THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Melody L. James, Appellate Panel Chairman, Commissioner

Case No. 2014-002294
WCC File No. 1106833

TIMOTHY MCMAHAN, APPELLANT/RESPONDENT,

V.

SC DEPARTMENT OF EDUCATION – TRANSPORTATION, EMPLOYER, AND STATE ACCIDENT FUND, CARRIER, RESPONDENTS/APPELLANTS.

INITIAL RESPONDENT'S BRIEF OF THE APPELLANT/RESPONDENT

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STATEMENT OF THE CASE

The Appellant filed a WCC Form No. 50 on May 16, 2013 alleging he sustained injuries by accident to his head, brain, back, internal organs, teeth, legs, mouth and ribs arising out of and occurring within the course and scope of his employment on June 15, 2011. The Respondents filed a WCC Form No. 51 on June 13, 2013 admitting the injury to his back, but denying all others. A Hearing was set for August 15, 2013.

A hearing was held before Commissioner Aisha Taylor on August 15, 2013. Commissioner Taylor found the Appellant to have reached maximum medical improvement prior to his death and awarded total disability benefits due to the fifty (50) percent or greater loss of use to his back under §42-9-30 based upon a fifty-four percent (54%) impairment rating from the authorized treating physician.

Within the statutory period, the Respondents filed a WCC Form 30 appealing her decision to the Appellate Panel. A review hearing was held on July 22, 2014. By Order dated September 30, 2014, the Appellate Panel reversed the decision of Commissioner Taylor, found the Claimant not to be at maximum medical improvement prior to his death, and found the claim abated with his widow receiving nothing. The Appellant was the first to file his appeal with the Court, followed by the Respondents' appeal. This Brief is in response to the Respondents' appeal.

FACTS

The Appellant was sixty-one (61) years old at the time of his death. His wife and Personal Representative of his Estate, Dorothy McMahan, was married to the Appellant for thirty-three (33) years. They had two (2) children. The Appellant had a high school education and served in the US Army as a mechanic. After discharge, he went to work as a mechanic. The last job he had was as a bus mechanic for the Respondent. All of the work he had done required heavy lifting, being on his feet, bending, stooping, and squatting. He had never in his life worked behind a desk. (HT, pp. 8-10).

On June 15, 2011, the Appellant had a horrible accident. A bus he was working on fell on top of him. He was admitted to MUSC in Charleston and underwent a three (3) level fusion surgery from T11-L1 with placement of plates and pedicle screws. He underwent a second surgery on October 9, 2011, to remove some of the screws and revise the previous surgery. The last time the Appellant was seen at MUSC, the authorized treating physician conducted a physical examination which revealed "left leg 4/5 strength, right 3/5, tight bilateral lumbar paraspinal muscles to palpation, kyphosis." He was given pain medications and a recommendation was made that be set up with pain management in Tennessee. (APA 3).

The Appellant moved to Tennessee to be with his elderly parents who were on their last days. The Respondents sent him to Dr. Patrick Bolt, who became his authorized treating physician in Tennessee. On April 23, 2012, the Appellant saw Dr. Bolt and underwent another physical examination and evaluation. Dr. Bolt noted his prior surgeries in Charleston and stated, "...he is able to flex 80% of normal...His quadriceps are 3/10 on the left, hip flexors are 3/10 on the left, otherwise full strength in the lower

extremities." Dr. Bolt ordered an updated MRI to make sure nothing else could be offered by way of treatment. The MRI showed no "new neural pinches" and "no pseudoarthroses." Dr. Bolt also ordered at CT, a Duplex scan of his left lower extremity, and an EMG. All of the tests except the EMG were done. Dr. Bolt commented that he thought the Appellant was at maximum medical improvement (MMI). He referred the Appellant to pain management. No other medical treatment was ordered. (APA 2).

On October 6, 2012, the Appellant died of unrelated causes. (APA 7).

