, Hector**
MRN: 74301902, Legal Sex: Male, [redacted] (49 yrs), Outpatient
Accession #: R14758321

## Final Result

MRI BRAIN WITHOUT AND WITH IV CONTRAST

HISTORY: Face numbness. Headache. Work-related head injury.

COMPARISON: Outside CT April 3, 2022

TECHNIQUE: Multisequence, multiplanar images of the brain were performed before and after the intravenous administration of 6 mL of GADOBUTROL 1 MMOL/ML IV SOLN contrast agent on a 1.5 Tesla MRI.

FINDINGS:

The ventricles are nondilated. As seen on CT, there are areas of encephalomalacia involving the inferior frontal lobes, right greater than left, as well as the anterior and lateral right temporal lobe. Postcontrast images do show subtle areas of linear enhancement at the margins with adjacent areas of T2 signal abnormality compatible with gliosis. These changes are not acute but could be late subacute (+/- 3 months) or chronic. No other focal lesion. No mass effect or hemorrhage. No extra-axial fluid collection.

The pituitary, pineal region, and foramen magnum are unremarkable, and flow voids are present in the major intracranial vessels and dural sinuses.

There is partial opacification of the right maxillary antrum and of the right mastoid air cells. There is susceptibility artifact superficial to the right globe compatible with eyelid implant. There is a left medial orbital wall remote injury.

IMPRESSION:

Right greater than left inferior frontal and right temporal encephalomalacia.

Electronically Signed by: Robert M. Barr, MD, FACR on 5/31/2022 2:54 PM

Signed by Robert M Barr, MD on 5/31/2022 2:54 PM

## Appointment Info

Exam Date
5/31/2022

Department
Novant Health Imaging Center (Gastonia)
704-862-7188
920 Cox Rd, Building C, STE 101
GASTONIA NC 28054-3456

## Reason for Exam

No reason for exam was entered

## Diagnosis

Facial nerve paralysis

## Providers

Ordering Provider
Neela Rao, MD
704-295-3000
200 SOUTH HERLONG AVE
SUITE 201
ROCK HILL SC 29732

# CT TEMPORAL BONE WO IV CONTRAST

NOVANT HEALTH

**Lopez Vasquez, Hector**
MRN: 74301902, Legal Sex: Male [redacted] (49 yrs), Outpatient
Accession #: R14758322

## Final Result

CT TEMPORAL BONES:

COMPARISON: MRI brain May 31, 2022, brain CT April 3, 2022.

CLINICAL INDICATION: Right cranial VII nerve paralysis

Axial images were obtained through the temporal bones at 0.625 mm collimation without contrast. From axial source images, coronal reformations were created. Source axial and reformatted images are reviewed at high resolution bone algorithm. CT dose reduction techniques were used.

FINDINGS: There is a fracture of the right temporal bone. The fracture runs predominantly in a horizontal plane along the longitudinal axis of the right temporal bone. The posterior aspect of the fracture lies in the region of the mastoid sinuses. The fracture line extends anteriorly through the mastoid sinuses traversing the middle ear cavity. The anterior aspect of the fracture extends through the right facial nerve canal near the junction of the labyrinthine and tympanic segments. The most anterior aspect of the fracture is seen on coronal views exits the skull base about 8 mm anterior to the carotid canal.

There is no evidence of ossicular disruption. The footplate of the stapes appears normally positioned within the oval window. The otic capsule appears intact with no evidence of pneumolabyrinth.

There are multiple opacified mastoid air cells posteriorly. The fracture does not appear to extend into the sigmoid notch (the bony groove for the sigmoid venous sinus).

There are displaced fractures involving the junction of the frontal process of the maxilla and the nasal bones bilaterally. A fracture is suspected through the perpendicular plate of the ethmoid bone though this region is somewhat difficult to evaluate due to streak artifacts arising from the patient's eyelid closure device.

There is a fracture through the medial wall the left orbit (lamina papyracea).

Mucosal thickening is present along the floor the right maxillary sinus.

The left temporal bone is unremarkable in appearance.

IMPRESSION:
1. Horizontal plane fracture along the longitudinal axis of the right temporal bone extends through the right facial nerve canal near the junction of the labyrinthine and tympanic segments.

## Appointment Info

Exam Date
5/31/2022

Department
Novant Health Imaging Center (Gastonia)
704-862-7188
920 Cox Rd, Building C, STE 101
GASTONIA NC 28054-3456

## Reason for Exam

No reason for exam was entered

## Diagnosis

Facial nerve paralysis

## Providers

Ordering Provider
Neela Rao, MD
704-295-3000
200 SOUTH HERLONG AVE
SUITE 201
ROCK HILL SC 29732

2. Opacified mastoid air cells in the vicinity of the fracture. Diastases of the right lambdoid suture.
3. Facial fractures involve the nasal bones and the left lamina papyracea.

Comment: Brain parenchymal contusions are poorly visualized on this exam performed to evaluate the temporal bones but are much better seen on the patient's brain MR from May 31, 2022.

Electronically Signed by: Paul Tobben, MD on 5/31/2022 1:50 PM

Signed by Paul J Tobben, MD on 5/31/2022 1:50 PM

Metrolina Diagnostic Center
127 Professional Park Dr.
Rock Hill, SC 29732
Phone #: (803)329-8635
Fax:

**Name:** HECTOR LOPEZ VASQUEZ
**Patient ID:** M257570
**DOB:** [redacted]
**Phone:**
**Acc #:** 399534

**Exam Date:** 6/22/2022 08:08 AM
**Exam Name:** MRI JNT OF LWR EXTRE W/O CONTRAST I 73721 - right
**Reason:**
**Referrer:** JAMES N RENTZ JR, M.D.
**2nd Referrer:**

**MRI OF THE RIGHT KNEE WITHOUT CONTRAST**

CLINICAL DATA: Right knee pain, work related injury.

TECHNIQUE: MRI of the right knee was performed without contrast using multiple pulse sequences in multiple planes. All images were obtained utilizing a 1.5 Tesla Siemens open bore system.

FINDINGS: The anterior cruciate and posterior cruciate ligaments are intact.

The lateral meniscus is normal. There is an undersurface free edge tear of the posterior horn of the medial meniscus.

The medial collateral ligament is intact.

There is a chronic appearing fracture of the posterolateral tibial plateau. The lateral collateral ligament complex is intact.

The quadriceps and patellar tendons are within normal limits.

There is no soft tissue mass or cyst within the popliteal fossa.

IMPRESSION:
1. Subacute fracture of the posterior lateral tibial plateau. There is no associated ACL injury. Radiographic correlation is recommended.

2. Degenerative free edge tear of the posterior horn and body of the medial meniscus.

PAUL AITCHISON, MD
Radiologist
Prisma Health- UMG Department of Radiology- Midlands
Report Typed By: SL

**Report Electronically Signed by:** Paul Aitchison M.D.
**Report Electronically Signed on:** 6/22/2022 10:53 AM

**Patient Name:** HECTOR LOPEZ VASQUEZ
**Patient ID:** M257570
**Completed Date:** 6/22/2022 08:08 AM
**Technologist:** Christine Pierre-Louis
**Transcribed By:** Sue Leon
**Transcribed Date:** 6/22/2022 09:14 AM

**Exam:** MRI JNT OF LWR EXTRE W/O CONTRAST I 73721 - right
**Acc #:** 399534
**Interpreting Rad:** Paul Aitchison M.D.
**Finalized Date:** 6/22/2022 10:53 AM

| | | |
|---|---|---|
| STATE OF SOUTH CAROLINA<br><br>COUNTY OF YORK<br><br>Hector Lopez-Vasquez,<br>Claimant,<br><br>-vs-<br><br>Ox Paper Tube DBA Core Carolina, LLC<br><br>Employer,<br><br>and<br><br>Berkshire Hathaway Homestate Insurance Company<br><br>Carrier,<br><br>Defendants. | ) | BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION<br><br>**NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF HECTOR LOPEZ-VASQUEZ, CLAIMANT**<br><br>WCC FILE NO. 2202001<br><br>SUPPLEMENT ONE |

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND AMITY S. EDMONDS, ESQUIRE, ATTORNEY FOR DEFENDANTS:**

**YOU ARE HEREBY NOTIFIED THAT THE** Claimant, Hector Lopez-Vasquez, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), and Rule 67-612, herewith submits the following reports/physician or other evidence on behalf of the Claimant, to wit:

| **NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE** | **DATE OF REPORT(S)** | **PAGES** |
|---|---|---|
| APA 13: Semi Desai, MD Carolinas Rehabilitations - Charlotte | 7-20-2022 | 199 - 201 |
| APA 14: Charlotte Eye, Ear, Nose & Throat | 7-22-2022 | 202 - 206 |

**YOU ARE FURTHER NOTIFIED** that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the hearing before Honorable T. Scott Beck, Commissioner, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the employee-claimant.

**YOU ARE FURTHER NOTIFIED** that the following witnesses may be called on behalf of the Claimant:

Hector Lopez-Vasquez
302 Charlotte Street
York, SC 29745

Family members, friends, co-workers, former co-workers and neighbors.

**ELROD POPE LAW FIRM**

By: _____
Andrew W. Creech, Esquire
P. O. Drawer 11091
Rock Hill, South Carolina 29731
(803) 324-7574
ATTORNEYS FOR CLAIMANT

Rock Hill, South Carolina

August 8, 2022

**CERTIFICATE OF SERVICE**

WCC FILE NO. 2202001

The undersigned hereby certifies that she is a secretary to the attorney for the employee-claimant in the above-entitled action and that the foregoing **NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF HECTOR LOPEZ-VASQUEZ, CLAIMANT, SUPPLEMENT ONE** was served to the following address:

Amity S. Edmonds, Esquire
**GALLIVAN, WHITE & BOYD**
PO Box 10589
Greenville, SC 29603

Casey Barber
Casey Barber

Rock Hill, South Carolina
August 8, 2022

Atrium Health

CMG REHABILITATION ASSOCIATES
1100 BLYTH BLVD
CHARLOTTE, NC 28203

HECTOR VASQUEZ
302 CHARLOTTE ST
YORK, SC 29745

July 20, 2022

To Whom It May Concern,

Mr. Hector Lopez Vasquez was admitted to CMC from 2/18/2022 to 3/2/2022. Mr. Vasquez was involved in an accident at work and subsequently have a traumatic brain injury along with several polytrauma injuries. As a result of his injuries, his wife will be required to care for him at home as his caregiver 24 hours a day/7 days per week as the patient can not be left alone at this time.

Please reach out with any questions or concerns.

Sincerely,
Sima A. Desai, MD
Carolinas Rehabilitation
Phone:704-355-7073, Fax: 704-355-4442

Atrium Health

**Carolinas Rehab Clinic Main**
1100 Blythe Blvd
Charlotte, NC 28203
P (704) 355-7073
F (704) 355-4442

*Patient Name:* **VASQUEZ, HECTOR LOPEZ**
*Care Unit:* **RGNC**

*MRN #:* **0008783081**
*FIN #:* [redacted]

*Patient Address:* **302 CHARLOTTE ST**
**YORK, SC 29745**
*Insured Name:* LLC, OX PAPER TUBE AND CORE CAROLINA
*Insured Address:*

*Member #:*

*Policy #:* *55138263*

*DOB:* [redacted]
*Age:* **49 Years** *Sex:* **Male**
*Ht:* **172.72 cm** *Wt:*

*Home Phone:* **(803) 818-8656**
*Work Phone:* ( ) -
*Relationship:* Employee
*Ins Co Name:* Workers Comp
*Ins Co Address:* PO BOX 2831
CLINTON, IA 52733
(800)671-0022

*Group #:* 999999

***Allergies:*** tetracycline

*Ordering MD:* DESAI , SIMA AJIT MD
*Attending MD:* DESAI , SIMA AJIT MD
*Diagnosis:* S06.5X1A-Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, initial encounter
G43.009-Migraine without aura, not intractable, without status migrainosus
***See Patient Record for More Diagnosis***

*Ordered Procedure:* **Referral** *Order ID #:* 32506262173
*Diagnosis* : Traumatic subdural hematoma with loss of consciousness of 30 minutes or less, S0 6.5X1A, G43.009, R42, H53.8
*Diagnosis* : Migraine headache without aura, S06.5X1A, G43.009, R42, H53.8
*Diagnosis* : Vestibular dizziness involving both inner ears, S06.5X1A, G43.009, R42, H53.8
*Diagnosis* : Blurry vision, S06.5X1A, G43.009, R42, H53.8
*Requested Start Date/Time* : 07/20/22 13:12:00 EDT
*Priority* : Routine
*Foreign System* : EPIC
*Foreign System* : EPIC
*Referring To* : Other
*Reason for Referral* : Patient will need to remain out of work for now
*Requested Schedule Timeframe* : Next Available

Order Comments:

*Ordered By: :* DESAI , SIMA AJIT MD *Date/Time:* 07/20/2022 13:12 EDT
*Electronically Signed By:* DESAI , SIMA AJIT MD *Date/Time:* 07/20/2022 13:12 EDT
*Communication Type:* Written

chs_dcpambreqgen08

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

# Lopez Vasquez, Hector

MRN: 2002480767

**Neela Rao, MD**
Physician
Specialty: Otolaryngology

Progress Notes
Signed

Encounter Date: 7/22/2022

History was provided by patient through a Spanish interpreter at bedside

Subjective

Hector Lopez Vasquez is a 49 y.o. male who presents with dysphagia patient also complains of pain in the roof of his mouth. Patient denies globus sensation, hoarseness, hemoptysis, and heartburn. He has not had any treatment thus far. He continues to with voice and swallowing therapy.

The patient sustained nasal trauma a few months ago, in a work-related trauma. He reports a 500 pound paper roller fell onto his face. He suffered a severe fracture of his petrous temporal bone resulting in right-sided facial paralysis as well as several facial fractures. He underwent a nasal fracture repair by a plastic surgeon at Novant in February. He has since undergone eyelid surgery for lagophthalmos and exposure keratopathy. He will additionally need dental implants and knee surgery. The dates for these procedures have not been delineated.

He reports right facial nerve weakness is very slightly improving

He will be seeing an oral and maxillofacial surgeon for persistent facial pain.

Objective

Temp 36.7 °C (98.1 °F) | Wt 73 kg (161 lb)

**Constitutional**
- General Appearance: Healthy, alert, active, cooperative, and in no distress

**Head**
- Inspection: normocephalic, atraumatic, without lesions or tenderness

**Face**
- Inspection: no craniofacial deformities, no scars, lesions or masses
- Palpation: Sinus tenderness was absent
- Facial Strength: facial movement was normal and symmetrical

**Eyes**
- Eyelids/Appearance: right with postsurgical appearance
- Conjunctiva: clear

- Sclera: white

**Ears**

- Hearing: Responds to conversational voice
- External Ears: auricles normal bilaterally
- External Auditory Canal:
    - Right: patent
    - Left: patent
- Tympanic Membrane:
    - Right: 50% clean and dry perforation
    - Left: normal landmarks and mobility
- External Nose: Severe external deviation to the left with markedly irregular nasal bones. Oblique and irregular scarring approximately 4 cm of left nasal dorsum
- Intranasal Exam:
    - General: no nasal masses or foreign bodies noted anteriorly
    - Septum: S-shaped deviation bilaterally
    - Turbinates: Moderate inferior turbinate hypertrophy
    - Mucosa: within normal limits
    - Secretions: No purulent or clear rhinorrhea
    - Vestibule: within normal limits
- Nasopharynx: not visualized due to patient's gag

**Oral Cavity / Oropharynx**

- Lips: healthy without lesions
- Teeth/gums: dentition within normal limits for age
- Floor of Mouth: normal mucosa, moist, soft to palpation, nontender, no stones or lesions
- Oral Mucosa: oral mucosa moist, no mucosal lesions present
- Tongue: normal mucosal surface with no lesions and normal movement
- Hard Palate: hard palate without masses or lesions
- Soft Palate:soft palate without masses or lesions
- Uvula: normal
- Tonsils:
    - Right: normal without erythema or exudates
    - Left: normal without erythema or exudates
- Oropharynx:pharyngeal walls normal in appearance without lesions

**Neck**

- Inspection: general appearance normal, supple, no tenderness, no masses, tracheal position midline
- Lymph Nodes: No lymphadenopathy present
- Thyroid: normal size, no tenderness, nodules or mass present on palpation
- Submandibular Glands:
    - Right: normal size, no tenderness, nodules, or mass on palpation
    - Left: normal size, no tenderness, nodules, or mass on palpation
- Parotid Glands:
    - Right: normal size, no tenderness, nodules, or mass on palpation
    - Left: normal size, no tenderness, nodules, or mass on palpation

**Chest/Respiratory:**

- Respiratory Effort: unlabored respirations, no intercostal retractions or accessory muscle use
- Auscultation of Lungs: normal breath sounds

**Cardiovascular**

- Auscultation of Heart: Regular rate and rhythm; no murmurs, gallops, or rubs
- Carotid Arteries: Normal pulses bilaterally
- Extremities: No edema

**Musculoskeletal**

- Inspection and Palpation: no joint tenderness, deformity or swelling, no muscular tenderness noted

**Skin**
- pink, warm, well perfused, no rashes

**Neurological/Psychiatric**
- Orientation: alert, oriented, normal speech, no focal findings or movement disorder noted
- Mood and Affect: normal
- Cranial Nerves: CN II-XII grossly normal

**Procedure: Fiberoptic Nasal Endoscopy and Laryngoscopy**
Procedure was performed to get adequate inspection of patient's larynx and pharynx not provided by routine mirror exam. Patient was counseled regarding the nature of the procedure. Risks, alternatives, and benefits were discussed. Risks include pain, bleeding, need for repeat endoscopy, or other unforeseen circumstances. Topical vasoconstrictive and anesthetic sptrays were administered into the pharynx through the nasal cavity. The flexible nasopharyngoscope was advanced through one nostril into the pharynx. All aspects of the pharynx were inspected including the nasopharynx, oropharynx (including base of tougue and vallecula), and hypopharynx (pyriform sinuses and post-cricoid region). All aspects of the larynx were then inspected including the epiglottis, aryepiglottic folds, arytenoids, false cords, true cords, and subglottis. Procedure tolerated well without complications.

**Nasal Findings**
**Right:** Septum moderately deviated. Middle meatus and sphenoethmoid recess clear. Eustachian tube orifice patent. Nasopharynx clear.
**Left:** Septum severely deviated. Middle meatus and sphenoethmoid recess clear. Eustachian tube orifice patent. Nasopharynx clear.

**Pharyngeal Findings**
**Nasopharynx:** ET orifices clear. Adenoids non-obstructive (1+). Nasopharynx without mass or lesions.
**Oropharynx:** No retropalatal narrowing. No concentric narrowing at the tonsillar level. No retroglossal narrowing. No retroepiglottic narrowing noted. Lingual tonsils normal. Vallecula clear.
**Hypopharynx:** Normal mucosa.

**Laryngeal Findings**
**Epiglottis:** normal.
**Aryepiglottic folds**: normal.
**Arytenoids:** normal.
**False vocal cords:** normal.
**True vocal cords:** normal bilaterally.

Assessment/Plan

| | Diagnosis | ICD-10-CM | ICD-9-CM | Plan |
|---|---|---|---|---|
| 1. | **Dysphagia, unspecified type** | **R13.10** | **787.20** | **Modified Barium Swallow (74230)** |
| 2. | Perforation of right tympanic membrane | H72.91 | 384.20 | |

| | | | |
|---|---|---|---|
| 3. | Closed fracture of facial bone, unspecified facial bone, initial encounter (CMS/HCC) | S02.92X A | 802.8 |
| 4. | Hypertrophy of both inferior nasal turbinates | J34.3 | 478.0 |
| 5. | Nasal congestion | R09.81 | 478.19 |
| 6. | Nasal valve collapse | J34.89 | 478.19 |
| 7. | Nasal septal deviation | J34.2 | 470 |

- We will proceed with modified barium swallow for dysphagia
- We may consider scheduling of functional nasal surgery once he has been evaluated by maxillofacial surgery and he is healed from any planned interventions. We discussed that he will require at least 6 weeks after his nasal surgery before he may proceed with other surgeries to protect his nose
- Return in about 4 weeks (around 8/19/2022) for follow-up.

Neela Rao MD

Neela Rao, MD

Electronically signed by Neela Rao, MD at 7/22/2022 5:21 PM

Office Visit on 7/22/2022 *Note shared with patient*

## Additional Documentation

Vitals: Temp 36.7 °C (98.1 °F) Wt 73 kg (161 lb)

| | | |
|---|---|---|
| STATE OF SOUTH CAROLINA | ) | BEFORE THE SOUTH CAROLINA |
| | ) | WORKERS' COMPENSATION COMMISSION |
| COUNTY OF YORK | ) | |
| | ) | |
| Hector Lopez-Vasquez, | ) | |
| Claimant, | ) | |
| | ) | |
| -vs- | ) | |
| | ) | **NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF HECTOR LOPEZ-VASQUEZ, CLAIMANT** |
| Ox Paper Tube DBA Core Carolina, LLC | ) | |
| | ) | |
| Employer, | ) | |
| | ) | |
| and | ) | |
| | ) | |
| Berkshire Hathaway Homestate Insurance Company | ) | WCC FILE NO. 2202001 |
| | ) | |
| Carrier, | ) | |
| | ) | SUPPLEMENT TWO |
| Defendants. | ) | |
| | ) | |

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND AMITY S. EDMONDS, ESQUIRE, ATTORNEY FOR DEFENDANTS:**

**YOU ARE HEREBY NOTIFIED THAT THE** Claimant, Hector Lopez-Vasquez, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), and Rule 67-612, herewith submits the following reports/physician or other evidence on behalf of the Claimant, to wit:

| **NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE** | **DATE OF REPORT(S)** | **PAGES** |
|---|---|---|
| APA 15: AH Musculoskeletal Inst. - Rock Hill | 6-29-2022 | 210 - 219 |
| APA 16: Charlotte Eye, Ear, Nose & Throat | 8-23-2022 | 220 - 226 |

**YOU ARE FURTHER NOTIFIED** that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the hearing before Honorable T. Scott Beck, Commissioner, for insertion in the file of the South Carolina Workers'

Compensation Commission and inclusion into evidence on behalf of the employee-claimant.

**YOU ARE FURTHER NOTIFIED** that the following witnesses may be called on behalf of the Claimant:

Hector Lopez-Vasquez
302 Charlotte Street
York, SC 29745

Family members, friends, co-workers, former co-workers and neighbors.

**ELROD POPE LAW FIRM**

By: _____

Andrew W. Creech, Esquire
P. O. Drawer 11091
Rock Hill, South Carolina 29731
(803) 324-7574
ATTORNEYS FOR CLAIMANT

Rock Hill, South Carolina
September 1, 2022

**CERTIFICATE OF SERVICE**

WCC FILE NO. 2202001

The undersigned hereby certifies that she is a secretary to the attorney for the employee-claimant in the above-entitled action and that the foregoing **NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF HECTOR LOPEZ-VASQUEZ, CLAIMANT, SUPPLEMENT TWO** was served to the following address:

Amity S. Edmonds, Esquire
**GALLIVAN, WHITE & BOYD**
PO Box 10589
Greenville, SC 29603

Casey Barber

Casey Barber

Rock Hill, South Carolina
September 1, 2022

Atrium Health

**AH Musculoskeletal Inst Rock Hill**
**134 Professional Park Dr**
**Rock Hill, SC 29732-**
**Phone: 803-329-3130 Fax: 803-329-4533**

## Office/Clinic Visit Notes

DOCUMENT NAME: Orthopaedic Visit Note

**Ortho office note-proced**

Patient: **VASQUEZ, HECTOR LOPEZ** **MRN: 8698563** **FIN:** [redacted]
Age: **49 years** Sex: **Male** DOB: [redacted]
Associated Diagnoses: **None**
Author: **RENTZ JR, JAMES N MD**

**Visit Information**
**Primary Care Provider**

**Chief Complaint**
**6/29/2022 10:57 EDT WC--MRI results of the right knee.**

**History of Present Illness**
_He returns for the MRI results of his right knee. The entire visit was done with the video interpreter and in the presence of his case manager. He continues to complain of pain in the knee and also episodes of the knee wanting to give out especially if he twists or turns with weightbearing. He does feel like therapy has helped some of the pain but it has not resolved.

**Review of Systems**
**Constitutional**: Negative.
**Respiratory**: Negative.
**Gastrointestinal**: Negative.
**Immunologic**: Negative.
**Musculoskeletal**: Negative except as stated in HPI.
**Integumentary**: Negative.
**Neurologic**: Negative.
**Psychiatric**: Negative.

**Health Status**
**Allergies**:
Allergic Reactions (Selected)
*Severity Not Documented*
Tetracycline- Rash.
**Current medications**: (Selected)
Prescriptions
*Prescribed*

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## Office/Clinic Visit Notes

Glucometer: See Instructions, Daily, Duration of need--99--Lifetime. E11.9 once per year, 1 Each, 0 Refill(s)
Glucophage 1000 mg oral tablet: 1,000 mg, 1 tablet, ORAL, BID (2 times a day), 60 tablet, 1 Refill(s)
Lancets: See Instructions, Daily, Duration of need--99--Lifetime. E11.9 4 times daily, 9 Each, 0 Refill(s)
Levemir FlexPen 100 units/mL subcutaneous solution: 16 units, SUBCUTANEOUS, qHS (each night at bedtime), Take 16 units at night before bed., 15 mL, 1 Refill(s)
NovoLIN R PenFill 100 units/mL injectable solution: 10 units, SUBCUTANEOUS, TIDAC (3 times a day before meals), Take 10 units with meals; do not take if blood sugar less than 140, 15 mL, 1 Refill(s)
SUMAtriptan 25 mg oral tablet: 25 mg, 1 tablet, ORAL, PRN (As needed), for 30 day(s), may repeat dose in 2 hours if needed, PRN: Headache, 18 tablet, 1 Refill(s)
Test Strips: See Instructions, Daily, Duration of need--99--Lifetime. E10.9 4 times daily, 99 Each, 1 Refill(s)
gabapentin 300 mg oral capsule: 300 mg, 1 capsule, ORAL, q8h, 90 capsule, 0 Refill(s)
gabapentin 300 mg oral capsule: See Instructions, 1-2 capsule ORAL TID (3 times a day) 30 day(s) -Start by taking 1 capsule TID - if still having headaches after 10 days can increase to 2 capsules TID, 180 capsule, 2 Refill(s)
sodium chloride 0.65% nasal spray: 1 spray, NOSTRIL, EACH, PRN (As needed), PRN: Dry Nasal Passages, 1 Each, 0 Refill(s)

Documented Medications

*Documented*

atorvastatin 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily
metFORMIN: ORAL, 0 Refill(s)
pioglitazone: ORAL, Daily, 0 Refill(s)

**Problem list**:

All Problems

Diabetes mellitus / SNOMED CT 121589010 / Confirmed
Fracture follow-up / SNOMED CT 283788016 / Confirmed

**Histories**

**Family History**:

No family history items have been selected or recorded.

**Social History**

**Social & Psychosocial Habits**

**Home/Environment**
12/07/2020 **Marital Status:** Single

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## Office/Clinic Visit Notes

**Alcohol**
12/07/2020 **Use:** Denies

**Drug Abuse**
12/07/2020 **Use:** Denies

**Employment/School**
12/07/2020 **Status:** Employed

**Tobacco**
02/18/2022 **SHX Smokeless Tobacco Use** Never
**Smoking Status:** Never smoker
**# Years Active Cigarette Smoker:** 0
**Current or Former Smoking History - Avg # Packs/Day (20 cigs** 0
**Started at age:** 0 Years
**Stopped at age:** 0 Years

05/04/2022 **SHX Smokeless Tobacco Use** Never
**Smoking Status:** Never smoker
**# Years Active Cigarette Smoker:** 0
**Current or Former Smoking History - Avg # Packs/Day (20 cigs** 0

**Vape/E-Cigarette**
02/18/2022 **Vape/E-Cigarette Use:** Never

05/04/2022 **Vape/E-Cigarette Use:** Never
.

**Physical Examination**
**VS/Measurements**
Measurements from flowsheet : Measurements - Standard

| | | |
|---|---|---|
| 6/29/2022 10:57 EDT | Height (inches) | 68 inch |
| | Clinical Weight Contributor (lb) | 159 lb |

, BMI : Body Mass Index

| | | |
|---|---|---|
| 6/29/2022 10:57 EDT | Body Mass Index | 24.18 kg/m2 |

**General**: Alert and oriented, No acute distress.

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## Office/Clinic Visit Notes

Ambulation status: With steady gait, Assistive devices ( Walker ).
Appearance: Within normal limits.
Behavior: Appropriate.
Skin: Within normal limits.
**HENT**: Normocephalic.
**Neck**: Supple, Non-tender.
**Respiratory**: Respirations are non-labored.
**Cardiovascular**: Good pulses equal in all extremities.
**Musculoskeletal**: He has no gross swelling of the right knee today. He is tender over the medial joint line with palpation. No gross instability..
**Integumentary**: Warm, Dry.
**Neurologic**: Alert, Oriented, Normal sensory, Normal motor function.
**Cognition and Speech**: Oriented, Speech clear and coherent.
**Psychiatric**: Cooperative, Appropriate mood & affect.

**Review / Management**

**Radiology results**

Magnetic Resonance Imaging, I have reviewed the MRI with him and explained that it does show the tibial plateau avulsion fracture but no other bony abnormality and the bony structure of the knee is intact. It also shows a posterior horn medial meniscus tear which would be consistent with his symptoms of the knee wanting to give out and his continued pain.

**Impression and Plan**

IMP: _Medial meniscus tear of the right knee. I have explained that the only way to resolve this would be an arthroscopy with partial medial meniscectomy and he would like to proceed with that. I discussed the surgery with the patient including the potential risks and benefits as well as the peri-and postoperative course. I will see back around surgery. We will continue therapy until surgery and after surgery. We will continue the same work restrictions with sitdown work only until and after surgery until stated otherwise.

**Dx/Order Association Plan**:

Diagnosis: **1.** Complex tear of medial meniscus of right knee
Comment:
Other status: Follow-Up Appt; For (Dx): post-op As scheduled (Completed)
Est OV Level 4; Mod MDM or 30-39 Mins - 99214; 06/29/22 11:30:00 EDT, Complex tear of medial meniscus of right knee (Completed)

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## Office/Clinic Visit Notes

**End of Orders**

**Electronically Signed By: RENTZ, JAMES N MD**
**06/29/2022 11:32 AM**

**Provider:** RENTZ JR,JAMES N MD
**Date of Service:** 6/29/2022
**Visit #:** 6538117561

**Pt Name:** VASQUEZ, HECTOR LOPEZ
**Org MRN#:** 8698563
**DOB:** [redacted] **Sex:** Male

**~~Printed~~:** 8/20/2022 14:05 EDT

**Print ID:** 572446702

Atrium Health

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**134 Professional Park Dr**
**Rock Hill, SC 29732-**
**Phone: 803-329-3130 Fax: 803-329-4533**

## Correspondence & Follow Up

DOCUMENT NAME: Message Center Note

**Addendum by BRADLEY, TERRI J on August 05, 2022 14:46:17 EDT**
In my WC folder

**Addendum by BRADLEY, TERRI J on June 30, 2022 13:23:58 EDT**

| | |
|---|---|
| **WC Carrier:** | Berkshire Hathaway |
| **ADJUSTER:** | Hannah Morine |
| **NCM:** | Stacia Hagerty |
| **PHONE #:** | NCM 704-641-5548 adjuster 402-952-6241 |
| **FAX #:** | NCM 888-808-0955 adjuster 415-675-5469 |
| **CLAIM #:** | 55138263 |
| **CPT CODE:** | 29881 |
| **DX CODE:** | S83.231A |
| | Faxed surgery order, 6-29 office and work notes to NCM Stacia Hagerty requesting authorization for surgery. |
| | |
| | |

**Provider:** RENTZ JR,JAMES N MD
**Date of Service:** 6/29/2022
**Visit #:** 6538117561

**Pt Name:** VASQUEZ, HECTOR LOPEZ
**Org MRN#:** 8698563
**DOB:** [redacted] **Sex:** Male

**Printed:** 8/20/2022 14:05 EDT

**Print ID:** 572446702

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**134 Professional Park Dr**
**Rock Hill, SC 29732-**
**Phone: 803-329-3130 Fax: 803-329-4533**

## Correspondence & Follow Up

**Addendum by BRADLEY, TERRI J on June 29, 2022 15:17:33 EDT**

---

From: BRADLEY, TERRI J
To: BRADLEY, TERRI J;
Sent: 6/29/2022 15:17:33 EDT
Subject: FW: WC JNR surgery order right knee scope

**IN PROGRESS**

---

From: SMITH , LATORYA
To: COSA , RH SURGERY SCHEDULING;
Sent: 6/29/2022 11:46:24 EDT
Subject: WC JNR surgery order right knee scope

Physical therapy order for post op already given to case manager while at appointment so she is aware of this. Patient does speak Spanish so when calling you will need an interpreter.

Atrium Health

Atrium OR Scheduling Office Use Only
Confirmation/Account # - Surgery Date/Time - Initials

Send form to:
Fax: 704-667-1992 or Email: PinevilleORScheduling@atriumhealth.org

# Atrium Health Surgical Services Scheduling Form

Do not fax requests for same or next-day posting - Call the scheduling office for these requests.
Information in **bold** is required. Illegible faxes or those missing required information will be returned.

