

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC File No. 0506037

RECEIVED
MAR 18 2015
SC Court of Appeals

Frank Wilson, Employee, Appellant,

v

American LaFrance, Employer, and
AIG C/O Gallagher Bassett Services, Inc., Carrier, Respondents.

INITIAL BRIEF OF RESPONDENTS

MCANGUS GOUDELICK & COURIE LLC

Helen F Hiser
Erin L Hantske
735 Johnnie Dodds Blvd., Suite 200
P.O. Box 650007
Mount Pleasant, South Carolina 29465
(843) 576-2900

Attorneys for Respondents

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STATEMENT OF ISSUES ON APPEAL

- I. Whether Claimant failed to prove a compensable injury to his thoracic spine, his right lower extremity or his left lower extremity and, therefore, is not entitled to treatment for same?
- II. Whether Claimant is entitled to reimbursement for costs incurred in 2009 and before to evaluate and treat his left shoulder?
- III. Whether the Commission properly declined to address Claimant's February 23, 2012 Motion?
- IV. Whether the Commission properly denied Claimant's request for reimbursement of his expenses for the April 18, 2012 and September 18, 2012 Commission hearings?
- V. Whether the procedure at and Order issued by the Circuit Court were proper?

STATEMENT OF THE CASE¹

This claim has been before the South Carolina Workers' Compensation Commission numerous times and has a lengthy procedural history. Claimant was injured in a work-related automobile accident on May 16, 2005. Respondents admitted compensable injuries to Claimant's low back, right shoulder, lungs, and ribs, and began providing causally-related medical care and treatment. Claimant was referred to and began seeing Dr. Don Stovall in August 2005 for treatment of his neck, back and right shoulder pain. Claimant was also seen by various other physicians for his lungs, ribs and bladder. (Decision and Order of Single Commissioner J Alan Bass, dated April 17, 2008, pp. 3-4 ("2008 Single Commissioner Decision")).

After providing medical care for over a year and a half, on February 8, 2007 Respondents filed a Form 21 request to stop payment of temporary compensation and requesting a finding of permanency. (2008 Single Commissioner Decision, p. 4). A hearing was held before Commissioner Bass on April 10, 2007. Claimant, who was represented by legal counsel, argued that he had not reached Maximum Medical Improvement ("MMI") and sought an MRI of his left shoulder and neck. (2008 Single Commissioner Decision, p. 5). After a prehearing conference, Commissioner Bass denied Respondents' motion to leave the record open for a pulmonary Independent Medical Evaluation ("IME"), (Transcript of April 10, 2007 Hearing before Commissioner Bass, p. 3, line 10 – p. 4, line 10 ("2007 Hr'g Tr.")), but agreed to leave the record open for 30 days so that the parties could take the deposition of pulmonologist Dr. Cary

¹ Respondents note that, in his Statement of Issues on Appeal/Statements of the Case, Claimant raises a number of contested issues and argument, in violation of Rule 208(b)(1)(C), SCACR (the statement of the case "shall not contain contested matters ..."). For example, Claimant alleges various shortcomings in the process before the Circuit Court, which Respondents address in detail below in Section V. In addition, to the extent his statement that he suffered multiple injuries to his left shoulder and back implies that his left shoulder was found to be compensable from the date of his accident, and/or that his thoracic spine has ever been found to be compensable, those implications are incorrect as is explained in more detail below.

Fechter. (2008 Single Commissioner Decision, p. 5) (*see also* 2007 Hr'g Tr. p. 5, lines 19-22). This is the only item that the record was left open to receive. (2008 Single Commissioner Decision) (2007 Hr'g Tr.).

Commissioner Bass found that Claimant suffered work-related injuries to his neck, low back, right shoulder, ribs, and lungs. He found that Claimant had reached MMI for his neck, low back, right shoulder, and ribs, but not for his lungs. (2008 Single Commissioner Decision, p. 11). Respondents were ordered to provide medical treatment for Claimant's lungs until he reached MMI, as well as orthopaedic management for his neck, low back, and right shoulder as recommended by Dr. Stovall. (2008 Single Commissioner Decision, at pp 12-13). In his recitation of the evidence, Commissioner Bass noted that Claimant acknowledged he had not complained about his left shoulder until his deposition in February 2007, had not brought it up to Dr. Stovall, and had not mentioned it to Dr. Chris Tountas, whom he had seen for an IME. (2008 Single Commissioner Decision, p. 6) (*see also* 2007 Hr'g Tr. p. 10, lines 23-25) (2007 Hr'g Tr. p. 16, line 9 – 18, line 6). Although Claimant testified that he was having issues with his left shoulder, (2007 Hr'g Tr p. 18, lines 12-18), there is no indication in the transcript of the 2007 Hearing or in the 2008 Single Commission Decision that any agreement had been reached during the prehearing conference regarding his left shoulder. Because Commissioner Bass did not find Claimant's left shoulder to be a compensable injury, no treatment or testing was ordered for his left shoulder. The 2008 Single Commissioner Decision was not appealed.

Some time thereafter, Claimant sought treatment for his low back pain with an orthopedic doctor other than Dr. Stovall. Claimant was last seen by Dr. Stovall on March 2, 2009, at which point Dr Stovall stated he believed Claimant was at MMI, that he was not a surgical candidate for his cervical or lumbar spine, and recommended EMG and nerve conduction studies of the

right lower extremity, and evaluation by a sports medicine physician for Claimant's right shoulder complaints. (Decision and Order of Single Commissioner David W. Huffstetler, filed April 16, 2009, pp. 5-6 ("2009 Single Commissioner Decision"). Claimant then asked his primary care physician for a referral to Southeastern Spine Institute where he was seen by Dr. Thomas F. Roush. (*Id.* p. 6) (*see also* Transcript of March 20, 2009 Hearing before Commissioner Huffstetler, p. 12, line 15 – p 13, line 9) ("2009 Hr'g Tr.")).

Respondents again filed a Form 21 request to stop payment of temporary compensation and requesting a finding of permanency. The parties were heard by Single Commissioner David W. Huffstetler on March 20, 2009. Claimant, who was represented by legal counsel, argued that he had not reached MMI, requested shoulder surgery as recommended by Dr. Stovall and back surgery as recommended by Dr. Roush, and complained "that he had not received the orthopaedic management outlined in Commissioner Bass' Order." (2009 Single Commissioner Decision, pp. 7-8) (*see also* 2009 Hr'g Tr., p. 5, lines 17-22). Claimant disagreed with Respondents' counsel's statement that Commissioner Bass had not found his left shoulder compensable. (2009 Hr'g Tr. p. 7, lines 1-6). Claimant further testified that Commissioner Bass had instructed him "to get [an] updated MRI scan of my cervical spine to rule out that the pain that I as experiencing in my left shoulder was not coming from my cervical spine." (2009 Hr'g Tr. p. 11, lines 11-16) (2009 Single Commissioner Decision p. 8). Commissioner Huffstetler found that Claimant suffered compensable injuries to his low back, neck, right shoulder and ribs (but not his left shoulder), that he had not reached MMI, and that he was entitled to treatment for his back through Southeastern Spine Institute. (2009 Single Commissioner Decision pp. 10-11). The 2009 Single Commissioner Decision was not appealed

Thereafter, Claimant filed a Form 50 seeking compensation for his tonsils and left shoulder. (Decision and Order of Single Commissioner Derrick Williams, filed April 5, 2010, pp 2-3 (“2010 Single Commissioner Decision”).² Commissioner Williams noted that Claimant claimed he “suffered a compensable injury to the left shoulder during ‘work hardening’ physical therapy and during a Functional Capacity Evaluation regarding the admitted injuries of the neck, low back, ribs, lungs and right shoulder,” and that he had pursued treatment of his left shoulder on his own with Dr. William Estes, since Respondents had denied the same. (2010 Single Commissioner Decision, pp. 3, 5-6). Respondents denied compensable injuries to Claimant’s left shoulder and tonsils. The parties were heard by Single Commissioner Derrick Williams on March 23, 2010. Claimant was represented by counsel at this hearing. Commissioner Williams denied compensation for the tonsils but found Claimant’s left shoulder to be compensable and ordered treatment through Dr. John Graham. (2010 Single Commissioner Decision, pp. 7-8). The 2010 Single Commissioner Decision was not appealed.