On February 27, 2013, Dr. Bolt issued his opinions regarding MMI and impairments. Dr. Bolt stated, "I would say that he was at maximum medical improvement when I saw him on 4/23/2012." Dr. Bolt commented that the Claimant was "totally disabled" and assigned a fifty-four percent (54%) impairment for his work-related injury. He completed a WCC Form 14B indicating the date of MMI to be April 23, 2013. This would be nearly six months prior to his death. (APA 2).

A hearing was set to determine if the Claimant had reached MMI prior to his death, and if so, to determine if the Respondents could rebut the presumption that he was totally disabled. The Respondents set the deposition of Dr. Bolt, but chose to cancel it. No depositions were taken of anyone except for the Appellant's wife. No medical opinions were submitted to refute the authorized treating physician's diagnosis that the Appellant was at MMI prior to his death.

At the hearing, the Appellant's wife testified that the second surgery helped his pain and that she noticed an improvement. She testified that the Appellant's back condition did not change once they got to Tennessee. She testified that by the time he got to see Dr. Bolt, the Appellant had gotten about as good as he was going to get. He was

not making any major improvements, "He stayed the same." No attempt was made to cross-examine her. (HT, pp 10-12).

The Respondents made multiple arguments in an attempt to have the claim abated. First, even though they denied his legs were compensable body parts and no doctor ever diagnosed him as paraplegic, the Defendants contended the Appellant was paraplegic under §42-9-10(C), therefore contended his claim should abate. Second, they stated that it is illegal for the Commission to even consider a WCC Form 14B completed after any Claimant has passed. Third, the Defendants asserted that the Appellant had not reached maximum medical improvement before his death. Fourth, the Defendants asserted that it is illegal for the Commission to rule on permanent disability after a person has died. The Defendants chose not to present any evidence to rebut the presumption that the Appellant was totally disabled in the event the Commissioner found his claim would not abate.

The hearing commissioner weighed the evidence and agreed with the only medical opinion in evidence concerning MMI, that the Appellant had reached MMI nearly six (6) months prior to his death. She rejected all of the Respondents' arguments, and since they offered no evidence to rebut the presumption that he sustained a fifty (50) percent or greater disability to his back, she awarded total disability benefits to the Appellant's wife.

Upon application for review to the Appellate Panel, a review hearing was held where the Respondent renewed all of the same arguments they made to the hearing commissioner. By its Order, the Appellate Panel denied all but one (1) of the Respondents' issues on appeal. They found the Appellant had not reached MMI prior to

his death and stated no benefits were due to his widow. The Respondents appealed that decision stating the claim should be denied for two (2) additional reasons. They contend it is illegal for the Commission to even consider this case despite a statute directing them to do so. And second, they contend the Appellant was paraplegic despite no doctor diagnosing that condition.

ARGUMENT

I. WHEN A PERSON DIES FROM NONCOMPENSABLE CAUSES, THE STATUTE REQUIRES THE COMMISSION TO DETERMINE WHAT COMPENSATION, IF ANY, HIS FAMILY IS OWED.

A. The statute provides two (2) situations where a widow may be compensated.

Section §42-9-280 provides, "When an employee receives or is entitled to compensation under this Title for an injury covered by the second paragraph of §42-9-10 or 42-9-30 and dies from any other cause than the injury for which he was entitled to compensation, payment of the unpaid balance of compensation shall be made to his next of kin dependent upon him for support, in lieu of the compensation the employee would have been entitled to had he lived." (Emphasis added).

The statute above envisions two situations where the claim would not abate following a death from unrelated causes. The first is when an award has already been given ("when an employee receives...compensation) and the second is when the employee "is entitled to compensation..." (Emphasis added).

This is an accepted claim and the Appellant was deemed to be at maximum medical improvement before his death. The authorized treating physician has issued his impairment rating. Therefore, the Commission has the right to determine if he was entitled to compensation, just as it does in nearly every other claim. This has been the

Commission's long-standing interpretation of the statute and usually results in an award identical to the impairment rating, sometimes higher.