**Facility** (select from drop-down menu): ○ Pineville ☑ COS

**Surgery Date:** _____ **Patient In-Room Time:** _____

**Surgeon Name:** Dr. James Rentz **Assistant:** no

Requested Surgeon Control = **Total SCT** 45 mins

*Three patient identifiers are required. You may leave this section blank & attach a demographics page that contains all required information.*

**Patient's Name:** Hector Vasquez **DOB:** [redacted]

**Social Security #:** _____ Atrium MRN: 86985603 **Sex:** Male ☑ Female ○

**Insurance:** Patient's Insurance ☑ Work Comp ☒

**Requested Patient Bed Type:** Outpatient ☑ 24-hr Observation ○ Same-Day Admit ○

Latex Allergy: YES ○ NO ☑

**Patient's Weight:** 159 BMI 24.18

**Procedure Description** (Do NOT abbreviate):

- ☐ Carpal Tunnel Release- CPT: 64721
- ☐ DeQuervains Release- CPT: 25000
- ☑ Knee Arthroscopy w/ Meniscectomy- CPT: 29880(Medial AND Lateral) CPT: 29881 (Medial OR Lateral)
- ☐ ACL Reconstruction- CPT: 29888
- ☐ Total Knee Arthroplasty: CPT: 27447
- ☐ Trigger Finger Release- CPT: 26055

Dx S83.231A

**Laterality** (if applicable): Left ○ Right ☑ Bilateral ○

**Special Needs** (Equipment, Implants, Interpreter, Contact Precautions, etc.): 8

**Anesthesia Type:** Choice **Anesthesia block needed:** Yes ○ No ○

**Sent By:** **Email:**

Infectious Disease (TB,Shingles, MRSA,C-Diff) Ø Pregnancy: ☐ YES ☑ NO Diabetes: ☐ YES ☑ NO

Blood Thinner: ☐ YES ☑ NO Medication:

Allergies: ☑ YES ☐ NO tetracycline

H & P Appointment: ☐ YES ☑ NO

Work/School Note Given: ☑ YES ☐ NO Surgery Folder Given: ☑ YES ☐ NO

Last Seen Date: 6.29.22 Home Health Care Needed: ☐ YES ☑ NO

Special Instructions: PT after surgery DME Needed: already has walker

Post-OP Appointment: 10-14 days w/ Portz Clearance Needed: Ø

Covid 19 Vaccination ☐ YES ☐ NO

Date of Injections: 1st Injection:____ 2nd Injection:____

Total Joint Discharge Disposition

| 0- Day LOS | 1- Day LOS | 2- Day LOS | 3+Day LOS |
|---|---|---|---|
| a. Home- Self Care | a. Home- Self Care | a. Home-Self | a. Home- Self Care |
| b. Home- HH | b. Home- HH | b. Home- HH | b. Home-HH |
| c. SNF | c . SNF | c. SNF | c. SNF |

## CPT CODES:

### WRIST & FOREARM
DeQuervain- 25000
Ganglion Wrist (Dorsal) or Volar- 25111
Recurrent Ganglion (Dorsal or Volar- 25112
CMC Arthroplasty- 25447
Tendon Transfer w/ CMC Arthroplasty- 25310
Arthrodesis Fusion CMC Joint Graft- 25805
ORIF Radial Shaft-25515
ORIF Radius & Ulna- 25575
ORIF Extra-Articular- 25607
ORIF Intra-Articular 2 Fragments- 25608
ORIF Intra-Articular 3 Fragments- 25609
Closed Reduction-Wrist- 25605
Closed Reduction manip.- Radial Shaft- 25505
Closed Reduc. manip.- Radius/Ulna- 25565
Closed Reduc.w/o manip.- Radius/Ulna- 25560
Perc Skeletal Fixation/Pinning- 25606
Ulnar Nerve (Guyons Canal)- 64719
Carpal Tunnel Release- 64721

### FINGERS & HAND
Trigger Finger/Thumb- 26055
I&D Finger/Hand- 26011
Dupuytren Palm Only- 26121
Dupuytren include Digit- 26123
Palmer Fasciectomy additional Digit- 26125
Epidermal inclusion Cyst/Subcutaneous > 1.5cm-26116
Ganglion/Mucous/Giant Cell Cyst tendon sheath- 26160
Excision Osteophyte Finger- 26210
Extensor Tendon Repair-26418
Repair Mallet Finger/Extensor Tendon Distal-26433
Gameskeeper Thumb/Ulnar Collateral Lig. Repair- 26540
Finger DIP Fusion- 26860

### ELBOW & HUMERUS
Olecranon Bursa Excision- 24105
Distal Biceps Tear Repair- 24342
Triceps Repair @ Elbow- 24342
Tennis Elbow/Common Extensor Tendon Release- 24359
ORIF Humeral Shaft- 24515
ORIF Distal Humerus- 24516
ORIF Distal Humeral Supracondylar- 24545
ORIF Medical Epicondyle- 24575
ORIF Olecranon- 24685
Ulnar Nerve (Elbow)- 64718

### SHOULDER & CLAVICLE
Distal Clavicle Excision- Open- 23120
Shoulder Acromioplasty- 23130
RCR Chronic or Open-23412
RCR Scope (RC Revision)- 29827
Biceps Tenodesis Open Scope- 23430
ORIF clavicle w/wo fixation-23515
ORIF Proximal Humerus- 23615
Shoulder AC Reconstruction- 23550
Shoulder Manipulation- 23700
Labrum Rep. scope/sup capsular recon.-29806
Decompression Scope- 29826
Distal Clavicle Scope-29824
Major Debridement Scope w/ Tenotomy- 29823

### ANKLE
Achilles Tendon Repair- 27650
Repair Tendon Flexor (peroneal/tibial)-27658
ORIF Proximal Fibula-27784
ORIF Distal Fibula-27792
ORIF Bimalleolar ankle- 27814
ORIF Trimalleolar ankle- 27822
Repair Syndemosis ankle/Open- 27829
Open ankle osteochondral defect (OATS)- 28446

### FOOT & TOES
Plantar Fascia Release- 28008
Morton's Neuroma- 28080
Excision Bone Spur Heel/Foot- 28100
Bunionette- 28110
Haguland Excision- 28118
Hammertoe (PIP Arthroplasty)- 28160
Resection Pinning-DIP Toes- 28160
Excision Navicular Accessory foot- 28238
Hammertoe /Claw toe correction- 28285
Condylectomy Toe- Metar. Head Plantar- 28288
Dorsal Chielectiomy Hallux Rigidus- 28289
Chielectomy Hallux Rigidus @ Implant- 28291
McBride Bunionectomy Halgus Valgus-28292
McBride @ Proximal Metar. Osteotomy- 28295
Cheveron Metatarsal Osteotomy Distal- 28296
Osteotomy Metatarsal- 28308
Endoscopic Plantar Fasciotomy-29893

### KNEE
I & D Bursa Knee- 27301
Excision Bakers Cyst Knee- 27345
Excision Ganglion Cyst Knee- 27347
Patella Tendon Repair- 27380
Quadriceps Tendon Repair- 27385
Total Knee-Unicompartmental- 27446
Total Knee Arthroplasty- 27447
TKR Rev.-Unicompart./Total Insert Exc.-27486
ORIF Patella - 27524
ORIF Tibial Plateau- 27535
Knee Jt. Manipulation- 27570
Knee -Lateral Release-29873
Loose Bodies-Knee- 29874
Synovectomy-PLICA-Limited- 29875
Major Synovectomy/Chondromalacia- 29876
Chrondroplasty/Debridment-29877
Medial AND Lateral Meniscectomy- 29880
Medial OR Lateral Meniscectomy- 29881
Meniscus Repair Medial AND Lateral-29883
Meniscus Repair Medial OR Lateral-29882
ACL Reconstruction- 29888

### HIP
Total Hip Arthroplasty- 27130
Revision Total Hip- Both Components- 27134
Revision Total Hip- Acetab. Component- 27137
Trochcanter Femoral Nail Prox. Femur-27245
Core Decompression- 27299

### MISCELLANEOUS
I & D Hematoma Wound- 10140
I & D Complex Post-Op Woun-10180
Foreign Body Hand/Finger-Deep- 20525
Hardware Removal/Complicated- 20680

CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

# Lopez Vasquez, Hector

MRN: 2002480767

**Ophth Exam** 8/23/2022
SouthPark Ophthalmology

Provider: Catherine Cuite, MD (Oculoplastics Ophthalmology)
Primary diagnosis: Facial paresis

## Demographics

| Name | MRN | Sex | DOB Age |
|---|---|---|---|
| Hector Lopez Vasquez | 2002480767 | Male | [redacted] (49 y.o.) |

## HPI

3 month re check right side facial Paralysis with Platinum weight in place 4-19-22. Tends to have a little discomfort on the outer corner at times. Eye feels comfortable. Using otc ung aTID and qhs, uncertain of the name.

## ROS

Positive for: Neurological, Musculoskeletal, HENT, Eyes
Negative for: Constitutional, Gastrointestinal, Skin, Genitourinary, Endocrine, Cardiovascular, Respiratory, Psychiatric, Allergic/Imm, Heme/Lymph

## Allergies

as of 8/23/2022

Allergies last reviewed by Catherine Cuite, MD on 8/23/2022 1017

**TETRACYCLINE**

Reactions: Hives
Reaction type: Allergy
RxNorm: 10395
Severity: Medium
Noted on: 03/08/2022

## Medication Changes

As of 8/23/2022 10:17 AM

None

## Medication List at End of Visit

As of 8/23/2022 10:17 AM

| | Refills | Start Date | End Date |
|---|---|---|---|
| **amitriptyline (ELAVIL) 50 MG tablet** | | 3/17/2022 | |
| 50 mg per 1 tablet, ORAL, qHS (each night at bedtime), 90 tablet, 0 Refill(s), Pharmacy: Walmart Pharmacy 1144, Height, 172.72, cm, 03/17/22 13:05:00 EDT, Weight, 61.6, kg, 02/18/22 22:55:00 EST | | | |
| Patient-reported medication | | | |
| **atorvastatin (LIPITOR) 20 MG tablet** | | 3/18/2022 | |
| Take 20 mg by mouth once daily. - Oral | | | |
| Patient-reported medication | | | |
| **gabapentin (NEURONTIN) 300 MG capsule** | | | |

| | Refills | Start Date | End Date |
|---|---|---|---|
| Take 600 mg by mouth 3 (three) times a day. - Oral<br>Patient-reported medication | | | |
| Levemir FlexTouch 100 UNIT/ML solution pen-injector<br>INJECT 16 UNITS SUBCUTANEOUSLY EVERY DAY AT BEDTIME<br>Patient-reported medication | | 5/2/2022 | |
| NovoLIN R FlexPen 100 UNIT/ML solution pen-injector<br>Patient-reported medication | | 3/2/2022 | |
| magnesium oxide (MAG-OX) 400 MG tablet<br>Take 400 mg by mouth daily. - Oral<br>Patient-reported medication | | 6/23/2022 | |
| metFORMIN (GLUCOPHAGE) 1000 MG tablet<br>Patient-reported medication | | 3/2/2022 | |
| nortriptyline (PAMELOR) 10 MG capsule<br>Take 30 mg by mouth. - Oral<br>Patient-reported medication | | 6/23/2022 | 6/23/2023 |
| Riboflavin 400 MG tablet<br>Take 400 mg by mouth daily. - Oral<br>Patient-reported medication | | 6/23/2022 | |
| SUMAtriptan (IMITREX) 25 MG tablet<br>TAKE ONE TABLET BY MOUTH ONCE DAILY AS NEEDED MAY REPEAT 2ND DOSE AFTER DE TWO HORAS SI EL HEADACHE SIGE<br>Patient-reported medication | | 6/22/2022 | |

## Current Medications

| | Taking? | Last Dose |
|---|---|---|
| amitriptyline (ELAVIL) 50 MG tablet | ✓ | Taking |
| atorvastatin (LIPITOR) 20 MG tablet | ✓ | Taking |
| Continuous Blood Gluc Sensor (FreeStyle Libre 14 Day Sensor) misc | ✓ | Taking |
| gabapentin (NEURONTIN) 300 MG capsule | ✓ | Taking |
| Levemir FlexTouch 100 UNIT/ML solution pen-injector | ✓ | Taking |
| magnesium oxide (MAG-OX) 400 MG tablet | ✓ | Taking |
| metFORMIN (GLUCOPHAGE) 1000 MG tablet | ✓ | Taking |
| Microlet Lancets misc | ✓ | Taking |
| nortriptyline (PAMELOR) 10 MG capsule | ✓ | Taking |
| NovoLIN R FlexPen 100 UNIT/ML solution pen-injector | ✓ | Taking |
| OneTouch Ultra test strip | ✓ | Taking |
| Riboflavin 400 MG tablet | ✓ | Taking |
| SUMAtriptan (IMITREX) 25 MG tablet | ✓ | Taking |

## Medical History

| Diagnosis | Date | Comment | Source |
|---|---|---|---|
| Diabetes mellitus (CMS/HCC) | | | |

| Diagnosis | Date | Comment | Source |
|---|---|---|---|
| High cholesterol | | | |
| Hypertension | | | |
| Migraine | | | |
| Work related injury | | | |

## Surgical History

| Procedure | Laterality | Date | Comment | Source |
|---|---|---|---|---|
| EYE SURGERY | | | for stitches and to help close | |
| EYELID SURGERY | Right | | platinum weight RUL | |
| FACIAL FRACTURE SURGERY | | | | |
| NOSE SURGERY | | | | |

## Tobacco Use

Never smoked or used smokeless tobacco.

## Vaping Use

Never used

## Alcohol Use

Yes.
Comments: rare

## Drug Use

Never.

## Family History as of 8/23/2022

No family history on file.

## Social Identity

| Preferred Language | Ethnicity | Race |
|---|---|---|
| Spanish | Hispanic or Latino | Other |

## Social Documentation

No social documentation on file.

## Base Eye Exam

### Visual Acuity (Snellen - Linear)

| | Right | Left |
|---|---|---|
| Dist sc | 20/25- | 20/20 |

### Pupils

| | Pupils |
|---|---|
| Right | PERRL |
| Left | PERRL |

### Visual Fields

| Left | Right |
|---|---|
| Full | Full |

### Extraocular Movement

| Right | Left |
|---|---|
| Full | Full |

### Neuro/Psych

Oriented x3: Yes

Edited by: Jeanne Hitsman, COA

## Slit Lamp and Fundus Exam

### External Exam

| | Right | Left |
|---|---|---|
| External | Nose broken and deformed as prior | |

### Slit Lamp Exam

| | Right | Left |
|---|---|---|
| Lids/Lashes | good blink no lag: tarsorrhaphy and weight in good position, no edema or erythema: Blink is still slow but improving gradually: Based on asymmetry now would NOT remove either of the two procedures on the right eyelids | Normal |
| Conjunctiva/Sclera | minimal tear lake | White and quiet |
| Cornea | clear without PEE or abrasion | Clear |
| Anterior Chamber | Deep and quiet | Deep and quiet |
| Iris | Round and reactive | Round and reactive |
| Lens | 1+ NS | 1+ NS |

Edited by: Catherine Cuite, MD

## Problem List

as of 8/23/2022

Tympanic membrane perforation, right
Dysfunction of right eustachian tube
Facial paralysis on right side
Facial pain
Sinus pressure
Nasal congestion
Deviated nasal septum
Diabetes mellitus type 2 without retinopathy (CMS/HCC)
Multiple fractures of facial bones (CMS/HCC)
Traumatic brain injury with loss of consciousness (CMS/HCC)

Exposure keratitis
Closed head injury

## Visit Diagnoses

| | Codes | Comments |
|---|---|---|
| Facial paresis - Primary | ICD-10-CM: G51.0<br>ICD-9-CM: 351.0 | |
| Facial trauma, sequela | ICD-10-CM: S09.93XS<br>ICD-9-CM: 908.9 | |
| Lagophthalmos, paralytic, right | ICD-10-CM: H02.233<br>ICD-9-CM: 374.21 | |
| Closed fracture of nasal bone with delayed healing, subsequent encounter | ICD-10-CM: S02.2XXG<br>ICD-9-CM: V54.19 | |

## Progress Notes

### Catherine Cuite, MD

Status: Signed

**1. Facial paresis**
Right
After work injury
May be permanent
Will hope for recovery especially during this first yeart

**2. Facial trauma, sequela**
Nasal fracture see 4
Causing facial nerve paralysis
Per patient there is also Jaw and palate injury

Patient is comfortable enough today to do a field of vision
Explained purpose of baseline field

**3. Lagophthalmos, paralytic, right**
Causing corneal ulceration in the past and requiring both tarsorrhaphy and weight.
May in the future be able to take down the tarsorrhaphy and or remove this weight if his recovery is complete enough: these procedures would of course be included under his workers compensation
IF it never recovers he will need lifetime care for this injury
Would not evaluate for opening or removal for another 6 months or so: client should be allowed this long before decision made based on rate of nerve recovery
Continue to use drops
Be aware that as the weather gets colder he may need to change from drops to gels or ointments

**4. Closed fracture of nasal bone with delayed healing, subsequent encounter**
Return to Dr Rao for nasal evaluation and reconstruction as appropriate
First will get OMF consulation and repair of jaw prior to nasal work per request of the nasal surgery specialist

Referral to OMF awaited eagerly, no appointment exists as of today. Not sure why the delay.
Knee was also injured per patient and has no appointment for that repair either.

Electronically signed by Catherine Cuite, MD at 8/23/2022 10:24 AM

## Orders Placed in This Encounter

Normal Orders This Visit

Automated Visual Field, Intermediate - OU - Both Eyes

Questions:

Type:

Strategy:

## Instructions

After Visit Summary (Automatic SnapShot taken 8/23/2022)

Encounter electronically signed by Catherine Cuite, MD at 8/23/2022 10:24 AM

| | | |
|---|---|---|
| STATE OF SOUTH CAROLINA | ) | BEFORE THE SOUTH CAROLINA |
| | ) | WORKERS' COMPENSATION COMMISSION |
| COUNTY OF YORK | ) | |
| | ) | |
| Hector Vasquez-Lopez, | ) | |
| Claimant, | ) | |
| | ) | |
| -vs- | ) | **Brief of Claimant/Appellant** |
| Ox Paper Tube & Core LLC | ) | |
| Employer, | ) | **to the Full Commission** |
| | ) | |
| and | ) | |
| | ) | WCC FILE #: 2202001 |
| Berkshire Hathaway. Homestate Insurance Company, | ) | |
| Carrier, | ) | |
| | ) | |
| Defendants. | ) | |
| | ) | |

## STATEMENT OF THE CASE

Claimant, Hector Vasquez-Lopez, was catastrophically injured at work on February 18, 2022, after being crushed by a 500lb roll of paper. The claimant's injuries included a severe brain injury with multiple intracranial hemorrhages, including subdural and subarachnoid hemorrhages. Post-injury MRIs later confirmed encephalomalacia (permanent brain damage). Complications from the brain injury included partial right-sided facial paralysis, dysphagia, headaches, dizziness, unsteadiness, and cognitive, vestibular, and short-term memory deficits. The claimant also sustained multiple poly-trauma fractures and injuries, including nasal valve collapse, closed fracture of the nasal, cribriform plate fracture, right corneal ulceration, skull fractures, temporal bone fracture, lateral tibial plateau fracture of the right leg, bilateral shoulder injuries each requiring surgical intervention, neck injury, low back injury, and numerous dental injuries restricting Mr. Vasquez to only eating food that has been pureed in a blender, which remains the case today.

Mr. Vasquez was eventually discharged home from the hospital on March 03, 2022. Since discharge, Claimant has required attendant care for assistance with his ADLs. The claimant initially required 24 hours of care as recommended by the authorized treating brain injury specialist, Dr. Desai, however as of the date of the 10/19/22 single commissioner hearing,

the extent of attendant care recommended by Dr. Desai was reduced to waking hours only from 6:00 a.m. to 9:00 p.m. or 15 hours a day. The claimant's longtime partner – Julianna Roldan-Dimas, quit her full-time job at Black and Decker to provide this care since Claimant returned home from the hospital. At some point, Defendants offered to provide the attendant care through a licensed nurse, nursing aid, or licensed professional caregiver; however, Claimant was unable to accept this offer and thus declined due to various reasons outlined in detail below. Thereafter, the Claimant filed a Form 50 request for hearing seeking payment on behalf of his longtime partner, Julianna Roldan-Dimas, for past rendered non-professional attendant care services and for ongoing future attendant care services at a rate of $14.21 per hour. The claimant specifically requested Ms. Roldan-Dimas be paid for the care as opposed to a stranger chosen by the insurance company for the following reasons:

1. The claimant is in a loving, long-term relationship with Ms. Roldan-Dimas and prefers Ms. Roldan-Dimas provide the care, as he trusts her and is most comfortable with her.
2. The claimant is non-English speaking and thus can easily communicate his needs or issues to Ms. Roldan-Dimas. All previous home health aides were English-speaking only.
3. Dr. Desai, the Defendants' chosen authorized treating brain injury physician, testified in her deposition that Ms. Roldan-Dimas is clearly capable of providing the level of needed care and that it is medically preferable to have a loved one or family member provide the care as opposed to a stranger, as a patient's recovery is often better when surrounded, supported, and cared for by a loved one.
4. The claimant and Ms. Roldan-Dimas both live in a home owned by her daughter Julianna and Julianna's husband, Juan. Also, in the home lives Julianna's two young daughters ages 5 and 8, and Ms. Roldan-Dimas' son. Julianna (the homeowner) testified that they would not allow an unknown third-party caregiver to be in their home from 6:00 a.m. - 9:00 p.m., seven days a week, for various reasons, all of which are understandable.

Defendants then timely filed a Form 51 denying payment to Ms. Roldan-Dimas for her

attendant care services. Defendants offered a kitchen sink defense arguing various positions outlined in their legal brief that was submitted at the hearing, including:

1. Non-professional attendant/supervisory care services are not considered "treatment or medical care or treatment" despite being recommended by the authorized treating/attending physician.
2. Dr. Desai's (authorized brain injury specialist) opinions should be dismissed because she was unaware of Ms. Roldan-Dimas' level of education.
3. If the Commission determines attendant/supervisory care is considered "medical care or treatment" pursuant to 42-15-60(A), it must be with a licensed and skilled medical provider chosen by the Defendants.
4. If the Commission awards non-professional attendant care payments to Ms. Roldan-Dimas, it should only be up to the amount annual amount of what she was earning as a factory worker, working 40 hours a week - - instead based on the amount of hourly care she was actually providing which is 105 hours per week.

A hearing was held on the attendant care issue on October 19, 2022. Before the hearing, the parties resolved the issue regarding entitlement and the amount owed for past attendant care services. Thus, the only issue before the single commissioner was whether Ms. Roldan-Dimas was entitled to ongoing payments of attendant care services provided to the Claimant as recommended by his authorized treating brain injury physician.

On May 23, 2023, the Single Commissioner issued an Order with various findings and conclusions, which essentially held that 42-15-60(A) only provides statutory authority to award attendant care payments to a licensed professional caregiver and that allowing payment to a non-professional family member would create a "liability conundrum."

Thereafter, Claimant timely filed a Form 30 asserting numerous errors of law and fact, which serve as the basis for this appeal.

## STATEMENT OF FACTS

Claimant, Hector Vasquez-Lopez, was catastrophically injured at work on February 18, 2022, after being crushed by a 500lb roll of paper. Mr. Vasquez-Lopez's injuries included a severe brain injury with multiple intracranial hemorrhages, including subdural and subarachnoid hemorrhages. Post-injury MRIs later confirmed encephalomalacia (permanent brain damage) to various regions of his brain. Complications from the brain injury included partial right-sided facial paralysis, dysphagia, headaches, dizziness, gait unsteadiness, and cognitive, vestibular, and short-term memory deficits. The claimant also sustained multiple poly-trauma fractures and injuries, including nasal valve collapse, closed fracture of the nasal, cribriform plate fracture, right corneal ulceration, skull fractures, temporal bone fracture, lateral tibial plateau fracture of the right leg, bilateral shoulder injuries each requiring surgical intervention, neck injury, low back injury, and numerous dental injuries restricting Mr. Vasquez only to eat food that has been pureed in a blender, which is still required to this day.

Upon hospital discharge, Claimant's longtime partner Ms. Roldan-Dimas quit her full-time job of 8 years at Black & Decker to care for Claimant (Hrg. Tr. Pg 18). On April 16, 2022, Dr. Sima Desai, the authorized treating brain injury specialist, opined Claimant required 24-hour attendant care. Dr. Desai also opined that Ms. Roldan-Dimas was capable of providing that care. (Cl. APA pg. 161-162).

Due to the catastrophic nature of Claimant's injuries, care services provided by Ms. Roldan-Dimas initially included assistance with medication management for Claimant's various medications, which he required throughout both the day and night, including consistent application of eye drops to his right eye so it would not dry out as his facial paralysis prevented his ability to close the eye; assisting Claimant to and from the bathroom; bathing Claimant; cooking and then pureeing all of Claimant's food so he can eat; assisting Claimant with getting in and out of bed and safely moving around the house; dressing Claimant; and driving Claimant to all medical appointments and pharmacy pick-ups. (Roldan-Dimas Depo. Pg. 29:8-17, 30: 1-32:3; *see also* D&O Finding of Fact #7)

Following discharge, the worker's compensation carrier provided home health nurses to teach Ms. Roldan-Dimas how to care for Claimant safely. This included teaching proper medication management, safe transfer of positions, gait assistance, nutritional guidance, and safety precautions to avoid falls, among other things. (*See* Claimant APA 2 generally). The home health nurses also would check Claimant's vital signs, evaluate his physical condition, and help monitor his blood sugar levels due to his pre-existing diabetes (Id*)*. The records indicate these visits would last between 45 minutes to 1 hour each day, and the remainder of the care that day would be provided by Ms. Roldan-Dimas. At no point during these visits did any of the home health nurses express concern about Ms. Roldan-Dimas' quality of care, and on March 29, 2022, it was expressly noted that the therapist had no concerns with the care plan being provided. (*See Cl. APA p. 84)*. On March 31, 2022, the home health note indicates the caregiver, Ms. Roldan-Dimas, had achieved all the patient caregiver goals. (Cl. APA p. 94; Def. APA pgs. 400-403). Additionally, it is essential to note that Ms. Roldan-Dimas testified that none of the home healthcare givers spoke Spanish. As such, Ms. Roldan-Dimas had to make sure her daughter or son was present to serve as an interpreter for her and Claimant. (Hrg. Tr. p. 19)

On September 12, 2022, Defendant took the deposition of Dr. Sima Desai. Dr. Desai is a double board-certified physiatrist in physical medicine rehabilitation and brain injury medicine. (Desai Depo pg. 8). Dr. Desai testified that Claimant initially needed 24-hour attendant care; however, as of the date of the deposition, he had progressed to the point where only attendant care during waking hours was needed. (Desai Depo. p. 40: 1-6). Dr. Desai also testified that Mr. Vasquez did not need skilled nursing care but someone to supervise him, assist with ADLs, and ensure he doesn't fall. (Desai Depo p. 24). Dr. Desai testified that Ms. Roldan-Dimas could provide this care and had been doing so successfully for the six months since the injury. (Desai Depo pgs. 26, 28, 38-41). Additionally, Dr. Desai opined Ms. Roldan-Dimas is the preferred caregiver from a medical standpoint for a variety of reasons, including 1) She is a competent caregiver; 2) She speaks Spanish; 3) Mr. Vasquez is comfortable with her and prefers to have her present; 4) Patients recover better when being cared for by people they know and love. (Desai Depo pgs. 38-39 and p. 48).

Finally, at the hearing, Andrea Angeles-Roldan testified. Andrea is the daughter of Ms. Roldan-Dimas and considers Claimant to be her father though they are not biologically related.

Andrea testified that she and her husband, Juan, own the home where Claimant and Ms. Roldan-Dimas reside. Andrea's two young daughters, ages 8 and 5, and her younger brother also stay there. (Hrg. Tr. p. 43). Andrea testified that she used to work full-time, as her mother, Ms. Roldan-Dimas, would help watch the girls when needed. After the accident, her mother became fully occupied caring for Claimant. Thus Andrea had to reduce her work schedule to watch the children. (Hrg. Tr. p. 42-44). Andrea testified that Ms. Roldan-Dimas discussed allowing outside caregivers to watch over Claimant; however, Andrea and her husband would not allow it. Andrea testified that neither she nor Juan was comfortable having strangers in their house all day, every day. Andrea testified that when she was younger, she was sexually abused. As a result, she does not like having people over and is highly protective of her daughters being around strangers. (Hrg. Tr. p. 45). Andrea testified that it is awkward having a stranger around all the time, and even just having the initial home health nurses come in and stay for 45 minutes to 1 hour several days a week disrupted their family atmosphere and negatively affected her daughters. (Hrg. Tr. p. 46-47).

**Allegations of Error**

On May 30, 2023, Claimant timely filed a Form 30 alleging the errors of fact and law, challenging Findings of Facts #23, #32 and Conclusions of Law #8, #10, #11, #13, #14, #15, #18, #19, #20, and #21. The challenges made to the Single Commissioner Order can be summarized as to allege:

1. As a matter of law, the Single Commissioner erred in Finding 42-15-60(A) limits attendant care only to licensed professional services.

2. The Single Commissioner erred in failing to find Claimant was justified in declining licensed outside attendant care services and ordering payment of those services to Ms. Roldan-Dimas, as any other finding is not supported by the preponderance of the evidence in the record.

## Argument

### I. The Commission has the Authority to Order Non-Professional Attendant Care Under 42-15-60(A)

The Single Commissioner's restrictive interpretation that 42-15-60(A) prohibits non-professional or unlicensed attendant/supervisory care is an error of law and not supported by the case law, which broadly interprets the authority provided under 42-15-60(A), which reads:

> "The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty. In addition to it, the original artificial members as reasonably may be necessary must be provided by the employer. **During any period of disability resulting from the injury, the employer, at his own option, may continue to furnish or cause to be furnished, free of charge to the employee, and the employee shall accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician unless otherwise ordered by the commission for good cause shown. The refusal of an employee to accept any medical, hospital, surgical, or other treatment or evaluation when provided by the employer or ordered by the commission bars the employee from further compensation until the refusal ceases and compensation is not paid for the period of refusal unless, in the opinion of the commission, the circumstances justified the refusal, in which case the commission may order a change in the medical or hospital service.** If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission."

#### A. Dr. Desai, Authorized Attending Physician, Ordered Non-Professional Attendant Care Provided by Ms. Roldan-Dimas as necessary.

The statute clearly reads, "*In a case of disability from an injury, the employer shall furnish, and the employee shall accept an attending physician and any medical care or [other] treatment that is considered necessary by the physician.*" In the current case, the employer furnished Dr. Desai as the attending physician double board certified in physical rehabilitation medicine and brain injury medicine and focuses most of her practice on treating brain-injured patients.

Dr. Desai opined that the Claimant requires attendant/supervisory care and recommended that his significant other, Ms. Roldan-Dimas provide the care. Dr. Desai provided numerous reasons that Ms. Roldan Dimas is better suited and medically preferable to provide this care than a licensed stranger. Dr. Desai's reasons included Ms. Roldan-Dimas 1) is a competent caregiver; 2) speaks Spanish and can communicate needs and concerns directly with Claimant; 3) The Claimant is comfortable with her and prefers to have her present; 4) Patients recover better when

being cared for by people they know and love. (Desai Depo pgs. 38-39 and pg. 48).

**B. Neither 42-15-60(A) nor 42-15-60(C) make any distinction between licensed professional care and non-professional care**

The Commissioner somehow reads 42-15-60(A) to only apply to licensed professional attendant/supervisory care; however, such a requirement is nowhere in the statute. The statute clearly reads that as long as the attending physician recommends the care or treatment as medically necessary, the Defendants must provide it. In this case, the recommended care is non-professional attendant care provided by his significant other. Additionally, it is essential to note that both the Defendants and the Single Commissioner acknowledge that non-professional attendant care is allowed under 42-15-60(c). However, as in 42-15-60(A), the distinction or mention of professional vs. non-professional care is found nowhere.

The claimant's position is further strengthened beyond just the plain and ordinary reading of the statute when looking at case law that displays the broad authority the appellant courts have interpreted 42-15-60(A) to have. One example is the SC Court of Appeals opinion in Harrison v. SC Opinion No. 2021-UP-117. While Claimant recognizes this case is unpublished and has no binding authority, it does clearly reflect how broadly the appellate courts interpret the language in 42-16-60(A). In Harrison, the Claimant sustained significant injuries and required home modification to include stair lifts or elevators placed in his home and modifications to his bathrooms, which his attending physician deemed medically necessary. Defendants agreed to provide modifications to Claimant's primary home under 42-15-60(A) but refused to provide the modifications to his secondary beach home where Claimant planned to retire. The Commission initially found that "modifications to Claimant's second home are not a reasonable and necessary medical cost under Section 42-15-60(A)". The Court of Appeals subsequently reversed, noting "modifications to claimant's second home are contemplated by the worker's compensation act as reasonable and necessary medical costs" as contemplated under 42-15-60(A).

It is inconceivable to argue that the "reasonable and necessary medical care" language under 42-15-60(A) allows construction modifications to an injured worker's secondary beach home. Still, it does not cover non-professional medical services deemed medically necessary by the Defendant's chosen physician for a catastrophic brain-injured worker that now requires assistance and supervision with most of his activities of daily living.

Additional support comes from the case of Thompson v. S.C. Steel Erectors 396. SC.606 (1997). In Thompson, the Claimant sustained a spinal cord injury rendering him a paraplegic. The factual recital in the case states, "Steel Erectors admitted the accident...began paying [Thompson] weekly benefits of $507.34, as well $1,000.00 per month to Thompson's wife to aid with his care." Thompson then later filed a Form 50-request for hearing alleging he was permanent and totally disabled under 42-9-10(c), seeking lifetime benefits and also seeking home modifications. Defendants ultimately admitted Thompson was entitled to lifetime benefits. However, they disputed the extent of home modifications. Though perhaps not directly on point, which arguably is only because the Defendants in Thompson did not dispute their obligation under 42-15-60(A) to provide non-professional attendant care payments, Thompson does serve as an example of attendant care payments being made to a spouse before the Claimant being at MMI and being found permanently and totally disabled.

Another case that supports 42-15-60(A) allows for non-professional attendant care is the appeal to the Circuit Court in Andrew McDaniel vs. Hans Lenger, LLC[1]. In McDaniel, the Circuit reversed the Full Commission order and awarded future attendant care payments to Claimant's wife after Claimant sustained a severe brain injury. Interestingly, the Circuit also reversed the Full Commission's denial of payment for past rendered non-professional/spousal attendant care services, noting Claimant's wife was entitled to attendant care payments from the date Claimant was discharged home from the rehab facility. Presumably, Claimant was not yet at MMI at the time of his initial discharge from the hospital, yet benefits were still owed, which thus would have been paid pursuant to 42-15-60(A).

The Single Commissioner tries to further reason his decision in Conclusions of Law 8-13 by noting 42-15-60(c) specifically mentions "reasonable and necessary nursing services" while 42-15-60(A) does not. While that is true, neither subsection makes any mention of professional/licensed services vs. non-professional services. The claimant would further point out that 42-15-60(c) specifically references "Medicines, nursing services, prosthetics, sick travel" while 42-15-60(A) does not. To accept the single commissioner's interpretation that 42-15-60(A) does not cover non-professional attendant care since "nursing services" is referenced in 42-15-

[1] In Conclusion of Law 18, The Single Commissioner disregards McDaniel in part by concluding McDaniel was an Appellate Panel order which is not binding. The McDaniel Order was a Circuit Order reversing the Appellate Panel.

60(C) but not in part 42-15-60(A) - - the Commission would also have to accept the same argument and interpretation that "necessary nursing services, prosthetics, medicines, and sick travel" are not covered under 42-15-60(A) since they are not specifically referenced in that subsection like they are in 42-15-60(C), and thus are only covered once a Claimant is at MMI and deemed permanently and totally disabled. Such interpretation is in direct contradiction to well-established law.

In conclusion, non-professional attendant care services have been ordered as medically necessary by the Defendant's chosen attending brain injury physician. Any care, including non-professional attendant care, that has been deemed medically necessary and ordered by the attending physician is considered "medical care or treatment" or "other treatment" as contemplated within 42-15-60(A). The claimant has pointed the Commission's attention to cases that illustrate the Court's broad interpretation of "medical care and other treatment" in this subsection. Furthermore, the defendants cannot point to any cases that hold 42-15-60(A) does not apply non-professional care.

## II. Claimant has shown good cause for refusing Defendant's offer for 3rd party attendant care and requesting Commission order care be provided by his significant other

Once the Commission determines that 42-15-60(A) grants the authority to award non-professional care, the Court should find that the Claimant is justified in declining the offered professional care and that good cause exists to award payment to Ms. Rolden-Dimas. As noted above, 42-15-60(A) states in pertinent part:

> "……**and the employee shall accept, an attending physician and any medical care or treatment considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown.**

The statute goes on to read:

> "…..**The refusal of an employee to accept any medical, hospital, surgical, or other treatment or evaluation when provided by the employer or ordered by the commission bars the employee from further compensation until the refusal ceases and compensation is not paid for the period of refusal unless, in the opinion of the commission, the circumstances justified the refusal, in which case the commission may order a change in the medical or hospital service.**"

The claimant and Ms. Rolden-Dimas live in a home owned by Julianna's daughter, Andrea Angeles-Roldan, and her husband, Juan. Andrea's two young daughters also live there, along with her younger brother. In short, five adults and two minors live in a modest three-bedroom single-family residence.

Andrea, the homeowner, testified that she and her husband would not allow a rotation of unknown strangers in their home for all waking hours, particularly when she has young children in the home. Andrea also testified that she was sexually abused as a child, and because of the abuse, she is extremely weary of letting strangers in her home or around her family. It is indeed an understandable, reasonable, and justifiable position for Andrea and her husband. It is easy to understand how much unnecessary awkwardness and tension would accompany a constant rotation of caregiving strangers surrounding this close-knit family during all waking hours. Andrea testified that simply having the initial home health nurses in her home for 45 minutes a day, several days a week, for two months was enough to affect her small children and their family environment negatively.

Furthermore, the Claimant cannot accept and thus cannot unjustifiably refuse in-home care from a licensed 3rd party when Claimant does not own the home. The actual homeowners will not allow these 3rd parties in their home during all waking hours, every single day.

Additionally, Dr. Desai testified that it is medically preferable and better for Claimant's recovery to be cared for by a loved one as opposed to some unknown caregiver, regardless of whether they are licensed or not. Put another way; it is more medically beneficial for the Claimant to have care provided by Ms. Roldan-Dimas than care provided by some revolving door of unknown professional caregivers.

Another important consideration is that Claimant and Ms. Rolden-Dimas only speak Spanish. Upon the Claimant's initial discharge home, the Defendants sent home health aides to evaluate Mr. Vasquez-Lopez's medical needs, and none of these home health therapists spoke Spanish. Thus, Andrea or her younger brother had to ensure they were available to serve as an interpreter. The language barrier is yet another reason for good cause.

Finally, and perhaps most importantly, the Claimant very much wants his long-time loving partner to care for him instead of some rotation of unknown licensed caregivers. Claimant has sustained catastrophic and permanently life-altering injuries. Claimant's life and the lives of his

entire family have been turned upside down and changed forever. To this day, the Claimant requires certain assistance with bathing or using the restroom. To require that assistance be provided by various unknown 3rd party caregivers instead of his willing longtime partner serves only to unnecessarily humiliate a man already grappling with having his life completely turned upside down. It is reasonable for the Commission to consider what the injured party wants, and Claimant wants his long-time loving partner to be alongside him and provide the care he needs.