Claimant filed another Form 50 in 2011, raising issues regarding the treatment provided for his left shoulder through Dr. Graham. He also requested reimbursement for the two visits to Dr. Estes “in 2009 regarding the evaluation for his shoulders.” (Decision and Order of Single Commissioner Andrea C. Roche, filed August 11, 2011, p 4 (“2011 Single Commissioner Decision”). Respondents argued that Claimant was receiving appropriate medical care and denied responsibility for the 2009 visits to Dr. Estes because those visits were not authorized and compensability of his left shoulder was in dispute at that time. The parties held an extensive pre-trial conference with Commissioner Roche, at which Claimant represented himself *pro se*, but there was no recorded hearing. Commissioner Roche held that Claimant was receiving

² Claimant took the position that removal of his tonsils would aid in his breathing which was compromised by the injury to his ribs and lungs.” (2010 Single Commissioner Decision, p 3)

appropriate medical treatment with Drs. Richardson, Graham, Spandorfer and Goudelocke.³ She ordered Respondents to provide a second opinion for Claimant's shoulders with Dr. James DeMarco. Claimant sought reimbursement for two visits to Dr. Estes in 2009 regarding evaluation of his shoulders, which Commissioner Roche denied. (2011 Single Commissioner Decision, pp. 4-5). The 2011 Single Commissioner Decision was not appealed.

Claimant filed another Form 50, representing himself *pro se*. Instead of a recorded hearing, the parties participated in a lengthy pre-trial conference with Commissioner Avery B. Wilkerson, Jr. on November 30, 2011. Among other issues, Claimant "requested that the Commission address the issue of potential medical neglect, medical malpractice, bias, and any inappropriate action and/or practice as it relates to the Claimant's medical treatment ...". (Decision and Order of Single Commissioner Avery B. Wilkerson, filed February 10, 2012, p. 5 ("Feb. 2012 Single Commissioner Decision")). Commissioner Wilkerson found that Claimant had reached MMI for his low back, bladder, lungs and right shoulder, but not for his left shoulder, and ordered treatment with Dr. Estes. (Feb. 2012 Single Commissioner Decision, pp. 6-7). Commissioner Wilkerson also explained that he "does not have jurisdiction to address the allegation of medical neglect, medical malpractice, bias, or any inappropriate action and/or practice on behalf of the authorized treating physicians." He also rejected Claimant's request that the Decision reflect "additional physicians by which the Claimant was allegedly mistreated. The South Carolina Workers' Compensation Commission lacks jurisdiction to address those pleadings for relief alleged by the Claimant." (Feb. 2012 Single Commissioner Decision, p. 8). Respondents were ordered to pay Claimant's transportation costs for one of the two recent

³ Commissioner Roche found that, in addition to his other admitted injuries, Claimant had suffered a compensable injury to his bladder (2011 Single Commissioner Decision, p. 5)

hearings. (Feb. 2012 Single Commissioner Decision, p. 9). The Feb. 2012 Single Commissioner Decision was not appealed.

Claimant filed a Motion with the Commission on January 17, 2012 and also served Respondents' counsel. (Cl. 2012 APA pp. 40-46). After the Commission returned the Motion for failure to include a filing fee, (Cl. 2012 APA p. 47), Claimant refiled it on February 17, 2012, (Cl. 2012 APA pp. 48-54), and again on February 23, 2012, (Cl. 2012 APA pp. 58-66), serving it on Respondents' counsel each time. In this Motion, Claimant again requested that the Commission address his allegations of medical neglect, malpractice, bias and inappropriate action or practice, and added a request that, if the Commission could not decide those issues, that it forward his allegations to the State Attorney General's office. (Cl. 2012 APA pp. 60-62).

The instant proceeding was initiated by Claimant filing a Form 50 Request for Hearing with the Commission. (Claimant's Form 50, dated Feb 17, 2012). Claimant, representing himself *pro se*, claimed that the body parts that were affected by his work-related injury were his back, neck, ribs, lungs, right shoulder, left shoulder, bladder, right leg, left leg, right arm, and left arm. He asserted that he was in need of additional medical care for his back and bilateral lower extremity in the form of an EMG/Nerve Conduction Study. (*Id.*). In an attachment to his Form 50, Claimant raised seven issues, including:

1. that he was entitled to an MRI of his back as recommended by Dr. Donald R. Johnson, II,
2. that he was entitled to a Bilateral Lower Extremity EMG/Nerve Conduction Study as recommended by Dr. Johnson;
3. the lack of prescription drug coverage;
4. allegations that Commissioner Bass's April 17, 2008 Decision and Order instructed Respondents to "provide the Claimant with a **Cervical Spine MRI** to determine if there were any significant changes that could be related to the Claimant's **Left Shoulder pain**. If there were no significant changes noted on the Claimant's

Cervical Spine MRI, then [Respondents] would provide the Claimant with a **Left Shoulder MRI** to verify and determine if there were any related issues noted on the Claimant's **Left Shoulder MRI** that could be related to the Claimant's **Left Shoulder Pain**," leaving the record open for 30 days for these tests. Claimant also alleged that the 2008 Single Commissioner Decision had been altered and that Respondents purposefully delayed authorization of a cervical spine MRI in order to defeat his claim;

5. that the Commission address issues Claimant raised in a Motion filed on January 17, 2012 (as resubmitted on February 17, 2012 and February 23, 2012) regarding "medical neglect, medical malpractice, bias, any inappropriate action and or any inappropriate practice (if any) as it relates to" exhibits presented at a hearing before Commissioner Roche on July 21, 2011;
6. that Utica-Mohawk language be included in any final settlements or agreements, and
7. reimbursement for filing the Form 50 with the Commission and for transportation to and from the Commission hearing.

(Attachment to Claimant's Form 50, dated Feb. 17, 2012).

Respondents admitted Claimant suffered compensable injuries to only his neck, low back, bilateral shoulders, ribs, bladder and lungs in the May 16, 2005 accident, and denied compensability to any other body parts. (Resp Form 51, dated Feb. 27, 2012). Respondents also disagreed that Claimant was entitled to a bilateral lower extremity EMG/nerve conduction study and/or a thoracic MRI, as neither alleged injury was causally related to his compensable accident. Respondents explained that Claimant's prescription drug coverage through First Script was terminated unilaterally by the provider when that company ceased handling South Carolina claims and that, upon notification by Claimant, Respondents took steps to restore the prescription coverage. (Id.).

The parties were heard on April 18, 2012 by Commissioner Avery B. Wilkerson, Jr. who issued his Decision and Order on June 21, 2012. (Transcript of April 18, 2012 Hearing before Single Commissioner Wilkerson ("2012 Hr'g Tr")). Single Commissioner Wilkerson noted that the parties had attempted to resolve the issues via telephone conference on March 3, 2012,

March 5, 2012, and March 9, 2012, however, Claimant failed to return the Commissioner's calls in a timely manner and/or make himself available for the scheduled tele-conferences. Claimant explained that his failure to call during the entire month of March 2012 and/or make himself available for the scheduled tele-conferences was due to being sick (Decision and Order of Single Commissioner Avery B. Wilkerson, filed June 21, 2012, p. 6 ("June 2012 Single Commissioner Decision"))).

