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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
Appellate Panel

SCWCC No.: 1205647

O'Shea L. Brown, Claimant.....Appellant

v.

Steel Technologies, Employer and

Twin City Fire Ins. Co., Carrier.....Respondents.

Appellate Case No. 2016-001992

RECORD ON APPEAL

JOE ANN CALVY, LLC
Joe Ann Calvy
P.O. Box 610
Kingstree, SC 29556
Telephone: (843) 354-5504
Facsimile: (843) 354-5845
Attorney for Appellant

CROWE LAFAVE, LLC
Matthew C. LaFave
Post Office Box 1149
Columbia, S. C. 29202
Telephone (803) 724-5727
Facsimile: (803) 724-5731
Attorney for Respondents

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DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1205647

O'Shea L. Brown,.....Claimant,

vs.

Steel Technologies, Employer, and
Twin City Fire Ins. Co., Carrier.....Defendants.

HEARING:

Held in Isle of Palms, South Carolina
February 6, 2015

APPEARANCES:

Claimant represented by:
Joe Ann Calvy, Esquire
Joe Ann Calvy, LLC
Post Office Box 610
Kingstree, SC 29556-0610

Defendants represented by:
Matthew C. LaFave
Crowe LaFave, LLC
500 Taylor Street, Suite 401
Post Office Box 1149
Columbia, SC 29202

PURPOSE OF HEARING:

To determine issues as set forth on Claimant's
Form 50 and Defendants' Form 51.

DECISION AND ORDER:

Commissioner R. Michael Campbell, II

FILED:

January 27, 2016

APA SUBMISSIONS

The APA submissions are as follows:

For Claimant:

APA#	MEDICAL PROVIDER	DATE(S)	PAGE(S)
(1)	Claire Orthopaedics	7/16/14	1-6
(2)	Rehabilitation Consultant Feryal Jubran, CRC	7/14/14	7-13
(3)	Carolina Orthotics & Prosthetics	2/27/14 - 6/19/14	14-23
(4)	Lowcountry Orthopaedics	1/30/14	24-26
(5)	Clarendon Memorial System	11/11/13	27-30
(6)	Pain Specialists of Charleston	9/24/13 - 6/27/14	31-97
(7)	CPM Physical Therapy	3/29/13 - 6/20/13	98-141
(8)	Coastal Vascular & Vein Center	1/9/13 - 6/19/14	142-186
(9)	Roper St. Francis	7/24/12 - 2/19/14	187-224
(10)	Coastal Occupational Medicine	5/2/12 - 6/26/12	225-232

EXHIBIT #

(11)	WCC Form 20	233
(12)	Correspondence between Attorney LaFave and Dr. Rudolph	234-235
(13)	Correspondence between Attorney LaFave and Dr. Morrison	236-237
(14)	McLeod Vascular Associates	238-251
(15)	Correspondence from Dr. Harry Rudolph	252
(16)	Independent Medical Evaluation, Dr. Rodney Alan	253-257

For Defendants:

EXHIBIT #

(1)	Vocational Evaluation by Dr. Robert Brabham	241-251
(3)	Transcript from Dr. Edward Morrison's Deposition	N/A
(4)	Transcript from Dr. Edward Tavel's Deposition	N/A

STIPULATIONS

1. The Commission has jurisdiction to hear the matters presented.
2. Venue is proper in Charleston County.
3. The parties were timely and properly notified of the Hearing on February 6, 2015.
4. All parties were represented by counsel.
5. The Claimant's average weekly wages is \$840.36, with a compensation rate of \$560.27.

6. The Commission's file is part of the record with the exception of self-serving declarations and unstipulated medical reports.
7. The APA submissions of both parties are admitted with note of Defendant's objection to the record from Claire Orthopaedics.

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. However, a dispute arose as to the question of causation with respect to a vascular condition present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. § 42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues.

EVIDENCE OF THE CASE

Claimant's Testimony

Direct Examination

Claimant testified that he was transporting a load of steel to a vendor in Charlotte North Carolina on April 30, 2012. During the process of making this delivery he testified that he went to get on the back of the trailer and bumped his right knee. Immediately after the incident Claimant testified to calling his supervisor, Maurice Byrd, to report what happened. Despite the occurrence Claimant testified that he continued to process the delivery and also transported another load the following day in Greensboro, North Carolina.

Claimant testified that approximately two (2) to three (3) days after the incident he went to see a doctor at the direction of his employer. At this initial evaluation he stated that he was simply provided some medications though after some time, approximately five (5) or six (6) months, he was sent to an orthopedist. Claimant was referred to Dr. Rudolph for his surgery, which eventually occurred in the form of a partial medial meniscectomy. Claimant testified that approximately an hour and a half to two hours later he began to experience swelling, which he was told was a result of his having surgery. Claimant's testimony was that prior to this incident and his surgery he had never experienced any swelling and following the surgery, despite assurances it would improve, his swelling worsened.

Claimant was eventually referred to Dr. Morrison who treated him for a vascular problem. Upon being seen by Dr. Morrison Claimant testified that he was recommended to undergo a vein closure, which was done. However, Plaintiff testified that the vascular surgery that he underwent has not helped with his swelling so he was eventually referred to Dr. Tavel for pain management. Dr. Tavel has been treating him from issues relative to his having developed

hip and back pain as well, which were attributed to changes in his gait from the swelling of his lower extremity.

Cross Examination

On cross, Claimant admitted that he was present for the deposition of Dr. Morrison when he concluded the vascular condition was not related to the work injury but rather was attributable to his obesity. Claimant further testified that the issues he is experiencing with his back has been attributed to his altered gait on account of the swelling in his leg.

Redirect Examination

On redirect, Claimant addressed his employment status contending that he was unable to work in any capacity on account of the limitations established by Drs. Rudolph and Tavel. Claimant testified that he was not supposed to lift or squat and that he could work in a position where he was sitting or standing, but this was for limited periods of time. Claimant also testified that he was supposed to be permitted a ten (1) minute break for every one (1) hour of work. To this extent Claimant testified that his employment prior to Steel Technologies provided "very minimum" sitting while serving as an assembler.

Recross Examination

Claimant testified that his previous employment, which included jobs as an assembler for Steel Related Technologies and Petting House, afforded him only about one (1) hour per shift to complete his duties in a seated fashion. However, when presented with his deposition transcript Plaintiff acknowledged he previously testified to spending half of his time seated with the other half standing over a twelve (12) hour shift as an assembler, which also required no lifting.

Summary of the Medical Evidence

Claimant was initially seen on May 2, 2012 at Coastal Occupational Medicine by Dr. Byron Williams with complaints of right knee pain. Following multiple visits to Dr. Williams Claimant was eventually referred to Dr. Harry Rudolph on account of continued complaints of pain. Claimant was eventually seen, on July 24 2012, by Dr. Rudolph who ordered an MRI, which eventually confirmed the presence of a meniscus tear. On account of the findings of the MRI Claimant underwent a partial medial meniscectomy on October 2, 2012. Following the prescribed course of treatment established by Dr. Rudolph Claimant was found to have reached maximum medical improvement on February 19, 2014 for the knee issue.

During the course of his treatment Dr. Rudolph had referred Claimant to a vascular specialist, Dr. Edward Morrison, for evaluation of Claimant's lower extremity swelling. Upon examining the Claimant Dr. Morrison recommended he undergo the closure of his right greater saphenous vein, which was completed on February 14, 2013. Despite the procedure Claimant continued to experience swelling and his treatment was eventually transitioned to Dr. Tavel for ongoing pain management. Eventually, Dr. Tavel opined that Claimant had, from a pain management perspective, achieved maximum medical improvement as well.

Claimant submitted, medical questionnaires, as completed by Drs. Rudolph and Morrison with the focus largely on that of Dr. Morrison. It is noted in the medical questionnaire completed by Dr. Morrison the vascular condition was likely an underlying condition aggravated by his work related injury. However, Dr. Morrison was later deposed and upon extensive questioning by both parties under direct and cross-examination he retracted his previous conclusion and opined that the vascular condition, within a reasonable degree of medical certainty, was not created, activated or exacerbated either by Claimant's original knee injury or

his surgery. In an attempt to counteract the opinion of Dr. Morrison Claimant presented a report from Dr. Gabor Winkler who concluded the work related accident did aggravate Claimant's pre-existing vascular condition.

Based on the stipulations of the parties, the testimony and evidence received and produced at the hearing, as well as my personal observation of the witnesses, the undersigned Commissioner finds the following facts based upon the preponderance of the evidence:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Steel Technologies, as the Employer, and Twin City Fire Insurance Company as the Carrier.
2. Counsel for both parties received order instructions on November 9, 2015.
3. Claimant sustained an admitted injury to his right knee arising out of and in the course and scope of his employment on April 30, 2012.
4. Claimant's knee injury was specifically a torn medial meniscus for which he required a partial medial meniscectomy on October 2, 2012.
5. Claimant's need for a partial medial meniscectomy was causally related to the admitted injury occurring on April 30, 2012.
6. Claimant alleged additional injuries, which included a vascular condition of the right lower extremity, the right hip, and lower back.
7. Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and

thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom.

8. Claimant underwent various treatments and evaluations with multiple physicians for his work related and alleged causally related injuries, including surgery.

9. Dr. Rudolph found Claimant to be at maximum medical improvement for his knee injury on February 19, 2014 with a noted 13% impairment of the right lower extremity.

10. Dr. Rudolph's impairment rating was noted to include an increase for the Claimant's swelling.

11. I find that Claimant has satisfied his burden of proof relative to the causal connection between his work related accident and the resulting knee injury, which required a partial medial meniscectomy.

12. The medical records support my determination that Claimant sustained an injury by accident arising out of and in the course of his employment to his right knee.

13. I give the greatest weight to the findings of the authorized treating physicians, which included Dr. Rudolph, Dr. Morrison and Dr. Tavel as well as the deposition testimony proffered by Drs. Morison and Dr. Tavel.

14. Based on the greater weight of the evidence, I find that the Claimant's vascular condition was not caused, activated, or aggravated by the compensable right knee injury or the treatment received as a result of said injury.

15. Based on the greater weight of the evidence, I find that the additional injuries alleged by Claimant as to the right hip and lower back, are attributable to his altered gait, which was the direct result of his lymphedema, which I have already found to be unrelated to the admitted injury of April 30, 2012.

16. Based on the greater weight of the evidence, I find that Claimant reached maximum medical improvement for his admitted injury to his right knee on February 19, 2014.

17. Claimant is entitled to an award of 12% permanent partial disability to his right leg for this admitted injury.

18. Lacking a definitive opinion from Dr. Rudolph relative to future medical treatment for Claimant's admitted injury; I find that Claimant is not entitled to future medical care.

19. I find that Defendants are entitled, as of the date of this hearing, to terminate temporary total disability compensation on account of my having found Claimant to be at maximum medical improvement on February 19, 2014.

20. I find that Defendants are not entitled to any credit for overpayment for compensation paid from the date of maximum medical improvement until the date of this hearing as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.

21. I find that Defendants are also not entitled to any credit for overpayment for compensation paid between the date of this hearing and the date the Order Instructions were issued as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.

CONCLUSIONS OF LAW

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. S.C. Code Ann. § 42-1-120 defines disability.

2. S.C. Code Ann. § 42-1-160 defines injury. Pursuant to this statute, Claimant suffered an injury by accident arising out of and in the course of his employment to his right knee.

3. S.C. Code Ann. § 42-9-200 provides for temporary disability benefits. Pursuant to this section, Claimant is entitled to temporary total disability benefits from the period of May 2, 2012, to February 19, 2014.

4. S.C. Code Ann. § 42-9-210 affords Defendants a deduction from the amount of compensation to be paid when disability payments were made when they were not due and payable. Pursuant to this statute Defendants are not entitled to a deduction from compensation payable as this section was not pled and Defendants did not proceed with a Form 21, Request for Hearing to Stop Compensation.

5. S.C. Code Ann. § 42-15-60 provides for the provision of medical treatment to injured workers. Claimant is not entitled to continuing medical treatment with regards to the compensable injury to his right knee.

6. S.C. Code Ann. § 42-1-40 and Reg. 67-1603 set forth appropriate methods for calculating the average weekly wage and compensation rate. On this basis, Claimant's average weekly wage is \$856.52, with a compensation rate of \$571.04.

Based on the above Statement of the Case, Evidence of the Case, Findings of Fact, and Conclusions of Law, the following Order is made:

AWARD

Based on the foregoing, it is hereby:

ORDERED that Claimant's average weekly wage is \$856.52, with a corresponding compensation rate of \$571.04; it is further

ORDERED that Claimant suffered a compensable injury by accident to his right knee necessitating a partial medial meniscectomy; and it is further

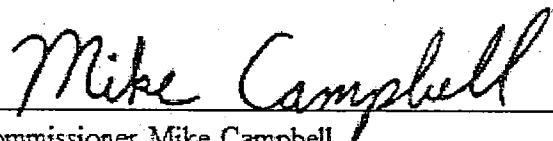
ORDERED that Defendants shall pay for any previously authorized and causally related medical treatment incurred by Claimant relative solely to his right knee; and it is further

ORDERED that Defendants are relieved of any further responsibility for payment of temporary total disability benefits; and it is further

ORDERED that Defendants are hereby relieved of any further responsibility for any of Claimant's ongoing medical treatment; and it is further

ORDERED that Defendants shall pay an award to Claimant of Thirteen Thousand Three Hundred Sixty-Two and 34/100 (\$13,362.34) Dollars as a result of his 12% disability to the right lower extremity.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION


Commissioner Mike Campbell

This 27th Day of January 2016
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid, in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).
January 27, 2016

By: Barbara Cheeseboro, Administrative Assistant to Commissioner Campbell

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1205647

O'Shea L. Brown, ... Claimant,

vs.

Steel Technologies, Employer, and
Twin City Fire Ins. Co., Carrier, ... Defendants.

HEARING:

Held in Columbia, South Carolina
June 20, 2016

APPEARANCES:

Claimant represented by:
Joe Ann Calvy, Esquire
Joe Ann Calvy, LLC
Post Office Box 610
Kingstree, SC 29556-0610

Defendants represented by:
Matthew C. LaFave
Crowe LaFave, LLC
500 Taylor Street, Suite 401
Post Office Box 1149
Columbia, SC 29202

PURPOSE OF HEARING:

To determine issues as set forth on Claimant's and
Defendants' Form 30, Request for Commission Review.

DECISION AND ORDER:

Commissioners Melody L. James, Chair, Aisha Taylor, and
T. Scott Beck

FILED:

September
~~August~~ 20th, 2016

BACKGROUND

Pursuant to Forms 50 and 51, a hearing was held on February 6, 2015 before Commissioner Michael Campbell to determine compensability of Claimant's lymphedema as well as his alleged affect on his hip and lower back. Further, Commissioner Campbell was asked to render a conclusion as to Claimant's entitlement to an award of disability as well as his entitlement to future medical treatment. On November 9, 2015 the Single Commissioner issued an Order finding that the only injury causally related to this admitted claim was to Claimant's right knee, which necessitated surgical repair in the form of a partial medial meniscectomy. The Single Commissioner further found that Claimant failed to meet his burden of proving causal connection between the accident and the lymphedema, hip and lower back issues. As a result of the foregoing findings the Single Commissioner found Claimant was entitled to 12% permanent partial disability and no future medical treatment.

On February 3, 2016 Claimant filed a Form 30 alleging that the Single Commissioner erred in denying Claimant's claims for his lymphedema and associated right hip and lower back, finding that Claimant was not at permanent and total disability, at maximum medical improvement, entitled to 12% permanent partial disability to the right lower extremity, and not entitled to future medical treatment. On February 10, 2016 Defendants filed a Form 30 alleging the Single Commissioner erred in denying them a credit for compensation paid from the date of the Hearing, February 6, 2015 until the date of the ruling, November 9, 2015.

On June 20, 2016 oral arguments were heard by the Full Commission, which was comprised of Commissioners James, Taylor, and Beck.

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer.

~~However, a dispute arose as to the question of causation with respect to a vascular condition~~
present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. § 42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues.

EVIDENCE OF THE CASE

Claimant's Testimony

Direct Examination

Claimant testified that he was transporting a load of steel to a vendor in Charlotte North Carolina on April 30, 2012. During the process of making this delivery he testified that he went to get on the back of the trailer and bumped his right knee. Immediately after the incident

Claimant testified to calling his supervisor, Maurice Byrd, to report what happened. Despite the occurrence Claimant testified that he continued to process the delivery and also transported another load the following day in Greensboro, North Carolina.

~~Claimant testified that approximately two (2) to three (3) days after the incident he went~~
to see a doctor at the direction of his employer. At this initial evaluation he stated that he was simply provided some medications though after some time, approximately five (5) or six (6) months, he was sent to an orthopedist. Claimant was referred to Dr. Rudolph for his surgery, which eventually occurred in the form of a partial medial meniscectomy. Claimant testified that approximately an hour and a half to two hours later he began to experience swelling, which he was told was a result of his having surgery. Claimant's testimony was that prior to this incident and his surgery he had never experienced any swelling and following the surgery, despite assurances it would improve, his swelling worsened.

Claimant was eventually referred to Dr. Morrison who treated him for a vascular problem. Upon being seen by Dr. Morrison Claimant testified that he was recommended to undergo a vein closure, which was done. However, Plaintiff testified that the vascular surgery that he underwent has not helped with his swelling so he was eventually referred to Dr. Tavel for pain management. Dr. Tavel has been treating him from issues relative to his having developed hip and back pain as well, which were attributed to changes in his gait from the swelling of his lower extremity.

Cross Examination

On cross, Claimant admitted that he was present for the deposition of Dr. Morrison when he concluded the vascular condition was not related to the work injury but rather was attributable

to his obesity. Claimant further testified that the issues he is experiencing with his back has been attributed to his altered gait on account of the swelling in his leg.

Redirect Examination

~~On redirect, Claimant addressed his employment status contending that he was unable to~~
work in any capacity on account of the limitations established by Drs. Rudolph and Tavel. Claimant testified that he was not supposed to lift or squat and that he could work in a position where he was sitting or standing, but this was for limited periods of time. Claimant also testified that he was supposed to be permitted a ten (1) minute break for every one (1) hour of work. To this extent Claimant testified that his employment prior to Steel Technologies provided "very minimum" sitting while serving as an assembler.

Recross Examination

Claimant testified that his previous employment, which included jobs as an assembler for Steel Related Technologies and Petting House, afforded him only about one (1) hour per shift to complete his duties in a seated fashion. However, when presented with his deposition transcript Plaintiff acknowledged he previously testified to spending half of his time seated with the other half standing over a twelve (12) hour shift as an assembler, which also required no lifting.

Summary of the Medical Evidence

Dr. Byron Williams initially saw claimant on May 2, 2012 at Coastal Occupational Medicine with complaints of right knee pain. Following multiple visits to Dr. Williams Claimant was eventually referred to Dr. Harry Rudolph on account of continued complaints of pain. Claimant was eventually seen, on July 24 2012, by Dr. Rudolph who ordered an MRI, which eventually confirmed the presence of a meniscus tear. On account of the findings of the MRI Claimant underwent a partial medial meniscectomy on October 2, 2012. Following the

prescribed course of treatment established by Dr. Rudolph Claimant was found to have reached maximum medical improvement on February 19, 2014 for the knee issue.

During the course of his treatment Dr. Rudolph had referred Claimant to a vascular specialist, Dr. Edward Morrison, for evaluation of Claimant's lower extremity swelling. Upon examining the Claimant Dr. Morrison recommended he undergo the closure of his right greater saphenous vein, which was completed on February 14, 2013. Despite the procedure Claimant continued to experience swelling and his treatment was eventually transitioned to Dr. Tavel for ongoing pain management. Eventually, Dr. Tavel opined that Claimant had, from a pain management perspective, achieved maximum medical improvement as well.

Claimant submitted, medical questionnaires, as completed by Drs. Rudolph and Morrison with the focus largely on that of Dr. Morrison. It is noted in the medical questionnaire completed by Dr. Morrison the vascular condition was likely an underlying condition aggravated by his work related injury. However, Dr. Morrison was later deposed and upon extensive questioning by both parties under direct and cross-examination he retracted his previous conclusion and opined that the vascular condition, within a reasonable degree of medical certainty, was not created, activated or exacerbated either by Claimant's original knee injury or his surgery. In an attempt to counteract the opinion of Dr. Morrison Claimant presented a report from Dr. Gabor Winkler who concluded the work related accident did aggravate Claimant's pre-existing vascular condition.

Based on the stipulations of the parties, the testimony and evidence received and produced at the hearing, as well as my personal observation of the witnesses, the undersigned Commissioner finds the following facts based upon the preponderance of the evidence:

FINDINGS OF FACT
(Single Commissioner)

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Steel Technologies, as the Employer, and Twin City Fire Insurance Company as the Carrier.

2. Counsel for both parties received order instructions on November 9, 2015.

3. Claimant sustained an admitted injury to his right knee arising out of and in the course and scope of his employment on April 30, 2012.

4. Claimant's knee injury was specifically a torn medial meniscus for which he required a partial medial meniscectomy on October 2, 2012.

5. Claimant's need for a partial medial meniscectomy was causally related to the admitted injury occurring on April 30, 2012.

6. Claimant alleged additional injuries, which included a vascular condition of the right lower extremity, the right hip, and lower back.

7. Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom.

8. Claimant underwent various treatments and evaluations with multiple physicians for his work related and alleged causally related injuries, including surgery.

9. Dr. Rudolph found Claimant to be at maximum medical improvement for his knee injury on February 19, 2014 with a noted 13% impairment of the right lower extremity.

10. Dr. Rudolph's impairment rating was noted to include an increase for the Claimant's swelling.

11. I find that Claimant has satisfied his burden of proof relative to the causal connection between his work related accident and the resulting knee injury, which required a partial medial meniscectomy.

~~12. The medical records support my determination that Claimant sustained an injury by accident arising out of and in the course of his employment to his right knee.~~

13. I give the greatest weight to the findings of the authorized treating physicians, which included Dr. Rudolph, Dr. Morrison and Dr. Tavel as well as the deposition testimony proffered by Drs. Morison and Dr. Tavel.

14. Based on the greater weight of the evidence, I find that the Claimant's vascular condition was not caused, activated, or aggravated by the compensable right knee injury or the treatment received as a result of said injury.

15. Based on the greater weight of the evidence, I find that the additional injuries alleged by Claimant as to the right hip and lower back, are attributable to his altered gait, which was the direct result of his lymphedema, which I have already found to be unrelated to the admitted injury of April 30, 2012.

16. Based on the greater weight of the evidence, I find that Claimant reached maximum medical improvement for his admitted injury to his right knee on February 19, 2014.

17. Claimant is entitled to an award of 12% permanent partial disability to his right leg for this admitted injury.

18. Lacking a definitive opinion from Dr. Rudolph relative to future medical treatment for Claimant's admitted injury; I find that Claimant is not entitled to future medical care.

19. I find that Defendants are entitled, as of the date of this hearing, to terminate temporary total disability compensation on account of my having found Claimant to be at maximum medical improvement on February 19, 2014.

~~20. I find that Defendants are not entitled to any credit for overpayment for compensation paid from the date of maximum medical improvement until the date of this hearing as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.~~

21. I find that Defendants are also not entitled to any credit for overpayment for compensation paid between the date of this hearing and the date the Order Instructions were issued as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.

CONCLUSIONS OF LAW
(Single Commissioner)

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. S.C. Code Ann. § 42-1-120 defines disability.
2. S.C. Code Ann. § 42-1-160 defines injury. Pursuant to this statute, Claimant suffered an injury by accident arising out of and in the course of his employment to his right knee.
3. S.C. Code Ann. § 42-9-200 provides for temporary disability benefits. Pursuant to this section, Claimant is entitled to temporary total disability benefits from the period of May 2, 2012, to February 19, 2014.
4. S.C. Code Ann. § 42-9-210 affords Defendants a deduction from the amount of compensation to be paid when disability payments were made when they were not due

and payable. Pursuant to this statute Defendants are not entitled to a deduction from compensation payable as this section was not pled and Defendants did not proceed with a Form 21, Request for Hearing to Stop Compensation.

5. ~~S.C. Code Ann. § 42-15-60 provides for the provision of medical~~
treatment to injured workers. Claimant is not entitled to continuing medical treatment with regards to the compensable injury to his right knee.

6. S.C. Code Ann. § 42-1-40 and Reg. 67-1603 set forth appropriate methods for calculating the average weekly wage and compensation rate. On this basis, Claimant's average weekly wage is \$856.52, with a compensation rate of \$571.04.

Based on the above Statement of the Case, Evidence of the Case, Findings of Fact, and Conclusions of Law, the following Order is made:

AWARD

Based on the foregoing, it is hereby:

ORDERED that Claimant's average weekly wage is \$856.52, with a corresponding compensation rate of \$571.04; it is further

ORDERED that Claimant suffered a compensable injury by accident to his right knee necessitating a partial medial meniscectomy; and it is further

ORDERED that Defendants shall pay for any previously authorized and causally related medical treatment incurred by Claimant relative solely to his right knee; and it is further

ORDERED that Defendants are relieved of any further responsibility for payment of temporary total disability benefits; and it is further

ORDERED that Defendants are hereby relieved of any further responsibility for any of Claimant's ongoing medical treatment; and it is further

ORDERED that Defendants shall pay an award to Claimant of Thirteen Thousand ~~Three Hundred Sixty-Two and 34/100 (\$13,362.34) Dollars as a result of his 12% disability to~~
the right lower extremity.

DISCUSSION

The Claimant sustained an injury to his right knee while climbing atop the trailer of his truck, which eventually led to his requiring a partial medial meniscectomy on October 2, 2012. The Defendants accepted the claim to Claimant's knee and provided him all of the related medical treatment. Claimant contends that following, and as a result of the injury/surgery, he began experiencing significant swelling in the right lower extremity, which was eventually determined to be lymphedema by Dr. Edward Morrison. Dr. Morrison concluded, in his deposition, that the lymphedema was not causally related to either the original injury or the resulting surgery.

Claimant, by and through his counsel, argued the Single Commissioner erred in finding the Claimant's lymphedema and associated back and hip problems as unrelated to the injury occurring on April 30, 2012. Specifically, Claimant argued the evidence supported a finding of compensability despite the existence of Dr. Morrison's deposition transcript where he, as the treating physician, clearly and conclusively testified that the lymphedema was unrelated to the original injury or the surgery. In opposition of Dr. Morrison's conclusions Claimant relied upon an independent medical examination conducted by Dr. Gabor Winkler at the behest of his counsel. Defendants submitted the greater weight should be afforded to Dr. Morrison as the one most familiar with Claimant's care and treatment and based upon the fact he proffered testimony,

under oath, that found the vascular condition as unrelated. Defendants further contended the overwhelming evidence indicated the lymphedema has led to Claimant having an altered gait, which was the proximate cause of the hip and low back issues as indicated by Dr. Morrison and Dr. Edward Tavel. Given the evidence supported denying compensability of the lymphedema so to must the hip and low back be found as unrelated. Based upon the denial of the lymphedema and all other purportedly affected body parts Claimant is left with only an injury to his right knee and as such an award must be confined to S.C. Code Ann. § 42-9-30 as required by law thus Claimant cannot maintain a claim for permanent and total disability.

By virtue of the foregoing conclusions that the substantial evidence submitted in this case clearly supports a finding that the compensable injury resulted in only an injury to his right knee. Therefore, the case must be evaluated based exclusively on an injury to the right lower extremity necessitating a partial medial meniscectomy, which affords Claimant 2% impairment. While noting Dr. Rudolph assigned Claimant a much higher impairment it was clear from the evidence that his impairment was increased exponentially to account for the condition later concluded to be unrelated by Dr. Morrison. Based upon the exclusion of the lymphedema the claim clearly, as supported by substantial evidence, was one for the right knee only that led to a partial meniscectomy. Under the same theories as previously set forth Defendants argued that Claimant was found to be at maximum medical improvement by Dr. Rudolph on February 19, 2014, which was uncontroverted as to his knee injury. The additional issues for which Claimant has continued to seek treatment are for either lymphedema directly or issues stemming therefrom and as such Claimant was at maximum medical improvement as determined by the treating physician. Finally, there was simply no evidence to support a finding that Claimant was entitlement to any future medical treatment as it related to the compensable right knee injury.

The final issue presented to the Full Commission stemmed from the holding by the Single Commissioner that Defendants were not entitled to any credit for overpayment of temporary-total disability compensation on account of S.C. Code Ann. § 42-9-210 not having been pled in the ~~Pre-Hearing Brief nor had Defendants filed a Form 21, Request for Hearing to stop~~ compensation wherein a request for credit would have been made. Defendants conceded that there was uncertainty surrounding the issue of maximum medical improvement and as such no Form 21 was filed but the issue of a credit for overpayment is one of equity. The prevailing case law is well settled that a credit for overpayment should be issued when the delay in termination of benefits was not occasioned by any fault of Defendants. In this case neither party caused or otherwise contributed, directly or indirectly, to the delay in the issuance of the Single Commissioner's ruling, which spanned some nine (9) months. Therefore, Defendants argued that under the theory of equity they are, at a minimum, entitled to a credit for compensation paid from the date of the hearing until benefits terminated, on November 9, 2015, with the issuance of the order instructions by the Single Commissioner.

FINDINGS OF FACT
(Full Commission)

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Steel Technologies, as the Employer, and Twin City Fire Insurance Company as the Carrier.
2. The hearing before the Single Commissioner occurred on February 6, 2015.
3. Counsel for both parties received order instructions on November 9, 2015.
4. Claimant's sustained a compensable knee injury, which required a partial medial meniscectomy that occurred on October 2, 2012.

5. Claimant's need for a partial medial meniscectomy was causally related to the admitted injury occurring on April 30, 2012.

6. Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom.

7. Dr. Rudolph found Claimant to be at maximum medical improvement for his knee injury on February 19, 2014 with a noted 13% impairment of the right lower extremity.

8. Dr. Rudolph's impairment rating was noted to include an increase for the Claimant's swelling, which was attributed to a vascular condition known as lymphedema, which Dr. Morrison concluded to be unrelated to the accident or resulting treatment.

9. We find that Claimant has satisfied his burden of proof relative to the causal connection between his work related accident and the resulting knee injury, which required a partial medial meniscectomy.

10. We give the greatest weight to the findings of the authorized treating physicians, which included Dr. Rudolph, Dr. Morrison and Dr. Tavel as well as the deposition testimony proffered by Drs. Morison and Dr. Tavel.

11. Based on the greater weight of the evidence, we find that the Claimant's vascular condition, lymphedema, was not caused, activated, or aggravated by the compensable injury to Claimant's right knee or the treatment received as a result of said injury.

12. Based on the greater weight of the evidence, we find that the additional injuries alleged by Claimant as to the right hip and lower back, are attributable to his altered gait,

which are the direct result of his lymphedema, which has already found to be unrelated to the admitted injury of April 30, 2012.

13. Based on the greater weight of the evidence, we find that Claimant reached maximum medical improvement for his admitted injury to his right knee on February 19, 2014.

14. We find Claimant is entitled to an award of 12% permanent partial disability to his right lower extremity for this admitted injury.

15. We find there is insufficient evidence to order any recommended future treatment that would lessen the period or extent of Plaintiff's disability as it pertains exclusively to the compensable injury to his right lower extremity; therefore, we find that Claimant is not entitled to future medical care.

16. We find that Defendants are entitled, as of the date of this hearing, to terminate temporary total disability compensation on account of my having found Claimant to be at maximum medical improvement on February 19, 2014.

17. We find that the Defendants continued to pay temporary total disability compensation from February 6, 2015 through November 9, 2015, while the parties awaited the order instructions of the Single Commissioner.

18. We find that neither party nor their respective counsel contributed to the delay in issuance of the order instructions between February 6, 2015 and November 9, 2015.

19. We find that Defendants are entitled to a credit for overpayment of temporary total disability compensation paid between the date of this hearing, February 6, 2015 and the date the Order Instructions were issued, November 9, 2015 though no credit shall be awarded for any temporary total disability compensation paid prior to the date of the hearing.

20. Defendants are entitled to a credit for compensation paid from February 6, 2015 and ending November 9, 2015, which totals Twenty-Two Thousand Five Hundred Ninety-Six and 85/100 (\$22,596.85) Dollars.

~~21. Defendants credit is in excess of Claimant's permanent partial disability award, thus no payment is due to the Claimant.~~

22. After Claimant's permanent partial disability award is applied to the aforementioned credit, Defendants have a resulting net credit of Nine Thousand Two Hundred Thirty-Four and 51/100 (\$9,234.51) Dollars.

23. The net credit owed to Defendant may be applied toward any future payments of permanency as ordered by this Commission or a higher court, if any; however, in no way shall this finding be construed to award Defendants reimbursement directly from the Claimant.

CONCLUSIONS OF LAW **(Full Commission)**

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. S.C. Code Ann. § 42-1-120 defines disability.
2. S.C. Code Ann. § 42-1-160 defines injury. Pursuant to this statute, Claimant suffered an injury by accident arising out of and in the course of his employment to his right knee.

3. S.C. Code Ann. § 42-9-200 provides for temporary disability benefits. Pursuant to this section, Claimant is entitled to temporary total disability benefits from the period of May 2, 2012, to February 19, 2014.

~~4. S.C. Code Ann. § 42-9-210 affords Defendants a deduction from the~~
amount of compensation to be paid when disability payments were made when they were not due and payable. Pursuant to this statute Defendants are entitled to a deduction from compensation payable as Defendants continued to pay temporary total disability compensation when it was not due and payable from February 6, 2015 through November 9, 2015.

5. S.C. Code Ann. § 42-15-60 provides for the provision of medical treatment to injured workers. Claimant is not entitled to continuing medical treatment with regards to the compensable injury to his right knee.

6. S.C. Code Ann. § 42-9-35 provides for benefits relating to the aggravation of pre-existing conditions. There was substantial evidence presented in the record to support a conclusion that Claimant's pre-existing condition(s) were not aggravated by the compensable injury or the treatment relating thereto.

7. S.C. Code Ann. § 42-1-40 and Reg. 67-1603 set forth appropriate methods for calculating the average weekly wage and compensation rate. On this basis, Claimant's average weekly wage is \$856.52, with a compensation rate of \$571.04.

ORDER OF THE FULL COMMISSION

Pursuant to S.C Code Ann. § 42-17-50, we, the Appellate Panel, have reviewed the Decision and Order of the Single Commissioner and weighed the evidence as presented at the initial hearing and considered all issues raised in the briefs of the Parties, as well as

those issues raised at the Full Commission Review hearing.

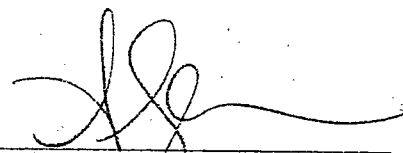
After careful review, The Appellate Panel of the South Carolina Workers' Compensation Commission, by unanimous vote, AFFIRM IN PART and REVERSE

~~IN PART the Single Commissioner's order consistent with our Findings of Fact and~~

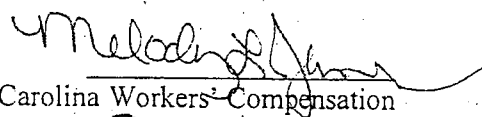
Conclusions of Law as above.

IT IS THEREFORE ORDERED that, the findings of fact and conclusions of law of the Single Commissioner are incorporated herein as if set forth verbatim unless specifically reversed in the Order of the Full Commission.

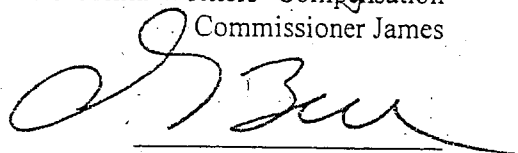
AND IT IS SO ORDERED.



South Carolina Workers' Compensation
Commissioner Taylor



South Carolina Workers' Compensation
Commissioner James



South Carolina Workers' Compensation
Commissioner Beck

Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Kim Falls on September 20, 2016

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov



WCC File #: 1205647
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: O'Shea Brown SSN: 251-69-6544 Employer's Name: Steel Technologies
Address: 533 Taft Rd. Address: 1220 S. Steel Circle
City: Salters State: SC Zip: 29590 City: Huger State: SC Zip: 29450
Home Phone: 843-356-9590 Work Phone: _____ Insurance Carrier: Hartford Accident & Indemnity Co.
Preparer's Name: Joe Ann Calvy Law Firm: Joe Ann Calvy, LLC Preparer's Phone #: 843-354-9000

A claim for workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 4/30/2012

- ☒ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction
1. The claimant sustained an injury to right leg, right hip, and back (Part(s) of Body Injured) on 4/30/2012 (Month/Day/Year) in Mecklenburg county, state of NC. Body part(s) affected are: right leg, right hip, and back
2. Briefly describe how the accident occurred. Claimant bumped his right knee on trailer while climbing onto it.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 4/30/2012 (Month/Day/Year) in the following manner: Maurice Burroughs, supervisor
- ☒ 7. Due to injury, the claimant is in need of (check one):
☒ (a) medical examination and treatment for: back
☒ (b) additional medical examination and treatment for: right leg, right hip
- ☐ 8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: _____
- ☐ 9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
☐ (1) General Disability: ☐ Total ☐ Partial ☐ (2) Specific Disability: ☐ Total ☐ Partial ☐ (3) Wage Loss
- ☒ 9a. ☒ A determination of permanent disability is premature at this time.
- ☐ 10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of: _____
- 10a. At the time of the injury, the Claimant was paid weekly wages of \$_____, and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident: _____
11. Further grounds or unusual aspects of claim: _____
- 11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
See attachment.
- 11b. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe: No
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☐ 13a. I am filing a claim. I am not requesting a hearing at this time. 14. Estimated time needed for hearing: _____
- ☒ 13b. I am requesting a hearing. A \$25 fee is required.
- ☐ Mediation
☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to _____
address _____ on the _____ day of _____ 20____, by ☐ first class postage ☐ certified mail ☐ personal service.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature: _____ Attorney for Claimant: jcalvy@sc.rr.com Title: _____ June 16, 2014
Date: _____

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50

Revised 7/13

50

Employee's Notice of Claim and/or
Request for Hearing

P31

FORM 50 ATTACHMENT FOR O'SHEA BROWN

11a. Charleston Bone & Joint-255 East Bay Street-Charleston, SC 29403; Coastal Vascular & Vein Center-1327 Ashley River Rd., Bldg B-Charleston, SC 29407; Pain Specialists of Charleston, P.A.-2695 Elms Plantation Blvd., Suite A-Charleston, SC 29406; Clarendon Health System-10 Hospital Street-Manning, SC 29102; Coastal Occupational Medicine-3605 Meeting Street, Suite C-Charleston, SC 29405; CPM Physical Therapy-148 B Sauls Street-Lake City, SC 29560; Low Country Orthopaedics-2880 Tricom Street-N. Charleston, SC 29406; Carolina Orthotics and Prosthetics, Inc.-3465 W. Montague Ave.-Suite 101-N. Charleston, SC 29418

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

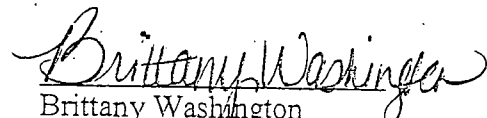
O'Shea Brown)
Claimant,)
)
)
vs.)
)
Steel Technologies)
)
Defendant (s),)
_____)

CERTIFICATE OF SERVICE

I, Brittany Washington, hereby certify that I mailed a copy of the Form 50 to the below addressee by placing a copy of the same in the United States mail with sufficient postage attached this 16th day of June, 2014.

Att'n: Judicial Department
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202-1715

Twin City Fire Insurance Co.
SE Workers' Comp. Claim Center
P.O. Box 14473
Lexington, KY 40512


Brittany Washington
Legal Assistant to
Joe Ann Calvy
Attorney at Law
P. O. Box 610
Kingstree, S. C. 29556
(843) 354-5504

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739 www.wcc.sc.gov



WCC File #: **1205647**
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: O'Shea Brown SSN: 251-69-6544 Employer's Name: Steel Technologies
Address: 533 Taft Road Address: 1220 S. Steel Circle
City: Salters State: SC Zip: 29590 City: Huger State: SC Zip: 29450
Home Phone: (843) 356-9590 Work Phone: () Insurance Carrier: Hartford Accident & Indemnity, Co.
Date of Injury: April 30, 2012
Preparer's Name: Matthew C. LaFave Law Firm: Crowe LaFave, LLC Preparer's Phone #: (803) 724-5727

Date of Injury or Illness: **4/30/2012**

Estimated time for hearing: **90 minutes**

Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer/Carrier in answer to the claim, respectfully shows:

1. It is ☒ Admitted ☐ Denied the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are: Defendants admit only that Claimant sustained a compensable injury to his right knee. Defendants deny compensability of all other alleged body parts.
2. It is ☒ Admitted ☐ Denied both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:
3. It is ☒ Admitted ☐ Denied the relationship of employer and employee existed at the time in question. The reasons for denial are:
4. It is ☒ Admitted ☐ Denied at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:
5. It is ☒ Admitted ☐ Denied notice of injury was given the employer. The reasons for denial are:
6. It is ☒ Admitted ☐ Denied the employee ☒ Needs ☒ Is Entitled to Additional medical care as a result of injury or illness. The reasons for denial are: Defendants admit that Claimant is entitled to the additional medical treatment as set forth on the completed Physicians' Statements.
7. It is ☐ Admitted ☒ Denied the employee is entitled to temporary total disability for the period(s) of : Claimant has been placed at maximum medical improvement by all treating physicians in this case, most recently May 2, 2014
8. It is ☒ Admitted ☐ Denied the employee is permanently disabled. The reasons for denial are: Defendants admit only that Claimant is disabled relative to the accepted right knee injury in accordance with the applicable impairment rating(s).
9. It is ☐ Admitted ☒ Denied the employee has serious disfigurement.
10. It is contended that an average weekly wage of \$ To be determined applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: S.C. Code Ann. §§ 42-1-160, 42-9-10, 42-9-20, 42-9-30, 42-9-35, and 42-15-60.

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature

Attorney for the Defendants
Title

matt@crowelafave.com
Email

June 23, 2014
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission's Judicial Department at 803-737-5675 or judicial@wcc.sc.gov or mediation@wcc.sc.gov. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

WCC Form # 51
Revised 07/13

51

Employer's Answer to Request for Hearing

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Claimant,

v.

Steel Technologies,

Employer,

and

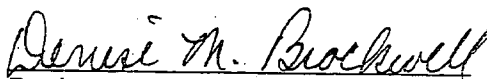
Hartford Accident & Indemnity Co.,
Carrier,

Defendants.

CERTIFICATE OF SERVICE

I, Denise M. Brockwell, paralegal to Matthew C. LaFave do hereby certify that I have served the **WCC Form 51, Employer's Answer to Request for Hearing**, in the above-captioned action, by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows:

Joe Ann Calvy, Esquire
P.O. Box 610
Kingstree, SC 29556


Denise M. Brockwell
Paralegal to Matthew C. LaFave

Columbia, South Carolina
June 24, 2014

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov



WCC File #: 1295647
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: O'Shea Brown SSN: 251 - 69 - 6544 Employer's Name: Steel Technologies
Address: 533 Taft Road Address: 1220 S. Steel Circle
City: Salters State: SC Zip: 29590 City: Huger State: SC Zip: 29450
Home Phone: (843) 356 - 9590 Work Phone: () - Insurance Carrier: Hartford Accident & Indemnity Co.
Preparer's Name: Matthew C. LaFave Law Firm: Crowe LaFave, LLC Preparer's Phone #: (803) 724 - 5727

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ Claimant ☒ Employer (check one) Date of Injury or Illness: 4/30/2012

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Whether or not the Single Commissioner erred in denying Defendants request for credit for compensation paid from the date of the hearing, February 6, 2015 until the date said benefits were terminated upon being informed of the ruling, November 9, 2015.

SCWCC

FEB 12 2016

JUDICIAL

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ Mediation

☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Joe Ann Calvy, Esq., Joe Ann Calvy, LLC
Address PO Box 610, Kingstree, SC 29556 on the 10th day of February 2016, by ☒ first class postage ☐ certified mail ☐ personal service.

Attorney for the Defendants
Title

matt@crowelafave.com
Email

February 10, 2016
Date

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.