## III. The Single Commissioners Finding in Conclusion of Law 20 that Ordering Non-Professional Unskilled Care Before MMI Could Complicate Liability for Subsequent Injury; Create an Employer/Employee relationship; and Create an Accountability gap in Monitoring Claimant's progress is an Error of Both Fact and Law Unsupported by any Evidence in the Record.

### A. The ordering of non-professional care before MMI does not complicate liability for subsequent injury.

Defendants argue, and the Single Commissioner found, that awarding non-professional attendant care before MMI somehow could create liability complications for any subsequent injury. No explanation or reasoning was given to explain this finding; thus, responding is somewhat difficult. However, the Appellant will attempt.

The concern lies with who would bear the liability if the Claimant was injured while receiving non-professional attendant care. First, any subsequent injury the Claimant incurs while receiving treatment for work injuries is considered compensable and the employer's responsibility.

If the caregiver's negligence somehow caused those injuries, then Claimant would also have a 3rd party negligence claim against the caregiver, and the worker's compensation carrier would have a subrogation lien against a portion of the proceeds recovered from the 3rd party claim. That remains true regardless of whether the caregiver is a nonprofessional family member or a licensed medical provider. If the claimant is injured due to the negligence of Ms. Roldan-Dimas, Claimant would have a viable negligence claim against her, just like he would against any other 3rd party defendant, regardless of what certifications they have. Interfamily negligence lawsuits occur routinely. If the Claimant chose not to bring a negligence lawsuit against her, under 42-1-560, the worker's compensation carrier could bring the claim against her on behalf of the Claimant. Additionally, it is unclear why this concern seems to only exist before the Claimant is at MMI, but

once he is at MMI and care is provided per 42-15-60(c), the concern disappears. However, any potential "liability conundrum" remains.

**B. A non-professional caregiver does create an employee/employer relationship between the caregiver and employer/carrier.**

The single commissioner also incorrectly finds that somehow by awarding Ms. Roldan-Dimas payment for her non-professional care services to Claimant, there could become an employment relationship between Mr. Roldan-Dimas and the Defendant employer, Ox Paper Tube & Core. First, the payments made to Ms. Roldan-Dimas would be made by the worker's compensation insurance carrier, not Ox Paper Tube.

Secondly, providing payment to Ms. Roldan-Dimas is no different than providing payment to any other treatment provider. I would submit that all parties agree that under no circumstance would the worker's compensation carrier's payment to Dr. Desai for the treatment she has been providing the Claimant make Dr. Desai an employee of either Defendant employer or carrier.

Thirdly, it is undisputed that non-professional attendant care benefits are covered under 42-15-60(C). If this potential conflict of an employer/employee relationship argument had any viability whatsoever, that conflict would still occur under 42-15-60(c), which it does not. This finding and consideration is clear error.

**C. Ms. Roldan-Dimas' inability to speak English does not affect her ability to document or monitor the Claimant's medical care and is wholly unsupported by any evidence in the record**

Finally, the Single Commissioner's finding that Ms. Roldan-Dimas' inability to speak or write in English could somehow create an accountability gap and complicate the ability to monitor his progress is unsupported by any evidence in the record. The only evidence in the record shows Ms. Roldan-Dimas can monitor and document Claimant's status in Spanish and did so successfully when she was logging Claimant's daily blood sugar levels, which became uncontrolled following the accident. (*See* Roldan-Dimas Depo p. 22:23-23-10). This is further confirmed by the home health notes, which indicate the patient caregiver, i.e., Ms. Roldan-Dimas met all goals, including successfully demonstrating "neurologic medication purpose, correct technique, proactive adjustments....activity engagement, **monitoring and integration of ongoing home program.**

*(See Cl. APA pg. 94).* Furthermore, the Claimant's progress is monitored adequately by the numerous therapists and doctors he sees multiple days every week, with no one expressing concern regarding Ms. Roldan-Dimas' quality of care. (Hrg. Tr. Pg. 21). Additionally, Dr. Desai, who ordered the attendant care, testified that Ms. Roldan-Dimas is competent and capable of providing the care she has successfully been doing independently since Claimant was discharged from the hospital. (Desai Depo p. 12:22-25, p. 13:1-13, p. 26:12-22, p. 27:19-28:1-3 and *see also* Single Commissioner D&O Findings of Fact 10-13). Finally, no doctor has recommended or ordered that there be formal documentation for the type of care Ms. Roldan-Dimas is providing Claimant.

D. **Ordering payment for non-professional care to Ms. Roldan-Dimas benefits both Claimant and Defendant alike, while refusal to award the payment provides a windfall.**

Awarding payment for non-professional attendant care to Ms. Roldan-Dimas instead of an outside licensed and skilled professional, as ordered by the single commissioner, is mutually beneficial to both parties. As the record reflects, before Claimant's injury Ms. Roldan-Dimas worked full-time at a job she had held for over eight years. Following the Claimant's injury, Ms. Roldan-Dimas felt compelled to quit her job to provide her husband with the needed care.

Both parties agree that the average payment for a non-professional caregiver like Ms. Roldan-Dimas is about $14.41 per hour. As one might expect, the hourly wage for a skilled home health LPN is approximately $27.00 per hour, and an RN is between $40.00-$50.00 per hour. One must then ask, why would the insurance carrier agree to pay for care at $27.00 per hour but refuse to pay Ms. Roldan-Dimas a rate half of that? Claimant submits that the reason is the worker's compensation insurance carrier has been fully aware, since Claimant's discharge home, that Claimant did not wish to have an unknown 3rd party provide care for him at all waking hours of the day, Nor could he accept the care even if he wanted to due to his living arrangement at his daughter's home. In essence, the carrier has taken its current position, refusing to pay Ms. Roldan-Dimas to obtain a financial windfall by avoiding payment of any home care at all.

Conclusion

In Conclusion, the plain language of 42-15-60(A) allows payment for non-professional care provided by loved ones when such care has been ordered by the attending physician provided

by the Defendant. In the current case, Dr. Desai ordered non-professional care because it is medically necessary and opined that Ms. Roldan-Dimas is the most suitable provider for the abovementioned reasons. Additionally, for numerous reasons outlined above, specifically the fact that the homeowners where Claimant resides have prohibited him from accepting outside professional care, good cause exists to order payments to Ms. Roldan-Dimas.

Finally, the refusal to award payments to Ms. Roldan-Dimas and only authorize payment to an outside 3rd party provides a windfall to the Carrier as they do not have to pay for a medically needed benefit for which the Claimant otherwise cannot accept. Thus, Ms. Roldan-Dimas is forced to remain out of gainful employment and provide this care for free, while the Carrier can avoid payment for these services altogether.

Respectfully Submitted,

Andrew W. Creech

DEFENDANTS'/RESPONDENTS' BRIEF

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 2202001

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|---|---|---|
| Hector Lopez- Vasquez | ……. | Claimant/Appellant |
| | vs. | |
| Ox Paper Tube & Core Carolina, LLC, Employer, and Berkshire Hathaway Homestate Insurance Company, Carrier | ……. | Defendants/Respondents |

APPEARANCES: Defendants/Respondents represented by:

Amity S. Edmonds
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DECISION AND ORDER: May 23, 2023

HEARING HELD: October 19, 2022

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## STATEMENT OF CASE

This claim arises out of an admitted work accident occurring on February 18, 2022, resulting in multiple injuries, including intercranial hemorrhages, facial fractures, and traumatic brain injury. The claimant was initially hospitalized before being discharged on March 2, 2022. That same day, Defendants provided the claimant with a Home Health Assessment with Rock Hill Kindred at Home, wherein his home health needs were evaluated. Defendants authorized and provided Home Health as recommended. *See generally* (Claimant's APA 2).

The claimant presented for his first post-operative evaluation with Dr. Desai, the authorized treating physical medical specialist, on March 17, 2022. Dr. Desai evaluated his various injuries and recommended multiple referrals to other specialists to treat and evaluate his injuries. Although she made various referrals for treatment with other specialties, Dr. Desai did not make any recommendation for home health attendant care. (Claimant's APA, pp. 156-160).

Subsequently, and without seeing the claimant again, on April 6, 2022, the claimant obtained a medical questionnaire from Dr. Desai, indicating he required 24/7 attendant care. Specifically, Dr. Desai checked "yes" to questions asking whether the claimant required 24-hour attendant care, 7 days per week, and whether the claimant's "significant other, Ms. Julianna Roldan-Dimas, is capable of providing the required 24-hour attendant care" to the claimant. (Claimant's APA, pp. 161-162). Upon receipt, Defendants offered to provide 24/7 attendant care with a professional home health nurse; however, the claimant declined to accept this treatment as he insisted he preferred Defendants to pay his fiancé, Juliana Roldan-Dimas, an hourly rate to provide the recommended 24/7 attendant care.

There is no disputing Defendants consistently offered, and the claimant consistently declined, professional home health care as recommended by Dr. Desai. On April 26, 2022, the claimant filed a Form 50, Request for Hearing, wherein they checked box 7(b) indicating they were seeking "additional medical examination and treatment," consisting of 24-hour attendant care for the claimant. They also confirmed in the Form 50 that, "Claimant declined outside 3rd party care [offered by Defendants]" as he and Ms. Roldan-Dimas "agreed it would be best for [Ms. Roldan-Dimas] to care for [Claimant's] needs." As such, they alleged "Ms. Roldan-Dimas is entitled to payment for the care she is providing."

Defendants subsequently timely filed a Form 51, denying the claimant was entitled to any additional medical treatment as Defendants had authorized all causally related medical treatment

to which he was entitled. Prior to the hearing, the claimant and Defendants resolved the claimant's entitlement to attendant care through the hearing date pursuant to a Consent Order.

A hearing was held on October 19, 2022, with the only issue being whether the Commission would allow Defendants to retain their statutory right to direct medical care pursuant to S.C. Code Ann. § 42-15-60(A) for any attendant care needs to which the claimant was entitled, or whether the Commission would order Defendants to compensate the claimant's fiancé, Ms. Roldan-Dimas, for providing attendant care as requested by the claimant. The parties agreed the claimant was not at maximum medical improvement and, therefore § 42-15-60(C) was not applicable. Accordingly, any award of medical benefits was governed by subsection (A).

At the hearing, Defendants acknowledged the claimant was entitled to attendant care. However, Defendants contended they retained the right to control medical care and any such attendant care should be provided by a licensed, skilled, and trained medical professional of their choosing pursuant S.C. Code Ann. § 42-15-60(A). Specifically, Defendants argued that since the claimant had not yet been deemed to have sustained permanent and total disability, the Commission must award medical treatment pursuant to S.C. Code Ann. § 42-15-60(A), which limits the treatment available to "medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be necessary." It was Defendants' position that because the claimant's fiancé, Ms. Roldan-Dimas, was not qualified to provide medical services or treatment pursuant to section 42-15-60(A), the Commission was without authority to Order Defendants to compensate Ms. Roldan-Dimas for providing non-professional attendant care. Ms. Roldan-Dimas is only 9$^{th}$ grade educated, admitted she only understands a little English, is not capable of reading English, and has no medical or first aid training. (Roldan-Dimas Dep. 19:8-11). Accordingly, Defendants contended she was not qualified to provide "medical, surgical, hospital, and other treatment," under section 42-15-60.

Defendants also argued they retained the right to direct medical care under the Act and that while the Commission has the authority to order treatment other than that provided by the carrier for good cause shown, this statutory authority is limited to situations where "in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the Commission." S.C. Code § 42-15-60(A)(emphasis added). Importantly, not only was there no evidence of an

emergency warranting Defendants' statutory right to direct care being stripped away, the record was entirely devoid of any medical opinion stating the claimant's condition would be worsened in any way if his attendant care needs were provided by a licensed, trained professional, as Defendants requested.

Moreover, Defendants argued that Dr. Desai's opinions on whether Ms. Roldan-Dimas was qualified to provide attendant care for the claimant, on which the claimant so heavily relied, failed to meet the expert standards as required under *Young v. Tide Craft, Inc*., 270 S.C. 453, 242 S.E.2d 671 (1978), as she failed to take into consideration the material facts of the case. Specifically, Dr. Desai confirmed in her September 12, 2022, deposition she had no direct knowledge of Ms. Roldan-Dimas' education, training or experience relating to providing attendant care, her ability to assist with ambulation or transfers, the claimant's diabetic condition, or Ms. Roldan-Dimas' ability to manage the claimant's diabetic condition. (Dr. Desai Dep. 26:6-22; 27:10-28:4). Likewise, Dr. Desai further acknowledged she had no knowledge of the specific care being provided to the claimant and was not aware the claimant had previously declined professional attendant care services offered by Defendants. (Dr. Desai Depo. p. 32:24-33:3). Accordingly, Defendants asked the Commission to give greater weight to the expert opinion of Dr. Maria Lopes-Virella, M.D., Ph.D., who, after reviewing the claimant's medical records and the deposition testimony of Ms. Roldan-Dimas, opined Ms. Roldan-Dimas was not a licensed health care provider and was not qualified to provide attendant care to the claimant. (Defendants' APA 22, p. 429).

Accordingly, Defendants sought an Order from the Commission finding (1) they retained the right to direct any and all medical care required for Claimant pursuant to 42-15-60(A); (2) that any necessary attendant care services required by Claimant must be provided by a licensed, skilled, medical professional; and, (3) that the claimant was limited to no more than 15 hours per day of skilled attendant care.

At the hearing, the claimant and Ms. Roldan-Dimas admitted Defendants had offered to provide a trained home health care aide as recommended by Dr. Desai, but the claimant refused to accept these professional medical services. (Hearing Tr: 30: 1-11). The claimant argued they had shown good cause for his refusal to accept medical care offered by Defendants because the claimant and Ms. Roldan-Dimas live with Ms. Roldan-Dimas' daughter, Andrea Angeles-Roldan, who was uncomfortable with having "stranger third parties" in their home to provide medical care the claimant needed to maximize his recovery. According to Andrea Angeles-

Roldan's testimony at the hearing, she and her husband did not want strangers in their home around her children, although she acknowledged she and multiple other family members were always present when her children were home. (Hearing Tr: 48:1-9).

The claimant also indicated he was more comfortable having his fiancé provide his care, than a professional home health aide. In other words, the claimant's position was that even though Defendants had offered to provide adequate medical services as recommended, because he was more comfortable with his fiancé staying home with him, the Commission should usurp Defendants' statutory right to direct medical care and order Defendants to pay a non-professional to provide medical services under section 42-15-60(A).

Even though Ms. Roldan-Dimas acknowledged she had no training in mobility techniques or even basic first aid, the claimant argued in their legal brief submitted to the Hearing Commissioner that any care, "to include non-professional attendant care, that has been deemed medically necessary and ordered by the attending physician is considered 'medical care' as outlined within 42-15-60(A)." Their argument seems to be that if a doctor orders a non-professional and unqualified individual to provide "services," those services qualify as medical treatment under the Act. Interestingly, even though Ms. Roldan-Dimas was asking to be compensated as a home health attendant, when asked at the hearing about the duties of a home health aide, she testified she had never been trained on those specific duties, but she felt she was doing a good job. (Hearing Tr: 30:18-31:25).

The claimant's argument boiled down to their belief that even though Ms. Roldan-Dimas was not a medical professional or medically trained, Defendants should be ordered to pay her almost 2.5 times what she was earning before the claimant's accident for providing "medical services" under section 42-15-60(A), because she and the claimant were more comfortable with her being paid for these services than a "third-party stranger." Prior to the claimant's accident, Ms. Roldan-Dimas was earning approximately $640.00 per week working on an assembly line at Black & Decker, for a total of approximately $33,000.00 annually. (Hearing Tr: 29:4-10). However, following the claimant's accident, Ms. Roldan-Dimas made the decision to quit her gainful full-time employment of her own accord, despite Defendants consistently offering to provide professional home health care services, and then asked the Commission to start paying her to care for the claimant. (Hearing Tr: 37:17-38:1).

At the hearing, Ms. Roldan-Dimas admitted she and the claimant were asking the Commission to require Defendants to pay her approximately $78,000.00 per year, based on

$14.41 per hour for 15 hours per day, 7 days per week. (Hearing Tr: 34:21-25). This equates to almost 2.5 times what she was earning prior to making the decision to quit her job at Black & Decker, for providing services for the claimant she was not qualified or trained to provide. Specifically, Ms. Roldan-Dimas confirmed at the hearing she had no training in medical billing, no professional liability insurance, no training in fall prevention, and no training in handling patients with vestibular deficits. (Hearing Tr. 31:3-32:5). Despite this, the claimant asked the Hearing Commissioner to order Defendants to authorize and pay for medical treatment consisting of attendant care 15-hours per day to be paid directly to Ms. Roldan-Dimas, at a rate of $14.41 per hour, for a total of approximately $78,000.00 annually.

On May 23, 2023, the Hearing Commissioner issued a Decision and Order finding the claimant was entitled to an award of attendant care pursuant to S.C. Code Ann. § 42-15-60(A)(2007, as amended), but that such care must be provided by a licensed medical professional of Defendants' choosing based upon the plain language of the statute. The Hearing Commissioner held that since the claimant had not reached MMI, an award of medical benefits must be pursuant to subsection (A), which did not contemplate non-professional unskilled services. Accordingly, the Commission was without authority to order Defendants to pay Ms. Roldan-Dimas for providing medical services. While subsection (C) includes more expansive language with regard to medical benefits which can be awarded after a finding of permanent and total disability, the Hearing Commissioner found that if the legislature intended for unskilled attendant care or unskilled nursing services to be awarded prior to a finding of permanent and total disability, it would have expressly included such a benefit in the enumerated list under subsection (A) either in 1980 when it added subsection (C), or in 2007 when it amended subsection (A). Likewise, the Hearing Commissioner held that finding a claimant's unlicensed significant other can render "treatment" pursuant to subsection (A), prior to a finding of permanent and total disability, creates a liability conundrum for Defendants should the claimant suffer a subsequent injury due to the fault of the unskilled attendant care, as Defendants would have no legal remedy or subrogation rights. Accordingly, the Hearing Commissioner held the claimant was entitled to 15 hours daily of licensed, professional in-home attendant care per day with a medical provider of Defendants' choosing, pursuant to S.C. Code Ann. § 42-15-60(A)(2007, as amended).

Thereafter, the claimant filed a Form 30, alleging the Hearing Commissioner erred in finding the Commission was without authority to order Defendants to provide unskilled attendant

care pursuant to S.C. Code Ann. § 42-15-60(A), and in failing to order Defendants to compensate Ms. Roldan-Dimas for caring for the claimant.

## STANDARD OF REVIEW

South Carolina Code Section 42-17-50 empowers the Full Commission to make its own findings of fact and to reach its own conclusions of law consistent with or inconsistent with those of the hearing Commissioner. *Green v. Raybestos-Manhattan*, 250 S.C. 58, 156 S.E.2d 318 (1967). However, an appellant must establish by a preponderance of the evidence the facts which will entitle him to an award under the Workmen's Compensation Act at the time of the original hearing. *Herndon v. Morgan Mills*, 246 S.C. 201, 143 S.E.2d 376 (1965). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel. *DeBruhl v. Kershaw Cnty. Sheriff's Dep't.*, 303 S.C. 20, 24, 397 S.E.2d 782, 785 (Ct. App. 1990).

## QUESTIONS PRESENTED

1. Whether the Hearing Commissioner correctly held the Commission is without authority to award unskilled attendant care pursuant to § 42-15-60(A)?
2. Whether the Hearing Commissioner properly concluded Defendants retained their statutory right to direct medical care pursuant to § 42-15-60(A)?
3. Whether the Hearing Commissioner correctly held Ms. Roldan-Dimas was not qualified to provide "medical, surgical, hospital, and other treatment" under § 42-15-60(A)?
4. Whether the Hearing Commissioner correctly found liability concerns outweigh the claimant's desire to have Defendants pay his fiancé as a medical provider under the Act?

## ARGUMENT

### I. The Hearing Commissioner correctly found the claimant is limited to medical treatment provided by a qualified medical provider pursuant to S.C. Code § 42-15-60(A).

There is no dispute the claimant in this case has not reached maximum medical improvement and, likewise, he has not been deemed permanently and totally disabled. Therefore, any award of medical treatment is governed by § 42-15-60(A). While the claimant argues there is no distinction between benefits allowed under subsection (A) and subsection (C), a review of the plain language in light of the legislative amendments to the statute clearly suggests otherwise.

The Hearing Commissioner found that pursuant to subsection (A), the claimant is entitled to attendant care but such care must be provided by a licensed professional, based upon the plain language of the statute. The claimant argues the Hearing Commissioner erred in failing to order non-professional attendant care because section 42-15-60 does not make any distinction between professional and non-professional care. However, the claimant mistakenly couches the issue as that of whether the Act distinguishes between professional and non-professional care. We agree the Act does not distinguish between those two phrases. The Act does, however, make a clear distinction between what the Commission is allowed to award with regard to medical treatment at various stages of a case.

If the legislature had not intended to create a distinction between the types of medical benefits that could be awarded, there would be no reason to draft an entire subsection which relates solely to cases where a claimant has been deemed permanently and totally disabled. Importantly, when the legislature amended section 42-15-60 in 2007, the various versions of the bill illustrate a clear intention to keep distinct the benefits provided in cases of lifetime medical benefits once a claimant is deemed permanent and total disability, verses those provided for in all other cases. During the 2007 amendment process, the legislature had the opportunity to use the more inclusive language of subsection (C) in subsection (A), but failed to do so.

Specifically, section § 42-15-60(A), addresses the carrier's obligation for providing treatment prior to the claimant being found permanently and totally disabled, and provides the employer/carrier shall provide "medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be necessary . . . for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty." S.C. Code Ann. § 42-15-60(A)(2007, as amended)."

On its face, the language of subsection (A) limits the Commission's authority to order only "medical . . . and other treatment," and, as aptly pointed out by the Hearing Commissioner, "[w]hat a legislature says in the text of a statute is considered the best evidence of the legislative intent or will. Therefore, courts are bound to give effect to the expressed intent of the legislature." *Hodges v. Rainey*, 341 S.C. 79, 85 (2000) (internal citations omitted). "[T]he cardinal rule of statutory construction is that the court must ascertain and effectuate the intent of the legislature and in interpreting a statute, the court must give the words their plain and ordinary meaning without resorting to a tortured construction which limits or expands the statute's

operation." *Gattis v. Murrells Inlet VFW # 10420,* 353 S.C. 100 (2006). Our Supreme Court has held, "[w]henever possible, legislative intent should be found in the plain language of the statute itself." *State v. Pitman*, 373 S.C. 527, 561 (2007) (citing *Whitner v. State*, 328 S.C. 1, 6, 492 S.E.2d 777, 779 (1997). "Where the statute's language is plain and unambiguous, and conveys a clear and definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning." *Hodges*, 341 S.C. at 85, 533 S.E.2d at 581.

In this instance, the language of subsection (A) is clear and unambiguous with regard to what treatment can be ordered, as the statute only uses the terms "medical" and "treatment," both of which on their face would be defined as services provided by a healthcare professional. To suggest the legislature intended the word "treatment" in section § 42-15-60, which is titled, "Time period medical treatment and supplies furnished," to encompass care provided by an unlicensed and untrained individual, requires a giant leap from the plain language of the statute. Such an argument should be supported by clear evidence showing an intent on the part of the legislature to broaden the scope of the statute beyond the plain language; however, the claimant has failed to provide any such evidence.

Moreover, when seeking to determine the meaning of a statute, "the Court should not concentrate on isolated phrases within the statute, but rather, read the statute as a whole and in a manner consonant and in harmony with its purpose." *Duke Energy Corp. v. South Carolina Dept. of Revenue*, 415 S.C. 351, 355 (2016). If there is any question as to whether subsection (A) limits the Commission's authority to medical professionals and medical treatment, looking to the title of section § 42-15-60,"Time period medical treatment and supplies furnished; refusal to accept medical treatment; settled claims; total and permanent disability," reinforces Defendants' position that this statute section was intended to address an injured worker's entitlement to medical treatment. Unlicensed, unskilled, and untrained services such as those the claimant is seeking the Commission to compensate his fiancé for certainly do not qualify as medical treatment from a common sense standpoint.

It is also important to point out that when reading section § 42-15-60 as a whole, it is clear the legislature intended to delineate different benefits under this statute section to individuals deemed permanently and totally disabled, verses other injured workers. Specifically, subsection (C) outlines a carrier's obligations for providing medical treatment and care in cases where the claimant has already been found permanently and totally disabled. In those cases, the carrier's obligation is much broader as it relates to medical treatment and "other care" that may

be necessary as a result of a work accident over the claimant's lifetime, as the plain language of the statute states a carrier must provide "reasonable and necessary nursing services . . . medical, hospital, and other treatment or care . . . during the life of the injured employee" S.C. Code Ann. 42-15-60(C)(2007, as amended). This provision was added by legislative amendment in 1980.

Unlike in subsection (A), subsection (C) specifically provides authority for the Commission to award "other treatment or care." The legislature chose to add an entirely different term in subsection (C), when they included other "care," which is not by definition something that can only be provided by a healthcare professional. Importantly, both subsections (A) and (C) were drafted to use the word "and" between the phrases "medical" and "other treatment," which inextricably connects the two words; however, subsection (C) added the term "or care" after "medical" and "other treatment" in the list of benefits that could be ordered after a finding of permanent and total disability. As a matter of statutory interpretation, the legislature's use of "and" connects the separate clauses of "medical" and "other treatment" together, while the use of "or" in subsection (C) evidences the legislature's intent that other "care" could encompass non-professional services, not provided for in subsection (A).

While there have been cases which have awarded non-professional attendant care to be paid by a carrier, the cases that have provided for non-professional attendant care or other non-medical treatment deal with situations where a claimant has either been found permanently and totally disabled or the parties concede they are permanently and totally disabled. Defendants are not aware of any case law interpreting § 42-15-60(A) as allowing for non-family members of an injured worker or non-professionals to be compensated for attendant care before a claimant has been deemed permanently and totally disabled. In *Pressley v. REA Const. Co., Inc.,* 374 S.C. 283 (S.C. Ct. App. 2007), the carrier admitted the claimant was permanently and totally disabled, and conceded he was entitled to lifetime medical benefits. The issue, however, was whether the claimant's mother was entitled to compensation for providing non-professional attendant care. Ultimately, the Court of Appeals held that under § 42-15-60, an injured employee is entitled to receive "reasonable and necessary nursing services," which permitted the Commission to award non-professional attendant care in that case. Notably, however, the "reasonable and necessary nursing services" provision is only mentioned in subsection (C) which, again, only pertains to cases where a claimant has been deemed permanently and totally disabled.

The claimant also relies on various North Carolina cases to support their position. However, as correctly pointed out by the Hearing Commissioner, those cases deal with notably

dissimilar statutory language than that included in our Act. Importantly, in 2011, North Carolina's statute was amended to include "attendant care services prescribed by a health care provider" in the definition of "medical compensation." Defendants concede that if the plain language of § 42-15-60(A) included any such language, the claimant's request in this case would be consistent with the Commission's statutory authority. However, our statute, despite being amended twice, contains no such provisions. Considering the claimant is seeking to establish entirely novel case law and expansion of § 42-15-60(A) plain language, they carry the burden of proving the legislature intended such a result and they have failed to do so.

Accordingly, Defendants contend the Hearing Commissioner correctly found that while the claimant is entitled to attendant care, such services must be provided by a licensed medical professional, as this conclusion is consistent with the plain language of § 42-15-60(A).

## II. The Hearing Commissioner correctly found the claimant's fiancé, Juliana Roldan-Dimas is not qualified to provide medical treatment pursuant to S.C. Code § 42-15-60(A).

The Commission is without legal authority to require Defendants to pay the claimant's fiancé for non-professional attendant care under § 42-15-60(A), as such does not constitute medical treatment, and she is not qualified to provide medical services.

There is no disputing Ms. Roldan-Dimas has no medical training and she is not a licensed healthcare provider. Beyond that, she confirmed at the hearing she has not been trained in the duties of a home health care aide, she has no training in medical billing, she has no professional liability insurance, she has not been trained in fall prevention, she has no training in handling patients with vestibular deficits, and she has no first aid training. (Hearing Tr. 31:3-32:5). Likewise, Ms. Roldan-Dimas testified during her deposition that she completed the ninth grade in Mexico but is unable to read English. (Roldan-Dimas Depo. p. 9:7-9,12:13-19; Hearing Tr. 28:9-18). Additionally, at the hearing, she confirmed that if she were needed to complete daily medical logs in English of the claimant's daily progress and details of the attendant care she was providing, she would be unable to do so. (Hearing Tr. 28:9-18). Under our Act, medical providers are required to provide medical documentation to carriers and employers and failure to do so results in liability for fines and penalties against the providers. Considering Ms. Roldan-Dimas is incapable of communicating in English, there is simply no way she could comply with any documentation requirements, leaving Defendants clueless as to what "services" she is

providing the claimant at their expense, his progress, any of his vitals, or his daily needs. Requiring Defendants to compensate her would in essence allow her to reap the financial rewards of being a medical provider, without any of the responsibilities of a licensed, skilled, and trained medical provider.

Ms. Roldan-Dimas' work experience is limited to factory work, with no training in even first aid. (Roldan-Dimas Depo. p. 18:2-18). She confirmed at the hearing that she has no other job or work experience, she has never worked in a medical or rehabilitation setting, and she has no certifications or on-the-job training. (Hearing Tr. 29:15-25). Ms. Roldan-Dimas has never been trained in first aid, fall management, or handling wound care. (Roldan-Dimas Depo. p. 19:12-21:1). Accordingly, to suggest Ms. Roldan-Dimas is capable of providing services for the claimant which would tend to lessen his overall period of disability is quite absurd, considering she has zero training or knowledge to assist her with doing so.

The Hearing Commissioner's decision is further supported by the opinions of Dr. Maria Lopez-Virella, a board-certified physician in pathology and lipidology and a Professor at the Medical University of South Carolina, who opined any necessary attendant care should be provided by a licensed and trained skilled home health care aide or nurse to ensure the claimant's best possible recovery. Importantly, Dr. Lopez-Virella reviewed the deposition testimony of Ms. Roldan-Dimas, as well as the medical evidence, when rendering her opinions. (Defendants' APA 22, p. 429).

This is in stark contrast to the opinions offered by Dr. Desai, who acknowledged in her deposition that she had no direct knowledge whatsoever of Ms. Roldan-Dimas' specific abilities to provide attendant care or even the relationship between the claimant and Ms. Roldan-Dimas. In her deposition, Dr. Desai confirmed she believed Ms. Roldan-Dimas was married to the claimant, even though they are not married. Dr. Desai Dep. 26:2-5. She also admitted she has no direct knowledge of Ms. Roldan-Dimas' education, her training or experience as it relates to providing attendant care services, or her training or ability to assist with ambulation or transfers of the claimant. Dr. Desai Dep. 26:6-22; 27:10-28:4. It is clear Dr. Desai's opinions as to Ms. Roldan-Dimas' qualifications were based solely on what the claimant wanted, not any specific knowledge of Ms. Roldan-Dimas' credentials. If our legislature intended a claimant's desires to guide medical decision making, the claimant would have been given statutory authority to direct medical care. Instead, Defendants were granted that right.

Accordingly, even if the Commission had the authority to order non-professional attendant care in this case, Defendants contend Dr. Desai's opinions with regard to whether Ms. Roldan-Dimas is qualified to provide the necessary attendant care should be given little to no weight, considering her lack of direct knowledge as to Ms. Roldan-Dimas' education, training, and qualifications.

## III. Defendants maintain the right to direct medical care under § 42-15-60

Under the Act, Defendants maintain the right to direct medical care pursuant to § 42-15-60 and the claimant has outright refused to accept professional attendant care services as offered by Defendants. The claimant admitted in his pleadings that as early as April 26, 2022, approximately 2.5 months have his accident when they filed a Form 50, he declined outside 3rd party care offered by Defendants because he and Ms. Roldan-Dimas "agreed it would be best for [Ms. Roldan-Dimas] to care for [Claimant's] needs." Likewise, Ms. Roldan-Dimas testified in her deposition and at the hearing that the claimant was offered home health services by Defendants upon his release from the hospital, but those services were declined by her and the claimant because the claimant told her he felt more comfortable having her assist him at home. (Hearing Tr. 30:8-11). As of the time of the hearing, the claimant's refusal to accept professional attendant care has continued.

Moreover, while the Commission has the authority to order treatment other than that provided by the carrier, this statutory authority is limited to situations where "in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the Commission." S.C. Code § 42-15-60(A)(emphasis added). As stated above, "[w]here the statute's language is plain and unambiguous, and conveys a clear and definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning." *Hodges*, 341 S.C. at 85, 533 S.E.2d at 581. In this instance, not only is there no emergency giving rise to the Commission usurping Defendants' right to direct medical care by ordering Defendants to provide treatment with a different provider than that offered, Ms. Roldan-Dimas simply does not qualify as a "physician" or a medical provider.

While Defendants can empathize with the claimant's comfort level with his fiancé, even if we set aside the statutory limitations discussed above, this is not a sufficient reason to deny Defendants' their statutory right to direct medical care. Beyond that, even if you view Dr. Desai's deposition testimony in the light most favorable to the claimant, she testified Ms. Roldan-Dimas is competently providing the required attendant care. Dr. Desai Dep. 48:16-19. She did not, however, testify that it would be detrimental to the claimant or his recovery if he received attendant care by a professional. In fact, when asked directly whether a professional would be better suited to provide the necessary attendant care than a non-professional, Dr. Desai testified, "they're equal." Dr. Desai Dep. 42:10-25.

This testimony certainly does not rise to the level of establishing facts sufficient to strip the Defendants of their right to direct medical care, particularly when a claimant has outright and repeatedly refused to accept care offered by Defendants and then seeks to gain financially from their own refusal, like the claimant would in this case. Allowing the claimant to do so would create a flood gate situation where injured workers could demand compensation for family members and friends for any reason, so long as a doctor says it could benefit them. This could lead to situations where an injured worker asks their doctor to order a friend to provide companionship while staying overnight in a hospital while recovering from surgery to make the claimant more comfortable. Would Defendants then be required to compensate their friend or spouse because the doctor felt having someone with them they knew would be beneficial even though there is hospital staff there qualified and available to provide the necessary care? There is no evidence to support this was the legislature's intent, yet that is a realistic result that could flow from such a finding in this case.

Moreover, our Courts have confirmed S.C. Code § 42-15-60 "does not give a unilateral right to claimants to select their treating physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature." *Turner v. South Carolina Dept. of Health and Environmental Control*, 377 S.C. 540 (Ct. App. 2008). Importantly, Defendants are not aware of any case law that has found it proper for the Commission to usurp Defendants' right to direct medical care where the Defendants have offered to provide treatment with a licensed healthcare provider, in favor of an untrained non-professional as requested by the claimant. Doing so in this case would not only undermine the statutory mandate that medical treatment be directed by Defendants, but it would be the equivalent of giving the claimant the unilateral right to select with whom they seek medical treatment, which was rejected in *Turner*.

## IV. The Hearing Commissioner correctly found liability concerns outweigh the claimant's desire to have Defendants pay his fiancé as a medical provider under § 42-15-60.

The claimant questions how the Hearing Commissioner could find there would be a liability concern with ordering non-professional attendant care before a claimant reaches MMI, but not after they reach MMI since Defendants acknowledge non-professional attendant care can be ordered under subsection (C) once a claimant is deemed permanently and totally disabled. First, as detailed above, the statute made the distinction in benefits available after a finding of permanent and total disability, not the Hearing Commissioner. More importantly, once a claimant is found to be permanently and totally disabled, Defendants' indemnity liability is capped, since the claimant has already been found entitled to the statutory maximum of 500 weeks of benefits. S.C. Code § 42-15-10. There is no increased liability for indemnity benefits at that point, even if additional injury occurs due to the fault of the unskilled individual providing attendant care.

Additionally, prior to a claimant reaching maximum medical improvement, the goal of medical treatment is to lessen a claimant's overall period of disability and achieve the best possible recovery. Accordingly, both the Commission and Defendants have a significant interest in ensuring medical care being provided to the claimant is aimed at achieving those goals and it is axiomatic that achieving the best possible medical outcome requires care with the best possible trained and qualified medical providers. On the other hand, once a claimant reaches maximum medical improvement but is found permanently and totally disabled, they have unfortunately reached a point where they are not expected to make significant improvements. That is not the point we are at with this claimant, which is precisely why Defendants insist on providing medical treatment with trained professionals – but the claimant continues to refuse to accept.