Commissioner Wilkerson held that Claimant failed to carry his burden of proving he was entitled to treatment for his thoracic spine, right lower extremity, left lower extremity or any other body part aside from the admitted injured body parts. Commissioner Wilkerson found that the delay in Claimant's prescription coverage was not the Respondents' fault, as "[t]here was a change with the prescription company and counsel for [Respondents] tried to call the Claimant and wrote letters to the Claimant without a response." Commissioner Wilkerson denied Claimant's request for transportation costs to attend the hearing, because Claimant "requested the hearing and he has been very uncooperative in the resolution of these issues." Although Respondents requested expenses in the amount of \$1,150.00 incurred in preparing for and attending the hearing, that request was denied. Commissioner Wilkerson stated that, although he was inclined to award Respondents \$500.00 in costs, "due to the fact that [Respondents] would be bearing the cost of writing that Order," he waived awarding costs at that time but advised that he "would strongly consider a 100% reimbursement to [Respondents] on any future request for defense costs in further defending this claim." Commissioner Wilkerson found "defense counsel and her firm to be trustworthy and diligent in efforts to assist the Claimant with his workers' compensation claim." Claimant agreed to return phone calls and "to communicate with all

parties to help reduce expenses on all involved ” Finally, Commissioner Wilkerson held that any award of permanency was premature (June 2012 Single Commissioner Decision, pp. 9-13).

Claimant timely appealed to the Full Commission, raising nine separate issues. In addition to the seven issues listed on his Form 50, Claimant also sought reimbursement for the right and left shoulder evaluation performed by Dr. Estes in 2009, as well as lifetime maintenance, including hardware, as it relates to his back injury. Claimant disagreed “with having to provide payment expenses of the Defendants in this claim,” and also disputed statements made by Commissioner Wilkerson regarding Defense counsel. (Cl. Form 30, dated June 14, 2012 and resubmitted on or around June 27, 2012, with attachments).

An Appellate Panel of the Full Commission heard the parties on September 18, 2012 and issued the Commission Decision and Order on January 7, 2013 (“Commission Decision”). With some modifications to the June 2012 Single Commissioner Decision, the Commission held that Claimant failed to carry his burden of proving he was entitled to treatment for his thoracic spine, right lower extremity, left lower extremity or any other body part aside from the admitted injuries. Any award of permanency was premature and no costs were awarded. (Commission Decision, pp. 12-13). The Commission also addressed Claimant’s argument that, in his request for a proposed order, Commissioner Wilkerson included a finding that Claimant “has had quite the runaround from the carrier for treatment, checks and prescription problems,” which had been inadvertently omitted from the June 2012 Single Commissioner Decision (Commission Decision, p. 9) (Transcript of September 18, 2012 Hearing before the Appellate Panel of the Full Commission, p. 7, lines 3-13 (“Full Comm’n Hr’g Tr.”)). The Commission noted that the omission was the result of a scrivener’s error and amended “all the previous Findings of Fact relating to the credibility of the parties.” (Commission Decision, p. 9). The Commission

affirmed Commissioner Wilkerson's finding that the delay in prescription coverage was not Respondents' fault, and that "the main problem in this case," is Claimant's distrust of Respondents' counsel, her law firm and the insurance carrier. (Commission Decision, p. 11).

Although Claimant initially appealed to this Court, this matter was transferred to the Circuit Court since the injury occurred prior to 2007.⁴ (Order of the Court of Appeals, dated July 5, 2013) Claimant's notice of appeal raised five separate issues: 1) whether his thoracic spine injury is compensable, 2) whether he is entitled to a bilateral lower extremity EMG/nerve conduction study, 3) whether he is entitled to reimbursement for evaluation and treatment expenses for his left shoulder incurred in 2009, 4) issues raised in his February 27, 2012 Motion, and 5) reimbursement for expenses and transportation costs related to the hearings before Single Commissioner Wilkerson and the Appellate Panel. (Claimant's Notice of Appeal of the Commission Decision, dated February 6, 2013).

The parties were heard by the Honorable Diane S. Goodstein on September 6, 2013. Following a lengthy hearing, (Transcript of Sept. 6, 2013 Hearing before Judge Goodstein ("2013 Hr'g Tr.")), Judge Goodstein issued an order on December 17, 2013, indicating that the record before the court appeared to be incomplete and ordering the Commission to transmit the record of the proceeding pursuant to S.C. Code 1-23-380(A)(3) (2005). (Order, filed December 17, 2013 ("2013 Circuit Court Order")).

Upon receipt of the entire file from the Commission, the Circuit Court scheduled another hearing for March 12, 2014. At that hearing, the Honorable Maité Murphy advised the parties that the Commission file provided to the court consisted of two boxes of unorganized materials. Judge Murphy ordered the parties to submit a record so that the court could review the

⁴ S C Code Ann § 42-17-60 provides for direct appeals to the Court of Appeals for injuries occurring after July 1, 2007

Commission Decision. The parties resubmitted their briefs to the Circuit Court with all of the relevant portions of the Commission Record Attached. The court indicated no further submissions were required from either party. (Letter from John Guerry, Law Clerk, Hon. Maité Murphy, dated June 19, 2014).

The Circuit Court issued its opinion on August 19, 2014, affirming the Commission Decision in its entirety. (Order, filed August 19, 2014 (“2014 Circuit Court Order”). Specifically, the Circuit Court upheld the Commission’s determinations: that Claimant failed to carry his burden of proving a compensable injury to his thoracic spine, his right lower extremity or his left lower extremity; that Claimant was not entitled to reimbursement for costs incurred in 2009 and prior to evaluate and treat his left shoulder; that it lacked jurisdiction to hear Claimant’s complaints of medical neglect, malpractice, bias, or inappropriate actions or practices by the authorized treating physicians; and that Claimant was not entitled to reimbursement of expenses associated with the April 18, 2012 and September 18, 2012 Commission hearings. The Circuit Court declined to address any allegations of bias on the part of Commissioner Wilkerson, and also denied Claimant’s request to consolidate the instant appeal with his appeal of an April 9, 2014 Commission Decision that remanded certain issues to the Single Commissioner for further determination.

Claimant timely appealed to this Court.

STANDARD OF REVIEW

Judicial review of a Commission decision is directed by the substantial evidence rule of the Administrative Procedures Act, S.C. Code Ann. § 1-23-380(5). Lark v. Bi-Lo, Inc., 276 S.C 130, 276 S.E.2d 304 (1981). A reviewing court should affirm the decision of the Full Commission unless it is clearly erroneous in view of the substantial evidence of the whole

record. Lark, 276 S.C. at 136, 276 S.E.2d at 307. The reviewing court may not substitute its own judgment for that of the Full Commission as to the weight of the evidence on a question of fact, but may reverse if the decision is affected by errors of law. S.C. Code Ann. §1-23-380(5). The Administrative Procedures Act “mandates that the commission take the evidence, judge the credibility and weight of that evidence, and from that judgment determine the facts of the case.” Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 381, 440 S.E.2d 401, 403 (Ct. App 1994).

Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the same conclusion the administrative agency reached in order to justify its action. Pierre v. Seaside Farms, Inc., 386 S.C. 534, 540, 689 S.E.2d 615, 618 (2010). The findings of the Full Commission are presumed correct and can be set aside only if unsupported by substantial evidence or based on an error of law. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 186, 414 S.E.2d 162, 163 (1992).

The Full Commission is the ultimate fact finder in workers’ compensation cases. Ross v. American Red Cross, 298 S.C. 490, 492, 381 S.E.2d 728, 730 (1989). It is not within the appellate courts’ purview to reverse findings of the Full Commission which are supported by substantial evidence. Broughton v. South of the Border, 336 S.C. 488, 496, 520 S.E.2d 634, 637 (Ct. App. 1999). Where there is a conflict in the evidence, either by different witnesses or the testimony of the same witness, the factual findings of the Commission are conclusive. Anderson v. Baptist Med. Ctr., 343 S.C. 487, 492-93, 541 S.E.2d 526, 528 (2001). “The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission’s finding from being supported by substantial evidence.” Sharpe v. Case Prod., Inc., 336 S.C. 154, 160, 519 S.E.2d 102, 105 (1999).

ARGUMENT

I. Claimant did not prove a compensable injury to his thoracic spine, his right lower extremity or his left lower extremity and, therefore, is not entitled to treatment for same.