The Respondents take the position that the only way for the next of kin to receive compensation is if the Appellant had already been before the Commission and given award before his death. Of course, this completely ignores the second class of people specifically mentioned in the statute. Please notice the statute only states, "When an employee...is entitled to compensation under this Title...and dies from any other cause than the injury for which he was entitled to compensation, payment...shall be made to his next of kin..." (Emphasis added). If the legislature intended to only compensate a deceased Claimant's family when an award has already been given as the Respondents suggest, they would have left out the second class for those who are "entitled to compensation," and inserted the term, "and dies after an award has been issued." The language of the statute explicitly states those who have already received an award of compensation AND those who are entitled to compensation are both entitled to their awards so long as they are based upon the second paragraph of §42-9-10 or 42-9-30.

"The Court generally gives deference to an administrative agency's interpretation of an applicable statute or its own regulation." Brown v. S.C. Dep't of Health and Envtl. Ctrl., 348 S.C. 507, 560 S.E.2d 410 (2002). Below is a list of claims decided by the Commission demonstrating their interpretation and practical application of the statute.

Wright v. All My Sons, WCC 0524754 (2008). This was an admitted leg claim. The Claimant died of unrelated causes. No award had been given at the time of death. The authorized treating physician assigned his impairment treating after he died. The full commission's unanimous award was identical to the impairment rating.

Bourne v. USC, WCC 0414625 (2011). This was an accepted back claim. The Claimant died of unrelated causes. No award had been given at the time of death. The full commission's unanimous award was identical to the impairment rating.

Cumbee v. C of C, WCC 9523133 (2002). This was an accepted back and psychological claim. The authorized treating physician assigned a twenty percent (20%) impairment rating for the back injury before his death. The Claimant died of unrelated causes. No award had been given at the time of his death. He was declared at MMI for the psychological injury after his death. The Claimant's widow testified regarding his age, education, work history and transferable skills. The award was permanent and total disability for a fifty percent (50%) or greater disability to his back.

Faulkenberry v. Springs Industries, WCC 0118462 (2002). This was an admitted back and leg claim. The Claimant died of unrelated causes. No award had been given at the time of death. The Claimant's widow testified regarding his pain, limitations and ability to work. The award was permanent and total disability for a fifty percent (50%) or greater disability to his back.

Heimerl v. Pelham Fire Dept, WCC 0414792 (2012). This was an admitted right hip and psychological claim. The Claimant died of unrelated causes. No award had been given at the time of death. The authorized treating physician assigned at forty percent (40%) impairment for the hip injury. The Claimant was still treating at time of death for the psychological injury. The Claimant was found not to be at MMI for the psychological injury at the time of death. The full commission's unanimous award was identical to the impairment rating for the hip.

Henry v. Gold Mechanical, WCC 0417344 (2007). This was an admitted carpal tunnel claim. The Claimant died of unrelated causes. No award had been given at the time of death. The full commission's unanimous award was identical to the impairment rating.

Johnson v. Efco Corp., WCC 9917051 (2002). This was an admitted claim. The Claimant died of unrelated causes. No award had been given at the time of death. The Claimant's widow testified regarding his pain, limitations and ability to work. The award was permanent and total disability.

The Commission's long-standing interpretation is supported by the law. In construing a workers' compensation statute, "the words must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute's operation." Adkins v. Comcar Industries, Inc., 323 S.C. 409, 475 S.E.2d 762 (1996). The clear words of the statute provide a person who has already received an award of compensation AND a person who is entitled to compensation are both entitled to their awards so long as they are based upon the second paragraph of 42-9-10 or 42-9-30. The purpose of the statute is to provide the next of kin with "the compensation the employee would have been entitled to had he lived." A sixty (60) year old veteran who has always done heavy manual labor with a fifty-four percent (54%) impairment rating to the back would clearly be entitled to total disability benefits for a fifty percent (50%) or greater disability had he lived.

B. The Respondents' due process rights were not violated by the hearing commissioner following the law.

The Respondents claim their due process rights were violated by the hearing commissioner in awarding benefits after the Appellant had passed. The reasoning is that they lost the ability to cross-examine the witnesses and present witness of their own.