While the claimant argues there are no liability concerns with ordering Defendants to pay claimant's fiancé for providing attendant care deemed necessary by the treating physician, Defendants vehemently disagree. First, as aptly pointed out in the claimant's brief, "any subsequent injury the claimant incurs while receiving treatment for work injuries is considered compensable and the employer's responsibility." It is difficult to understand how the claimant can acknowledge this fact, yet argue there is no increased liability if the treatment being provided is offered by an untrained non-professional provider, particularly one who is uninsured like Ms.

Roldan-Dimas. It goes without saying that someone who is not trained to provide specific medical services but does so anyway, runs a much higher risk of causing additional injury to the injured worker. The mere fact that such injury would be the responsibility of the carrier is precisely why the Hearing Commissioner correctly found ordering Defendants to pay Ms. Roldan-Dimas for services she is not qualified to provide creates a liability concern for Defendants.

The claimant next asserts that in the event the claimant were injured due to Ms. Roldan-Dimas' lack of training or negligence, Defendants would have a 3rd party negligence claim against Ms. Roldan-Dimas. Considering Ms. Roldan-Dimas admitted she does she not own a home, but she is also uninsured, it is quite confusing how the claimant believes Defendants would be able to seek any amount of indemnification from Ms. Roldan-Dimas for her negligence. (Hearing Tr. 31:3-32:5). Rather, their acknowledgement of Defendants' subrogation rights, while also acknowledging Ms. Roldan-Dimas is untrained and unlicensed further supports Defendants' position that doing so creates a significant liability concern. On the other hand, if the claimant were willing to accept professional attendant care as offered by Defendants and he then suffered an injury due to that providers' negligence, not only would the claimant have the right to bring an action against the provider, but Defendants would likewise have the ability to seek indemnification considering the licensed and trained provider would have adequate coverage. Additionally, in the latter scenario, Defendants would have chosen the provider and, therefore, would arguably share some responsibility; whereas, in this instance, Defendants would have been forced to pay an unqualified individual and also bear the entire risk of any negligence on their part. This is fundamentally and inherently unfair to Defendants.

The claimant also disputes that ordering Defendants to pay Ms. Roldan-Dimas for non-professional attendant care creates concerns of an employer-employee relationship between the carrier and Ms. Roldan-Dimas, and supports their position by stating "providing payments to Ms. Roldan-Dimas is no different than providing payment to any other treatment provider." First, we would point out the fact that Ms. Roldan-Dimas simply cannot provide medical treatment since she is not a healthcare provider. Beyond that, other legitimate and licensed treatment providers are employees of the medical facility for whom they work, making it impossible for them to be deemed employees of the carrier. Likewise, legitimate healthcare professionals employed by a healthcare facility are not only covered under their employer's insurance policies, but the employers accept the risk associated with their employee's actions. This is not the case with Ms.

Roldan-Dimas as she is unemployed and would not be under the supervision or control of a healthcare facility. Importantly, she would not be under the supervision or control of anyone, which is yet another concern with ordering Defendants to pay her for services she is not qualified to provide, given her lack of training and licensing.

Not only is Ms. Roldan-Dimas untrained and unqualified in even basic first aid, she admits she is unable to read or speak English, and she would have no way of providing necessary documentation to the carrier as required under S.C. Code § 42-15-90 and S.C. Code § 42-15-95. Under these statute sections, a medical provider is required to provide documentation to the carrier concerning their treatment, recommendations, and services before being entitled to any compensation for their services. Clearly, given Ms. Roldan-Dimas' lack of education, training, or ability read/speak English, she simply would not be able to provide the requisite documentation to the carrier.

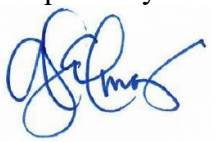
Lastly, there is no way to dispute the potential motives for secondary gains should Defendants be ordered to pay Ms. Roldan-Dimas for providing non-professional attendant care at this stage of the claimant's recovery. Ms. Roldan-Dimas testified she wanted the Commission to order Defendants to pay her more than $1,500.00 per week, which equates to more than $78,000.00 per year, for providing care to the claimant. This is more than double what she earned prior to the claimant's accident while working for Black & Decker, where she earned approximately $33,000.00 annually. (Hearing Tr. 29:4-10;37:4-16). Ultimately, Ms. Roldan-Dimas confirmed that despite Defendants' offering to provide professional in-home attendant care, consistent with recommendations of the authorized treating physician, she and Claimant declined to accept such treatment because they preferred she quit her job and stay home with the claimant. (Hearing Tr. 37:17-38:19). While we would hope Ms. Roldan-Dimas would not intentionally seek to prolong the claimant's recovery, there is no way to ignore the financial benefit she and the claimant would realize if her earnings were substantially increased, which causes grave concern given her earnings would be inextricably tied to the claimant continuing to require attendant care.

## CONCLUSION

For the reasons outlined above, Defendants request the Appellate Panel affirm the Hearing Commissioner's findings that Defendants maintain the right to direct medical care, any attendant care the claimant needs must be provided by a licensed healthcare provider of Defendants'

choosing, and Ms. Roldan-Dimas is not entitled to compensation for providing attendant care to the claimant when she and the claimant refused professional services with a healthcare provider offered by claimant when doing so would directly and significantly financially reward them.

Respectfully submitted,



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Berkshire Hathaway Homestate Insurance Company

August 15, 2023

STATE OF SOUTH CAROLINA

BEFORE THE WORKERS' COMPENSATION COMMISSION

WCC. NO. 2202001

HECTOR LOPEZ-VASQUEZ,

Employee,

vs.

OX PAPER TUBE & CORE CAROLINA, LLC,

Employer,

BERKSHIRE HATHAWAY HOMESTATE INSURANCE COMPANY,

Carrier/
Defendants.

WEB CONFERENCE DEPOSITION OF

| | |
|---|---|
| DEPONENT: | JULIANA ROLDAN DIMAS, interpreted |
| INTERPRETER: | Farrah Edwards |
| DATE: | June 9, 2022 |
| TIME: | 10:30 a.m. - 1:08 p.m. |
| LOCATION: | Elrod Pope Law Firm<br>212 E. Black Street<br>Rock Hill, South Carolina |
| TAKEN BY: | Attorney for the Defendants |

REPORTED BY: KATHRYN J. LINDLER

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Farrah Edwards, Interpreter

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STIPULATIONS

(At said time and place, the following stipulation was entered into between the attorneys present:)

IT IS HEREBY STIPULATED AND AGREED BY AND between the parties hereto, through their respective attorneys, that the deposition of JULIANA ROLDAN DIMAS may be taken before Kathryn J. Lindler, a certified Court Reporter for South Carolina at this time and place; oral interrogatories, direct and cross, to be propounded to said witness as by law provided.

It is further stipulated and agreed that all irregularities as to notice of time and place and manner of taking said deposition are hereby waived, each party reserving the right to object at the time of trial to any question or answer as to the competency, relevancy, or materiality thereof, but that objections as to the form of questions and nonresponsiveness of answers must be made at the time of taking said deposition or shall be deemed to be waived.

It is further stipulated that the reading and signing of said deposition by the witness are hereby expressly waived.

Thereupon,

FARAH EDWARDS, INTERPRETER,

being first duly sworn to interpret correctly from English to Spanish and Spanish to English hereinafter certified, interpreted as follows:

Thereupon,

JULIANA ROLDAN DIMAS,

being first duly sworn to tell the truth, the whole truth and nothing but the truth, as hereinafter certified, testified as follows:

EXAMINATION

BY MS. EDMONDS:

Q. First of all, I would like to thank Juliana for being here and express my sincere apologies for the accident that we are here to discuss today.

A. Yes.

Q. My name is Amity Edmonds and I'm an attorney with Gallivan White and Boyd and I represent Ox Paper Tube and Core in Mr. Hector Lopez-Vasquez workers' compensation claim.

MS. EDMONDS: Before we get started, as far as interpretation, I just want to confirm that you are a court certified interpreter?

INTERPRETER: Yes.

MS. EDMONDS: As far as translation is

concerned throughout the deposition obviously, I ask that you please give responses as if they're coming directly from Juliana and if any clarification is needed that you request that from me.

INTERPRETER: Yes, ma'am, I will.

MS. EDMONDS: Very good.

Q. Juliana, have you ever had your deposition taken before?

A. No.

Q. The reason I have you here today is I just want to ask you some questions about Hector's work accident. Also I'm going to just ask you some general background questions about you, your education, things of that nature just to learn a little bit more about you and the nature of Hector's injuries.

A. Yes, that's fine.

Q. Throughout the deposition, be sure to give verbal responses to any of my questions versus a nod of the head so that the interpreter and the court reporter can take down your verbal response.

A. Yes, that's fine.

Q. Also, particularly since we are using an interpreter, if you need any clarification on any of the questions that I've asked or you need me to

rephrase the question, I'm more than happy to do that. Just let me know.

A. Yes, that's fine.

Q. You understand you're under oath to tell the truth as if you were before a judge and jury?

A. Yes, that's fine.

Q. I mention that not because I think you will be dishonest, but I want to stress the importance of you letting me know if you don't understand one of my questions or need me to rephrase. Otherwise, I have to assume you understood and answered truthfully, okay?

A. Okay. That's fine.

Q. If I could, please, get your full name.

A. Juliana Roldan Dimas.

Q. Have you ever gone by any other names?

A. No.

Q. What is your current address?

INTERPRETER: Interpreter is going to ask Ms. Juliana to please spell the street address.

A. 302 Charlotte Street, York, South Carolina.

Q. How long have you been at that address?

A. I've been living there seven years.

Q. Who do you live with?

A. My daughter, the house is of my daughter.

Q. What is your daughter's name?
A. Andrea Angeles Roldan.
Q. Can you spell that please?
INTERPRETER: A-N-D-R-E-A. A-N-G-E-L-E-S. R-O-L-D-A-N.
Q. Does anybody else live with you?
A. Yes. So her husband, her two girls and, of course, me, oh, my younger son, and me and my husband.
Q. Could you give me the names of everyone who lives in the house.
INTERPRETER: Interpreter will be asking Ms. Juliana the names. The husband, Andrea's husband's name is Juan Gonzales. I will spell Gonzales for you. G-O-N-Z-A-L-E-Z. The two girls' name, one of them is Grace Gonzalez Angeles. The other girl's name is Alondra, A-L-O-N-D-R-A, Gonzalez Angeles. Juliana's younger son is Arthur Angeles Roldan. And do you need -- well, you have Hector already.
Q. Grace is how old?
A. Four.
Q. And what about Alondra?
A. Seven.
Q. And Arthur?

A. Twenty.
Q. Andrea, she's married to Juan, is that right?
A. Yes.
Q. Before living on Charlotte Street, where did you live?
A. The same street, but 117 Charlotte Street.
Q. How long have you been in the York area?
A. Twenty-two years that I've been here in the United States.
Q. Where were you before you came to the United States?
A. Mexico.
Q. Are you a legal resident?
A. Yes.
Q. Do you have a Social Security Number?
A. Yes.
Q. What is that?
INTERPRETER: Interpreter will be verifying Social with client.
A. 656-36-8202.
Q. Does Andrea work?
A. Yes.
Q. What does she do?
A. She's a waitress in a restaurant, Charandan.
Q. Can you spell the name of that restaurant?

A. C-H-A-R-A-N-D-A-N.
Q. Does she have a set work schedule?
A. Sometimes it depends. She could work only three days out of the week. So it really all depends on the schedule that the manager is giving her for that week.
Q. Some days she only works three days. Other days, does she work five or six days a week?
A. Yes, sometimes four, five.
Q. Does she work during the day or at night?
A. The day.
Q. What time does she typically go in and what time does she typically get off?
A. Sometimes she starts at 11:00 and then gets out at 5:00 or sometimes she gets out at 2:00 in the afternoon or sometimes more in the afternoon, you know, later in the afternoon. It just depends what the manager gives.
Q. Is that the only job she has is working as a waitress?
A. Yes.
Q. What about Juan, does he work?
A. Yes, he works.
Q. What does he do?
A. He works in construction.

Q. What days of the week does he work?
A. He does work from Monday through Friday.
Q. What time does he leave and what time does he come back home?
A. He usually starts at 7:00; comes back at 5:00. So he leaves early, around 6:00, you know.
Q. Is that the only job he has?
A. Yes.
Q. What about Arthur, does he work?
A. Being that he studies, he only works during the weekend, you know, Saturday, Sunday.
Q. Is he in school?
A. Yes. He actually was in school. He graduated in May so right now he's still looking for a job that could be more stable, more time.
Q. Congratulations on the graduation.
A. Thank you.
Q. Right now, he is only working on the weekends, is that right?
A. Yes, just Sundays for now, but he does sometimes goes on Saturdays.
Q. What does he do?
A. In the same restaurant that my daughter works in.
Q. Does he wait tables or does he have a

different job?
A. He cleans tables, sometimes he washes dishes, whatever they ask him.
Q. What about the two daughters or your granddaughters, do they go to school or do they stay home?
A. Yes, they go to school.
Q. Are they in daycare during the summer or are they home?
A. They're at home.
Q. At home?
A. Yes.
Q. Juliana, do you speak any English at all?
A. Very, very little. I mean, the basic, the basic.
Q. Do you understand English?
A. A little bit, not too much.
Q. The same?
A. Yeah, the same.
Q. Do you work, Juliana?
A. Yes. I worked before the accident that happened to my husband, I did.
Q. Where were you working before the accident?
A. I was working at Standard Black and Decker.
Q. Where is that located?

A. It's in front of Fort Mill, that building in front of it.
Q. It's in Fort Mill?
A. Yes.
Q. We'll talk about that a little bit more in a few minutes, but what I want to first do is a little bit more information about your education. How far did you go in school?
A. I only studied until nine in Mexico.
Q. Until ninth grade or the age of nine?
A. Yes, grade nine; ninth grade, yes.
Q. After you stopped studying, did you get any other schooling or any other education of any type?
A. No. No. I just study until then.
Q. Are you able to read English?
A. No. No. No. I can't.
Q. Just so I understand the family dynamics. Is Andrea -- first of all, are you and Hector married?
A. No, we are not legally married.
Q. How long have you all been together?
A. Thirteen years, 12 - 13 years.
Q. Have you ever been married?
A. Who me?
Q. Yes.
A. Yes. Yes.

Q. How many times?
A. Just one time.
Q. Did that marriage end in divorce?
A. Yes. I am divorced.
Q. How long have you been divorced?
A. I got divorced in 2016.
Q. What is your ex-husband's name?
A. Arturo Angeles Cruz. C-R-U-Z.
Q. I just have to clarify. If you were divorced in 2016, which is only about six years ago, but you were saying that you and Hector have been together for 12 or 13 years. Can you explain that to me please?
A. I separated in 2009 with my husband.
Q. Andrea, is she your daughter?
A. Yes.
Q. She's not Hector's daughter?
A. No.
Q. And then Arthur, is that your son?
A. Yes.
Q. Also not Hector's?
A. No. I mean, he raised him when he was small. He was eight years old so he considers him like his father.
Q. I completely understand. Does Hector have

any other children or biological children?
A. Yes, in his country, El Salvador.
Q. How old are his children?
A. I honestly don't know. The only thing I do know is that it is four kids and they're already pretty much adults. Yeah, they are adults.
Q. Does Hector speak English?
A. No, he does not understand.
Q. The two little girls, Alondra and Grace, when they are home during the summer and Andrea and Juan are working, who is watching them?
A. My son is there and that's why he hasn't looked for a full-time job, because he's there looking after them. And he also helps me with Hector, you know, anything that I need. That is the reason why I have told him not to look for a full-time job so he could help.
Q. Do you have a driver's license?
A. Yes.
Q. Is that a South Carolina driver's license?
A. Yes.
Q. Do you happen to have that number on you?
INTERPRETER: Interpreter has the license.
MS. EDMONDS: If you could just provide me the number please.

INTERPRETER: Of course. It's 102616492.
Q. I forgot to ask early on, Juliana, what is your date of birth?
A. February 16, 1978.
Q. As far as your work history, I know you said prior to this accident you were working for Standard Black and Decker. How long have you worked with them?
A. This May coming up, I would have been eight years with them.
Q. The May that just past?
A. No, this one, this one. This May. Eight years. I started in 2013 -- no, 2014.
Q. What was your job -- actually, let me back up. Are you still an employee?
A. Right now I'm on FMLA, but I am asking for a permit, you know, but if they don't give it to me, then I'm just going to have to stay with my husband.
Q. I'm sorry, you said you're asking for what?
INTERPRETER: Just to clarify with her. She just mentioned permit. Okay. She's asking -- I'm sorry to clarify. She's asking.
A. I am asking for permit for FMLA and I'm hoping they give it to me, but if not, I'm going to have to resign so I can be with my husband.

Q. What is your job title there?
A. Assembly line. It was an assembly line for drills.
Q. Were you making drills?
A. Yes.
Q. Have you had the same job since you've been working there, since 2014?
A. Yes, it's the same.
Q. What was your work schedule?
A. So I always worked from Monday through Thursday ten hours, but this year they did change it from Monday to Friday for eight hours. But I've always worked the Monday through Thursday.
Q. This year once they changed you over to Monday through Friday, what time would you go in and what time would you get off?
A. I would go in from 7:00 in the morning to 3:30.
Q. Was that an hourly job?
A. Eight hours, they would pay me eight hours.
Q. How much would you make per hour?
A. Sixteen an hour.
Q. Do you work any overtime?
A. Once in awhile, but not that much.
Q. Prior to working at Black and Decker, where

did you work?
A. I worked in another factory, American Eagle, but they closed down and I worked there for like four years. It's also -- it was also in York, the factory.
Q. Did you work on an assembly line there as well?
A. No, I would just be there cleaning some type of rims, just cleaning.
Q. Cleaning some type of what? I'm sorry.
INTERPRETER: Okay, I'm sorry, just clarifying with her what she meant by cleaning in Spanish. It's rims. She cleaned the rims of the cars.
A. That's what I cleaned, the rims that go on the cars.
Q. Any other job duties you had there other than cleaning the rims?
A. No, I would just do that.
Q. Was that an hourly job? You got paid by the hour?
A. Yes, hourly.
Q. Do you recall how much you made per hour?
A. Yeah, around $9.
Q. Before American Eagle, where were you?

A. I did not work.
Q. Did not work?
A. Yes, before I didn't work, because my kids were small.
Q. Do you have any other type of work experience at any point?
A. No. No.
Q. Have you ever received any sort of certifications, on-the-job training, anything like that?
A. No.
Q. Have you ever been first aid certified or trained?
A. No.
Q. Have you ever been trained with infection control or management?
A. I don't understand the question.
Q. Have you ever received any training on how to handle wound care or infections or anything of that nature?
A. No.
Q. Have you ever been trained in taking someone's vitals, their blood pressure, things of that nature?
A. The only thing I got is I can remember the

nurse at the hospital showing me how I could put my husband's insulin. She taught me how to check his sugar and also, you know, to put the insulin.

Q. You said that the nurse at the hospital showed you how to administer insulin?

A. Yes, so it was like the day before he was leaving the hospital that the nurse taught me. She said I'm going to show you how to put the insulin, you know, and make sure everything and she asked me do you think I could do it and I said, yeah, I can do it.

Q. How are you administering insulin? What did she tell you to do?

A. Okay, first you have to clean with alcohol. She taught me to go in the arm just a little soft part of the arm or I could go to the stomach and put it there. She taught me just to make sure that I look more soft skin.

Q. Anything else that's required for that?

A. No, not really. Just make sure I check with the little machine his sugar, but it's easy.

Q. How often did she tell you to check his sugar with the machine?

A. Three times a day.

Q. What were you told as far as what the blood

sugar level should be?
A. In the morning, around 6:00 or 7:00 in the morning, I check for his sugar and then I just make sure that I'm not going to put the insulin if the number is above -- I'm sorry, if it's above 140, then I do put the insulin, but if it's below that, then I don't.
Q. When do you check again?
A. In the afternoon before he eats.
Q. What time is that typically?
A. Around 12:00 - 1:00, that it's around his lunch.
Q. Then when do you check it again?
A. Nighttime again, I have to check for it, because now I have to put an insulin that I only put once a day and this is not the one that I have, you know, along with the one I have to put three times a day.
Q. Tell me what you mean by that. You have to use a different insulin, is that what you're saying?
A. Yes, I put two different insulins.
Q. Are there any other times where you have to check the insulin or is it just during those times?
A. Just three days out of the week -- I mean --
Q. Three days out of the week?

A. Out of the day, I'm sorry.
Q. Have you been instructed on any red flags or things to look for as far as blood sugar being too high?
A. Definitely after the accident, his blood pressure has kept high, but the nurse told me that that would be normal because of so much going on, so that's why it would probably continue a little high.
Q. What I was asking is, are you aware of what to look for to know whether or not his blood sugar is high outside of testing it?
A. Yes, the machine. I don't know.
Q. That's the only way you would know if his blood sugar is high?
A. Yes, with the machine.
Q. Do you keep a written log of the findings from that machine every day?
A. A month ago he was complaining that his fingers were hurting because of all the pinching. So a month ago, we decided to use the patch on the arm and all I have to do now is just scan the machine.
Q. What I was asking is, do you write down what the readings are on the machine? Do you keep a piece of paper or a notebook that shows what those

readings are?
A. Yeah, I was writing on the paper, you know, what the numbers were. So like that every time the nurse would ask me, I would show her what the record is, but now with the little machine, it just kind of keeps a record of what the number is.
Q. When is the last time you would keep a written record of what his blood sugar levels were?
A. It's been like a month since I put the patch, yeah, because the patch is only 14 days.
Q. When you are checking his blood sugar on a daily basis, is it typically normal where it should be or is it high or is it low?
A. So in the mornings usually, it might be a little bit under 140 or sometimes it does go up a little bit to 160. Now during lunch or in the afternoon it's when sometimes it is a little bit high between 200 and 240. It just all depends. It depends. Sometimes they are different numbers.
Q. Typically it's high in the afternoons, is that what you're saying?
A. Yes. Yes, every day. Every day, yes, and I have told the doctor and I have told the doctor.
Q. What doctor is that?
A. Yes, it's Dr. Shiland, that is our family

doctor and I always -- and I also let the nurse that would come and visit me, us at home, I would let her know as well.

Q. Over let's say the past week or so, has Hector's blood sugar been over 200?

A. Yes, it's usually -- that's always between 200 - 240 when I check in the afternoon, it's always every day around that number, and the doctor that checks him says that is normal because of everything that's going on with him.

Q. When it's over 200, what do you do?

A. I have to put the insulin.

Q. Then do you check it again?

A. Yes.

Q. Does that make it go down below 140?

A. Yes, it goes down.

Q. Dr. Shiland, the primary care doctor, is that who Hector was treating with for diabetes before this accident?

A. Yes.

Q. How long has that been his family doctor to your knowledge?

A. I don't really remember, maybe three or four years. We went to another -- we were going to another clinic before we came to her.

Q. What was that clinic's name?
A. No. No. I don't remember. I'm not too sure of the name of the clinic.
Q. Do you know where it was located?
A. The one on 161 right here on Rock Hill, but I think it changed name. I don't remember.
Q. Do you know how long it's been since Hector was diagnosed with diabetes?
A. I'm not too sure, but maybe between six or seven years.
Q. As far as his treatment for diabetes, before this accident, what would he do to treat it?
A. No, he would just take medicine. He would not put the insulin. I want to say maybe one time he used insulin, because that was very high, but he's always used medicines. So it was only that one time that I remember exactly that he did use insulin.
Q. Would he test his blood sugar at home?
A. Yes.
Q. Do you know, you may not know, but was his diabetes considered under control with the medication or did he have frequent spikes in his blood sugar?
A. He would control himself. He had it under

control. He would check it.
Q. Aside from Doctor -- is it Shilah or Shiloh?
A. Honestly, I don't know if it's Shilah or Shiloh.
Q. We'll go with Shilah, because I think that's what you were saying. Aside from Dr. Shiland, did he treat with anybody else for diabetes to your knowledge?
INTERPRETER: I'm sorry, she was giving me the card. Can you repeat the question again? I apologize.
Q. To your knowledge, did Hector treat with anybody else for his diabetic condition other than Dr. Shiland?
A. No, just with her at the clinic.
Q. Did he ever have to go to the emergency room for any problems with blood sugar or anything of that nature?
A. Yes, it was that time that they had to put the insulin, that's when. Yeah, and I don't remember if that was really two or three years ago.
Q. What hospital did he go to?
A. Here in Rock Hill, Piedmont, that's where he went, Piedmont.
Q. Any other emergency rooms before this

accident that you are aware of aside from Piedmont Medical that Hector has ever had to go to?

A. Not that I know of.

Q. As far as Hector's current condition, what things does he require assistance with on a daily basis?

A. He cannot take a bath. He still gets very dizzy with the trauma that he suffered. So when he gets up, he has to go very slow because he starts getting a little bit dizzy and then he has to sit down a little bit. When he does walk, he walks just a little bit, but very slow. So he could be sitting down in a chair, but it cannot be for a long time, because he gets tired.

Q. How long can he sit in a chair before he gets too tired to do that any longer?

A. Yeah, you can say one hour - an hour and a half he could be, you know, sitting down, but, of course, he gets up a little bit and then he just doesn't want to be laying down too much.

Q. After that hour, what does he do?

A. Yes, he gets his walker, he walks around a little bit, because we want him to stay a little active. We want him to walk around a little bit. He walks from the kitchen to the living room, but,

yes, he does get tired.
Q. You said that he walks with a cane?
A. It's a walker, the one that has the little wheels in the front.
Q. Does he use the walker all the time or does he sometimes walk without it?
A. Yeah, he has to, he has to, because he gets dizzy so even when we're about to give him a bath, he has to use it, because, you know, he gets dizzy, especially going to the bathroom. And, of course, his knee is fractured because of the accident, so...
Q. Does he do any sort of exercises from physical therapy at home?
A. Okay, nobody has gone. The only person that he has gone is for the speech and then that particular person said because they haven't fixed his mouth, there's really not a lot that she could do with his speech. And they just gave us a schedule this week saying that he is going to go to therapy twice a week so like that.
INTERPRETER: I'm going to clarify what hospital she mentioned or the therapy. I'm sorry. Interpreter is clarifying. What she was talking about was for the speech therapy is that he's going to start going twice a week.

Q. Has anybody talked to you about him undergoing physical therapy?

A. I don't know. I just got a paper and I don't know if they're going to do physical therapy there for that as well, and then she handed me a paper. And to the house they went twice, but after that, for the knee, but they never came back.

Q. You said as far as things that you have to assist Hector with, you have to help him take a bath. What else do you have to do outside of helping him take a bath and help monitor his insulin?

A. I do everything. I cook. I clean the sheets. I clean so everything could be clean. I give him his medicine and time. I help him take a bath. I take him to his appointments. Sometimes he has two appointments the same day.

Q. As far as the medicine, what all medicine is he taking?

A. He's taking one that he has to take two every eight hours, so two pills every eight hours, and depending on the pain that he may have, he is taking Motrin, something like that.

Q. Anything else that you have to help him with during the day?

A. Practically I do everything. I cook for him. I have to make sure that I blend the food very well, because he cannot chew.
Q. You blend the food. How does he eat it?
A. Once it's nicely blended, he eats it with a spoon.
Q. He's able to feed himself with a spoon?
A. Yeah, he eats with a spoon.
Q. As far as getting dressed, is he able to dress himself?
A. I have to help him, I have to help him dress, especially to put the T-shirt on, because he has so much fractures, especially on the nose, you know. He says that he gets very tired if he's trying to do it, you know, on himself. So, yes, I help him put on his T-shirt.
Q. Is he able to put his own pants on?
A. I do help him, because every time he tries to bend down, he does get dizzy so I do help him.
Q. What about going to the bathroom, is he able to go to the bathroom on his own?
A. During the day, he could walk to the bathroom. It's just at nighttime that he uses the little seat that we have next to us, but even at nighttime, I have to be careful, because he does

kind of still get dizzy. So he has to be, you know, just sit there for a little while. And I have to be constantly checking on him, because like, for example, last night, he was just not feeling well. He was feeling dizzy so I have to make sure, you know, and check up on him.

Q. Are you talking about during the night you're checking on him?

A. Yes.

Q. What are you checking for?

A. It's when he wakes up that I have to make sure, you know, that he's okay and he can wake up and he just feels very tired and he will just sit there for a little while, and, you know, I just have to make sure. It's just that dizziness, it just doesn't go away.

Q. I just want to clarify something as far as him going to the bathroom. During the day, he can go to the bathroom by himself? He doesn't need any assistance, is that correct?

A. I mean, I'm constantly checking up on him, you know. I'm constantly checking up on him when he goes to the bathroom, you know. I need to make sure that he's okay, but we just want him to stay active so that's why he goes, you know, to the bathroom.

Q. Does he go to the bathroom by himself?
A. During the day he goes to the bathroom, but not alone, because I'm checking up on him.
Q. Not to be too graphic, but is he able to wipe himself or you have to assist with that?
A. Yes, he does clean himself.
Q. As far as the dizziness is concerned, has he fallen at home on account of the dizziness?
A. No, he has not fallen, because, again, I'm always with him checking up on him to make sure.
Q. You were telling me earlier about when he gets into -- if he's sitting in a chair for an hour, he has to get up and walk, things of that nature. Does he get up from the chair by himself?
A. Yeah, he stands up very slowly, but, of course, I'm there, you know, sometimes if I have to grab his arm just to make sure, but he has to, you know, he's going to go very slow. He's never alone. He's never alone. Yeah, not even during the day, he's not alone, because I have to keep checking on him.
Q. I understand you're checking on him, but I'm just trying to make sure that I understand. When you say you're checking on him, does that mean you're close by or you're checking in the room to

make sure he's good? What do you mean when you say you check on him?

A. Well, I'm near him, you know, and sometimes if, for example, if I'm in the kitchen, but as long as he's sitting down, you know, I am kind of keeping an eye on him to see what he is doing, but if he's about to get up, then, yes, I am near him, you know, to assist him.

Q. Let's say you're in another room and he's in the chair, does he just get up or does he call you and let you know he wants to get up from the chair?

A. Yes. Yes, he does tell me to come and help me or my son that's there also helps him.

Q. As far as bathing, I know you said that you help him with that. What part is he not able to do or what do you have to help him do as far as bathing is concerned?

A. I cannot just open -- he cannot just open the shower and let the water down. So what I try to do is just get a container and I fill it up with warm water, cold water, and then I put his chair inside and so then I get a little, you know, something or cup so I can pour it over him, because the head is still so fragile that the water cannot, you know, hit it.

Q. The house that you all live in, is it one story or is it two stories?
A. It's just one.
Q. Do you and Hector sleep in the same bed or same bedroom?
A. Yes.
Q. In the same bed?
A. Yes.
Q. If you can, Juliana, will you give me your daily routine? Start with what time you get up in the morning and then all the way through the day.
A. So the first thing I do is to wake up, to check his sugar.
Q. What time is that? That's usually 6:00 or 7:00 a.m.?
A. Yeah, between 6:00 and 7:00 in the morning. Of course, it depends, because if we appointments, then I have to wake up earlier. So, of course, then I check the sugar. I have to make sure if it's above 140 and then, of course, you know, depending on how it goes, what I have to do next and then I start heading towards the kitchen to start making breakfast.
So while I'm in the kitchen cooking, of course, he's still laying down. He does not get up

until breakfast is ready. So, of course, once he's eating, then I have to give him the medicine that he has to take after he eats breakfast.

Q. When you wake up in the morning, is Hector already awake or do you wake him?

A. No, he does wake up and then I check his sugar and then he's just laying there while I do other stuff.

Q. You head to the kitchen to cook breakfast. What kind of things do you prepare for breakfast?

A. He likes to drink hot milk and if he's a little bit hungry, then I like to blend some vegetables for him.

Q. Once breakfast is ready, do you call in there and let him know or what happens? How does he know his breakfast is prepared?

A. I go to the bed and I help him get up, because I don't want him to just be laying there, you know, such a long time. So I do tell him to get up.

Q. Then he comes in and eats breakfast you said and then you give him his morning medications, is that right?

A. Yes, I do give him his medicine and then sometimes he says I just want to sit here for a

little while, you know, in the seat after he eats.
Q. Then what do you all do?
A. So, of course, I have to -- now it's time to clean. I have to go to the kitchen, clean up everything and, of course, depending if we do have appointments that morning, then I have to start getting him ready for the appointments so it just all depends.
Q. While you're cleaning the kitchen, what is Hector doing?
A. After he eats breakfast, he just stays there in the seat for a little while. Because the nurse did tell me to make sure that he at least sits for at least an hour or so, but, of course, if he gets tired, then he could lay back down again if he wants to.
Q. Does he eat breakfast at a table in the kitchen or is it somewhere else?
A. In the dining room table.
Q. Is that a separate room than the kitchen?
A. Yes.
Q. Once he gets finished sitting there for that hour or so and you're finished with the kitchen, what happens next?
A. Well, he will ask me that he feels tired and

that he does want to go and lay down for a little while and he's constantly tired, I mean, because of the trauma. The doctor did say that it was going to be normal for him to continue to feel that way, just very tired.

Q. He may go lay down. If he doesn't go lay down, what does he do?

A. Well, he does have to go lay down, because he just -- he gets too tired, but he will walk around a little bit if he can, but he does have to lay down because of being so tired.

Q. After an hour or so, he will go lay down in the bed?

A. Yes, he keeps himself -- yeah, he'll go lay down for a little while and then he'll get up and he'll lay down so that's how he, you know, keeps... yeah, because I cannot take him outside. The nurse said that maybe the light and he mentions too that when he goes outside, the light, you know, being outside really affects him, so, I cannot take him.

Even if I want to take him outside on the porch, you know, and I put on some sunglasses, he just can't. He can't be outside for a very long time, because he starts complaining that the light, you know, is starting to affect him.

Q. Do you prepare lunch later in the day?
A. Of course, yeah, time goes by so fast. So after all that, yes, I have to start preparing lunch. I check his insulin, make sure everything is okay and, you know, it's just a routine.
Q. After breakfast and before you start preparing lunch, what are you doing?
A. I'm washing clothes. I'm taking the sheets off of the bed. I change the sheets every single day, because I want him to feel fresh. I want him to feel clean. Or sometimes I have to start making a list of things, you know, I have to buy, I have to shop so my son can go and sometimes the doctors or nurses, I'm talking to them, you know, over the phone to be cheeking on things. So, I mean, it's a lot of things during the day.
Q. As far as lunch, you prepare that. How long does that process take?
A. It just depends, you know. Sometimes he just wants vegetables or a little meat. It depends. Maybe an hour.
Q. Are you making lunch for just you and Hector or are you marking lunch for everybody in the house?
A. Yeah, I just cook for me and Hector, because, you know, pretty much my kids, they go out to eat or

my daughter is in charge of, you know, feeding the girls. So pretty much, because I want to concentrate on him, because, of course, they're not going to eat the same, you know, because Hector has a total different diet.

Q. When the girls are there and neither of their parents are there, who prepares food for them?

A. Yeah, my son helps out, you know, and also the good thing is that my daughter, she has her schedule to the point that she can just cook and take care of the girls and then once the food is prepared, then my son could just go ahead and give it to the girls.

Q. When you're preparing lunch, what is Hector doing?

A. He goes to his bed to sleep or sometimes he'll just sit there in the chair just looking at me.

Q. After lunch is prepared, you clean up from lunch and all that, is that right?

A. Yes, and I do the same routine every day and the afternoon the same.

Q. After lunch, while you're cleaning up, is Hector in the bed usually or is he in the living room?

A. Yes. As I mentioned before, it depends. Sometimes he could be laying down, sometimes he could be sitting or sometimes he could just be walking around a little bit.

Q. After lunch, what do you do?

A. It depends again. I'm there with him and if I need to make a grocery list, I'll do it and I'll send my son to go get it. He gets depressed. I'm there with him, you know, to entertain him, to talk to him.

Q. You said your son will go to the grocery store for you?

A. Yes, he helps me a lot, especially ever since Hector, you know, got into the accident. Honestly, I haven't even left the house. I haven't even gone to a restaurant, because I'm always there, but...

Q. You don't do any of the grocery shopping?

A. My daughter, my daughter when she has her days off, she will go and do grocery shopping as well.

Q. My question was. Have you gone to the grocery store at all since this accident?

A. No. My daughter is the one that does it or my son, I'll send him.

Q. Have you left your home and left Hector there

at any point since this accident?
A. No, I've always been there with him. The medicines the same way. My son is the one that has to take them and bring them.
Q. You have not been out of his sight even one time since this accident took place?
A. I've always been there next to him. Since the hospital, I've been there day and night.
Q. Obviously today Hector is not with you, is he?
A. Yes, my son is there with him.
Q. Are the two girls there as well?
A. Yes.
Q. Do you ever leave the house and let your son stay with Hector other than today?
A. No. No. Just today. I'm always with him.
Q. If you have a doctor's appointment or something like that, what do you do?
A. After the accident, I haven't done any appointments with the doctors.
Q. Tell me what the evening entails. What time do you prepare dinner?
A. Around 4:00 I start. And sometimes it depends, because if we have appointments, it just, you know, all depends and sometimes, you know, the

appointments are as far as Charlotte, you know. Especially after the accident, there's been so many appointments.