A claimant in a workers' compensation proceeding bears the burden of proving he is entitled to compensation and an award cannot rest on surmise, conjecture or speculation. Clade v. Champion Labs., 330 S.C. 8, 11, 496 S.E.2d 856, 858 (1998). In this case, the Circuit Court properly affirmed the Commission determination that, based on the testimony and evidence before it, Claimant did not carry "his requisite burden of proof, required under the South Carolina Workers' Compensation Act, to establish that an injury involving the thoracic spine, right lower extremity, left lower extremity, or any other body part aside from the admitted injuries listed above arose out of or occurred in the course of his employment with [Respondents] on May 16, 2005." (Commission Decision, p. 12). This conclusion is supported by substantial evidence in the record and should be upheld on appeal. *See, e g*, Broughton, 336 S.C. at 496, 520 S.E.2d at 637.

A Claimant did not meet his burden of proving that any problems he was having with his thoracic spine were related to his compensable injury.

Claimant erroneously argues that he is entitled to evaluation of and/or treatment for his thoracic spine based on Commissioner Huffstetler's 2009 Single Commissioner Decision. At the hearing before Commissioner Huffstetler, Claimant testified to treatment for his shoulders, his lumbar and cervical spine, but did not mention his thoracic spine. (2009 Hr'g Tr. p. 12, line 15 – 15, line 13).⁵ Specifically, he testified that he first started seeing the doctors at Southeastern Spine because he was "getting frustrated with the lack of medical attention that was given to my

⁵ Claimant also requested that a nerve conduction study be ordered to determine whether his urinary problems were related to his cervical or lumbar spine injuries (2009 Hr'g Tr p 17, line 21 – p 18, line 23)

lumbar spine, cervical spine. This actually took place ... with my family doctor. I asked him to refer me to the best spine doctor that I can go to and off the top of his head, he said well the best you can go to is Southeastern Spine ... And, at that time, I said, well, can you refer me there . . .” (2009 Hr’g Tr. p. 12, line 15 – 13, line 5). In fact, when reciting the reasons he could not return to work, Claimant pointed to “[m]ultiple pain levels and all of my injuries – my lower back, my lumbar spine, my cervical spine, right shoulder, left shoulder ...” but made no mention of his thoracic spine. (2009 Hr’g Tr. p. 19, lines 1-15). Claimant discussed updated MRI’s he had had for his head, lumbar spine, cervical spine, and left shoulder. (2009 Hr’g Tr. p. 21, line 20 – p. 23, line 5). Commissioner Huffstetler specifically asked Claimant about the problems he was having, including his right shoulder, neck, lower back, right lung, and ribs, but neither Commissioner Huffstetler nor Claimant mentioned Claimant’s thoracic spine. (2009 Hr’g Tr. p. 24, line 20 – p. 28, line 12). Thus, Claimant’s thoracic spine was not raised in the 2009 Hearing and Commissioner Huffstetler was not ordering treatment for a condition that was not before him.

Although Claimant is correct that Commissioner Huffstetler ordered Respondents to “provide medical treatment for the Claimant’s back through Southeastern Spine Institute,” (2009 Single Commissioner Decision p. 11), that treatment was for compensable, work-related injuries only. *See, e g*, Nettles v. Spartanburg Sch. Dist. # 7, 341 S.C. 580, 589, 535 S.E.2d 146, 150 (Ct. App. 2000) (holding that “Workers Compensation only awards benefits for disabilities causally connected to a work-related injury”); Munn v. Nucor Steel, 336 S.C. 28, 32, 518 S.E.2d 289, 290 (Ct. App. 1999) (holding that, under the Workers’ Compensation Act (“Act”), “any medical treatment claimed under § 42-15-60 must be causally related to the ‘injury by accident’ arising out of and in the course of employment”). Conclusion of Law No. 2 states that Claimant

“sustained a compensable injury by accident arising out of and occurring in the course and scope of his employment with [Respondents] on or about May 16, 2005, to his **low back, neck**, right shoulder, ribs, and lungs ” (2009 Single Commissioner Decision p. 10) (emphasis added). There is no mention of and no treatment was ordered for Claimant’s thoracic spine in the 2009 Single Commissioner Decision. Furthermore, the records from Southeastern Spine submitted by Claimant as part of his 2009 Pre-Hearing Brief do not mention any treatment to the thoracic spine. (Cl. 2009 APA pp. 153-156) Thus, the treatment ordered for Claimant’s back through Southeastern Spine Institute was to his cervical and lumbar spine, which had been determined to be compensable, but not to his thoracic spine, which had not. (2009 Single Commissioner Decision, pp. 10-11).

Claimant argues that Dr. Stovall told him that, “he would not evaluate and treat the Thoracic Spine (mid to upper Back) because his primary focus would be the Appellant’s Lumbar Spine (Low Back), Cervical Spine (Neck) and Right Shoulder,” and that, “once the Appellant’s Lumbar Spine (Low Back) was completely evaluated and treated, then the Thoracic Spine (mid to upper Back) pain should be resolved or lessened.” (App. Br pp. 3-4). However, there simply is no evidence of any such statements in the Record.⁶ Instead, with respect to Claimant’s back, Dr. Stovall diagnosed and treated Claimant for cervical/neck pain, and lumbar/lower back pain. (See Resp. 2009 APA, pp. 15-46).⁷

Furthermore, although records from the Palmetto Comprehensive Center for Pain of the Southeastern Spine Institute dated December 29, 2011 noted that Claimant was complaining of

⁶ Claimant asserts that certain facts “would be supported by the medical reports, medical documents and all sup-porting documents to be introduced as evidence ” (App. Br. p 5) However, he has not indicated in his Brief which documents or evidence in the Record support his claims regarding various body parts and he cannot now “introduce” new evidence into the Record.

⁷ Claimant’s assertions regarding medical bias and purported motives underlying Dr Stovall’s treatment and medical records, (App Br p. 4), are completely unsubstantiated and should be disregarded.

pain in his mid-back, or thoracic region, as well as thoracic radiculitis, (Cl. 2012 APA pp. 9-10), this report does not link any issues he was having with his thoracic spine to his May 16, 2005 accident. The February 24, 2012 record from the same office noted a diagnosis of thoracic radiculitis, among other things, and notes Claimant was complaining of midback pain but, again, does not link any thoracic issues to his work-related accident. (Cl. 2012 APA pp. 11-12).

Although Claimant provided Dr. Richardson with a letter, asking whether he agreed with Dr. Johnson's course of treatment and that injuries to his "Back, Legs and Arms" were causally related to his lumbar and cervical spine injuries, Dr. Johnson was treating Claimant for his neck and lumbar spine problems and neither proposed nor provided any treatment whatsoever to his thoracic spine. (Cl. 2012 APA pp. 2-6). Specifically, Dr. Johnson provided a diagnosis of "low back injury, L5-S1, neck." (Cl. 2012 APA p. 6). Therefore, the only reasonable interpretation of both Dr. Johnson and Dr. Richardson's statements regarding Claimant's back is that they were referring only to his cervical and lumbar issues. Finally, simply opining that Claimant would benefit from the treatment outlined in the December 29, 2011 and/or February 24, 2012 office visits only demonstrates that Dr. Richardson agreed with the recommendation for an "MRI of his thoracic spine to rule out any type of thoracic pathology with his new on-set of pain," (Cl. 2012 APA p. 10), and that Claimant should "see his primary care physician as soon as possible to confirm that it is not his heart causing the associated symptoms he is having as [the Physician's Assistant] was concerned there may be a component of cardiac disease associated." (Cl. 2012 APA p. 12).