WCC File #: 1205647
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: O'Shea Brown SSN: _____ Employer's Name: Steel Technologies
Address: 533 Taft Road Address: 1220 S. Steel Circle
City: Salters State: SC Zip: 29590 City: Huger State: SC Zip: 29450
Home Phone: (843) 356-9590 Work Phone: () Insurance Carrier: Hartford Accident & Indemnity Co.
Preparer's Name: Joe Ann Calvy Law Firm: Joe Ann Calvy, LLC Preparer's Phone #: (843) 354-9000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: 04/30/2012
(m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

Did the single commissioner err in finding that Claimant was not **permanently and totally disabled** when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Did the single commissioner err in finding that Claimant's alleged additional injuries for the **vascular condition and associated right hip and lower back** are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Did the single commissioner err in finding that Claimant reached **maximum medical improvement** on February 19, 2014, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Did the single commissioner err in finding that Claimant is entitled to an award of **12% permanent partial disability to his right leg**, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Did the single commissioner err in finding that Claimant is not entitled to **future medical treatment**, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

SCWCC

FEB - 5 2016 ✓

JUDICIAL

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-05 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

STATE OF SOUTH CAROLINA

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

O'Shea Brown

Claimant,

vs.

Steel Technologies

Defendant (s),

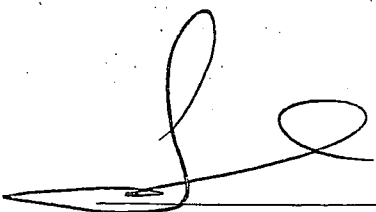
CERTIFICATE OF SERVICE

I, Joe Ann Calvy, hereby certify that I mailed a copy of the WCC Form 30

Request for Commission Review, to the below addressee by placing a copy of the same
in the United States mail with sufficient postage attached this 3rd day of September 2016

Att'n: Judicial Department
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202-1715

Matthew C. LaFave, Esquire
Crowe LaFave, LLC
P O Box 1149
Columbia, S. C. 29202



Joe Ann Calvy
Attorney at Law
P. O. Box 610
Kingstree, S. C. 29556
(843) 354-5504

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1205647

O'Shea L. Brown.....Claimant,

vs.

Steel Technologies, Employer, and
Twin City Fire Ins. Co., Carrier.....Defendants.

APPELLANT'S BRIEF TO THE FULL COMMISSION

HEARING:

Held in Isle of Palms, South Carolina
February 6, 2015

APPEARANCES:

Claimant represented by:
Joe Ann Calvy, Esquire
Joe Ann Calvy, LLC
Post Office Box 610
Kingtree, SC 29556-0610

Defendants represented by:
Matthew C. LaFave
Crowe LaFave, LLC
500 Taylor Street, Suite 401
Post Office Box 1149
Columbia, SC 29202

PURPOSE OF HEARING:

To determine issues as set forth on Claimant's
Form 50 and Defendants' Form 51.

DECISION AND ORDER:

Commissioner R. Michael Campbell, II

APA SUBMISSIONS

The APA submissions are as follows:

For Claimant:

APA#	MEDICAL PROVIDER	DATE(S)	PAGE(S)
(1)	Claire Orthopaedics	7/16/14	1-6
(2)	Rehabilitation Consultant	7/14/14	7-13
	Feryal Jubran, CRC		
(3)	Carolina Orthotics & Prosthetics	2/27/14 - 6/19/14	14-23
(4)	Lowcountry Orthopaedics	1/30/14	24-26
(5)	Clarendon Memorial System	11/11/13	27-30
(6)	Pain Specialists of Charleston	9/24/13 - 6/27/14	31-97
(7)	CPM Physical Therapy	3/29/13 - 6/20/13	98-141
(8)	Coastal Vascular & Vein Center	1/9/13 - 6/19/14	142-186
(9)	Roper St. Francis	7/24/12 - 2/19/14	187-224
(10)	Coastal Occupational Medicine	5/2/12 - 6/26/12	225-232

EXHIBIT

(11)	WCC Form 20	233
(12)	Correspondence between Attorney LaFave and Dr. Rudolph	234-235
(13)	Correspondence between Attorney LaFave and Dr. Morrison	236-237
(14)	McLeod Vascular Associates	238-251
(15)	Correspondence from Dr. Harry Rudolph	252
(16)	Independent Medical Evaluation, Dr. Rodney Alan	253-257

For Defendants:

EXHIBIT

(1)	Vocational Evaluation by Dr. Robert Brabham	241-251
(3)	Transcript from Dr. Edward Morrison's Deposition	N/A
(4)	Transcript from Dr. Edward Tavel's Deposition	N/A

STIPULATIONS

1. The Commission has jurisdiction to hear the matters presented.
2. Venue is proper in Charleston County.
3. The parties were timely and properly notified of the Hearing on February 6, 2015.
4. All parties were represented by counsel.
5. The Claimant's average weekly wages is \$840.36, with a compensation rate of \$560.27.

6. The Commission's file is part of the record with the exception of self-serving declarations and unstipulated medical reports.
7. The APA submissions of both parties are admitted with note of Defendant's objection to the record from Claire Orthopaedics.

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. However, a dispute arose as to the question of causation with respect to a vascular condition present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. § 42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues. Claimant asserted that but for the work injury, surgery to his knee would have not been needed and the resulting permanent and enormous swelling to his right lower extremity would not have occurred, notwithstanding the back and hip pain.

EVIDENCE OF THE CASE

Claimant's Testimony

Direct Examination

Claimant testified that he was transporting a load of steel to a vendor in Charlotte North Carolina on April 30, 2012. During the process of making this delivery he testified that he went to get on the back of the trailer and bumped his right knee. Immediately after the incident Claimant testified to calling his supervisor, Maurice Byrd, to report what happened. Despite the occurrence Claimant testified that he continued to process the delivery and also transported another load the following day in Greensboro, North Carolina.

Claimant testified that approximately two (2) to three (3) days after the incident he went to see a doctor at the direction of his employer. At this initial evaluation he stated that he was simply provided some medications though after some time, approximately five (5) or six (6) months, he was sent to an orthopedist. Claimant was referred to Dr. Rudolph for his surgery, which eventually occurred in the form of a partial medial meniscectomy. Claimant testified that approximately an hour and a half to two hours after the surgery he began to experience swelling, which he was told was a result of his having surgery. Claimant's testimony was that prior to this incident and his surgery he had never experienced any swelling and following the surgery, despite assurances it would improve, his swelling worsened.

Claimant was eventually referred to Dr. Morrison who treated him for a vascular problem. Upon being seen by Dr. Morrison Claimant testified that he was recommended to undergo a vein closure, which was done. However, Plaintiff testified that the vascular surgery that he underwent has not helped with his swelling so he was eventually referred to Dr. Tavel for pain management.

Dr. Tavel has been treating him from issues relative to his having developed hip and back pain as well, which were attributed to changes in his gait from the swelling of his lower extremity.

Cross Examination

On cross, Claimant admitted that he was present for the deposition of Dr. Morrison when he concluded the vascular condition was not related to the work injury but rather was attributable to his obesity. Claimant further testified that the issues he is experiencing with his back has been attributed to his altered gait on account of the swelling in his leg.

Redirect Examination

On redirect, Claimant addressed his employment status contending that he was unable to work in any capacity on account of the limitations established by Drs. Rudolph and Tavel. Claimant testified that he was not supposed to lift or squat and that he could work in a position where he was sitting or standing, but this was for limited periods of time. Claimant also testified that he was supposed to be permitted a ten (1) minute break for every one (1) hour of work. To this extent Claimant testified that his employment prior to Steel Technologies provided "very minimum" sitting while serving as an assembler.

Recross Examination

Claimant testified that his previous employment, which included jobs as an assembler for Steel Related Technologies and Petting House, afforded him only about one (1) hour per shift to complete his duties in a seated fashion. However, when presented with his deposition transcript Plaintiff acknowledged he previously testified to spending half of his time seated with the other half standing over a twelve (12) hour shift as an assembler, which also required no lifting.

Summary of the Medical Evidence

Claimant was initially seen on May 2, 2012 at Coastal Occupational Medicine by Dr. Byron Williams with complaints of right knee pain. Following multiple visits to Dr. Williams Claimant was eventually referred to Dr. Harry Rudolph on account of continued complaints of pain. Claimant was eventually seen, on July 24 2012, by Dr. Rudolph who ordered an MRI, which eventually confirmed the presence of a meniscus tear. On July 24, 2012, Dr. Morrison noted that Claimant denied any back or hip pain at that time. (APA p. 215) On account of the findings of the MRI, Claimant underwent a partial medial meniscectomy on October 2, 2012. (APA p. 224) When Claimant returned on October 10, 2012, Dr. Rudolph noted a significant amount of swelling. (APA p. 210) By the time he returned on October 21, 2012, Dr. Rudolph noted a significant amount of swelling all the way down to his foot after his knee surgery. He also noted that there was a "deathly difference between the right leg and the left leg." That the leg below the knee was a problem (APA. P. 208) By November 28, 2012 Dr. Rudolph had made a referral to a vascular doctor, Dr. Morrison, and noted on December 19, 2012 that there were chronic swelling and skin changes after the surgery. (APA p. 204) Following the prescribed course of treatment established by Dr. Rudolph, Claimant was found to have reached maximum medical improvement on February 19, 2014 for the knee issue.

Upon examining the Claimant, Dr. Morrison recommended he undergo the closure of his right greater saphenous vein, which was completed on February 14, 2013. Despite the procedure Claimant continued to experience swelling and his treatment was eventually transitioned to Dr. Tavel for ongoing pain management. Eventually, Dr. Tavel opined that Claimant had, from a pain management perspective, achieved maximum medical improvement as well.

On March 19, 2014 Dr. Morrison completed a questionnaire from the Employer's attorney and in that questionnaire, Dr. Morrison indicated to a "reasonable degree of medical certainty" that

Claimant was diagnosed as having venous stasis disease and edema, that the knee injury likely exacerbated his underlying venous reflux disease, that the condition and underlying vascular surgery was as a direct result of the work injury in that the venous closure procedure was done to help improve the pain and edema which was "worsened by the knee injury," that the lymphedema is related to Claimant's work injury in that "the lymphedema and venous stasis disease was exacerbated by the knee injury, however; he likely had malfunctioning venous valves prior to injury." That he referred Claimant to Dr. Tavel for pain management and that the referral was related to the work injury because "the work injury can cause reflex sympathetic dystrophy." (APA. 237) In a later deposition, Dr. Morrison denied that the resulting venous stasis and edema condition was work related. On November 14, 2014, Dr. Gabor Winkler, a vascular surgeon, reviewed the medical evidence and opined to "a reasonable degree of medical certainty" that Mr. Brown's chronic swelling is a direct result of the work injury to his right knee, that the impact of the injury could have caused the immediate swelling as well as the ultimately resulting permanent swelling. That the surgery was further worsened by the arthroscopic knee surgery. He also opined to a reasonable degree of medical certainty that the impairment due to the swelling in the right leg is and will remain a permanent problem and disability for Claimant and that even with lymphedema therapy, compression, therapy, and weight loss some level of improvement in his symptoms can be achieved, it is extremely unlikely that he will return to normal function and that his permanent disability is as a direct result of his work injury. (APA p. 239) Dr. Alan, the orthopedist that evaluated Claimant also agreed.

Based on the stipulations of the parties, the testimony and evidence received and produced at the hearing, as well as my personal observation of the witnesses, the undersigned Commissioner finds the following facts based upon the preponderance of the evidence:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Steel Technologies, as the Employer, and Twin City Fire Insurance Company as the Carrier.

2. Counsel for both parties received order instructions on November 9, 2015.

3. Claimant sustained an admitted injury to his right knee arising out of and in the course and scope of his employment on April 30, 2012.

4. Claimant's knee injury was specifically a torn medial meniscus for which he required a partial medial meniscectomy on October 2, 2012.

5. Claimant's need for a partial medial meniscectomy was causally related to the admitted injury occurring on April 30, 2012.

6. Claimant alleged additional injuries, which included a vascular condition of the right lower extremity, the right hip, and lower back.

7. Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom.

8. Claimant underwent various treatments and evaluations with multiple physicians for his work related and alleged causally related injuries, including surgery.

9. Dr. Rudolph found Claimant to be at maximum medical improvement for his knee injury on February 19, 2014 with a noted 13% impairment of the right lower extremity.

10. Dr. Rudolph's impairment rating was noted to include an increase for the Claimant's swelling.

11. I find that Claimant has satisfied his burden of proof relative to the causal connection between his work related accident and the resulting knee injury, which required a partial medial meniscectomy.

12. The medical records support my determination that Claimant sustained an injury by accident arising out of and in the course of his employment to his right knee.

13. I give the greatest weight to the findings of the authorized treating physicians, which included Dr. Rudolph, Dr. Morrison and Dr. Tavel as well as the deposition testimony proffered by Drs. Morison and Dr. Tavel.

14. Based on the greater weight of the evidence, I find that the Claimant's vascular condition was not caused, activated, or aggravated by the compensable right knee injury or the treatment received as a result of said injury.

15. Based on the greater weight of the evidence, I find that the additional injuries alleged by Claimant as to the right hip and lower back, are attributable to his altered gait, which was the direct result of his lymphedema, which I have already found to be unrelated to the admitted injury of April 30, 2012.

16. Based on the greater weight of the evidence, I find that Claimant reached maximum medical improvement for his admitted injury to his right knee on February 19, 2014.

17. Claimant is entitled to an award of 12% permanent partial disability to his right leg for this admitted injury.

18. Lacking a definitive opinion from Dr. Rudolph relative to future medical treatment for Claimant's admitted injury; I find that Claimant is not entitled to future medical care.

19. I find that Defendants are entitled, as of the date of this hearing, to terminate temporary total disability compensation on account of my having found Claimant to be at maximum medical improvement on February 19, 2014.

20. I find that Defendants are not entitled to any credit for overpayment for compensation paid from the date of maximum medical improvement until the date of this hearing as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.

21. I find that Defendants are also not entitled to any credit for overpayment for compensation paid between the date of this hearing and the date the Order Instructions were issued as Defendant's did not at any time raise S.C. Code Ann. § 42-9-210.

CONCLUSIONS OF LAW

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. S.C. Code Ann. § 42-1-120 defines disability.
2. S.C. Code Ann. § 42-1-160 defines injury. Pursuant to this statute, Claimant suffered an injury by accident arising out of and in the course of his employment to his right knee.
3. S.C. Code Ann. § 42-9-200 provides for temporary disability benefits. Pursuant to this section, Claimant is entitled to temporary total disability benefits from the period of May 2, 2012, to February 19, 2014.
4. S.C. Code Ann. § 42-9-210 affords Defendants a deduction from the amount of compensation to be paid when disability payments were made when they were not due and payable. Pursuant to this statute Defendants are not entitled to a deduction from compensation

payable as this section was not pled and Defendants did not proceed with a Form 21, Request for Hearing to Stop Compensation.

5. S.C. Code Ann. § 42-15-60 provides for the provision of medical treatment to injured workers. Claimant is not entitled to continuing medical treatment with regards to the compensable injury to his right knee.

6. S.C. Code Ann. § 42-1-40 and Reg. 67-1603 set forth appropriate methods for calculating the average weekly wage and compensation rate. On this basis, Claimant's average weekly wage is \$856.52, with a compensation rate of \$571.04.

ISSUE ON APPEAL

Defendants raised 5 exceptions to the single commissioner's Decision and Order in the Form 30 Request for Commission Review. While preserving all 5 exceptions and incorporating them herein by reference, for clarity and brevity, the exceptions have been consolidated into the following issues on appeal:

1. Did the single commissioner err in finding that Claimant was not permanently and totally disabled when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
2. Did the single commissioner err in finding that Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
3. Did the single commissioner err in finding that Claimant is entitled to an award of 12% permanent partial disability to his right leg, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
4. Did the single commissioner err in finding that Claimant is not entitled to future medical treatment, when such a finding was against the greater weight and preponderance of

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reliable and substantial evidence in the record and is based on erroneous legal conclusions?

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ARGUMENTS

1. Did the single commissioner err in finding that Claimant was not permanently and totally disabled when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

ck driver
np knee

priors This truck driver suffered a knee injury from bumping his knee on a truck trailer, which
it for" resulted in 1. an immediate swollen knee with arthroscopic right knee surgery and partial
immediate medial meniscectomy, 2. subsequent and continuous chronic post-operative swelling of the
chronic right knee, leg and foot despite great vein ablation and compression therapy by a vascular
surgery ck, hip surgeon, lymphedema treatments and pain management 3. back and hip pain from his altered
rec only gait. Based on his resulting ratings, functional limitations and vocational assessments,

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Claimant asked the single commissioner to find him permanently and totally disabled.

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The single commissioner made a finding that the knee was causally related to the work injury. He did not find the lymphedema/chronic swelling causally related to the work injury or the back and hip. It is the Claimant's position that but for the work injury, he would not have needed treatment or the surgery and thus the resulting excessive swelling would not have occurred. For the Single commissioner to now deny this vascular condition is unjust.

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Under our law, the employer takes you as he finds you and is responsible for every problem he causes or makes worse.

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Dr. Morrison, the authorized treating physician at Coastal Vascular and Vein Center, opined that the Claimant has venous stasis disease caused by malfunctioning venous valves that were present prior to the work injury and that the irreversible edema in his surgical leg post surgery is not work related but was probably a pre-existing condition that was dormant until it was exacerbated/aggravated by the work injury. (Claimant's APA p. 236) (Dr. Morrison's Dep.

see from
had
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arthroscopy
p. 12 lines 22-25, p. 13 lines 1-8, p. 44 line 25, p. 45 lines 1-19) Dr. Gabor A. Winkler, at McLeod Physician Associates, agreed to see Claimant for an independent medical evaluation and opined that the chronic swelling in the surgical leg is a direct result of the work-related injury that he sustained and the subsequent surgery that was necessary. (Claimant's APA p. 249)

Although we have two vascular specialists with different views as to how the swelling occurred, one with the opinion that Claimant had a pre-existing condition that is now causing the edema in the surgical leg and the other with ^{the} opinion that the injury and subsequent surgery caused the surgery), it is the Claimant's position that either opinion supports a finding including the vascular condition as a causal link to the work injury. If you conclude that the venous condition was pre-existing, South Carolina's workers' compensation laws do not punish employees for their pre-existing conditions. The law expressly provides that an injured worker may recover benefits if the pre-existing condition was aggravated by a work-injury.

It is true workers' compensation claims can become more complicated when they are related to pre-existing conditions or contributing illnesses. For example thyroid disorders, diabetes, blood disease, anemia and hypertension are examples of "contributors" or pre-existing conditions that may impact a workers' health or ability to recover after an injury. Although these medical conditions have the potential to drive up claim costs and extend recovery time, the injured worker should not be punished for it. The applicable workers' compensation statute is listed below:

SECTION 42-9-35. Evidence of preexisting injury or condition.

(A) The employee shall establish by a preponderance of the evidence, including medical evidence, that:

(1) the subsequent injury aggravated the preexisting condition or permanent physical impairment; or

(2) the preexisting condition or the permanent physical impairment aggravates the subsequent injury.

(B) The commission may award compensation benefits to an employee who has a permanent physical impairment or preexisting condition and who incurs a subsequent disability from an injury arising out of and in the course of his employment for the resulting disability of the permanent physical impairment or preexisting condition and the subsequent injury. However, if the subsequent injury is limited to a single body part or member scheduled in Section 42-9-30, except for total disability to the back as provided in Section 42-9-30(21), the subsequent injury must impair or affect another body part or system in order to obtain benefits in addition to those provided for in Section 42-9-30.

(C) As used in this section, "medical evidence" means expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed health care provider.

(D) The provisions of this section apply whether or not the employer knows of the preexisting permanent disability.

(E) On and after the effective date of this section, an employee who suffers a subsequent injury which affects a single body part or member injury set forth in

Section 42-9-30 is limited to the recovery set forth in that section.

HISTORY: 2007 Act No. 111, Pt I, Section 19, eff July 1, 2007, applicable to injuries that occur on or after that date.

Despite the above statute and Dr. Winkler's causation theory, the single commissioner found that the resulting lymphedema and resulting back and hip pain were not causally related to this work injury. To be more thorough, on July 24, 2012 Claimant saw Dr. Rudolph, an orthopedic specialist. Dr. Rudolph noted swelling in the lower extremity and noted that Claimant had no back or hip pain at the time. (Claimant's APA p. 215) On October 2, 2012, Claimant had right knee surgery. (Claimant's APA p. 224) When he returned to Dr. Rudolph on October 10, 2012 Dr. Rudolph noted a significant amount of swelling. (Claimant's APA p. 210) By the time he returned on October 31, 2012 Dr. Rudolph noted a significant amount of swelling all the way down to his foot after his knee surgery. He also noted that there was a "deathly difference between the right leg and the left leg," and that the leg below the knee was a problem (Claimant's APA. P. 208) By November 28, 2012, Dr. Rudolph had made a referral to a vascular doctor, Dr. Morrison, and noted on December 19, 2012, that there was chronic swelling and skin changes after the surgery. (Claimant's APA p. 204) On March 19, 2014, Dr. Morrison completed a questionnaire from the Employer's attorney and in that questionnaire, Dr. Morrison indicated to a "reasonable degree of medical certainty" that Claimant was diagnosed as having venous stasis disease and edema, that the knee injury likely exacerbated his underlying venous reflux disease, that the condition and underlying vascular surgery was as a direct result of the work injury in that the venous closure procedure was done to help improve the pain and edema which was "worsened by the knee injury," that the lymphedema is related to Claimant's work injury in that "the lymphedema and venous

stasis disease was exacerbated by knee injury, however; he likely had malfunctioning venous valves prior to injury" He indicated that he referred Claimant to Dr. Tave for pain management and the referral was related to the work injury because "the work injury can cause reflex sympathetic dystrophy." (Claimant's APA. 237) In a later deposition, Dr. Morrison denied that the resulting venous stasis and edema condition was related to the surgery but maintained his position that the vascular condition was probably aggravated by the work injury. (Dr. Morrison Dep. p. 12 lines 22-25, p. 13 lines 1-8, p. 44 line 25, p. 45 lines 1-19) In his deposition, Dr. Morrison noted that Claimant has a significantly edematous and swollen leg and that his working diagnosis was that Claimant had edema of multifactorial origin, lymphatic and venous disease with the primary cause of his edema being venous disease and truncal obesity. (Dr. Morrison Dep. p. 7, lines 16-20, p. 9, line 20-25, p. 10, lines 1-2)) On November 14, 2014, Dr. Gabor Winkler, a vascular surgeon, reviewed the medical evidence and opined to "a reasonable degree of medical certainty" that Mr. Brown's chronic swelling is a direct result of the work injury to his right knee, that the impact of the injury could have caused the immediate swelling, as well as the ultimately resulting permanent swelling. He further stated that the swelling was further worsened by the arthroscopic knee surgery and he opined to a reasonable degree of medical certainty that the impairment due to the swelling in the right leg is and will remain a permanent problem and disability for Claimant and that even with lymphedema therapy, compression, therapy, and weight loss, some level of improvement in his symptoms can be achieved, it is extremely unlikely that he will return to normal function and that his permanent disability is as a direct result of his work injury. (Claimant's APA p. 239) Dr. Alan, the orthopedist that evaluated Claimant agreed. Dr. Alan opined that the knee condition is a direct result of the work injury and that

the vascular impairment of the right lower extremity is also causally related to the work injury as an unanticipated complication of the treatment for his injury. (Claimant's APA p. 254)

As for causation for the hip, on examination Dr. Ahearn noted that Claimant's gait in and out of the brace was strongly right antalgic with a right hip lurch and with shortened right foot stance. (Claimant's APA p.4) On Dr. Ahearn's APA p.5, Dr. Ahearn noted that all opinions he rendered in his report are most probable with a reasonable degree of medical certainty, that pain to the back is authorized and being managed by Dr. Tavel, a pain specialist. (Claimant's APA pp. 31 and 38) Physical therapy records as early as March 29, 2013 note abnormality of gait. (Claimant's APA p. 138) On February 18, 2013 Claimant complained to the vascular doctor of back and hip pain. (Claimant's APA p. 158 and p. 160) On March 20, 2013 Claimant told the orthopedist, Dr. Rudolph, that his pain has radiated up to his back and hip and he noted that Claimant was walking with a significant limp. (Claimant's APA p. 198) The Defendants accepted and paid for treatment to the hip. up

As for causation for the back, on examination, Dr. Ahearn, the orthopedist, noted that Claimant's lumbar motion was limited to fingertips even with knees only and with very little reversal of the lumbar curve and that there was midline L3-L5 spinal tenderness, palpable low paralumbar muscular spasm, and right sciatic notch tenderness. (Claimant's APA pp. 4, 5) back
Dr. Ahearn noted that all opinions he rendered in his report are most probable with a reasonable degree of medical certainty. He noted that pain to the back is authorized and being managed by Dr. Tavel, a pain specialist. (Claimant's APA pp. 31,38, 184) Physical

Therapy records as early as March 3, 2013 noted abnormality of gait. (Claimant's APA p. 138) On December 16, 2013 Claimant made complaint of back pain in addition to hip, leg and foot pain. (Claimant's APA p. 149) Dr. Alan, the orthopedist, agreed with causation and opined that the Claimant's lumbar radiculopathy is causally related to his work injury as an exacerbation and/or acceleration of the normal degenerative process of the lumbar spine secondary to severe gait impairment. (Claimant's APA p. 254) The defendants accepted and paid for treatment to the back.

Following the above treatment, ratings and restrictions were assigned as follows: Claimant received a 60% permanent impairment to the lower extremity for lymphedema with sedentary work restrictions including no lifting, pushing, pulling, squatting, kneeling, crawling and no continuous sitting or standing greater than 1 hour at a time without a 10 minute break and no climbing ladders or stairs. (Dr. Tavel WCC Form 14B, Claimant's APA p. 97) Dr. Ahearn agreed. (Claimant's APA p. 3) Dr. Ahearn assigned a 15% permanent impairment to the knee, (Claimant's APA p. 5) 12% permanent impairment to the hip for mild hip arthritis that became symptomatic from antalgic gait, (Claimant's APA p.6) and a 5% whole person permanent impairment for L5-S1 disc desiccation with contained circumferential annular tear in the mild broadly bulging disc (Claimant's APA p. 6 and Dr. Rudolph at Claimant's APA p. 191) Because of the death of Dr. Ahearn during this case, Claimant was evaluated by Dr. Rodney K. Alan on April 30, 2012. The ratings assigned by Dr. Alan were 3% whole person for chronic pain, 60% right lower extremity for chronic lymphedema, 7% for right knee for the residual patellar instability and 2% to the right lower extremity for partial meniscectomy. He also assigned a 5% whole person rating to the lumbar. His total whole person rating

assigned was 33%. (Claimant's APA p. 253) Dr. Alan noted that the Claimant is restricted to sedentary work but it may not be feasible given Mr. Brown's chronic opioid dependence.

(Claimant's APA p. 254)

Vocational assessments are as follows: Fi Fi Jubran, Claimant's vocational expert, opined that his work history has been heavy in exertion, but because of Dr. Tavel's sedentary work restrictions, it is highly unlikely he will be able to find or sustain employment and she does not believe a reasonable stable market exists for Claimant and she believes he is unemployable. (Claimant's APA pp. 10-11) If by chance he could find sedentary work which she feels is highly unlikely, he would be limited to wages of \$7.25 per hour. She believes because Dr. Tavel has indicated Claimant will need 10 minute breaks after sitting for an hour, that would be an accommodation most employers would not be willing to tolerate.

(*id.*) Robert E. Brabham, Employer's own vocational expert, opined that "[a]t the time of this evaluation, it was apparent that due to the profound lower extremity swelling, he is experiencing limitations in sitting and standing of such severity that as yet, even any sedentary work, which might otherwise have been suggested, is precluded." (Defendant's APA pp. 10-11)

2. Did the single commissioner err in finding that Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Please see Argument 1. In the event that the Full Commission does not find that Claimant is permanently and totally disabled, then it is Claimant's position that his vascular condition and associated hip and back pain are casually related to the work injury and adopts the arguments for the same in Argument 2 as if listed here verbatim.

Did the single commissioner err in finding that Claimant is entitled to an award of 12% permanent partial disability to his right leg, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

In the event that the Full Commission finds that the Claimant is not permanently and totally disabled, it is Claimant's position that his permanent impairment rating is higher than 12% based on the assigned impairment ratings depicted by the doctors in Argument 1 above and adopted verbatim in this argument.

Did the single commissioner err in finding that Claimant is not entitled to future medical treatment, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

Future medical care was addressed as follows:

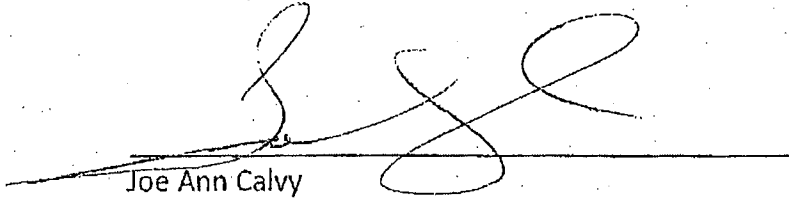
Claimant will need pain medications including compounding cream, DME equipment, liver and kidney function tests yearly if using chronic NSAIDs or narcotics containing acetaminophen, further knee surgery. (Tavel 14B p. 97, Rudolph p.187) Claimant "has had the worst result that he can have status post a medial meniscal tear." (Rudolph p.187) Dr. Alan noted that future treatments for Mr. Brown include ongoing lymphedema evaluation and treatment, future treatment for knee arthritis status post meniscectomy, ongoing pain management, durable medical equipment including a cane, brace for the knee and lumbar support. (Claimant's APA p. 254) Dr. Morrison indicated in his deposition that significant weight loss to the tune of an 80-100 pound weight loss coupled with exercise and expensive monthly lymphatic pumps and lymphatic massages would be recommended for future improvement of the medical condition. (Dep p. 56 lines 5-25, p. 57 lines 1-7) In addition, Dr. Morrison also testified that only 10% to 20% of his patients with chronic lymphedema who loses the recommended weight will get better and that those with the most significant improvement will have to include weight loss, exercise and lymphatic pumps and lymphatic massages in their routine. (Dep. p. 33 lines 3-25, p. 34 lines 1-p. 35 lines 1-12) Dr. Morrison went on to say that chronic massage is a chronic condition and most people are going to need treatment once a month usually for a life, that it is rare that someone gets lymphatic massage and is cured. They get better, the fluid is cleared. They can utilize the stocking and they can function better but it is a long term problem. (*Id.*)

Added

CONCLUSION

Claimant prays that the Commission makes findings consistent with the above arguments.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Joe Ann Calvy", is written over a horizontal line.

Joe Ann Calvy
P. O. Box 610
Kingstree, S. C 29556
843-354-9000
Attorney for Employee

Kingstree, S. C.
March 17, 2016

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Employee/Appellant,
v.
Steel Technologies,
Employer,
and
Hartford Accident & Indemnity Co.,
Carrier,
Respondents.

RESPONDENT'S BRIEF

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. It was as a result of this injury that Claimant was recommended for and did undergo a partial medial meniscectomy. However, a dispute arose as to the question of causation with respect to certain other conditions Claimant alleges to have been related to this claim and the resulting injury and/or treatment. Specifically, Claimant presented an allegation that a vascular condition was aggravated or activated as a result of the original knee injury, the resulting surgery or both. Claimant further alleged that as a result of the chronic lymphedema experienced in his right lower extremity he began to suffer hip and low back pains. Claimant alleged that he was permanently and totally disabled under S.C. Code Ann. § 42-9-10 on account of the injury to one body part with an affect to others. Defendant's admit compensability of the right knee injury and accept the partial medial meniscectomy as related but denied compensability of all other conditions or affected body parts. Therefore,

Defendants submit that in accordance with the prevailing law on account of an injury to a scheduled member Claimant's recovery is solely and exclusively confined to S.C. Code Ann. § 42-9-30.

Defendants contended the physician most familiar with Claimant's vascular condition, Dr. Edward Morrison, concluded under oath in a deposition that Claimant's vascular condition was not related to this claim. Specifically, Dr. Morrison both in the face of direct examination and cross-examination concluded the vascular condition did not occur as a result of the injury or resulting treatment nor was it aggravated or exacerbated by the knee injury or surgery. In fact, Dr. Morrison described with particularity why it was implausible, thus lacking medical certainty, that the meniscal tear or resulting arthroscopic surgery could have affected Claimant's vascular condition. Due to the conclusions of Dr. Morrison and the opinions of other physician's it was argued by Defendants that the hip and back were likewise unrelated. It had been established throughout the evidence that the hip and back issues were occasioned by an alteration of Claimant's gait, which was noted to be a direct result of Claimant's chronic lymphedema. Given the lack of a causal connection between the lymphedema and the underlying claim any issues flowing therefrom must too be found unrelated thus not compensable.

The hearing took place before Commissioner R. Michael Campbell, II on February 6, 2015 in Isle of Palms, South Carolina. Commissioner Campbell, on November 9, 2015, issued his order instructions in this matter. Specifically, Commissioner Campbell noted Claimant sustained a compensable injury to his right knee, which resulted in a partial medial meniscectomy. Commissioner Campbell further found that Claimant had, as to the right knee injury, achieved maximum medical improvement on February 19, 2014. Commissioner Campbell finally concluded, as to the right knee injury, that Claimant had sustained 12%

permanent partial disability to his right lower extremity and that no physician had required any future medical treatment. However, Commissioner Campbell ruled Claimant's vascular condition, right hip, and lower back conditions were not caused, activated or aggravated by his right knee injury. Based upon these conclusions Commissioner Campbell found Claimant was not permanently and totally disabled given the injury only involved one body part.

Claimant appealed this ruling by Commissioner Campbell.

QUESTIONS PRESENTED BY APPELLANT

- I. Did the single commissioner err in finding that Claimant was not permanently and totally disabled when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
- II. Did the single commissioner err in finding that Claimant's alleged additional injuries for the vascular condition and associated right hip and lower back are not supported by the greater weight of the evidence and thus are not casually related to the admitted injury of April 30, 2012 or treatment occurring as a result therefrom, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
- III. Did the single commissioner err in finding that Claimant is entitled to an award of 12% permanent partial disability to his right leg when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?
- IV. Did the single commissioner err in finding that Claimant is not entitled to future medical treatment, when such a finding was against the greater weight and preponderance of reliable and substantial evidence in the record and is based on erroneous legal conclusions?

LAW and ANALYSIS

- I. The single commissioner did not err in finding that Claimant was not permanently and totally disabled.
- II. The single commissioner did not err in finding that Claimant's alleged additional injuries for the vascular condition and right hip and lower back were not supported by the greater weight of the evidence and thus are not causally related to the admitted injury of April 30, 2012.

Respondent addresses Appellant's first and second questions presented together as the two are so intertwined. An injured worker may, under two separate statutes argue for permanent and total disability. First, a claimant may argue such a status under S.C. Code Ann. § 42-9-10, which requires, at a minimum, a showing of an injury to one body part with an affect on one or more additional body parts. The second statute under which a claimant may pursue permanent and total disability, which is most commonly known as the scheduled member section, is S.C. Code Ann. § 42-9-30(21). Specifically the foregoing schedule member section requires evidentiary proof that a claimant has sustained "fifty percent or more loss of use of the back" to be entitled to a presumption of permanent and total disability.

It is generally accepted, in order to maximize recovery, a claimant may choose to proceed under either the general disability sections, S.C. Code Ann. §§ 42-9-10 or 42-9-20, or the scheduled member section, S.C. Code Ann. § 42-9-30. *Lee v. Harborside Cafe*, 350, S.C. 74, 564 S.E.2d 354 (Ct.App. 2002). However, where there is only evidence of a scheduled loss, without a showing of an additional complication to another body part, then the Courts have held scheduled recovery is exclusive. *Id.* In the instant case Claimant exercised his right to proceed under all available sections in an effort to maximize his recovery. However, Defendants maintained this was a case where the scheduled recovery under S.C. Code Ann. § 42-9-30 was exclusive given the only injury related to this claim was to Claimant's right lower extremity.

Claimant asserts that he sustained, in addition to the admitted injury to his right knee, a vascular condition diagnosed as chronic lymphedema and related issues with his right hip and back. Claimant, in support of his causation theories, relied nearly exclusively on the opinions of independent medical examinations elicited by his attorney in lieu of those proffered by the treating physicians. Specifically, Plaintiff challenged the causation opinions

of, vascular surgeon, Dr. Edward Morrison with opinions of Dr. Gabor Winkler as to the issue of Claimant's lymphedema. The issues with Claimant's reliance on the opinions by Dr. Winkler are many, but perhaps none more glaring than he saw Claimant on only one occasion for an independent medical examination on November 14, 2014, which was nearly two and one half years after the original knee injury. Perhaps equally problematic for Claimant's causation issue was the medical evidence presented by the Defendant, which came largely in the form of the depositions of Dr. Edward Morrison and Dr. Edward Tavel. Dr. Morrison was the vascular surgeon who was most familiar and most involved with Claimant's lymphedema as he was the first vascular surgeon involved and the one who performed the greater venous saphenous closure. Dr. Morrison was directly and cross-examined by both attorneys answering some very pointed questions on the issue as follows:

Q: Is it your opinion, in Mr. Brown's case, that his current condition is directly attributable to the arthroscopy that he underwent?

A: His current condition of venous disease and lymphatic disease is attributable to the arthroscopy?

Q: Yes, sir.

A: No.

See Deposition of Dr. Morrison, P. 12, ll. 9-17.

A: in my experience, chronic lymphedema does not result from a single meniscus tear and repair.

See Deposition of Dr. Morrison, P. 37, ll. 5-7

Q: is it your testimony to a reasonable degree of medical certainty that the treatment that you are providing to Mr. Brown is not work related at all?

...

Q: Do I [sic] think it's related to his work injury? Are you treating because of ...

A: No, ma'am. I do not think so.

See Deposition of Dr. Morrison, P. 38, ll. 3-19.

A: Do I think it's a major surgery that's going to precipitate a massive edema, I do not.

See Deposition of Dr. Morrison, P. 44, ll. 14-16.

A: Now, I don't even have the orthopedic results, but was a knee trauma, and maybe one of y'all could tell me about that, you know, a meniscus tear, which you can do walking the hall, did that precipitate his edema? In my opinion, ma'am, it did not precipitate his edema.

See Deposition of Dr. Morrison, P. 45, ll. 13-19.

Simply put there was no question as to Dr. Morrison's stance on any perceived causal connection between Claimant's right knee injury or resulting surgery and the chronic lymphedema he was treating. Moreover, Dr. Morrison, based upon his familiarity with Claimant and his treatment was in the best possible position to evaluate and comment on the causal relation thus his deposition should have been afforded the greatest weight in this regard. Dr. Winkler, as previously noted, was retained at the expense of Claimant's counsel for the sole and exclusive purpose of commenting on causation though his retention came more than two and one half years after the work related accident and without the benefit of any involvement in his care.

Based upon the nature of the argument presented in the Appellant's Brief it would appear he contends an error occurred simply because he had, in terms of simple numbers, more opinions finding causation than Defendants did in opposition. However, the sheer volume of opinions is of little consequence when determining which evidence should be afforded the greater weight. In fact it is well settled "the Commission is given discretion to weigh and consider *all* the evidence, both lay and expert, when deciding whether causation has been established." *Tiller v. National Health Care Center of Sumter*, 334 S.C. 333, 339-40, 513 S.E.2d 843, 846 (1999); (see *Ballenger v. Southern Worsted Corp.*, 209 S.C. 463, 40

S.E.2d 681 (1946)). Likewise, such testimony is not always dispositive on the issue of causation as the Court noted “[e]xpert medical testimony is designed to aid the Commission in coming to the correct conclusion; therefore, the Commission determines the weight and credit to be given to the expert testimony.” *Id.*; (see *Poston v. Southeastern Construction Co.*, 208 S.C. 35, 36 S.E.2d 858); (see also *Hines v. Pacific Mills*, 214 S.C. 125, 51 S.E.2d 383 (1949). In this case Appellant cannot simply stand on the presumption that he has more opinions than Defendants, as that does not equate to substantial evidence when the contradictory opinion deserves the greatest weight. Defendants have produced the opinion of the physician most closely involved with Claimant’s treatment, for the longest period of time and in the most impactful manner as it was proffered under oath and subjected to cross-examination by Claimant’s counsel. It was the decision of the single commissioner to assign the specific weight to the submitted medical opinions and his conclusion is directly supported by sufficient evidence submitted by Defendants and as such was not afoul of the substantial evidence rule.

Respondents turn their attention to Appellant’s assertion that he has also had an affect to his right hip and lower back as indicated in the medical records where has been documented to complain of such issues. However, the Appellant’s complaints relate, as it appears in the evidence, to pertain to his altered gait, which has been attributed to the excessive swelling in his leg. More specifically, there are conclusions rendered by the Dr. Mason Ahearn who was again retained by Appellant’s Counsel, that the hip and back were a direct result of his altered gait, which bore a direct connection to the severe swelling in his lower extremity. (Claimant’s APA # 1, p. 5). It is important here to note that the Independent Medical Evaluation completed by Dr. Ahearn was not undertaken until July 15, 2014 thus he had, until that date, absolutely no familiarity with the injury, treatment, or Claimant himself.

He rendered these conclusions based exclusively on his one time appointment with the Appellant. The absence of familiarity with more than two years of Appellant's care is significant in determining the weight, if any, to afford the opinion of Dr. Ahearn. Moreover, as indicated by the Appellant's Brief they elicited no opinions from any of the treating physicians on the issue of causation, which is directly resulting from the absence of any treatment, by Respondents, for these alleged conditions.

Appellant has, in his brief, attempted to taint this case with patently false assertions in an effort to convince this Commission of the causation of the hip and back. Specifically, Appellant has alleged, "[t]he Defendants accepted and paid for treatment of the hip." Appellant makes a similar assertion as to the back when claiming, "[t]he Defendants accepted and paid for treatment to the back." Appellant has presented no tangible evidence that would support these blanket, and false, assertions as to accepting and paying for treatment of body parts unrelated to this claim. In fact, the record has evidence that completely contradicts these claims by and through the deposition testimony of Dr. Edward Tavel. Counsel for Appellant actually inquired as to whether or not Dr. Tavel is "actively treating his back" to which Dr. Tavel responded flatly "no." (See Deposition of Dr. Tavel, P. 22, ll. 12-14). Furthermore, Dr. Tavel notes that he had never rendered any opinion on causation of the back. Finally, and most compelling is Appellant's own statement during this deposition wherein he interjected by stating "[t]hey never approved it, workman's comp." (See Deposition of Dr. Tavel, P. 23, ll. 8-9). Based upon Appellant's own words it is readily clear that there was never any acceptance of or treatment for his alleged back and hip issues. Furthermore, in the notes and deposition of Dr. Tavel it was always noted the hip pain was referred pain from the lower back as opposed to the assertion by Respondent that it was gait related. Dr. Tavel was merely retained by Dr. Morrison to evaluate for the possibility of reflex sympathetic dystrophy,

which was ruled out. To the extent Claimant asserts his hip and back were a result of an altered gait this was an issue also covered by Dr. Morrison in his deposition when he noted the swelling could "absolutely" lead to an alteration of his gait. Respondents thus submit that there is a substantial amount of credible evidence in this case to support the finding of the single commissioner that the hip and back were also not causally related to the accepted knee injury. In fact, the evidence presented from physicians who were actually involved in his care seems to support the notion that the swelling was unrelated and the hip and back pains, if as a result of an altered gait were a byproduct of the unrelated swelling.

Therefore, in summary, Respondents argue that substantial evidence existed to support the decisions of the single commissioner as to the purported affects to other body parts and unrelated vascular conditions. Based upon the prevailing law the absence of any other affected body parts would lead to recovery being exclusively confined to the scheduled member section of S.C. Code Ann. § 42-9-30. Moreover, due to the fact that the scheduled body part involved was not the back, as in subsection 21, this case cannot be found to result in a permanent and total disability.

III. The single commissioner did not err in finding that Claimant is entitled to an award of 12% permanent partial disability to his right leg.

As indicated above Respondent notes the decision rests exclusively with the commissioner as to how the admitted evidence is to be evaluated. Specifically, the medical evidence submitted is only to be utilized to aid the commissioner and is not dispositive of any one particular issue. In this case Appellant points in his brief only to those opinions he believes support his argument that the hearing Commissioner erred. In a manner similar to all other arguments made Appellant seeks to rely almost exclusively to those independent medical examinations arranged for by his counsel as the brief focuses exclusively on the ratings from Dr. Mason Ahearn and Dr. Rodney K. Alan. It is uncontroverted that neither Dr.

Ahearn nor Dr. Alan had any role or involvement in Appellant's treatment but rather each only evaluated him on a one-time occasion. Dr. Ahearn's independent medical examination was completed July 16, 2014 and Dr. Alan's was completed December 31, 2014. In fact, Respondent acknowledged that at least in the visit to Dr. Alan he spent only approximately one hour with him, but Appellant seeks to rely on his opinion as the evidence to challenge the finding of the single commissioner.