Q. But let's just talk about a day where you don't have an appointment. You start dinner around 4:00 p.m., is that right?

A. Yes, around 4:00 I start.

Q. What time do you all eat?

A. Between 6:00 - 7:00.

Q. It takes you a couple of hours to get dinner prepared?

A. Like one and a half hours.

Q. After dinner, what do you all do? Do you have to clean the kitchen?

A. Yes, of course, I have to go clean the kitchen, make sure things are clean and also I keep myself busy, because I have to organize whatever appointments he may have so that keeps me busy. And, of course, I have to do things, my things, you know. I have to keep myself, you know, I have to take a shower, do stuff for me, fold the clothes, you know, do everything.

Q. The appointments, there is a nurse case manager that lets you all know when he has appointments, is that correct?

INTERPRETER: I'm sorry, can you repeat that again.

Q. Juliana, there's a nurse case manager who coordinates Hector's medical appointments, isn't that correct?

A. Yes, she's the one that does all the appointments.

Q. While you're cooking dinner starting around 4:00 o'clock up until about 6:00 or 7:00 when you all eat, what is Hector doing?

A. He keeps himself busy. Like every day he'll lay down a little bit or he'll sit down a little bit or he'll walk around. The same thing that he does every day. He keeps himself doing the same thing, because he can't go out.

Q. Does Hector take a shower or a bath every day?

A. Yes, every day.

Q. When do you all do that? What time of day?

A. It depends on the appointments, you know. If he has appointments, then we could go take a shower during the day or in the afternoon. It just depends on the appointments.

Q. After dinner, after you're finished cleaning the kitchen, what do you guys do in the evening?

A. Of course, I take a shower, you know. I do things that I need to do and then, of course, depending on what, you know, how he feels, but usually sometimes time goes by so fast and if he's really tired, then by around 9:00 o'clock, we start going to bed.

Q. Do you both go to bed around 9:00 o'clock?

A. Yes, he goes around that time. He goes to sleep. I give him all his medicines and around 9:00 o'clock, he goes to bed.

Q. What about you, Juliana, do you also go to bed at 9:00 o'clock?

A. Yeah, I do, I go to bed. Yes.

Q. I'm very jealous of that.

A. I get tired. I get tired too, and with all this going on, sometimes I can sleep and sometimes I can't.

Q. Once you all go to bed around 9:00 o'clock, you all sleep until, I think you said, 6:00 or 7:00 o'clock the next morning, is that right?

A. I always wake up around 6:00 or 7:00 and, of course, Hector is different. Sometimes he will wake up three or four times during the night and, of course, when he wakes up, I have to wake up, because it's just, you know, I have to be checking on him

and, then, of course, there's some nights that he could be very, you know, calm, but like last night, he was not. He was very, you know, he kept waking up and so, but again there are some nights that he could be a little calm.

Q. When he wakes up, what does he do?

A. Of course, he'll wake up and like, for example, last night, when he woke up, he said I feel like a lot of pain and she said well I already gave you the medicine, you know, I can't -- I can't give you any more. The medicine does help a little bit, but not, you know, as much.

Q. Does he just lay there or what -- when he wakes up, does he just continue to lay in the bed?

A. Yeah, he'll just -- you know, he'll lay there or sometimes he'll just sit up and complain again of how much pain he has and he'll just stay there and then, of course, I'm already up, because I have to be watching him, making sure that he's okay while he's up.

Q. When he wakes up at night, do you have to do anything for him other than provide him comfort?

A. Sometimes, he'll ask me please, you know, he'll tell me please give me more medicine, but I can't, you know. So there's really nothing else I

can do. I told him I can't give him more. He'll just lay there.

Q. When he goes to bed at night, he doesn't get up again out of the bed until 6:00 or 7:00 o'clock the next morning, is that right?

A. Yes, sometimes he will and sometimes he'll wake up three or four times, you know, during the night.

Q. What I meant by get up, I meant get out of the bed. He doesn't get out of the bed again until the next morning, is that accurate?

A. No, he wakes up around 6:00 or 7:00 in the morning.

Q. I think I asked the question poorly so I'm going to rephrase it. Once he lays down at 9:00 o'clock at night, he doesn't get back out of the bed until 6:00 or 7:00 o'clock the next morning even though he may wake up throughout the night, is that accurate?

A. Yes, he wakes up or he gets out when it's time for breakfast.

Q. Juliana, were you all offered a professional home health nurse to come to your house at any point since he was released from the hospital?

A. So they did. They did offer, but Hector said

that he felt more comfortable having me, you know. Especially at home, it's not just me and Hector, you know, it's our other family is there as well.

Q. By other family, you mean your daughter and her children, right?

A. My son, and, of course, I wasn't going to leave him alone anyway, because he's my husband.

Q. You were offered to have a professional come in, but you all declined to have them come assist you, is that right?

A. So, yes. The workers' comp, she did say that she would offer 24-hour nurse, but again, you know, Hector was saying, but she's not going to cook for me. She's not -- I don't know exactly what she was going to do, but when it comes to the appointments, you're going to have to be the one taking me. So exactly, you know, we don't know what she was going to do, but I was going to have to do a lot too.

Q. Your son, he just graduated from high school in May, is that right?

A. No, technical school.

Q. Did he go to school in person during the week before he graduated?

A. Just two days out of the week he would go and then just two days he would be at home.

Q. When your son was in school and you needed to go take a shower or something like that, who would be there with Hector?

A. So my daughter was there to help me. So something that we always did was just make sure that our schedules would work. For example, if my daughter had, you know, Mondays and Tuesdays off, and Arthur, you know, was going to school on Monday, then, of course, you know. So we just always make sure that our schedule, we worked around our schedules so we could help me a lot, help each other.

Q. Juliana, I am confident that this has been an incredibly stressful and difficult time for you and again I'm very, very sorry about that. Have you been able to take any breaks to do anything for yourself other than care for Hector since this happened?

A. No. No. No. I haven't rested.

Q. Have you been able to go get your hair done or anything like that?

A. No. No. No. I mean, I haven't been able these past few months to do anything personal for me. Like I mentioned before, I haven't even gone to a restaurant, you know, to eat. No.

Q. Is it fair to say the only time you ever leave your house is to take Hector to a doctor's appointment?
A. Yes.
Q. Do you have a car?
A. Yes.
Q. What kind of car?
A. Dodge 2016.
Q. Is that a car? A SUV?
A. It's four cylinder, little car.
Q. Do you know the name of the medication Hector was taking for diabetes before this accident?
A. No, no, I don't remember the pills he was taking.
Q. Do you know what pharmacy he would use or you would use to get that filled?
A. The one that's here in Infinity in Rock Hill.
Q. You didn't go to like CVS or Walgreens? You always went to Infinity?
A. It's the pharmacy that's inside of the clinic, Habitat.
Q. I believe that's all the questions I have for you, but if you'll just give me one second to look through my notes. I saw somewhere in the notes when Hector first came home from the hospital that I

believe he had lost a good amount of weight and there was some difficulty monitoring his blood sugar. Has he started to gain some weight?

A. Yes, he's a little bit fuller now. Yeah, he was able to recuperate a little.

Q. I believe that's all the questions I have for you, Juliana. I really appreciate your time. Drew may have some questions for you.

EXAMINATION

BY MR. CREECH:

Q. I got a few. Some we have already discussed, but I want to go back over it. Juliana, before this accident you were working at Black and Decker?

A. Yes.

Q. I believe you were making $16 an hour?

A. Yes.

Q. You would typically work at least 40 hours a week?

A. Yes, 40 hours.

Q. I think you've been in that same job for eight years, is that right?

A. Yes, eight years.

Q. How long have you and Hector lived together?

A. Twelve - 13 years.

Q. Even though you all aren't formally married,

do you describe him to other people as your husband and does he describe you to other people as his wife?

A. Yes.

Q. Does he claim your children as his own?

A. Yes, yes, he raised especially my little one, he raised him.

Q. The home that you live in, who actually owns that house?

A. My daughter and her husband.

Q. You actually live in their house? It's not your house?

A. Yes, it's not my home.

Q. In that home, it's you and Hector, right? Your daughter Andrea and her husband Juan. Your son and Andrea's two little girls, is that right?

A. Yes.

Q. There are seven family members that live in the house together?

A. Yes.

Q. I want to talk a little bit more about the problems and issues that Hector has. When Hector wakes up in the morning, is he able to get out of bed by himself or do you typically have to help him get up?

A. So when he wakes up, you know, I don't have to really help him, but I'm there, you know, just making sure, checking that if he gets up, you know, because again his dizziness affects him a lot so I have to be there just making sure when he gets up or if he's going to sit down.

Q. You mentioned his dizziness. Have there been occasions where you have seen him stumble or almost fall if someone hadn't been around him?

A. He loses his balance every time he gets up, you know, it causes an imbalance.

Q. Is it your understanding that one of the many injuries that he sustained was an injury to his brain?

A. Yes, yes, he knows, he knows that it was for that.

Q. Have you noticed any issues with Hector's memory?

A. Yeah, a little bit, because I've noticed when he's going to say something, he thinks a little bit more. Yeah, first he has to think about what he's going to say.

Q. What about his medications, does he remember what medications he's taking and which one he's had or do you have to help him with that?

A. No, I have to help him with that, because he doesn't know. He doesn't know what medicine.
Q. Is Hector currently getting insulin injections every day?
A. Yes.
Q. Did he require insulin injections before this accident?
A. No, no, he only, two or three years ago, he only put insulin once and that was two or three years ago, but everything has always been the pills.
Q. If you weren't there, would Hector be able to administer the insulin to himself when he needed it?
A. No, he cannot.
Q. Why not?
A. Because he's not concentrating on how much he has to put or when he has to put it.
Q. That was the question I was trying to get at earlier. Does he have issues paying attention and concentrating and keeping focused now?
A. A little bit.
Q. Can Hector drive?
A. No.
Q. Do you prepare all his food?
A. Yes, everything; me everything.
Q. Everything has to be pureed in a blender

before it's sent to him?
A. Yes.
Q. Who keeps track of when his doctor's visits are, you or him?
A. Me. I'm the one that has everything.
Q. Would he be capable of doing that himself?
A. No, no, he cannot. It's too much.
Q. You were asked earlier whether you had any type of nursing certificate. Has any doctor told you that you need a nursing certificate to help care for Hector?
A. No. No.
Q. Is it your understanding that the doctor said you're perfectly capable of caring for Hector?
A. Yeah. I mean, all. They just told me just, you know, like I mentioned before, the nurse just taught me how to make sure everything is in control, the sugar, make sure I have everything right and that's what I've been doing, because I want to keep everything in control.
Q. Right now does Hector have some issues with his mouth?
A. Yes, he has some. It's damaged, his mouth is damaged. His teeth, his front teeth fell. He has issues eating, you know, biting into his food and

that's why I have to blend or puree everything.
Q. Are you all waiting to get in to see a specialized dental surgeon?
A. Yes, we are still waiting. We are still waiting to get an appointment with the dental specialist so they can, but again we're still waiting.
Q. You haven't heard anything from workers' comp on that?
A. The only thing that I've heard is that until that insurance has not want to approve it and until insurance does approve it, all we can do is wait.
Q. Are you still waiting to see another specialist for Hector's nose to help with his breathing?
A. Supposedly there is a nose surgery, but again they haven't said anything, because until insurance does not approve it, there's nothing we can do. We're just waiting.
Q. It's your understanding that this recommended surgery hasn't been authorized yet or you're still waiting for approval?
A. Not yet, no. When they approve it, they will call me, but until it's not approved, they're not going to call.

Q. Would Hector prefer you taking care of him or some stranger that he doesn't know?

MS. EDMONDS: I'm going to object to hearsay.

Q. You can answer.

INTERPRETER: I'm sorry, you still want me to ask the question.

MR. CREECH: Yes, please.

A. Of course, I feel more comfortable that you're with me, because, again, as I told earlier, that he feels like there's more people in the house and he just feels more comfortable just with me.

Q. What about Andrea and Juan who own the house, what is your understanding of who they prefer to take care of Hector, you or some stranger?

MS. EDMONDS: Again, I'm going to object to hearsay, but she can go ahead and answer.

A. Yeah, they prefer me being with him.

Q. That's all I have.

MR. CREECH: Amity, do you have any other questions?

EXAMINATION

BY MS. EDMONDS:

Q. I just want to make sure I understood. For the surgery for the nose, have you been told that it's been denied or it just hasn't been authorized?

A. So yesterday I actually spoke to the workers' comp nurse and she told me that they're still waiting, they're still waiting, because last week they only did the CT scan and the MRI last week. Because every time I talk to her, I'm kind of like, you know, I want to remind her and the same thing with the knee.

Q. The nurse, you're talking about Stacian, is that right?

A. Yes, she's the one that gives me the appointments.

Q. Stacian, she speaks Spanish, correct?

A. Yes, she does speak Spanish.

Q. I don't have any other questions for you. Thank you.

(At this time, the deposition is concluded.)

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 2202001

**EMPLOYEE/CLAIMANT: HECTOR LOPEZ-VASQUEZ**

**EMPLOYER: OX PAPER TUBE & CORE CAROLINA, LLC**

**CARRIER: BERKSHIRE HATHAWAY HOMESTATE INS. COMPANY**

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**DEPOSITION OF DR. SIMA A. DESAI**

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PURSUANT TO NOTICE, THE WITHIN DEPOSITION OF **DR. SIMA A. DESAI** WAS TAKEN BY THE DEFENDANTS VIA ZOOM CONFERENCING ON THE 12TH DAY OF SEPTEMBER, 2022, AT THE HOUR OF 12:59 P.M. THE WITNESS WAS LOCATED AT HER OFFICE IN CHARLOTTE, NORTH CAROLINA, ATTENDED BY COUNSEL AS FOLLOWS:

**JAN L. WHITWORTH**
**VERBATIM REPORTER**

---

**WHITWORTH COURT REPORTING**
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**EXHIBITS**:

NONE MARKED

* DIGITAL RECORDING RETAINED FOR SIX (6) MONTHS FROM DATE OF CERTIFICATION.

PURSUANT TO NOTICE AND/OR AGREEMENT TO TAKE DEPOSITIONS, THE WITHIN DEPOSITION WAS TAKEN BY THE ABOVE-NAMED COURT REPORTER, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, BY CONSENT OF ALL PARTIES.

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**STIPULATIONS**:

IT IS AGREED BY AND BETWEEN COUNSEL FOR THE PARTIES AS FOLLOWS:

1. THE DEPOSITION IS BEING TAKEN PURSUANT TO THE RULES OF THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION.
2. THE READING AND SIGNING OF THE DEPOSITION TRANSCRIPT ARE **WAIVED** BY THE WITNESS AND THE PARTIES.

* * * *  * * * *  * * * *  * * * *

**THE COURT REPORTER**:

I am Jan Whitworth, the court reporter. This deposition is being held via Zoom video conferencing. The witness today has been identified as Dr. Desai, and she is located at her office in Charlotte, North Carolina. Do the parties stipulate and agree that Dr. Desai will be sworn in under oath remotely and her testimony will be given as if sworn under oath in person?

**BY MS. EDMONDS**:

Yes.

**BY MR. CREECH:**

Claimant agrees.

**BY THE COURT REPORTER:**

Thank you. And, Doctor, if you can raise your right hand, please?

* * * * * * * * * * * * * * * * *

THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE WHOLE TRUTH AND NOTHING BUT THE TRUTH CONCERNING THE MATTER HEREIN:

**DR. SIMA A. DESAI,**

BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS FOLLOWS:

**BY THE COURT REPORTER:**

Thank you, ma'am.

Q. Dr. Desai, as I mentioned before we get started, my name is Amity Edmonds. I'm an attorney with Gallivan, White & Boyd, and I represent the employer Ox Paper Tube & Core in the workers' compensation claim involving Mr. Lopez-Vasquez. First of all, we'd like to thank you for being here today, but more importantly thank you for the treatment that you provided to Mr. Lopez-Vasquez. This was obviously a very significant injury or accident with a lot of different injuries, and it's a complex case, and you've been helping him along with that,

and we are very very appreciative of that.

A. Thank you.

Q. Now, have you -- first of all, I want to make sure as far as the medical records are concerned that I have everything. The last date of service I have is July 20th of 2020; is that less than you saw him?

A. Yes. Yep, July 20th, 2022, yeah.

Q. Okay, great. All right. And the reason we're here today is just I want to ask you a couple of questions to clarify his current treatment needs. Certainly we're are not disputing any of the treatment that you provided or anything of that nature or causation of any of these conditions that you've been treating him for as it relates to his physical injuries and the brain injury that he sustained, but do just want to get a little clarification on a couple of the needs he requires, as far as attendant care. I'm going to try to be as brief as possible, but if you need a break for any reason obviously just let me know. I understand that you're very very busy. So just let me know if you need to go off the record.

A. Sure.

Q. And as I'm sure you're aware, just make sure any opinions you give today are stated to a reasonable

degree of medical certainty on a more likely than not basis, okay?

A. Okay.

Q. All right. Lastly, since we're doing this remotely if there's any sort of connectivity issues or you can't hear me or anything, please don't hesitate to speak up, so I can make sure we don't take any more time than necessary, okay?

A. Sure, thanks.

Q. All right. Now, if you can just tell me a little bit about your education and background.

A. Sure. Do you want me to start with my undergrad? How far back do you want me to go?

Q. Yeah, you can just start with your undergrad and go from there.

A. Sure. So I did My undergraduate at Emory University in Atlanta, Georgia. Followed that with a post baccalaureate with a Master's in Pharmacology at Tulane in New Orleans, followed by medical school at Ross University School of Medicine. Followed that by one year of internal medicine training as mandated by the American Board of PM&R in Flushing Medical Center in Queens, Flushing New York City. Followed that by my actual rehab residency physical medicine and rehabilitation at Tufts University in

Boston, Massachusetts. Followed that by a brain injury fellowship at the University of Texas Health Science Center in Houston, Texas. Followed that by moving here to for my position here at Carolinas Rehab as a brain injury physiatrist and have been here since August of 2019.

Q. 2019?

A. (No verbal response)

Q. Is that a yes?

A. Yes, I'm sorry.

Q. That's Okay. All right. Thank you. And you are board certified in what ---

A. I am board certified in physical medicine and rehab as well as brain injury medicine.

Q. And have you ever had any training in diabetes management?

A. No. Well, as an intern, I manage diabetes, but I don't actively manage that for my patients. We have hospitalists and internal medicine doctors who I will typically refer out for further management.

Q. Okay. And at the beginning I didn't hear you said. You said as something you were?

A. When I was an intern in my first year of medicine, it's required that we learn some basics of how to manage diabetes at a very basic level.

Q. Gotcha. Okay. But no specialized training or anything like that?
A. No.
Q. All right. You ever had any training in endocrinology, lipidology or pathology?
A. No.
Q. All right. What did you do to prepare for your deposition today?
A. I have reviewed all his records, printed off what I feel is appropriate for his care and spoken with all of his therapists his physical therapists, his occupational therapists and his speech therapists to determine where he is right now.
Q. And the physical therapist, who is that?
A. I don't know her name off the top of my head.
Q. That's okay.
A. I'm sorry. I can pull up his chart.
Q. Who is she with?
A. She's with Carolinas Rehab. They're all under the Atrium umbrella.
Q. Okay. The same thing for occupational and speech therapy?
A. Yeah, because he doesn't see the same person every time. So I had to get the information from the primary therapist.

Q. Okay. Gotcha. So you spoke with them. You said you pulled the records and reviewed them?
A. Uh-huh.
Q. Did you have any discussions with Mr. Lopez-Vasquez or his attorney or Juliana?
A. Yeah. I spoke with Mr. Lopez-Vasquez and his wife at their appointment, as well as their workers comp case manager that day when they came, and I also spoke with his lawyer via phone.
Q. And you said you spoke with Mr. Lopez-Vasquez and Juliana. I'm just going to call her Juliana for ease of reference ---
A. Sure.
Q. --- throughout the course of the deposition, but for the record initially it's Juliana Roldan-Dimas, I think is how you say it, and we'll just call her Juliana. So you spoke with her and Mr. Lopez-Vasquez at the appointment in July?
A. Uh-huh. And his workers' comp case manager, Stasia Hann.
Q. And then, also, with Mr. Creech?
A. Yes.
Q. Okay. And that was all at that appointment?
A. I spoke with Mr. Creech separately via phone call.
Q. You spoke with him separately on a phone call?

A. Yes.
Q. Do you know when that was?
A. I don't know. In -- in prep for the original date, it was maybe like a week or two before this, before the original deposition that was scheduled last time before unfortunate our power went off.
Q. I know, that was crazy.
A. That was crazy.
Q. All right. And so when y'all spoke, did you talk about the testimony that you would give here today?
A. We spoke about questions that could be asked during this testimony.
Q. Okay. And what questions, specifically, did y'all discuss?
A. We discussed his current level of function and the care that he currently requires and what that entails currently.
Q. Okay. And at that point when you spoke with Mr. Creech, did y'all reach a conclusion?
A. Yeah, I mean, I spoke with him with what my opinion is of where Mr. Vasquez is at the moment and my medical opinion.
Q. And what your testimony would be?
A. Sorry?
Q. Are you there?

A. Yeah.
Q. It looked like you froze.
A. Oh, no. Do you see me now?
**BY MR. CREECH:**
I can.
**BY THE COURT REPORTER:**
I can. I can hear you.
**BY THE WITNESS:**
Can other people see me?
**EXAMINATION RESUMED BY MS. EDMONDS:**
Q. I can now, yes.
A. Okay.
Q. Can you hear me?
A. I can, yeah.
Q. Okay. So, I didn't hear your answer, your response.
A. I said that we spoke via the phone about his current level of function and the care that he currently receives and my medical opinion of what his care that I think he should have.
Q. Okay. And did y'all discuss any conclusions as to what your testimony would be today?
A. We concluded that his wife is able to provide the 24/7 supervision that he currently needs, and that I think she is the most appropriate caregiver for him given that she does provide all his current

activities of daily living, his independent -- his IADLs as we call them, as well, as providing him with mobility help.

Q. All right. And as far as the physical speech and occupational therapists that you spoke with in advance of the deposition, did you talk to them in advance of today's deposition or the one we have scheduled for August 15?

A. The one we had scheduled.

Q. Okay. All righty. And then you said that you had pulled some medical records that you felt were relevant. Which record would those be?

A. I just pulled my most recent note so that I have access to it, and then just reading through all his therapy notes on my electronic -- on our electronic health record.

Q. Okay. Any other notes outside of the therapy notes and your records that you've reviewed?

A. No.

Q. Okay. Now, from the records that I have, and I may not have them all, but from what I do currently possess, the first record that happened to you is from March 17th. Is that correct, or did you say and before that?

A. That's probably the first time I saw him, because

his injury was February 18th, and I did not -- I don't recall seeing him in the actual hospital. So March would be appropriate for when was the first time I saw him?

Q. Okay. And do you have that record with you?

A. I don't have it printed. I can pull up his actual record. We recently went to a new health record system. So everything is unfortunately in two places. We have Epic, which is our new health record and then Cerner, which is our old health record, and they're still in the process of merging all of it over.

Q. Oh, goodness.

A. Yeah. Some of what I have?

Q. Well, that's fine. I actually, have the record pulled up. If it's easier, I could just share my screen.

A. Okay.

Q. But that's completely up to you. I think I can figure out the screen sharing. So, I will just give that a whirl.

A. Okay. If it's my note, I can speak to it, because I tend to write in the same manner as best as possible

Q. Okay. Tell me if you can see. Can you see your record?

A. Yep, I can see that.
Q. Okay. I'm very proud of myself. And the date, I didn't see it up top, but if we scroll down and I'll get back up, but just to confirm, we're looking at the record for Mark 17th, and this is your record; is that right?
A. Yep.
Q. Okay. And so at this time you indicated, you know, that he was presenting after a hospitalization, and then as we go down and look at some of your notations, and I can go as slow as you'd like, but you indicate that "He's ambulating with RW very slowly." What does RW mean?
A. RW is a rolling walker.
Q. Okay. And then you indicate for his therapies, he's in home physical therapy working on his right knee, home SLP, which is speech language.
A. Right.
Q. Okay. And home occupational therapy and home RN visits; is that right?
A. That is correct.
Q. Okay. And then at that time you discussed what all therapies he was currently receiving since being discharged from the hospital; is that right?
A. Correct.

Q. Okay. And you went through all the treatment he was currently receiving for his various injuries and then you evaluated what additional treatment you felt like he needed for each of his conditions. If we go down and look at the assessment, you go through each of the diagnoses and what treatment you feel like he needs; is that correct?

A. That is correct.

Q. Okay. So was it your role to kind of look at it globally and figure out ---

A. Yes.

Q. --- what treatment he needed?

A. Yeah. My role as the physiatrist in cases such as these is kind of just being the quarterback of the team, and so I try to facilitate any and all consultations that would be appropriate after an injury such as this. So it's not unusual especially in workers' comp cases where I actually have to take on a bit of a larger role in terms of referring out to additional specialists. You know, in this case it was orthopedics, nutrition. He was already seeing plastic surgery. We had discussed at that appointment with his diabetes it wasn't something I manage, so I wanted to make sure that the primary care who, which I think was Affinity Health Center

was managing that because it's not something I manage. So that was something we had spoken about at that visit. So yeah that's typically -- that's typically my role.

Q. Okay. Very Good. And so looks like from going through this report from March 17th, you made multiple referrals, which we'll talk about them, specifically, in a minute, but this was all the treatment, and correct me if I'm wrong, you were outlining all the treatment that you felt Mr. Lopez-Vasquez needed as a result of this work accident.

A. Yeah. Based on current symptoms at that time. There may have been more to the note. That would be my guess. Usually I will ---

Q. And we're going to go through each of them quickly.

A. Okay.

Q. But I just want to make sure as a general -- the general purpose of that evaluation was to assess what all treatment he needed and then you made those referrals?

A. Correct.

Q. And you noted here on this part that's highlighted "All referrals were given to workers' comp case manager today," and that you recommended he would not return to work; is that right?

A. Correct.
Q. Okay. And then looking at the referrals, you know, you initially indicate that he would benefit from outpatient SLP therapy, as well as plastics. You referred him to orthopedics for his right lower extremity. For his mood, you indicated we needed to increase the amitriptyline. Is that how you say that?
A. Yes, that's how you say it.
Q. Okay. Because his wife was concerned that he was depressed. You go on to indicate that he needs neurology for his headaches, vestibular evaluation and therapy for dizziness. You, also, recommended that you see a neuro ophthalmologist and you placed that referral. You recommended a vision therapy and an OT consult, ---
A. Yep.
Q. --- and then an additional ophthalmology referral, as well, as that he continue to follow up with ENT and plastic; is that right?
A. Yep.
Q. Okay. And, you know, you had mentioned briefly indicated earlier with regards to amitriptyline that his wife was concerned about his depression. So is it your understanding that Juliana is Mr. Lopez-

Vasquez's wife?

A. Uh-huh.

Q. Okay. And at that point, again, you made all the referrals, and you tell him to return to the clinic in two months to be evaluated by you again; is that right?

A. Correct.

Q. Okay. And, sorry, one additional referral with occupational therapy, PT, speech and audiology therapy?

A. Sorry. Those referrals, they're like, they're automatic when they're therapy orders. So they all say OT, PT, speech, audiology. So if I have to do a PT referral and an OT referral and a speech referral, I'm essentially writing that order three separate times. So that's why that gets listed more than once.

Q. Okay. That makes sense, because it was noted throughout the record.

A. Yeah.

Q. Okay. And so looking at all the referrals that we just discussed and all the referrals that are included in your record at this March 17th visit, you didn't make any recommendations or issue any referrals for 24/7 attendant care; is that correct?

A. Not at that time because the wife was already on leave at that time. So she was helping him in the house.

Q. Okay. But, as far as having workers' compensation provide for this attendant care, that's not something that you addressed or made any sort of referral for that initial visit; is that right?

A. It was not brought up at that visit. So, yeah, it still isn't something I addressed.

Q. Okay. And then with regard to his diabetes, you noted -- let me get back to it -- that he's still taking steroids due to injury for inflammation, and glucose remains elevated; therefore, he needs insulin for management of this given steroid induced hyperglycemia. As far as I don't see He mentioned in here of any of the A1C levels or glucose levels. Was there ---

A. So there was discussion in that appointment that his glucose levels had been high, and they wanted to know what I would do about it, and I said "Well, he needs to really see a primary-care physician," and there was already someone managing it at that time, which is why I said "Well, then the steroids need to be clarified as to how long he needs them," because he's never -- this was like a -- seemed like a

relatively new diagnosis. He had never managed this before. So that was something that I had just recommended. I didn't -- I wasn't managing his diabetes by any means.

Q. Okay. And so the discussion, was that with Mr. Lopez-Vasquez and Juliana?

A. Yes, as well, as the workers' comp case manager.

Q. Okay. But you didn't have any of the medical records concerning his preexisting diabetes or anything like that?

A. No.

Q. Is that a no?

A. No. Yeah, sorry. No.

Q. That's Okay. And I should have said this at the beginning, if I'm reminding you of that, I'm not trying to be rude or fuss at you or anything. I'm just trying to make sure the court reporter can get your response, okay?

A. Makes sense. Thank you.

Q. All right. So you really were just noting this because it's something that was raised, but not something that you had any prior medical records of or really any knowledge of what the actual readings were, as far as his diabetes at that point in time?

A. That is correct.

Q. Okay. All right. And then while there was no referral or recommendation for the 24/7 attendant care made at that March 17th visit, I was provided a questionnaire that looks like was completed on April 6th by Mr. Creech, and I can pull that up, as well, Is this a questionnaire that you recognize?

A. Yes.

Q. Okay. And I'm just going to scroll to the signature page. Is this your signature?

A. That is my signature Okay.

Q. Okay. And so you completed this at the request of Mr. Creech?

A. I did.

Q. All right. Did y'all have a conversation or a meeting or anything in advance of that?

A. No. I mean, this is typical of a form that I fill out for plenty of my brain injury patients who require any sort of supervision at home after an injury.

Q. Okay.

A. So for me this was just filling out regular paperwork that I fill out for all my patients.

Q. Okay. But she said y'all did or did not have a conversation?

A. We did not have a conversation about it. It was

just paperwork that had been in -- it's in -- like we have like paperwork box offices. So it was in my typical paperwork, and, you know, a message had been left for me that to -- if I felt like it was appropriate to fill it out from I think family or someone either from workers comp, as well. I'm not really sure; it was a long time ago.

Q. Okay. So it wasn't until you received this request or this questionnaire from Mr. Lopez-Vasquez's attorney that you made any sort of recommendation with regard to attendant care?

A. I mean, in general brain injury patients are recommended to always have someone at home with them any times they've had -- sorry, my computer went blank -- anytime they have a head injury, 24/7 supervision it's typically just a kind of a blanket thing we tell a lot of our patients and their family members that they should have just given the injury. We don't always know every deficit that may -- that they may have. And so it's a recommendation we make for all of our patients especially if they have any sort of physical or cognitive deficit.

Q. Okay. And would you not -- if someone is in need of 24/7 supervision, would you not typically recommend that they participate in some sort of inpatient

program?

A. Not necessarily. We have plenty of patients who go home from acute care hospital, but one of our big recommendations is that they always have someone at home with them to help provide supervision and help get them to and from the bathroom, because brain injury patients typically are still very unsteady on their feet, and so not everyone needs inpatient rehab, and even some of our inpatient rehabs don't, you know, do have to have a level of enough severity to meet the qualifications for inpatient rehab, which would require 24 hour nursing care around the clock, which not every patient needs to have. And so that -- that's one of the big stipulations for having inpatient rehab.

Q. Okay. In the event that Mr. Lopez-Vasquez lived at home alone, what would your recommendation have been?

A. Our recommendation would have been he would need to have private duty help, someone to help them at the house to have 24/7 supervision. Like, typically most people have a caregiver like a wife or, you know, older children, someone in their family a loved one who typically will provide the care that they need and is capable of providing the care they

need.

Q. Okay. So as of April 6th when you completed this, what, specifically, did Mr. Lopez-Vasquez require 24/7 attendant care for?

A. All of his activities of daily living, so the typical dressing bathing showering, you know, mobility. Despite him being able to mobilize, he's not necessarily safe in that he even at this point, his most recent PT note said he remains a high fall risk based on his TUG scores, which are a standardized measurement of where you fall on the fall risk spectrum. You can either fall in a low fall risk, a medium fall risk, or a high fall risk. A high fall risk would mean that you're at high risk to fall at any moment, and so all -- the majority of brain injury patients have some sort of fall risk, and Mr. Vasquez still remains a high fall risk, and because of his needs of needing help with his ADLs, as well, as mobility along with his cognitive deficits, between all three of those things he warrants to have someone with him at home.

Q. Okay. In that questionnaire, which I just took down, but you indicate that Ms. Juliana Rodan Dimas is capable of providing the 24 hour attendant care to Mr. Vasquez; is that right?

A. That is correct.
Q. Okay. And what is your knowledge of Juliana's relationship with Mr. Vasquez? You believe that she's his wife?
A. Yes, she is his wife.
Q. Okay. What is your knowledge of her education level?
A. I don't have knowledge of her education level in terms of her highest level of education.
Q. Okay. What's your knowledge with regard to her training and experience?
A. I mean, she hasn't -- there's been no falls in the home. She -- the patient himself feels comfortable with her providing his level of care, which is a pretty large thing with our brain injuries. A lot of them don't -- feel uncomfortable with, you know, people they don't know in the house, and Juliana does speak Spanish. And so that is his comfort level with language. So from my experience speaking with her, seeing her at the appointments and her engagement with him, she is a great advocate for him and provides good level of care.
Q. And do you speak Spanish?
A. I do not.
Q. Okay. Are you able to communicate with Juliana as a

Spanish speaking woman?

A. We always have interpreters at all the visits present with case management. So that way everything is being relayed in the preferred language.

Q. Okay. And what's your knowledge with her experience with monitoring and managing or treating a diabetic condition?

A. From my knowledge, she has been able to assist with all of those things from the primary care. So I don't have a direct input or knowledge into how his diabetes is managed. So I can't really speak to that, but based on what the case manager has told me at following visits, his diabetes was under control, so, that's just it.

Q. But you haven't had any direct discussions with her about that?

A. No, because I don't manage diabetes, so...

Q. Okay. And then what about with her training or ability to assist with ambulation, with transfers, lifting, things of that nature, have you had any discussions with her about that?

A. I mean, she is present for -- was present for all the home health visits while, you know, home PT, home OT, home speech. If they have any concerns,

they bring them to -- to my knowledge. They'll call the office and say "I'm concerned about this loved one providing care," and there were no issues that were brought to my knowledge.

Q. So, as far as your conversations with Juliana about her capabilities and ability to provide attendant care, you haven't had any discussions with her about that personally; is that correct?

A. I mean, in the office visits, you know, our discussion is how is he doing, what is he doing in the home, and she is able to provide that knowledge back of what he's doing in the home and what they try to do to stay active. You know, she for a long time was having to make him his meals, which were like pureed things when he couldn't really eat solid food, and so she was asking what more could she do and what exercises she could be doing at home. So we -- we spoke to the relative knowledge within the visit of her ability to care for him and everything that she was providing for him during those visits.

Q. Okay. And so from the records that I have, it looks like the next time you saw Mr. Lopez-Vasquez was May 4 of 2022; is that right?

A. Yeah. I mean, about two months post the original visit. Yes.

Q. Okay. And is that -- do you have that record or no?
A. I don't, because it's all in the old system.
Q. That's okay. And, of course, my computer is not cooperating with me either, but in looking at that record, it appears that you noted he was referred to physical therapy, occupational therapy and speech language therapy, but had not yet started that. So you weren't aware that he was undergoing home health occupational therapy, speech therapy and physical therapy at the time -- at the time you saw him on May 4th?
A. In my March note, I put he was in home PT/OT speech, and then the goal is once that starts to taper off, we want to get people to outpatient. So typically there's always a delay with workers' comp and getting people out of home health and then to outpatient therapy, because typically that will require transportation and making sure that the receiving facility, the Atrium facility has the ability to take on that patient. So typically when I will put "That hasn't been started yet," it means that we're -- just in we're waiting for it -- for it to start.
Q. Okay. But you were talking about outpatient, not in home?