The fact that a claimant may benefit from medical care, standing alone, does not establish a causal link between compensable and non-compensable body parts. *See, e g* , Nettles, 341 S.C. at 589, 535 S.E.2d at 150; Munn, 336 S.C. at 32, 518 S E.2d at 290. Without more, the facts that

the Commission ordered treatment for Claimant's back through Southeastern Spine, and that the doctors there recommended that he receive treatment to his thoracic spine simply do not establish a causal connection between his work-related injury and any problems he is having with his thoracic spine. The back has been recognized as a medically complex area of the body. *See McLeod v. Piggly Wiggly Carolina Co.*, 280 S.C. 466, 471, 313 S.E.2d 38, 41 (Ct. App. 1984); *see also Brown v. Peoplease*, 402 S.C. 476, 482-83, 741 S.E.2d 761, 764-65 (Ct. App. 2013) (same, and finding that a "few medical references in the record are insufficient to prove a causal link"). And as noted above, Claimant bears the burden of proving he is entitled to compensation, including specifically, establishing a causal link between his employment and an alleged injury *Clade*, 330 S.C. at 11, 496 S.E.2d at 858.⁸

Claimant's assertion that the medical care ordered by Commissioner Huffstetler in 2009 "was due to the Appellant not receiving the orthopaedic management outlined in" Commissioner Bass's 2007 Commission Decision, (App. Br. p. 4), is simply incorrect. Although Commissioner Huffstetler noted Claimant's testimony where he, "explained [that] he had not received the orthopaedic management outlined in Commissioner Bass' Order," (2009 Single Commissioner Decision p. 8), that was not a holding but was merely the Commissioner's recitation of Claimant's hearing testimony. Furthermore, as noted above, the 2008 Single Commissioner Decision found that "Claimant suffered a work-related injury to his neck, low back, right shoulder and ribs," as well as his lungs. Commissioner Bass also found that Claimant had reached MMI for all of his compensable injuries except for his lungs, and ordered medical

⁸ The Circuit Court also noted that Claimant had attempted to rely on medical reports that were never admitted as part of the Commission record and, in fact, post-date the April 18, 2012 hearing before Commissioner Wilkerson. The Circuit Court correctly held that those records are not part of the record in this case and cannot be considered by an appellate forum. *See* S C Code Ann § 1-23-380(4) (appellate review must be confined to the record); S C Code Regs § 67-612(J); *Martin v. Rapid Plumbing*, 369 S.C. 278, 287, 631 S E 2d 547, 552 (Ct App. 2006)

treatment for only Claimant's lungs. (2008 Single Commissioner Decision, pp. 11-13). Claimant was receiving the ordered orthopedic management for his neck and lower back, but simply was frustrated with the rate of progress or improvement. (See Cl. 2009 APA p 155) (Resp. 2009 APA pp. 37-40).

This Court should uphold the determination by both the Circuit Court and Commission that Claimant failed to prove he suffered a compensable injury to his thoracic spine and/or is entitled to medical treatment for the same

B. Claimant did not prove that any bilateral lower extremity problems he was having were related to his compensable injury

First of all, Claimant has not addressed this issue in his Brief, other than listing it twice. (App. Br. pp. 3, 5). Cursory and unsupported arguments are deemed abandoned on appeal. In the Matter of the Care and Treatment of McCracken, 346 S.C. 87, 92, 551 S.E.2d 235, 238 (2001). Therefore, this Court should hold that Claimant has abandoned his argument that he is entitled to a Bilateral Lower Extremity EMG/nerve conduction study.

However, in the event this Court reaches this issue, for many of the same reasons that Claimant's thoracic spine is not compensable, Respondents are not responsible for paying for a Bilateral Lower Extremity EMG/nerve conduction study. This is because Claimant has not proven any problems he may be having with his bilateral lower extremities are causally related to his May 16, 2005 accident. The Commission properly and correctly found that Claimant failed to carry his burden of proving compensable injuries to his right and left lower extremities. (Commission Decision, pp. 11-12). As this finding is supported by substantial evidence, this Court should uphold the Commission on this point.

Claimant's sole and erroneous assertion regarding this issue is that, by authorizing treatment with the Southeastern Spine Institute, Commissioner Huffstetler was also ordering

treatment of his bilateral lower extremities and/or any other body part treated by Southeastern Spine. The fact that a treating physician ordered a test or treatment of a body part in addition to those accepted or determined by the Commission to be compensable does not mean those other body parts are automatically deemed compensable. Instead, Respondents are only responsible for paying for treatment for those injuries that have been determined to be causally related to Claimant's work-place accident. *See, e g*, Nettles, 341 S.C. at 589, 535 S.E.2d at 150; Munn, 336 S C at 32, 518 S.E.2d at 290.

On March 2, 2009, Dr Stovall recommended that a nerve conduction study be performed. (Resp. 2010 APA p. 142). However, the "EMG and nerve conduction studies of the right lower extremity reveal[ed] a normal study, no evidence of lumbar radiculopathy." (Resp. 2010 APA p 143). At the hearing before Commissioner Huffstetler, Claimant agreed that at his last appointment with Dr. Stovall, Dr. Stovall said there were no indications Claimant's urinary symptoms were the result of his neck or lower back. (2009 Hr'g Tr. p. 23, lines 7-11). Thus, Commissioner Huffstetler clearly was not ordering any studies or treatment of Claimant's bilateral lower extremities. (2009 Hr'g Tr. p. 16, line 25 – p. 17, line 7).

Although records from the Palmetto Comprehensive Center for Pain of the Southeastern Spine Institute for December 29, 2011 note that Claimant had been diagnosed with lumbar radiculitis and that he complained of "new on-set leg pain," and suggests "a bilateral lower extremity EMG/nerve conduction study to further evaluation [sic] this patient's lower extremity pain," (Cl. 2012 APA pp. 9-10), this report does not link any issues he was having with his bilateral lower extremities to his May 16, 2005 accident. The February 24, 2012 record from the same office also notes a diagnosis of lumbar radiculitis, among other things, but does not provide any causal link to his work-related injury. (Cl. 2012 APA pp 11-12). Although Claimant

provided Dr. Richardson with a letter, asking whether he agreed with Dr. Johnson's course of treatment and that injuries to his "Back, Legs and Arms" were causally related to his lumbar and cervical spine injuries, the only statement in this letter made "to a reasonable degree of medical certainty" was whether Claimant would "benefit from the evaluation and treatment requested and recommended in [Claimant's] December 29, 2011 office visit medical note." (Cl. 2012 APA pp. 2-6, 14). Benefitting from treatment is not the same as being causally related *E g*, Munn, 336 S.C. at 32, 518 S.E.2d at 290.

Without more, the facts that the Commission ordered treatment for Claimant's back through Southeastern Spine, and that the doctors there recommended that he undergo a Bilateral Lower Extremity EMG/nerve conduction study do not establish a causal connection between his work-related injury and any problems he may be having with his bilateral lower extremities. The claimant in a workers' compensation proceeding bears the burden of proving he is entitled to compensation, including specifically, a causal link between his employment and alleged injury. Clade, 330 S.C. at 11, 496 S.E. 2d at 858.

In the end, Claimant simply failed to prove any problems he is having with his bilateral lower extremities are causally linked to his work-related injury and is not entitled to treatment for same. This Court should affirm both the Circuit Court and the Commission holding that Claimant failed to prove a compensable injury to his left and right bilateral lower extremities.

II. Claimant is not entitled to reimbursement for costs incurred in 2009 and before to evaluate and treat his left shoulder.

The Circuit Court properly upheld the Commission's denial of Claimant's request for reimbursement of costs he incurred in 2009 and prior relating to his left shoulder. To begin with, this issue was resolved against Claimant in the 2011 Single Commissioner Decision, which was not appealed. Claimant requested "reimbursement for the two visits to Dr. William Estes in

2009 regarding the evaluation for his shoulders,” before Commissioner Roche in 2011. (2011 Single Commissioner Decision, p. 4) She held that Respondents “are not responsible for reimbursement related to the Claimant’s treatment with Dr. William Estes in 2009.” (2011 Single Commissioner Decision, p. 5). This issue was not appealed to the Full Commission and, as such, is now the law of the case. *See, e g*, Brunson v. American Koyo Bearings, 367 S.C. 161, 165-66, 623 S.E.2d 870, 872 (Ct. App. 2005) (findings of fact and conclusions of law of the Single Commissioner become the law of the case unless appealed to the Full Commission), *citing* Green v. City of Columbia, 311 S.C. 78, 80, 427 S.E.2d 685, 687 (Ct. App. 1999). Because the uncontested 2011 Single Commissioner Decision became the final Commission Decision with respect to this issue, Claimant is barred from raising it again in this proceeding. *See, e g*, Garris v. Governing Bd of the S.C. Reins. Fac., 333 S.C. 432, 449, 511 S.E.2d 48, 57 (1998) (explaining that the “primary purposes of the doctrine, commonly known today as claim preclusion, are to bring an end to litigation and prevent a defendant from being forced to defend the same action repeatedly”).