Admitted into evidence in this case was the opinion of Dr. Harry Rudolph who was the orthopedic who performed the surgery on Appellant's injured right knee. On July 17, 2014 Dr. Rudolph responded to a questionnaire noting he had assigned a 13% impairment to the right lower extremity based upon Table 16-3 of the AMA Guides for Evaluation of Permanent Impairment, which he contended addressed a meniscus injury. Respondent notes that Table 16-3 deals with the upper extremity as opposed to the lower extremity. Specifically, Dr. Rudolph referenced Appellant's meniscal injury but gave him the highest number he could because of the vascular injury. (Claimant's APA #12, p. 234). The AMA guides to Evaluation of Permanent Impairment, table 17-33, note that the surgery undergone by Appellant, a partial medial meniscectomy, result in an estimated impairment of 2% to the lower extremity. Furthermore, it is readily apparent, based upon the statements of Dr. Rudolph that his rating was significant increased due to the vascular injury, which Dr. Morrison opined was not causally related to the knee injury. The evidence submitted in this case was substantial evidence in support of the single commissioner's finding that there was 12% permanent partial disability to the right lower extremity thus this ruling was not in error.

IV. The single commissioner did not err in finding that Claimant is not entitled to future medical treatment.

The single commissioner specifically found that "[l]acking a definitive opinion from Dr. Rudolph relative to future medical treatment for Claimant's admitted injury; I find that Claimant is not entitled to future medical care. The decision to order future medical care rests with the commissioner pursuant to S.C. Code Ann. §42-15-60. Specifically, the foregoing statute allows for additional time for the provision of medical treatment, to be ordered by the commission, provided it will "tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty." S.C. Code Ann. §42-15-60(A).

In Respondent's Brief there is merely a recitation of incidents where future medical care might have been addressed by any one of the numerous physician reports. In fact, Respondent references those opinions of Dr. Morrison and Dr. Tavel who were both discussing treatment to address the chronic lymphedema in the right lower extremity. To the extent any treatment has been discussed or recommended by either physician there is no basis to order Respondents to provide such treatment or modalities for a condition already determined to not be causally related to the admitted right knee injury. It was made explicitly clear from the holding of the Commissioner that he was looking directly to the opinion and recommendation of the authorizing orthopedic surgeon who operated on the accepted right knee. This reliance is understandable on account of it being the opinion of the person most heavily involved in his treatment.

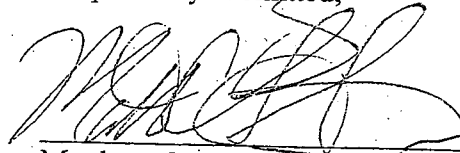
The conclusion rendered by the single commissioner points to the absence of any opinion by Dr. Rudolph being offered within a reasonable degree of medical certainty. It is noted in Finding of Fact # 18 that there was no "definitive opinion from Dr. Rudolph relative to future medical treatment." It is clear that the applicable statute requires a reasonable

degree of medical certainty as to any opinions relative to future medical needs to support a commissioner's order. Respondent directs attention to Claimant's APA 9, p. 187, which is the record in which Dr. Rudolph opined Appellant had reached MMI. In the aforementioned record Dr. Rudolph merely notes "he *may* need further surgery in this knee with a possible debridement of the medial meniscus and release of the patella. Physical therapy I think would be necessary first to see how well therapy could realign the patella with strengthening." It is clear from this opinion that it lacks any definitive certainty as he begins the assertion with the qualifier of may, which is not more likely than not but rather simply something possible but unknown or uncertain. However, the opinion of Dr. Rudolph, in this same report, is weakened even further when he notes "[a]ll of this is predicated upon the fact of getting the swelling out of the leg first. If the swelling in the leg persists I don't think any type of therapy to the knee is going to really help him." It is readily clear that a reading of the full scope of Dr. Rudolph's opinion that he is without any medical certainty as to what Respondent needs to either lessen the period or extent of disability or if any such treatment would even be plausible in the future.

CONCLUSION

A full and complete review of the record shows substantial evidence in support of the findings of the single commissioner. Despite the general assertions by Appellant there has been nothing offered in support of his contentions that the decisions were based on erroneous legal conclusions. In fact, Appellant did not even so much as present any case law to the commission to establish the basis for a contention that the single commissioner committed errors in the legal conclusions rendered. For the foregoing reason the single commissioner's Order should be affirmed with the exception of issues appealed by Employer/Carrier separately.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'M. LaFave', written over a horizontal line.

Matthew C. LaFave, Esquire

Crowe LaFave, LLC

PO Box 1149

Columbia, SC 29202

Phone: 803.724.5727

matt@crowelafave.com

Attorney for the Respondents

This 24th Day of March 2016
Columbia, South Carolina

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Claimant,

v.

Steel Technologies,
Employer,

and

Hartford Accident & Indemnity Co.,
Carrier,

Defendants.

CERTIFICATE OF SERVICE

I, Denise M. Brockwell, paralegal for Crowe LaFave, LLC, do hereby certify that I have served the **Respondent's Brief**, by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows:

Joe Ann Calvy, Esquire
P.O. Box 610
Kingstree, SC 29556

Denise M. Brockwell
Denise M. Brockwell
Paralegal

March 24, 2016

COPY

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1205647

O'Shea L. Brown.....Claimant,

vs.

Steel Technologies, Employer, and
Twin City Fire Ins. Co., Carrier.....Defendants.

APPELLANT'S (CLAIMANT'S) REPLY BRIEF

In its response to Appellant's Brief, Respondent believes despite the response from Respondent, his arguments concerning the single commissioner's error is still sufficient to support his appeal.

For clarity, the Respondent has alleged that the Appellant made false accusations with respect to the Respondent accepting and paying for medical care to the back and hip. The evidence clearly shows that the Respondent provided treatment to the back and hip. (Claimant's APA, CPM Therapy pp. 126, 134, 138, Dr. Stem at Lowcountry Ortho. pp. 24-26, Pain Specialist of Charleston pp. 36, 50)

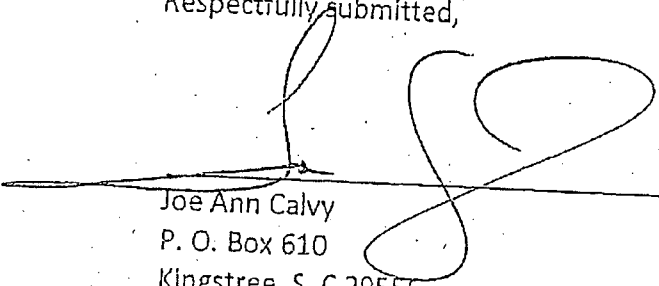
Also, respondent concluded that Appellant has not listed any case law to support the errors listed in the appeal. The Appellant alleged in the brief that either the vascular condition which he believes renders him totally and permanently disabled, was caused by the work injury or it was a pre-existing condition that was dormant until the work injury that aggravated the condition. "The claimant's right to compensation for aggravation of a pre-existing condition arises when the claimant has a dormant condition that becomes disabling because of the aggravating injury."

Anderson v. Baptist Med. Ctr., 343 S. C. 487, 493, 541 S.E.2d 526, 528 (2001) "Workers' compensation claimant who has a permanent physical impairment or preexisting condition may receive benefits for a subsequent work-related disability if he establishes by a preponderance of the evidence that the subsequent injury aggravated the preexisting condition or permanent physical impairment. Burnette v. City of Greenville (S. C. App. 2012), 401 S. C. 417, 737 S. E.2d 200, rehearing denied. Hines v. Pacific Mills, 214 S. C. 125, 51 S. E.2d 383 (1949) In all of these cases, the court made determinations as to whether a pre-existing condition (Anderson's was an alleged pre-existing psychological condition, Burnette's was an alleged pre-existing back injury, and Hine's an alleged pre-existing tumor to his testicles. The court looked at the evidence in each of these cases to determine if the alleged pre-existing injury or condition was aggravated by the subsequent work injury.

CONCLUSION

Claimant prays that the Commission makes findings consistent with the above arguments.

Respectfully submitted,



Joe Ann Calvy
P. O. Box 610
Kingstree, S. C 29556
843-354-9000
Attorney for Employee

Kingstree, S. C.
April 4, 2016

Joe Ann Calvy, LLC

ATTORNEY AT LAW

P.O. Box 610 • 209 W. MILL STREET • KINGSTREE, SC 29556

TELEPHONE: (843) 354-5504

FAX: (843) 354-5845

E-MAIL: JCALVY@SC.IR.COM

PAGER: 1-800-800-9698

April 4, 2016

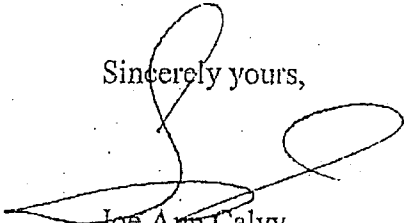
Att'n: Matthew LaFave, Esquire
Crowe & LaFave, LLC
Attorneys at Law
P.O. Box 1149
Columbia, SC 29202

Re: My Client: O'Shea Brown v. Steel Technologies
W.C.C. File No.: 1205647
Date of Injury: 04/30/2012

Dear Mr. LaFave:

Enclosed herewith, please find the **Appellant's (Claimant's) Reply Brief** along with Certificate of Service, in connection with the above matter.

Sincerely yours,



Joe Ann Calvy
Attorney at Law

JMC/

Enc:

STATE OF SOUTH CAROLINA

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

O'Shea Brown

Claimant,

vs.

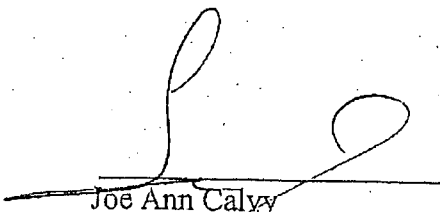
Steel Technologies

Defendant (s),

CERTIFICATE OF SERVICE

I, Joe Ann Calvy, hereby certify that I mailed a copy of the Appellant's (Claimant's) Reply Brief to Matthew LaFave, Esquire by placing a copy of the same in the United States mail with sufficient postage attached this 4th day of April, 2016.

Att'n: Matthew LaFave, Esquire
Crowe & LaFave, LLC
Attorneys at Law
P.O. Box 1149
Columbia, SC 29202


Joe Ann Calvy
Attorney at Law
P.O. Box 610
Kingstree, S. C. 29556
843-354-9000

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work injury
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records (adolph)

expert expert
verdict status
no mm I
↓
record


Joe Ann Calvy, LLC

ATTORNEY AT LAW

P.O. Box 610 • 209 W. MILL STREET • KINGSTREE, SC 29556

TELEPHONE: (843) 354-5504
FAX: (843) 354-5845

E-MAIL: JCALVY@SC.RR.COM
PAGER: 1-800-800-9698

VIA eCase

March 18, 2016

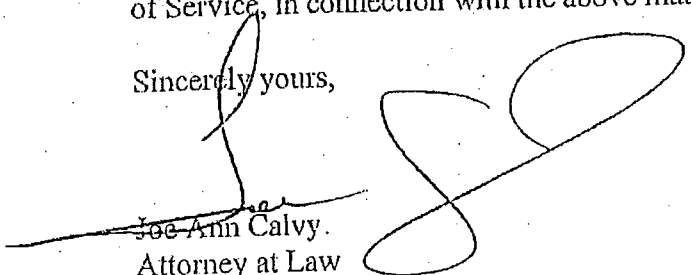
Judicial Department
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202-1715

Re: O'Shea Brown vs. Steel Technologies and Twin City Fire Ins. Co.
W.C.C. File No.: 1205647
Date of Injury: 04/30/2012

Dear Sir/Madame:

Enclosed herewith, please find Appellant's Brief to the Full Commission, along with Certificate of Service, in connection with the above matter.

Sincerely yours,


Joe Ann Calvy
Attorney at Law

JMC/

enc:

cc: Matt LaFave, Esquire (with Appellant's Brief)

STATE OF SOUTH CAROLINA

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

O'Shea Brown

Claimant,

vs.

Steel Technologies

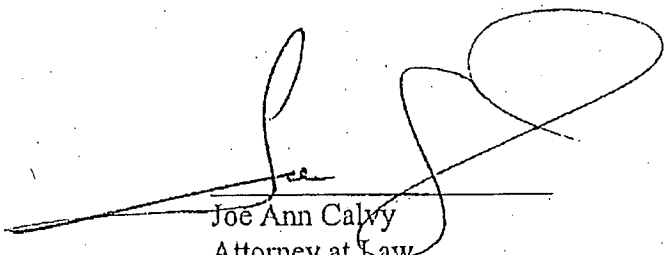
Defendant (s),

CERTIFICATE OF SERVICE

I, Joe Ann Calvy, hereby certify that I mailed a copy of the Appellant's Brief to the below addressee by eCase to the S. C. Workers' Compensation Commission and by placing a copy of the same in the United States mail with sufficient postage attached this 18th day of March, 2016 and addressed to Matthew LaFave, Esquire.

Att'n: Claims Department
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202-1715

Matthew LaFave, Esquire
Crowe & LaFave, LLC
Attorneys at Law
P.O. Box 1149
Columbia, SC 29202


Joe Ann Calvy
Attorney at Law
P. O. Box 610
Kingstree, S. C. 29556
(843) 354-5504

IN THE SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION
STATE OF SOUTH CAROLINA
SCWCC NO.: 1205647

O'SHEA BROWN,

Employee/Claimant,

vs.

STEEL TECHNOLOGIES,

Employer/Defendant,

and

HARTFORD ACCIDENT & INDEMNITY
CO.,

Carrier/Defendant.

APPELLANT'S BRIEF

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. However, a dispute arose as to the question of causation with respect to a vascular condition present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the

evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. § 42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues.

The hearing took place before Commissioner R. Michael Campbell, II on February 6, 2015 in Isle of Palms, South Carolina. Commissioner Campbell notified the parties on November 9, 2015 of the decision in this case. Specifically, Commissioner Campbell found Claimant sustained a compensable injury to his right knee, which necessitated a partial medial meniscectomy. Commissioner Campbell further found that Claimant had, as to the right knee injury, achieved maximum medical improvement on February 19, 2014 and required no further medical care for his knee. Commissioner Campbell also concluded Claimant sustained 12% permanent partial disability to his right lower extremity.

However, Commissioner Campbell ruled Claimant's vascular condition, right hip and lower back conditions were not caused, activated or aggravated by his right knee injury. Additionally and finally, Commissioner Campbell concluded that despite Claimant having achieved maximum medical improvement nearly a year prior to the hearing and Defendants having continued to pay temporary total disability benefits up through and until the Order Instructions were issued on November 9, 2015 no credit for overpayment of compensation was due. Specifically, Commissioner Campbell contended that because no Form 21, Request for Hearing was submitted nor was S.C. Code Ann. § 42-9-210

raised Defendants were not entitled to a credit for any compensation paid to Claimant.

Defendants appealed the Decision and Order filed by Commissioner Campbell as to their entitlement to a credit for overpayment of compensation.

QUESTIONS PRESENTED BY APPELLANT

- I. Whether or not the Commissioner erred in denying Defendants any credit for overpayment of temporary total disability compensation.

LAW and ANALYSIS

- I. **Whether or not the Commissioner erred in denying Defendants any credit for overpayment of temporary total disability compensation.**

In the Decision and Order the Single Commissioner concluded S.C. Code Ann. § 42-9-201 “affords Defendants a deduction from the amount of compensation to be paid when disability payments were made when they were not due and payable.” Relying solely and exclusively on the foregoing statute the Single Commissioner Concluded Defendants were not entitled to a deduction from compensation to be paid. More specifically it was concluded that Defendants had no entitlement to a credit because they had not proceeded with a Form 21, Request for Hearing to Stop Compensation nor had this section been pled by Defendants in either a Form 51, Answer to Employee’s Request for Hearing or Form 58, Pre-Hearing Brief.

It is understood that defendants are able to proceed with a Form 21, Request for Hearing to terminate temporary total disability compensation upon Claimant reaching maximum medical improvement. Furthermore, Defendants concede that no such filing was made in this case; however, Defendants submit this was in light of the complex medical history at issue, which had not yet been fully vetted. Moreover, the statute relied upon by the Single Commissioner does not specifically require it to be pled to be applicable to payments of compensation and such a requirement by the Single Commissioner was in error. While it is commonly accepted in South

Carolina that an affirmative defense not raised is forever waived the foregoing statute is not a defense in any form thus there is no statutory requirement that it be raised for a reduction to be awarded by a commissioner. This statute on its face entitles a defendant to a credit when there have been payments made by an employer and carrier "with reference to liability under the provisions of the Act and intended to be in lieu of compensation." *Corbin v. Kohler Co.*, 351 S.C. 613, 625, 571 S.E.2d 92, 99 (Ct.App. 2002); (see also *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 298, 519 S.E.2d 583, 599 (Ct.App. 1999)). There is no case that requires a defendant, in order to be deemed entitled to a reduction under S.C. Code Ann. § 42-9-210 to be a moving party through submission of a Form 21, Request for Hearing nor does any case obligate this to be referenced in any pleading to be entitled to a reduction. The Single Commissioner in having obligated Defendants, in the instant case, to have acted in a manner inconsistent with or absent a legal obligation to do so in order to support their entitlement to a credit is in error and should be reversed. The conclusion of the Commissioner, in finding Claimant was at maximum medical improvement as of February 19, 2014, sufficiently supports a basis for a reduction in any compensation to be paid under the Act for disability.

The entitlement to a reduction under the aforementioned statute traditionally turns on whether or not benefits were paid in contemplation of an employer and/or carrier's liability under the Act. In essence it is routinely analyzed in the progeny of cases addressing this subject whether or not the particular benefits paid were done so in lieu of compensation. Typically benefits paid, where this statute is commonly at issue, are those involving short-term or long-term disability benefits. The Court of Appeals has repeatedly noted that "only those payments are deductible which are made in contemplation of the legal obligation of the employer to pay compensation to a disabled employee, the intent with which such payments are made becomes

important.” *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 298, 519 S.E.2d 583, 599 (Ct.App. 1999); (quoting *Brittle v. Raybestos-Manhattan, Inc.*, 241 S.C. 255, 127 S.E.2d 884 (1962)). There is no dispute that the benefits Defendants were paying Claimant for which an entitlement to a reduction is claimed were in connection with their legal obligations to pay under the Act to a disabled employee. Therefore, any of those benefits paid by Defendants beyond the date Claimant was entitled to receive them are subject to a credit in accordance with S.C. Code Ann. §42-9-210.

In fact, a literal reading of the statute references “[a]ny payments made by an employer to an injured employee during the period of his disability ... which by the terms of this title were not due and payable when made may ... be deducted from the amount to be paid as compensation.” Defendants again submit the payments made beyond the date of Claimant’s disability shall be deducted from any amount to be paid as compensation as clearly indicated by the statute. It is clear, based upon the evidence in the record and the decisions by the Single Commissioner as to the period of disability that Defendants paid benefits, in contemplation of their liability under the Act, beyond a period when they were due and payable thus entitling them to a reduction. Moreover, even absent such a request by Defendants through a Form 21, Request for Hearing to Stop Compensation, the issues pertinent to awarding a credit were being presented in conjunction with Claimant’s Form 50, Request for Hearing as he was seeking a determination of maximum medical improvement and entitlement to payment of permanent and total disability compensation or permanent partial disability compensation.

Finally, it is noted that even after the hearing occurred, on February 6, 2015, Defendants through no action or inaction of its own, continued payment of disability benefits until November 9, 2015. It was only after the receipt of the order instructions on the aforementioned

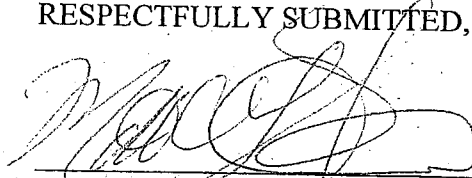
date in November that Defendants could even claim entitlement to a reduction under the statutory section relied upon by the Single Commissioner. Defendants submit S.C. Code Ann. § 42-9-210 references only "payments made" thus it does not contemplate payments yet to be made. In the instant proceedings Defendants argue there was no claim for deduction under this section for payments yet to be made thus any payments made after the hearing could not have been claimed as the entitlement had not yet ripened.

CONCLUSION

While it is noted that Defendants did not file a Form 21, Request for Hearing to Stop Compensation in this case there is simply no legal requirement that they do so, either in the Act or in the progeny of cases addressing the issue of a deduction from compensation. Therefore, to impose an obligation on Defendants that is not based upon an established legal precedent must be found to be in error and subject to reversal by this Honorable Commission. Moreover, it is apparent the Defendants were saddled with more nine (9) additional months of compensation payments through no action or inaction on their part but rather an undue delay in a ruling being issued in this case. The matter was heard on February 6, 2015 and the Defendants were not advised of a ruling or permitted, by Order of the Commission, to terminate compensation benefits until November 9, 2015 thus this delay was not of their doing and to not award a credit, at a minimum for this period, is in error and must be reversed.

(SIGNATURE PAGE FOLLOWS)

RESPECTFULLY SUBMITTED,



Matthew C. LaFave, Esq. (S.C. Bar # 75365)

CROWE LAFAVE, LLC

Post Office Box 1149

Columbia, South Carolina 29202

Phone: 803.724.5727

matt@crowelafave.com

ATTORNEY FOR THE DEFENDANTS

March 17, 2016

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Claimant,

v.

Steel Technologies,
Employer,

and

Hartford Accident & Indemnity Co.,
Carrier,

Defendants.

CERTIFICATE OF SERVICE

I, Denise M. Brockwell, paralegal for Crowe LaFave, LLC, do hereby certify that I have served the **Appellant's Brief**, by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows:

Joe Ann Calvy, Esquire
P.O. Box 610
Kingstree, SC 29556

Denise M. Brockwell
Denise M. Brockwell
Paralegal

March 17, 2016

Joe Ann Calvy, LLC

ATTORNEY AT LAW

P.O. Box 610 • 209 W. MILL STREET • KINGSTREE, SC 29556

TELEPHONE: (843) 354-5504

FAX: (843) 354-5845

E-MAIL: JCALVY@SC.RR.COM

PAGER: 1-800-800-9698

April 4, 2016

Att'n: Matthew LaFave, Esquire
Crowe & LaFave, LLC
Attorneys at Law
P.O. Box 1149
Columbia, SC 29202

Re: My Client: O'Shea Brown v. Steel Technologies
W.C.C. File No.: 1205647
Date of Injury: 04/30/2012

Dear Mr. LaFave:

Enclosed herewith, please find the Respondent's (Claimant's) Brief along with Certificate of Service, in connection with the above matter.

Sincerely yours,

Joe Ann Calvy
Attorney at Law

JMC/

Enc:

STATE OF SOUTH CAROLINA

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

O'Shea Brown

Claimant,

vs.

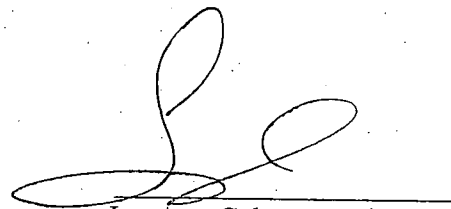
Steel Technologies

Defendant(s),

CERTIFICATE OF SERVICE

I, Joe Ann Calvy, hereby certify that I mailed a copy of the Respondent's (Claimant's) Brief to Matthew LaFave, Esquire by placing a copy of the same in the United States mail with sufficient postage attached this 4th day of April, 2016.

Att'n: Matthew LaFave, Esquire
Crowe & LaFave, LLC
Attorneys at Law
P.O. Box 1149
Columbia, SC 29202



Joe Ann Calvy
Attorney at Law
P.O. Box 610
Kingstree, S. C. 29556
843-354-9000

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1205647

O'Shea L. Brown.....Claimant,

vs.

Steel Technologies, Employer, and
Twin City Fire Ins. Co., Carrier.....Defendants.

RESPONDENT'S (CLAIMANT'S) BRIEF TO THE FULL COMMISSION

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. However, a dispute arose as to the question of causation with respect to a vascular condition present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. §

42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues. Claimant asserted that but for the work injury, surgery to his knee would have not been needed and the resulting permanent and enormous swelling to his right lower extremity would not have occurred, notwithstanding the back and hip pain.

EVIDENCE OF THE CASE

Claimant's Testimony

Direct Examination

Claimant testified that he was transporting a load of steel to a vendor in Charlotte North Carolina on April 30, 2012. During the process of making this delivery he testified that he went to get on the back of the trailer and bumped his right knee. Immediately after the incident Claimant testified to calling his supervisor, Maurice Byrd, to report what happened. Despite the occurrence Claimant testified that he continued to process the delivery and also transported another load the following day in Greensboro, North Carolina.

Claimant testified that approximately two (2) to three (3) days after the incident he went to see a doctor at the direction of his employer. At this initial evaluation he stated that he was simply provided some medications though after some time, approximately five (5) or six (6) months, he was sent to an orthopedist. Claimant was referred to Dr. Rudolph for his surgery, which eventually occurred in the form of a partial medial meniscectomy. Claimant testified that approximately an hour and a half to two hours after the surgery he began to experience swelling, which he was told was a result of his having surgery. Claimant's testimony was that prior to this incident and his

surgery he had never experienced any swelling and following the surgery, despite assurances it would improve, his swelling worsened.

Claimant was eventually referred to Dr. Morrison who treated him for a vascular problem. Upon being seen by Dr. Morrison Claimant testified that he was recommended to undergo a vein closure, which was done. However, Plaintiff testified that the vascular surgery that he underwent has not helped with his swelling so he was eventually referred to Dr. Tavel for pain management. Dr. Tavel has been treating him from issues relative to his having developed hip and back pain as well, which were attributed to changes in his gait from the swelling of his lower extremity.

Cross Examination

On cross, Claimant admitted that he was present for the deposition of Dr. Morrison when he concluded the vascular condition was not related to the work injury but rather was attributable to his obesity. Claimant further testified that the issues he is experiencing with his back has been attributed to his altered gait on account of the swelling in his leg.

Redirect Examination

On redirect, Claimant addressed his employment status contending that he was unable to work in any capacity on account of the limitations established by Drs. Rudolph and Tavel. Claimant testified that he was not supposed to lift or squat and that he could work in a position where he was sitting or standing, but this was for limited periods of time. Claimant also testified that he was supposed to be permitted a ten (1) minute break for every one (1) hour of work. To this extent Claimant testified that his employment prior to Steel Technologies provided "very minimum" sitting while serving as an assembler.

Recross Examination

Claimant testified that his previous employment, which included jobs as an assembler for Steel Related Technologies and Petting House, afforded him only about one (1) hour per shift to complete his duties in a seated fashion. However, when presented with his deposition transcript Plaintiff acknowledged he previously testified to spending half of his time seated with the other half standing over a twelve (12) hour shift as an assembler, which also required no lifting.

Summary of the Medical Evidence

Claimant was initially seen on May 2, 2012 at Coastal Occupational Medicine by Dr. Byron Williams with complaints of right knee pain. Following multiple visits to Dr. Williams Claimant was eventually referred to Dr. Harry Rudolph on account of continued complaints of pain. Claimant was eventually seen, on July 24 2012, by Dr. Rudolph who ordered an MRI, which eventually confirmed the presence of a meniscus tear. On July 24, 2012, Dr. Morrison noted that Claimant denied any back or hip pain at that time. (APA p. 215) On account of the findings of the MRI, Claimant underwent a partial medial meniscectomy on October 2, 2012. (APA p. 224) When Claimant returned on October 10, 2012, Dr. Rudolph noted a significant amount of swelling. (APA p. 210) By the time he returned on October 21, 2012, Dr. Rudolph noted a significant amount of swelling all the way down to his foot after his knee surgery. He also noted that there was a "deathly difference between the right leg and the left leg." That the leg below the knee was a problem (APA. P. 208) By November 28, 2012 Dr. Rudolph had made a referral to a vascular doctor, Dr. Morrison, and noted on December 19, 2012 that there were chronic swelling and skin changes after the surgery. (APA p. 204) Following the prescribed course of treatment established

by Dr. Rudolph, Claimant was found to have reached maximum medical improvement on February 19, 2014 for the knee issue.

Upon examining the Claimant, Dr. Morrison recommended he undergo the closure of his right greater saphenous vein, which was completed on February 14, 2013. Despite the procedure Claimant continued to experience swelling and his treatment was eventually transitioned to Dr. Tavel for ongoing pain management. Eventually, Dr. Tavel opined that Claimant had, from a pain management perspective, achieved maximum medical improvement as well.

On March 19, 2014 Dr. Morrison completed a questionnaire from the Employer's attorney and in that questionnaire, Dr. Morrison indicated to a "reasonable degree of medical certainty" that Claimant was diagnosed as having venous stasis disease and edema, that the knee injury likely exacerbated his underlying venous reflux disease, that the condition and underlying vascular surgery was as a direct result of the work injury in that the venous closure procedure was done to help improve the pain and edema which was "worsened by the knee injury," that the lymphedema is related to Claimant's work injury in that "the lymphedema and venous stasis disease was exacerbated by the knee injury, however; he likely had malfunctioning venous valves prior to injury." That he referred Claimant to Dr. Tavel for pain management and that the referral was related to the work injury because "the work injury can cause reflex sympathetic dystrophy." (APA. 237) In a later deposition, Dr. Morrison denied that the resulting venous stasis and edema condition was work related. On November 14, 2014, Dr. Gabor Winkler, a vascular surgeon, reviewed the medical evidence and opined to "a reasonable degree of medical certainty" that Mr. Brown's chronic swelling is a direct result of the work injury to his right knee, that the impact of the injury could have caused the immediate swelling as well as the ultimately resulting permanent swelling. That the surgery was further worsened by the arthroscopic knee surgery. He

also opined to a reasonable degree of medical certainty that the impairment due to the swelling in the right leg is and will remain a permanent problem and disability for Claimant and that even with lymphedema therapy, compression, therapy, and weight loss some level of improvement in his symptoms can be achieved, it is extremely unlikely that he will return to normal function and that his permanent disability is as a direct result of his work injury. (APA p. 239) Dr. Alan, the orthopedist that evaluated Claimant also agreed.

ISSUE ON APPEAL

ARGUMENTS

1. Whether or not the Commissioner erred in denying Defendants any credit for overpayment of temporary total disability compensation.

Appellant/Defendant argues that its failure to file a WCC Form 21 Request for Hearing to Stop Compensation was a result of complex medical history at issue, which had not been fully vetted. At the hearing, Appellant did not request credit for overpayment. In fact, Respondent's later inquiries to the single commissioner after the hearing were solely on the issue of temporary total benefits post the hearing. There is also no evidence that the Appellant did anything to mitigate the size of the credit, like filing a request for a hearing at any time after the Claimant reached MMI. Filing a WCC Form 21 would have guaranteed the Appellant a hearing within 60 days verses trying to get almost 2 years worth of credit from someone who has been unable to return to work and was unsuccessful at proving he is temporarily and totally disabled at trial. While the evidence clearly shows that this hearing was held February 6, 2015, the hearing instructions to prepare the order were not mailed to the parties until November 10, 2015. This was some 9

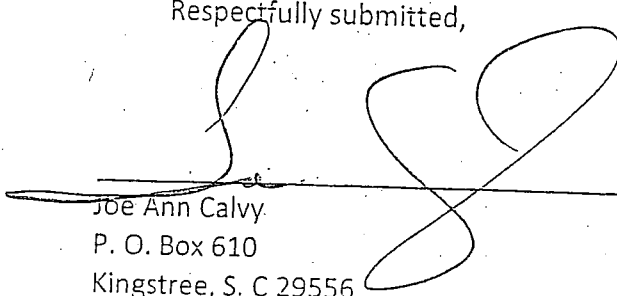
months after subsequent order was signed and filed. In Sanders v. Meadvestvaco Corp., 638 S.E. 2d 66, 371 S. C. 284 (S.C. App., 2006) and Watson v. Xtra Mile Driver Training, Inc., 399 S. C. 455, 732 S.E.2d 190 (Ct. App. 2012), credit for overpayment of temporary total benefits were awarded, but in both cases the defendants had filed a WCC Form 21 requesting credit for overpayment. It is unclear from Curiel v. Environmental Management Services, 376 S. C. 23, 655 S. E.2d 482 (2007) as to whether a WCC Form 21 was filed.

Notwithstanding the above, if this Commission finds that Appellant was entitled to credit for overpayment of temporary total benefits despite the failure to request the credit at the hearing, then the Respondent takes the position that equity should not allow the Appellant to receive an automatic credit from the date of MMI (February 19, 2014) to the date of the single commissioner's order was filed (January 27, 2016). This is a period of almost 2 years.

CONCLUSION

Claimant prays that the Commission makes findings consistent with the above arguments.

Respectfully submitted,



Joe Ann Calvy
P. O. Box 610
Kingstree, S. C 29556
843-354-9000
Attorney for Employee

Kingstree, S. C.
March 17, 2016

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

COPY

O'Shea Brown,
Employee/Respondent,
v.
Steel Technologies,
Employer,
and
Hartford Accident & Indemnity Co.,
Carrier,
Appellants.

APPELLANT'S REPLY BRIEF

QUESTIONS PRESENTED BY APPELLANT

- I. Did the single commissioner err in refusing to award Defendants/Appellants credit for overpayment of TTD compensation.

LAW and ANALYSIS

- I. The single commissioner erred in refusing to award Defendants/Appellants credit for overpayment of TTD compensation.

Respondent, in his brief, argues in support of the decision of the Single Commissioner to refuse to award any credit to Defendants/Appellants for overpayment of Compensation. Specifically, Respondent focuses on the absence of a Form 21, Request for Hearing having been filed by Appellants. In support of his position Respondent cited to three different cases where a credit for overpayment was awarded in light of S.C. Code Ann. § 42-9-210. Again, S.C. Code Ann. § 42-9-210 provides, in pertinent part, "any payments made by an employer ... during the period of his disability ... which by the terms of this Title were not due and payable when made may, subject to the approval of the commission, be deducted from the amount of to be paid as compensation."

Appellants, in their previously submitted brief has openly acknowledged no Form 21, Request for Hearing had been filed nor was S.C. Code Ann. § 42-9-210 referenced in their Form 58, Pre-Hearing Brief. However, a review of the aforementioned statute simply indicates no such requirement exists to deem a credit is warranted. The plain and ordinary language of the statute reveals a credit is due when benefits were paid though not due. There is no pre-requisite in the statute for such a credit to be deserved. In fact, Appellant has failed to present a single case that would support his apparent contention that in order to be entitled to a credit the employer/carrier are required to have submitted a Form 21, Request for Hearing.

It is significant to note the single commissioner held that Claimant had reached maximum medical improvement on February 19, 2014. Furthermore, Respondent, despite appealing numerous other findings, has not challenged the determination of MMI thus disposing of that issue insofar as it applies to the instant issue before The Panel. The prevailing case law, as even supported by those cases cited by Respondent, indicates that "the date of maximum medical improvement signals the end of entitlement to temporary total disability benefits." *Curiel v. Envtl. Mgmt. Servs. (MS)*, 376 S.C. 23, 29, 655 S.E.2d 482, 485 (2007). Therefore, based upon the unchallenged conclusions rendered by the single commissioner, and the aforementioned conclusions the entitlement to temporary total disability benefits in the instant case ceased on February 19, 2014. In theory, based upon the application of S.C. Code Ann. § 42-9-210 Appellants submit they were paying benefits when they were not due and payable such affording them the right of a credit for such overpayment.

Respondent has cited, in his brief, two other cases; *Sanders v. Meadvestavco Corp.*, 371 S.C. 284, 638 S.E.2d 66 (Ct.App. 2006) and *Watson v. Xtra Mile Driver Training*, 399 S.C. 455, 732 S.E.2d 190 (Ct.App. 2012) to contend a Form 21 is a requirement for an

employer and carrier to be awarded a credit for overpayment of benefits. In *Sanders v. Meadvestavco Corp.*, 371 S.C. 284, 638 S.E.2d 66 it is clear that a Form 21 was filed by the defendants though nothing in the holdings of the Court indicate this was a requirement for determining if a credit was due for overpayment of benefits. In fact in *Sanders*, the Court simply notes it was undisputed as to the date the claimant had reached MMI and benefits were to be terminated on that date in favor of entry of a permanent award. *Id.* 371 S.C. at 295. In fact in this case the inquiry by the Court focused on the delay in the hearing having occurred. The Court eventually reversed the Single Commissioner and Full Commission who had only awarded credit from the day preceding the hearing before the single commissioner. Specifically, the Court held the delay in the hearing was the result of actions on the part of both parties. The record in the case before the Full Commission reflects a hearing request having been filed by Respondent initially on June 11, 2014 to address all pertinent issues, which Appellants answered June 23, 2104. The matter was originally scheduled for a hearing on December 18, 2014 though was postponed at the request of Claimant to be rescheduled, and eventually adjudicated February 6, 2015. The issue of whether or not Respondent had reached maximum medical improvement was thus going to be before the single commissioner upon setting of the hearing based on the foregoing Form 50, Request for Hearing thus rendering it unnecessary and seemingly duplicative for a similar request by Appellants. The hearing was delayed through no fault of Appellants. Furthermore, and most significant in this case, is the delay in the rendering of a decision by the single commissioner who took I excess of nine (9) months to rule. It cannot be ever contended that the delay in the ruling from February 6, 2015 to November 9, 2015 was through any doing of the Appellants such that they should be precluded from an award of a credit for that period, at a minimum. In fact,

Appellants began inquiring as to a ruling as early as May 4, 2015 without any corresponding decision from the single commissioner.

Similarly, in *Watson*, a Form 21 was filed but as noted previously there was no indication or determination by the Court that this was a pre-requisite for determining entitlement to a credit for overpayment, as it would appear Respondent is arguing. In *Watson* it is noted that there nearly three months elapsed between the date of MMI and the date of the Form 21 filing by the employer and carrier. Much the same as in the instant case the employee, in *Watson* argued it was not equitable to award compensation back to the date of MMI. The Court held in *Watson* that “[b]ecause equity follows the law, XTRA is entitled to credit for any TTD compensation payments it made to Watson after the date of MMI.” *Watson*, 399 S.C. at 465. The holding in *Watson* is very significant to the case at bar as the court noted “equity follows the law,” which designates the entitlement to a credit as an equitable one and never indicates a party must request it as it is legal in nature. Simply put, based upon the aforementioned statute and prevailing case law Appellants are entitled to credit for overpayment of compensation beginning with the determination of maximum medical improvement, which was determined to be February 19, 2014 and was unchallenged by Respondent. Respondent seeks to employ the principles of equity when noting a credit in this case could cover nearly two (2) years though has put forth no evidence or argument indicating why Appellants should be denied their equitable right to a credit.

Finally, the aforementioned statute is the impetus of an employer and carrier’s entitlement to a credit. A close reading of the statute refers to “compensation paid when not due and payable,” which implies only those payments that had been made and does not seem to contemplate payments to be made while awaiting a ruling. In fact, Appellants contend they would not, under S.C. Code Ann. § 42-9-210, have had a claim to make for a credit for the

payments made from February 6, 2015 through November 9, 2015. Therefore, it is implausible to deny Appellants a credit, at a minimum, for those payments made during a delay that was outside of their control and that had not yet been made at the time of the initial hearing. The right to a credit is one that is equitable and the delay in rendering a decision was through no fault of the Appellants thus entitling them, by law, to a credit for overpayment.

CONCLUSION

The applicable statute and prevailing case law establish Appellants entitled to a credit for overpayment as one that began to accrue on the date of maximum medical improvement, which was not set until the ruling issued by the single commissioner on November 9, 2015. This ruling was made more than nine (9) months after the hearing on February 6, 2015, which occurred as a result of a Form 50, Request for Hearing filed June 11, 2015. The delay in this hearing taking place and the ruling being made should not form a basis for the denial of Appellants equitable right to a credit for overpayment. Moreover, at a minimum, the statute establishing an employer and carriers right to a credit only contemplates payments already made for purposes of a credit and does not address payments that may be made as was a significant issue in this case. In this case, the payments made by Appellant from February 6, 2015 through November 9, 2015 would not be ripe for a claim for credit under S.C. Code Ann. § 42-9-210 as they had not yet been made. Finally, the delay in rendering a decision was through no fault of Appellants and to deprive them of a right to overpayment of compensation during at least that period of time is improper.

(SIGNATURE PAGE FOLLOWS)

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'M. LaFave', written over a horizontal line.

Matthew C. LaFave, Esquire

Crowe LaFave, LLC

PO Box 1149

Columbia, SC 29202

Phone: 803.724.5727

matt@crowelafave.com

Attorney for the Appellants

This 8th Day of April 2016
Columbia, South Carolina

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Claimant,

v.

Steel Technologies,
Employer,

and

Hartford Accident & Indemnity Co.,
Carrier,

Defendants.

CERTIFICATE OF SERVICE

I, Denise M. Brockwell, paralegal for Crowe LaFave, LLC, do hereby certify that I have served the **Appellant's Reply Brief**, by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows:

Joe Ann Calvy, Esquire
P.O. Box 610
Kingtree, SC 29556

Denise M. Brockwell
Denise M. Brockwell
Paralegal

April 8, 2016

IN THE SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION
STATE OF SOUTH CAROLINA
SCWCC NO.: 1205647

O'SHEA BROWN,

Employee/Claimant,

vs.

STEEL TECHNOLOGIES,

Employer/Defendant,

and

HARTFORD ACCIDENT & INDEMNITY
CO.,

Carrier/Defendant.

APPELLANT'S BRIEF

STATEMENT OF THE CASE

This case involves an accepted injury by accident to Claimant's right knee, which occurred on April 30, 2012 as he was climbing a ladder to get atop the bed of his trailer. However, a dispute arose as to the question of causation with respect to a vascular condition present in Claimant's right lower extremity. Claimant sought a determination of compensability for the right lower extremity vascular condition, along with alleged issues to his hip and lower back, and a finding that he was permanently and totally disabled pursuant to S.C. Code Ann. § 42-9-10. Defendants' contend that the medical evidence, specifically the opinion espoused by Dr. Morrison in his deposition, contradict any assertion that the vascular condition is causally related to either the original injury of April 30, 2012 or treatment received as a result thereof. Moreover, the allegations of issues with his hip and lower back are solely as a result of an alteration to his gait attributable exclusively to the vascular issues. Defendants' submit that the

evidence of the case support simply a finding of a compensable injury to the right knee, which necessitated a partial medial meniscectomy, and as such Claimant is only entitled to an award under S.C. Code Ann. § 42-9-30 for the right lower extremity. Alternatively, Defendants' argued that if the Commissioner was to find the vascular condition to be causally related he was not yet at maximum medical improvement for those issues.

The hearing took place before Commissioner R. Michael Campbell, II on February 6, 2015 in Isle of Palms, South Carolina. Commissioner Campbell notified the parties on November 9, 2015 of the decision in this case. Specifically, Commissioner Campbell found Claimant sustained a compensable injury to his right knee, which necessitated a partial medial meniscectomy. Commissioner Campbell further found that Claimant had, as to the right knee injury, achieved maximum medical improvement on February 19, 2014 and required no further medical care for his knee. Commissioner Campbell also concluded Claimant sustained 12% permanent partial disability to his right lower extremity.

However, Commissioner Campbell ruled Claimant's vascular condition, right hip and lower back conditions were not caused, activated or aggravated by his right knee injury. Additionally and finally, Commissioner Campbell concluded that despite Claimant having achieved maximum medical improvement nearly a year prior to the hearing and Defendants having continued to pay temporary total disability benefits up through and until the Order Instructions were issued on November 9, 2015 no credit for overpayment of compensation was due. Specifically, Commissioner Campbell contended that because no Form 21, Request for Hearing was submitted nor was S.C. Code Ann. § 42-9-210

raised Defendants were not entitled to a credit for any compensation paid to Claimant. Defendants appealed the Decision and Order filed by Commissioner Campbell as to their entitlement to a credit for overpayment of compensation.

QUESTIONS PRESENTED BY APPELLANT

- I. Whether or not the Commissioner erred in denying Defendants any credit for overpayment of temporary total disability compensation.

LAW and ANALYSIS

- I. **Whether or not the Commissioner erred in denying Defendants any credit for overpayment of temporary total disability compensation.**

In the Decision and Order the Single Commissioner concluded S.C. Code Ann. § 42-9-201 "affords Defendants a deduction from the amount of compensation to be paid when disability payments were made when they were not due and payable." Relying solely and exclusively on the foregoing statute the Single Commissioner Concluded Defendants were not entitled to a deduction from compensation to be paid. More specifically it was concluded that Defendants had no entitlement to a credit because they had not proceeded with a Form 21, Request for Hearing to Stop Compensation nor had this section been pled by Defendants in either a Form 51, Answer to Employee's Request for Hearing or Form 58, Pre-Hearing Brief.