A. Correct.
Q. Okay, great. Were you given the home health notes, or did you have any discussions with them during that period of time?
A. We typically get like a stack of papers of what they did in home health, and they're pretty limited, but yeah, I mean, those are things I review with the workers' comp at their appointments to see if there's anything I missed, because sometimes there's paperwork that we don't always get.
Q. Okay. And I did get my computer to operate again. So I will just pull up the report just so we're all looking at the same thing. Can you see here that this is from the May 4th visit?
A. Yes.
Q. Okay. And as far as the assessment and plan, you indicated -- you reiterated that he needed this outpatient therapy that we've already talked about: physical therapy, occupational and speech therapy. Then you indicate as far as headaches are concerned that he's going to be started on gabapentin and sumatriptan and then, also, refer him to neurology; is that correct?
A. Correct.
Q. Okay. And then you go on to indicate that he was

set up for orthopedic evaluation in May, as well as the ENT for rhinoplasty and septoplasty; is that right?

A. Correct.

Q. And he's supposed to see Dr. White for Neuro ophthalmology as well, but I don't see any indication of anything concerning diabetes, but I think that's because as you've confirmed earlier that's not something you were actually treating or monitoring?

A. Right. I only documented it because I wanted to keep it in mind for the next visit if there was a major issue, did we need to plug them in to endocrinology or someone with a higher level of experience.

Q. Okay. And then you indicated that as far as caregiver support, the wife was seeking paperwork to extend her FMLA, and you indicated that you would complete some paperwork if she provided that from her employer; is that right?

A. Correct, because we were wondering, you know, if she had an extension of FMLA that -- that would be ideal, and I would be happy to fill that paperwork out. So that's why I asked her to reach back out to her employer and see if there was paperwork that we

needed to complete on our end to extend her FMLA or whatever leave they may have that may be different.

Q. And so you -- but again, there's no referral written for the workers' compensation carrier for a home health aide at this visit; is that right?

A. Correct, because the wife was providing all the care at home and taking time off to provide all the care that he needed.

Q. Okay. But then it looks like a couple of days later, you drafted a letter indicating that his wife would be required to care for him at home 24 hours a day seven days a week. Did you complete that at the request of Mr. Creech or Juliana?

A. That was completed at the request of -- I'm not actually sure who. I want to say it could have been the workers' comp actually, asking for it, because we were trying to work with her work and getting an extension placed on her FMLA, and so she has -- she had been his primary caregiver the entire time, and so that's why that letter was written to explain what she was doing and to provide an increased level of time where she could continue being the caregiver.

Q. And were you aware that workers' compensation offered a professional home health aide ---

A. I was not.
Q. --- that was declined?
A. I was not aware of that.
Q. Okay. And then the last time you saw him -- well, I guess I shouldn't assume anything, but from my record the next time you saw him was July 20th, which was the last time you've seen him?
A. Correct.
Q. Okay.
A. And I had only recently been told by that appointment that there was this case, and so that was new knowledge for me.
Q. What there was what, I'm sorry?
A. That there was like an ongoing case going on. That was -- that was the first time I'd heard of this.
Q. Okay. And in looking at that record, you noted that he was improving with his activities of daily living and that his wife was just supervising him?
A. So providing supervision being there so that if he starts to feel dizzy and needs to sit down, she can be there to help them if he needs it, but being there as a presence, which is not unusual for a lot of our brain injury patients, they typically continue to require supervision for long periods of time between their cognitive deficits, their

vestibular deficits. That's something that's very common in our population of patients.

Q. Okay. And supervision with, which activities specifically?

A. So, typically when I say supervision, I just mean with everything in general. So supervision with their ADLs, supervision with mobility, supervision with their cognition, so that, you know, he's not maybe getting up and trying to cook a meal like alone. So that's typically what in my world of super -- that's what I mean, in supervision someone just being there to monitor.

Q. Okay. And, but he's making progress at this point, with his his ability to perform his activities of daily living?

A. He continues to make progress. Yes.

Q. Okay. And then it looks like, you know, again, go through the treatment plan, recommend he continue all the therapies we've already discussed and then, essentially, defer to the different specialists that have gotten involved: the ENT for the rhinoplasty, Dr. Raya or Rao, I don't...

A. I think it's Rao.

Q. Rao, okay. For procedures regarding the facial fracture, referring out -- or deferring out for the

dental treatment that he needs. He's treating with Dr. Rentz for his orthopedic needs for the right lower extremity, and then you listed some medications. This was one thing I wasn't sure about. You said continue gabapentin, nortriptyline, magnesium and riboflavin per neurology. So is that something you were prescribing, or that's what the neurologist is prescribing?

A. That's what the neurologist is prescribing, but I like to just keep track of who's prescribing what, because in cases like this where you have literally, several physicians managing several different things, things sometimes get lost in the weeds, and so I always just write down who's prescribing what. In the event that they run out of a medication or something like that, I know who to kind of reach out to.

Q. Okay. And I didn't see unless I'm wrong any new or different treatment that was recommended at this particular visit?

A. No new treatment, no. Just continuing his current treatment plans.

Q. Okay. And the same thing with the diabetes, you're not ---

A. Right.

Q. --- prescribing that anymore?
A. Right. Yeah, if I'm not managing at all, I won't comment on it.
Q. Okay. And again, no recommendation for a referral for 24/7 attendant care, but you completed the same letter indicating that his wife would need to care for him?
A. Correct.
Q. Okay. But you're not sure if that's being completed for her employer or for Mr. Creech?
A. Correct. I was filling that out on behalf of just the brain injury patient Mr. Vasquez himself the fact that he needs supervision, he needs someone to be at home with him, essentially, all the time.
Q. All right. Now, we took Juliana's deposition back on June 9th. So it would have been about six weeks, I guess, before you saw Mr. Lopez-Vasquez the last time. And, you know, trying to walk through what their typical day and schedule was like, the types of things that they did, and what she explained to us is that on a typical day that they would get up between 6:00 and 7:00 am, go to bed at 9:00 pm. During that period of time overnight, he doesn't get out of bed until the following morning, and I think when asked, specifically, by Mr. Creech if she had

to help Mr. Lopez-Vasquez get out of bed in the morning, she said no she doesn't have to help them, but she likes to stay in there to check on him. Understanding that they're both sleeping between 9:00 pm and 7:00 am, would you agree that that's not a period of time that he requires supervision?

A. I mean, yes, typically when most people are sleeping they're not getting out of bed, but in the event -- I mean, Mr. Vasquez has ongoing vestibular deficits where he gets dizzy going from standing to lay -- or laying to sitting, sitting to standing, so -- and he still falls under a high fall risk category from his physical therapist, so based on that, I would say if he were to get up in the middle of the night to go to the bathroom, I would be a little concerned that if there was nobody around to potentially be there even, you know, in the event he stumbles and unfortunately, falls and hits his head again, that could be very detrimental for him because he's already had one brain injury. I wouldn't want another. So if he's sleeping through the night with no issues, yes, no one needs to necessarily physically be there, but there's always that risk that we run of if someone gets up in the middle of the night and stumbles, I mean, then that's the

risk.

Q. And while Juliana is sleeping, do you agree that she's not providing supervision at that point in time, right?

A. Correct.

Q. Okay. All right. One of the reasons that we're here is because Mr. Lopez-Vasquez's attorney has filed a hearing request with the commission asking us to pay Juliana $14.41 per hour 24 hours a day seven days a week to provide supervised care, which is, approximately, $125,000 per year. From the carrier's standpoint, if Mr. Lopez-Vasquez requires this level of attendant care, then certainly they would prefer to provide that with a licensed and trained home health aide. Would you not agree that a licensed and trained home health aide would be in a better position to provide any medical treatment or care that Mr. Lopez-Vasquez would need in light of his condition?

A. I think given how far we out -- how far we are out from Mr. Vasquez's injury at this point, and the fact that Juliana has been able to provide all the care that he has needed, I think that Juliana is a perfectly competent individual to continue to provide that care. Juliana speaks Spanish. Mr.

Vasquez speaks Spanish. I think a language barrier is a very big issue culturally, as well, as just having a stranger in your home not someone you know, and typically the attendants that our provider provided by workers comp they're not the same people every time. So he has the strongest relationship with his significant other, which is Juliana. So I feel in brain injury patients, we find that loved ones do provide great care, because they're connected through a bond with their significant other, and I think that's a big thing that drives brain injury patients and their care for a loved ones is that that comfortability with someone they know is able to provide the competent care he needs And so I think at this point, Juliana is competent to continue to provide that care that he needs.

Q. Okay. But you would agree that no one individual can provide supervision on a 24/7 basis. They have to sleep. They have to go to the bathroom. They have to shower, correct?

A. Yes. They have to shower; they have to sleep, absolutely.

Q. Okay. So is it your opinion that he needs 24/7 attendant care, or that he needs attendant care for some other period of time that can be provided by

her because she can't provide 24/7 care?

A. I think the daytime awake time care, I don't know how to phrase that, but the waking hours of where he would be awake from that 6:00 am to 9:00 pm, the waking hours is where I think Juliana is perfectly competent providing that.

Q. All right. As far as Ms. -- or Juliana's deposition testimony, she indicated that Mr. Lopez-Vasquez is able to go to the restroom on his own; he's able to get up out of bed on his own. She provides meals for him. She cleans. She -- and she likes to be there just to make sure that -- that he's Okay. She, also, administers his medications. Administering medications, would that not be best suited to be done by someone who is licensed and skilled and trained in administering medications and in particular diabetic medication?

A. I think with a lot of my brain injury patients, their loved ones are the ones who do all of their medications, provide all their -- Mr. Vasquez currently doesn't have a tube feed or tube feeding requirements, but that is something we teach our families to provide, because at the end of the day, they're the ones that are living with them long term, and they're the ones that are living with the

long term deficits I'm having a brain injury. So I think Juliana has been able to provide competent care for him this entire time including his medications. He continues to have cognitive deficits with his speech therapists. They're improving, but he continues to have cognitive deficits in, which he needs help taking his own medications, and Juliana has been able to provide that successfully.

Q. I understand. My question was wouldn't a licensed and trained skilled home health aide be more qualified to provide attendant care that Mr. Lopez-Vasquez needs than Juliana?

A. I can't ---

**BY MR. CREECH:**

She answered your question, and it was no.

**THE WITNESS ANSWERS:**

A. Yeah, I mean, I can't really ---

**BY MS. EDMONDS:**

She didn't answer the question.

**THE WITNESS RESUMES ANSWER:**

A. --- say that, because I don't know what care they're providing. I would say they're equal, because loved ones can be taught how to do pretty much everything for their loved one.

**EXAMINATION RESUMED BY MS. EDMONDS:**

Q. Also going back to the diabetes, in the questionnaire that you completed for Mr. Creech, you indicated that the accident had aggravated his pre existing diabetic condition. You've never reviewed any of his prior medical records concerning his diabetic condition, have you?

A. I mean, he was on steroids. So steroids will -- can cause worsening of any sort of diabetes or hyperglycemia that's new. So anytime you're on steroids that is something that's very commonly treated in the medical community. I've had plenty of patients who have steroid induced hyperglycemia. I don't necessarily manage it, but it's something I see very often that is pretty common.

Q. Okay. But for Mr. Lopez-Vasquez in particular, did you have an opportunity to review his records from prior to his work accident?

A. When I first saw him, I was told that his blood sugars have now become uncontrolled, and our discussion was the steroids are likely causing that uncontrolled. So I didn't have -- I had access to his records in the hospital stay, which is what I reviewed, which is what I had access to, and based on that, we -- we came to the conclusion that this

was likely steroid-induced hyperglycemia, and that's why his blood sugar's had become difficult to control.

Q. Gotcha. Okay. But when you complete that questionnaire, you didn't have those prior records or and had not reviewed them; is that right?

A. No, I had based it on my knowledge of my visit from that week before and the records I always have available to me, my own records, the ones from the hospital.

Q. And so understanding that he had control diabetes before, then was administered steroids as a result of this accident, then obviously that led you to the conclusion that he had aggravated his ---

A. Correct.

Q. --- preexisting diabetes?

A. That was my assumption, I mean the progression of what I see in patients.

Q. Okay. That's all the questions I have, but if you give me just one second. I'm looking through my notes.

(Off the record briefly)

**EXAMINATION RESUMED BY MS. EDMONDS:**

Q. From a brain injury standpoint, I know you said that Mr. Lopez-Vasquez was improving. Is he improving as

you would expect to given the degree of injuries that he sustained?

A. He is. He is improving. He continues to make gains in physical therapy, occupational therapy and speech therapy, which is very encouraging. Given the severity of his injury, he continues to make gains. So that's very promising and encouraging for me.

Q. Okay. Anything -- and I know we talked about that there's a lot of other specialists involved, and they're treating specific injuries. As far as the treatment that you're directing right now, is it mostly just the therapies that we've talked about?

A. Yeah.

Q. Okay. So no medications that you're prescribing?

A. I am -- I am just looking at my list here, all his meds. No, I'm not prescribing any of his medications currently.

Q. Okay. And I know this is just pure speculation, but just because I'm curious, what type of time frame do you feel like it will take to treat his brain injury before he gets to a point of maximum medical improvement?

A. The complicated part about brain injuries is that no two brain injuries are the same, and that's why I think brain injury is challenging to work with. So

it's truly really hard for me to say, because he had such a significant injury with lots of fractures that he's still dealing with. He's still unfortunately dealing with several of the primary issues that he had, which is why he is still seeing so many specialists. So I really -- I really can't predict. Newer research is telling us that brain injury patients continue to make gains like 10 years post injury. So I can speak to that evidence that a lot of patients are still continuing to make gains even 10 years out from their injury. I would say usually within the first five years is when I see the biggest improvement in my patients, and then after the five years I start to see more of a plateau of reaching kind of more of a baseline and seeing that that's probably where their deficits remain.

Q. Okay. And from your standpoint outside of, you know, having these other specialists evaluate him, what additional treatment do you anticipate he will need outside of the therapy?

A. Yeah. I mean, I think he'll continue to need lots of vigorous physical therapy, occupational therapy and speech therapy to work on all the current domains that he still needs help with. Outside of

that because he has so many polytrauma injuries between his facial fractures, his mandible fractures, his hearing loss, myself, what I'll be personally managing is just the chronic kind of long term deficits from a brain injury, which is typically the cognitive piece and the mobility piece is what we see typically lingers in these patients. So that will be something at a later date that we'll continue to work on, but right now, I think we're just trying to get him to continue to make progress in his -- in his goals.

Q. And is he undergoing formal vestibular therapy right now?

A. He is, and he's doing a little bit of both with his physical therapist who does both vestibular, as well, as physical therapy working on the neck and range of motion.

Q. And this has nothing to do with you unnecessarily, but part of the issue that we have is being able to get actual medical records from Atrium. So we don't really have a lot of these physical therapy records or really any of them.

A. Okay.

Q. Do you have any suggestions on how we can go about getting them so we can monitor where he is from a

medical standpoint?

A. I mean, they're typically all in the medical record. The easiest way maybe just calling up our therapy department. I think most of his therapies are in Pineville, and I think they'd be happy to print out his therapy, which they could even do when he goes for therapy sessions. As a patient himself, he does have access to his entire full medical record. So I tell my patients that if they can just get on the website at home and login, they can actually print even my notes that I write about them and take them to doctor's appointments that they have with other physicians.

Q. Is it like MyChart or something that they have to go to?

A. MyChart, yeah.

Q. Okay.

A. Now that we're on Epic, it might be a little bit easier would be my guess, because now everything has been -- is trying to be fully consolidated in one location.

Q. Okay. And it's called Epic?

A. Uh-huh, E-P-I-C.

Q. Okay.

A. And we have like a MyChart, so that's where

everything could be pulled from.

Q. Okay, gotcha. All right. I think that's all the questions that I have for you. Drew may have some though.

**BY MR. CREECH:**

**Just a few short follow up.**

**EXAMINATION BY MR. CREECH:**

Q. Dr. Desai, I just want to make sure the record is clear. It remains your opinion that Mr. Vasquez requires 24 hour attendant care supervision since he's been home from the hospital through today?

A. Correct.

Q. And he'll need that for some period of time on going, yet to be determined?

A. Correct.

Q. And currently, Ms. Juliana has been performing -- providing that care, and in your medical opinion she's been doing it competently?

A. Correct. That's my opinion.

Q. And in your opinion, do -- in a way is it almost more -- more preferable to have a caregiver that a patient is comfortable and familiar with as opposed to a stranger?

A. Correct. That would be my opinion that patients do better with people they know.

Q. And I believe there is some talk about no one person can provide care 24 hours a day seven days a week, but is it your understanding that Mr. Vasquez not only lives with Juliana, but other members of their family?

A. Correct. Yes, I'm aware of that.

Q. And so if Mr. Juliana needs to go take a shower or step out for a little bit, that typically there's another family member that is capable of watching over him while she steps out?

A. Correct.

Q. Lastly, I wanted to ask you a quick question about Mr. Vasquez's last brain MRI. I've got a date of May 31st, 2022.

A. Okay.

Q. Do you have that available?

A. I can try to pull it up.

Q. Well, let me ask you this. I can just read it, and then I can ask you a question.

A. Okay.

Q. If that's okay.

A. Sure.

Q. The impression of that MRI notes right greater than left inferior frontal and right temporal encephalomatia (phonetic).

A. Uh-huh, encephalomalacia.
Q. Encephalomalacia. Can you tell me what that is and what that means?
A. So, let me think about how to word this properly. Encephalomalacia is, essentially, a part of the brain that was injured initially, and so the best way I kind of tell my patients is when you fall and then you get a scar on your leg -- well, you get a scab, and then the scab turns into a scar. Our brain does the same thing. So Mr. Vasquez had an injury to his brain. The brain had an acute -- he had acute blood in his brain, and so now, the brain now has a permanent scar, and that scar, essentially, is a bit of like a black hole. And so what that is is it's somewhat it may not become dead tissue, but it could become dead tissue and encephalomalacia is just a fancy word for there is scarring on the brain, and that area of the brain isn't healthy anymore. And so now, he has a permanent scar there that over time could lead to secondary deficits. As he ages, he'll more likely have atrophy in that part of the brain, because it's no longer like functional. It's not healthy tissue there. It's tissue that's been scarred and has -- it's been injured. And so that's the best way to

kind of put that.

Q. So -- and that answers a lot of my question. So I mean, encephalomalacia is a -- it's a severe injury; is that correct?

A. Encephalomalacia unfortunately, can't tell you degree of injury it can just tell you that that part of the brain has been injured from some sort of injury. In his case, his was, you know, bleeding on the brain, and so we know that he's always going to have encephalomalacia in the parts of the brain where -- where he had significant bleeding.

Q. Okay. And so it's a permanent condition that potentially can create progressive decline over time?

A. We can't associate any decline currently with it, but we just know that that area of the brain is more likely to atrophy over time, and so that's kind of the best way of putting it. It's, essentially, just loss of brain tissue from the injury.

Q. And the parts of his brain that we -- those findings were we're seen, what is that -- what parts of the brain does that control, or what is the -- what does that do?

A. So the front part -- and then sorry, can you read me off the other part? You said frontal and the...?

Q. Yeah. It had right and left inferior frontal and then right temporal.

A. So your frontal part of your brain is a lot of your behavior, what stops you from saying something impulsive if you don't like someone that's the part of the brain that kind of prevents you from saying crazy and rude things. That's the best way to put it. That's your frontal lobe. That's -- it's essentially your stop sign. Your brain says "Don't say that," and so you're able to hold your tongue and not say something. Your temporal part of your brain has to do a lot of with your memory and your cognition. The frontal does, too. They're all actually interconnected. The brain is more like a circuit, and so if you think of the brain like a circuit if one part is damaged, another part of the brain is going to try to reset the circuit and work in a different way, but as a result all of our brain -- the majority of my brain injury patients with this severity of injury will continue to have cognitive deficits likely lifelong.

Q. Dr. Desai, that's all the questions I have. Thank you so much for your time.

A. Yeah, you're welcome.

**BY MR. CREECH:**

Amity, you got anything else?

**FURTHER EXAMINATION BY MS. EDMONDS:**

Q. Yeah, I've just got a couple of quick questions for you. First of all, with regard to the attendant care, in your experience, how long is that necessary for someone that has suffered the type of injuries that Mr. Lopez-Vasquez has?

A. Unfortunately, it's very variable. I know that's why I can't tell you why, but as Mr. Vasquez continues to improve, he has made great gains in such a short process, or in the several months that I've been seeing him he's continuing to make really good gains. So I'm hopeful that he's not going to need 24/7, you know, lifetime. I do definitely have some patients who have to have a lifetime of 24/7, and that's typically -- that happens sometimes. So I'm hopeful that eventually Mr. Vasquez is not going to need someone with him there all the time and that he'll be able to do a lot of things independently without someone being there for him. So I'm hopeful for that, but I can't predict when that's going to be.

Q. Okay. Well, in particular with you noting last time that he's progressing with his ADLs and his wife is just supervising him, that means that he's doing it,

she's just there in case he needs her?

A. Right. So I mean, those are -- those are great, I mean, I think a great accomplishment in and of itself. So my goal maybe within the next year I mean, that would be my goal.

Q. And when he comes in, are you able to speak with him?

A. Uh-huh.

Q. He can communicate with you?

A. Yes. He can communicate with me. It is hard because he does have dysarthria, so, you know, speaking Spanish with the interpreter, and then having the interpreter speak back, sometimes the dysarthria it makes it a little bit hard to sometimes understand him. So we have to repeat things several times, but we are able to have a conversation.

Q. Okay. And the main reason that you're recommending this attendant care is more or less just to make sure he doesn't fall?

A. Yeah, I mean, he remains, you know, currently, with talking with his physical therapist based on her objective testing, he remains a high fall risk. And anytime someone remains a high fall risk, it's ideal if you can have someone be with you at home until

your fall risk kind of drops. As you become stronger and your body get stronger and you continue with your rehab, his fall risk should diminish over time.

Q. Okay.

A. Sorry.

Q. Sorry, I didn't mean to interrupt.

A. I was just saying his fall risk should improve over time, so...

Q. And that's what the walker is for, right?

A. Yes.

Q. And earlier -- I just want to make sure I understand, you had indicated he actually needed supervision during the waking hours, but then a few minutes ago when Mr. Creech asked you, you said he needed attendant care 24/7. So is it during the waking hours, or is it 24/7?

A. During the waking hours. So for me that would be from the time he gets up to the time he goes to bed.

Q. Okay. That's all the questions I have for you.

**BY MR. CREECH:**

Nothing further. Thank you again, Dr. Desai, for everything.

**BY THE WITNESS:**

Thanks.

**Hector Lopez-Vasquez v. Ox Paper Tube & Core Carolina, LLC**

W.C.C. File No.: 2202001

SS#: [redacted] DOB: [redacted]

***The following medical opinions are given to a reasonable degree of medical certainty on a "more likely than not" (greater than 50% probability) standard:***

1. I am Board Certified Physician in Pathology and Lipidology.

   Yes ✓ No _____

2. I currently serve as a Professor at the Medical University of South Carolina in the Division of Endocrinology, Diabetes and Medical Genetics, Department of Medicine, and Department of Pathology, as well as a Professor in the Department of Microbiology and Immunology, where I have served for over 20 years.

   Yes ✓ No _____

3. I have thoroughly reviewed the below mentioned medical records and deposition testimony and based on my experience and expertise, reached the expert medical opinions detailed herein, which are stated within this questionnaire to a reasonable degree of medical certainty on a "more likely than not" basis:
   - Affinity Health Center, PA Shaylo Reyes:
     - Dates of Service: 12/5/19, 1/7/2020, 4/16/20, 7/16/20, 10/16/20, 1/20/21, 2/24/21, 5/6/21, 8/12/21, 3/18/22, 4/4/22;
   - Carolina Medical Center:
     - Date of Service: 3/2/22;
   - Home Health Care Certification and Plan of Care:
     - Date of Service: 3/4/22;
   - Kindred at Home:
     - Dates of Service: 3/4/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/22/22, 3/24/22, 3/25/22, 3/29/22. 3/31/22, 4/12/22, 4/19/22, 4/28/22, 5/5/22, 5/19/22, 6/1/22;
   - Carolina Neurosurgery & Spine, Dr. Stetler Progress Note:
     - Date of Service: 3/16/22;
   - Atrium Health Plastic and Reconstructive Surgery Progress Note:
     - Date of Service: 3/23/22;
   - Charlotte Eye Ear Nose & Throat:
     - Date of Service: 4/19/22 and 5/25/22;
   - Atrium Health Musculoskeletal Institute Rock Hill, Dr. James Rentz Jr.:
     - Date of Service: 6/29/22;
   - Atrium Health- Carolinas Rehab Clinic, Dr. Sima Desai:
     - Dates of Service: 3/17/22, 5/4/22;
   - Dr. Sima Desai Questionnaire and Correspondence, dated 4/6/22, 5/12/22 and 7/20/22;
   - Deposition Transcript of Juliana Roldan Dimas dated 6/9/22

   Yes ✓ No _____

4. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, Mr. Lopez-Vasquez was diagnosed with Type II Diabetes Mellitus prior to his work accident on February 18, 2022.

Agree ✓ Disagree _____

5. Based on my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, Mr. Lopez-Vasquez was on a consistent regimen of prescription Metformin, Glipizide, and Actos to treat his diabetic condition prior to his work accident.

Agree ✓ Disagree _____

6. Based on my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, Mr. Lopez-Vasquez was also noted to be taking Levimir insulin injections to treat his diabetic condition prior to his work accident, according to the January 7, 2020, April 16, 2020, and July 16, 2020 medical records from Affinity Health.

Agree ✓ Disagree _____ While on insulin therapy Mr. Lopez-Vasquez's glucose control was adequate.

7. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, Mr. Lopez-Vasquez reported he was not adhering to his diet and was counseled on the dangers of an elevated glucose level on more than one occasion.

Agree ✓ Disagree _____

8. According to the Affinity Health Care records dated October 16, 2020, Mr. Lopez-Vasquez's medication list no longer included Levimir insulin injections and at that visit his A1C level was uncontrolled at 10.0.

Agree ✓ Disagree _____

9. A normal A1C level for an individual with Type II diabetes is at, or below, 7%.

Agree ✓ Disagree _____

10. According to the Affinity Health Care records dated January 20, 2021, Mr. Lopez-Vasquez's A1C was 13.0, and he reported he was not checking his blood sugar at home and refused to restart insulin as recommended.

Agree ✓ Disagree _____

11. Based on my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, the last available date of service prior to his work accident was August 12, 2021, at which time his A1C level was documented to be 12.4, which is considered uncontrolled.

Agree ✓ Disagree _____

12. Based on my review of Mr. Lopez-Vasquez's medical records, between October 16, 2020, when he was noted to no longer be taking Levimir insulin injections, and August 12, 2021, the last available record prior to his accident, Mr. Lopez-Vasquez was seen by his primary care physician at Affinity Health on five different occasions and each time his A1C levels were documented as uncontrolled.

Agree ✓ Disagree _____

13. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records predating his February 18, 2022 work accident, between October 16, 2020 and August 12, 2021, his A1C levels exceeded 9%, which is considered dangerously high for someone with Type II diabetes.

Agree ✓ Disagree _____ These levels of HbA1c will increase the risk of developing diabetic complications

14. Based on my review of Mr. Lopez-Vasquez's medical records following his February 18, 2022 work accident, he was seen by his primary care PA, Shaylo Reyes, on March 18, 2022, at which time his A1C level was documented to be 11.1, which is considered uncontrolled.

Agree ✓ Disagree _____

15. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records both predating and following his February 18, 2022 work accident, Mr. Lopez-Vasquez's A1C levels were uncontrolled prior to his February 18, 2022 work accident, and remained uncontrolled following his work accident.

Agree ✓ Disagree ___ Mr. Lopez-Vazquez have insulin-requiring type 2 diabetes before and after his work accident

16. In light of the fact that Mr. Lopez-Vasquez's A1C levels were uncontrolled prior to and following his February 18, 2022 work accident, I cannot state to a reasonable degree of medical certainty, on a more likely than not basis, that his February 18, 2022 work accident caused a worsening of his pre-existing uncontrolled diabetic condition.

Agree ✓ Disagree ___

If you disagree, please explain the basis for your opinion that the work accident caused a worsening of Mr. Lopez-Vasquez's pre-existing uncontrolled diabetic condition:

Both traumatic brain injury (TBI) and prednisone usually worsen diabetes control. However, according to HbA1c levels, the degree of control of Mr. Lopez-Vazquez was not markedly affected by his TBI and prednisone. Likely his diabetic control prior to the accident was so poor due to his refusal to take insulin that weight loss and restarting insulin therapy overcome any possible deteriorating effects.

17. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records, I **do believe**/ **do not believe** (*please circle one*), to a reasonable degree of medical certainty, on a more likely than not basis, that Mr. Lopez-Vasquez suffered from Type I – Insulin Dependent Diabetes following his February 18, 2022 work accident.

If necessary, please explain the basis for your opinion: TBI will not usually cause either type 1 or type 2 diabetes.

TBI may became associated with hyperglycemia for a period of time since the stress and the use of steroid drugs, commonly used in these situations, markedly increase insulin resistance but the problem is reversed once the patient recovers.
Mr. Vazquez has an insulin-requiring type 2 diabetes.

18. If you believe the February 18, 2022 work accident caused or aggravated Mr. Lopez- Vasquez's diabetic condition, please outline any medical treatment you believe, to a reasonable degree of medical certainty, he requires for his diabetic condition as a result of his February 18, 2022 work accident.

Please outline any causally related medications and/or therapies, as well as the anticipated frequency and duration of the same:

Although Mr.Lopes-Vasquez's TBI did not impact his degree of diabetic control closely monitoring and adjustments in therapy should be made to further improve his degree of glucose control. Follow-up by an diabetologist and nutrition input are strongly recommended.

19. Based on my experience and training as a Board Certified MD in Pathology and Lipidology, and my review of Mr. Lopez-Vasquez's medical records, **I do believe** / **do not believe** (*please choose one*), to a reasonable degree of medical certainty, on a more likely than not basis, that Mr. Lopez-Vasquez requires attendant care to assist with activities of daily living and/or medication management as a result of his February 18, 2022 work accident.

If you believe Mr. Lopez-Vasquez requires attendant care, please answer the following sub-questions:

A) Please specify the recommended frequency/duration (i.e., the number of hours per day/week) you recommend for any attendant care needs:

Mr. Lopez-Vasquez is not yet able to perform his living activities or take his medications or do glucose monitoring without assistance so he will need attendant care for treatment of his diabetes likely 3 times/day (approximately 30 minutes each time) until he can perform these tasks on his own.

B) I **do**/**do not believe** Mr. Lopez- Vasquez requires 24/7 attendant care.

Please explain, if necessary: _____

20. Regardless of the answer to Question 19, please confirm whether you believe to a reasonable degree of medical certainty, based on your training and experience and your review of Mr. Lopez-Vasquez's medical records, that if attendant care is ordered, such care should be provided by a licensed and trained skilled home health care aide or nurse to ensure the best possible recovery from his February 18, 2022 work accident:

Agree ✓ Disagree _____

Please explain, if necessary:

_____

21. Based on Ms. Juliana Roldan-Dimas' June 9, 2022 deposition testimony, Ms. Roldan-Dimas is not a licensed health care provider and is not qualified to provide medical, surgical, hospital, and/or other treatment that may be required by Mr. Lopez-Vasquez as a result of his February 18, 2022 work accident.

Agree ✓ Disagree _____

Please explain, if necessary:

_____

I, Dr. Maria F. Lopes-Virella, M.D., Ph.D., do hereby swear and affirm that by signing below I have personally reviewed and completed the above questionnaire, that the opinions stated are my own and are intended to serve as an expert report, having the same weight as any medical record, note or Form 14B that I might otherwise prepare. All such opinions rendered hereinabove are given more likely than not to a reasonable degree of medical certainty.

Maria Lopes-Virella

Dr. Maria F. Lopes-Virella, M.D., Ph.D.