The fact that Claimant was representing himself *pro se* in 2011 when Commissioner Roche issued her Decision does not absolve him of the obligation to preserve issues for appeal and/or to timely appeal decisions by the Single Commissioner or the Full Commission. *See* Elam v. South Carolina Dept. of Transp., 361 S.C. 9, 15, 602 S.E.2d 772, 775 (2004) (the requirement of timely appeal is jurisdictional, and “if a party misses the deadline, the appellate court lacks jurisdiction to consider the appeal and has no authority or discretion to ‘rescue’ the delinquent party by extending or ignoring the deadline...”); State v Policao, 402 S.C. 547, 558, 741 S.E.2d 774, 779 (Ct. App 2013) (*pro se* litigants are responsible for preserving issues for appellate review). Because Claimant did not timely appeal Finding No. 7 in the 2011 Single

Commissioner Decision to the Full Commission, it is the law of the case and cannot be overturned at this late date.

Even if this Court considers this issue, which Respondents assert has been finally resolved so that further review is precluded, it should be denied for the same reasons that Commissioner Roche denied it in 2011. The medical appointments Claimant had with Dr. Estes in 2009 were not authorized and, at that time, his left shoulder neither had been accepted by Respondents nor found to be compensable by the Commission. Instead, in 2009, compensability of Claimant's left shoulder was in dispute. (2011 Single Commissioner Decision, p. 4) (2012 Hr'g Tr. p. 33, line 13 – p. 37, line 10). It was not until 2010 that Commissioner Williams held Claimant's left shoulder to be compensable. (2010 Single Commissioner Decision, pp 7-8).

Claimant's assertions that Commissioner Bass "**ordered** the Respondents to provide the Appellant with an updated Cervical Spine MRI to address and determine the Appellant's Left Shoulder pain," (App. Br. p. 5), and that "if the updated Cervical Spine MRI did not reveal any significant changes from the previous Cervical Spine MRI, then Respondents were **ordered** to provide the Appellant with a Left Shoulder MRI," are both incorrect and not supported by the 2008 Single Commissioner Decision. The only medical treatment ordered by Commissioner Bass in 2008 was to Claimant's lungs and "orthopaedic management for the Claimant's neck, low back, and right shoulder as recommended by Dr. Stovall on October 11, 2006." (2008 Single Commissioner Decision, pp. 12-13). Dr. Stovall's recommendations on October 11, 2006 included recommendations for medications and that Claimant continue his home exercise program for his cervical and lumbar spine issues.

For the patient's right shoulder, I have discussed the options with him. He may continue to take medication and perform his home rotator cuff exercises. He could have injections in the right shoulder approximately every six months if this

gives him significant relief for a period of time. He would also have the option of surgical intervention which would include an arthroscopy of the shoulder.

There was no mention whatsoever of Claimant's left shoulder. (Resp. 2010 APA pp. 123-124).

Claimant also asserts that Commissioner Bass left the record open for "thirty (30) days for the Respondents to provide[] Appellant with both the updated Cervical Spine MRI and Left Shoulder MRI." (App. Br. p. 5). However, the only evidence for which the record was left open was for the deposition of pulmonologist Dr. Fechter. (2008 Single Commissioner Decision, p. 5) (*see also* 2007 Hr'g Tr. p. 5, lines 19-22). To the extent Claimant is implying that reimbursement of evaluation and/or treatment of his left shoulder was authorized by Commissioner Bass in an "off the record" conversation, there simply is no evidence of the same. If Commissioner Bass ordered any evaluation and/or treatment of Claimant's left shoulder, it was incumbent on Claimant to capture that statement on the record or have it included in the 2008 Single Commissioner Decision.⁹ Claimant has failed to provide any evidentiary support for his allegations regarding what Commissioner Bass ordered, if anything, concerning his left shoulder. Thus, this Court should flatly reject Claimant's unsupported assertions. Hutson v South Carolina State Ports Auth., 399 S.C. 381, 389, 732 S.E.2d 500, 504 (2012) (Commission decision cannot be based on speculation).

Claimant's opinion that any evaluation of his left shoulder was delayed intentionally by Respondents "to prevent the Left Shoulder injury from being made a part of the Appellant's South Carolina Workers' Compensation Commission claim," is baseless and unsupported. He has presented absolutely no evidence to support his allegation. Unsupported allegations and conjecture are insufficient to support a compensation award. Clade, 330 S.C. at 11, 496 S.E.2d at 858.

⁹ As noted above, Claimant was represented by counsel at the hearing before Commissioner Bass in 2007.

This Court should uphold both the Circuit Court and Commission's denial of Claimant's request for further review of this issue, and deny his request for reimbursement of medical costs for his left shoulder incurred in 2009 and before.

III. The Commission properly declined to address Claimant's February 23, 2012 Motion.

Claimant's argument on this point is particularly cursory, contradictory and without any legal basis or support in the Record. Claimant asserts that Commissioner Wilkerson lacked jurisdiction to hear or make a ruling in this case and implies that he somehow improperly "involve[d] himself in his matter ..." (App. Br. p. 6). At the April 18, 2012 hearing, Commissioner Wilkerson attempted to explain to Claimant that the Commission (and not simply Commissioner Wilkerson individually) lacked jurisdiction over the allegations of medical bias and mistreatment he was raising. (2012 Hr'g Tr., p. 11, line 15 – p. 14, line 18 (Commissioner Wilkerson explaining that he had already ruled on the issue of Claimant's complaints about his treatment by certain doctors, and that neither he nor the Commission had jurisdiction to resolve the medical malpractice/bias issue)). Claimant's position appears to be that Commissioner Wilkerson did not have jurisdiction to hear his Motion, but that the Commission and/or this Court do. He is wrong on both fronts.

"The question of subject matter jurisdiction is a question of law." On appeal, the "appellant bears the burden of showing that the circuit court's decision is against the preponderance of evidence." Hernandez-Zuniga v. Tickle, 374 S.C. 235, 244, 647 S.E.2d 691, 695 (Ct. App. 2007). Although an appellate court takes a "broader scope of review," it does not "ignore the findings of the Commission ..." Pikaart v. A&A Taxi, Inc., 393 S.C. 312, 317, 713 S.E.2d 267, 270 (2011). As Commissioner Wilkerson correctly held, and the Circuit Court properly concluded, the Commission lacks jurisdiction to consider issues of medical neglect,

malpractice, bias and any inappropriate action or practice. (Feb. 2012 Single Commissioner Decision, p. 8) (Order, p. 18-20).

The “Commission’s jurisdiction and authority is circumscribed by the Workers’ Compensation Act.” Price v. Peachtree Elec. Servs., Inc., 396 S.C. 403, 409, 721 S.E.2d 461, 464 (Ct. App. 2011), *citing* Marchbanks v. Duke Power Co., 190 S.C. 336, 2 S.E.2d 825 (1939). “An administrative agency has only such powers as have been conferred by law and must act within the authority granted for that purpose.” Bazzle v. Huff, 319 S.C. 443, 445, 462 S.E.2d 273, 274 (1995). “The right to workmen’s compensation is wholly statutory and exists only under the circumstances provided in the Workmen’s Compensation Act. The right of any claimant to compensation is dependent upon the terms of the Act.” Dameron v. Spartan Mills, 211 S.C. 217, 218, 44 S.E.2d 466, 467 (1947) (noting that, “the rights acquired under the Workmen’s Compensation Act being purely statutory, the parties are bound by the terms thereof ...”). There is no provision in the Act or the Commission’s Regulations authorizing it to consider and resolve allegations of medical neglect, malpractice, bias and/or any inappropriate action or practice.