It is understood that defendants are able to proceed with a Form 21, Request for Hearing to terminate temporary total disability compensation upon Claimant reaching maximum medical improvement. Furthermore, Defendants concede that no such filing was made in this case; however, Defendants submit this was in light of the complex medical history at issue, which had not yet been fully vetted. Moreover, the statute relied upon by the Single Commissioner does not specifically require it to be pled to be applicable to payments of compensation and such a requirement by the Single Commissioner was in error. While it is commonly accepted in South

Carolina that an affirmative defense not raised is forever waived the foregoing statute is not a defense in any form thus there is no statutory requirement that it be raised for a reduction to be awarded by a commissioner. This statute on its face entitles a defendant to a credit when there have been payments made by an employer and carrier "with reference to liability under the provisions of the Act and intended to be in lieu of compensation." *Corbin v. Kohler Co.*, 351 S.C. 613, 625, 571 S.E.2d 92, 99 (Ct.App. 2002); (see also *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 298, 519 S.E.2d 583, 599 (Ct.App. 1999)). There is no case that requires a defendant, in order to be deemed entitled to a reduction under S.C. Code Ann. § 42-9-210 to be a moving party through submission of a Form 21, Request for Hearing nor does any case obligate this to be referenced in any pleading to be entitled to a reduction. The Single Commissioner in having obligated Defendants, in the instant case, to have acted in a manner inconsistent with or absent a legal obligation to do so in order to support their entitlement to a credit is in error and should be reversed. The conclusion of the Commissioner, in finding Claimant was at maximum medical improvement as of February 19, 2014, sufficiently supports a basis for a reduction in any compensation to be paid under the Act for disability.

The entitlement to a reduction under the aforementioned statute traditionally turns on whether or not benefits were paid in contemplation of an employer and/or carrier's liability under the Act. In essence it is routinely analyzed in the progeny of cases addressing this subject whether or not the particular benefits paid were done so in lieu of compensation. Typically benefits paid, where this statute is commonly at issue, are those involving short-term or long-term disability benefits. The Court of Appeals has repeatedly noted that "only those payments are deductible which are made in contemplation of the legal obligation of the employer to pay compensation to a disabled employee, the intent with which such payments are made becomes

important.” *Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 298, 519 S.E.2d 583, 599 (Ct.App. 1999); (quoting *Brittle v. Raybestos-Manhattan, Inc.*, 241 S.C. 255, 127 S.E.2d 884 (1962)). There is no dispute that the benefits Defendants were paying Claimant for which an entitlement to a reduction is claimed were in connection with their legal obligations to pay under the Act to a disabled employee. Therefore, any of those benefits paid by Defendants beyond the date Claimant was entitled to receive them are subject to a credit in accordance with S.C. Code Ann. §42-9-210.

In fact, a literal reading of the statute references “[a]ny payments made by an employer to an injured employee during the period of his disability ... which by the terms of this title were not due and payable when made may ... be deducted from the amount to be paid as compensation.” Defendants again submit the payments made beyond the date of Claimant’s disability shall be deducted from any amount to be paid as compensation as clearly indicated by the statute. It is clear, based upon the evidence in the record and the decisions by the Single Commissioner as to the period of disability that Defendants paid benefits, in contemplation of their liability under the Act, beyond a period when they were due and payable thus entitling them to a reduction. Moreover, even absent such a request by Defendants through a Form 21, Request for Hearing to Stop Compensation, the issues pertinent to awarding a credit were being presented in conjunction with Claimant’s Form 50, Request for Hearing as he was seeking a determination of maximum medical improvement and entitlement to payment of permanent and total disability compensation or permanent partial disability compensation.

Finally, it is noted that even after the hearing occurred, on February 6, 2015, Defendants through no action or inaction of its own, continued payment of disability benefits until November 9, 2015. It was only after the receipt of the order instructions on the aforementioned

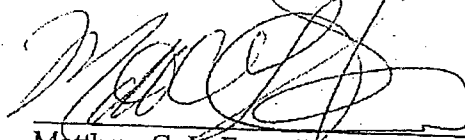
date in November that Defendants could even claim entitlement to a reduction under the statutory section relied upon by the Single Commissioner. Defendants submit S.C. Code Ann. § 42-9-210 references only "payments made" thus it does not contemplate payments yet to be made. In the instant proceedings Defendants argue there was no claim for deduction under this section for payments yet to be made thus any payments made after the hearing could not have been claimed as the entitlement had not yet ripened.

CONCLUSION

While it is noted that Defendants did not file a Form 21, Request for Hearing to Stop Compensation in this case there is simply no legal requirement that they do so, either in the Act or in the progeny of cases addressing the issue of a deduction from compensation. Therefore, to impose an obligation on Defendants that is not based upon an established legal precedent must be found to be in error and subject to reversal by this Honorable Commission. Moreover, it is apparent the Defendants were saddled with more nine (9) additional months of compensation payments through no action or inaction on their part but rather an undue delay in a ruling being issued in this case. The matter was heard on February 6, 2015 and the Defendants were not advised of a ruling or permitted, by Order of the Commission, to terminate compensation benefits until November 9, 2015 thus this delay was not of their doing and to not award a credit, at a minimum for this period, is in error and must be reversed.

(SIGNATURE PAGE FOLLOWS)

RESPECTFULLY SUBMITTED,

A handwritten signature in black ink, appearing to read 'M. LaFave', written over a horizontal line.

Matthew C. LaFave, Esq. (S.C. Bar # 75365)

CROWE LAFAVE, LLC

Post Office Box 1149

Columbia, South Carolina 29202

Phone: 803.724.5727

matt@crowelafave.com

ATTORNEY FOR THE DEFENDANTS

March 17, 2016

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 1205647

O'Shea Brown,
Claimant,

v.

Steel Technologies,
Employer,

and

Hartford Accident & Indemnity Co.,
Carrier,

Defendants.

CERTIFICATE OF SERVICE

I, Denise M. Brockwell, paralegal for Crowe LaFave, LLC, do hereby certify that I have served the **Appellant's Brief**, by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows:

Joe Ann Calvy, Esquire
P.O. Box 610
Kingstree, SC 29556

Denise M. Brockwell
Denise M. Brockwell
Paralegal

March 17, 2016

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.1205647

O'SHEA L. BROWN,	)	
	)	HEARING
CLAIMANT,	)	BEFORE COMMISSIONER
	)	R. MICHAEL CAMPBELL, II
v.	)	
	)	<u>TRANSCRIPT</u>
STEEL TECHNOLOGIES,	)	
	)	
EMPLOYER,	)	
AND	)	 COPY
	)	
TWIN CITY FIRE INSURANCE	)	
COMPANY,	)	
	)	
CARRIER,	)	
DEFENDANTS.	)	
	)	

THE WORKERS' COMPENSATION HEARING, TAKEN
BEFORE CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR
THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF
10:05 A.M., FRIDAY, FEBRUARY 6, 2015, ISLE OF PALMS
CITY HALL, 1207 PALM BOULEVARD, ISLE OF PALMS, SOUTH
CAROLINA 29451.

CORA ELLIS BRUTON
COURT REPORTER
131 BROWNING COURT
LEXINGTON, SOUTH CAROLINA 29073
803-397-0189

APPEARANCES

FOR THE CLAIMANT

JOE ANN CALVY, ESQUIRE
POST OFFICE BOX 610
KINGSTREE, SOUTH CAROLINA 29556-0610
843-354-5504

FOR THE DEFENDANT

MATTHEW C. LaFAVE, ESQUIRE
CROWE, LaFAVE, ATTORNEYS AT LAW
POST OFFICE BOX 1149
COLUMBIA, SOUTH CAROLINA 29202
803-724-5729

REPORTED BY

CORA ELLIS BRUTON
COURT REPORTER
131 BROWNING COURT
LEXINGTON, SOUTH CAROLINA 29073
803-397-0189

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EXHIBITS

(No Exhibits Proffered)

1 THE COURT: Today's date is February 6, 2015.

2 This is South Carolina Workers' Compensation Case File
3 Number 1205647.

4 This is the case of the Claimant O'Shea Brown
5 represented by Attorney Joe Ann Calvy. The Employer
6 is Steel Technologies. The Carrier is Twin City Fire
7 Insurance Company; both Defendants represented by
8 Attorney Matthew C. LaFave.

9 The date of accident is April 30, 2012. There is
10 an average weekly wage of \$856.52 with a corresponding
11 compensation rate of \$571.04.

12 APAs have been submitted. Are there any
13 objections to APAs, jurisdiction, venue or any other
14 items?

15 MS. CALVY: No objections from the Claimant.

16 MR. LaFAVE: No objections from the Defendants,
17 Your Honor.

18 THE COURT: Without objection the Commission's
19 File becomes a part of the record with the exception
20 of self-serving declarations and unstipulated medical
21 reports.

22 Ms. Calvy, we're here today on your Form 50, so
23 if you would please put your position on the record
24 and let us know what you're seeking here today.

25 MS. CALVY: Okay. Thank you, Commissioner.

1 Commissioner, our position is that the Claimant is
2 permanently and totally disabled. He has been unable
3 to return back to work and has also seen two
4 vocational experts that basically says that he is
5 unemployable and is on disability. We are also
6 seeking future medical care. The Claimant is
7 currently in pain management and he is dependent on
8 his pain medication to help with the pain that he's
9 having. And I believe that covers everything,
10 Commissioner.

11 THE COURT: Okay. Mr. LaFave.

12 MR. LaFAVE: Thank you, Commissioner. As we
13 discussed earlier, our position is simply that this is
14 a right knee injury. A right knee injury that
15 required a partial medial meniscectomy to the right
16 knee for which he's been placed at maximum medical
17 improvement by Dr. Rudolph. There are additional
18 issues surrounding the issues of lymphedema. There is
19 also a claim for a hip and a back that's also directly
20 tied to, in our opinion, to the lymphedema issue. We
21 contend the lymphedema is not at all related and that
22 was testified to by the treating vascular surgeon, Dr.
23 Edward Morrison. Our understanding is that the
24 Claimant has presented a report from Dr. Winkler
25 contradicting that. Again, we indicate Dr. Winkler is

1 not a treating physician, was not involved in the
2 vascular surgery, came into the role of an IME doctor
3 in this particular case. The Claimant has also seen
4 Dr. Rodney Allen. Dr. Allen, again, ties the back and
5 the hip to the lymphedema and his altered gait as a
6 result of lymphedema. So our position is simply
7 Claimant's at maximum medical improvement for the
8 affected body part which is the right knee. In the
9 alternative if the Commissioner finds the lymphedema
10 to be related our position is, again, in reliance on
11 Dr. Morrison's deposition, there is additional
12 treatment that can be provided him that, in Dr.
13 Morrison's own words, "Would provide significant and
14 dramatic relief relative to the swelling in his leg."

15 THE COURT: Okay. Thank you. Ms. Calvy,
16 anything more?

17 MS. CALVY: Nothing further.

18 THE COURT: Mr. Brown, before we get started I
19 have a couple of quick instructions for you, sir. If
20 you would please speak up and speak clearly for us.
21 It's important, obviously, that we all hear what you
22 have to say, but most importantly the court reporter.
23 So if you could speak up and speak clearly for us.
24 Also, if you are asked a yes or no question please
25 give us a verbal yes or no answer. Try and stay away

1 from things like uh-huh and huh-uh, that's too easily
2 misunderstood for the record. So if you would help us
3 out with those things it would be appreciated.

4 THE WITNESS: Yes, sir.

5 THE COURT: Please raise your right hand. Do you
6 swear or affirm that the testimony you're about to
7 give is the truth, the whole truth and nothing but the
8 truth?

9 THE WITNESS: Yes, sir.

10 THE COURT: Okay. Please state your name for the
11 record.

12 THE WITNESS: My name is O'Shea Lamont Brow.

13 THE COURT: Thank you, Mr. Brown. Ms. Calvy,
14 your witness.

15 MS. CALVY: Commissioner, since this is the first
16 time having a hearing in front of you, how -- how do
17 you like these hearings to go? Do you like me to be
18 as thorough as I can with work history, education,
19 that type thing?

20 THE COURT: It doesn't matter. I mean if you
21 want to run through some of his background information
22 feel free to do so. If you decide to go right into
23 the heart of the matter you can do that. It's really
24 whatever you are most comfortable doing.

25 MS. CALVY: Okay. Well, I'll go into the heart

1 of the matter and maybe come back to some of that.

2 THE COURT: Okay.

3 O'Shea Lamont Brown

4 Having first been duly sworn testified as follows:

5 DIRECT EXAMINATION

6 BY MS. CALVY:

7 Q Mr. Brown, can you tell us how your injury
8 occurred, and it can be brief.

9 A Well, been in Charlotte -- Charlotte, North
10 Carolina about to take a load of steel off the back of
11 the truck, and when I get on the back of the trailer I
12 bumped my right knee on the back of the trailer. And
13 after I bumped my knee I called -- got on the phone
14 and I called Maurice Byrd, my supervisor and let him
15 know what happened. And I mean it was hurting me when
16 it first happened. I still went up there and take a
17 load of steel off. So, I let him know and he asked me
18 whether I been all right. I told him yeah. I mean,
19 for right now, it hurt me, but when I went to get up
20 the next morning to go to work that's when my whole
21 knee was swoll up and I couldn't hardly put no
22 pressure on it to walk.

23 Q Okay. And at what point did you see a
24 doctor?

25 A It was like -- I think it was like a couple

1 days after, because I went -- they already had me down
2 on the load sheet to go to Greensboro the next day.

3 But the policy, I mean I had to give enough time.

4 That's why I had hate to call in, because they would a
5 tried to give me -- try to write me up or give me some
6 points or whatever. So I went to Greensboro. I got
7 up that same morning to take the load, but when I got
8 up I couldn't go right then. I just had to wait
9 around. I went -- so I finally went in like 5:30 that
10 morning.

11 Q You went to work?

12 A I went to work.

13 Q Okay.

14 A And then a -- well, a couple of people had
15 been on the floor, they saw my leg was swell up, my
16 knee was swell up through my pants I mean. But I
17 still tried to take the load just to try to keep from
18 getting write up, because I ain't -- I had already
19 been committed to the load, you know.

20 Q Okay. So when did you go to the doctor?

21 A I think it was on the -- I want to say the
22 2nd, I think.

23 Q How many days after the accident?

24 A It was like two -- two or three days.

25 Q Okay. And so when you went to see the

1 doctor, you went to Doctors Care? Where did you go?

2 A Dr. Byron Williams, the company doctor.

3 Q All right. And what kind of treatment did
4 he recommend for you?

5 A Well, he just gave me -- he just gave me
6 some medicine. And after that he tell me it would
7 take probably about a few days. I think he give me
8 some -- he started to -- at first he tried to say it
9 was fluid. I think he gave me some fluid tablets and
10 some pain tablets.

11 Q Okay. And so at some point did he have to
12 send you to somebody else?

13 A Well, later -- yeah, later on down the road.
14 This probably been like -- I want to say like four,
15 five, six months later.

16 Q Okay. And what kind of treatment had you
17 had before you went on to a specialist; medication?

18 A Just medication.

19 Q Okay. And so when you got to the specialist
20 what kind of problems were you having at that time,
21 six months later?

22 A Well, I -- that's when I started having
23 problems with my back. Because my gait been off and
24 my leg and stuff. I mean, my back and whatever. But
25 the knee, that's when I -- when I had the surgery done

1 that's when I started getting all the swelling and
2 stuff in my leg.

3 Q Okay. Before we get to the surgery, now you
4 went to Dr. Rudolph, right?

5 A Uh-huh.

6 Q Okay. What kind of problem were you having
7 with your knee at that point?

8 A Swelling in the knee and couldn't hardly put
9 no pressure on my leg. It's only been in the knee.

10 Q Okay. It was just in the knee at that time?
11 The swelling was just in your knee?

12 A Yeah.

13 Q Did you have any swelling in your leg or
14 your foot or anything?

15 A No, not -- because I was still wearing my
16 regular shoes. I mean if it did, it was very, very
17 minimum. I mean it was very -- ain't been that much,
18 but the most -- the bigger bother in the knee area.

19 Q Okay. And was the -- did Dr. Rudolph
20 recommend surgery right off or did he try other
21 things?

22 A No, when he -- he tell me to take -- to take
23 the -- what do you call them things? Where that thing
24 where they put you in -- the MRI?

25 Q Uh-huh.

1 A And that's when he get the report back and
2 he recommended surgery.

3 Q Okay. All right. And so after the surgery
4 how was your knee?

5 A After I took my surgery, about an hour and a
6 half, two hours, I could feel my -- like swelling
7 coming in my whole leg. I told them -- when I had --
8 I told them --

9 Q Who did you told?

10 A They kept me there probably like an hour --

11 Q Oh, okay.

12 A -- when I been in recovery. And they tell
13 me probably because -- by me having surgery, that was
14 probably -- I could maybe had a feeling like that.

15 Q Okay.

16 A So I -- I think -- I think a few days after
17 that I had went back to Dr. Rudolph and that's when I
18 could feel -- I mean that's when I tell him about the
19 whole swelling being in my leg.

20 Q All right. And what -- what did he do for
21 you?

22 A Well, he -- I keep -- just keep going back
23 like every three or four weeks and he said it would
24 probably take time, you know.

25 Q For the swelling to go down?

1 A Uh-huh.

2 Q Did the swelling ever go down?

3 A No, it got worse and worse.

4 Q Okay. What about now, is the swelling
5 better now?

6 A No.

7 Q No? Well, how bad is the swelling?

8 A Well, from my foot all the way up to my
9 right hip and up in my side and my back, my lower
10 back.

11 MS. CALVY: We are going to ask you to view it
12 for us, Commissioner. Would you like to do that now?

13 THE COURT: Sure. I can step around. I can see
14 the swelling. Let the record reflect that he is
15 indicating his right ankle area between the calf and
16 the ankle and the shin.

17 Q Okay. And so did Dr. Rudolph ever refer you
18 to anybody else to try to help with the swelling?

19 A Yeah, that's when he sent me to Dr.
20 Morrison. Said he was thinking it was something
21 vascular, some kind of vascular problem. So I went to
22 Dr. Morrison and when Dr. Morrison saw it he -- I
23 think he recommend me to have the vein closure done on
24 my -- the big (inaudible) vein. So they got that
25 blocked off.

1 Q You had that surgery done?

2 A Yeah.

3 Q Did that help?

4 A No. He said he would have tried -- if they
5 would do that would probably take the swelling off,
6 but they would probably try to -- make the blood or
7 whatever to try reverse or whatever the flow in my
8 leg, but that ain't help either.

9 Q Okay. Now, what other doctors have you seen
10 that the Employer has sent you to? Did you go to the
11 pain management doctor?

12 A Yeah, Dr. Tavel. I went to Dr. Stan once.

13 Q What has Dr. Tavel done for you?

14 A Well, pain management. I mean really they
15 had supposed to been getting back with him about the
16 back pain but they ain't never said nothing else to
17 him about it.

18 Q Okay. Did he do some treatment to your
19 back?

20 A No.

21 Q Okay. Has anybody done any treatment to
22 your back?

23 A No.

24 Q Okay. Now, you have a cane with you today.
25 Was that prescribed by someone?

1 A Yes. Dr. -- I think it was Dr. Morrison.

2 Q Okay. All right. Now, your back, now what
3 kind of problems are you having with your back?

4 A Well, I -- like -- I think like two disk
5 messed up in my lower back. But what they say was by
6 me -- by my gait being off and I guess by that vein,
7 the circulation to your back, or whatever -- I mean,
8 to your nerves and stuff.

9 Q What would you say is your worse problem?

10 A Well, my hip, my leg and my back. I mean
11 all -- all that be hurting. Everything be hurting at
12 one time.

13 Q Okay. So far as the back, how often do you
14 have pain in your back?

15 A It's like all day. I mean I take pain
16 medicine it'll -- it ease it off but it don't stop.
17 When it start -- when the medicine start to wear off I
18 have to take like more, like every four to six hours.

19 Q So do you always have some form of back
20 pain?

21 A Uh-huh.

22 Q Yes? Okay. Then what about your hip? How
23 often do you have hip pain?

24 A All the time, in like -- like in the hip
25 joint, all the time it be hurt.

1 Q Okay. Is it when you're walking?

2 A Yeah, walking. I mean when I'm walking and
3 I be trying to keep the pressure off, most off this
4 side and try to put it on the left leg.

5 Q Okay. What about standing? Do you have any
6 problem with your hip when you stand?

7 A Yes.

8 Q Can you describe that pain you have in your
9 back?

10 A It's like a -- it's a shooting pain. Like a
11 shooting pain, it be back and forth.

12 Q Shooting from where to where?

13 A I mean like -- it's like from my hip joint
14 to my back.

15 Q Okay. Do you have any numbness and tingling
16 anywhere?

17 A Yes.

18 Q Where?

19 A Well, (inaudible), I mean -- well, my back
20 and my leg.

21 Q Which leg?

22 A My right leg.

23 Q Okay. And how often do you have numbness?

24 A I mean sometime maybe -- I mean difficult
25 all -- all day, really, because I mean sometime I

1 can't really -- if I tap on this leg or whatever --

2 Q On your right leg?

3 A -- I can't really feel it. It's a big
4 difference, really.

5 Q If you tap on your right leg you can't feel
6 the pain?

7 A I mean I can -- I can barely the knee.

8 Q Okay. All right. How long have you been
9 out of work?

10 A Since April the 30th, 2012. I mean that's
11 when it happened. I mean it's been since the 2nd, May
12 the 2nd, 2012.

13 Q Okay. And since that time you have not been
14 back to work?

15 A No.

16 Q And you just drove a truck? What were your
17 duties?

18 A Just to take -- take loads from different
19 destinations like North Carolina, South Carolina and
20 Georgia.

21 Q Okay. Did you have to unload?

22 A No, I just had to take the -- take the
23 chains and stuff off the load and they come out there
24 with the forklift and take them off.

25 Q Okay. What do you do to relieve --

1 MS. CALVY: His mom has some water out there.

2 Can I get it from her right quick?

3 THE COURT: Sure. And she's welcome to sit in
4 here if she wants to; but whatever she wants to do.

5 Q My question was what do you do to relieve --
6 alleviate some of the pain that you have?

7 A Well, I just try to take -- they try to tell
8 me to keep it elevated. I try and do that, but I just
9 take my medicine and whatever.

10 Q Okay. And you -- what about like your back
11 pain and your hip pain? Do you do anything in
12 particular to try to relieve the pain, besides the
13 medication?

14 A Well, just like I said, they tell me to not
15 to sit too long or whatever and stand too long. I try
16 to get up and move around just a little bit. When I
17 start to hurt I can't stand up but for so long.

18 Q Do you have a brace -- is that a brace on
19 your leg today?

20 A Yeah.

21 Q Okay. How often do you have to wear that?

22 A They tell me just wear it, except when I'm
23 sleeping. I got to wear it all the time except when
24 I'm sleeping.

25 Q Except when you're sleeping?

1 A Yeah.

2 Q And do you wear it all the time?

3 A Uh-huh.

4 Q Okay.

5 A Yes.

6 Q How does it help you?

7 A Well, it helps -- helps -- the way they got
8 it design it helps take the weight, keep the pressure
9 off my leg some. It don't be as bad, you know, but
10 it help with the -- with the weight.

11 Q Okay. Now you had the surgery and you had
12 swelling. Now, did the surgery help your knee?

13 A No, I -- no, I still can feel that right in
14 there where they -- where I had the surgery, I still
15 can feel all that in there. But I think one of them
16 MRI reports stated -- state that it still -- still
17 damaged stuff up in there.

18 Q Has any further treatment been recommended
19 for your knee?

20 A No.

21 Q No? Has anybody considered more surgery for
22 your knee?

23 A I mean, they was supposed to been getting
24 back, but they ain't never say nothing.

25 Q So it was discussed?

1 A Uh-huh.

2 Q All right. When you're sitting do you have
3 any problem with your hip, your back or your leg?

4 A Yes.

5 Q Yes? What kind of problems are you having?

6 A Pain in the hip and back. I mean it's going
7 to be hurting.

8 Q Do you have to alternate sitting and
9 standing to help with the pain or what do you do?

10 A Yeah, I mean I sort of -- a lot of time I
11 just -- I try to recline back or whatever and lay to
12 -- sort of like lay to the side, off on the left side.
13 I mean I've tried different -- different routines, but
14 it don't really help that much.

15 Q Okay. What kind of walking do you do? Do
16 you walk in the mall?

17 A No.

18 Q Are you able to go grocery shopping and
19 things like that?

20 A No, I usually let my mom do it.

21 Q Okay. What if when you have to do it, how
22 do you handle that?

23 A I don't -- I don't do it. I mean my mom, I
24 let her do it.

25 Q Okay. How far do you usually walk? What

1 kind of walking do you do during the day?

2 A If anything, I just do probably like go out
3 on -- go out on the porch or whatever and sit down.
4 And I go to my mom house, because she's like --
5 probably like from here to the parking area to go to
6 her house. But otherwise, when I go over there, I
7 just usually sit down or whatever, go over there and
8 talk to her or whatever. I don't usually do nothing
9 no more.

10 Q Why not?

11 A I can't. My back pain -- the pain and stuff
12 in my back and my leg and stuff.

13 Q Okay. Do you ever have occasion where you
14 have to like get out and go and walk a block or so?

15 A No.

16 Q No? You don't put yourself in that position
17 or what?

18 A No. Like I say my leg be hurting me so bad,
19 I be trying to -- trying to stay calm as much as I
20 could.

21 Q Okay. Do you have problems climbing stairs
22 and things like that?

23 A Yeah.

24 Q How do you handle that when you're in places
25 that you have to climb stairs?

1 A I take my time and try to get up, just like
2 when I was coming in this morning. I mean just take
3 time to do it. Try to keep the pressure off -- off
4 the right side.

5 Q Okay. Dr. Winkler, the vocational expert
6 you went and saw that's located in Florence, did you
7 go in person to see Dr. Winkler?

8 A Yes, ma'am.

9 Q When was that?

10 A I think that was --

11 Q I think he's a vascular --

12 A -- a couple weeks ago.

13 Q I think that's a vascular surgeon. When did
14 you see him?

15 A I think it was like a couple weeks ago.

16 Q Okay. So tell me a little bit about your
17 work history. What kind of work have you done other
18 than truck driving?

19 A Well, I used to -- I used to go -- I used to
20 work for Disability and Special Needs. That was
21 probably back in before I started driving trucks.
22 When I used to work -- when I first got out of school
23 I was a supervisor at O'Neil, but they closed down. I
24 worked there from '93 to '99.

25 Q That was like a sewing plant?

1 A Yeah, they was -- was a dye plant.

2 Q How long were you a truck driver?

3 A I was driving truck ever since 2000.

4 Q 2000?

5 A Uh-huh.

6 Q Okay. Up until the time you were injured?

7 A Yes.

8 Q Okay. And the O'Neal was like a sewing
9 plant and you did that for four or five years?

10 A About six years or something like that.

11 Q And what type of physical work did that
12 include?

13 A Well, you really just been standing at the
14 machines. The machine been doing all the work. Just
15 watching the machine dye the material.

16 MS. CALVY: And Commissioner, there is two
17 vocational reports in our APAs that thoroughly goes
18 over the work history for him. So I'll rely on that.

19 THE COURT: Okay.

20 Q What about education? What kind of
21 education do you have?

22 A I went to -- finished twelfth grade. I
23 graduated twelfth grade. And then I had like
24 technical -- I mean technical -- building construction
25 class at C.E. Murray.

1 Q What kind of class was that?

2 A It was building construction.

3 Q Building and Construction?

4 A Uh-huh. Yes. I'm sorry.

5 Q And what did you do with that? Did you have
6 any jobs that you utilized that with?

7 A I mean when I was working with Disability
8 and Special Needs, do little simple stuff like that,
9 but otherwise --

10 Q Okay. How old are you now?

11 A 40.

12 Q You're 40? Okay. Have you done any jobs
13 where you just kind of just was able to sit around and
14 work?

15 A No.

16 Q No? Do you have any military background?

17 A No.

18 Q And how are you supporting yourself now?

19 A Off -- off the workmen comp what I'm getting
20 every week.

21 Q Do you have to get help in the house with
22 cooking and cleaning and things like that?

23 A Yeah, my momma, she do a lot of cleaning and
24 stuff and my oldest daughter.

25 Q How old is your daughter?

1 A My oldest daughter, she 21.

2 Q Okay. And what kind of things can you do in
3 the house?

4 A Little simple thing, like something to put
5 in the microwave right quick or whatever I can do,
6 can't do no cooking for a long time.

7 Q Okay. Sweeping the floors, mopping, are you
8 doing any of that?

9 A No.

10 Q No vacuuming?

11 A No.

12 Q Okay. What kind of medications are you
13 taking?

14 A Hydrocodone 7.5 and Meloxicam and Ibuprofen.

15 Q And all this is for pain?

16 A Yes.

17 Q The Employer's paying for the medication?

18 A Yes.

19 Q Yews? Okay. When was the last time you've
20 been to the pain management doctor?

21 A I think it was in December. I got another
22 appointment coming up, I think it's next -- next week,
23 I think, on the 12th.

24 Q Next week. And what does he do for you?

25 A When every time I go he give me the medicine

1 for the pain and stuff.

2 Q Okay.

3 MS. CALVY: I think that's all the questions I
4 have at this time, Commissioner.

5 THE COURT: Okay. Mr. LaFave.

6 MR. LaFAVE: Thank you, Commissioner.

7 CROSS EXAMINATION

8 BY MR. LaFAVE:

9 Q Mr. Brown, you just testified that you have
10 never had a sitting job; is that right?

11 A Yes, sir.

12 Q Do you recall your deposition?

13 A A sitting job?

14 Q Do you recall giving a deposition in this
15 case?

16 A Uh-huh.

17 Q Is that a yes?

18 A Yes.

19 Q Okay. Do you recall testifying to having
20 worked for Steel Related Technologies?

21 A Yeah, but it ain't -- it really ain't -- you
22 could work and stand, but there ain't no sitting --
23 sitting -- no -- no continuous sitting.

24 Q Okay. But the question that you asked --
25 that you were asked was whether or not you had ever

1 had a job sitting down working?

2 A Well, it really ain't been no sitting job,
3 really.

4 Q Okay. You didn't do a job at Steel Related
5 Technologies as an assembler where you were allowed to
6 sit and do the job?

7 A Very, very minimum.

8 Q Okay. Is that a yes, you were allowed to
9 sit at that job?

10 A Yes.

11 Q What about Petting House where you worked as
12 an assembler, were you allowed to sit during that job?

13 A Very minimum. I mean it was no long time
14 sitting.

15 Q Neither of those jobs required you to do any
16 lifting did they?

17 A I mean very minimum, because you had the
18 cranes doing -- doing all the lifting.

19 Q Okay. But did they require you to do any
20 lifting?

21 A Very minimum.

22 Q Okay. You also had a job where you were
23 working for the Department of Special Needs; is that
24 right?

25 A Yes.

1 Q Okay. And you were taking employees, or I
2 guess clients in the special needs departments to
3 different job sites?

4 A Yes.

5 Q Okay. Were you not sitting doing that job
6 while you were supervising them getting their job
7 done?

8 A No, that's driving when you're sitting, but
9 I had to stand up and watch them because they were
10 handicap.

11 Q Okay. So you weren't actually sitting while
12 you were watching them do their job?

13 A No.

14 Q Okay. You testified also that you saw Dr.
15 Winkler, the vascular surgeon that your attorney sent
16 you to a couple weeks ago?

17 A Yes.

18 Q Okay. I'm looking here at your attorney's
19 -- the APAs that y'all submitted.

20 MR. LaFAVE: Which is APA Number 14,
21 Commissioner, page 38.

22 THE COURT: Okay. Thank you.

23 Q Any idea why this indicates November 14 of
24 2014 for this report for Dr. Winkler?

25 THE COURT: I'm sorry, Mr. LaFave, can you repeat

1 what page you were on?

2 MR. LaFAVE: Page 238.

3 THE COURT: Page 238?

4 MR. LaFAVE: APA Number 14.

5 THE COURT: Okay.

6 MS. CALVY: That's an amendment. He has two
7 reports, page 249 of my APAs.

8 BY MR. LaFAVE:

9 Q There is an initial report, November 14th,
10 2014, correct? Are you aware of that? Did you see
11 Dr. Winkler on November 14, 2014?

12 A No.

13 Q Okay. So this report was generated by Dr.
14 Winkler, without you having seen him, correct?

15 A Yes.

16 Q Okay.. How many times have you seen Dr.
17 Morrison prior to November 14th, 2014?

18 A How much time I seen him for what time now?

19 Q Before November 14th of 2014, how many times
20 have you seen Dr. Morrison?

21 A I can't recall. I know the -- I want to say
22 five -- I'm going to say five -- I'm going to say
23 anywhere from five to seven times.

24 Q Okay. And Dr. Morrison is the vascular
25 surgeon that did the greater saphenous closure,

1 correct?

2 A Yes.

3 Q Okay. And I think you testified, if I heard
4 you correctly, that you still have issues where that
5 surgery was done?

6 A No, that's the -- she asked me about the
7 orthopedic surgeon.

8 Q Okay. Do you have any problems where that
9 saphenous --

10 A I still can feel it. That run up - like run
11 from here all the way up -- you can see --

12 Q Where is the -- where is the scar on your
13 leg from that saphenous closure?

14 A That would be somewhere like right in about
15 where my calf at, somewhere like that.

16 Q Okay. And you sat through Dr. Morrison's
17 deposition, correct?

18 A Yes.

19 Q Okay. Do you recall that deposition?

20 A Yes.

21 Q Do you recall Dr. Morrison testifying that
22 your lymphedema is not related to your workers'
23 compensation claim?

24 A Yeah, he said that in the report and he went
25 back and changed what he said.

1 Q My question to you was: In his deposition do
2 you recall him saying that it was not related to your
3 work injury?

4 A Yeah, that's what he said.

5 Q Okay. Do you recall what his testimony was
6 that it was related to?

7 A I forget how -- how he said it, but I
8 remember him saying -- saying something about what it
9 was related to. I can't remember exact whatever he
10 called it.

11 Q Isn't it true that Dr. Morrison determined
12 in the deposition that your issue was your -- your
13 obesity?

14 A He said that, but he changed -- went back
15 and changed in his report too.

16 Q But in the deposition he testified under
17 oath that your lymphedema was as a result of your
18 obesity, correct?

19 A Well, one time in the beginning he wasn't
20 saying that. He said weight wasn't no issue.

21 Q My question was in his deposition did he
22 attribute it to your obesity?

23 A That's what he said in his deposition.

24 Q Okay. Do you have any idea how much the
25 report from Dr. Winkler costs from 2014?

1 A How much it cost?

2 Q How much it cost to get that report from Dr.
3 Winkler?

4 A I don't know.

5 Q Okay. You saw him then for the first time,
6 if I understand correctly, January 20th, 2015,
7 correct?

8 A Yeah.

9 Q Do you recall how much that visit cost?

10 A I don't know.

11 Q Do you recall the date of the greater
12 saphenous closure surgery that Dr. Morrison did?

13 A Yes, sir, that's February 2013, Valentine's
14 Day.

15 Q Okay. So nearly -- nearly two years later
16 before you even saw Dr. Winkler for the first time,
17 correct?

18 A Yes.

19 Q Okay. How long was the appointment with Dr.
20 Winkler?

21 A I believe Dr. Winkler, I been in there
22 probably about -- about a hour -- about a hour.

23 Q Okay. Dr. Winkler spent an entire hour with
24 you in that visit?

25 A Yes.

1 Q Okay. Did he perform any tests?

2 A Well, he examined me.

3 Q Okay. Did he perform any tests?

4 A No.

5 Q Okay. You also saw a Dr. Rodney Allen,
6 correct?

7 A Yes.

8 Q All right. Who arranged for that visit?

9 A My attorney.

10 Q Okay. Do you know how much that visit cost?

11 A No, sir.

12 Q How much time did you spend with Dr. Allen?

13 A About the same?

14 Q About an hour?

15 A Yes.

16 Q Did he do any tests?

17 A No.

18 Q The hip problem that you're complaining of,
19 has any doctor told you what that's a result of?

20 A Far as -- far as my gait being off.

21 Q Okay. And Dr. Allen concluded that that was
22 a result of lymphedema and swelling in your leg,
23 correct?

24 A Yeah.

25 Q Okay. Is that the same with your back?

1 A Yeah.

2 Q Okay. You testified earlier that you have
3 issue with two disks in your back; is that right?

4 A Yeah.

5 Q And that was from an MRI?

6 A Yeah.

7 Q Has any doctor told you that that's a result
8 of the injury that you sustained to your knee?

9 A By my gait being off.

10 Q Has any doctor said it's a result of the
11 injury to your knee when you bumped your knee on the
12 trailer?

13 A Well, they tell me my gait, my altered gait.

14 Q So it's your altered gait, not your knee
15 injury?

16 A Well, they say all that come from that --
17 from the knee injury, by me walking oddly.

18 Q Which is a result of the swelling in your
19 leg, correct?

20 A Yes.

21 Q Okay. You testified that there was some
22 indication of some additional treatment for your knee;
23 is that right?

24 A Yes.

25 Q Who is the doctor that indicated --

1 A Dr. Rudolph --

2 Q Hold on, let me finish my question. Who is
3 the doctor that indicated you needed additional knee
4 treatment?

5 A Well, Dr. Rudolph, when I went back to him
6 and they saw that my kneecap was sitting out of place,
7 I supposed to be going back to see -- the insurance
8 supposed to be getting back -- because my kneecap
9 sitting on the right, it ain't sitting in the middle.
10 And what the MRI report shows when they went in there
11 and did the first surgery everything still the same.
12 So ain't nothing change from the first surgery inside
13 there.

14 Q What's the treatment that's been
15 recommended?

16 A Well, they saying something about knee
17 surgery again. I can't tell you exactly what --

18 Q Who is they?

19 A I mean Dr. Rudolph. I mean they told
20 Daffney -- they supposed to be getting back with
21 Daffney Creech. And they supposed to be getting back
22 with her and letting her know what they going to do
23 about the knee surgery again. Nobody never say
24 nothing. That's the same thing about the back or
25 whatever, ain't nobody never got back with them about

1 that either.

2 Q When was knee,-- when was the additional
3 knee surgery recommended?

4 A This was -- I want to think this was back in
5 March or April of last year.

6 Q Okay. Has the doctor ever at any point
7 concluded that the knee surgery that you're now
8 talking about is related to your original bumped knee
9 on the trailer?

10 A Yes.

11 Q Who?

12 A Dr. Rudolph, because I went to get another
13 MRI report done and that's when he said -- Dr.
14 Rudolph, because I had two MRI report. And the first
15 one been just for the knee, when I first got injured.
16 And the second time it was for my knee, back and my
17 hip and stuff.

18 Q Okay. So the issue with your knee, is it
19 your contention that the issue has never been
20 resolved?

21 A No.

22 Q Is that a no it's never resolved?

23 A Talking about working on my knee.

24 Q The issue that was seen in the second MRI,
25 are you -- is it your testimony that that was not

1 resolved during the first surgery?

2 A No.

3 Q And that was determined by Dr. Rudolph
4 somewhere?

5 A Yeah, I mean it supposed to be -- like I say
6 they supposed to be getting back with him to see what
7 they can do by me having -- by me going back to get
8 the -- get the correction done in this knee.

9 Q Has Dr. Rudolph ever expressed any concern
10 over potential complications from a second surgery?

11 A I mean they say right now -- I mean I
12 remember him saying something about right now by my
13 knee being big like this, they going to try to wait to
14 see if some of the swelling go out my leg. And that
15 -- I remember him saying that. But I supposed to be
16 having another one-- him talking about doing another
17 knee surgery.

18 Q Okay. So despite what you're alleging to be
19 complications from knee surgery, they're already
20 talking about a second knee surgery; is that what your
21 testimony is?

22 A Yes, I mean but they ain't nobody never said
23 nothing back, so I really ain't got no -- no answer on
24 that.

25 Q Going back real quick to the assembly jobs

1 that you had. When was the last time you worked as an
2 assembler?

3 A Before I started working at Steel Technology
4 in 2009, that was at Steel Related Technology.

5 Q Okay. So 2009 -- as recently as 2009 you
6 worked as an assembler?

7 A I'm going to say after 2009. December 2008
8 coming up to -- because I started with Steel
9 Technology the first of January the coming year.

10 Q So December of 2008 you were working as an
11 assembler?

12 A Before Steel Tech call me, because I put in
13 a application with them and they called me.

14 Q Okay. Explain to the Commissioner what the
15 responsibilities were for you as an assembler at Steel
16 Related Technologies?

17 A Well, similar rules for Nucor Steel, big
18 log, like you putting like bearings in it and you
19 putting like the grease before you put the bearings.
20 And building, putting the shaft in with the crane.
21 That was it.

22 Q Okay. What do you have to do in so far as
23 putting the bearings in as an assembler?

24 A You grease -- well, you clean them out. You
25 clean -- make sure they ain't no -- no metal shavings

1 in and you grease them down and you put the bearings
2 in. Sometime they slide right on in once you grease
3 them.

4 Q Okay. And that's not a job that can be done
5 sitting down?

6 A Well, you do very minimum sitting. Very
7 minimum.

8 Q Okay. If your shift was eight hours, how
9 much time would you spend sitting doing that job?

10 A I mean certain things you have to get down
11 low on, because if we tearing one down, that's
12 minimum. I mean throughout the day you standing the
13 most -- the majority of the day doing a bunch of
14 standing.

15 Q Okay. How much time throughout the day
16 would you be sitting down?

17 A I'm going to say about a hour, if you really
18 look at it.

19 Q The job restrictions that you have
20 currently, has anybody told you what you should not
21 do?

22 A No lifting, squatting, standing.

23 Q Okay. Isn't it true that Dr. Rudolph has
24 indicated you can have a job sitting and standing but
25 you have to be able to change positions?

1 A He said no sitting and standing for ten --
2 ten -- no standing for no long period of time; no
3 sitting for no long period of time.

4 Q Okay. And that was a result of the
5 swelling, correct?

6 A A result of the swelling in my leg?

7 Q Yes.

8 A You talking -- talking Rudolph -- what Dr.
9 Rudolph say?

10 Q That's why Dr. Rudolph gave you that
11 restriction, correct?

12 A I mean he give me the restriction, I mean
13 because I ain't had -- I ain't had no job. I was
14 terminated. I ain't had no job to go to.

15 Q But he gave you -- he gave you work
16 restrictions allowing you to take a job where you
17 could -- so long as you could sit and stand and change
18 positions, correct?

19 A Well, he give me the restrictions, but he
20 said no sitting, standing -- I mean no sitting, no
21 standing for no long period of time. So, no sitting
22 or standing, squatting, whatever.

23 Q But as long as you can change positions?

24 A No, he didn't say that.

25 Q Okay. And Dr. Tavel gave you similar

1 restrictions, didn't he?

2 A No, I ain't had -- not as I can recall. No
3 sitting, no.

4 MR. LaFAVE: Commissioner, bear with me one
5 second.

6 THE COURT: Take your time.

7 A Not as I can recall. He said no sitting,
8 standing or squatting.

9 Q Okay. So Dr. Rudolph completed a
10 questionnaire --

11 MR. LaFAVE: Page 234, Commissioner.

12 Q -- where he indicates that you can't stand
13 or walk more than 15 minutes at a time; is that right?
14 Do you have any reason to disagree with that?

15 A I mean I couldn't remember exactly how it
16 been, maybe something like that. I couldn't tell you
17 exactly how he worded it.

18 Q And you sat through Dr. Tavel's deposition,
19 too; did you not?

20 A Yes.

21 Q And you heard Dr. Tavel indicate that you
22 had certain work restrictions, correct?

23 A Yes.

24 Q Okay. And Dr. Tavel, in his deposition,
25 attributed those to the swelling in your leg, didn't

1 he?

2 A I mean you -- you're asking me the question?

3 Q Yes.

4 A The same restriction as he got me in, no
5 sitting, squatting, standing.

6 Q For a certain period of time, though?

7 A That's all I remember. No -- no sitting,
8 squatting or standing for no long period of time.
9 That's what -- that's what -- that's the understanding
10 I get.

11 Q But it was not a restriction that said you
12 cannot take a job where you can sit or stand, correct?

13 A Exactly what he tell me I can't -- no he --
14 he didn't tell me that. I just go on the restriction
15 what he -- listen at what he said. I can't stand,
16 sit, squat for no long periods of time.