Date: August 6, 2022

**CURRICULUM VITAE**

**MARIA FERNANDA LEAL LOPES-VIRELLA. M.D., Ph.D.**


| | | | |
|---|---|---|---|
| **Date of Birth:** | [redacted] | **Nationality:** | U.S. Citizen |
| **Place of Birth**: | Vila Nova de Foz Côa, Portugal | **Marital Status**: | Married<br>Two daughters |
| **Home Address:** | [redacted] | | |

**Office Address:** Ralph H. Johnson VA Medical Center
Medical University of SC
Strom Thurmond Building, Rm 529
114 Doughty Street
Charleston, SC 29425
(843) 789- 6823
FAX (843) 789- 6854
Email <virellam@musc.edu>


## GRADUATE EDUCATION

| | | |
|---|---|---|
| 7/31/1967 | School of Medicine<br>University of Lisbon<br>Lisbon, Portugal | M.D. with Honors |
| 5/12/1990 | School of Medicine<br>University of Lisbon<br>Lisbon, Portugal | Ph.D. with Honors<br>Internal Medicine and<br>Biochemistry |

## POST-GRADUATE CLINICAL TRAINING

| | |
|---|---|
| 1967-68 | Internship<br>Hospital Sta Maria, Lisbon, Portugal |
| 1970-1973 | Resident in Medicine<br>Hospital Sta Maria, Lisbon, Portugal |
| 1973-1975 | Resident in Clinical Pathology<br>Hospital Sta Maria, Lisbon, Portugal |
| 1975-1977 | Fellow in Endocrinology<br>Medical University of SC, Charleston, SC |
| 1977-1979 | Resident in Clinical Pathology, MUSC, Charleston, SC |
| 1979 | Fellow in Clinical Pathology<br>Medical University of SC, Charleston, SC |

## POST-GRADUATE RESEARCH TRAINING

| | |
|---|---|
| 1968-1969 | University of Birmingham Medical School, UK, Post-doctoral Fellow |
| 1971-1973 | University of Lisbon, School of Medicine, Portugal<br>Research scholarship: National Institutes of High Education |
| 1975-1977 | Medical University of SC, U.S.A, Fellow in Endocrinology. |
| 1977 | Massachusetts Institute of Technology, Cambridge, USA<br>Robert S. Lees, Mentor |

## CERTIFICATION AND LICENSURE

| | |
|---|---|
| 1968 | License to practice Medicine, Portugal |
| 1975 | Educational Council for Foreign Medical Students |
| 1979 | South Carolina State Board of Medical Examiners (FLEX) |
| 1979 | State of South Carolina License |
| 1984 | Board Certification by the American Board of Pathology |
| 2005 | Board Certification by the American Board of Lipidology |

## ACADEMIC APPOINTMENTS

| | |
|---|---|
| 1977-1979 | Instructor in Medicine, Medical University of South Carolina, Charleston, SC |
| 1979-1984 | Assistant Professor, Division of Endocrinology, Metabolism and Nutrition, Department of Medicine, Medical University of South Carolina, Charleston, SC |
| 1981-1984 | Assistant Professor, Department of Pathology, Medical University of South Carolina, Charleston, SC (joint appointment) |
| 1984-1989 | Associate Professor, Division of Endocrinology, Metabolism and Nutrition, Department of Medicine and Department of Pathology, MUSC, Charleston, SC |
| 1987-present | Tenure, Medical University of South Carolina, Charleston, SC |
| 1989-Present | Professor, Division of Endocrinology, Diabetes and Medical Genetics, Department of Medicine (primary appointment) and Department of Pathology, Medical University of South Carolina, Charleston, SC |
| 1991-Present | Professor, Department of Microbiology and Immunology, MUSC, Charleston, SC (joint appointment) |
| 2003-Present | Present Adjunct Professor, Bioengineering Department, Clemson University |

## HOSPITAL APPOINTMENTS

| | |
|---|---|
| 1980-present | Attending, Medical University of South Carolina, Charleston, SC |
| 1981-87 | Co-Director, Diabetic and Lipid Clinic, MUSC, Charleston, SC |
| 1984-2019 | Staff Physician, Ralph H. Johnson VA Medical Center, Charleston, SC |
| 1987-2019 | Chief, Nutrition Support Team, Ralph H. Johnson VA Medical Center, Charleston, SC |
| 1989-1997 | Co-Director of the Lipid Clinic, Ralph H. Johnson VA Medical Center, Charleston, SC |
| 1990-2019 | Clinical Chemistry Section Chief, Laboratory Services, Ralph H. Johnson VA Medical Center, Charleston, SC |

## HONORS AND AWARDS

| | |
|---|---|
| 1978-83 | Special Emphasis Research Career Award, National Heart, Lung and Blood Institute and National Institutes of Arthritis, Metabolism and Digestive Diseases |
| 1984-86 | Clinical Investigator, VA Research and Development Award |
| 1986 | John A. Colwell Award for Outstanding Contributions to Diabetes Research, American Diabetes Association, South Carolina Affiliate |
| 1987 | Squib-Preis Award for the best publication submitted to "Die Osterreichisch Gesellschaft für Innere Medizin" |
| 1996-1998 | Chair, Council on Complications, American Diabetes Association |
| 1999-2000 | President-Elect, Southeast Lipid Association |
| 2000-2001 | President, Southeast Lipid Association |
| 2001 | Edwin Bierman Lectureship Award, American Diabetes Association |
| 2002-present | Alpha Omega Alpha |
| 2003, 2006 | Mary Jane Kugel Award, JDRFI, May 2003 and 2006 |
| 2004-2008.1.1 | Member, Board of Directors, National Lipid Association |
| 2005-2012 | Member of the American Board of Clinical Lipidology |
| 2005 | VA Vision 7 Henry Middleton Award for Excellence in Research |
| 2008-2010 | Member of the Committee on Qualification of Biomarkers as Surrogate Endpoints in Chronic Disease Risk, Institute of Medicine, The National Academies |
| 2011 | Charleston Research Institute, Board of Directors |
| 2012 | Outstanding Foreign Investigator Award, Japan Society of Diabetic Complications |
| 2015-Present | Member of National Academy of Inventors |

## MAJOR RESEARCH INTERESTS

Glycation/oxidation of lipoproteins and lipoprotein metabolism in diabetes

Macrophage activation and immune-mediated mechanisms of complications in diabetes

LDL receptor gene regulation

Mechanisms of endothelial dysfunction and plaque rupture

Study of biomarkers identifying patients at risk to develop diabetic complications

## PROFESSIONAL ORGANIZATIONS

Fellow of the American Heart Association,
Fellow, Council on Arteriosclerosis, Thrombosis and Vascular Biology, AHA
Fellow, Council on Nutrition, Physical Activity and Metabolism, AHA
Fellow, American College of Nutrition
Fellow, American College of Pathology
American Diabetes Association
American Federation for Clinical Research

Southern Society for Clinical Investigation
American Society for Nutritional Sciences
Society for International Nutrition Research
Southeast Lipid Association, Past President
National Lipid Association, Past member of Board of Directors
Endocrine Society

## MAJOR COMMITTEE ASSIGNEMENTS

### National and Regional

| | |
|---|---|
| 1983-1986 | Representative of the Medical University of South Carolina to the American Federation for Clinical Research and Member of the Legislation Liaison Group for the American Federation for Clinical Research. |
| 1984-1990 | Member of the Lipid-Apolipoprotein Standardization Subcommittee of the International Union of Immunological Societies. |
| 1988 | Representative of the Medical University of South Carolina to the Southeastern Region of Medical Educators in Nutrition. |
| 1993-1996 | Member of the Abstract Review Committee for the American Diabetes Association Annual meetings on the category of Lipids/Lipoproteins. |
| 1995-1999 | Member, National Lipid Education Council. |
| 1997-2001 | Member of the Abstract Review Committee for the American Diabetes Association Annual meetings on the category of Complications. |
| 1998-2002 | Member, Research Career Scientist Evaluation Committee, Department of Veterans Affairs. |
| 2003-2007 | Member, Research Career Development Committee, Department of Veterans Affairs. |
| 2005-Present | Member, American Board of Clinical Lipidology |
| 2012-Present | Member, NPAM Young Investigators Award Committee, AHA |
| 2013-15 | Member, Familial Hypercholesterolemia Writing Committee, Obesity Committee of the Council on Nutrition, Physical Activity, and Metabolism American Heart Association |

### Medical University of South Carolina

| | |
|---|---|
| 1983 | Chair, Task Force to create a course of Clinical Nutrition for Medical Students |
| 1983. | Member, Task Force to create a course of Exercise Physiology |
| 1985-1988 | Member, University Research Committee. |
| 1986-1990 | Chair, Department of Medicine Research Development Committee, |
| 1986-1989 | Member, Molecular Cell Biology Program Admissions and Recruitment Committee. |
| 1987 | Member, Nutrition Task Force (Wellness Center). |
| 1989-1991, 1997-00 | Member, Faculty Senate, Medical University of SC |
| 1989-2002 | Member, Medical School Curriculum Committee |
| 1998-2001 | Member, Advisory Committee, MUSC Dietetic Internship Program. |
| 1998-2001 | Member, College of Medicine Appointments, Promotion and Tenure Committee, Medical University of SC |
| 2003-2006 | Member, College of Medicine Tenure Committee, MUSC |
| 2004-Present | Member, Steering Committee for the NIDDK Short-Term Research Training |

| | |
|---|---|
| | Program for Health professional Students |
| 2004-Present | Member, Steering Committee Lipidomics and Pathobiology Training Program |
| 2014 | Member, Endocrinology Search Committee |
| 2014 | Member, Steering Committee for the NIDDK Short-Term Research Training Program for Health professional Students |

**Ralph H. Johnson VA Medical Center**

| | |
|---|---|
| 1984-1986 | Member, VA Research and Development Committee. |
| 1988-1991 | Chair, Space Subcommittee, VA Research Development Committee. |
| 1990-1994 | Chair, VA Drug Utilization Evaluation Committee. |
| 1991-Present | Chair, VA Nutrition Committee. |
| 1997-2000 | Chair, VA Research and Development Committee |
| 2004-2012 | Member, VA Space Committee |
| 2004-2008 | Chair, VA Research and Development Committee |

**EDITORIAL BOARDS and EDITORIAL ADVISORY PANELS**

| | |
|---|---|
| 1990-Present | Portuguese Journal of Nutrition, Editorial Board |
| 1992-1995 | Diabetes Care, Editorial Board |
| 1992-1995 | Journal of Women's Health, Advisory Committee |
| 1992 | Diabetes, Guest Editor |
| 2002-2010 | Editor, National Lipid Association Newsletter |
| 2007-present | Associate Editor, Journal of Clinical Lipidology |
| 2010 | Guest Editor for Clinical Immunology. Special Issue on Immunology and Cardiovascular Disease |
| 2013 | Co-Editor of Special Edition of Frontiers in Endocrinology: Frontiers in Diabetes |

*Ad Hoc Reviewer for:*
American Journal of Clinical Nutrition; American Journal of Physiology; Arteriosclerosis, Thrombosis and Vascular Biology; Atherosclerosis; Biochimica Biophysica Acta; Circulation, Clinical Chemistry; Clinical Immunology and Immunopathology; Diabetes; Diabetes Care ; Diabetic Medicine; Diabetologia; European Journal of Clinical Investigation; Journal of the American Medical Association; Journal of Clinical Investigation; Journal of Lipid Research, Journal of Pharmacology and Experimental Therapeutics; Metabolism; New England Journal of Medicine; Proceedings of the National Academy of Sciences.

**GRANT REVIEW STUDY SECTIONS**

| | |
|---|---|
| 1988-1991 | American Diabetes Association, National Research Review Committee. |
| 1989 | NIH Program Project Site Visit (PI: A.Gotto, Baylor College of Medicine, Houston, Texas. |
| 1991-1995 | Nutrition Study Section, National Institutes of Health. |
| 1991-1994 | Endocrinology Merit Review Board, Department of Veterans Affairs |
| 1995-2004 | VA Career Development Programs (Endocrinology, Cardiovascular and Geriatrics)-Ad Hoc Reviewer |
| 1995-Present | VA Merit Review Boards (Endocrinology, Cardiovascular and Immunology)- |

Ad Hoc Reviewer

| | |
|---|---|
| 1995-1999 | National Institutes of Health Reviewers Reserve. |
| 1996 | NIH Program Project Site Visit (PI: A.Chait, Univ of Seattle, Seattle, WA). |
| 1998 | American Heart Association Mid-Atlantic Peer Review Research Consortium. |
| 1998-2001 | Member, Research Career Scientist Evaluation Committee, Department of Veterans Affairs |
| 2001-2008 | Member, Medical Science Review Committee, Juvenile Diabetes Research Foundation International |
| 2004-2006 | Member, Research Career Development Committee, Department of Veterans Affairs |
| 2005 | Member, Integrative Physiology of Obesity and Diabetes (IPOD) Study Section, National Institutes of Health (Ad Hoc reviewer) |
| 2005 | NIH Program Project Special Review Committee (PI: Alan Tall, Columbia University, NewYork NY) |
| 2008-2011 | Member, SubCommittee for Endocrinology A , Department of Veterans Affairs Joint Biomedical Laboratory Research and development and Clinical Science Research and development Scientific Merit Review Board |
| 2008-2011 | Member, Vascular Biology Study Section, NIH |
| 2009-2010 | Ad Hoc reviewer for Program Project Grants (NHLBI and NIDDK) |
| 2015- | Ad-hoc Review study section (NHLBI/Vascular and Cell Biology) |

**PRESENT EXTRAMURAL-FUNDED RESEARCH GRANTS**

**A. As Principal Investigator**

**R01 DK099177, NIDDK, NIH** **Lopes-Virella/Klein (Co-PIs)** 04/01/2014-01/31/2021
*Role of Sphingolipids in the Development of Diabetic Nephropathy* $1,636,185 Total DC

**B. As Co-Investigator**

**U01NS080168, NIH/NINDS (Sub-award)** **Chimowitz (PI)** 10/01/2014-02/28/2021
*Carotid Revascularization for Primary Prevention of Stroke – CREST 2* $588,010/year

**R01 DE027070, NIDCR, NIH** **Huang, Y (PI)** 04/01/2018-3/31/2023
*Acid sphingomyelinase as a Target in Metabolic Syndrome-Exacerbated Periodontitis*
$250,000/year

**51BX003913, VAMR, Dept Veteran Affairs** **Klein, RL( PI)** 10/1/2017-9/30/2021
*The Role of Deoxysphingolipids in Peripheral Neuropathy* $150,000/year

**PAST EXTRAMURAL-FUNDED RESEARCH GRANTS**

1. NHLBI and NIADDK, NIH, AM00591 SRC. “SERCA: Diabetes Mellitus – Cardiovascular " PI, $235,405 (direct costs), 7/1/78-6/30/83.
2. American Diabetes Association: “Study of Proteinuria as an Index of Renal Function in Diabetes," PI, $5,000 (direct costs), 11/1/79-6/30/81.
3. American Heart Association, SC Chapter: "Cell Lipoprotein Interactions in Insulin Dependent Diabetes Mellitus,” PI, $12,000 (direct costs), 7/1/83-6/30/84.
4. NHLBI, NIH, HL30929. "Lipoprotein Metabolism and Cell Lipoprotein Interactions," PI, $202,597 (direct costs), 8/1/83-7/30/87.

5. VA Career Development Program: "VA Clinical Investigator Award," PI, $265,000, 1/1/84-12/31/86.
6. VA Merit Review Research Program: "Lipoprotein Metabolism and Cell-Lipoprotein Interactions in Diabetes Mellitus" –Principal investigator $120,438, 4/1/85-3/31/88 (years 1-3); $320,500, 4/1/88-3/31/93 (years 4-8); $564,645, 4/1/93-3/31/98 (years 9-13
7. Diabetes Treatment Centers of America : "The Pathogenesis of Arteriosclerosis in Diabetes Mellitus. The Role of Abnormal Platelet-Lipoprotein Interactions," PI, $30,000 (direct costs), 1/1/87-12/31/88.
8. American Heart Association : "Cyclosporine, Lipoprotein Metabolism and Arteriosclerosis in Heart Transplant Patients," PI, $35,957, 7/1/90-6/30/92.
9. NIH-1 R01 NS29627-01: "Southeastern Consortium on Racial Differences in Strokes," $160,438 (sub-contract). PI- Kenneth J. Gaines, University of Tennessee, Memphis, TN (total budget: $1,753,458), 7/1/91-6/30/95.
10. NHLBI, NIH, R01-HL46815 : "Macrophage Activation and Lipoprotein Metabolism," PI, $634,155, 8/1/94-11/30/2002
11. American Heart Association: "Molecular Mechanisms of LDL-receptor upregulation in Cholesterol-laden Cells," PI, $165,000, 1/1/98-1/1/99.
12. MUSC Heart Research Center: "Post-transcriptional Regulation of Scavenger Receptor Expression," PI, $150,000, 12/1/97-11/30/01.
13. NIH-R01 DK34818: "Epidemiology of Diabetic complications: Phase II," PI: Trevor Orchard, sub-contract to Lopes-Virella, $90,873, 3/1/1999-2/28/01.
14. Merck & Co: "Low Density Lipoprotein Oxidation and Endothelial Dysfunction in NIDDM. Effect of Simvastatin Therapy," PI, $32,841, 6/1/99-5/31/01.
15. NIH, PO1 HL-55782 and JDFI: "Markers and Mechanisms of Macrovascular Disease in IDDM" (Garvey W.T. -P.I.), Project 2: "Modified LDL Autoimmunity and Vascular Diseases in IDDM," Lopes-Virella - Project Leader, $580,639, 7/1/96 - 8/31/01 (years 1-5).
16. VA Merit Review Research Program: "Lipoprotein Metabolism and Cell-Lipoprotein Interactions in Diabetes Mellitus" –Principal investigator, $120,438, 4/1/85-3/31/88 (years 1-3); $320,500, 4/1/88-3/31/93 (years 4-8); $564,645, 4/1/93-3/31/98 (years 9-13); $519,800, 4/1/98-3/31/03 (years 14-18)
17. Merck. Lipid Preceptorship Program, PI: Lopes-Virella, $60,000, 4/15/99-12/31/03
18. Juvenile Diabetes Foundation International: "Immune Mechanisms of Micro/Macrovascular Disease in Type 1 Diabetes", Principal Investigator, $675,000 (direct costs), 8/1/02-7/31/05
19. 5 P20 RR017696-04/ NIH/NCRR (PI: Steve London): South Carolina COBRE for Oral Health $1,678,135/year. 09/30/02-06/30/07. (Lopes-Virella Co-Investigator)
20. NIH, PO1-HL-55782: "Markers and Mechanisms of Macrovascular Disease in Diabetes Mellitus" Lopes-Virella (PI) $1,894024/year 10, $8,371,184- total for years 6-10 (9/1/2001-8/31/2008).
21. Glaxo-SmithKline/University of Oklahoma (PI:T.Lyons): Markers and Mechanisms of Vascular Disease in Diabetes 11/10/03-11/9/09. Current year direct costs: $103,000. Entire contract direct costs: $546,250. Principal Investigator for MUSC subcontract
22. Juvenile Diabetes Foundation (1-2006-49): Immune mechanisms of nephropathy in type 1 diabetes. 3/1/06-2/28/09. Direct costs $150,000/year, Total direct costs $450,000.
23. VA Merit Review Research Program: "Lipoprotein Metabolism and Cell-Lipoprotein Interactions in Diabetes Mellitus", $550,000 from 4/1/2003-9/31/2007, 579,900 from 10/1/2007 to 9/30/2011.
24. NIH,NIDDK, 3RO1 DK081352-02S1 (ARRA): Biomarkers of Vascular Disease Progression in Type 1 Diabetes- $309,610 (DC) 9/25/2009-8/31/2011

25. NIH, NIDDK , DK87805 (ARRA) subcontract from University of Oklahoma HSC (PI of original grant : Dr. Jian-xing Ma) : Lipoprotein-Related Mechanisms and Markers in Diabetic Retinopathy, $74,664 9/07/2009-9/6/2011
26. VA Research Service: REAP (PIs J Raymond and G Gilkeson): Inflammatory Mediators of Renal Diseases–$187,500/year. 1/1/05-19/30/11. (Lopes-Virella -Co-Investigator)
27. RO1 HL 077192 NIH/NHLBI (PI: A. Jaffa) Lipoproteins, CTGF and Diabetic Vascular and Renal Disease. $250,000/year. 01/01/06-12/31/2010
28. NIH/ NHLBI R01 HL079274-01 (PI: S. Hammad). Sphingolipid signaling induced by LDL-immune complexes. $200,000/year, 4/1/06-3/31/2011
29. Takeda Pharmaceuticals – The effect of alogliptin on Vascular Inflammation and atherosclerosis. $144,476 1/23/2009-12/31/2010
30. VA Research Program, (Site PI: Maria Lopes-Virella): VA Cooperative Study CSP #565-Nephron D study $80.000/yr, Total direct costs 425,400 from 7/1/2008-6/30/2013
31. NIH, RO1 DK081352 (PI: Maria Lopes-Virella): Biomarkers of Vascular Disease Progression in Type 1 Diabetes. $443,996 /year $1, 811,561 total from 9/1/2008 to 7/31/2013
32. NIH/NIDDK RO1DK088778 (PI: K.Hunt): Longitudinal Assessment of LDL Immune Complexes and type 1 Diabetes Complications, $125,000/year 07/01/10-06/30/13
33. NIH/NIDCD, R01 DE016353:"The Effect of Statin on Diabetes-associated Periodontal Disease" PI: Y Huang, $1,250,000, 7/20/2010-4/30/2015
34. NIH/NIDDK through Georgia Regents University (DiaComp), U24DK076169: "Association of Plasma Deoxysphingolipids with Neuropathy in the DCCT/EDIC Cohort " PI: Klein, R, $47,816 /year; 10/1/2013-9/30/2014
35. VA Merit Review Research Program: BLRD Merit Award (BX002281) Lopes-Virella (PI). *Lipoproteins and Inflammation in the Development of diabetic complications*, $639,500 from 10/1/20013-12/31/2017
36. NIH/NIDDK -R01 DK101034: John Arthur (PI). *Biomarkers of Early Renal Functional Decline in Type 2 Diabetes*. 04/01/2014-01/31/2018, $1,300,652 Total DC
37. Bristol-Meyers Squibb: *MUSC-BMS Fibrosis Collaboration.* Lackey, Karen (PI). Renal Project 1: *Biomarkers of Disease Progression.* Project Leader: Lopes-Virella $228,000, 7/14/2015-12/31/2016

**COMPLETED CLINICAL TRIALS**

1. Clinical Research International : "Lovastatin Dose Ranging Multicenter Study in Patients with Type II Hypercholesterolemia," PI, $50,000, 7/1/87-6/30/90.
2. Merck Sharp & Dohme: "Simvastatin Compared to Lovastatin in Patients with Hypercholesterolemia," PI, $20,232, 7/1/89-6/30/91.
3. In Vivo, Inc.: "Effect of Pravastatin on Controlling Hypercholesterolemia: A Special Patient Population," PI, $7,768, 12/1/91-8/31/92.
4. Sandoz : "An Open-Label Study of Fluvastatin in the Treatment of Patients with Hypercholesterolemia in Clinical Practice Settings," PI, $7,200, 6/1/93-6/1/94.
5. Merck & Co: "ExPRESS-FH (A Multicenter, Open Label Expanded Use Study to Evaluate Tolerability of Simvastatin 80 mg in Patients with Heterozygous Familial Hypercholesterolemia," PI, $32,000, 6/1/97-12/31/98
6. Bristol-Myers Squibb: "The Collaborative Study Group Trial: The Effect of Irbesartan on Morbidity and Mortality in Hypertensive Patients with Type II Diabetes and Diabetic Nephropathy," PI, $72,200, 9/1/98-8/30/00.
7. Parke Davis: "The Challenge Study," PI, $69,150, 10/1/98-12/31/99.
8. Keryx Biopharm/Medpace, Inc: The Collaborative Study Group Trial: The Effect of Sulodexide in

Type 2 Diabetics with Microalbuminuria or Overt Diabetic Nephropathy; Lopes-Virella (PI), 03/01/05-07/31/08

9. Glaxo-SmithKline, (PI: Maria Lopes-Virella) : A clinical outcomes study of darapladib vs placebo in subjects with chronic coronary heart disease to compare the incidence of major adverse cardiovascular events (MACE). $354,765.00; 10/10/2008 – 3/31/2013

## MENTORING

### Mentorship of Junior Faculty

1. Timothy Lyons, MD –1987 to 1992. Currently Chief of Endocrinology, University of Oklahoma City, OK.
2. Rick Klein, PhD – 1984 until 1986. Currently Associate Professor of Medicine, MUSC/VA
3. Yuchang Fu, PhD – Mentor from 1998 – 2000. Currently Associate Professor (with tenure) of Nutrition Sciences, University of Alabama, Birmingham
4. Yan Huang, MD, PhD – 1995-1999. VA Merit Review type 2 (mentor-based) entitled "Regulation of Matrix Mettaloproteinase-1 by Oxidized LDL", $286,800, 10/1/99-9/30/02. Currently Associate Professor of Medicine at MUSC/VA.
5. Samar Hammad, PhD, 2001-2003 (Co-mentor with Lina Obeid, MD). Currently Associate Professor of Regenerative Medicine and Cell Biology
6. Jyotika Fernandes, MD - COBRE for Oral Health, Leader of Project 1 "Epidemiological Study of Periodontal Disease and Diabetes: Cytokine genes and Inflammation Factors "(PI of COBRE: Steve London), co-mentorship with JJ. Saunders, 2003-2008. Currently Associate Professor of Medicine, MUSC/VA, Charleston, SC
7. Kelly Hunt, PhD – 2009-2012. Currently Associate Professor of Division of Biostatistics and Epidemiology, Medical University of South Carolina, Charleston, SC
8. Baqiyyah Conway, PhD -2014-Present. Currently Assistant Professor, Department of Epidemiology, School of Public Health, West Virginia, Morgantown, WV

### Mentorship of Visiting Scientists

**1.** Jun Watanabe, M.D, Visiting Scientist from 1986-88. Associate Professor, Kyushu University School of Medicine, Fukuoka, Japan

**2.** Christoph Gisinger, M.D. Visiting Scientist 1988-90. Professor of Medicine, Univ of Vienna, Vienna, Austria

**3.** Rudolph Jokl, M.D., 1991 Visiting Scientist . Assist Prof Endocrinology, MUSC. Currently in Private Practice

**4.** Alicia Jenkins, MD. Visiting Scientist 1993-. Senior Lecturer, Melbourne University, Australia

**5.** Akira Takei, M.D., Visiting Scientist 1996-98. Assistant Professor Kyushu University School of Medicine, Fukuoka, Japan

**6.** Mitsunori Masakado, MD. Visiting Scientist 2000-2002. Assistant Professor, Kyushu University School of Medicine, Fukuoka, Japan

**7.** Pavel Kraml, MD. Visiting Scientist 2002-2003. Fulbright Scholar. Associate Professor, Charles University, Prague, Czech Republic

**Mentorship of Graduate Students**

| Name | Role | Present Position |
|---|---|---|
| Richard R. Griffith | Thesis Advisor (M.D., Ph.D.) (1985-1988) | NIH post-doctoral fellow<br>Allergy/Immunology<br>Currently Private Practice |
| Kendrick A. Shunk | Thesis Advisor (M.D., Ph.D.) 1989-1993 | Currently Associate Clinical Professor, UCSF, California |
| Tharaknath Rao | Thesis Advisor<br>Masters degree (1992-1994). | Residency Baylor College of Medicine Houston, TX<br>Currently Rheumatologist, Ann Arbor, MI |
| Malabika Ghosh | Thesis advisor Ph.D. degree 1994-1996 | Gladstone Research Inst, San Francisco, CA |
| Daniel Atchley | Thesis advisor, Ph.D. degree 1998-2002 | Major, US Air Force.<br>Currently Associate Professor, College of Pharmacy, Harding University,Searcy,Arkansas |
| Silvana Vielma | Thesis advisor, Ph.D. degree 1999-2002 | Chief of the Department of Public Health for the State of Merida, Venezuela |
| Miran Jaffa | Thesis co-advisor, PhD degree 2004-2009 | Assistant Professor of Biostatistics, American University of Beirut, Beirut, Lebanon |

**Mentoring of Post-Doctoral Fellows (Research Training)**

| Name | Status | Present Position |
|---|---|---|
| Lillian Harstine, M.D. | Post-doctoral fellow 1981-82 | Private Practice Endocrinology |
| David Mordes, M.D. | Post-doctoral fellow 1982-83 | Private Practice Endocrinology |
| Robert Mountcastle, M.D. | Post-doctoral fellow 1983-84 | Private Practice Endocrinology |
| Timothy J. Lyons, M.D. | Post-doctoral fellow 1984-86 | Chief of Endocrinology University of Oklahoma Oklahoma City, OK |
| Marina Mironova, M.D. | Post-doctoral fellow 1994-2000 | Private Pratice-Internal Med Residency |
| Sinikka Koskinen, M.D * | Post-doctoral fellow 1996-1999 | Staff Physician University of Helsinki. |
| Sumita Bandyopadhyay, Ph.D. | Post-doctoral fellow 1998-2000 | |
| Silvana Vielma, MD. PhD** | Post-doctoral Fellow 2002-2003 | Associate Professor, Univ Merida,Venezuela |
| Ja-Ran Ku, MD | Post-doctoral fellow 2003-2004 | Director Div. Endocrinology Dept Medicine, Trinity |

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| | | Hospital, Daegu, Korea |
| Lynn Poole, MD, PhD | Post-doctoral fellow 2003-05 | Residency in Harvard Medical School |
| Alena Nareika, MD | Post-doctoral fellow 2003-2005 | |
| Antonio Saad, MD | Post-doctoral fellow 2004-2007 | Residency, General Surgery, USC/LAC, USA |
| Souzan Abdel-Razik, MD | Post-doctoral fellow 2008-2010 | Family Medicine Residency |

- JDF postdoctoral fellowship award, $33,000/year, 7/1997-6/30/99
** Fullbright Scholar

**Mentoring of Undergraduate Students (Summer Projects)**

Richard Davis, Medical University of South Carolina (1979)
Soyun Han, Goucher College, Maryland (1980)
William J. Lawing, Chapel Hill, North Carolina (1984)
Carolyn Cray, Rollins College, Florida (1985)
Cynthia Collie, Medical University of South Carolina (1985)
Anne Kulze, Medical University of South Carolina (1986)
Andrea Williams, Medical University of South Carolina (1987)
E.J. Prijoles, SC Governor's School for Science and Mathematics (1992)
Greg Niemer, Medical Student, Medical University of South Carolina (1992)
Christina Altman, College of Charleston, Charleston, SC (1993, 1994, 1995)
Nafees Bin Zafar, Academic Magnet High School (1994, 1995). Won first place in the 1999-2000 SC Junior Science and Humanities Symposium, Columbia, SC (12/95)
Rachel Rackley, State of SC Governor's School for Sciences and Mathematics (1996). Won first place in the 1999-2000 SC Junior Science and Humanities Symposium, Columbia, SC (12/96)
Nathan Nussbaum, State of SC Governor's School for Sciences and Mathematics (1997)
Andrew Fleming, College of Charleston (1998)
Kevin Huang, Ohio State University (1998)
Michael Wertheimer, University of Colorado (1998)
Antuan Crawford, Academic Magnet High School (1998)
Shan Wu, State of SC Governor's School for Sciences and Mathematics (1999). Won first place in the 1999-2000 SC Junior Science and Humanities Symposium, Columbia, SC (12/99)
Octavia Smalls, Claflin College (1999)
Leslie Fielder, South Carolina Governor's School for Science and Mathematics (2000)
Fran Anderson, Darmouth College (2000)
Gregor Krings , Medical Scientist Program, Medical University of South Carolina (2000, 2001)
Adam Gorod, Porter-Gaud High School (2001). Won 2$^{nd}$ place on MUSC Research Day
David McCarty, South Carolina Governor's School for Science and Mathematics (2001)
Ryan Wilson, South Carolina Governor's School for Science and Mathematics (2002)
Jeffrey Abrams, South Carolina Governor's School for Science and Mathematics (2002)
Meriana Martin, Dental School, Medical University of SC, Charleston, SC (2002)
Arlene Mendez, University of Puerto Rico, Puerto Rico (2002). 1$^{st}$ place on MUSC Research Day.
Katrina Hering, Medical University of SC (2004)
Edward Crosswell, Medical University of SC (2006)
Aundrea Eason, Medical University of SC (2008)
Alexander Winters, Medical University of SC (2009)
Katalina Romero , Medical University of SC (2011). Honorable Mention, MUSC Research Day.
Kelsey Derrick, Charleston Research Institute (2014).

Jonathan Motts, Medical University of SC (2014)
Jonathan Elk, Charleston Research Institute (2015)

## TEACHING ACTIVITIES

### Medical Courses

| | |
|---|---|
| 1982-1987 | Introduction to Clinical Reasoning, sophomore medical students, *Small Group Preceptor* |
| 1984-2000 | Pathology and Laboratory Medicine Course, sophomore medical students *Lecturer and Small Group Preceptor* |
| 1984-Present | Physical Diagnosis Course, sophomore medical students |
| 1986-2000 | Clinical Nutrition Course, junior medical students *Course Director, Lecturer and Small Group Preceptor* |
| 1999-Present | GCRC/Cardiovascular Risk Factor Management, Senior Elective |
| 2000-2002 | Nutrition in Health and Disease, Freshmen, sophomores and juniors *Course Director, Lecturer and Small Group preceptor* |
| 2001-2010 | Course of Immunology and Infectious Diseases, sophomore medical students, *Lecturer* |
| 2004-Present | Seminars for MD/PhD students, MUSC, *Lecturer* |
| 2005-2007 | Pathophysiology of Disease, Course for Physician assistant students, *Lecturer* |
| 2007-2010 | Clinical Pathology Cases Discussion, Sophomore Medical Students |
| 2008-2010 | Pathophysiology of Disease , 2nd Year medical students, Lectures on Lipids and Lipoproteins, Treatment of Lipid Disorders and Nutrition Support. |
| 2007-2013 | Pathology and Nutrition, Obesity Day for sophomore medical students, Lecturer |

### Graduate and post-graduate Courses/Programs

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| 1974, January | Physiopathology Basis and Laboratory Detection of Dysproteinemias, Ciudad Sanitaria Jose Antonio, Zaragoza, Spain, *Lecturer* |
| 1974, Mar/Apr | II Basic Immunology Course, Gulbenkian Institute of Science, Oeiras, Portugal, *Lecturer* |
| 1979, October | Management of Diabetes and Endocrine Disorders, Hilton Head, South Carolina, *Lecturer* |
| 1982 | Lipid and Steroids, MCBP Program, Medical University of SC, *Lecturer* |
| 1991 | 38th Annual Postgraduate Course, American Diabetes Association, San Diego, California, *Lecturer* |
| 1984-Present | Research Conferences, Endocrine Rounds and Clinic Preceptorship for Endocrinology Fellows and Medicine Residents, MUSC |
| 1985-Present | Faculty Member for a Clinical Fellowship on Endocrinology |
| 1990-Present | Housestaff Core Lectures, MUSC |
| 2002-2005 | Advanced Course of Cardiology for Graduate students, MUSC, *Lecturer* |
| 2006 | Foundations in Biomedical Sciences (Core curriculum course of the College of Graduate studies #701/702) MUSC |
| 2010- | Faculty member for a Fellowship on Clinical Chemistry, Med Univ of SC |
| 2011 | Fellowship in Lipidology: Director and Faculty member. |
| 2012- Present | Lipids in Pathobiology, Course for MD/PhD students at MUSC, lecturer |
| 2020 | Metabolic Syndrome, Obesity, Fatty Liver & Diabetes, in MCBP 803 |

**MEETINGS/SYMPOSIA/WORKSHOPS**

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|---|---|
| 1990, May 11 | Management of Lipid Disorders, Charleston, South Carolina, *Program Chair* |
| 1991, Dec 7-8 | Diabetes and Lipids Connection: Novel Approaches to its Diagnosis and Treatment, Charleston, South Carolina, *Program Chair* |
| 1992, Dec 12 | Lipid Disorders - Strategies for Successful Treatment of Women, Elderly, and Post-coronary Bypass Patients, Charleston, South Carolina, *Program Chair* |
| 1991, June 20 | Satellite Symposium on Diabetes and Macrovascular Complications, XIV International Diabetes Federation Congress, Charleston, South Carolina, *Program Chair* |
| 1992-2000 | Southeast Annual Lipid Conferences, *Program Committee Member* |
| 1994, Nov 12-13 | Satellite Symposium on Diabetes and Macrovascular Complications, XV International Diabetes Federation Congress, Osaka, Japan, *Program Committee Member* |
| 1997, Jan 10 | Diagnosis and Management of Lipid Disorders in Diabetes, Charleston, SC, *Program Committee Member* |
| 1997, June 20 | Satellite Symposium on Management of Lipid Disorders in Diabetes, 57th Annual Meeting, American Diabetes Association, Boston, Massachusetts. *Moderator* |
| 1997, June 21-24 | 57$^{th}$ Annual Meeting, American Diabetes, Association, Boston, Massachusetts, *Program Committee* |
| 1997, June 21-24 | Relative importance of triglyceride-rich lipoproteins and LDL on Macrovascular Disease, Council on Complications Discussion Session, 57th Annual Meeting, American Diabetes Association, Boston, Massachusetts, *Moderator* |
| 1997, July 25-27 | Satellite Symposium on Atherosclerotic Vascular Disease in Diabetes, XVI International Diabetes Federation Congress, Helsinki, Finland, *Program Committee Member* |
| 1997, July 20-24 | Hyperglycemia and Macrovascular Disease Symposium, 16$^{th}$ International Diabetes Federation Congress, Helsinki, Finland,*Chair* |
| 1998, June 13-16 | 58$^{th}$ Annual Meeting, American Diabetes, Association, Chicago, Illinois, *Program Committee Member* |
| 1998, June 13-16 | Targets and goals to reduce cardiovascular risk in diabetes, Council on Complications Discussion Session, 58$^{th}$ Annual Meeting, American Diabetes Association, Chicago, Illinois, *Moderator* |
| 1998, June 13-16 | Hyperglycemia and Macrovascular Disease Symposium, 58$^{th}$ Annual Meeting, American Diabetes Association, Chicago, Illinois, *Chair* |
| 1999, June 19-22 | Aggressive Lipid Management in the Diabetic Patient, *Meet the Professor Sessions,* 59$^{th}$ Scientific Sessions, American Diabetes Association, San Diego, California |
| 1999, August 6-8 | Southeast Lipid Association Second Annual Scientific Meeting, Homestead, Hot Springs, Virginia *Program Chair* |
| 1999, August 18 | Diagnosis and Management of Lipid Disorders in Diabetes, Charleston, SC, *Program Committee Member*. |
| 2000, June 9-13 | Use of Combination Therapy to Achieve Appropriate Lipid and Blood Pressure Goals in the Diabetic Patient, *Meet-the-Professor sessions* |

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| | (shared with George Bakris, MD), 59th Scientific Sessions, American Diabetes Association, San Antonio, Texas |
| 2000, Nov 3-5 | 17th IDF Satellite Symposium on "Lipoproteins, Vascular Biology and Macrovascular Disease in Diabetes", Cancun, Mexico, November 3-4, 2000, *Program Chair* |
| 2001, Jan 18-20 | Prevention VI: Diabetes and Cardiovascular Disease, Amer Heart Assoc, Orlando |
| 2003, Aug 24-29 | Poster session on Oxidative stress in vascular disease, 18th IDF congress, Paris France, *Moderator* |
| 2006, Sept 22-24 | 15th SouthEast Lipid Research Conference, Callaway Gardens, Georgia, *Program Chair* |
| 2010, June | Session of Cardiovascular Complications of Diabetes, 70th Scientific Sessions, American Diabetes Association, Orlando, FL, *Chair.* |
| 2010, June21-22 | Workshop on a report on Qualification of Biomarkers as Surrogate Endpoints in Chronic Disease Risk, Institute of Medicine, The National Academies, Washington, DC, *Member* |
| 2012, June 8-12 | Symposia on Macrovascular Disease in type 1 Diabetes, ADA ,72nd Annual Meeting, Lecture on " The role of inflammation in the CAD of type 1 Diabetes" |
| 2014, June 24 | Symposia on Clinical Diabetes: An attack on Vasculature, ICE/ENDO Meeting, Chicago, IL, June 2014. Presentation on "Immunological Basis of Vascular Complications in Diabetes". |
| 2016, April 1-4 | Meet the Professor Sessions on Hypertriglyceridemia and Low HDL Cholesterol, 98th Annual meeting of the Endocrine Society, 2016. |

## INVITED PRESENTATIONS

### INTERNATIONAL

1. Abnormal LDL Metabolism in Diabetes Mellitus, International Workshop on Macrovascular Disease in Diabetes Mellitus: Pathogenesis and Prevention, October 18-20, 1984, Garmisch, Germany.
2. Macrovascular and Cardiovascular Complications of Diabetes, International Symposium on Current Challenges and Directions in Diabetes Research, Juvenile Diabetes Foundation International, November 1-16, 1985, Monte Carlo, Monaco.
3. Metabolism of LDL and HDL in Cultured Cells, International Symposium on Atherosclerosis in Diabetes Mellitus, June 1, 1986, Osaka, Japan.
4. Métabolisme Dès Lipoproteines Au Cours Du Diabète Sucré, 28th Journées de Diabétologie de L'Hôtel Dieu, May 11-13,1987, Paris, France.
5. Hypercholesterolemia-Diagnostic Criteria, International Symposium of Cholesterol and Cardiovascular Disease: Consensus Conference, February 19-20, 1988, Lisbon, Portugal.
6. Pathogenesis of Arteriosclerosis- New Concepts, IV Latin Meeting on Vascular Research, November 6-9,1988, Lisbon, Portugal.
7. Virus and Arteriosclerosis, 4th Congress of EuroMedicine, November 8-12, 1988, Montpellier, France.
8. Hyperlipoproteinemias and Arteriosclerosis, XI Portuguese Congress of Cardiology, April 26-29, 1989, Funchal, Madeira.
9. Immune Mechanisms in the Pathogenesis of Atherosclerosis, 5th International Colloquium, Foundation de Recherche Sur l'Atherosclerose, March 14-16, 1990, Brussels, Belgium.