Similarly, the Commission does not have statutory authority to forward Claimant’s complaints to the State Attorney General’s office. Under S.C. Code Ann. § 42-9-440, the Commission is required to “report all cases of suspected false statement or misrepresentation, as defined in Section 38-55-530(D), to the Insurance Fraud Division of the Office of the Attorney General for investigation and prosecution, if warranted, pursuant to the Omnibus Insurance Fraud and Reporting Immunity Act.” However, that is the only provision of the Act requiring or authorizing the Commission to report anything to the State Attorney General’s office. (*See* 2012 Hr’g Tr., p. 11, line 15 – p. 14, line 18).

Beyond ordering medical care and treatment, and authorizing a change of physicians in appropriate cases (which, in fact, was done here to accommodate Claimant), the Commission has no authority to hear and decide allegations of medical neglect, malpractice, bias, or inappropriate action or practice. Because the Act is in derogation of the common law, its terms are strictly construed, "leaving it to the Legislature to amend and define its ambiguities." Wigfall v. Tideland Utils., Inc., 354 S.C. 100, 110, 580 S E 2d 100, 105 (2003).

Finally, the issue of whether Commissioner Wilkerson treated Claimant unfairly or lacked impartiality was not raised in Claimant's Form 30 notice of appeal and, therefore, is not preserved for appellate review. Only issues raised in the application for review to the Full Commission are preserved for review. *E g*, Brunson, 367 S.C. at 166, 623 S.E.2d at 872. In addition, this issue was not argued to the Full Commission. (Full Comm'n Hr'g Tr.). In order to preserve an issue for appeal, it must be raised to the lower tribunal. Transportation Ins. Co. v. South Carolina Second Injury Fund, 389 S.C. 422, 431, 699 S.E.2d 687, 691 (2010) (refusing to consider issues not raised below); Elam, 361 S.C. at 23, 602 S.E.2d at 780 (explaining that "[i]t is axiomatic that an issue cannot be raised for the first time on appeal ...), *see also* Bazzle, 319 S.C. at 446, 462 S.E.2d at 274 (issues not raised before the lower tribunal need not be addressed by the appellate court). Frankly, there is no evidence of and no reason to believe Commissioner Wilkerson was biased or lacked impartiality, simply because he ruled against Claimant in his compensation claim.

This Court should affirm that the Commission lacks authority to resolve the issues of medical malpractice or bias raised in Claimant's. This Court also should reject Claimant's baseless assertions regarding Commissioner Wilkerson.

IV. The Commission properly denied Claimant's request for reimbursement of his expenses for the April 18, 2012 and September 18, 2012 Commission hearings.

The Commission properly denied Claimant's request for reimbursement of expenses he incurred in the April 18, 2012 and September 18, 2012 hearings. The April 18, 2012 hearing was initiated by Claimant's filing a Form 50 seeking, among other things, additional medical treatment, resolution of the prescription drug coverage issue, as well as raising the allegations of medical neglect, malpractice, bias and inappropriate actions on the part of the authorized treating physicians. (June 2012 Single Commissioner Decision, pp. 4-5). Attempts to resolve these issues via a telephone conference were defeated by Claimant's failure to timely return telephone calls to the Commission or to respond to correspondence from Respondents' counsel. (June 2012 Single Commissioner Decision, pp. 6, 10) (2012 Hr'g Tr., p. 3, lines 2-22) (*see also* 2012 Hr'g Tr. p. 7, lines 8-18) (2012 Hr'g Tr. p. 51, lines 19-25). Furthermore, the April 18, 2012 Hearing would have been held in Charleston, instead of St. George (thereby saving Claimant some travel expenses), had Claimant returned Commissioner Wilkerson's phone calls in March 2012. (2012 Hr'g Tr. p. 53, line 18 – p. 55, line 24).

As for the Hearing before the Appellate Panel on September 18, 2012, those costs should also be denied. Claimant sought review of the 2012 Single Commissioner Decision. Although the Commission revised some of Commissioner Wilkerson's findings, by and large it affirmed the 2012 Single Commissioner Decision. (Commission Decision, p. 9). S.C. Code Ann. § 42-17-80 provides that, "[i]f the Commission ... shall determine that such proceedings have been brought, prosecuted or defended without reasonable grounds, it may assess the whole cost of the proceedings upon the party who has brought or defended them." The fact that the Commission did not impose costs indicates that it concluded Respondents' defense was reasonable. *See*

Dameron, 211 S.C. at 222, 44 S.E.2d at 467 (finding evidence in the case supported the Commission's factual conclusion regarding imposition of costs). Where a party prevails on most of the points appealed, it can hardly be found to have defended without reasonable grounds. Therefore, the Commission properly declined to award any costs or fees. (Commission Decision, p. 13)

To the extent Claimant is alleging that he is entitled to hearing costs because of the inadvertent failure to include one proposed finding included in Commissioner Wilkerson's Directive/request for a proposed order, (Directive, mailed on April 27, 2012), Claimant's argument fails for several reasons. First, the proposed order was drafted and sent to both Claimant and Commissioner Wilkerson for review. Commissioner Wilkerson did not add or change any findings regarding whether Claimant "has had quite the runaround from the carrier for treatment, checks and prescription problems," prior to signing and issuing his June 2012 Single Commissioner Decision. Second, the Appellate Panel determined that the omission of this directive/finding was an inadvertent scrivener's error and amended "all the previous Findings of Fact relating to the credibility of the parties." (Commission Decision, p. 9) Notably, the Commission did not include any finding reflecting that Claimant has been subjected to a "runaround" but, instead, reaffirmed Commissioner Wilkerson's view that Claimant's distrust of Respondents' counsel and the insurer is "the main problem in this case," and denied his request for costs. (Commission Decision, pp 9, 11)

Because the Commission Decision to not award Claimant costs is both proper and supported by substantial evidence, this Court should affirm.

V. The procedure at and Order issued by the Circuit Court were proper

Claimant makes several allegations of unfairness and/or impropriety arising from the Circuit Court's review and handling of this case. None have any merit and should be dismissed by this Court. First, he asserts that Judge Murphy "would disregard the December 17, 2013 court **ORDER** of the Honorable Goodstein." (App. Br. p. 1). There is no evidence that Judge Murphy disregarded any directive in the 2013 Circuit Court Order, which simply ordered the Commission to provide the Circuit Court with the record. (2013 Circuit Court Order, p. 2). In particular, Judge Goodstein noted the absence of certain hearing transcripts and orders. The Commission provided the record and the parties were heard again on March 12, 2014.

To the extent Claimant alleges he should have had another chance to make his substantive arguments, he was provided a full and fair opportunity to set out his arguments and points on appeal at the September 6, 2013 hearing before Judge Goodstein (2013 Hr'g Tr. p. 4, line 8 – 21, line 11; p. 24, line 15 – 41, line 23; p. 44, line 27 – 49, line 25). In fact, at one point in the hearing, when Judge Goodstein thought she had heard all of his issues, Claimant advised her that he had more issues to discuss, which he was allowed to present to the Court in detail. (Id. p. 27, line 13 – 41, line 23; p. 44, line 27 – 49, line 25). At the end of that hearing, Judge Goodstein advised the parties that she would review the file and take the arguments from the hearing into consideration. (Id. p. 47, line 6 – 48, line 17). There are no issues that Claimant raised on appeal to this Court that he was not able to articulate fully to the Circuit Court. Judge Goodstein's 2013 Circuit Court Order simply noted the lack of a "complete and accurate record." (2013 Circuit Court Order, p. 2). As Claimant indicated in a letter to the Circuit Court, the purpose of the 2013 Circuit Court Order was to "allow the court to have a complete record in

order to make a determination as it relates to,” this case. (Letter from Frank Wilson to Cheryl Graham, Clerk of Court, dated June 6, 2014).

Judge Murphy was assigned this case at the time the record was received from the Commission. Judge Murphy noted that the record as received from the Commission consisted of boxes of untabbed or unorganized documents. (Transcript of March 12, 2014 Hearing before Judge Murphy, p. 3, line 21 – 4, line 12 (“2014 Hr’g Tr.”)). Judge Murphy advised that a subsequent review of the rules indicated that the burden was on the parties to provide an accurate record and transcript of record.” (2014 Hr’g Tr. p. 3, lines 21-24).¹⁰ Judge Murphy noted that it was the appellant’s obligation to provide an adequate record on appeal, and requested that Claimant and Respondents put the record together in an organized fashion so that a decision could be rendered in the appeal.