17 Q Okay. Have you actively sought any work at
18 any point since the injury?

19 A No.

20 Q So you haven't even applied anywhere to see
21 if there's a job that you can do?

22 A No. I'm still on workmen's comp.

23 Q So that's why you haven't applied for jobs
24 is because you have workers' comp?

25 A I ain't -- I can't work right now.

1 Q But that's why you haven't applied for jobs
2 because you are on workers' comp right now, right?

3 A I mean when you look at it, my opinion, I
4 ain't -- I ain't workable right now.

5 Q Okay. But that -- that's your opinion, you
6 haven't taken any steps to see if there's a job out
7 there that you can do, correct?

8 A Like I said, 'm still on workmen's comp.

9 Q But you haven't seen if there's a job out
10 there that you can do? You haven't tried, have you?

11 A No.

12 MR. LAFAVE: That's all I have, Commissioner.

13 THE COURT: Ms. Calvy.

14 MS. CALVY: Okay.

15 REDIRECT EXAMINATION

16 BY MS. CALVY:

17 Q Now you have seen two vocational experts
18 related to this accident, right?

19 A Yes.

20 Q And these are experienced people that can
21 find you jobs, right?

22 MR. LAFAVE: Object to the form.

23 THE COURT: Sustained. Please rephrase.

24 MS. CALVY: Okay.

25 BY MS. CALVY:

1 Q Did any of these vocational experts list any
2 job -- did they tell you any job that you can do?

3 A No.

4 Q Did any of them tell you that you can work?

5 A No.

6 Q Okay. Now, according to APA page 10 to 11
7 of the Claimant's Brief, did Dr. Tavel tell you that
8 you needed a ten minute break every hour while you're
9 working?

10 A Yes.

11 Q Okay. On every hour you have to have a ten
12 minute break, right?

13 A Yes.

14 Q Okay. And just for clarification, Dr.
15 Winkler, the vascular doctor that you saw in Florence,
16 there's two reports. One of them you weren't there,
17 right, when he did that report, right?

18 A Yes.

19 Q The second report he did he examined you?
20 You went to him in person and saw him, right?

21 A Yes, ma'am.

22 Q Okay. And just for clarification, it sounds
23 like Dr. Rudolph may have suggested further surgery to
24 your knee, right?

25 A Yeah.

1 Q And is it that he -- listening to the
2 testimony it sounds like he didn't do further surgery
3 because of the swelling; is that why?

4 A Yes.

5 Q Okay. And was that going to be address
6 maybe sometime later after the swelling goes down?

7 A Yeah, they was supposed to get back and see
8 -- try to see if some of the swelling would go out the
9 leg.

10 Q Okay. And all these jobs that the attorney
11 mentioned -- do you remember the jobs that he
12 mentioned to you a few minutes ago?

13 A About the Petting House, yeah.

14 Q Okay. Petting house, let's start with that
15 one. Okay. About how much sitting would you do at
16 Petting House?

17 A Very minimum. I mean just like I say, I
18 mean certain things you have to do to get down and
19 take like the bearing out, or take to get down to
20 loose a bolt out or something, but the rest of the
21 time you standing up.

22 Q It's a stand up job?

23 A Yeah. Very minimum sitting.

24 Q What other jobs did he mention to you?

25 A Steel Related Technologies.

1 Q How much sitting on that job?

2 A Very minimum. Same about the Petting House.

3 You do the same thing, like assembly.

4 Q And it was a stand up job?

5 A Stand up.

6 Q Okay. Any other jobs he mentioned to you?

7 A What he say about the job I had for

8 Disability and Special Needs.

9 Q And you said you were only sitting mainly
10 when you were driving?

11 A Driving, yeah, the rest of the time I had to
12 be right by them, because they were sort of like
13 handicap people. And you can't just be way off
14 sitting down nowhere, if something were to happen I
15 could lose my job.

16 Q Okay. And then you told me they terminated
17 you?

18 A Yeah.

19 Q When and why?

20 A Well, I know when I went back to the company

21 --

22 MR. LAFAVE: Objection.

23 MS. CALVY: I'll rephrase.

24 THE COURT: Sustained.

25 MR. LAFAVE: It exceeds the scope of cross

1 examination.

2 MS. CALVY: I don't think so because he -

3 MR. LaFAVE: I never got into any issues about
4 him being terminated on cross examination.

5 MS. CALVY: It came up, Commissioner, during the
6 examination.

7 THE COURT: I don't recall about his termination.

8 MS. CALVY: Okay. He didn't mention it, but my
9 client did.

10 THE COURT: I'm going to sustain his objection.

11 MS. CALVY: Okay. All right. Let's see if I
12 have any other questions for you. I think that's it.

13 THE COURT: Okay. Thank you, Ms. Calvy.

14 MR. LaFAVE: I just have a couple of real quick
15 questions, Commissioner.

16 THE COURT: Sure.

17 RE-CROSS EXAMINATION

18 BY MR. LaFAVE:

19 Q Mr. Brown, your attorney just asked you
20 about Dr. Tavel's restrictions. Do you recall that?

21 A Uh-huh.

22 Q She asked you about a specific restriction,
23 the ten minute breaks. Do you recall that question?

24 A Uh-huh. Yes, sir.

25 Q Okay. And you recall me just having been up

1 here asking you questions about Dr. Tavel's
2 restrictions; do you recall that?

3 A Yeah.

4 Q And when I asked you questions about his
5 restrictions you couldn't really remember them, could
6 you?

7 A She went into details, because she was
8 giving me what he said. She tell me.

9 Q But when I asked -- but when I asked you
10 questions about the restrictions he gave you, you
11 didn't say anything about a ten minute break, did you?

12 A I told you I had restrictions, but I had ---
13 he told me I had every ten minutes, but I man I
14 remembered as much as I can remember.

15 Q All right. Your testimony today has been
16 truthful, hasn't it?

17 A Yes.

18 Q Okay. And you've been asked a number of
19 questions about your job with Steel Related
20 Technologies as well as Petting House, correct?

21 A Yes.

22 Q And you were asked specifically how much
23 time you spent sitting versus standing, correct?

24 A Very minimum.

25 Q Yeah. And when I asked you a question you

1 said at most one hour out of your shift, correct?

2 A Very minimum. I mean if you put all the
3 time together sitting down, it probably average up to
4 an hour.

5 Q And you recall giving a deposition in this
6 case, right?

7 A Yes.

8 Q And you recall me asking you similar
9 questions during your deposition?

10 A I remember you asking me questions.

11 Q Okay. Do you recall what your testimony was
12 in your deposition about how much time you spent
13 sitting versus standing at Steel Related Technologies?
14 If you don't I'm happy to show you a copy of your
15 deposition if you think it will refresh your memory.

16 A Like I said minimum standing. I mean
17 minimum sitting.

18 MR. LAFAVE: Commissioner, I'm going to show him
19 -- this is on our APAs, on an as needed -- but I'm
20 going to show him and I will hand up a copy of his
21 deposition transcript.

22 Q Mr. Brown, I'm going to show you page 20,
23 starting with at the job at Steel Related
24 Technologies. Can you read that question aloud for
25 the Court and can you read your answer, right here,

1 "At that job at Steel Related Technologies".

2 A Oh, "At the job at Steel Related
3 Technologies how much time would you say you spend on
4 your feet versus sitting down?" "It was like half and
5 half. We work like 12 hours. Probably like half
6 time, half like six something, like that." That's
7 what I say.

8 Q Okay. So your testimony in your deposition
9 back on July 30th, 2014 was that it was about half and
10 half sitting versus standing?

11 A Like I say -- I say half and half you
12 sitting down and you try to get up. You try to loosen
13 something and you standing right back up trying to
14 (inadubible).

15 Q But my question for you was: In your
16 deposition, when you were asked how much time you
17 spent sitting versus standing, you said half and half,
18 didn't you?

19 A That's probably what I said at the time.

20 Q But that's what you testified to, you just
21 read it, right?

22 A Yeah.

23 Q Okay. But yet sitting here today in front
24 of the Commissioner under oath, you're now saying that
25 you spent about an hour of your day sitting?

1 A Just like I say I mean very minimum. I mean
2 it ain't like you sitting no long period of time,
3 because you have to stand up to assemble stuff.

4 Q But that's not what you testified to in your
5 deposition, correct?

6 A Half and half, I mean.

7 Q Okay. But your testimony here today --

8 MS. CALVY: Objection. Asked and answered,
9 Commissioner.

10 THE COURT: Yes, let's move on.

11 MR. LAFAVE: That's all I have, Commissioner.

12 THE COURT: Okay. Ms. Calvy, anything more?

13 MS. CALVY: I don't have anything, Commissioner.
14 I just want to hand up that deposition.

15 THE COURT: Okay. Other than the deposition
16 nothing more?

17 MS. CALVY: Nothing further, Commissioner, from
18 the Claimant.

19 THE COURT: Well, that concludes this hearing.

STATE OF SOUTH CAROLINA)
)
 COUNTY OF LEXINGTON) CERTIFICATE

BE IT KNOWN THAT I TOOK THE FOREGOING WORKERS'
 COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN AND
 FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF 50
 TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND
 COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT
 THE TIME AND PLACE AFORESAID TO THE BEST OF MY SKILL
 AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF
 ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE
 OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES
 HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 254TH DAY OF
 NOVEMBER, 2015.

 CORA ELLIS BRUTON
 NOTARY PUBLIC FOR SOUTH CAROLINA
 MY COMMISSION EXPIRES DECEMBER 31, 2024

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1205647

O'Shea Brown,)
)
Claimant,)
)
v.)
)
Steel Technologies and)
)
Employer,)
)
and)
)
Twin City Fire Insurance)
Company,)
)
Carrier/Defendants.)
_____)

ORIGINAL

FULL COMMISSION PANEL HEARING

Monday, June 20, 2016
2:45 p.m. - 3:08 p.m.

The full commission panel hearing was held before the South Carolina Workers' Compensation Commission, 1333 Main Street, 5th Floor, Columbia, South Carolina, on the 20th day of June, 2016 before Barbara S. Ham, Court Reporter and Notary Public in and for the State of South Carolina.



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APPEARANCES

COMMISSION PANEL:

Melody James, Chair
T. Scott Beck
Aisha Taylor

Joe Ann Calvy, Esquire
Joe Ann Calvy, LLC
209 West Mill Street
Post Office Box 610
Kingstree, South Carolina 29556
Attorney for the Claimant

Matthew C. LaFave, Esquire
Crowe LaFave
Post Office Box 1149
Columbia, South Carolina 29202
Attorney for the Employer/Carrier/Defendants

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1 COMMISSIONER JAMES: Are y'all unpacked enough? Are
2 you ready?

3 MS. CALVY: Yes.

4 COMMISSIONER JAMES: All right. And let's see who
5 is the -- let's talk about time, time here.
6 And I always get -- is today, I want to say
7 Tuesday. All right. Eight, Eight three and
8 three and as listed Joe Ann you are the first
9 Appellant so we will let you go first.

10 MS. CALVY: Okay. Thank you.

11 COURT REPORTER: Today is June 20, 2016. This is
12 South Carolina Workers' Compensation Case
13 Number 1205647. This is the case of O'Shea
14 Brown, Claimant vs. Steel Technologies,
15 Employer and Twin City Fire, Carrier. This is
16 a cross-appeal. The first Appellant is the
17 Claimant represented by Joe Ann Calvy. The
18 second Appellant is the Defendant represented
19 by Matthew C. LaFave. Each side is allowed ten
20 minutes for oral argument and the Appellant
21 three minutes in reply. You are requested to
22 argue the grounds of exception and stay within
23 the record.

24 COMMISSIONER JAMES: Just for correction before we
25 get started. This is a cross-appeal so it will



1 eight minutes, eight minutes, three and three.

2 COMMISSIONER TAYLOR: I thought it was two and two.

3 COMMISSIONER JAMES: Three and three.

4 COMMISSIONER TAYLOR: I thought two and two.

5 COMMISSIONER JAMES: Okay. Three and three, that's

6 fine.

7 MS. CALVY: Okay. Thank you, Commissioners.

8 Commissioners I am here today to appeal a case

9 I feel my Claimant is such an unfortunate

10 Claimant. Well he was 38 years old at the

11 time, he's 44 now. He had worked for this job

12 for nine years and it was a regular day at work

13 and he was driving his truck -- tractor truck,

14 got out of his truck and went around and

15 climbed onto the back of his trailer and bumped

16 his knee and that created total chaos for him.

17 He experienced immediate pain to his knee. He

18 saw an occupational doctor. The pain increased

19 and the swelling increased and then he saw Dr.

20 Rudolph who is an orthopaedic specialist. Dr.

21 Rudolph saw him and immediately noted that he

22 had significant swelling. At that point he had

23 surgery for meniscus tear, he had a medial

24 meniscectomy and arthroscopy. And immediately

25 -- within hours after that my client testified



1 and it is in the records that he noticed grave
2 swelling to his knee and from that point
3 forward the swelling increased, never went back
4 down. Dr. Rudolph finally gave up after he
5 said that there was a deathly difference
6 between the right leg and the left leg and
7 below the knee was a problem. So he thought it
8 might have been a vein problem so he sent him
9 to Dr. Morrison. Dr. Morrison looked at him,
10 noted the swelling. He did vascular surgery on
11 him in hopes of correcting the swelling. That
12 didn't work. He continued to have swelling
13 that would not go down. Dr. Morrison finally
14 released him and mentioned some future medical
15 care that he could use. He sent him over to a
16 pain specialist and the pain specialist has
17 been seeing him still helping him with the
18 pain. The reason why I'm here today is because
19 the Single Commissioner only found the knee
20 liable in this case, that was the only body
21 part that compensable and he awarded him 12
22 percent for the knee. He denied the resulting
23 back issues, hip issues and the vascular
24 problem which is the main reason why he is
25 probably unable to work at this time. As a



1 result of that we had two conflicting vascular
2 specialists that gave opinions on this case.
3 The treating doctor, Dr. Morrison, said that he
4 felt like my client had a dormant vascular
5 condition, a venostasis condition that was
6 present lying dormant and the we add he had
7 never seen any other doctors prior to this
8 accident and never had any problems with his
9 knee. He was working, he was fine. And so Dr.
10 Morrison said it was a condition that was lying
11 dormant and when he had the work injury it
12 exacerbated the underlying venous condition and
13 it caused him to have swelling. And so the
14 Single Commissioner felt like because of that,
15 because he had this underlying problem that the
16 venous condition was not related to the work
17 injury. I then sent him to Dr. Winkler, he is
18 a vascular surgeon, and he's the head vascular
19 surgeon at McLeod Hospital in Florence. Dr.
20 Winkler looked him and Dr. Winkler said I think
21 it is work related and it happened as a result
22 of the bump on the knee. The bump on the knee
23 caused the vascular condition. I did raise
24 that question to the authorized treating
25 doctor, Dr. Morrison, and he said that he don't



1 think a bump of that nature would cause a
2 venous problem. Of course he was not there, he
3 doesn't know how hard my client hit his knee
4 but that's what he said. But Dr. Winkler said
5 that he believes that a bump on the knee could
6 cause such conditions. Dr. Morrison did say
7 that he noticed in knee replacements where the
8 person may have had a venostasis disease but
9 not in this particular case. So based on that
10 we are asking that my client is totally and
11 permanently disabled because of the venous
12 condition in his leg, the knee issue. There's
13 no dispute about the hip and the back so far as
14 whether the leg problem caused that as a
15 result of an altered gait. The dispute is
16 whether or not it is related to the vascular
17 condition and that's why the Single
18 Commissioner denied it. I did do some case
19 searching -- well first I will just mention the
20 statute, statute 42-9-35, talks about whether
21 you can have a condition that is lying dormant
22 that can be exacerbated by a work injury and
23 therefore it is compensable. And then I did
24 some case research and it was hard. I found
25 some cases but it is usually only the main



1 things that we are here for like the back and
2 psychological issues and things like that. But
3 then I find a case of *Hines vs. Pacific Mills*.
4 It's an old case, it's a 1949 case. But in
5 that case the client got a hernia from
6 straining and when the surgeon went to do the
7 surgery for the hernia he noticed that the
8 client had some type of disease tumor on his
9 testicle and so the surgeon went ahead and did
10 the surgery on the tumor and did the hernia at
11 the same time. So the issue was whether or not
12 the tumor was related to the accident and the
13 case kind of goes into that, what the court --
14 the court found that if the tumor was related
15 to the hernia he would have had some type of
16 underlying hematoma or some proof that there
17 was something recent that happened and there
18 wasn't anything there so the court did not find
19 the tumor related. But the tumor was
20 classified as a disease and in this case my
21 client has a venostasis disease that one doctor
22 says was aggravated as a result of the injury
23 and another doctor don't say that. He just
24 says that the bump caused it. But I think this
25 is a good case to show that this could be



1 considered a dormant disease that my client had
2 that was fine but for the accident he would
3 have been driving his truck hopefully and he
4 would have been doing fine but because of that
5 he has a condition where he has what Dr.
6 Morrison described as irreversible swelling.
7 Dr. Morrison named some things he could do like
8 massage therapy and losing weight and things
9 like that but he couldn't give a significant
10 number of his previous patients that had
11 benefitted well from it. Dr. Winkler the other
12 vascular surgeon said that even if my client
13 did all the items -- all the things that Dr.
14 Morrison mentioned that my client still would
15 not see significant recovery and I'm just look
16 at his legs. I don't know whether y'all want
17 to review his legs or not but from my opinion
18 one of the legs look at least two to two and
19 half bigger, size bigger than the other leg.
20 And the ratings -- so far as the ratings with
21 the venostasis disease being included, Dr.
22 Tavel, the pain management doctor, gave him a
23 rating that was over 60 percent to the right
24 leg coupled with the 12 percent for the knee
25 and there are some ratings in the evidence for



1 the hip and for his back.

2 COMMISSIONER TAYLOR: I think the Single
3 Commissioner's order noted that the 12 percent
4 or I think the 13 percent impairment rating
5 included the swelling. Is that correct?

6 MS. CALVY: I saw that in -- I saw it in the
7 Commissioner's order too.

8 COMMISSIONER TAYLOR: In the order but where did
9 that -- because there's nothing that out or I
10 guess delineates that rating. I didn't see
11 anything and I just wanted to make sure I
12 wasn't missing something. Is there something
13 that sets forth the breakdown of that?

14 MS. CALVY: I didn't see that.

15 COMMISSIONER TAYLOR: Okay.

16 MS. CALVY: I just saw it in the order myself.

17 COMMISSIONER TAYLOR: All right.

18 MS. CALVY: Yeah. I think that's it. Let me just
19 make sure I covered my issues.

20 COMMISSIONER JAMES: And I think your time is up,
21 you'll have three minutes in cross.

22 MS. CALVY: I didn't hear anything go off. I'm
23 sorry.

24 COMMISSIONER JAMES: It did.

25 COMMISSIONER TAYLOR: It's real light. I was asking



1 you a question at the same time.

2 **MS. CALVY:** Oh, okay. Well, thank y'all for the
3 extra time.

4 **COMMISSIONER TAYLOR:** Thank you.

5 **COMMISSIONER JAMES:** Mr. LaFave?

6 **MR. LaFAVE:** Thank you, Commissioners. Just to go
7 back in time briefly. This is an accident that
8 happened in April of 2012. There's no dispute
9 the nature or extent of the actual accident
10 itself. He was getting on top of his trailer
11 and as he was climbing up to the top he bumped
12 his knee on the ladder. No dispute that he
13 notified his employer. He did have eventual --
14 eventually underwent a partial medial
15 meniscectomy which under the AMA guides gives
16 a two percent rating. Commissioner in answer
17 to your question, the initial Form 14B upon
18 which a Single Commissioner relied as to
19 determine the date of MMI ---

20 **COMMISSIONER JAMES:** Uh-huh (affirmative response).

21 **MR. LAFAVE:** --- gave him a 13 percent. And what
22 that was that was an indication of two percent
23 for the medial meniscectomy plus what he notes
24 in the Form 14B was he increased it as high as
25 he could possibly go to account for the



1 swelling. Now fast forward obviously to Dr.
2 Tavel. Dr. Tavel actually gave him a separate
3 60 percent impairment rating for the
4 lymphedema. The issue here is the vascular
5 surgeon most familiar with this case is Dr.
6 Edward Morrison. Dr. Morrison was a vascular
7 surgeon to whom he was referred by the initial
8 treating orthopaedist when he essentially threw
9 his hands up and said, I can't get a grip on
10 whatever is going on with this gentlemen's leg.
11 He was then sent over to Dr. Morrison and Dr.
12 Morrison goes in and he does a surgical
13 procedure to close off one of his veins in
14 hopes of redirecting some of that fluid where
15 it is suppose to go which upwards towards the
16 heart then circulate back down in hopes of
17 getting a grasp on the swelling. Dr. Morrison
18 sat through a pretty extensive deposition on
19 this particular issue -- on the causation issue
20 which is really the main reason why we are here
21 as to Claimant's appeal. And Dr. Morrison was
22 asked several different times, several
23 different ways, is it your opinion in Mr.
24 Brown's case that his current condition is
25 directly attributable to the arthroscopy that



1 he underwent. He responds, his current
2 condition of venous disease and lymphatic
3 disease is attributable to the arthroscopy
4 which was his question back to me. I said yes,
5 sir and he says no. In my experience chronic
6 lymphedema does not result from a single
7 meniscus tear or repair. He goes through his
8 deposition transcript which was a part of the
9 record -- he goes through and talks about the
10 reasons why an arthroscopic procedure is not
11 going to have any affect on the vascular
12 condition. There's a fat pad that divides the
13 knee. They are working in the frontal
14 compartment, the vascular system is on the rear
15 which is separated by this fat pad. That's why
16 he goes into in a more invasive procedure such
17 as a total knee replacement there is a
18 potential for the development or compromise of
19 the vascular condition. Both parties were
20 present at the deposition. Both parties had
21 equal opportunity to question him on this and
22 he was unwavering in his opinion as to the
23 vascular condition not being causative related.
24 Therefore jumping forward you have Dr. Tavel's
25 60 percent, that goes completely out of the



1 window. You have Dr. Ahern and Dr. Allen, both
2 whom were retained as IME doctors on the knee,
3 both of their opinions if you side with Dr.
4 Morrison's conclusion who again we believe
5 should carry the greater weight as being the
6 treating physician. He's the one that did the
7 surgery. He's the one most familiar with this
8 individual and his course of treatment as
9 opposed to an IME doctor with whom he spent an
10 hour. In addition to that Claimant's also
11 appealed the back and the hip which again
12 there's only evidence that would indicate due
13 to the swelling his gait has been altered as a
14 result. He has potentially developed some
15 issues with his back and his hip and it was out
16 contention, supported by the Single
17 Commissioner's ruling, that those issues are
18 unrelated. As to our appeal, we appealed one
19 minor ruling by the Commissioner and that was
20 the Commissioner's decision to not grant a
21 credit for overpayment. Commissioner noted
22 that there was no Form 21 filed which there was
23 not.

24 MS. CALVY: I am going to object.

25 MR. LAFAVE: 42 ---



1 MS. CALVY: Just because he's moving on his appeal,
2 does it really matter?

3 COMMISSIONER JAMES: It doesn't. You divide the
4 time up the way you want to.

5 MS. CALVY: Okay. All right.

6 MR. LAFAVE: Under 42-9-210, that was not pled in
7 the Form 58 either. However, we had even
8 conceded that there was no credit back. The
9 issue here was the fact that the Commissioner
10 elected to deny the Defendants a credit from
11 the date of the hearing until the date of the
12 order instructions which spans some nine
13 months. Under the law as it exists currently,
14 first of all 42-9-210 does not require the
15 filing of a Form 21. Also, there's nothing
16 about a Form 58 having to even reference 42-9-
17 210. In fact the case law as cited in our
18 brief specifically says that the right to a
19 credit is the right in equity and therefore the
20 Commission has discretion to grant a credit.
21 There was no -- through no fault of either
22 party, the Claimant or defense, there was no
23 basis to deny the employer and carrier a credit
24 at least from the date of the hearing until the
25 date of the order instructions. At nine months



1 that was nearly \$20,000.00 credit that my
2 client should have been entitled to in equity.
3 If you want to side with the fact that the 21
4 was not filed so we are not going back tot he
5 date of MMI or we are not going back to the
6 filing of the 21. If you even want to say 42-
7 9-210 wasn't cited in the Form 58 that's fine
8 that would go to compensation that had already
9 been paid. What the issue here is on our
10 appeal is this compensation that as of the date
11 of the hearing had not yet been paid. So even
12 if we had claimed 42-9-210 that would not have
13 addressed or begun to touch a potential
14 perspective credit because as of the date of
15 the hearing only after the conclusion of the
16 hearing was it determined that the claimant was
17 at maximum medical improvement. Therefore the
18 right to any credit post-hearing does not begin
19 to accrue and therefore even wouldn't be
20 compensated or accounted for in 42-9-210.
21 Therefore we would ask that the Single
22 Commissioner's ruling be affirmed in part with
23 the only obvious reversal being the entitlement
24 to credit from the date of the hearing until
25 the date of the order instructions as set forth



1 in our brief. Thank you.

2 COMMISSIONER JAMES: Uh-huh (affirmative response).

3 Ms. Calvy?

4 MS. CALVY: Commissioners, I think we can make the
5 same equity argument about the time period that
6 it took the Commission to make a decision. We
7 had the hearing February 6, 2015 and we didn't
8 get his instructions until November the 10th,
9 2015 despite us sending message and emails
10 inquiring about it. So to my client we can
11 make an equity issue. He's the Claimant versus
12 the company. Who should have to eat this loss?
13 I don't think it should be my client.

14 COMMISSIONER BECK: The loss should be his.

15 MS. CALVY: Well, I don't think it should be my
16 client's either because through no fault of his
17 own the Commissioner took nine months to make
18 a decision.

19 COMMISSIONER TAYLOR: Have y'all -- have you --
20 well, I will ask Mr. LaFave the same thing when
21 he comes back up for rebuttal. Have y'all
22 looked at *Sanders vs. Midwest Vaco* because in
23 that particular case it was similar
24 circumstances in that it was neither the
25 Defendants nor the Claimants fault in the



1 delay. In this case it was actually getting to
2 a hearing but they were asserting credit from
3 a prior time and so it was determined because
4 it was neither party's fault that it reverts
5 back to what the statute says which is entitles
6 the Defendants in this case to a credit. And
7 I just didn't know if that -- I didn't see it
8 in the brief so I didn't know if either of you
9 had looked at it.

10 MS. CALVY: I did look at Sanders. I think it had
11 relied on whether the Defendant had filed a
12 Form 21 too in Sanders and in that case they
13 did file a Form 21. In this case a Form 21 was
14 never filed at any time and that is something
15 that could have been done during the long wait
16 or not since we had already had our hearing but
17 none was never filed. A hearing was never
18 requested. The only way the case got moved and
19 even though my client was being paid temporary
20 benefits a hearing was never requested. He
21 continued to get these checks from the employer
22 so if a 21 was filed at some point I probably
23 would have some doubt about it but in this case
24 the Defendants did nothing to try to mitigate
25 the damages that was done to them at all. And



1 also with respect to Dr. Morrison. Yes we did
2 take Dr. Morrison's deposition and Dr. Morrison
3 also filled out a questionnaire -- a pretty
4 long questionnaire that Mr. LaFave sent him in
5 March of 2014 and in that questionnaire the
6 doctor was asked, please identify the specific
7 diagnosis for which you are treating the
8 Claimant, venostasis disease and lymphedema.
9 For each diagnosis referenced in response to
10 number one please indicate whether or not said
11 diagnosis is related in any way to Claimant's
12 workers' compensation claim. And if related
13 please specify how. Yes, the injury likely
14 exacerbated his underlying venostatis disease.
15 Can I have one more minute? I'll make it fast.

16 **COMMISSIONER JAMES:** If you will just finish your
17 thought..

18 **MS. CALVY:** . Okay. Well, with respect to Dr.
19 Morrison's statement about whether or not he
20 feels the venostasis disease and edema is
21 related to the accident, he answered yes in his
22 questionnaire and that is on page 236 of the
23 Claimant's brief.

24 **COMMISSIONER JAMES:** Thank you.

25 **MS. CALVY:** Thank you.



1 MR. LaFAVE: Thank you, Commissioners. Commissioner
2 Taylor, to address your question about Sanders,
3 it is specifically referenced in our reply
4 brief on pages two and three. Number one, we
5 will acknowledge that there was no Form 21
6 filed in this case. There was a Form 21 filed
7 in Sanders. But a reading of Sanders does not
8 indicate that a Form 21 is a pre-requisite for
9 entitling one to correct. Again we are willing
10 to concede no credit up until the date of the
11 hearing. Our issue is through no fault of
12 either party, defense or Plaintiffs, there was
13 ample time for a ruling to be provided. We
14 didn't cause any delay in that. In fact both
15 parties worked in conjunction to try and get a
16 ruling sooner than November of that same year
17 and therefore we believe in equity under 42-9-
18 210 we should at least be entitled to a credit
19 from that period of time. No one is eating a
20 loss or taking a loss. The Claimant still
21 continued to receive his temporary total
22 disability benefits during that time. If you
23 were going to make an argument in equity,
24 temporary total disability benefits at that
25 point would have been stopped and then you



1 could make the argument in equity that your
2 client suffered some injustice as a result of
3 not continuing those benefits. But he didn't
4 in this case. He continued to receive those
5 benefits. We are simply asking for what we
6 should be entitled to under the statute which
7 is a credit for that period of time where we
8 caused no delay. As to Dr. Morrison, we will
9 acknowledge he did complete a questionnaire
10 initially and said I do believe that there is
11 an aggravation. But if you look at his
12 deposition transcript it was clear when he was
13 asked questions he was answering the questions
14 as he was being asked them. He was asked
15 questions about this being an arthroscopic
16 procedure and immediately he said I appreciate
17 you bringing that to my attention that it was
18 that type of a procedure. And then repeatedly,
19 under oath, under direct and cross-examination
20 maintained this condition was not aggravated by
21 his work related injury nor was it aggravated
22 by the treatment that he underwent. And
23 therefore the Single Commissioner reached the
24 proper conclusion that the vascular condition
25 was not casual related as evidenced by Dr.



1 Morrison's opinion. Certainly one can argue he
2 had a questionnaire once but in this situation
3 he had a questionnaire and then sat through a
4 multi-hour deposition where he was subject to
5 both direct and cross-examination. There was
6 no benefit of direct and cross-examination of
7 the questionnaire. That was only done at the
8 deposition at which point in time clearly and
9 definitively concluded, it was not related.
10 Therefore we believe the Single Commissioner
11 reached a proper conclusion in that area.
12 Thank you.

13 COMMISSIONER JAMES: Thank y'all. That concludes
14 this hearing.

15 (There being no further questions, the deposition
16 concluded at 3:08 p.m.)
17
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25



CERTIFICATE

This is, to certify that the hearing consisting of twenty-two (22) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on September 16, 2016.

Barbara S. Ham

Barbara S. Ham
Court Reporter

Notary Public for South Carolina
My Commission Expires: April 13, 2026



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STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC File No. 1205647

O'Shea Brown,)
)
Claimant,)
)
v.)
)
Steel Technologies,)
)
Employer,)
)
and)
)
Hartford Accident &)
Indemnity Co.,)
)
Carrier, Defendants.)
_____)

COPY

DEPOSITION OF
EDWARD C. MORRISON, M.D.

Thursday, July 31, 2014
2:23 p.m. - 3:31 p.m.

The deposition of EDWARD C. MORRISON, MD, taken on behalf of the Defendant, at the Offices of Coastal Surgical Vascular Vein, 1327 Ashley River Road, Charleston, South Carolina on the 31st day of July, 2014 before Mary H. Occhipinti, Certified Court Reporter and Notary Public in and for the State of South Carolina, pursuant to Notice of Deposition.



APPEARANCES

Joe Ann Calvy, Esquire
 Joe Ann Calvy, LLC
 209 West Mill Street
 Kingstree, South Carolina 29556
 Attorney for the Claimant

Matthew C. LaFave, Esquire
 Crowe LaFave, LLC
 500 Taylor Street
 Columbia, South Carolina 29201
 Attorney for the Employer/Carrier

Also in appearance:

O'Shea Brown, Plaintiff

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EXHIBITS

There were no exhibits marked during this deposition.

STIPULATIONS

It is stipulated and agreed that this deposition is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.

It is stipulated by and between counsel and the witness that the reading and signing of the following deposition be, and the same are, hereby waived.



1 EDWARD C. MORRISON, M.D., having been duly sworn,
2 deposes and testified as follows:

3 DR. MORRISON - EXAMINATION BY MR. LAFAVE:

4 Q: Dr. Morrison, good afternoon. We met a few
5 minutes ago. My name is Matt LaFave. I'm here
6 today, again, as the attorney for ...

7 A: Yes.

8 Q: ... Steel Technologies and the workers'
9 compensation carrier in connection with a claim
10 filed against them by Mr. Brown, who I know
11 you've had occasion to treat. I'm here today
12 to take your deposition. Have you ever given
13 a deposition before?

14 A: I have, sir.

15 Q: Okay. I figured you had. I always ask the
16 question anyway. One main thing I'll remind
17 you of, doctor, is being here today, as a
18 vascular surgeon, I'm looking for your opinions
19 within a reasonable degree of medical
20 certainty. If you don't know something within
21 a reasonable degree of medical certainty, I
22 would just ask that you state that for the
23 record, is that fair?

24 A: Yes, sir.

25 Q: All right. And I'm not here to take up a whole



1 bunch of your time. I'm not going to belabor
2 each and every visit you've had with Mr. Brown.
3 I'm just looking for some key information, and
4 we'll hopefully get you out of here quickly.

5 A: Yes, sir. Can I ask you one question? Will
6 you spell your last name, sir, for me?

7 Q: Yes, sir. It's L-A ...

8 A: Yes, sir.

9 Q: ... capital F as in Frank, A-V-E.

10 A: L-A?

11 Q: F-A-V-E.

12 A: And your name ma'am, Ms. Kelly?

13 MS. CALVY: Calvy, C-A-L-, V like Victor, Y.

14 A: Okay, okay.

15 Q: Dr. Morrison, if you could state your full name
16 for the record, please?

17 A: Edward Chisolm Morrison.

18 Q: Dr. Morrison, can you give me your educational
19 background starting with undergrad, please?

20 A: Undergraduate school, I finished Washington Lee
21 University in 1980. Medical University of
22 South Carolina in '84. Five years of general
23 surgery training after that, from '84 to '89.
24 And then a year of vascular surgical training
25 in Houston, Texas, '89-'90. Then I came back



1 to Charleston and have been involved with this
2 practice, it's antecedents and it's ...

3 Q: Okay. Are you ABA certified, board certified?

4 A: American Board of Surgery, yeah.

5 Q: American Board of Surgery.

6 A: I'm certified by the American Board of Surgery,
7 American College of Surgeons and then the
8 American Board of Vascular Surgery, which is my
9 specialty, vascular surgery.

10 Q: Okay. And you said you started with the
11 practice here at what point in time?

12 A: 1990.

13 Q: 1990. You've been here ever since?

14 A: Yes, sir.

15 Q: Okay. Have you ever, at any point, been
16 disciplined by any of the boards that you're a
17 member of?

18 A: No, sir.

19 Q: Ever been tied up in any medical malpractice
20 claims?

21 A: My partner, Dr. Appleby, and I were named in a
22 medical malpractice lawsuit several years ago
23 that ended up in a, what do you call, a hung
24 jury, I don't know.

25 Q: Okay. So one went to trial and no jury.



1 verdict?

2 A: That's right.

3 Q: All right. Can you explain to me, just
4 generally, how you came to be involved in the
5 treatment of Mr. O'Shea Brown?

6 A: I can. And what I'm going to refer to, if it's
7 all right with y'all, since we are all of the
8 computer age, is medical records.

9 Q: Yes, sir.

10 A: And I first met Mr. Brown in January, I hope.
11 Let me make sure of this, of ... January, 2013.
12 And he had been referred by one of the
13 orthopaedic surgeons that we see in a similar
14 area. And referred for swelling of his leg and
15 issues related to that. And he had seen one of
16 the orthopaedic surgeons, I believe Dr.
17 Rudolph, about maybe some leg or knee
18 derangements and they wanted our opinions about
19 what's going on with his leg.

20 Q: All right. And in that visit, what was your
21 opinion as to what was going on with Mr.
22 Brown's leg?

23 A: It was my opinion, and again, I'm referring to
24 the medical records which you've got right in
25 front of you, that the patient had a very



1 swollen leg. In my opinion, it's probably
2 multifactorial, and that is ... I'll come back
3 to. The things that we can help and affect in
4 vascular surgical practice include venous
5 disease and lymphatic disease, so we did focus
6 on the veins. And he had significant reflux in
7 his greater saphenous vein. And talked to him
8 about stocking use and what all we could do
9 with that. So that's what we did in our first
10 visit back in January.

11 Q: And what was your treatment plan starting at
12 that point?

13 A: Our treatment plans are really multifactorial,
14 and let me tell you what I mean by that.

15 Q: Okay.

16 A: For someone to have, at a relatively young age,
17 I believe Mr. Brown was 38 at the time, a
18 significantly edematous and swollen leg, you
19 typically have to have several things going on.
20 Something busted with your veins or blood is
21 going in reverse. Something busted with your
22 lymphatics where blood does not go, excuse me,
23 a filtrated blood called lymphatic fluid does
24 not go back to your heart in the way God
25 intended it to do. And so, what we can do, is



1 shut down veins. And that sometimes
2 accommodates for that 10 to 20 percent of the
3 edema in the leg or the chronic swelling. If
4 there's a lymphatic involvement as well, we
5 push the patients that they've got to get
6 involved with lymphatic management, which
7 usually means weight management as well.

8 Q: Okay.

9 A: And let me finish. This is not a primary
10 lymphatic failure, this is a secondary
11 lymphatic failure. People who have primary
12 lymphatic failure, who are born with lymphatic
13 disorders, can be thin and asthenic, but
14 secondary is usually due to abdominal obesity.

15 Q: As far as the treatment plan, what was the
16 first order of business, as far as your
17 recommendation for moving Mr. Brown's treatment
18 forward?

19 A: After we ... after we had seen a big vein,
20 saphenous ... it's called saphenous vein, by
21 ultrasound, which was refluxing, we usually
22 offer to do what's called a VNUS Closure on
23 that, and that was done. And it closed, which
24 we can, you know, prove with ultrasound. And
25 that is, it's kind of part of a composite where



1 you've got to ... you've got to work on the
2 other things that are causing edema and
3 swelling of the leg.

4 Q: Okay.

5 A: And that would be lymphatic treatment. The
6 problem is, Mr. LaFave, of challenges, there's
7 no pill for lymphatic disease, okay. It is a
8 ... it is a, I want to say, a treatment plan
9 you have to come up with, including everything
10 from lymphatic massage to utilization of
11 Esmarks, utilization of lymphatic pumps, and
12 abdominal girth and weight. The more I've
13 gotten into this, involved within the last 10
14 to 15 years, is realizing plenty of people have
15 failure of lymphatics because of abdominal
16 girth. Your lymphatic fluid moves in a very
17 slow pace from the tip of your toes back to
18 your right heart. And it moves against gravity
19 and there are forces that inhibit it.

20 Q: Okay. What was your working diagnosis relative
21 to Mr. Brown?

22 A: My working diagnosis is that he had edema of
23 multifactorial origin, lymphatic and venous
24 disease.

25 Q: Okay. In your opinion, what was the primary



1 factor for his edema?

2 A: I would say venous disease and truncal obesity.

3 Q: Okay. What do you believe triggered the
4 swelling that you noticed in his leg in January
5 of 2013?

6 A: All I ... all I can tell you is that, you know,
7 Mr. Brown had a history of some sort of trauma
8 when he came to me from the orthopaedic
9 surgeon. That, you know, I never saw him
10 before that, never saw him during the trauma.
11 So can ... can I iterate that the edema, et
12 cetera, came from the trauma, I cannot, because
13 I never saw him beforehand.

14 Q: Okay. Is it plausible that the arthroscopic
15 surgery that he underwent from Dr. Rudolph
16 would have triggered the condition that you saw
17 on January of 2013?

18 A: Well, good question. And I appreciate you
19 bringing that to my attention, that he did have
20 arthroscopy for a meniscus injury. Everybody
21 who gets an arthroscopy gets a little swelling,
22 period. Even a skinny college girl gets a
23 little bit of swelling, okay. That typically
24 goes away right quickly. What I tell patients
25 over and over again as a vascular surgeon, that



1 if you have a chronically swollen leg and
2 lymphatic and venous failure, de novo, before
3 you have an injury or you consider a toe
4 procedure or something like that, that you have
5 to be very wary because the normal mechanisms
6 to clear, and I'm going to use the word clear,
7 like you're clearing fluid out of your legs,
8 they're gone. They're gone, okay. So there
9 are people who have trauma to the legs, whose
10 underlying edematous problems get much worse.
11 Occasionally, we'll see an orthopaedic patient,
12 you've told me not to digress, but let me give
13 you an example, who has a total knee
14 replacement. And it's an old lady and she's
15 moaning and groaning that she's swollen from
16 here down, and I never saw it beforehand, but
17 that can happen. It can aggravate underlying
18 edema. The other thing you'll see is,
19 occasionally, you'll see orthopaedic patients
20 who they know they have to put a knee
21 replacement in, who have got chronic venous and
22 lymphatic disease, and they send them to us
23 first and say get him in better shape, okay.
24 Do something to prevent the edema that may
25 accumulate. So big orthopaedic procedures,



1 you're going to have edema. Arthroscopy, seven
2 to 10 days, two weeks, but, you know, most
3 people are up in physical therapy, moving and
4 get moving.

5 Q: Okay.

6 A: And I'm not an orthopaedic surgeon, but I don't
7 see a whole lot downstream affects from
8 arthroscopy.

9 Q: Okay. Is it your opinion, in Mr. Brown's case,
10 that his current condition is directly
11 attributable to the arthroscopy that he
12 underwent?

13 A: His current condition of venous disease and
14 lymphatic disease is attributable to the
15 arthroscopy?

16 Q: Yes, sir.

17 A: No.

18 Q: Okay. Is it your opinion that his current
19 condition is first, it's just a swelling in and
20 of itself, is directly related to the surgery
21 that he underwent?

22 A: In my opinion, arthroscopy, which is two holes
23 in the knee, filling up the knee with some
24 fluid, putting the scope in and taking a little
25 device and chewing up the free piece of



1 cartilage, is usually fairly self-limited, as
2 far as how much swelling someone's going to
3 have. Is that going to cause chronic edema,
4 I've never seen it.

5 Q: Okay.

6 A: I've seen it from total knee replacements,
7 which is a big whack, big incision, mess, but
8 never seen it from arthroscopy.

9 Q: All right.

10 A: Can I ask you all at the table, I've got
11 piriformis syndrome and I don't sit well. I'm
12 sorry. So I may stand.

13 Q: Do what you've got to do to make yourself
14 comfortable.

15 A: It's just something I have to do to stretch.

16 Q: Sure. Now, my understanding ...

17 A: I don't want to make y'all uneasy, but it just
18 hurts.

19 Q: You're fine. My understanding, Doctor, is the
20 last time you saw Mr. Brown was, I think, June
21 6th?

22 A: I can confirm that. I was reviewing all this
23 yesterday between ... let's see. Let me just
24 see. One second. All right, that's 6/19, but
25 you mean June of this year, 6/19?



1 Q: Correct, 6/19.

2 A: Yes, sir.

3 Q: Okay.

4 A: Not six.

5 Q: And like I said before, I don't want to belabor
6 each and every visit you had, but between
7 January of 2013 and June 19th of 2014, did you
8 appreciate any improvements in the condition
9 that you were treating him for?

10 A: I've got to go back to the office records.
11 When we followed up, first after venous
12 closure, and he had a little relief and not
13 full relief. And we had recommended him to
14 really pursue more lymphatic management as
15 well, which I mentioned a minute ago, is a
16 major component of this. We couldn't feel good
17 pulses, because his leg was so swollen. And it
18 was incumbent to do arterial studies, which
19 were normal, thank God. But we did ask him
20 several times to proceed with lymphatic
21 management, which sometimes means everything
22 from massage to utilization of a lymphatic
23 pump, which is kind of, can be a burden, but
24 can be very effective as well.

25 Q: In your opinion, Dr. Morrison, the lymphatic



1 management that you're recommending, is that in
2 any way directly related to the arthroscopic
3 procedure or the underlying injury that he had
4 to his knee?