10. Immune Mechanisms of Atherosclerosis in Diabetes Mellitus, Satellite Symposium on Macrovascular Complications. XIV International Diabetes Federation Congress, June 20-22, 1991. Charleston, South Carolina
11. The Role of Immune Mechanisms in the Pathogenesis of Atherosclerosis in Diabetes Mellitus, XIV International Diabetes Federation Congress, June 23-28, 1991, Washington, DC.
12. Atherosclerosis and Auto-immunity in Diabetes, 1st International Symposium on Diabetes and Atherosclerosis, September 8-10, 1991, Dublin, Ireland.
13. Immune Mediated Mechanisms of Atherosclerosis in Diabetes Mellitus, 9th International Symposium on Atherosclerosis, October 6-11, 1991, Chicago, Illinois.
14. Atherosclerosis and Immune Mechanisms, 26th Annual Scientific Meeting of the European Society for Clinical Investigation, April 1-4, 1992, Vienna, Austria.
15. Interactions Between Lipopolysaccharides and Serum Lipoproteins and Their Possible Role in CHD, X Paavo Nurmi Symposium on Role of Infection and Inflammation in Vascular Disease, August 27-29, 1992, Helsinki, Finland.
16. Immunology of Modified Lipoproteins, 2nd International Symposium on Diabetes and Atherosclerosis, EASD Lipid Study Group, September 5-8, 1992, Karlovy Vary and Prague, Czechoslovakia.
17. Interrelated Metabolism Imbalances Linked to Hyperglycemia-induced Vascular Dysfunction, 4th International Symposium on Treatment of Diabetes Mellitus, October 26-27, 1993, Nagoya, Japan.
18. Dislipidemia and Atherosclerosis in Diabetes Mellitus: Cellular Mechanisms and Clinical Implications, I Portuguese Congress of Diabetes, February 25-26, 1994, Porto, Portugal.
19. Immune-Mediated Mechanisms of Atherogenesis in Diabetes, 15th International Diabetes Federation Meeting, November 6-11, 1994, Kobe, Japan.
20. Cytokines, Modified Lipoproteins and Arteriosclerosis in Diabetes Mellitus, Diabetes and Macrovascular Complications Symposium, November 12-13, 1994, Osaka, Japan.
21. Current Approaches to the Diagnosis and Treatment of Lipid Disorders in Diabetes Mellitus, November 14, 1994, Fukuoka, Japan.
22. Cytokines, Modified Lipoproteins and Atherosclerosis in NIDDM, XI Paavo Nurmi Symposium on Diabetes and Atherosclerosis, September 15-20, 1995, Helsinki, Finland.
23. Modified Lipoproteins and Atherosclerosis in Diabetes, Lipoprotein Study Group Workshop, European Association for the Study of Diabetes (EASD), March 20-22, 1997, Sorrento, Italy.
24. Autoimmunity of Atherosclerosis, Center of Immunology, Universidad de los Andes, April 25, 1997, Merida, Venezuela.
25. Is Atherosclerosis an Immunological Disease?, Satellite symposium on Atherosclerotic Vascular Disease in Diabetes, 16th IDF Congress, July 25-27, 1997, Lappeenranta, Finland.
26. Modified Lipoproteins and Receptor Interactions, British Hyperlipidemia Association Workshop, March 11, 1998, London, England.
27. Immunological Aspects of Atherosclerosis and Modified Lipoproteins and Endothelial Dysfunction, VI Meeting on Lipid Metabolism and Related Pathology, November 22-25, 1998, Costa da Caparica, Portugal.
28. Update on Lipid Therapy, XIV Venezuelan Congress of Medical Sciences, March 27-29, 2000, Merida, Venezuela.
29. Combination Therapy to Achieve Adequate Lipid and Blood Pressure Goals on Diabetes Mellitus Patients, IV Paulista Congreso, Endocrinology and Metabology, May 25-26, 2001,

São Paulo, Brazil.

30. Endothelial Dysfunction in Diabetes, IV Paulista Congreso, Endocrinology and Metabology, May 25-26, 2001, São Paulo, Brazil.
31. Antibodies Against Modified LDL and ox-LDL Immune Complexes as Predictors of Diabetic Complications, IV Paulista Congreso, Endocrinology and Metabology, May 25-26, 2001, São Paulo, Brazil
32. Hyperglycemia and insulin resistance in atherogenesis, International Congress of Diabetes, October 17-19, 2002, Buenos Aires, Argentina
33. Management of Cardiovascular Risk in Diabetes. What's new? Portuguese Congress of cardiology, April 28, 2003, Funchal, Madeira
34. Qualitative Modifications of Lipoproteins in Type 2 Diabetes, Symposium on Insulin Resistance and Type 2 diabetes, International Diabetes Federation Meeting, August 24-29, 2003, Paris, France
35. Development of capture assays for modified human LDL, 8th International Symposium on the Maillard reaction, August 28-September 1st, 2004, Charleston, SC.
36. Treatment of Diabetic Dyslipidemias. 75th European Atherosclerosis Society meeting, April 23-26, 2005. Prague, Czech Republic
37. Immunological Basis of Vascular Complications in Diabetes on Symposium entitled Clinical Diabetes: an attack on the Vasculature, International Society of Endocrinology and Annual Meeting of the Endocrine Society, Chicago, June 2-24, 2014.
38. ADA Guidelines and its importance in the management of type 1 and type 2 diabetes, ADA highlights meeting, September 22,23 and 24, 2017, Shanghai, Cheng-Du and Beijing, China

**NATIONAL AND REGIONAL**

***Invited Research Presentations***

1. HDL and CHD: The Lipid Hypothesis, Duke University School of Medicine and University of North Carolina School of Medicine, June 4-5, 1981, Durham and Chapel Hill, NC
2. Immunochemical Determination of Human Apolipoproteins by Laser Nephelometry, Workshop on Apolipoprotein Methods, NHLBI, NIH, September 21-22, 1982, Chevy Chase, Maryland.
3. Pathophysiopathology of Lipoprotein Disorders, Cholesterol Education Workshop of the SC Affiliate of the American Heart Association, March 19, 1988, Columbia, South Carolina.
4. Lipid Disorders as CHD Risk Factors, Workshop on Cardiovascular Risk Factors, SC Medical Association Annual Meeting, April 29-30, 1988, Charleston, South Carolina.
5. Interaction of Lipoproteins with Human Macrophages and Endothelial Cells in Diabetes Mellitus, 23rd International Research Symposium, American Diabetes Association, March 6-8, 1989, Hilton Head, South Carolina.
6. The Role of Insulin in Abnormalities of Lipoprotein Metabolism in NIDDM Patients, Consensus Conference on the Role of Cardiovascular Risk Factors in the Prevention and Treatment of Macrovascular Disease in Diabetes, American Diabetes Association, May 10-12, 1989, Denver, Colorado
7. Lipoproteins and Immune Response in the Vascular Wall and their Contribution to Atherosclerosis in Diabetes, International Symposium on Diabetes, Vascular Risks and Gliclazide, June 28, 1991, Washington, DC
8. Pathogenesis of Coronary and Peripheral Vascular Disease in Diabetes Mellitus, 7th Annual Regional Scientific Conference on Diabetes Mellitus, May 21-24, 1992, Ponte Vedra Beach, Florida.
9. Autoimmune Mechanisms of Atherosclerosis and Future Prospects for Intervention, 9th

Annual National Clinical Care Diabetes Conference: Update on Treatment of Vascular Disease in Diabetes, September 18-20, 1992, Norfolk, Virginia.

10. Role of Modified Lipoproteins in the Development of Arterial Disease in Diabetes, 53rd Annual Meeting, American Diabetes Association, June 12-15, 1993, Las Vegas, Nevada.
11. Autoimmunity, Macrovascular Disease and Diabetes, Research Seminar, East Carolina University, January 21, 1994, Greenville, North Carolina.
12. Heart Disease in Women, HCA Center for Research Education, May 6-7, 1994, Nashville, Tennessee.
13. Coronary Heart Disease Risk Factors and Mechanisms of Atherogenesis in Diabetes Mellitus: Clinical Implications, Medical Grand Rounds, Medical College of Georgia, December 16, 1994, Augusta, Georgia.
14. An Integrated View of the Role of Modified Lipoproteins in the Development of Atherosclerosis in Diabetes, Endocrinology Grand Rounds, Medical College of Georgia, December 16, 1994, Augusta, Georgia
15 Modified Lipoproteins, Auto-immunity and Atherosclerosis, University of Pennsylvania, April 25, 1995, Pittsburgh, Pennsylvania.
16. Cytokines and Adhesion Molecules, Research Seminar, Clinical Pharmacology Center, April 26, 1995, University of Pennsylvania, Pittsburgh, Pennsylvania
17. Regulation of LDL-Receptor Expression in Human Macrophages Activated by LDL-containing Immune Complexes, Research Seminar, Picower Institute for Medical Research, March 26, 1996, Manhasset, New York
18. Pathogenesis of Atherosclerosis in Diabetes, National Diabetes Consultant Meeting, Ranchero Bernado Inn, June 6, 1997, San Diego, California.
19. Macrovascular Disease in Diabetes. New Concepts and Therapies, Grand Rounds, Endocrinology and Metabolism Division, University of Minnesota, October 9, 1997, Minneapolis, Minnesota.
20. Regulation of LDL and Scavenger Receptor Expression in Human Macrophages, Research Conference, University of Minnesota, October 9, 1997, Minneapolis, Minnesota.
21. Inflammation and Atherogenesis, Grand Rounds in Medicine, Clemson University, November 14, 1997, Clemson, South Carolina.
22. Macrophage Activation and Macrovascular Disease, Biomedical Seminar Series, Clemson University, November, 14, 1997, Clemson, South Carolina.
23. Are Circulating Antibodies to LDL Relevant to the *in vivo* Risk of Developing Coronary Artery Disease?, Council on Complications Current Issues Session; American Diabetes Association 58th Scientific Sessions, June 13-16, 1998, Chicago, Illinois.
24. Activation and Gene Expression. Its Role in Atherosclerosis and Plaque Rupture, Southeast Lipid Conference, September 10-13, 1998, Lake Lanier, Georgia
25. Lipids, Immunocomplexes and Inflammation of the Vascular Wall, International Conference on Complications, Joslin Diabetes Center, October 23-25, 1998, Boston, Massachusetts.
26. Macrophage activation in plaque formation and rupture, Research Seminar, Diabetes and Endocrinology Division, Columbia University, October 19, 1999, New York, NY
27. The Role of Immune and Inflammatory Processes in the Development of Macrovascular Complications in Diabetes, University of Nebraska Medical Center, April 17-18, 2001, Omaha, Nebraska
28. The Edwin Bierman Award Lecture: Immune and Inflammatory Processes in the Development of Macrovascular Complications in Diabetes Mellitus, American Diabetes Association, 61st Annual Meeting, June 21-24, 2001, Philadelphia, Pennsylvania

29. Metabolic Syndrome, Southeast Lipid Association Annual Scientific Meeting. August 3-5, 2001, Charleston, South Carolina.
30. Dyslipidemia and Macrovascular Disease in Diabetes. What's new? Joslin Diabetes Center, March 11, 2002, Boston, MA.
31. What's new in the Pathophysiology of Atherosclerosis? Changes and Challenges in Cardiovascular Protection. Boston, MA, May 11, 2002
32. Physician and Scientist: Oil and Vinegar or Salad Dressing?, Southeast Lipid Association Annual Scientific Meeting, August 2-4, 2002, Williamsburg, Virginia.
33. Cardiovascular Disease in Diabetes, Council Discussion on Are diabetic complications preventable? , 63 rd annual meeting of the American Diabetes Association , June 13-17, 2003 New Orleans, Louisiana
34. Insulin Resistance, Workshop on Diabetic Complications: Progress through animal models, sponsored by National Institute of Diabetes & Digestive & Kidney Diseases, National Heart, Lung and Blood Institute, National Institute of Neurological Disease and Stroke, National Eye Institute and Juvenile Diabetes Research Foundation, October 20-21, 2003, Washington DC.
35. Cardiovascular Risk and lipid management. Gender differences. 13th South East Lipid Research Conference, Callaway Gardens, September 23-26, 2004
36. Inflammation and Cardiovascular Disease in Diabetes. Cardiology Fellowship Lecture series, University of Minnesota, Jan 5, 2005
37. Lipoprotein Metabolism, Inflammation and Obesity, Obesity day at the West Carolina University, NC, October 30, 2007
38. Development and Progression of Diabetic Complications: Is the Immune system the main culprit? Kresge Eye institute, Wayne State University, Detroit, MI, April 9, 2008
39. Lipid particles, auto-antibodies and Atherosclerosis 18th South East Lipid Research Conference, Callaway Gardens, September 24-27, 2009
40. Oxidized LDL and AGE-LDL Immune complexes strongly predict the development of cardiovascular disease in type 1 diabetes. American Diabetes Association, 70th Scientific Sessions in Orlando, FL, June 2010
41. The role of inflammation in the CAD of type 1 Diabetes Mellitus, American Diabetes Association, 72th Scientific Sessions, Philadelphia, Pennsylvania, June 2012
42. Immunological Basis of Vascular Complications in Diabetes, ICE/ENDO Meeting, Chicago, June 2014
43. The role and limitations of Biomarkers in Cardiovascular Disease in Biomarkers for Health and Disease symposium, Nutrition Advisory Panel, American Heart Association, Chicago, IL, November , 2014

***Clinical Presentations***

1. Cholesterol, Hypertension and Arteriosclerosis, 12th Annual Southeastern Conference on High Blood Pressure Control, October 22-24, 1986, Charleston, South Carolina.
2. Lipids and Lipoproteins as Risk Factors in NIDDM - When to Intervene, Council on Diabetes in Youth, American Diabetes Association 47th Annual Meeting, June 6-9, 1987, Indianapolis, Indiana.
3. Cholesterol and CHD," Community Health Section Conference, September 27-30, 1987, Savannah, Georgia.
4. Hyperlipidemias: Diagnosis and Treatment, 39th Annual Assembly of the South Carolina Academy of Family Physicians, December 3-5, 1987, Hilton Head, South Carolina.
5. Hyperlipidemias and Macrovascular disease in Diabetes: New Directions in Diabetes

Management, South Carolina and Georgia Affiliates, American Diabetes Association, May 19-22, 1988, Hilton Head, South Carolina

6. Women, Hormones and Cardiovascular Disease, Symposium on Practical Aspects of Hypertensive and Cholesterol Diseases, August 19-21, 1993, Nashville, Tennessee
7. Prevention of Cardiovascular Disease and Diabetes, Medical Grand Rounds, Bowman Gray School of Medicine, September 7, 1993, Winston-Salem, North Carolina
8. Update in the Treatment of Hypercholesterolemia, Myrtle Beach Medical Society, April 1994, Myrtle Beach, South Carolina
9. Update in the Diagnosis and Management of Hypercholesterolemia, Marion Memorial Hospital, May 23, 1994, Myrtle Beach, South Carolina.
10. Recognition and Treatment of the High Risk Patient for Cardiovascular Disease, Managing Health in the Aging, Southern Clinical Neurological Society, September 26, 1996, Charleston, SC.
11. New Advances in Lipid Management, Moody Air Force Base, April 4, 1997, Valdosta, Georgia.
12. Lipid Management in Clinical Practice: Improving Patient Outcomes, April 30, 1997, Greenville, South Carolina, sponsored by the Professional Postgraduate Services.
13. Advances in Lipid Therapy, Medical Education Programs, The Woodlands, September 6, 1997, Summerville, South Carolina.
14. Lipid Management in Clinical Practice: Improving Patient Outcomes, Session Leader, October 8, 1997, LMCP Regional Dinner Conference, Baltimore, Maryland.
15. Lipid Management in Diabetes, EDIC Study Coordinators Meeting, February 6, 1998, Charleston, South Carolina.
16. Diagnosis, Prevention and Treatment of Hypertriglyceridemia, Insulin Resistance Syndrome and Diabetic Dyslipidemia, LMCP CME District Symposium, July 25, 1998, Destin, Florida.
17. Management of Lipid Disorders, 4$^{th}$ Annual Diabetes Symposium for Primary Health Care Professionals, October 1, 1998, Charleston Hilton Hotel, Charleston, South Carolina.
18. Diet and CAD Risk. The Role of Vitamins, Annual South Carolina Dietetic Association, October 15-16,1998, Myrtle Beach, South Carolina.
19. Rationale for Cholesterol Lowering, National Lipid Education Council, November 14, 1998, Louisville, Kentucky.
20. Hyperlipidemia in the VA Setting: Focusing the Attack. A Case-Based Approach to Management, National Lipid Education Council, November 16, 1998, Chapel Hill, North Carolina
21. Hyperlipidemia in the VA Setting: Focusing the Attack, CME Clinical Conference, Professional Postgraduate Services, December 9, 1998, Richmond, Virginia.
22. Lipid Management in Clinical Practice: Improving Patient Outcomes, National Lipid Education Council, January 12, 1999, Charlotte, North Carolina.
23. Lowering the Risk of CHD: Clinical Benefits of Aggressive LDL-C Reduction, Dannemiller Memorial Foundation, October 6, 1999, West Palm Beach.
24. Lowering the Risk of CHD: Clinical Benefits of Aggressive LDL-C Reduction, Dannemiller Memorial Foundation, October 12, 1999, Charleston, SC.
25. Lowering the Risk of CHD: Clinical Benefits of Aggressive LDL-C Reduction, Dannemiller Memorial Foundation, October 26, 1999, Roca-Baton, Florida.
26. Lowering the Risk of CHD: Clinical Benefits of Aggressive LDL-C Reduction, Dannemiller Memorial Foundation, December 2, 1999, Tampa, Florida.
27. Lipoproteins and cardiovascular risk in Diabetes, June 15, 2000, Charleston Place, Charleston, South Carolina

28. Strategies in the Management of Cardiovascular Risk in Diabetes, New York, New York, June 25, 2000
39. Updating Lipid Management for Primary Care Physicians, July 13, 2000, Naval Weapon Station, Charleston, South Carolina.
40. Customizing Lipid Management According to the Patient's Profile, August 22, 2000, Beaufort, South Carolina.
41. Update in the Management of Lipid Disorders with Special Emphasis on Diabetic Patients, September 15, 2000, Myrtle Beach, South Carolina.
27. Reducing Cardiovascular Risks-Lipid Management in Diabetes, Southern Medical Association Meeting, March 25-28, 2001, Destin, Florida
43. Dyslipidemia and the Diabetic Patient, April 2, 2001, Medical Views, Southern Vistas, Charleston, South Carolina.
44. NECP-ATP-III guidelines and its clinical applications, June 15, 2001, Myrtle Beach, SC
45. The ATP-III Guidelines, Regional Advisory Meeting, 9/21-22,2001, Atlanta, Georgia
46. The need for intensive cholesterol lowering: a review of lipoproteins, landmark clinical trials and patient issues, Changes and Challenges in Cardiovascular Protection. May 11, 2002, Boston, MA
47. The Evolving Lipid Management Paradigm, University of Tennessee Cardiology Rounds, June 19,2002, Knoxville, Tennessee
48. The need for intensive cholesterol lowering: a review of lipoproteins, landmark clinical trials and patient issues, Changes and Challenges in Cardiovascular Protection, June 29,2002 St Louis, Missouri
49. The ATP-III evidence-based guidelines: what are the changes and the rationale. Changes and Challenges in Cardiovascular Protection, May 11, 2002, Boston, MA
50. Identifying and treating subgroups of high-risk patients for CHD and CVD. Changes and Challenges in Cardiovascular Protection, June 29, 2002, St Louis, Missouri
51. Management of Lipid Disorders. The new ATP-III guidelines, Focus on the female patient, Southern Medical Association, July 9, 2002, Kiawah Island, SC.
52. The Evolving Lipid Management Paradigm: Clinical Implications for Practice. The Evolving Lipid Management Paradigm: Centers of Excellence. Emory Conference Center, September 14, 2002, Atlanta, GA.
53. The Evolving Lipid Management Paradigm, East Jefferson General Hospital Cardiology Rounds, November 19,2002, Metairie, Louisiana
**54.** LDL-Apheresis-Beyond Drug Therapy-The principles and Therapeutic Applications, Workshop, SouthEast Lipid Association, 6th Annual Meeting, August 22-24, 2003, Roca Baton, Florida.
**55.** Heart Disease in Women. Gender differences in Risk and Management. In "Achieving Success in Women's Healthcare. Early Detection and Treatment." May 12-13, 2005. Atlanta, GA
**56.** The Endocannabinoid system: a new target for the reduction of cardiovascular risk factors. The Metabolic Syndrome. Sponsored by the Endocrine Society, May 31 (Houston, Texas) and June 1 (San Antonio, Texas), 2006
**57.** Management of lipid cases: Diabetes Fall Symposium for Primary Health Care professionals, September 10-12, 2008, North Charleston, SC
**58.** Medical co-morbidities, Obesity Day, April 14, 2010, Medical University of SC, Charleston SC.
**59.** Caring for dyslipidemia in patients with diabetes. Diabetes Fall Symposium for Primary Health Care professionals, September 23-24, 2010, North Charleston Convention Center,

North Charleston, SC

60. Hypertriglyceridemia and HDL-Cholesterol during "Meet the Professor" sessions of the 98th Annual Meeting of the Endocrine Society held in April 1-4, 2016, Boston, MA.
61. ADA guidelines: their influence on the study and clinical pratice of complications in type 1 and type 2 diabetes, Mini-symposium at the 77th ADA national meeting, June 9-13, 2017, San Diego, CA
62. Comparison of the American and Chinese treatment guidelines for Diabetes, Symposia on Shanghai, Cheung and Beijing, September 2017, China

## PEER-REVIEWED PUBLICATIONS

### MANUSCRIPTS

#### *A. PUBLISHED*

1. **Lopes MF**. "Chronic Broncho-Pulmonary Diseases and Mucoviscidosis." *Medicina Universal,* 11:261-281, 1968 (Port.).
2. **Lopes MF** and Levy ML. "About a Case of Cystic Fibrosis." *Revista Portuguesa de Pediatria,* 31:238-245, 1968 (Port.).
3. Virella G and **Lopes MF**. "The Immunoglobulins. IV. Monoclonal Gammopathies." *Medicina Universal,* 12:23-28, 1969 (Port.).
4. **Lopes MF**. "Pigeon Breeder's Disease." *0 Medico,* 55:795-799, 1970 (Port.)
5. Virella G and **Lopes-Virella MF**. "Effects of Therapeutically Useful Thiols (DL-penicillamine and Alpha-mercaptopropionylglycine) on Immunoglobulins." *Clin Exp Immunol,* 7:85-107, 1970 (Port.).
6. Virella G and **Lopes MF**. "Correlations Between Laboratorial Studies, Diagnosis, Therapy and Prognosis of Monoclonal Gammopathies." *Revista Portuguesa de Terapêutica Médica,* 4:190-200, 1970 (Port.).
7. **Lopes-Virella MF**, Palma Carlos ML and Ducla Soares A. "Clinical Trial of Alpha-Mercaptopropionylglycine (Tiolidon) in Rheumatoid Arthritis." *Revista Portuguesa de Terapêutica Médica,* 6:23-27, 1972 (Port.).
8. **Lopes-Virella MF**, Sequerra Amram S, Parreira F and Virella G. "Serum Lipoprotein Electrophoresis, II-Polyacrylamide Gel Electrophoresis." *0 Médico,* 69:496-500, 1973 (Port.).
9. **Lopes-Virella MF**, Martins Prata M, Virella G and Ducla Soares A. "Lipoproteins in the Nephrotic Syndrome." *0 Médico,* 70:153-155, 1974 (Port.).
10. **Lopes-Virella MF**, Virella G, Parreira F and Sequerra Amram S. "Comparative Analysis of Some Techniques for the Electrophoretic Separation of Serum Lipoproteins." *Revista Clinica Española,* 133:195-204, 1974 (Span.).
11. Virella G, Gervasio da Silva JJ, **Lopes-Virella MF** and Parreira F. "Intracellular Light Chains in Peripheral Lymphocytes of a Patient with Chronic Lymphatic Leukemia." *Sangre,* 20:456-466, 1975 (Span.).
12. **Lopes-Virella MF**, Sarji K, Virella G and Colwell JA. "Platelet Lipoproteins - A Comparative Study with Serum Lipoproteins." *Biochim Biophys Acta,* 439(2):339-348, 1976.
13. **Lopes-Virella MF** and Colwell JA. "Serum High Density Lipoprotein in Diabetic Patients." *Lancet,* 1:1291-1292, 1976.
14. **Lopes-Virella MF**, Stone P, Ellis S and Colwell JA. "Cholesterol Determination in High Density Lipoproteins Separated by Three Different Methods." *Clin Chem,* 23:882-884, 1977.
15. Virella G, Monteiro JN, **Lopes-Virella MF**, Ducla Soares A and Fudenberg HH.

"Asyncronous Development of Two Monoclonal Proteins (IgM k and g-1 Chains) in a Patient with Abdominal Lymphoma." *Cancer,* 39:2247-2253, 1977.

16. **Lopes-Virella MF**, Stone P and Colwell JA. "Serum High Density Lipoprotein in Diabetes." *Diabetologia,* 13:285-291, 1977.
17. Virella G and **Lopes-Virella MF**. "New Approaches to the Study of Proteinuria." *Clin Chem,* 23:1793-1794, 1977.
18. **Lopes-Virella MF** and Colwell JA. "Tight Metabolic Control may Normalize HDL and Check Macrovascular Disease in Diabetes." *Metab Therapy,* 6:1-3, 1977.
19. Virella G, **Lopes-Virella MF**, Levine J, Ogawa M and Gonzalez J. "Idiopathic Bence-Jones Proteinuria." *Acta Haematologica,* 60:269-279, 1978.
20. **Lopes-Virella MF**, Virella G, Rosebrock G, Sagel J, Gonzalez J and Colwell JA. "Early Diagnosis of Renal Malfunction in Diabetics: Abnormal Proteinuria Revealed by Sodium Dodecyl Sulfate-polyacrylamide Gel Electrophoresis." *Diabetologia,* 16:165-171, 1979.
21. Virella G, Munoz J, **Lopes-Virella MF**, Ward B and Gadsden R. "Rapid Immunochemical Determination of Free Hemoglobin in Plasma and Urine with a Laser Nephelometer." *Clin Chem,* 25:497-499, 1979.
22. **Lopes-Virella MF**, Virella G, DeBeukelaer M, Owens CJ and Colwell JA. "Urinary High Density Lipoprotein in Minimal Change Glomerular Disease and Chronic Glomerulopathies." *Clin Chim Acta,* 94:73-81, 1979.
23. Colwell JA, Halushka PV, Sarji KE, **Lopes-Virella MF** and Sagel J. "Vascular Disease in Diabetes. Pathophysiological Mechanisms and Therapy." *Arch Intern Med,* 139:225-230, 1979.
24. Sagel J, **Lopes-Virella MF**, Colwell JA and Levine JH. "Altered High Density Lipoprotein Cholesterol (HDL-CHOL) in Hypothalamic-Pituitary Disorders." *J Clin Endocrinol Metab,* 49:753-756, 1979.
25. Gordon L, Mayfield RK, Levine JH, **Lopes-Virella MF**, Sagel J and Buse MG. "Failure to Visualize Adrenal Gland in a Patient with Bilateral Adrenal Hyperplasia." *J Nucl Med,* 21:49-51, 1980.
26. **Lopes-Virella MF**, Adams K, O'Dell R and Virella G. "Cold Agglutinin Disease: A Case Complicated with an Episode of Acute Renal Failure." *Clin Immunol Newsletter,* 1(9):1-4, 1980.
27. **Lopes-Virella MF**, Virella G, Evans G, Malenkos SB and Colwell JA. "Immunonephelometric Assay of Human Apolipoprotein AI." *Clin Chem*, 26:1205-1208, 1980.
28. Virella G, Lopes-Virella M, and Estes G. "Nephelometric Assays in Clinical Immunology." Microbiology by American Society of Microbiology, 1981:326-331.
29. Colwell JA, **Lopes-Virella MF** and Halushka PV. "Pathogenesis of Atherosclerosis in Diabetes Mellitus." *Diabetes Care,* 4:121-133, 1981.
30. **Lopes-Virella MF**, Wohltmann J, Loadholt B and Buse MG. "Plasma Lipid and Lipoprotein in Young Type I Diabetic Patients. Relationship with Control." *Diabetologia,* 21:216-223, 1981.
31. Virella G, Wohltmann H, Sagel J, **Lopes-Virella MF**, Kilpatrick M, Philips C and Colwell JA. "Soluble Immunocomplexes in Patients with Diabetes Mellitus, Detection and Pathological Significance." *Diabetologia,* 21:184-191, 1981.
32. **Lopes-Virella MF**, Sherer G, Lees AM, Wohltmann H, Mayfield R, Sagel J, Leroy C and Colwell JA. "Surface Binding, Internalization and Degradation by Cultured Human Fibroblasts of Low Density Lipoproteins Isolated from Type I (Insulin-dependent) Diabetic

Patients: Changes with Metabolic Control." *Diabetologia,* 22:430-436, 1982.

33. **Lopes-Virella MF**, Wohltmann H, Mayfield RK, Loadholt CB and Colwell JA. "Effect of Metabolic Control on Lipid, Lipoprotein and Apolipoprotein Levels in 55 Insulin-dependent Diabetic Patients: A Longitudinal Study." *Diabetes,* 32:20-25, 1983.
34. Virella G, **Lopes-Virella MF**, Shuller C, Sherwood T, Espinoza A, Winocour P and Colwell JA. "Release of Platelet Activating Factor by Polymorphonuclear Leukocytes Stimulated by Immune Complexes Bound to Sepharose Particles in Human Erythrocytes." *Immunology,* 50:43-51, 1983.
35. Colwell JA, Winocour PD, **Lopes-Virella MF** and Halushka PV. "New Concepts About the Pathogenesis of Atherosclerosis in Diabetes Mellitus." *Am J Med,* 75:67-80, 1983.
36. Winocour PD, **Lopes-Virella MF**, Laimins M and Colwell JA. "Time-Course of Changes *In Vitro* Platelet Function and Plasma von Willebrand Factor Activity (VIII-R,WF) and Factor VIII Related Antigen (VIII-R, Ag) in the Diabetic Rat." *J Lab Clin Med,* 102:795-804, 1983.
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40. **Lopes-Virella MF**. "Circulating Elements." In "Workshop on Insulin and Atherogenesis." *Metabolism,* 12 (S1):87-91, 1985.
41. Mayfield RK, Halushka PV, Wohltmann HJ, **Lopes-Virella MF**, Chambers JK, Loadholt C and Colwell JA. "Influence of Glycemic Control on Platelet Function in Insulin-dependent Diabetic Patients." *Diabetes,* 34:1127-1133, 1985.
42. **Lopes-Virella MF**, Sherer G, Wohltmann H, Sens D and Colwell JA. "Diabetic Lipoprotein Deficient Sera. Its Effect in LDL Uptake and Degradation by Fibroblasts." *Metabolism,* 34:1079-1085, 1985.
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44. Lyons TJ, Patrick J, Baynes JW, Colwell JA and **Lopes-Virella MF**. "Degree of Glycation of LDL in a Group of Type I Diabetic Patients: Correlations with Other Parameters of Glycemic Control." *Diabetologia*, 29:685-689, 1986.
45. **Lopes-Virella MF** and Colwell JA. "Pharmacological Treatment of Lipid Disorders in Diabetes Mellitus." *Diabetes/Metabolism Reviews,* 3:691-722, 1987.
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47. Virella G and **Lopes-Virella MF**. "Infections and Atherosclerosis." *Transplantation Proceedings,* 19:26-35, 1987.

48. Lyons TJ, Klein RL, Baynes JW and **Lopes-Virella MF**. "Stimulation of Cholesteryl Ester Synthesis in Human Monocyte-derived Macrophages by Lipoproteins from Type I Diabetic Patients: The Influence of Glycation of Low Density Lipoprotein." *Diabetologia,* 30:916-923, 1987.

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51. Colwell JA and **Lopes-Virella MF**. "A Review of the Pathogenesis of Large Vessel Disease in Diabetes Mellitus." *Am J Med*, 85 (S5A):113-118, 1988.

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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APPEAL FROM THE
South Carolina Workers Compensation Commission
Appellate Panel

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SCWCC Case No. 2202001

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Hector Lopez-Vasquez, Employee,.....Claimant/Appellant

v.

Ox Paper Tube & Core Carolina, LLC and
Berkshire Hathaway Homestate Insurance, Employer,.....Defendants/Respondents

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NOTICE OF APPEAL

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Claimant, Hector Lopez-Vaquez, appeals the order of the South Carolina Workers Compensation Appellate Panel dated February 05, 2024. Appellants received written notice of entry of this order on February 05, 2024.

February 28, 2024

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**Hector Vasquez-Lopez v. Ox Paper Tube & Core Carolina, LLC;**
**And Berkshire Hathaway Homestead Ins. Co.:**
**SCWCC Case No. 1120778**

**Grounds for Appeal**

1. **Did the Single Commissioner and Full Commission err in making Finding of Fact #23 as it is completely irrelevant that Ms. Roldan-Dimas does not speak English and could not fill out logs in English?**

2. **Did the Single Commissioner and Full Commission err in finding that Ms. Roldan-Dimas refused Defendants offer of a third-party home health service provider only because the Claimant preferred her to provide the at-home care, when the record actually shows the offer was declined because Ms. Roldan-Dimas and her husband live in Ms. Roldan-Dimas' daughter's home who would not allow a third party care giver in their home at all times of the day and night.**

3. **Did the Single Commissioner and Full Commission err in Conclusion of Law #8 by interpreting 42-15-60(A) to only allow attendant care service by a licensed professional?**

4. **Did the Single Commissioner err in Conclusion of Law #10 by interpreting the differences and limitations of treatment between 42-15-60(A) and 42-15-60(c)?**

5. **Did the Single Commissioner and Full Commission err in Conclusion of Law #11 in the interpretation of 42-15-60(A) and its limitation on the Commission's ability to order non-professional attendant care, nursing services, and other reasonable treatment or care prior to MMI?**

6. **Did the Single Commissioner and Full Commission err in Conclusion of Law #13 by finding the Commission is constrained in its authority to order unskilled nursing services pursuant to 42-15-60(A)?**

7. **Did the Single Commissioner and Full Commission err in Conclusion of Law #14 that despite the authorized treating doctor ordering unskilled attendant care, 42-15-60(a) prohibits the Commissions ability to do so prior to MMI?**

8. **Did the Single Commissioner and Full Commission err in Conclusion of Law #15 that the cited cases by Claimant were not instructive on the broad authority granted in 42-15-60(A)?**

9. **Did the Single Commissioner and Full Commission err in Conclusion of Law #19 determining that unlicensed or non-professional care creates a liability conundrum?**

10. **Did the Single Commissioner and Full Commission err in Conclusion of Law #20 by concluding that by Ms. Roldan-Dimas being paid for the care she is providing to her**

**husband that she could somehow be an employee of the Defendant, or that by her not speaking English that somehow limits her ability to properly monitor Claimant?**

11. **Did the Single Commissioner and Full Commission err in Conclusion of Law #21 in failing to order payment or reimburse Ms. Roldan-Dimas for her care services, and instead only concluding that Defendants must provide care services with a licensed professional skilled home health aide and/or nurse, for which Claimant is unable to accept.**