Here, the authorized treating physician laid out an extremely detailed rationale for the impairment rating, all with references to the *AMA Guides*. The Defendants had his deposition scheduled before the hearing, but decided not to go forward, **so <u>they</u> cancelled it.** Therefore, it was the Respondents themselves who CHOSE not to cross-examine the authorized treating physician about MMI, the impairment rating, paraplegia, or anything concerning the Appellant's condition. After the Appellant's widow testified regarding his age, education, work history and transferable skills, it was the Respondents themselves who CHOSE not to ask her a single question or cross-examine her in any way.

The Respondents claim this statute also takes away their right to present evidence. The Respondents take the position in this appeal that the Appellant was either paraplegic or partially paraplegic. They go through the medical records, compare those to the medical literature, and point out all of the reasons why the Appellant *should* have been diagnosed with that condition. The truth is that nothing stopped them from hiring their own doctor to make the diagnosis rather than asking the Commission to do it for them. It was the Respondents themselves that made their own choices. Due process has nothing to do with the choices they made. This argument, while inaccurate to say the least, should have absolutely no merit.

II. THE COMMISSION WAS CORRECT IN CONCLUDING THE RESPONDENTS DID NOT PROVE PARAPLEGIA.

Paraplegic cases are among the most difficult to prove. I could never have proven the Appellant was paraplegic under the facts of this case. The Respondents have crafted an argument that creates the false sense that the Appellant was diagnosed as paraplegic. Based upon that argument, they cite many ways this case is similar to the case of Reed-Richards v. Clemson University, 371 S.C. 304, 638 S.E.2d 77 (Ct.App. 2006). The main difference is that here, the Appellant was never diagnosed as being "paraplegic," "partially paraplegic" or even "a little bit paraplegic."

Although the day after his injury, the emergency room doctor used the term paraplegic, but this was not a diagnosis. **The Defendants conveniently leave out the entire sentence where the term is found, which reads, "He was found to be paraplegic."** (Emphasis added) (APA 4). This is not a diagnosis, but a description of how they found the Appellant at the scene. He couldn't move his legs. This description was never made again by any other doctor because the Appellant was getting better and again, that was just a description of how they found him. **In fact, the section titled "Diagnosis" for the emergency room reads "Acute urinary retention, T12 vertebral body fracture, scalp laceration x 2." The "Secondary Diagnosis" was "Chronic obstructive pulmonary disease."** (Emphasis added) (APA 4). This is hardly the type of evidence it would take to prove permanent paraplegia. And then, the paraplegia claim gets even more difficult given his improvements over time with treatment.

Over the next two (2) years, the Appellant underwent two (2) surgeries that helped him recover and the word paraplegia was never even mentioned again. On September 29, 2011, just three (3) months later, the doctor noted "Patient is mobilizing

well with a walker, given the initial spinal cord injury." (Emphasis added) (APA 3). This is an improvement from his condition at the scene and emergency room.

On February 7, 2012, the physical examination revealed "left leg 4/5 strength, right 3/5, tight bilateral lumbar paraspinal muscles to palpation, kyphosis." (Emphasis added). This is a greater improvement from his condition at the scene and emergency room.

On April 23, 2012, Dr. Bolt noted his prior surgery in Charleston and stated, "He walks with a markedly pitched forward gait...he is able to flex 80% of normal...His quadriceps are 3/10 on the left, hip flexors are 3/10 on the left, otherwise full strength in the lower extremities." (Emphasis added) (APA 2). This is yet another improvement from his condition at the scene and emergency room.

On May 11, 2012, (the last time he saw the authorized treating physician before his death) the physical examination revealed "Quadriceps 3/5 left leg, hip flexion is 3/5 left leg, otherwise full strength in bilateral lower extremities. Pain-free full range of motion in bilateral hips, knees and ankles today." The MRI showed "a severe compression fracture, but no new neural pinches or pseudoarthroses." (Emphasis added) (APA 2).