5 A: So arthroscopy usually causes a little bit of
6 edema for a short period of time, not chronic
7 edema. Lymphatic management is for chronic
8 lymphatic failure. And just to give you a
9 little ... so that everybody is communicating,
10 blood goes down an artery and it has got to go
11 back up in veins. In between arteries and
12 veins are a fine God given channel of vessels
13 called lymphatics, which most people don't know
14 they have. But if you think about it, you've
15 got lymph nodes in your neck, your arm pits,
16 your groin. Lymphatic fluid moves extremely
17 slowly. And so when people have lymphatic
18 failure, and it doesn't move back up to their
19 heart ... legs like they do, they're going to
20 have a chronically swollen leg, okay. So I
21 just wanted to give, you know, where the word
22 lymphatic failure comes from.

23 Q: Okay. The condition of Mr. Brown's leg on June
24 19th of this year, when you last saw him, do
25 you expect with the lymphatic management, do



1 you expect his condition to improve?

2 A: Let me just get that note, if you don't mind.
3 One second, please, sir. My ... she's probably
4 down the hall. My PA, physician's assistant,
5 Brandy Price, saw him and noted, you know, seen
6 him in six months for follow-up. He's still
7 having chronic pain in his right leg. He's
8 wearing stockings. No skin breakdown or
9 ulcerations. There was some comment about new
10 chronic back pain, and I think he's had some
11 evaluation of that. With the persistent pain,
12 you know, we're obligated to make sure he
13 doesn't have anything else going on. He has no
14 evidence of what we call deep vein thrombosis
15 or a clot. Brandy, Ms. Price, did note that
16 his edema's worse. He had a hard time getting
17 it on. They had ordered, there is a and I
18 will tell you this, not to be dramatic, but at
19 56 years old, I have a hard time putting on my
20 socks sometimes in the morning because of this.
21 And a lymphadema stocking is very difficult
22 sometimes to put on. There are newer ones that
23 have velcro straps, which allow the patient, as
24 well, to put on. He may have a big body
25 habitus. Brandy said she had ordered them, but



1 the patient hadn't gotten it. And did try to
2 get him back to a vendor who can get that
3 special stocking for him and as well try to do
4 something with lymphatic massage, see if that
5 would help him.

6 Q: Okay. Given that his condition has persistent
7 for as long as it has, from roughly January of
8 2013 to June 19th, do you expect any further
9 improvement in the amount of swelling that he
10 has in that leg?

11 A: In my opinion, with a reasonable certainty
12 degree, any patient who has chronic lymphadema,
13 who is overweight, usually is not going to get
14 better until they lose a large amount of
15 weight. And I'm not picking on people who are
16 overweight, I just want to explain to you the
17 pathophysiology. Lymphatic fluid moves
18 exceptionally slow. And one of the things
19 that, whether I like getting involved with
20 this, but the last 15 years it has come out in
21 the whole lymphatic and venous literature of
22 research, is something that was never
23 appreciated before, and that is, with a large
24 abdominal girth, a panniculus, the flow is
25 obstructed at the pelvic region and it sits.



1 It doesn't get back to the heart. And the only
2 way you can get rid of it is to lose weight and
3 push on it. The newer types of lymphatic
4 stockings that, excuse me, pumps that we use
5 don't just sit here. They require pushing on
6 the abdomen as well in a rhythmic fashion to
7 move fluid up. Otherwise, patients are going
8 to sit with lymphadema.

9 Q: Okay. I don't want to put words in your mouth,
10 Doctor, so if I understand ... but I want to
11 make sure I understand what your testimony is
12 correctly. If Mr. Brown were to lose, and I
13 know the term significant is relevant and
14 relative, but if he were to lose a significant
15 amount of weight, you would expect his swelling
16 in his leg to improve?

17 A: In my experience, when people are able to lose
18 weight, they do have fairly significant
19 improvement. Does a patient with chronic
20 lymphadema ever get perfect, it's rare.

21 Q: Okay.

22 A: It's a tough problem.

23 Q: Okay. But with weight loss, you would expect
24 to see some improvement, maybe not back to a
25 hundred percent?



1 A: Weight loss is also, one of the other things I
2 should have brought up is that the mechanisms,
3 the God given mechanisms that exist in your and
4 my calf and thigh to help push fluid upstream,
5 are going work better with weight loss because
6 you're exercising, okay.

7 Q: I think my final question for you, and it's a
8 pretty straightforward one, is his condition in
9 his lower extremity irreversible?

10 A: I would probably tie that into the weight loss
11 and exercise thing.

12 Q: Okay.

13 A: If he could lose a significant amount of weight
14 and get normal body habitus, typically you can
15 have a very dramatic improvement then. Will
16 you always carry some degree of lymphadema to
17 your grave with you when you've had lymphadema
18 like that, you probably will. Yes, sir.

19 Q: Okay. Can somebody who has lymphadema have
20 little to no appreciable swelling?

21 A: In my experience, I'm going to say no. And I'm
22 not going to pick on the women in the room, but
23 you have a young lady or any lady who's got
24 edema and swelling of the legs, they're pretty
25 upset about it. And you tell them they don't



1 have any swelling, you're going to get what you
2 deserve, okay. So lymphadema, by definition,
3 clinically has swelling, okay.

4 Q: Okay.

5 A: So you're not going to have lymphadema, oh, by
6 the way, I've got lymphadema, but you can't see
7 it, okay. Am I answering your question?

8 Q: That does answer my question. That's it.
9 That's all I've got for you.

10 **DR. MORRISON - EXAMINATION BY MS. CALVY:**

11 Q: What was that lawsuit about, that malpractice
12 lawsuit?

13 A: What was it about?

14 Q: Yes, sir.

15 A: It was about a death in the hospital of a
16 patient.

17 Q: What happened?

18 A: What happened?

19 Q: Yes, sir.

20 A: The patient died.

21 Q: Okay. And what was the plaintiff alleging that
22 you and your partner did wrong?

23 A: They were alleging that we didn't monitor the
24 patient in the hospital. And the last time I
25 checked, monitoring a patient in the hospital



1 is the responsibility of the RN staff.

2 Q: And that was your defense?

3 A: Well, the man died of natural causes. He had
4 smoked about six million cigarettes in his
5 life. And he had multi-bed vascular disease.
6 He died in the hospital, and as the hospital
7 does, they had limited liability, so the
8 lawyers came after us.

9 Q: Okay. And did the plaintiffs sue the hospital
10 too or they just sued you and your partner?

11 A: Absolutely.

12 Q: Okay.

13 A: Yes, ma'am.

14 Q: Have you discussed weight loss with my client?

15 A: I have. Yes, ma'am.

16 Q: Okay. What kind of conversations did you and
17 him have about that?

18 A: I'm fairly direct about my comments about
19 weight, Ms. Kelly, I mean Ms. Calvy, because of
20 the morbidity associated with it. And I tell
21 them that ... and that includes anybody with
22 lymphadema or Type II diabetics with blood
23 vessel disease, that everything I do is, it's
24 sometimes palliative unless they can lose
25 weight. And I believe ... I believe firmly



1 that people need to try to lose weight.

2 Q: Okay. Did you know Mr. LaFave prior to this
3 case?

4 A: No, ma'am. I met him at 10 till 2:00 when I
5 came in the room.

6 Q: Okay. What about his firm, have you had any
7 dealings with his firm?

8 A: What is your firm, sir?

9 MR. LAFAVE: Crowe LaFave.

10 A: ' Are y'all local?

11 MR. LAFAVE: Columbia.

12 A: No, no dealings.. No, ma'am.

13 Q: Okay. Have you exchanged any correspondences,
14 other than just sending medical records, to Mr.
15 LaFave or his firm?

16 A: No, ma'am.

17 Q: No, okay. And have y'all exchanged any emails?

18 A: No, ma'am.

19 Q: Okay. Have y'all had any communications by
20 telephone?

21 A: No, ma'am.

22 Q: Okay.

23 A: I said I met him at 10 till 2:00.

24 Q: How much weight would you say my client has to
25 lose to get these results that you've told Mr.



1 LaFave about?

2 A: I would have to know your client's weight
3 currently. And then what I usually do, and I
4 don't have it stored in my brain, but I mean
5 there's a little wheel you can look at. Be in
6 mind, ideal body weight is based on height, so
7 ...

8 Q: Do you have that? Can you get that?

9 A: I can get it off the last record.

10 Q: Okay.

11 A: Weight, we are, hold on. I've got a 6/19
12 weight, 300 pounds, BMI 41. And the height is,
13 I don't know where that is. I probably would
14 have to ask him his height, because we don't
15 routinely get height?

16 Q: How tall are you?

17 MR. BROWN: 5' 11."

18 Q: 5' 11" .

19 A: 5' 11", okay. So what would I tell a 5'11"
20 person that weighs 300 pounds, how much
21 overweight they are, I would just go to the
22 standard statistics and tell he's 80 to 100
23 pounds overweight.

24 Q: So he needs to lose ... he needs to get down to
25 219 pounds?



1 A: I would say 80 to 100 pounds overweight from
2 300, so 200, 220, something like that.

3 Q: And you mentioned something else they would
4 have to do in addition to losing weight to try
5 to see some of the results you talked about?

6 A: Well, one of the things that we know that helps
7 mobilize lymphatic fluid, ma'am, is the normal
8 God given mechanism of walking, which people
9 take for granted until they lose it. And it's
10 simple, sounds simple, but heel/toe walking,
11 and that is, you know, how you walk. When you
12 lose that mechanism and you can't walk, you
13 cannot plant your heel, then go up on your toe,
14 you lose the first method that God gives you to
15 push fluid back upstream with lymphatic fluid,
16 which is your calf pumps and muscles deep in
17 the calf called the soleus. So they function
18 to help pump. As an example, someone who
19 stagger walks, who's elderly, et cetera, who
20 has a wide-based gait, they're going to get
21 edema because they can't ... they can't ...
22 like this, heel/toe walk.

23 Q: Okay. You mentioned early that the lymphadema
24 was aggravated. Do you remember that, Doctor?

25 A: Aggravated, well, help me remember what I might



1 have said. I said that he had an edematous leg
2 when I met him. With venous disease, any
3 arthroscopy even in a ... the thin asthenic
4 patient, is going to give you a little bit of
5 swelling for 10 days, two or three weeks.
6 That's about ... I think that's what I said.
7 I don't remember now.

8 Q: And did you see him during those 10 days or two
9 to three weeks after his surgery?

10 A: When was his arthroscopy, ma'am?

11 Q: I'm not sure.

12 A: I can look that up for you. See, we met Mr.
13 Brown on January, 2013, and I thought he had
14 already had repair by this orthopaedic surgeon
15 before he saw us. So I saw him from ... I
16 never saw him before anything like that was
17 done.

18 MR. LAFAVE: His surgery was October 2, 2012.

19 A: So I would have seen four months, three and
20 half, four months after that.

21 Q: Okay. When you saw him, he had ... did you
22 consider him to have chronic lymphadema and
23 edema in his leg at that time?

24 A: I'll read our exam. Yes, ma'am. Right lower
25 leg is edematous throughout and he clearly



1 looked like he had some venous disease on top
2 of that. No skin ulcerations. Left leg looked
3 normal.

4 Q: Okay.

5 A: Good pulses.

6 Q: And did you talk with him about whether he had
7 had any problems with swelling or anything like
8 that prior to his injury?

9 A: I may have, but I have no record of it.

10 Q: Okay. So you didn't ... right now, you don't
11 have any knowledge of it?

12 A: I don't know. I never saw Mr. O'Shea before
13 this time or before his injury. So I would
14 have no way of knowing what his leg looked
15 like.

16 Q: Okay. But when you started seeing him, that
17 wasn't a history that you felt like you needed
18 to know, whether he had had any swelling or any
19 problems with his leg, prior to having this
20 injury and having the surgery?

21 A: It would be important, but I ... for some
22 reason we didn't document it. So I have no way
23 of knowing.

24 Q: Okay. And the surgeon sent him to you?

25 A: Harry, Dr. Rudolph, who is an orthopaedic



1 surgeon, sent him to us. Rhett Rudolph, I
2 think is his real name. He goes by Harry.

3 Q: And did Dr. Rudolph tell you why he was sending
4 him here?

5 A: Edema, swelling.

6 Q: And what was your understanding as to where the
7 swelling was coming from at that time when you
8 saw my client?

9 A: I thought he had chronic lymphadema and venous
10 disease, as I was mentioning earlier.

11 Q: And is that what Dr. Rudolph thought at the
12 time or he just wanted you to figure out what
13 was ...

14 A: He had ... he had no idea. He fixed the
15 meniscus and had a chronically swollen leg and
16 was trying to get some help.

17 Q: Okay. Now, you stated earlier that you've seen
18 a person have the type symptoms that my client
19 have, but only after a total knee replacement.
20 What's the difference with the total
21 replacement versus ...

22 A: Arthroscopy?

23 Q: Yeah.

24 A: So an arthroscopy, and I'm not an orthopaedic
25 surgeon, but is a fairly minimally invasive.



1 Nothing we do is minor. There's no minor
2 surgeons, no minor surgery, only minor
3 surgeons, okay. So ... but with arthroscopy,
4 which is an outpatient procedure, patients are
5 given some anesthesia. Two little holes are
6 made in the skin. The knee cavity is filled up
7 with fluid. It's a fascinating procedure, if
8 you've never seen one. And through the second
9 hole is a camera. And in the second hole a
10 device is used which can literally clip up the
11 pieces of busted cartilage, or meniscus is the
12 cartilage. So, you know, take an athlete who
13 has a busted cartilage, they're usually up the
14 next few days. And once they have some physical
15 therapy, back on the field quickly. That
16 versus a total knee replacement is a major
17 procedure where a big incision is made,
18 typically from here to down here. The bone is
19 resected. I mean, it's a mess. You know, a
20 new joint is put in it. It's a big, big
21 orthopaedic procedure. And I know they are
22 done willy-nilly now, like a drop in a bucket,
23 but it's still a big procedure. It's a big
24 operation.

25 Q: Is there any type of test that a doctor can



1 have done prior to surgery to see if a person
2 has some lymphatic problems?

3 A: So, yes, ma'am. Your best test for lymphatic
4 problems is basically an exam still. If you
5 want to prove lymphatic failure, if you've got
6 some edema and swelling is unclear, there are
7 things you can do, which we don't really
8 utilize a whole lot, ma'am, because they can be
9 very ambiguous. And they're called nuclear
10 medicine studies. And I might as well bore you
11 with that for a minute. Nuclear medicine is a,
12 you know, a matter of injecting radionuclides
13 and seeing how fast they clear from the lower
14 leg. So a normal individual, if you inject
15 some radionuclide between the two toes and put
16 them under a camera in the nuclear medicine
17 department in the hospital, in about 20 minutes
18 that radionuclide is up here and already to the
19 right heart. And when they do the studies for
20 lymphadema in radio nuclear ... in nuclear
21 studies, they see dramatic delays of the
22 chemical. It doesn't get past here, it sits
23 here, or a lot of the pattern is it sits right
24 here in your abdomen, it doesn't move, because
25 of abdominal lymphatic compartment failure, if



1 you will. So that can be done.

2 Q: Okay.

3 A: Sometimes, and let me throw one other thing
4 out, sometimes patients will come to us who've
5 been to a multitude of doctors and maybe a
6 dermatologist biopsied him and, you know, under
7 pathology it says, oh, you know, big dotted
8 lymphatics and the dermis is swollen. Usually
9 you make that diagnosis with your eyes, just
10 looking at the patient.

11 Q: Okay. Other than swelling, is there any kind
12 of other symptoms a patient can have that
13 signals ...

14 A: Yes, ma'am.

15 Q: ... that they could have the underlying
16 problems that you talked about?

17 A: Well, swelling. Swelling edematous we call it.
18 You have skin changes because this lymphatic
19 fluid sits under the skin in the dermis. And
20 long-term, untreated, the body doesn't like
21 that, number one, and you're at risk for
22 recurrent skin infection. And secondly, what
23 long-term happens to people with lymphatic
24 lymphademosus, they get, it's kind of a paradox,
25 but the body starts scarring it up. And all of



1 a sudden, your leg becomes kind of rock hard
2 and ulcers if you have a constriction around it
3 down here. So if you look in a vascular
4 surgical textbook and see patients who have
5 long-term edema and don't manage it, their leg
6 goes from swelling to this rock hard fibrotic
7 kind of tough mess to deal with, okay. And
8 these people are, you know, people with chronic
9 lymphadema are at risk for skin infection.
10 Your lymphatics are your first line of dealing
11 with, you know, invasion, bacteria in your
12 body, no matter where you are. Take the
13 example of a lady who has had a mastectomy,
14 with a chronic and swollen arm, they will get
15 infected like that. The same will happen with
16 the leg.

17 Q: And can you answer whether or not, if my client
18 loses almost 100 pounds and he sees some
19 changes in the swelling ...

20 A: Would you ... I'm sorry, would you restate your
21 question, please?

22 Q: Okay. What if my client has ... he loses the
23 weight.

24 A: Yes, ma'am.

25 Q: I guess maybe see some changes in the swelling.



1 A: Yes, ma'am.

2 Q: Would you be able to recommend at that time
3 that he have any further knee surgery that his
4 orthopaedic surgeon feels like he needs?

5 A: If he has a significant derangement of the
6 knee, I would leave that judgement of the
7 orthopaedic surgeon. Yet, if patients come to
8 us with chronic lymphadema, and let me just
9 give you a clinical anecdote, a patient would
10 be sent from an orthopaedic surgeon who says,
11 look, I'm struggling with whether to fix this
12 knee. I'm worried about chronic lymphadema.
13 The patient already has chronic lymphadema.
14 Most of those people, some of them can get a
15 lot worse after surgery, for big total knee
16 replacements. With partial replacements and
17 arthroscopic, we don't expect them to get
18 worse, but a total knee is a big hit, okay. So
19 it depends on what ... and really to answer
20 your question, it depends on what surgery
21 they're considering doing.

22 Q: Okay. Have you ever had a patient with chronic
23 ... with a chronic condition like my client,
24 lose weight and saw significant changes in the
25 swelling?



1 A: Yes, ma'am. But the problem, weight loss is
2 extremely difficult.

3 Q: How often do your patients, let's say, can you
4 say about on average how many patients come
5 through a year ... through here a year with the
6 type of problems that my client has?

7 A: Wow. So a denominator of how many patients we
8 treat with chronic lymphadema here, it may
9 number in the 500s to a 1,000.

10 Q: Per year?

11 A: I mean, that we follow long-term.

12 Q: Long-term?

13 A: Yes, ma'am.

14 Q: Okay. And out of those 500 to 1,000, tell me
15 if any of them have made dramatic results, lost
16 weight and ...

17 A: The best results ... the best results we can
18 make are with weight loss and lymphadema pumps.
19 And probably, wow, never really considered
20 that. I would say far less than 50 percent,
21 but I can't give you an exact figure, because
22 I don't, you know, I couldn't ... I don't tally
23 it.

24 Q: So you really don't know how many?

25 A: I would say less than 50 percent.



1 Q: Okay. Less than 25 percent?

2 A: Probably 10 to 20 percent will get better.
3 They are ... the most significant improvement
4 you have with lymphadema is going to be weight
5 loss, lymphatic pumps, and lymphatic massage.
6 And nobody mentioned that, and if it's all
7 right with you, ma'am, I want to tell you a
8 little bit about that, but I can ... or I can
9 hold off.

10 Q: I'm okay. I need to know as much as I can.

11 A: Well, when we mention lymphatic massage, some
12 people say, well, I'm not going to a spa and
13 paying money. This is not about going
14 somewhere, you know, putting on Nirvana music
15 and feeling good about yourself. Lymphatic
16 massage is a very effective modality. Here's
17 the problem with it. Here's where I can't get
18 people to do it. Number one, it cost money,
19 and I'm not paying for it. Number two, if I
20 send a new patient today to one of the hospital
21 systems for ... to their outpatient lymphatic
22 massage therapist, it takes two to three months
23 to get an appointment. We have found our own
24 people who don't work with the hospital, so
25 they are few and far between, certified



1 lymphatic massage experts, but they do good
2 work. And the problem with lymphatic massage
3 is, it is a chronic condition and most people
4 are going to need treatment once a month or
5 something, usually for life. So it is rare
6 that someone gets lymphatic massage and is
7 cured. They get better, the fluid is cleared.
8 They can utilize the stocking and they can
9 function better. But you're never ... it's not
10 like you're taking an appendix out and you're
11 better the next day. I mean, they've got a
12 problem dealing with it long-term.

13 Q: Okay. So since this is secondary, you don't
14 know about what age you see this, because it
15 can come on at any point?

16 A: You're using the word secondary, so I assume
17 you're referring to secondary lymphadema versus
18 primary?

19 Q: Right.

20 A: Primary lymphadema has a couple of patterns.
21 And one of ... you know, before maturity and
22 menstruation or adolescence, praecox. And
23 there's a second pattern that will come in
24 early adulthood, and there's kind of an elderly
25 pattern of lymphadema. Can I ... can I ... the



1 difference between a primary and secondary
2 lymphadema usually has to do with, we ascribe
3 secondary lymphadema typically to, excuse me,
4 big trauma, radiation of the pelvis, pelvic
5 cancer surgery. You know, a woman's had her
6 labia, et cetera, removed, and the lymph nodes
7 removed, lymph nodes removed here, and a
8 secondary lymphadema occurs from that.

9 Q: Okay. How long did you say you've been
10 practicing?

11 A: I've been in private practice since 1990.

12 Q: And what were you doing prior to that?

13 A: I was in vascular fellowship in Houston for a
14 year and then five years in general surgery
15 training. And did four years of medical school
16 and then four years of college and before that,
17 high school.

18 Q: Okay. And is it your testimony today, to a
19 reasonable degree of medical certainty, that a
20 person such as Mr. Brown that hit his knee, had
21 an injury because he hit his knee on his work
22 truck, and then it ultimately resulted in
23 arthroscopic surgery.

24 A: The meniscus, yes, ma'am.

25 Q: Can you say that, to a reasonable degree of



1 medical certainty, that that, all of that
2 itself, could not cause him to be in the state
3 he is in right now, with respect to his chronic
4 edema?

5 A: In my ... in my experience, chronic lymphadema
6 does not result from a single meniscus tear and
7 repair.

8 Q: What about a hit or trauma to like the knee
9 area?

10 A: Trauma is another word. So trauma, be it to
11 say the pelvis or thigh, femur, et cetera,
12 would be broken bones and/or major
13 reconstructive surgery. Pinning, et cetera,
14 those folks can certainly develop some chronic
15 swelling. You typically have to have
16 obstruction in the lymphatics, either groin or
17 pelvis, if you will, ma'am, in order to get the
18 edema in your lower leg. So somebody whose got
19 a big pelvic fracture and a big trauma, a
20 woman's who has had radiation to the pelvis or
21 something, or a man with, you know, prostate
22 cancer, et cetera, they can get lymphadema.
23 But in order to get lymphadema from trauma, you
24 usually have to have fairly significant trauma
25 in the groin or pelvis.



1 Q: Give me one second, I'm sorry.

2 A: Take your time.

3 Q: And just to be clear, is it your testimony to
4 a reasonable degree of medical certainty that
5 the treatment that you are providing to Mr.
6 Brown is not work related at all?

7 A: The treatment that I'm providing is, you know,
8 related to ... to ... the diagnosis I'm dealing
9 with is chronic edema and lymphadema. So is it
10 my opinion, let me make sure I'm getting this
11 question correct, that the treatment that I am
12 prescribing for the patient is not related to
13 work? Do I think it's related to a meniscus
14 tear, is that what you mean ...

15 Q: Do I ...

16 A: ... or work?

17 Q: Do I think it's related to his work injury?
18 Are you treating because of ...

19 A: No, ma'am. I do not think so.

20 Q: Okay. Who pays you?

21 A: Who pays me?

22 Q: Yes, sir.

23 A: Oh dear. Probably insurance companies,
24 typically pays doctors. Insurance companies
25 pay me.



1 Q: You don't have any record of who is sending you
2 your checks when you see Mr. Brown?

3 A: Oh, to see Brown?

4 Q: Yes, sir.

5 A: To tell ... the truth of the matter is, I'm
6 kind of old school with that, ma'am. I don't
7 ... I don't have in front of me what patient's
8 balances are. I don't have in front of me what
9 patients pay. I don't really have in front of
10 me what the insurance is. I guess I could look
11 it up here, but I don't keep records. I mean,
12 I just do my job. If you'd like, I could
13 figure what his insurance is. It might take me
14 a few minutes, or I could get one of my folks
15 to help me, but I don't know. I'm sure it's in
16 this computer, but I don't look at that. Do
17 you need me to find out?

18 Q: Yes, sir.

19 A: Okay. Well, then I might have to find one of
20 these young ladies to help me.

21 DR. MORRISON: I apologize, Devon, but you know
22 ignorant I can be.

23 MS. DEVON: No, sir.

24 DR. MORRISON: The attorney has asked me about this
25 patient's chart.



1 MS. DEVON: Uh-huh (affirmative response).

2 DR. MORRISON: And I don't ever look at the
3 insurance. I don't even know where it is. Can
4 you show me?

5 MS. DEVON: Sure.

6 DR. MORRISON: You want to have a seat?

7 MS. DEVON: Thank you, sir. All right.

8 DR. MORRISON: Show me. I'll look over your
9 shoulder.

10 MS. DEVON: We're going to go to his hub.

11 DR. MORRISON: Okay.

12 MS. DEVON: And you want to go to his info.

13 DR. MORRISON: Yes, ma'am.

14 MS. DEVON: Okay. He has Gallagher and Bassett
15 Services Insurance. It's right down here.

16 DR. MORRISON: Arizona, the state. Okay.

17 MS. DEVON: Yes.

18 DR. MORRISON: Does that answer your question, ma'am?

19 MS. CALVY: Yes, sir.

20 A: Okay. And then some information about a
21 workman's comp claim and

22 MS. DEVON: It's based out of Charlotte and the
23 adjustor is Linda Cannon Rivera. And their
24 telephone number is 704-547-1586. Did you need
25 the claim number?



1 MS. CALVY: No, I have it.

2 MS. DEVON: Okay.

3 DR. MORRISON: Thank you. Anything else you need
4 from insurance?

5 MS. CALVY: No, sir.

6 DR. MORRISON: All right. Thank you, Devon.

7 MR. LAFAVE: Thank you.

8 MS. DEVON: You're welcome.

9 MS. CALVY: Okay. You testified earlier that y'all
10 see about 500 to 1,000 patients come through
11 here that y'all kind of monitor. How many of
12 them do you actually monitor?

13 A: Well, I checked the other day because we were
14 in some negotiations with the hospital, how
15 many active patients we have is around 15,000.
16 And of the three physicians here, three PAs, so
17 how many do I actually see? I see, ma'am, I
18 guess I could take some time from my insurance
19 ladies and find out how many office visits I
20 have a year, but there are weeks when there
21 are, between my physician assistant and myself,
22 100 to 120. We are a very, very busy vascular
23 practice.

24 Q: Okay. And since you've been here in 1990, have
25 you since that time you've been treating



1 people with chronic edema problems? You've
2 been doing that the whole time?

3 A: Well, whether you like it as a vascular surgeon
4 or not, chronic lymphadema falls in your lap,
5 okay. And a lot of people try to shun it.
6 It's difficult, it's tough. But, you know,
7 it's part of your work. And so I've been
8 treating patients with chronic edema since I
9 went into practice.

10 Q: Okay. Now, what type of care, future care, are
11 you recommending for Mr. Brown?

12 A: In the perfect world, is ... all that can be
13 done for exercising body habitus. In a
14 perfect world, as well, I mentioned lymphatic
15 massage. I don't really remember, I can check
16 here, Salters, South Carolina is in ... near
17 Florence. In a perfect world, you would be
18 able to find somebody who does lymphatic
19 massage and help him. In a perfect world as
20 well, you would be able to find somebody, and
21 I usually do this with every patient, is try to
22 charge a family member to help lymphatic
23 massage. You can't really master it, but you
24 can help out a little bit with wraps, et
25 cetera. And then as well, utilization of a



1 pump, lymphatic pump.

2 Q: Okay. And this may be my last question. Do
3 you know of any justification or reasoning for
4 a person who, if he has any type of lymphatic
5 problems, is unaware of it, living a normal
6 life. He has an injury, bumps his knee, has
7 surgery, and immediately after the surgery, of
8 course, he has swelling. And then he follows
9 up with his doctor, and every time he follows
10 up, his swelling gets worse and worse and
11 worse. It never gets better, never loses the
12 swelling, and it's the same way now. Do you
13 have any idea, any reason how something like
14 that could happen, and what the reason, the
15 cause of it could be, other than what ...

16 A: The patient ... the patients have chronic
17 lymphadema, typically.

18 Q: The patient has chronic lymphadema?

19 A: Yeah, chronic lymphadema.

20 Q: Underlying?

21 A: Yes, ma'am.

22 Q: Maybe that's aggravated by something, maybe?

23 A: Yeah. And as we mentioned a minute ago,
24 typically, you know, big, big surgeries can
25 aggravate it. It is ...



1 Q: What about little ... do you consider his
2 surgery a little surgery or what? Are you ...

3 A: Well, I don't mean to be pejorative, but from
4 what I do, I consider it sometimes little. But
5 I've never had arthroscopy, I don't want one.
6 But I don't grade it minor surgery. I'm going
7 to talk about trauma, level of trauma. It's
8 two small incisions. There's no blood loss.
9 There is no exchange massively of fluids. And
10 most orthopaedic surgeons are in and out in 15
11 minutes with an arthroscopy. So it's on grade,
12 if you ask me to grade that versus doing, you
13 know, a focal abdominal aneurysm, it's a one in
14 a hundred. Do I think it's a major surgery
15 that's going to precipitate a massive edema, I
16 do not. A total knee could, a total knee
17 replacement could, or big pelvic trauma that I
18 mentioned a minute ago, cancer, radiation, et
19 cetera. But not in my experience. In my
20 experience, I've never seen that.

21 Q: Okay. So your reason is that he had edema ...

22 A: I never saw him

23 Q: ... prior to?

24 A: I never saw him before.

25 Q: But you're saying he could have had it?



1 A: Absolutely.

2 Q: I'm asking what your reasoning is. I mean,
3 what could have triggered this?

4 A: I never saw him before the 13th of January,
5 2013. And if you are asking my opinion, I
6 assume the man had a chronically swollen leg
7 beforehand.

8 Q: The way it is right now? You're saying, you're
9 assuming that the way his leg is right this
10 minute, since you didn't see him before, that
11 that's the way it was when he ...

12 A: He probably had some chronic lymphadema and it
13 was ... Now, I don't even have the orthopaedic
14 results, but was a knee trauma, and maybe one
15 of y'all could tell me about that, you know, a
16 meniscus tear, which you can do walking the
17 hall, did that precipitate his edema? In my
18 opinion, ma'am, it did not precipitate his
19 edema.

20 Q: Did you review the surgical records or anything
21 to ...

22 A: I'm sure. Yeah, I reviewed them. They're
23 probably in here, the arthroscopy from Harry,
24 from Rhett Rudolph.

25 Q: Did you review them enough to see whether there



1 was any complications or any problems while the
2 surgery was going on or you're just assuming
3 all surgeons do this type of surgery the same?

4 A: Well, when he would have been sent, we would
5 have reviewed them. I could find them for you,
6 if you like, the original referral note from
7 Dr. Rudolph.

8 Q: I just want to be clear, because you ... you
9 ... while on the one hand you says that this
10 type of problem can occur if an aggravation
11 occurs. And then you quickly make sure you add
12 behind it that it has to be a big huge surgery.

13 A: It sure does. Yes, ma'am.

14 Q: For it to happen?

15 A: Yes, ma'am. It's typically not coming from
16 minimal trauma. I have ... in my experience,
17 I've never seen chronic lymphadema come from
18 minimal trauma to the leg.

19 Q: Well, would you agree that the client probably
20 did not at least have edema in that knee area
21 prior to the doctor deciding to perform surgery
22 on it? Would you agree with that?

23 A: I can't agree with that, because I never saw
24 him. I never saw him. I would defer that to
25 Dr. Rudolph.



1 Q: Okay. So basically, based on your testimony
2 today, you can't really tell us whether the
3 injury my client had came ... the problems that
4 my client is having now with his swelling and
5 edema, came from his work injury, simply
6 because of the fact that you didn't see his leg
7 prior to his work injury?

8 A: Two reasons, didn't see his leg, as I also told
9 you, in my experience, meniscal tears which
10 are, and let's understand this, is in the
11 compartment of the knee, nowhere near the
12 artery, nowhere near the vein, nowhere near the
13 lymphatic. Meniscus tears in the compartment
14 of the knee are not going to affect blood flow,
15 which is in the posterior compartment of the
16 knee, separated from the compartment of the
17 knee by a thick fascia and bone and ligament
18 structures. So in my opinion, they do not
19 relate.

20 Q: Okay, I understand that. But you ... since I
21 started asking you questions, you keep saying,
22 well, I didn't see his leg prior to the
23 surgery. I don't know how it was. So,
24 therefore, you can't comment on whether he had
25 edema there or not.



1 A: Well, you just asked me, did I think that the
2 meniscal tear caused his edema, and I said no.

3 Q: Okay.

4 A: I think he had chronic edema.

5 Q: Okay. So just to be clear, what is the reason
6 ... what are you saying you can't tell me,
7 because you couldn't ... you didn't know how
8 his leg looked prior to his injury? What is it
9 that you cannot give me an answer about today
10 because of the fact that you didn't see his leg
11 prior to his injury?

12 A: You're going to have to restate the question.

13 Q: Really?

14 A: Yes, ma'am.

15 Q: Okay.

16 A: Do you have a question for me?

17 Q: I just asked you the question three times, sir.

18 A: No, ma'am. That was extremely circuitous.

19 Q: Okay. All right. Well, I'll ask it probably
20 similar again and maybe we can keep asking it
21 until you figure out what I'm saying. Now,
22 I've asked you, and I'm not a doctor, I'm doing
23 the best I can with these questions and you
24 know what I'm asking you, sir. But I'll say
25 this, I've asked you several questions today



1 and you told me I can't answer that, because I
2 didn't see his leg prior to his injury.

3 A: And I never did.

4 Q: Right.

5 A: Correct.

6 Q: What I'm saying is, what was it ... what were
7 ... what were you ... what was it that you
8 couldn't answer, because of the fact that you
9 didn't see his leg, that I asked you?

10 A: What was it that I can't answer because I
11 didn't see his leg?

12 Q: I think one of the questions I asked you was
13 whether or not a person, such as my client ...
14 let's see what I can ... all right. So I asked
15 you, first of all, whether or not you could
16 tell whether or not my client had any edema
17 problems prior to his injury?

18 A: And my response, are you ready for my response?

19 Q: Yes, sir.

20 A: I never saw your client, so I cannot tell with
21 reasonable, with complete certainty.

22 Q: Did you see any of his family doctor medical
23 records or anything else?

24 A: I'm not so sure. I was looking through here
25 and I don't think we ever got any family doctor



1 medical records.

2 Q: Did you have or did you take a history from my
3 client and ask him whether he had any swelling
4 problems with swelling or anything prior to the
5 injury?

6 A: You had asked me that before. And I'm looking
7 at our first examination in the office and it
8 states he had an injury with a tractor trailer.
9 It didn't mention anything about any chronic
10 swelling beforehand, and a meniscus injury, and
11 had it, you know, repaired.

12 MS. CALVY: Do you have any other questions for the
13 doctor while I'm getting my thoughts together?

14 MR. LAFAVE: I have just a few brief follow-up
15 questions.

16 MS. CALVY: Okay.

17 DR. MORRISON - RE-EXAMINATION BY MR. LAFAVE:

18 Q: Dr. Morrison, did you notice any change over
19 the time that you treated Mr. Brown in his
20 gait?

21 A: There's a mention in a later note that he had
22 said he had back pain, and had an MRI, and he
23 had been using a cane. I'm not a gait expert.
24 I'll frequently get patients up and down the
25 hall and walk, you know, see how they're



1 walking. But I didn't quantitate anything,
2 however, there is some mention in there.

3 Q: Is it possible that the swelling could lead to
4 an alteration of his gait?

5 A: Absolutely.

6 Q: Okay. Now, I'm going to ask you this, based on
7 a sort of a hypothetical, Dr. Morrison.
8 Assuming Mr. Brown was anywhere from 260 to 300
9 pounds prior to his incident, is it possible
10 that lymphadema could have, at some point in
11 time, been noticed but mistaken for just simply
12 obesity?

13 A: Yes, sir. Absolutely.

14 Q: That's all I have.

15 MS. CALVY: Okay.

16 DR. MORRISON - RE-EXAMINATION BY MS. CALVY:

17 Q: Let me see if I have anymore.

18 A: I'm sorry, I've got to stand up. My apologies.

19 Q: What if I were to tell you, prior to the
20 injury, both of Mr. Brown's legs were exactly
21 the same? And since you're the treating
22 physician, I think you have observed that the
23 leg with the chronic problem is probably three
24 times bigger or two and a half times bigger
25 than his regular leg. So if I were to tell you



1 that they were normal prior to the injury

2 A: Yes, ma'am.

3 Q: ... would you be able to give any reasoning, at
4 that point, as to what could have happened to
5 him? You didn't observe it, but what if I just
6 was to tell you that?

7 A: Well, if you ... if I had known or if it was
8 told emphatically, without any doubt, that he
9 had no evidence of chronic swelling pre-
10 arthroscopy and that one leg went bad after
11 that, I would say, okay, they're got to be
12 temporally related. I would try to figure out
13 how. But again, I cannot ... I can't, in my
14 brain, understand how a knee arthroscopic
15 procedure is going to deal up with anything
16 lymphatics in the groin and the pelvis.

17 Q: So through your experience, you just have not
18 seen it?

19 A: I've never seen it, but I've seen it from total
20 knees, I've seen it from total hips. You
21 know, big whacks here and here, but I've never
22 seen it from arthroscopy.

23 Q: Okay. And do you typically see a person having
24 an altered gait, like if they have a tear or
25 something in their knee that may need surgery.



1 on, such as Mr. Brown?

2 A: Wow, we see altered gaits. The ideology is so
3 multifactorial, everything from knee,
4 orthopaedic injury, vascular disease, venous
5 disease, dementia and alcoholism to muscle
6 atrophy. So there are so many things that
7 cause altered gaits. From our standpoint, as
8 a vascular surgeon, you're looking for blood
9 supply and/or venous disease or lymphatic
10 disease. He's got normal artery supply and
11 he's, you know, the veins have been taken care
12 of, which give you about 10 to 20 percent of
13 your edema in your leg, but I think I'm
14 answering your question, I hope I'm answering
15 it. Do I ever see other causes of gait
16 disturbance, yes, ma'am.

17 Q: And just to be clear, do you see problems with
18 gait disturbance with people that have knee
19 injuries?

20 A: Well, I don't see primary injuries. So if I
21 have a patient who can't walk and has a problem
22 with the knee, I would get him to an
23 orthopaedic surgeon to get it evaluated.

24 Q: Okay. What does the word irreversible mean to
25 you doctor?



1 A: Irreversible?

2 Q: Yes.

3 A: Unable to be reversed.

4 Q: Okay, no matter what?

5 A: Well, it's kind of an absolute word.

6 Q: That's what I thought. Have you seen edema in
7 people that ... whose weight were within the B
8 ... their BMI? Let me say it right. Let me
9 say it right. Do you ... have you seen someone
10 who has edema whose weight was per the
11 guidelines of the insurance guidelines?

12 A: Absolutely, yes, ma'am. Let me make sure I
13 clarify that question, seen some of them for
14 lymphadema?

15 Q: For ... yeah.

16 A: Yes, ma'am. Lymphadema, who is ... who is not
17 obese, yes, ma'am.

18 Q: Okay. And how do you treat them, if weight
19 loss won't help them?

20 A: The most stark example of that is going to be
21 a young lady who has lymphadema praecox. And
22 all of a sudden they're, you know, 21 years old
23 and they've got edema. And they're crushed and
24 psychologically burdened. It's a tough
25 problem. What are you going to do? You're



1 going to make sure they're not having an
2 obstructed process in their pelvis or something
3 like that causing lymphatic obstruction. And
4 you're going to ... sometimes I do get nuclear
5 medicine scans on them. And the reason I do,
6 because I'm sick of dealing with insurance
7 companies that tell me patients don't have
8 lymphadema. And I say, thank you, clerk, here's
9 your lymphadema scan, which shows chronic
10 lymphadema and that patient needs lymphatic
11 massage for the rest of their life. And
12 massage, occasionally, obviously you need
13 stocking and occasionally need pumps.

14 Q: So what are the chances that my client's
15 condition would improve if he does those things
16 that you talked about, losing weight, using the
17 lymphatic pumps and the lymphatic massage?

18 A: I think he will improve. I think he'll never
19 be, I mean, I don't think he'll be as he was
20 when he was a kid. I didn't know him as a kid,
21 but when he was a young man, because there are
22 chronic skin changes that occur. Remember I
23 mentioned it a little while ago about the
24 fibrosis. The body doesn't ... and God didn't
25 design us for lymphatic fluid to sit in the



1 dermis. And the dermis, and that is skin right
2 under, you know, the layer right under what
3 we're looking at, tends to get fibrotic and
4 scarred.

5 Q: And if he does these things, you think that
6 leg, with the chronic condition, could return
7 back to the size of the other leg?

8 A: I think it could get much better, probably
9 never totally normal. I've never seen a whole
10 lot of people get totally normal.

11 Q: And you say about 10 to 20 percent of the
12 patients that y'all see can get back to some
13 type of normalcy once they do these things?

14 A: I think a higher percentage, but let me
15 redirect that for a second. The amount of
16 people I have with chronic lymphadema who are
17 ... who don't want to participate in doing all
18 that is pretty high, is fairly significant.

19 Q: And what's the main reason, the cost?

20 A: I'm going to go back to that lymphatic massage,
21 that tends to be it.

22 Q: About how much does that cost?

23 A: I don't know. I've never had it, but I think
24 typically a Blue Cross will pay for it, for a
25 couple of visits, and tell the patients they're



1 on their own. And that seems to be the push
2 back.

3 Q: But you don't know how much it is, but that
4 seems to be the biggest problem to you as to
5 why people can't ...

6 A: Compliance, especially with a lady with
7 lymphadema, that's her number one issue.

8 Q: Okay. I don't have any other questions I don't
9 think, unless ...

10 MR. LAFAVE: I have one follow up that I'll kick
11 myself if I don't ask you, Doctor.

12 DR. MORRISON - RE-EXAMINATION BY MR. LAFAVE:

13 Q: Have you ever treated a patient who has
14 developed edema without a preceding trauma to
15 either the hip or the knee or some other lymph
16 node?

17 A: Oh, yeah.

18 Q: Okay.

19 A: Well, I mean, just to reiterate, primary
20 lymphadema occurs. There are people who are
21 born with congenital abnormalities in
22 lymphatics that some don't ... you know, it's
23 usually devastating, but it seems to be, you
24 know, pubescent females. And they've been
25 doing fine until that time, then bingo. So you



1 do see edema primarily.

2 MS. CALVY: Let me see if I have anymore. Okay.

3 Yeah, oh okay. Yeah, I may just have one
4 follow up.

5 DR. MORRISON - RE-EXAMINATION BY MS. CALVY:

6 Q: I'm sorry, Doctor, you seem so antsy, like you
7 can't stay in one place too long.

8 A: That's my nature, plus I'm due in the operating
9 room at 3:30, that's why. But I've got time,
10 press on.

11 Q: Okay. You do know depositions could take
12 awhile.

13 A: I do know this started 40 minutes late.

14 Q: Okay. Forty minutes late, are you sure about
15 that? Forty minutes late? What time was the
16 deposition? I came in here at ... at least 15
17 to 20 minutes after 3:00.

18 COURT REPORTER: It started at 2:22.

19 A: All right. Twenty minutes late. I'm standing,
20 because of my piriformis, okay?

21 Q: Okay. But if when the patient came to see you,
22 he had already had problems with his hip and
23 his back, would the problems with the hip or
24 the back cause any of the problems that he's
25 seeing you for?



1 A: Cause gait disturbance, but I'm not aware of
2 hip or back causing chronic lymphadema.

3 Q: Okay. That's it, doctor. You're free to do
4 what you want to do.

5 (There being no further questions, the deposition
6 concluded at 3:31 p.m.)
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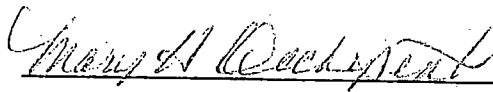


CERTIFICATE

This is to certify that the deposition of EDWARD C. MORRISON, M.D., consisting of fifty-nine (59) pages, is a true and correct transcript of the testimony given by said deponent after being duly sworn; said deposition was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on August 13, 2014.



Mary H. Occhipinti
Court Reporter

Notary Public for South Carolina
My Commission Expires: October 18, 2020



Transcript of the Testimony of
EDWARD M. TAVEL, JR., M.D.