Based on discussions with the Court during the March 12, 2014 hearing before Judge Murphy, (Affidavit of Erin L. Hantske, dated June 11, 2014), Respondents filed an Revised Pre-Hearing Brief with the Circuit Court, attaching all the portions of the record below that Respondents intended to include in the record on appeal (Revised Pre-Hearing Brief, dated March 19, 2014, with Attachment Index) This included all of the transcripts of hearings that were conducted at the Commission, and all of the Commission orders in this case. (See Attachment Index). Claimant filed his Appellant’s Record on Appeal with the Circuit Court on April 1, 2014. Subsequently, on June 6 and in response to a letter from Respondents indicating that Claimant had not served them with a copy of his Appellant’s Record on Appeal, (Letter from Helen Hiser to Cheryl Graham, Clerk of Court, dated May 6, 2014), Claimant asserted that

¹⁰ Respondents point out that the notes to 2006 revision of the Administrative Procedures Act indicate that the “act takes effect on July 1, 2006, and applies to any actions pending on or after the effective date of the act.” 2006 Act No 387, § 57 The 2006 revision deleted the provision that previously required the Commission to transmit a certified copy of the entire record of proceeding.

Respondents had failed to include in their attachments certain medical records he asserted supported his case. Claimant did not identify the records or explain why he had neither included nor more particularly identified any such medical records in his own Appellant's Record on Appeal. (Letter from Frank Wilson to Cheryl Graham, Clerk of Court, dated June 6, 2014).

In response, Respondents sought clarification from the Circuit Court as to what was required in order to complete the record for appellate review. (Letter from Helen Hiser to Cheryl Graham, Clerk of Court, dated June 12, 2014). In a letter dated June 19, 2014, the Court advised the parties that, "Respondents understanding of what the Court ordered during the March 12th, 2014 hearing is correct. The Court is in receipt of both the Respondent and Appellant's re-submitted briefs with their relevant portions of the Commission Record attached. Therefore no further submissions are required from either party." (Letter from John Guerry, Law Clerk, Hon. Maite Murphy, to Mr. Wilson and Ms. Hiser, dated June 19, 2014).

Clearly, Claimant had an opportunity to submit whatever portions of the Commission Record he believed were necessary to make his case to the Circuit Court. Respondents provided the Court with all of the items Judge Goodstein had noted were missing, and both parties provided other pertinent parts of the Commission record. If there were specific medical records that Claimant believed were relevant or necessary to his appeal, he failed to identify them and cannot now complain that the record is incomplete.

Finally, Claimant objects to the Circuit Court asking Respondents to prepare a draft proposed order. As the Circuit Court's request plainly states, Respondents were requested to "submit a proposed Order ... for [Judge Murphy's] consideration ..." (Email from John Guerry, Law Clerk, Hon. Maite Murphy, to Erin Hantske and Helen Hiser, dated July 18, 2014, and indicating the same would be mailed to Mr. Wilson). Circuit Courts routinely request the

prevailing party to draft a proposed order which the court then reviews prior to issuing. By signing and issuing the proposed order submitted by Respondents, Judge Murphy adopted the findings and conclusions as that of the Circuit Court. Appellant's civil rights have not been violated by this process. The Circuit Court request plainly states that, "[a]fter a careful consideration of the submitted memoranda and hearing oral arguments of both parties, the Court affirms the findings of the Full Commission in its entirety and dismisses Claimant's appeal." (Email from John Guerry, Law Clerk, Hon. Maite Murphy, to Erin Hantske and Helen Hiser, dated July 18, 2014, and indicating the same would be mailed to Mr. Wilson). Claimant's civil rights have not been violated or impinged in any way.

This Court should hold that the parties had an opportunity to present those portions of the record that support their positions, that Claimant was afforded an adequate hearing to state his position on appeal, and that the Circuit Court did not err in asking counsel for one party to draft a proposed order.

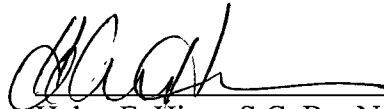
CONCLUSION

For the reasons stated herein, this Court should deny Claimant's challenges to the Circuit Court's affirmation of the Commission Decision. Instead, this Court should affirm the Commission Decision in its entirety and dismiss Claimant's appeal.

March 13, 2015

Respectfully submitted,

McANGUS GOUDELOCK & COURIE LLC



Helen F. Hiser, S.C. Bar No.: 76124
Erin L. Hantske, S.C. Bar No.: 76313
735 Johnnie Dodds Blvd., Suite 200
P.O. Box 650007
Mount Pleasant, SC 29465
(843) 576-2900

*Attorneys for Respondents American LaFrance and
AIG c/o Gallagher Bassett Services, Inc*

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM DORCHESTER COUNTY
Court of Common Pleas

The Honorable Maité Murphy

Civil Case No. 2013-CP-18-1299

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MAR 18 2015
SC Court of Appeals

Frank Wilson, Claimant, Appellant,

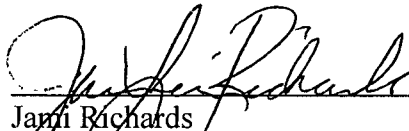
v.

American LaFrance, Employer, and,
AIG c/o Gallagher Bassett Services, Inc., Carrier, Respondents.

PROOF OF SERVICE

I certify that I have served the **Initial Brief of Respondents** and Respondents' **Designation of Matter to be Included in the Record on Appeal** on Frank Wilson by depositing a copy of it in the United States Mail, postage prepaid, on March 13, 2015, addressed as follows:

Mr. Frank Wilson, *pro se*
8755 Jessica Court
North Charleston, South Carolina 29406



Jami Richards
Legal Assistant to Helen F. Hiser
McANGUS GOUDELICK & COURIE LLC
735 Johnnie Dodds Blvd., Suite 200
PO Box 650007
Mount Pleasant, South Carolina 29465
(843) 576-2900

Attorneys for Respondents

mgc

Reply To

HELEN F. HISER
Direct Dial (843) 576-2930
helen.hiser@mgclaw.com

March 13, 2015

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MAR 18 2015

SC Court of Appeals

Via U.S. Mail

The Honorable Jenny Abbott Kitchings
South Carolina Court of Appeals
P.O. Box 11629
Columbia, South Carolina 29211

RE: Frank Wilson v. American LaFrance and AIG c/o Gallagher Bassett
Services, Inc.
Date of Accident: May 16, 2005
WCC File No.: 0506037
Our File No.: 2098.05297
Claim No.: 001961-031227-WC-02
Appellate Case No.: 2014-001996

Dear Ms. Kitchings:

Enclosed for filing please find the following documents:

1. original and one copy of the Initial Brief of Respondents;
2. original and one copy of the Designation of Matter to be Included in the Record on Appeal; and
3. original and one copy of Respondents' Proof of Service concerning items one and two.

Please file these documents and return the clocked-in copies in the enclosed, self-addressed stamped envelope.

Yours truly,
McAngus Goudelock & Courie, LLC



Helen F. Hiser

Enclosures

cc: Frank Wilson, *pro se*

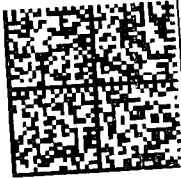
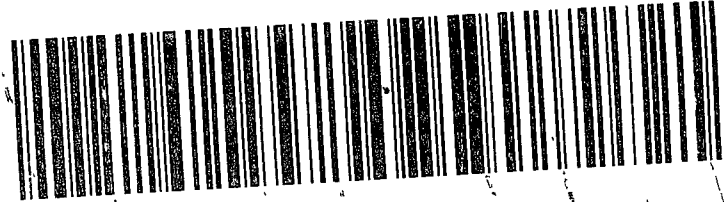
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SC Court of Appeals

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