The reality is that no doctor ever gave the diagnosis of paraplegia. Physical examinations of the Appellant demonstrated his ability to walk and full strength in both of his legs. The Respondents would deny a paraplegia claim under these facts and win. The only reason it is being asserted is because this is one (1) way to have the claim abate and deprive the Appellant's widow of the compensation she is due. If the case is so strong based on the records alone as they suggest, they could have easily sent those same

records to another doctor to review and weigh in on their assertion in an effort to meet their burden of proof. Finding paraplegia in this case would open the door to more of those claims and set a much lower threshold than what we all understand it to be.

CONCLUSION

The Respondents are asking the Court to change the law. Even though litigating a person's disability after death is specifically authorized and required by the statute, the Respondents are asking for a ruling stating this long-standing practice is illegal.

The Respondents are also asking that the standard for proving paraplegia be expanded to include cases where that diagnosis was never actually made, much less to a reasonable degree of medical certainty. Paraplegia cases are among the most complex, therefore our rules require more than simply a description of how someone was found at the scene. Our rules require a specific diagnosis from a treating doctor, much more than a single mention of the term the day after an accident, especially when the employee gets treatment over the two (2) years following. To prove paraplegia, our understanding is that a doctor needs to specifically diagnosis that condition at the close of treatment, and after all efforts to cure the person have been exhausted and he or she has been declared at MMI. The Respondents' Initial Brief goes through all the reasons they claim the authorized treating physician *should* have diagnosed the Appellant as paraplegic, but the truth is that he never even mentioned the term one time. To find the Appellant was paraplegic without a doctor making the diagnosis would require the Commission to make its own medical diagnosis.

The reality is that the hearing commissioner got it right. Clearly, this man would have been entitled to total disability benefits had he lived. It is only fair that his wife, as his next of kin, receives that compensation. That is the purpose of the statute and exactly

what our legislature intended to happen. The hearing commissioner applied the burden of proof even handedly, just as she would had the Appellant asserted paraplegia, and found the evidence insufficient to prevail.

For the reasons foregoing, the Appellant requests a full affirmation of the Commission's denial of the Respondents' issues on appeal and a reinstatement of the hearing commissioner's decision awarding total disability benefits for a fifty percent (50%) or greater disability to his back.

Respectfully Submitted

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17 day of December, 2014

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Melody L. James, Appellate Panel Chairman, Commissioner

App. Case No. 2014-002294
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TIMOTHY MCMAHAN, APPELLANT/RESPONDENT,

V.

SC DEPARTMENT OF EDUCATION – TRANSPORTATION, EMPLOYER, AND STATE ACCIDENT FUND, CARRIER, RESPONDENTS/APPELLANTS.

PROOF OF SERVICE

I certify that I have served the Initial Respondent's Brief of the Appellant/Respondent in the above-referenced matter dated December 17, 2014, addressed to the attorney of record, George T. Miars, Jr., Esquire, Willson Jones Carter & Baxley, P.A., 421 Wando Park Boulevard, Suite 100, Mt. Pleasant, SC, 29464

December 17, 2014

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December 17, 2014

The Honorable Jenny Abbott Kitchings
Clerk of Court
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RE: Timothy McMahan v. SC Department of Education-Transportation
WCC File No.: 1106833
Ct. App. Case No.: 2014-002294
DOI: 6/15/11

Dear Ms. Kitchings:

Enclosed please find for filing the original and one copy of the Initial Respondent's Brief of the Appellant/Respondent and Proof of Service of these items upon opposing counsel. Please return a file-stamped copy to me in the self-addressed, stamped envelope enclosed for your convenience.

By copy hereof to George T. Miars, Jr., Attorney for the Employer/Carrier (Respondents/Appellants), I am serving upon the Respondents/Appellants a copy of the Initial Respondent's Brief of the Appellant/Respondent as reflected on the Proof of Service.

Thank you very much for your assistance in this matter. With kind regards, I am

Sincerely,

Kevin B. Smith

KBS/jhd

Enclosures

cc: Dorothy McMahan
George T. Miars, Jr., Esquire

SC Court of Appeals

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