Date: October 21, 2014



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Condensed Transcript and Word Index

1230 Richland Street
Columbia, SC 29201
Phone: (803) 252-3445 / (800) 822-0896
Fax: (803) 799-5668
Email: contact@creelreporting.com
Internet: www.creelreporting.com

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC File No. 1205647

O'Shea Brown,)
)
Claimant,)
)
v.)
)
Steel Technologies,)
)
Employer,)
)
and)
)
Hartford Accident &)
Indemnity Co.,)
)
Carrier, Defendants.)
-----)

COPY

DEPOSITION OF
EDWARD M. TAVEL, JR., M.D.

Tuesday, October 21, 2014
4:22 p.m. - 4:53 p.m.

The deposition of EDWARD M. TAVEL, JR., M.D., taken on behalf of the Defendant, at the offices of Pain Specialists of Charleston, 2695 Elms Plantation Boulevard, Suite A, Charleston, South Carolina on the 21st day of October, 2014 before Mary H. Occhipinti, Certified Court Reporter and Notary Public in and for the State of South Carolina, pursuant to Notice of Deposition.



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1230 Richland Street / Columbia, SC 29201
(803) 252-3445 / (800) 822-0896

APPEARANCES

Joe Ann Calvy, Esquire
 Joe Ann Calvy, LLC
 209 West Mill Street
 Kingstree, South Carolina 20556
 Attorney for the Claimant

Matthew C. LaFave, Esquire
 Crowe LaFave, LLC
 500 Taylor Street
 Columbia, South Carolina 29201
 Attorney for the Employer/Carrier

Also in Attendance:
 O'Shea Brown

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EXHIBITS

There were no exhibits marked during this deposition.

STIPULATIONS

It is stipulated and agreed that this deposition is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.

It is stipulated by and between counsel and the witness that the reading and signing of the following deposition be, and the same are, hereby waived.



1 EDWARD M. TAVEL, JR., M.D., having been duly sworn,
2 deposes and testified as follows:

3 DR. TAVEL - EXAMINATION BY MR. LAFAVE:

4 Q: Good afternoon, Dr. Tavel. Again, my name is
5 Matt LaFave. We met just a second ago. I am
6 the attorney for Steel Technologies and their
7 workers' compensation insurance carrier. I'm
8 here today, obviously, to take your deposition.
9 I'm sure you've been through this process
10 before, but one thing I'll always remind the
11 physicians who I depose is, whenever I ask you
12 a question based on your medical expertise, I'm
13 looking for your opinion within a reasonable
14 degree of medical certainty. I would simply
15 ask that if you don't know the answer within a
16 reasonable degree of medical certainty, to
17 please state that so that the record is clear,
18 is that fair?

19 A: It is.

20 Q: All right. If we could start out, please, just
21 give me a brief educational history, starting
22 with undergrad.

23 A: Davidson College, class of '85. Medical
24 University of South Carolina, medical degree,
25 class of '89. University of North Carolina,



1 chief resident, finished '93. Trident
2 Anesthesia Group from '93 until 2009. Managing
3 partner the last five years. Pain Specialists
4 ... Pain Care Physicians of Charleston and
5 founded in 2007, I believe. It's all on my CV
6 there, and I've been I started this
7 practice in 2009 with three gals and now we're
8 at 15 and 5 providers.

9 Q: Okay. And are you board certified?

10 A: Anesthesia, American Board of Pain Medicine,
11 yes.

12 Q: Can you say that one more ... anesthesia and
13 ...

14 A: American Board of Pain Medicine and the
15 American Board of Anesthesia.

16 Q: Okay.

17 A: Would you like a copy of my CV.

18 Q: No, that's fine.

19 **COURT REPORTER:** I would.

20 A: Okay.

21 Q: And you said you started this practice here in
22 2009, correct?

23 A: That's correct.

24 Q: All right.

25 A: I've been doing this work for ... since 1993.



1 Initially in the context of the big group, for
2 the big anesthesia group I was a partner in.

3 Q: Okay.

4 A: And then I started to practice for them in
5 2007. It got so darn busy, I had to start my
6 own practice in 2009.

7 Q: All right. Not a bad reason to have to start
8 a practice.

9 A: We see about 25,000 people a year here, and a
10 lot of RSD.

11 Q: Have you ever been disciplined by any of the
12 boards?

13 A: Just my wife.

14 Q: Have you ever been a party to any medical
15 malpractice claims?

16 A: No, sir.

17 Q: Well, we're obviously here today to discuss
18 your involvement in the care of Mr. O'Shea
19 Brown. Can you tell me, Doctor, how you became
20 involved in Mr. Brown's care initially?

21 A: He showed up on my door.

22 Q: Okay. Was he referred to you by a doctor?

23 A: Patient was referred to our office for an
24 evaluation of lower limb pain. Dr. Morrison
25 would like Dr. Tavel to evaluate for possible



1 RSD.

2 Q: Okay. So your understanding of the reason for
3 the referral was what?

4 A: Well, let's see if I can pull up the notes
5 here. The patient needs an appointment for
6 chronic pain. That's the initial referral from
7 Dr. Morrison's office, it appears. Let me read
8 it through.

9 Q: Okay.

10 A: We haven't scheduled an appointment as of yet,
11 because we're waiting to hear back from the
12 adjuster per workers' comp. It looks like
13 initially for chronic pain, but let me just
14 read on. As far as his pain suggestion, that
15 this is RSD, I do not think this fits his
16 clinical picture. Dr. Morrison is speaking.
17 However, this is not my specialty and therefore
18 I would like Dr. Tavel's opinion on this. Will
19 make the referral.

20 Q: Okay. So the referral was to establish whether
21 or not Mr. Brown had RSD, is that a ...

22 A: It appears so.

23 Q: ... fair statement?

24 A: It appears so.

25 Q: What was your conclusion as far as whether or



1 not he had RSD?

2 A: You jumped right to the finish line, didn't
3 you. Let's see. I think I ... I'll have to
4 review the notes. I'll have to read through
5 his notes from the beginning to kind of get a
6 feel for where we are with him, as far as
7 that's concerned. Following his knee
8 arthroscopy, he developed pain and edema in the
9 right lower leg thought to be vascular. Not
10 improved with vascular surgery. He is
11 currently using a lymphatic pump. He continues
12 to report pain in his right leg. The patient's
13 physical exam findings are not consistent with
14 diagnosis of RSD. I believe that his pain is
15 mechanical in nature due to edema of his right
16 lower extremity. Patient also does ... does
17 also complain of pain radiating from his lumbar
18 region down into the anterior leg. I'm sorry,
19 I'm talking too quickly.

20 Q: You're fine.

21 A: Which may be of lumbar etiology resulting from
22 gait change due to right leg pain. If the low
23 back is part of the claim, I recommend this.
24 It looks like from that initial conversation,
25 it was ... I was not convinced that his pain



1 was RSD related.

2 Q: Okay. At that initial evaluation, can you walk
3 me through what your physical examination
4 consisted of?

5 A: General appearance: well nourished, obese.
6 Walking with an antalgic gait favoring the
7 left. Alert or in no acute distress.
8 Radiculopathy, nerve root, right, L4, quad,
9 medial calf. Right lower extremity edema, 4
10 plus. Pain to palpation of right lower
11 extremity. Motor strength, bilaterally normal.
12 That's the physical exam that's documented.
13 The typical person I see for an evaluation of
14 RSD, you're looking for some pretty consistent
15 physical findings, hair loss, temperature
16 insensitivity, disproportionate pain to touch,
17 hyperalgesia, which means the response to
18 touching is disproportionate, either that or
19 increased. In later phases, you'll see some
20 bone loss. It's not typically a mechanical
21 thing. It's not typically related to movement.
22 However, in the later phases of that disease
23 process, they do have some limitation in
24 movement. His picture clinically was not
25 consistent with that.



1 Q: Okay. What then, Doctor, was your working
2 diagnosis of Mr. Brown as of 09/24/2013?

3 A: Other noninfectious lymphedema, 457.1 primary.
4 After talking with the patient, will be giving
5 him compounding cream. Apply the cream twice
6 or three times a day for neuropathic pain,
7 which is another possibility in regard to the
8 pain. We referred him for a TENS unit for pain
9 control and return to the office on an as
10 needed ... the first time I saw him, return on
11 an as needed basis.

12 Q: Okay. What is the reason you had him returning
13 on an as needed basis, after the ...

14 A: I wasn't impressed that there was something I
15 could impact with. I didn't think it was
16 consistent with RSD. I thought it was more of
17 a lymphatic issue as it related to his vascular
18 situation.

19 Q: All right. Well, what's your experience with
20 the lymphatic system or the vascular system?

21 A: As far as identifying, RSD is pretty obviously
22 to me. I'm not a vascular doctor but, you
23 know, I can clearly identify and diagnose RSD.
24 I see that so often. I'm more concerned that
25 ... I was more concerned that it was not the



1 RSD issue.

2 Q: Okay.

3 A: The most common things are common. You don't
4 have to be a doctor to step back and think
5 about things in a common sense kind of manner.
6 Swelling of the leg, lymphedema. Vascular
7 surgery is probably related.

8 Q: Related? What do you mean related?

9 A: Well, you know, if it was a vascular issue,
10 there's a lymphatic drainage problem. That's
11 certainly more amenable to a vascular surgeon's
12 then is mine.

13 Q: All right. Along that line, with regards to
14 the vascular condition, is that something then
15 that you would defer back to Dr. Morrison on?

16 A: Well, typically, I'm asked to make a comment,
17 is this an RSD, and the answer to that is no.

18 Q: Okay.

19 A: There you go.

20 Q: But if it's something ... well, let me ask you
21 this question then. Is RSD a vascular
22 condition at its root?

23 A: No.

24 Q: Okay. So if it were a vascular condition such
25 as lymphedema, is that something you would have



1 to defer back to Dr. Morrison as a vascular
2 surgeon?

3 A: Lymphedema is not typically handled by a pain
4 guy.

5 Q: Okay.

6 A: I see people that are referred over for that,
7 but for secondary pain issues that are often
8 mechanical and pain receptor stretch type
9 things. But from a physiologic or an
10 improvement standpoint, a pain guy is not going
11 to be involved in that typically.

12 Q: Okay. You've used the term mechanical a couple
13 of times, Doctor. Can you tell me, in lay
14 person's terms, what you mean, as far as Mr.
15 Brown's case goes, that his issues were
16 mechanical in nature?

17 A: Well mechanical means ... let's just break it
18 down very simply. If you have a ... let's
19 take, for example, an orthopaedic injury. If
20 somebody comes to see me with a rotator cuff
21 tear, I can give them pain medicine. But the
22 problem is often the tear in the rotator cuff.
23 It's a mechanical issue. And I can't speak
24 with certainty, I'm not a vascular surgeon,
25 that this is a mechanical issue, but I can say



1 from a RSD standpoint, which it's not a
2 mechanical cause of the pain.

3 Q: Okay.

4 A: It was not that.

5 Q: Okay. What did you believe in your examination
6 was causing the gate alteration that you
7 mentioned?

8 A: Oh, that could be a list of about a mile long.
9 And typically these folks will, if they have a
10 pain issue, whatever it is, they'll, you know,
11 the hips were meant to align. And I'm not a
12 chiro and I don't really. ... I mean, you know,
13 chiropractors typically will talk about hip
14 alignment, but there's some truth to that,
15 because the hips are meant to be symmetrical.
16 Anything that throws those hips out of line, a
17 shorter leg, a broken foot, cast, pain, and you
18 deal with secondary issues that do with the
19 altered gate.

20 Q: Okay. What did you then believe was the cause
21 of his back problems that you referenced from
22 September 24th?

23 A: Yeah, I read that note to you a minute ago. If
24 that back was caused ... was covered by a
25 workers' comp claim, I would look at his back



1 and some radicular pain issues secondary to the
2 altered gate. I very rarely get that to go
3 though. It seems like there was a lot of
4 workers' comp and they very rarely do get that
5 part of the ... that ... you know, that ... you
6 have a primary problem. And that primary
7 problem leads to secondary issues.

8 Q: Okay.

9 A: And tertiary issues. And very rarely can I get
10 the tertiary or secondary issues covered by the
11 primary problem.

12 Q: Okay. If I heard you correctly, and I don't
13 want to put words in your mouth, but am I
14 hearing you correctly that you believe the back
15 could be related to the altered gate?

16 A: Yes..

17 Q: Okay. Do you have an opinion within a
18 reasonable degree of medical certainty whether
19 or not the back was a result of the altered
20 gate?

21 A: That's hard for me to say. It tends ... it
22 depends on time proximity. I see all different
23 spectrums here. Some folks it's five years,
24 and you guys will come at me and ask me five
25 years later. You do it all the time. And



1 other guys will, if there's a more immediate
2 short-term connection, I'm more able to do
3 that. The longer it goes, the less likely I am
4 to make that connection.

5 Q: Okay. Do you have any opinion, on way or
6 another, with regards to Mr. Brown's case
7 sitting here today?

8 A: No. I wasn't really asked to be involved in
9 that.

10 Q: Okay.

11 A: I didn't really pursue that train of thought.
12 I was asked specifically ... you know, with
13 workers' comp and the workers' comp system, I'm
14 asked to treat a particular body part and
15 evaluate ... a particular determination and
16 give a particular opinion. We can't just go
17 after everything. If I had been asked to be
18 involved with the back, I would have gotten
19 involved. I didn't get involved really to
20 speak on that at all, because I was not asked
21 to do that.

22 Q: All right.

23 A: So I really don't have an opinion there.

24 Q: Okay. Am I correct then, as of September 24th,
25 you did not have a working treatment plan for



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1 Mr. Brown, it was simply a return as needed?

2 A: No, no. I came up with ... I came up with a
3 treatment plan.

4 Q: Okay. What was the treatment plan?

5 A: Under planned treatment. Do you have my notes?

6 Q: Let me make sure. I think this is the right
7 one. I do.

8 A: Can you read it to me, planned treatment,
9 notes?

10 Q: I've got treatment.

11 A: Other noninfectious lymphedema, notes, and then
12 it's right there.

13 Q: "After talking with the patient?"

14 A: Yeah.

15 Q: Okay.

16 A: That's the treatment plan.

17 Q: So you prescribed him compounding cream and a
18 TENS unit, is that right?

19 A: Yes.

20 Q: Okay. What was the focus of the compounding
21 cream?

22 A: Neuropathic pain. Now, typically with those
23 creams, that's not an open invitation. I had
24 a deposition three months ago and you guys put
25 a million dollars cost plan on the compounding



1 cream. For me, it's not meant to be three
2 times a week for life. I have started, because
3 you guys ... I've had to do that because it's
4 not meant to be an open book forever.

5 Q: Okay.

6 A: I'll say two times a week, two to three times
7 a week, for so many weeks per year, so many
8 tubes period. It doesn't mean we're going to
9 be on compounding cream the rest of our lives.

10 Q: Okay. What is your typical ...

11 A: It depends on the patient. You know, their
12 utilization. You'll ask me that and I'll say,
13 well, all I really have to go on is their
14 previous history. I'm assuming you're asking
15 me what was the plan for the compounding cream?

16 Q: Correct.

17 A: Yeah. Typically what I'll say is, we go on
18 their history. And if they call me back and
19 they're heavy utilizers of this cream, I think
20 it must be helping to some period, and we
21 continue it for a fixed period of time, as you
22 see here.

23 Q: Okay.

24 A: If I don't hear back from them after about the
25 first tube, I assume they're not using it and



1 it's not very helpful, so I really don't
2 pursue.

3 Q: Okay. So you're ... the longest you would
4 prescribe it for, did I hear you correctly,
5 would be about a year ...

6 A: Not without reevaluating the patient.

7 Q: Okay.

8 A: I'm going to reevaluate. I don't ... I don't
9 write medicines and put you on for life here.

10 Q: Okay.

11 A: If I have you on narcotics, I'm going to try to
12 get you off. If I have you on compounding
13 cream, I'm going to reevaluate you to see if
14 it's still necessary.

15 Q: All right.

16 A: Yeah.

17 Q: When was the next time you saw Mr. Brown?

18 A: The initial visit was September 24, 2013. And
19 then we had a visit on March 13, 2014.

20 Q: Any changes that you noticed as of the March
21 13, 2014 visit?

22 A: He had been getting hydrocodone from Dr.
23 Rudolph. He said it's a 14 day supply and he's
24 running out. He takes three a day. He ... the
25 TENS unit provides him with ... we provided him



1 TENS and compounding cream. He received his
2 compounding cream in the mail. He said the
3 TENS and cream providing him with some relief.
4 And then we go down to the bottom here and we
5 are moving up to a different medication. We've
6 got him ... and then we started talking about
7 his back.

8 Q: Okay.

9 A: So at that point, really the back was more the
10 focus or the issue.

11 Q: Was there any difference noted by you in your
12 notes between the first visit and the second
13 visit relative to the back injury or the back
14 complaints?

15 A: He was getting medication at this point from
16 Dr. Rudolph, hydrocodone, three or four tablets
17 a day, every four to six hours. It provided a
18 30 percent relief of his problem. He needs the
19 medicine refilled today. So in the interval,
20 he had seen an orthopaedic who gave him the
21 narcotic.

22 Q: Okay.

23 A: And it was helpful for him. Had it been an
24 RSD, I would not have done that, and I didn't
25 initiate the narcotic. Apparently the ortho



1 guy did and it was helpful for him. So we
2 didn't really write the short-acting narcotics.
3 So if somebody is going to be on a pain
4 medication from here, they're going to be on a
5 long 12 hour medication, which is ... which was
6 the case. We moved it to an Opana ER, in
7 milligrams, which is a long-acting medication.

8 Q: And that prescription, was that for the leg,
9 the back or both?

10 A: I think we ... at that point, we had pretty
11 much been convinced that it was not RSD
12 related. We feel very strongly that his
13 unilateral right-side lymphedema is not solely
14 based on his weight. So at that point, it was
15 ... I don't see mention one way or the other,
16 but typically ... well, let me read. Let me
17 read.

18 Q: Okay. Now, on that point that you just
19 referenced, the feeling that his unilateral
20 right-sided lymphedema was not based solely on
21 this weight, did you render any other
22 conclusions as to what the lymphedema was based
23 on?

24 A: No.

25 Q: Okay. Is that something that you would defer



1 back to Dr. Morrison on?

2 A: Or a vascular surgeon or a vascular person.

3 Q: All right. When was the last time you saw Mr.
4 Brown?

5 DR. TAVEL: Mr. Brown, when did I see you last?

6 MR. BROWN: Last week.

7 DR. TAVEL: Okay, let me skip there.

8 MR. BROWN: It was last week, Thursday.

9 DR. TAVEL: How are you today, sir?

10 MR. BROWN: I'm doing good.

11 DR. TAVEL: All right.

12 MR. BROWN: It was last week, Thursday.

13 A: Okay, 10-17-14. Patient complains of low back
14 pain radiating to the right hip and down the
15 right leg. He complains of tingling, numbness
16 and weakness in the right leg. He complains of
17 swelling in the right leg. Continues to use
18 compounding cream for leg and back. He's doing
19 Opana ER, ten when we started him initially,
20 back in the day, and Norco once a day for
21 breakthrough pain. He gets 70 percent relief
22 from these medications. Reading on down here.
23 Urine drug screen, which we perform frequently
24 here, sent to the office, screening performed
25 indicates medications are present and taken as



1 prescribed. No illicit drugs noted. Refill
2 medications. He will follow up in eight weeks
3 for medications, which means he's been fairly
4 compliant. Referring ... electronic records
5 sent to referring providers.

6 Q: Okay.

7 A: I'm sorry, was there a question there?

8 Q: You covered it by explaining to me what
9 happened at that visit. You mentioned at the
10 10/17 visit that there was low back pain
11 radiating to the right hip and the right leg.
12 Do you have any opinion as to what the cause of
13 that was?

14 A: We have ... as far as I understand, we have
15 never been involved in the back as the primary
16 cause of his pathology. I don't think we ever
17 got coverage from workers' comp to do that and
18 we never really pursued that. His edema in his
19 leg was his painful condition.

20 Q: Okay.

21 A: And he was asked ... we were asked initially,
22 is this RSD? And we said, no. Good luck to
23 you. And we gave him a couple of little
24 treatments and he went on his way. And then he
25 went to his orthopaedist doctor ... his



1 orthopaedic doctor who felt like there was some
2 other things going on in regard to his leg and
3 he began him on the pain pills.

4 Q: Okay.

5 A: And pain pills we don't do for RSD. We've kind
6 of taken that off the table as the cause of his
7 problems. He clearly had a reason to have
8 pain, and clearly had a reason to have pain in
9 his leg. So he didn't specifically direct that
10 at his back, we were addressing, you know, with
11 regard to his leg.

12 Q: All right. But at these visits, are you
13 actively treating his back?

14 A: No.

15 Q: Okay.

16 A: No.

17 Q: All right. You're just noting the complaints
18 in your records, is that fair?

19 A: That's fair.

20 Q: So you've never, at any point during your care
21 of Mr. Brown in the, I guess, a little over a
22 year that you've been involved, rendered an
23 opinion as to whether or not his back is
24 somehow causally related to the workers' comp
25 claim?



1 A: That's right. We ... typically for a back
2 related issue, we'll order an MRI. We'll do
3 epidural steroid injections to try to minimize
4 the medications and get him improved. We were
5 never really asked to do that and we've never
6 really pursued that, to my knowledge.

7 DR. TAVEL: Is that correct?

8 MR. BROWN: Yes. They never approved it, workman's
9 comp.

10 A: Okay. I don't think ... from my understanding,
11 the back was never the primary focus with us.
12 It was always that leg.

13 Q: Okay.

14 A: We were asked to make a specific comment on the
15 diagnoses, you know, we did, and we sent him
16 on.

17 Q: Okay.

18 A: He bounced back because he was having pain
19 issues.

20 Q: Okay. And going back in time to when you
21 concluded Mr. Brown had reached maximum medical
22 improvement, and I was trying to pinpoint that
23 date for you to make it quicker in your notes
24 to find ...

25 A: Usually, for me, what will happen is, when I



1 see these folks, I will tell them they are at
2 maximum medical improvement. We'll do a
3 functional capacity evaluation, we'll do an
4 impairment rating, a 14-B, and move on down the
5 road. We never did that here. We weren't the
6 primary provider of his care. We were just
7 asked simply to render an opinion, and to be
8 honest, basically we didn't do any of that. My
9 normal mode of operation is, they come to me as
10 primary provider, me. We take an MMI, do an
11 FCE, do impairment rating. I rate them, send
12 them to you. But in this case, I was just
13 asked to do one particular evaluation, which I
14 did, and he went back to where he came from.

15 Q: Okay.

16 A: So I didn't do any of that in this case, as far
17 as I know.

18 Q: Well, we have a ... that was where I was
19 heading next, was to the 14-B that you had
20 completed.

21 A: Did he have an FCE?

22 Q: Well, that was going to be my next question for
23 you, after we started talking about the form
24 14-B. I was looking for the date.

25 A: A lot of times, the vascular guys won't know



1 what to do. And they'll send them to me and
2 say, can you fill this, can you ... are you
3 comfortable filling this thing out. So if I'm
4 asked to do it, because they don't know how to
5 do it, we'll do it.

6 Q: Okay. I want to see if I have a copy of the
7 form 14-B. Let me see whether I have a copy of
8 that.

9 A: Unfortunately, in some situations, people's
10 injuries don't allow them to do an impairment
11 ... a functional evaluation with the therapist.
12 I prefer that if I can, because in two to three
13 hours, they really get down to business with
14 the evaluation. Some people are not able to
15 tolerate that and will have to do without it.
16 Other times, the primary care renderers will
17 not be comfortable with it, and they will send
18 me the information and ask me to do it for
19 them.

20 Q: Okay.

21 A: But what I mentioned to you earlier is how I
22 normally like to operate with these things.

23 Q: Do you have any indication in your notes that
24 you had a functional capacity evaluation done

25 ...



1 A: No, I don't.

2 Q: ... in Mr. Brown's case?

3 A: I don't.

4 DR. TAVEL: Did I send you for a two hour test with
5 the physical therapist?

6 MR. BROWN: (Shakes head negatively.)

7 A: Yeah. No, I don't see it in my notes.

8 Q: All right.

9 A: Do you have it in yours?

10 Q: That's what I was looking for, and I can't seem
11 to put my hands on the form 14-B. Well, let me
12 ask you this question, then. In the form 14-B,
13 you provided a three percent rating for pain
14 and a 60 percent rating for lymphedema. Can
15 you explain to me where those ...

16 A: Yeah.

17 Q: ... percentages come from?

18 A: Usually the AMA Guidebook version ... you guys
19 like that version five, is more relevant for
20 you, so we do the AMA Guidebook version five
21 and we'll walk it out. Pain, you know, that's
22 ... that's a very subjective experience.
23 That's kind of the maximum you'll do, that I'll
24 do, and that often will be for pain. In regard
25 to the lymphedema, we just walk it down the



1 book. And it's kind of a cookbook. You open
2 the book to page 75 and just start reading it
3 off and you come up with a number. I don't
4 have it in front of me now.

5 Q: Okay.

6 A: And it ... that sets it out and you have to
7 figure it out, but that's how it typically
8 works.

9 Q: All right. For the purposes of the work
10 restrictions, and I apologize but I don't have
11 form 14-B on me, but for the purposes of the
12 work restrictions, being that you hadn't done
13 a functional capacity evaluation in this case,
14 can you tell me how you would determine work
15 restrictions in a situation where you don't
16 have the benefit of an FCE?

17 A: Yeah, it's nice. You know, for many, many,
18 years nobody did those. And I've started doing
19 them. I like that, if I can get it. Basically
20 you'll evaluate the patient, his capabilities,
21 how he ambulates in the office, what his level
22 of function is on a day-to-day basis,
23 subjectively as you hear from him and
24 objectively as I see it in the office. Now,
25 every now and again I get popped. I'll get



1 patients that are manipulative. I didn't sense
2 that in his case. But, you know, we have to
3 make an effort.

4 **MR. LaFAVE:** Oh, good. Thanks, Joe Ann. Thank you.

5 A: Shall I read it to you?

6 Q: Please.

7 A: Sedentary work restrictions, no lifting,
8 pushing or pulling. No squatting, no kneeling,
9 or crawling. No continuous sitting or standing
10 greater than an hour without a ten minute
11 break. No climbing ladders or stairs. Now,
12 typically, whether you're a doctor or not, you
13 can understand that somebody with significant
14 lymphedema ...

15 **DR. TAVEL:** Are you on a walker?

16 **MR. BROWN:** Yeah.

17 A: ... they can't do those things, so that's where
18 that came from.

19 Q: Okay.

20 A: In regard to his future medical needs, I try to
21 be reasonable here and I don't ... we don't
22 shoot the moon. I don't want to do compounding
23 cream for the rest of his life. I fixate on
24 that, because I was amazed that one of you guys
25 brought me a life care plan and in it was that



1 cost of about a million dollars. I said, what
2 the hell are you thinking, man. I'm sorry.

3 Q: No, that's fine.

4 A: Pain medications including compounding cream,
5 equipment. Patient will need liver and kidney
6 function test yearly if he continues on non-
7 steroidal or narcotic containing medication.
8 Since I've done this, and this was in August of
9 2014, I added another little phrase that says,
10 make a yearly attempt to wean medications.
11 Because I don't think it's fair to the patients
12 or to the providers of the insurance to expect
13 somebody to be on medications the rest of their
14 lives. So yearly, we make an attempt to get
15 you off the medicines. Nobody ever benefits
16 long term in a positive way on narcotics. It's
17 just not where we want to be if we can help it.
18 So we make an ... and that doesn't mean we pull
19 the rug out from under you, it just means we
20 make an effort yearly to try to get you off the
21 medicines.

22 Q: Okay. And as far as that goes, does that
23 include the compounding cream as well?

24 A: Yes, yes, yes.

25 Q: All right.



1 A: Absolutely.

2 Q: Now, at the last visit, October 17th, did you
3 continue to prescribe into the future more
4 compounding cream?

5 A: We did. I'm sure we did.

6 Q: Okay.

7 A: Let me look. October 17th ...

8 DR. TAVEL: Did I renew your compounding cream?

9 MR. BROWN: Yeah, I got some.

10 DR. TAVEL: I don't think we renewed it, because you
11 already had it.

12 MR. BROWN: Yeah, I already had it. I got it like
13 the Monday before last.

14 DR. TAVEL: Yeah, right.

15 A: Sometimes they get off cycle and we don't have
16 to renew every month, every medicine. So we
17 didn't ... we didn't renew it this month
18 because he already had it.

19 Q: All right. Is that a medication that you would
20 renew, based on his use and based on ...

21 A: Yeah, but not indefinitely. We have to put a
22 cap on this. I mean, that's not a magic
23 bullet. It's not ... it helps to some degree,
24 and his note indicates it helps some, but that
25 doesn't mean you want to do it forever. I



1 think at some point we make an effort to wean
2 it, and at some point he may go off of it.

3 Q: All right.

4 A: I'd like to see yearly, at least, to try to get
5 off some of this stuff.

6 Q: Okay.

7 DR. TAVEL: Am I talking too quickly for you?

8 Q: With regards to the form 14-B, what is the
9 condition that predicated the work
10 restrictions?

11 A: Well, his activity, his functionality, really.
12 I mean ...

13 DR. TAVEL: Are you ... are you able to walk?

14 MR. BROWN: I mean, I can walk, but it ain't ...

15 DR. TAVEL: Can you climb a ladder?

16 MR. BROWN: No, sir.

17 DR. TAVEL: Can you squat?

18 MR. BROWN: No, sir.

19 A: I mean, you don't have to be a physician to
20 look at the guy. He can't ... he's not ... he
21 doesn't have the functionality. So sedentary
22 means those things I just mentioned, no
23 lifting, pulling, squatting, kneeling or
24 crawling. And with his condition,
25 unfortunately, it's ... for whatever reason it



1 occurred, it occurred, and he's got ... he's
2 debilitated.

3 Q: Okay. And maybe my question wasn't clear, and
4 if it wasn't, I apologize ...

5 A: Was it predicated on?

6 Q: ... the question, what medical condition are
7 his limitations predicated on?

8 A: Severe lymphedema.

9 Q: Okay.

10 A: And neuropathic pain. Yeah.

11 Q: The neuropathic pain, is that also related to
12 the lymphedema?

13 A: That's a very small ... yes. That's a very
14 small component of it, though.

15 Q: All right.

16 A: You can envision any kind of ... any kind of
17 structure, if you stretch it and pull on it,
18 nerves are going to be involved.

19 Q: Okay.

20 A: So that's the main reason. I mean, the main
21 reason is the lymphedema in and of itself.

22 Q: Does that same determination hold true with
23 regards to the medication that you've
24 prescribed him on the form 14-B into the
25 future, the ... I think you said non-steroidal



1

....

2

A: Could you simplify that a little bit, that question?

3

4

Q: Sure.

5

A: Okay.

6

Q: Well, I'll ask the same question just with regards to the medicals then. What is the medical condition that forms the basis for the continued treatment into the future?

7

8

9

10

A: Lymphedema.

11

Q: All right.

12

13

14

15

16

17

A: We've never really focused on his back at all, and I don't think that's fair to him. I know he has the problem, but I was never asked to comment on that and I don't ... and I don't think that was his primary complaint that brought him to see me.

18

Q: Okay.

19

A: So we've never really fixated on that at all.

20

21

22

23

24

25

Q: Getting back to a question that I asked you earlier, and I want to make sure it's clear, relative to whether or not the lymphedema is related to his workers' compensation claim, would that be something you would defer to the vascular surgeon, in this case Dr. Morrison?



1 A: Correct.

2 Q: Okay. If you assume that Dr. Morrison has
3 concluded that it's not related, do you believe
4 that the work restrictions then that you've
5 prescribed there, would be related to his
6 workers' comp claim?

7 A: The work restrictions are related to his
8 lymphedema. I can't make the I'm not going
9 to make the comment, what caused the lymphedema
10 led to the end point. My ... my restrictions
11 are based on the end point, the lymphedema.

12 Q: All right.

13 A: And that would be for you two guys to talk it
14 out.

15 Q: I understand. Based on the AMA Guides for your
16 impairment rating for the lymphedema, assuming
17 Dr. Morrison felt the condition could improve
18 with certain changes on the part of Mr. Brown,
19 would you agree that that rating could also
20 then change?

21 A: It could be dynamic. And, unfortunately, we
22 can't ... we can't predict ten years from here.

23 Q: Sure.

24 A: And it may take five years, ten years, 20
25 years. I, unfortunately, have to deal with a



1 snapshot in time. I'm not ... certainly not
2 opposed to reevaluating the situation in a
3 fixed interval. I'd love to be able to say,
4 hey, he's only 20 percent impaired because he's
5 getting better.

6 Q: Sure.

7 A: I would love to be able to do that. I just
8 can't project ahead as to what will happen. I
9 just have to live in the here and now, where we
10 are now.

11 Q: Sure.

12 A: I'm certainly not opposed to reevaluating. If
13 he should improve, that's wonderful. I would
14 recommend we look at him again.

15 Q: Okay. That's all the questions I have for you,
16 Doctor.

17 MS. CALVY: I don't have any for you.

18 A: Are you the attorney on the other side?

19 MS. CALVY: I'm his attorney.

20 A: Okay, very good.

21 MS. CALVY: That's it.

22 (There being no further questions, the deposition
23 concluded at 4:53 p.m.)
24
25



CERTIFICATE

This is to certify that the deposition of EDWARD M. TAVEL, JR., M.D., consisting of thirty-five (35) pages, is a true and correct transcript of the testimony given by said deponent after being duly sworn; said deposition was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on November 18, 2014.



Mary H. Occhipinti
Court Reporter

Notary Public for South Carolina
My Commission Expires: 10/18/2020



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CLAIRE ORTHOPEDICS, PA
A. Mason Ahearn, MD FACS
752 Collins Meadow Drive
Georgetown, SC 29440
Phone: 843-545-4811
Fax: 843-435-4864
E-mail: shearnmedeval@yahoo.com
Website: medevalsc.com

Name: C. Shee Brown
Source: Joe Ann Calvy, Atty-at-Law

Employer: Steel Technologies, Huger, SC

DOB: July 8, 1974
DOI: April 30, 2012

July 16, 2014: An Independent Medical Evaluation (IME) was performed today within the specialty of orthopaedic surgery. This was done at the request of Joe Ann Calvy, Atty-at-Law of Joe Ann Calvy, LLC, Kingstree, SC. The patient provided me with photo identification, was advised of the restrictions which pertain to an IME, and was specifically informed that no doctor-patient relationship existed between us. My assistant, Rita G. Ahearn, RN, BSN was present throughout the encounter. Medical records were provided by Ms. Calvy and were reviewed prior to the IME.

In her letter of request, Ms. Calvy described Mr. Brown, who injured his right knee April 30, 2012, underwent arthroscopic partial medial meniscectomy, suffered severe chronic post operative swelling in the leg, and then developed right hip and low back problems. She has asked me to evaluate these issues for causality and to rate Mr. Brown.

First reviewed were notes by Coastal Occupational Medicine of Charleston, SC, Byron Williams, MD dated May 2, 2012. Dr. Williams noted the patient to be a truck driver for three years with Steel Tech, who on April 30 bumped his right knee on a truck trailer. He noted effusion and generalized tenderness. The x-rays were initially thought to reveal a fracture of the anterior tibial tubercle, but later interpreted as an old Osgood-Schlatter's defect. He was treated symptomatically, and then he was referred to orthopedics.

Next reviewed were notes by Harry P. Rudolph, MD, an orthopedist with Roper St. Francis Physician Partners in Mount Pleasant, SC, commencing July 24, 2012. Mr. Brown presented to Dr. Rudolph wearing a knee brace, and Dr. Rudolph noted swelling in the thigh and calf. He thought in terms of a medial meniscal tear and ordered an MRI. This study revealed a medial meniscal tear. On October 2, 2002 Dr. Rudolph did an arthroscopic partial medial meniscectomy. He followed Mr. Brown in the office postoperatively, and, immediately, he noted more swelling than usual in the leg. By October 31, he was worried about a DVT, but studies successfully ruled out this complication. By November 14 significant swelling was noted in both legs. In late November Dr. Rudolph requested consultation about this swelling, but the carrier denied this. By January 16, 2013, he noted Mr. Brown to have been seen by a vascular surgeon and to be awaiting a ligation of an incompetent saphenous vein. By March Dr. Rudolph

had Mr. Brown in PT for the swelling, and he mentioned the patient's complaint of right hip pain, and indicated that the knee was probably contributing to this. By June, Dr. Rudolph reported onset of low back issues. He ordered another MRI, which was done and showed no change in the medial compartment with no additional meniscal tearing. By October he noted that Mr. Brown had been using a lymphedema pump to no avail and that he had been considered for RSD with negative conclusions. By December he reported a lumbar MRI which showed L5-S1 dessication with disc bulging and a small annular tear. By January 8, 2014, Dr. Rudolph suggested "a fresh set of eyes", noted Mr. Brown to have a TENS unit, and essentially discharged him in his current disability status. On February 19, 2014, Dr. Rudolph noted that Mr. Brown had had a second opinion from a sports medicine orthopaedist, who had told him that he may have a new meniscal tear in the knee, and that his patella was malaligned laterally. However he expressed reticence to propose additional surgery, because of the massive swelling which followed the first procedure, some of which persisted. At that point, Dr. Rudolph described Mr. Brown as having "the worst result that he can have status post a medial meniscus tear". He indicated that he would fill out a SC WCC Form 14 B "with the appropriate numbers once we look them up", and that this form would contain the provision that additional meniscal or patellar surgery may be required in the future. At that point he considered Mr. Brown to be at Maximum Medical Improvement (MMI). No Form 14 B was included for my review.

Rudolph

Next reviewed were notes by Coastal Vein and Vascular center of Charleston, SC. All of these were signed by Brandy C. Price, PA-C, I shall assume for Edward C. Morrison, MD, a fellowship trained vascular surgeon. The first encounter was on January 9, 2013. On this visit the greater saphenous vein closure was recommended. Dr. Morrison accomplished this procedure February 14, 2013. On February 18 Mrs. Price recorded Mr. Brown's complaints of right hip and right low back pain, "radiating down his lower leg". By April 18 she noted an antalgic limp, Mr. Brown to report termination by his employer, and his report that his therapist had raised the possibility of RSD. She recommended a Flexitouch lymphatic pump and referred him to Dr. Tavel for RSD evaluation. By December 16 she noted that some skin breakdown had occurred but none that day. The situation was unchanged on the June 19, 2014 encounter.

Next reviewed were notes by Edward M. Tavel MD, an anesthesiology trained pain manager with Pain Management Specialists of Charleston, PA. Dr. Tavel saw the patient September 24, 2013 relative to the RSD issue. Dr. Tavel's physical findings were inconsistent with RSD, and he felt the pain to be mechanical in nature and caused by the swelling. He noted the low back pain and suggested a lumbar MRI. He treated Mr. Brown with a topical compounding cream and a TENS unit. He began treatment of the lumbar spine with a back support, and he assumed medication management from Dr. Rudolph. These encounters proceeded on a monthly or bimonthly basis and consisted of medication adjustment and laboratory verification of response and of no misuse. On May 2, 2014, Dr. Tavel issued a SC WCC Form 14-B Form, declaring Mr. Brown to be at MMI. He rated him with a 30% impairment due to pain, which I would presume to be a whole person impairment, and a 60% impairment to lymphedema right leg, which I

lymph
rating

lymph
restricted

would presume to be a right lower extremity impairment. He indicated Mr. Brown to be capable of sedentary duties only, no prolonged standing, or sitting, frequent changes of position, no lifting or carrying, no squatting, crawling, kneeling, and no ladders or repeated stair flights. He indicated that Mr. Brown's future medical needs would include compounding cream and medication, DIME requirements, and annual monitoring of liver and renal function in response to his medication.

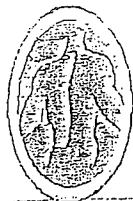
Finally reviewed were notes by Carolina Orthotics, CPM Physical Therapy, and Clarendon Health System, which documented studies ordered by and modalities accomplished under the direction of the managing physicians.

Mr. Brown was encountered as a now 40 year old high school graduate. He worked at Oneta Mills of Andrews in two manual capacities from his high school graduation until the mill's closure several years ago. From 2000 until 2006 he operated a US Mail contract truck. For the 3 1/2 years preceding the DOI he worked for Steel Technologies of Huger, SC as a medium distance 18 wheel truck driver. He hauled loads of steel sheets to Georgia and North Carolina, but he was home nights. He said he has not worked since the DOI and that he is currently unemployed. He sees Dr. Tavel about once monthly or bi-monthly for pain management, which is now just medication management. He sees Dr. Morrison about annually regarding lymph edema therapy and pump management. He was told by Dr. Rudolph to come back if the team decided he was a realistic candidate for additional meniscal or patellar release surgery on the right knee. He also told me that Dr. Rudolph had done a right hip (MRI), which revealed arthritis in that joint. I did not see a report of that study in my medicals for review. He did indicate that Dr. Rudolph gave him a cane and a knee brace.

cane
knee
brace
MRI
not

Currently Mr. Brown complains of right leg, thigh, knee, calf pain of about 7 of 10 in severity easing slightly at rest. He described it as aching and in the muscles, tingling. He said his knee snaps, pops, and gives way out of the brace. He complained of right groin and lateral trochanteric hip pain on weight bearing and joint motion. He complained low back right S1 joint axial pain with L5 or S1 sciatica to the foot but with no bowel or bladder manifestations.

Prior to the DOI Mr. Brown denied any problems with his low back, right hip, or right thigh, knee, or calf. He further denied medical or chiropractic encounters, surgery, injections, PT, bracing, medication or lost time from work/pleasure because of any such issues. He further denied automobile accidents with injuries, falls more than a few feet, sports injuries, fractures, or admissions to hospitals for trauma. He reported that in 1998 he twisted his right hand in a machine at Oneta and that he tore the ligaments about his right thumb. He said that he was treated conservatively with splinting and rehabilitation, and that he received two axillary injections during his recovery. He said that he was out of work about a year, and that Oneta had closed by the time he was cleared for full activity. At that he went to commercial trucker's school and got his DOT certification. He said that he never had any problems with his low back.



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L.

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

06/27/2014

Amanda McFann, NP

Reason for Appointment

1. Low Back Pain
2. Leg Pain

History of Present Illness**Pain Management:**

Patient complains of lower back pain and leg pain on the right. Patient continues to have pain in the right leg. He complains of tingling and numbness in the right leg to the foot. He rates his pain 7/10 today on a pain scale.

DOI: 4/30/2012

WORK STATUS: OUT OF WORK

Med Follow Up:

Patient comes in today for a medication follow up. On the previous visit we refilled Opana ER 10 mg Q12 and Norco 7.5/325 mg QD for pain. He is also taking Mobic for inflammation and using compounding cream for the right leg pain.

The relief that the medication provides is 60-70%. Compliance with the medical regimen has been as prescribed. Side effects of the medication include none. Patient denies any other concerns at this time.

Current Medications**Taking**

- Opana ER 10 MG Tablet Extended Release 12 Hour 1 tablet on an empty stomach every 12 hrs
- Norco 7.5-325 MG Tablet 1 tablet as directed qd
- Mobic 7.5 MG Tablet 1 tablet Once a day

Not-Taking/PRN

- Hydrocodone-Acetaminophen 7.5-325 MG Tablet as directed BID PRN
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery
Vein Closure

Family History

Father: alive
Mother: alive
2 daughter(s) - healthy.

Social History

no Alcohol.
Children: yes.
Married: yes.
Smoking Smoking Status: Never Smoker.

Allergies

N/A

Hospitalization/Major Diagnostic Procedure

Denies Past Hospitalization

Review of SystemsGastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation, Black or Tarry stools, difficulty swallowing.

Musculoskeletal:

Patient complaining of joint pain, joint swelling, joint stiffness.

Neurology:

Patient complaining of tingling, numbness, leg weakness, poor balance.

Vital Signs

Pain Scale 7/10, Ht 71, Wt 298, BMI 41.56, BP 163/104, HR 80, RR 20.

Assessments

1. Encounter for long-term (current) use of other medications - V58.69 (Primary)
2. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4
3. Other noninfectious lymphedema - 457.1

Treatment

1. Encounter for long-term (current) use of other medications

Refill Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60, Refills 0

Refill Norco Tablet, 7.5-325 MG, 1 tablet as directed, Orally, qd, 30 days, 30, Refills 1

Refill Mobic Tablet, 7.5 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 1

Clinical Notes: After talking with patient we will refill prescriptions for Opana ER 10 mg Q12 and Norco 7.5/325 mg QD for pain. Patient was also given a refill for Mobic for inflammation. Patient was given 2 months of medication. He will follow up in 8 weeks. Total time spent with patient in excess of 15 minutes with 50% of time spent counselling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for allowing me the opportunity to work with this patient.

2. Thoracic or lumbosacral neuritis or radiculitis, unspecified

Refill Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally**do not fill until 7/24/2014**, every 12 hrs, 30 days, 60, Refills 0

Follow Up

4 Weeks (Reason: Medication Follow Up)

Electronically signed by AMANDA MCFANN on 07/10/2014 at 08:38 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590
Home: 843-356-9590
Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by ROMFO, AMY

Date: 06/11/2014

Time: 04:20 PM

Reason Rx Remedies

Message

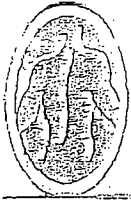
Valerie with Rx Remedies Pharmacy, requesting for Ketamine Compound to their fax 888-583-3752.
Valerie's # 866-904-4841.

Action Taken

ROMFO, AMY 6/11/2014 4:21:33 PM > message removed from nurse line ROMFO, AMY 6/11/2014
4:22:15 PM > sent to Debbie, is this something you are aware of? KUFEN, DEBORAH 6/16/2014 2:16:53
PM > need to contact kelly about this? ROMFO, AMY 6/16/2014 2:20:37 PM > forms given to kelly

Patient: BROWN, OSHEA L DOB: 07/08/1974 Provider: TAVEL, EDWARD M 06/11/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists
of Charleston, P.A.

BROWN, OSHEA I

39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590
Home: 843-356-9590
Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by BUXTON, ANGELA

Date: 06/10/2014

Time: 11:38 AM

Message PATIENT NEEDS MORE TENS PADS

Action Taken BUXTON, ANGELA 6/10/2014 11:39:11 AM > THANK YOU. Elam, Megan 6/12/2014 9:56:07 AM > Will
mail out today.

Patient: BROWN, OSHEAL DOB: 07/08/1974 Provider: TAVEL, EDWARD M 06/10/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL I

39 Y old Male, DOB: 07/08/1974

Account Number: 81501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER
BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

06/06/2014

vipcall: Edward M. Tavel, MD

History of Present IllnessMed Follow Up:

Initial UDS results: Results of initial UDS are appropriate, Urine sample will be sent to Aegis Lab for final confirmation and discussed at the follow up visit.

Electronically signed by EDWARD TAVEL, MD on 07/10/2014 at 08:37 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON

2695 ELMS PLANTATION BLVD

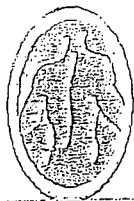
NORTH CHARLESTON, SC 294065017

Tel: 843-818-1181

Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Edward M. Tavel, MD 06/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-856-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

05/30/2014

Kinsey Knight, PA

Reason for Appointment

1. Low Back Pain

History of Present IllnessResponse to treatment since last visit:

Response to medications Mr. Brown is here today for a medication follow up. On patient's previous visit we refilled Mobic 7.5 QD, decreased Norco to 7.5-325 QD and refilled Opana ER 10 MG BID. Patient states 75-80% pain relief with current medication regimen and no side effects.

Pain Management:

Patient c/o low back pain that radiates into the right hip and down the BLE. Patient states numbness and tingling in the BLE and an increase in leg cramps. Patient rates pain level today 8/10 on a pain scale.

DOI: 4/30/2012

WORK STATUS: OUT OF WORK.

Current MedicationsTaking

- Hydrocodone-Acetaminophen 7.5-325 MG Tablet as directed BID PRN
- Opana ER 10 MG Tablet Extended Release 12 Hour 1 tablet on an empty stomach every 12 hrs
- Norco 7.5-325 MG Tablet 1 tablet as directed qd
- Mobic 7.5 MG Tablet 1 tablet Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery

Vein Closure

Family History

Father: alive

Mother: alive

2 daughter(s) - healthy.

Non-Contributory

Social History

no Alcohol.

Children: yes.

Married: yes.

Smoking Smoking Status:: Never Smoker.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Review of Systems

Constitutional:

Patient denies fever, loss of appetite, insomnia, weakness/fatigue, weight loss.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation, Black or Tarry stools, difficulty swallowing.

Neurology:

Patient denies dizziness, poor balance, blurred vision, arm weakness. Patient complaining of tingling, numbness, leg weakness.

Vital Signs

Pain Scale 8/10, Ht 71, Wt 298, BMI 41.56, BP 150/101, HR 78, RR 20.

Examination

General examination:

General appearance: alert and oriented to person, place and time.

Assessments

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4 (Primary)
2. Encounter for long-term (current) use of other medications - V58.69

39 year old male presents for WC med management. Pt states his medications are controlling his pain. He returns to Dr. Morrison next month. If no changes following Dr. Morrison's appt, and pts pain is stable, we will provide 8 weeks of medications in the future. My supervising physician, Dr. Edward Tavel, has reviewed this plan and is in agreement.

Treatment

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified

Notes: After talking with patient we will refill Opana ER and patient will continue with Norco and Mobic as directed. We will see patient back in 4 weeks for a medication follow up. Total time spent with patient in excess of 15 minutes with 50% of time spent counselling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for allowing me the opportunity to work with this patient.

2. Encounter for long-term (current) use of other medications

Refill Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60, Refills 0

Notes: UDS performed in the office today and sent to in office lab. Screening performed for confirmation that the current prescribed pain medications including Opana ER, and Norco are present and taken as prescribed. We will also confirm that no illicit drugs are present. Urine sample sent to Aegis lab for confirmation.

Procedure Codes

81003 URINALYSIS, AUTO, W/O SCOPE
82055 ASSAY OF ETHANOL
82570 ASSAY OF URINE CREATININE
83986 ASSAY OF BODY FLUID ACIDITY
84311 SPECTROPHOTOMETRY
G0431 DRUG SCR QUAL; SINGLE CLASS METH EA

Follow Up

4 Weeks (Reason: med f/u)

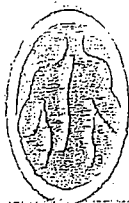
Electronically signed by KINSEY KNIGHT, PA on 07/10/2014 at 08:37 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Kinsey Knight, PA 05/30/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

33 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

05/14/2014

vipcall: Edward M. Tavel, MD

History of Present IllnessMed Follow Up:

Initial UDS results: Results of initial UDS are appropriate, Urine sample will be sent to Aegis Lab for final confirmation and discussed at the follow up visit.

Electronically signed by EDWARD TAVEL, MD on 07/10/2014 at 08:37 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON

2695 ELMS PLANTATION BLVD

NORTH CHARLESTON, SC 294065017

Tel: 843-818-1181

Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Edward M. Tavel, MD 05/14/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists
of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974
583 TAFT RD, SALTERS, SC, US 29590

Home: 843-356-9590

Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by Olalere, Trae

Date: 05/08/2014

Time: 10:05 AM

Message

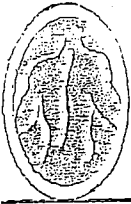
The NCM (Daphne) for this patient called and requested physician notes and the 14B for 5/2/14 visit to be faxed to 866-232-9182.

Action Taken

Millare, Katrina 5/12/2014 2:39:43 PM > FAXED INVOICE FOR 14B TO NCM

Patient: BROWN, OSHEAL DOB: 07/08/1974 Provider: TAVEL, EDWARD M 05/08/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists
of Charleston, P.A.

BROWN, OSHEAL L

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

05/07/2014

vipcall: Edward M. Tavel, MD

History of Present Illness

Med Follow Up:

Initial UDS results: Results of initial UDS are inconsistent, Urine sample will be sent to Aegis Lab for final confirmation and discussed at the follow up visit.

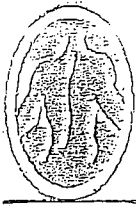
Electronically signed by EDWARD TAVEL, MD on 07/10/2014 at 08:37 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Edward M. Tavel, MD 05/07/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

05/02/2014

Kinsey Knight, PA

Reason for Appointment

1. Low Back Pain

History of Present Illness**Med Follow Up:**

Mr. Brown is coming in today for medication management. On previous visit we prescribed Norco 7.5-325MG BID prn pain. Patient states he is satisfied with the medication regimen. Patient states the pain will subside some with the medication.

The relief that the medication provides 70% Norco, 70% Opana ER. The duration of the effect of the medication is 4-5 hours Norco, 12 hours Opana ER.

DOI: 4/30/2012

WORK STATUS: OUT OF WORK.

Pain Management:

Patient rates pain 7/10 on a pain scale. Patient complains of low back pain that radiates into the RIGHT hip down the leg. Patient states swelling in the RIGHT leg. Patient states the pain is constant and is more severe when walking. Patient states numbness/tingling in the RIGHT leg.

Current Medications**Taking**

- Hydrocodone-Acetaminophen 7.5-325 MG Tablet as directed BID PRN
- Norco 7.5-325 MG Tablet 1 tablet as directed BID PRN
- Opana ER 10 MG Tablet Extended Release 12 Hour 1 tablet on an empty stomach every 12 hrs
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery

Vein Closure

Family History

Father: alive

Mother: alive

2 daughter(s) - healthy.

Non-Contributory

Social History

no Alcohol.

Children: yes.

Married: yes.

Smoking Smoking Status:: Never Smoker.

Allergies
NKDA

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Review of Systems

Constitutional:

Patient denies fever, loss of appetite, insomnia, weakness/fatigue, weight loss.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation, Black or Tarry stools, difficulty swallowing.

Neurology:

Patient denies tingling, numbness, dizziness, poor balance, blurred vision, arm weakness, leg weakness.

Vital Signs

Pain Scale 7/10, Ht 71, Wt 298, BMI 41.56, BP 167/90, HR 84, RR 20.

Assessments

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4 (Primary)
2. Encounter for long-term (current) use of other medications - V58.69

39 year old male presents for medication management. Today, pt is at MMI. We will continue Opana ER 10 mg BID; Norco 7.5-325 qd, and start Mobic 7.5 mg qd. Pt will be applying for disability as his permanent work restrictions are sedentary per Rudolph and Morrison. Will return in 4 weeks for medication management. Case manager Daphne was present for the encounter today. My supervising physician, Dr. Edward Tavel, has reviewed this plan and is in agreement.

Treatment

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified

Start Mobic Tablet, 7.5 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 1

Decrease Norco Tablet, 7.5-325 MG, 1 tablet as directed, Orally, qd, 30 days, 30, Refills 1

Refill Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60, Refills 0

Notes: After talking with patient we will refill patients prescriptions today for Opana ER 10MG every 12 hours as directed. Patient was prescribed Mobic 7.5MG QD and we will decrease Norco 7.5-325MG QD. Patient is satisfied and compliant with current medication regimen. Patient was given prescriptions for Opana ER. Prescriptions for Norco and Mobic were dispensed out of workers comp closet. Patient will return in 4 weeks for medication management. UDS performed in the office today and sent to in office lab. Screening performed for confirmation that the current prescribed pain medications including Opana ER and Norco are present and taken as prescribed. We will also confirm that no illicit drugs are present. Urine sample sent to Aegis lab for confirmation. Total time spent with patient in excess of 15 minutes with 50% of time spent counselling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for allowing me the opportunity to work with this patient.

Procedure Codes

81003 URINALYSIS, AUTO, W/O SCOPE

82542 COLUMN CHROMATOGRAPHY, QUANT

82570 ASSAY OF URINE CREATININE

89986 ASSAY OF BODY FLUID ACIDITY

84311 SPECTROPHOTOMETRY

G0431 DRUG SCR QUAL; SINGLE CLASS METH EA

Follow Up

4 Weeks (Reason: Medication Follow Up)

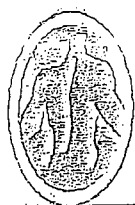
Electronically signed by KINSEY KNIGHT, PA on 07/10/2014 at 08:36 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Kinsey Knight, PA 05/02/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

04/11/2014

vpcall: Edward M. Tavel, MD

History of Present IllnessMed Follow Up:

Initial UDS results: Results of initial UDS are appropriate, Urine sample will be sent to Aegis Lab for final confirmation and discussed at the follow up visit.

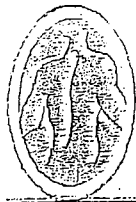
Electronically signed by EDWARD TAVEL, MD on 07/10/2014 at 08:36 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Edward M. Tavel, MD 04/11/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

04/07/2014

Kinsey Knight, PA

Reason for Appointment

1. Low Back Pain

History of Present IllnessResponse to treatment since last visit:

Patient was referred for a low back garment and back brace on previous visit. He states minimal relief with the garment at this time.

Response to medications Mr. Brown is here today for a medication follow up. On patient's previous visit we refilled Hydrocodone 7.5-325 BID PRN and prescribed Opana ER 10 MG BID. Patient states that he just received his Opana ER 2 days ago, so he only needs refills of the Hydrocodone today.

DOI: 4/30/2012

WORK STATUS: OUT OF WORK.

Pain Management:

Patient c/o low back pain that radiates into the right hip and down the right leg stopping at the foot. Patient rates pain level today 8/10 on a pain scale.

Current Medications**Taking**

- Opana ER 10 MG Tablet Extended Release 12 Hour 1 tablet on an empty stomach every 12 hrs
- Hydrocodone-Acetaminophen 7.5-325 MG Tablet as directed BID PRN
- Medication List reviewed and reconciled with the patient.

Past Medical History

No Medical History.

Surgical HistoryKnee surgery
Vein Closure**Family History**Father: alive
Mother: alive
2 daughter(s) - healthy.
Non-Contributory**Social History**no Alcohol.
Children: yes.
Married: yes.
Smoking Smoking Status: Never Smoker.**Allergies**

N.K.D.A.

Hospitalization/Major Diagnostic Procedure
No Hospitalization History

Review of Systems

Constitutional:

Patient denies fever, loss of appetite, insomnia.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation.

Neurology:

Patient complaining of poor balance, RIGHT leg weakness and tingling, numbness.

Vital Signs

Pain Scale 8/10, Ht 71, Wt 298, BMI 41.56, BP 168/96, HR 80, RR 20.

Examination

General examination:

General appearance: alert and oriented to person, place and time.

Assessments

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4 (Primary)
2. Encounter for long-term (current) use of other medications - V58.69

39 year old male with open WC case presents for med management. Pt has only taken 2 days of Opana due to insurance reasons. We will continue his medication as dosed today. He only needs refill for Norco. Will follow up in 4 weeks. Case manager was not present for today's appointment.

Treatment

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified

Start Norco Tablet, 7.5-325 MG, 1 tablet as directed, Orally, BID PRN, 30 days, 60. Refills 0

Notes: After talking with patient he will continue with Opana ER and Hydrocodone as directed. No refills of Opana ER needed today. We will change the Hydrocodone to Norco as directed. We will see patient back in 4 weeks for a medication follow up. , UDS performed in the office today and sent to in office lab. Screening performed for confirmation that the current prescribed pain medications including Opana, Hydrocodone are present and taken as prescribed. We will also confirm that no illicit drugs are present. Urine sample sent to Aegis lab for confirmation.

Procedure Codes

81003 URINALYSIS, AUTO, W/O SCOPE
82542 COLUMN CHROMATOGRAPHY, QUANT
82570 ASSAY OF URINE CREATININE
83986 ASSAY OF BODY FLUID ACIDITY
84311 SPECTROPHOTOMETRY
G0431 DRUG SCR QUAL; SINGLE CLASS METH EA

Follow Up

4 Weeks (Reason: med f/u)

Electronically signed by KINSEY KNIGHT, PA on 07/10/2014 at 08:36 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON

JUL/10/2014/THU 08:18 AM

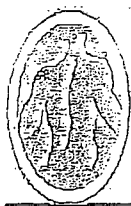
FAX NO.

P. 018

2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Kinsey Knight, PA 04/07/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists
of Charleston, P.A.

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590

Home: 843-356-9590

Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by Hildenbrand, Sarah

Date: 03/19/2014

Time: 09:07 AM

Message Patient is asking for a note stating that he is still out of work. He is here waiting.

Action Taken ISHERWOOD, NICOLE 3/19/2014 9:25:19 AM >

Patient: BROWN, OSHEA L DOB: 07/08/1974 Provider: TAVEL, EDWARD M 03/19/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974

Account Number: 81501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD CMORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

03/13/2014

Progress Note: Amanda McFann, NP

Reason for Appointment

1. Low Back Pain
2. Leg Pain

History of Present IllnessResponse to treatment since last visit:

DOI: 4/30/2012

work status: not working since the injury.

Mr. Brown is here today for a follow up. On the patient's last visit, we provided him with TENS unit and compounding cream. He receives compound cream in the mail. He states TENS and compound cream providing him with some relief. He also takes Hydrocodone and is satisfied with the medication. He needs more pads for TENS unit

Patient states he has been getting the hydrocodone from Dr. Rudolph, but that it's a 14 day supply and that he's running out. Currently he takes 3-4/day (q4-6h).

Med Follow Up:

The relief that the medication provides 30%. The onset of the relief provided by the medication is less than 30 minutes. The duration of the effect of the medication is 3-4 hours. Compliance with the medical regimen has been as prescribed. Side effects of the medication include none.

Patient needs Hydrocodone refill today. Patient takes Hydrocodone 2-3 times a day and sometimes takes it every 4-6 hours.

Pain Management:

Patient rates pain 8-9 on the pain scale. Patient complains of low back pain at L5 that is radicular from RIGHT hip down into the RIGHT foot. He also complains of swelling to RLE. He states he has pain in his LEFT knee to LEFT foot intermittently since he is compensating on that side. He walks with a cane. Patient c/o numbness/tingling to low back and RLE. Pain is aggravated by nothing in particular, his pain is constant. Pain is improved by compound cream and Hydrocodone.

Current Medications**Taking**

- Hydrocodone-Acetaminophen 7.5-500 MG Tablet as directed BID PRN
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery
Vein Closure

Family History

Father: alive
Mother: alive
2 daughter(s) - healthy.
Non-Contributory

Social History

no Alcohol.
Children: yes.
Married: yes.
Smoking Smoking Status: Never Smoker.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems**Constitutional:**

Patient denies fever, loss of appetite, insomnia.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation.

Neurology:

Patient complaining of poor balance, RIGHT leg weakness and tingling, numbness.

Vital Signs

Pain Scale 8-9/10, Ht 71, Wt 298, BMI 41.56, BP 158/90, HR 89, RR 18.

Assessments

1. Other noninfectious lymphedema - 457.1 (Primary).
2. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4
3. Encounter for long-term (current) use of other medications - V58.69, Risk: Low

Treatment

1. Other noninfectious lymphedema

Refill Hydrocodone-Acetaminophen Tablet, 7.5-325 MG, as directed, Orally, BID PRN, 30 days, 60, Refills 0

Start Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60, Refills 0

Notes: After talking with the patient, we will refill Hydrocodone 7.5-325 mg BID PRN and start Opana 10 mg every 12 hours for pain management. Patient was given prescriptions today. We will see the patient back in 4 weeks for medication management. We feel very strongly that his unilateral right sided lymphadema is not solely based on his weight. Patient referred for a EXO 631 back brace to support weak spinal muscles. Total time spent with patient in excess of 15 minutes with 50% of time spent counselling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for allowing me the opportunity to work with this patient.

Referral To:

Reason: EXOS 637 Back Brace to support weak spinal muscles|Low back garment to help with pad placement due to large treatmeant area

2. Thoracic or lumbosacral neuritis or radiculitis, unspecified

Referral To:

Reason: EXOS 637 Back Brace to support weak spinal muscles|Low back garment to help with pad placement due to large treatmeant area

3. Encounter for long-term (current) use of other medications

Notes: UDS performed in the office today and sent to in office lab. Screening performed for confirmation that the current prescribed pain medications including Hydrocodone and Opana are present and taken as prescribed. We will also confirm that no illicit drugs are present. Urine sample sent to Aegis lab for confirmation.

Procedure Codes

81003 URINALYSIS, AUTO, W/O SCOPE

82542 COLUMN CHROMOTOGRAPHY, QUANT

82570 ASSAY OF URINE CREATININE

JUL/10/2014/THU 08:17 AM

FAX No.

P. 014

83986 ASSAY OF BODY FLUID ACIDITY
84311 SPECTROPHOTOMETRY
G0431 DRUG SCR QUAL; SINGLE CLASS METH EA

Follow Up

4 Weeks (Reason: Medication Follow Up)

Electronically signed by AMANDA MCFANN on 07/10/2014 at 08:36 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON

2695 ELMS PLANTATION BLVD

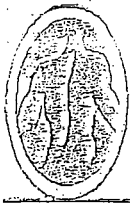
NORTH CHARLESTON, SC 294065017

Tel: 843-818-1181

Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: Amanda McFann, NP 03/13/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590

Home: 843-356-9590

Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by Elam, Megan

Date: 02/03/2014

Time: 10:35 AM

Message

Mr Brown's NCM Daphne left me a voicemail stating that he needs more TENS pads and compression stockings. I have sent a request to RS Medical for a new supply of pads, but I can not help him with the stockings. Please contact Daphne at 843-452-7412.

Action Taken

KUFEN, DEBORAH 2/3/2014 12:06:36 PM > compression stocking, does that need to come from her pcp MCFANN, AMANDA B 2/3/2014 12:22:14 PM > needs f/u foot stockings. This hasn't been addressed. ISHERWOOD, NICOLE 2/6/2014 4:00:09 PM > please schedule this patient BUXTON, ANGELA 2/6/2014 5:03:16 PM > scheduled WC FU appt on 2.11.14 at 10:30 am - placed on Amanda's schedule. Do you want me to let Daphne know and make sure that's a good day/time for her? ISHERWOOD, NICOLE 2/7/2014 8:01:37 AM > YES PLEASE BUXTON, ANGELA 2/7/2014 11:02:03 AM > Nicole, Daphne said she has the compression socks taken care of so patient will NOT need a FU visit right now. She said he will need one in the future but she will let us know when. I called patient to cx the appt for 2.11.14.

Patient: BROWN, OSHEA L DOB: 07/08/1974 Provider: TAVEL, EDWARD M 02/03/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Pain Specialist of Charleston

CLIA: 42D1094637

2695 Elms Plantation Blvd
Charleston, SC 29406

Contact:

Phone #: 843-815-1181

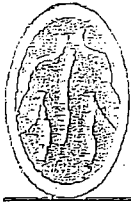
Test Result Final Report

Printed on: 06/02/2014 8:55 PM by Simmons, Vickie

Donor Name:	Brown, Oshea	Accession:	00000577
MRN:		Agency:	Pain Specialists of Charleston P.A.
DOB:	07/08/1974	Requesting Party:	Edward M Tavel Jr, MD
Collection Date:	05/30/2014 12:00 AM	Test Date:	5/2/2014
Collected By:	Studebaker, Racquel	Tested By:	Vickey Simmons

Screening Results		
Test	Result	Cutoff
Amphetamine	Negative	> 500 ng/mL
Barbituate	Negative	> 200 ng/mL
Benzodiazepine	Negative	> 200 ng/mL
Cannabinoid	Negative	> 50 ng/mL
Cocaine	Negative	> 300 ng/mL
Ethyl Alcohol	Negative	> 100 mg/dL
Methadone	Negative	> 300 ng/mL
Opiate	Positive	> 300 ng/mL
Oxycodone	Positive	> 300 ng/mL
PCP	Negative	> 25 ng/mL
Creatinine	Normal	< 20 mg/dL
Oxidant	Normal	> 200 µg/ml
pH	Normal	< 4.5 OR > 9
Specific Gravity	Normal	< 1.003 OR > 1.035 g/ml

Lab Director Cynthia A. Schandl M.D.



Pain Specialists of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590
Home: 843-356-9590
Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by Hildenbrand, Sarah

Date: 11/13/2013

Time: 01:26 PM

Message

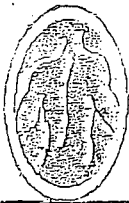
Carol Cambell the NCW is asking about the compounding cream for the pt again. GHe still has not recieved it. Please call to advise. Carol's number is 843-847-1452

Action Taken

Hildenbrand, Sarah 11/13/2013 1:26:43 PM > ISHERWOOD, NICOLE 11/13/2013 1:49:34 PM > Megan
please have Kelly look into this, this has taken forever to complete Elam, Megan 11/14/2013 3:48:13 PM
> Message has been passed along to Kelli

Patient: BROWN, OSHEAL DOB: 07/08/1974 Provider: TAVEL, EDWARD M 11/13/2013

Notes generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists
of Charleston, P.A.

BROWN, OSHEAL

39 Y old Male, DOB: 07/08/1974
533 TAFT RD, SALTERS, SC, US 29590

Home: 843-356-9590

Provider: TAVEL, EDWARD M

Telephone
Encounter

Answered by KUFEN, DEBORAH

Date: 10/09/2013

Time: 05:01 PM

Message

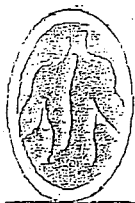
Carol campbell patients case manager called and states that she has questions about the compounding cream order, and 843-884-2818, or call # 843-847-1452

Action Taken

KUFEN, DEBORAH 10/9/2013 5:06:34 PM > did you find the copy? ISHERWOOD, NICOLE
10/15/2013 2:36:28 PM > kelly will call and explain the process for the compounding cream

Patient: BROWN, OSHEAL DOB: 07/08/1974 Provider: TAVEL, EDWARD M 10/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L

59 Y old Male, DOB: 07/08/1974

Account Number: 31501

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L Insurance: GALLAGHER

BASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

09/24/2013

PROGRESS NOTES: BRITTANY D WHITESIDE, PA

Reason for Appointment

1. Leg Pain

History of Present Illness**Pain Management:**

Patient was referred to our office for an evaluation for lower limb pain. Dr. Morrison would like Dr. Tavel to evaluate for possible RSD. Patient states he was injured on the job after hitting his knee on a trailer, unloading steel. He states since the injury he has had knee surgery and a vein closure. Patient states he has started to have lower back pain and hip pain. He states since his gait has been off balance he has started to also have pain in the left foot.

The patient is complaining of pain located in the lower limb on the right. The pain began 4/30/2012. The pain occurred after a work accident. The pain is described as sharp, shooting, aching, stabbing. The pain radiates to the right foot. The severity of the pain is 8/10 average. The timing of the pain is continuous. The pain is improved by Hydrocodone. The pain is aggravated by walking, standing. Medications that have been utilized include narcotics. Treatments have included physical therapy, surgery on the right knee.

DOL: 4/30/2012

work status: not working since the injury.

Med Follow Up:

Patient takes Hydrocodone 7.5/500 mg QD-BID.

Current Medications**Taking**

- Hydrocodone-Acetaminophen 7.5-500 MG Tablet as directed BID
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery

Vein Closure

Family History

Father: alive

Mother: alive

2 daughter(s) - healthy.

Social History

no Alcohol.

Children: yes.

Married: yes.

Smoking Smoking Status: Never Smoker.

Allergies

N.E.D.A.

Hospitalization/Major Diagnostic Procedure
Denies Past Hospitalization

Review of SystemsCardiology:

Patient denies chest pain (angina), shortness of breath, dizziness, irregular heartbeats (palpitations), cold extremities, Hypertension. Patient complaining of swelling in ankles.

Constitutional:

Patient denies fever, loss of appetite, insomnia, weakness/fatigue, weight loss, weight gain, rash.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation, Black or Tarry stools, difficulty swallowing, heartburn.

Musculoskeletal:

Patient complaining of joint pain, joint swelling, joint stiffness, leg cramps, muscle cramps.

Neurology:

Patient denies dizziness, blurred vision, arm weakness, headache. Patient complaining of leg weakness, poor balance, tingling, numbness.

Respiratory:

Patient denies wheezing, shortness of breath, cough, use of inhalers.

Vital Signs

Pain Scale 8/10, Ht 71, Wt 298, BMI 41.56, BP 146/99, HR 89, RR 20.

Physical ExaminationGeneral:

General appearance: well nourished, obese, pleasant, walks with antalgic gait favoring the left, well developed, in no acute distress, alert and oriented x4 with appropriate mood and affect, African American. Build: obese.

Radiculopathy by nerve root:

L4 right, quadriceps, medial calf.

Extremities:

Edema: Right lower extremity with +4 non-pitting edema, pain to palpation of right lower extremity.

Neurological:

Cranial nerves: within normal limits. Sensory: normal. Motor: normal strength bilaterally. Coordination: normal. Gait: antalgic favoring the left side.

Assessments

1. Other noninfectious lymphedema - 457.1 (Primary)
2. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4

Patient seen today by Dr. Tavel and Midlevel provider. Patient presents to us today for evaluation of right lower leg pain following a work-related injury in 2012. Patient is s/p right knee arthroscopy by Dr. Rudolph in November 2012, and s/p vein closure by Dr. Morrison in January 2013. Following his knee arthroscopy he developed pain and edema in his right lower leg that was thought to be vascular in nature, but was not improved with vascular surgery. Patient is currently using a lymphatic pump for lymph drainage. He continues to report pain in the right leg, and was sent to us to evaluate for possible RSD. Patient's physical exam findings are not consistent with diagnosis of RSD, and I believe that his pain is mechanical in nature due to edema of his right lower extremity. Patient does also complain of pain radiating from his lumbar region down into his anterior leg, which may be of lumbar etiology resulting from gait change due to right leg pain. If patient's low back is a part of the WC claim, I would recommend lumbar MRI to rule out pathology. At this time I will prescribe a compound cream that could be helpful for his leg pain along with a TENS unit for chronic pain relief. Patient will return to clinic on an as-needed basis.

Treatment

1. Other noninfectious lymphedema

Notes: After talking with patient we will prescribe compounding cream that will be mailed to the patient's home. Patient

was instructed to use the cream 2-3 x a day for neuropathic leg pain. Patient will be referred to RS Medical for a TENS unit device for pain control. Patient will return in office on a as needed basis. Total time spent with patient in excess of 30 minutes with 50% of that time spent counseling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for this kind referral and I look forward to working with you in the care of this patient.

Referral To: DME EQUIPMENT RS MEDICAL

Reason: TENS Unit to relieve daily chronic pain

Follow Up
prn

Electronically signed by BRITTANY WHITESIDE, PA-C on 07/10/2014 at 08:35 AM EDT

Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
2695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 294065017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: BRITTANY D WHITESIDE, PA 09/24/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



PHYSICAL THERAPY

Patient Name: OSHEA L BROWN Date Seen: 3/29/2013
 Diagnosis: 719.49 Pain in Joint (Multiple Sites) Date of Birth: 07/08/1974 (38 years old)
 719.56 Stiffness of joint, lower leg
 728.87 Muscle Weakness (generalized)
 781.2 Abnormality of gait

Dr. Rudolph,

Treatment to Include:

Body Mechanic Training (97110) - , Core Stabilization (97110) - , Flexibility (97110) - , Neuromuscular Re-educ - 97112: , ROM (97110) - , Therapeutic Exercise - 97110: , Cryotherapy- 97010: , Heat- 97010: , IFC E-Stim- 97014: , Ultrasound- 97035: , Manual Stretching- 97140: , Soft Tissue Mobs- 97140: , Spine Mobilization- 97140: , Manual techniques - 97140, Dynamic Activity - 97350, Aquatic Therapy - 97113.

Subjective:

Pt is a 38 yo male with c/o R back and LE pain.
 • LB to R LE - foot - Current: 9/10 Best: 8/10 Worst: 10/10

Objective:

Observation: Posture
 Sitting- anterior head and shoulders, with R LE extended
 Standing - elevated x , anterior head and shoulders, wt bearing through L LE
 Gait - decreased stance on R, R knee in ext no flexion. foot flat gait.
 Ankle - AROM: (Dorsi-Flexion - R: -9 Degrees / L: Degrees).
 Ankle - PROM: (Dorsi-Flexion - R: 0 Degrees / L: Degrees).
 Ankle - Girth: (Bi-Malleolar - R: 32 / L: 0).
 Knee - AROM: (Flexion - R: 51 Degrees / L: Degrees), (Extension - R: 0 Degrees / L: Degrees).
 Knee - PROM: (Flexion - R: 58 Degrees / L: Degrees), (Extension - R: Degrees / L: Degrees).
 Knee - Girth: (5 cm above - R: 56.5 cm / L: 0 cm), (Joint - R: 48.5 cm / L: 0 cm), (5 cm below - R: 45.5 cm / L: 0 cm).
 Knee - Muscle Testing: (Hamstrings - R: 4/5 / L:), (Quadriceps - R: 4/5 / L:).
 Hip - AROM: (Flexion - R: limited / L:).
 Myotomes: (L1,2 - Hip flexors - R: 2/5 / L: 5/5), (L3 - Quadricep - R: 4/5 / L: 5/5), (L5 - Dorsi flexors - R: 3+/5 / L: 5/5), (S1,2 - Gastroc / Hams - R: 4/5 / L: 5/5), (Hip Adductors - R: 4/5 / L: 5/5), (Hip Abductors - R: 4/5 / L: 5/5).
 Palpation: Pt is TTP at calf, knee, ankle, LB, gluts
 Note possible cellulitis, pt with blisters posterior calf, pitting edema, poor to no pedal pulse on R
 note shine and skin discoloration redness upper lower leg, darkness lower lower leg, possible PSD/osteomyelitis

Assessment:

- Evaluation has determined decrease in functional status for this patient.
 - Evaluation has found subjective and objective deficits that can be addressed by physical therapy intervention.
 - Pt presents with s/s consistent with derangement of posterior R knee with possible RSD/osteomyelitis and vascular compromise effecting strength, ROM, gait, posture, function and pain. 719.49, 719.56, 728.87, 781.2
- Potential To Reach Goals: Good

Goals Achieved:

Short Term Goals:

- Pt independent with HEP (Not Met)
- Pt tolerates 30-45 min of ther ex for strengthening (Not Met)
- Pain decreased 25% (Not Met)

Patient Summary

Page 1 of 2

Brown, Oshea L
 523 Taft Road, Selters, SC, US 29590
 DOB: 07/09/1974 Age: 40 Y Sex: Male
 Home: 843-356-9590
 Work:
 Cell: 843-356-9590
 Email:

Primary Insurance: Gallagher and Bassett Services
 PCP: Robert J Allen, MD
 Account Number: 126756

Allergies: N.K.D.A

Medical History

Active Problem List		Specify	Notes	Added On	Modified On	Modified By
Code	Name					
459.81	Venous Insufficiency			04/10/2013	08/27/2013	pinto, lauren M
457.1	Lymphedema			06/19/2014	06/19/2014	Price, Brandy E
278.00	Obesity, unspecified			06/19/2014	06/19/2014	Price, Brandy E
Past Medical History						
derangement of posterior horn of medial meniscus tear						

Medications

Name strength formulation, Sig: take route frequency
 Compression Stockings 15-20 mm Hg, Sig: as directed During Day
 Opana 10 MG Tablet, Sig: 1 tablet on an empty stomach as needed Orally every 6 hrs
 Hydrocodone-Acetaminophen 5-500 MG Capsule, Sig: 1 capsule as needed Orally every 6 hrs
 Meloxicam 15 MG Tablet, Sig: 1 tablet Orally Once a day

Surgical History

Date	Reason
02-14-2013	right knee arthroscopy VeneFit Closure RLE GSV

Social History

Name	Value
Tobacco Use/Smoking	Are you a: nonsmoker
Marital status:	married
Occupation:	Pt. on Workmens Compensation

Family History

Relation : Description

Father: alive

Mother: alive

Vitals

Name	Date	Value
BP	06/19/2014	134/96
HR	06/19/2014	80
Ht	06/19/2014	5 ft 11 in
Wt	06/19/2014	297
BMI	06/19/2014	41.42

Patient Encounters

Date	Visit	Reason	Diagnosis
07/09/2014	TEL	Chart	
06/19/2014	VASMO		W w/Other Complications (pain/swelling/edema)
06/19/2014	FU1	SMO FU/CHRONIC PAIN/VSD.	Lymphedema VSD
02/21/2014	TEL		
12/31/2013	TEL		
12/16/2013	FU1	SMO FU/VSD/EDEMA	Lymphedema Venous Insufficiency
09/11/2013	TEL	Other	
08/27/2013	FU1	FU/LYMPHATIC PUMP7/28/RIGHT LEG	Lymphedema Obesity, unspecified W w/Other Complications (pain/swelling/edema)
05/16/2013	VASMO	abi	Pain in Limb
05/16/2013	FU1	1MO FU/VSD/CHRONIC PAIN	Pain in Limb

Patient Summary

Page 2 of 2

Brown, Oshia L

333 Telford Road, Salters, SC, US 29590

DOB: 07/08/1974 Age: 40 Y Sex: Male

Home: 843-356-9590

Work:

Cell: 843-356-9590

Email:

Primary Insurance: Gallagher and Bassett Services

PCP: Robert J Allen, MD

Account Number: 126756

Allergies: N.K.D.A

04/24/2013	TEL		VSD
04/16/2013	FU1	2MO FU/VSD	VSD
			Pain in Limb
04/18/2013	TEL		
03/14/2013	FU1	4 WK/VC RLE GSV	VV w/Other Complications (pain/swelling/edema)
02/16/2013	FU1	post closure pain	VV w/Other Complications (pain/swelling/edema)
02/16/2013	VASMO	P/VC RLE GSV	Aftercare following surgery of the circulatory system, NEC
02/14/2013	OSVC	VC RLE GSV	Varicose veins of the lower extremities with other complications
			VSD
02/14/2013	VASOS	VC RLE GSV	
02/13/2013	TEL	Premeds for VC 02/14/2013	
01/09/2013	VASMO	RLE PAIN AND EDEMA	Varicose veins of the lower extremities with other complications
01/09/2013	NP1	H.Rudolph/ RLE EDEMA -DVT	VSD

Referrals

Incoming Referrals					
Referral From	Referral To	Start Date	End Date	Reason	
Harryrhett P Rudolph, MD		11/30/2012	11/30/2013		
Outgoing Referrals					
Referral From	Referral To	Start Date	End Date	Reason	
Edward C Morrison, MD	Edward Tavel, MD	04/19/2013	04/18/2014	Patient needs an appointment for chronic pain.	

**COASTAL VASCULAR
&
VEIN CENTER****Brown, Oshea L**

39 Y old Male, DOB: 07/08/1974

Account Number: 126756

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

PCP: Robert J Allen, MD Referring: Edward C Morrison, MD

Appointment Facility: CVVC Main Office Vascular Lab

06/19/2014

Edward C. Morrison, MD

Current Medications

None

Reason for Appointment

1. RLE Venous study

Past Medical HistoryDerangement of posterior horn of medial
meniscus tear**Assessments**

1. VV w/Other Complications (pain/swelling/edema) - 454.8 (Primary)

Procedure Codes

93971 Duplex scan of UE or LE veins, unilateral or limited study- Office

Electronically signed by Edward Morrison MD, MD on
07/09/2014 at 05:44 PM EDT

Sign off status: Pending

CVVC Main Office Vascular Lab
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-577-8868

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Edward C. Morrison, MD 06/19/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

39 Y old Male, DOB: 07/08/1974

Account Number: 126756

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

PCP: Robert J Allen, MD Referring: Edward C Morrison, MD

Appointment Facility: CVVC Main Office

06/19/2014

Progress Note: Brandy E. Price, PA-C

Current Medications

Taking Compression Stockings 15-20 mm Hg as directed During Day
 Taking Meloxicam 15 MG Tablet 1 tablet Once a day
 Taking Hydrocodone-Acetaminophen 5-500 MG Capsule 1 capsule as needed every 6 hrs
 Taking Opana 10 MG Tablet 1 tablet on an empty stomach as needed every 6 hrs
 Medication List reviewed and reconciled with the patient

Past Medical History

Derangement of posterior horn of medial meniscus tear

Surgical History

right knee arthroscopy
 VeneFit Closure RLE GSV 02-14-2013

Family History

Father: alive
 Mother: alive

Social History

Tobacco Use:
 Tobacco Use/Smoking Are you a:
 nonsmoker.
Miscellaneous:
 Marital status: married.
 Occupation: Pt. on Workmens Compensation.

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

Denies Past Hospitalization

Review of Systems

No nausea, vomiting, fever, or chills. No SOB or CP. Remaining ROS negative.

Reason for Appointment

1. 6MO FU/CHRONIC PAIN/VSD.

History of Present IllnessGeneral:

Patient here today for 6 month follow up CVI/lymphedema. He states he is still having chronic pain in his right leg. He is wearing compression stockings to control swelling. He reports no skin breakdown or ulcerations. He now has chronic back pain in addition to his right knee and leg pain which he says is from is altered gait. No SOB or CP. No claudication. No rest pain. Remaining ROS negative.

Vital Signs

HR 80 /min, BP 134/96 mm Hg, Ht 5 ft 11 in, Wt 297 lbs, BMI 41.42
 Index.

Examination & StudiesGeneral Examination:

Patient is alert and oriented in no apparent distress. Neurologically grossly intact. He is morbidly obese. Heart is RRR. Lungs are clear. Neck is soft and supple without bruits. Edema of the right leg is quite severe with stasis dermatitis. Left leg is normal with no edema or skin changes. 2+ pedal pulses.

Vascular Labs:

No DVT of further reflux noted.

Assessments

1. Lymphedema - 457.1 (Primary)
2. VSD - 459.81

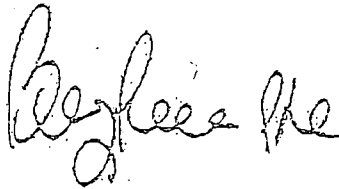
Treatment**1. Lymphedema**

Notes: Lymphedema now causing debilitating edema and pain. He wears compression stockings but has a hard time getting them on. He never recieved his velcro stockings I ordered for him last visit. I will send him to carolina orthotics for a pair today. I will also refer him to lymphatic massage with nodal drainage to see if this offers him any relief.

2. VSD

Notes: Venous reflux treated. No further problems with his veins.

Follow Up
6 Months



Electronically signed by Brandy Price, PAC on 06/19/2014 at
12:02 PM EDT

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 06/19/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

39 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and
Bassett Services Payer ID: 00000
PCP: Robert J. Allen, MD Referring: Edward C Morrison,
MD

Appointment Facility: CVVC Main Office

12/16/2013

Progress Note: Brandy E. Price, PA-C

Current MedicationsCompression Stockings 15-20 mm Hg as
directed During DayMedication List reviewed and reconciled with
the patient**Active Problem List**

459.81 Venous Insufficiency

Past Medical HistoryDerangement of posterior horn of medial
meniscus tear**Surgical History**right knee arthroscopy
VeneFit Closure RLE GSV 02-14-2013**Family History**Father: alive
Mother: alive**Social History**Tobacco Use:Tobacco Use/Smoking Are you a:
nonsmoker.**Allergies**

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Review of SystemsNo shortness of breath or chest pain.
Remaining review of systems negative.**Reason for Appointment**

1. 3MO FU/VSD/EDEMA

History of Present IllnessGeneral:

Patient is here today for followup of his lymphedema and venous stasis disease. He now has a new complaint. He's reporting back, right hip and left foot pain. He is seeing Dr. Rudolph. He had an MRI. He states he has a herniated disc. In regards to his venous insufficiency and lymphedema he admits he is no better. He's had minimal improvement with closure. He states he's wears a stockings and uses his pump as prescribed but did not wear his stockings today because he was coming to see us. He's had skin breakdown but this has healed. He denies any chronic ulcers. He continues to ambulate with a cane. He has gained weight. He is unable to exercise due to the pain.

Vital SignsHR 88 /min, BP sitting: 152/102, Ht 5 ft 11 in, Wt 305 lbs, BMI 42.53
Index.**Examination & Studies**General Examination:

Patient is alert and oriented in no apparent distress. Neurologically he is grossly intact. Heart regular rate and rhythm. 2+ radial pulses. Palpable pedal pulses. Severe edema in the right lower leg. Significant stasis dermatitis. Areas of healed ulceration of the right leg. Left leg is normal. No edema or skin breakdown. No chronic skin changes.

Assessments

1. Lymphedema - 457.1 (Primary)
2. Venous Insufficiency - 459.81

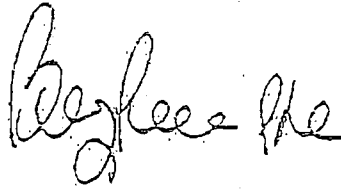
Treatment**1. Lymphedema**

Continue all current treatment. Encouraged weight loss. Reminded him to use his pump for an hour twice a day. I spent a significant amount of time at the patient and his caseworker discussing his situation. There are no further surgical options for him. I suspect he will have long-term troubles with edema and chronic skin changes. He is at high risk for ulceration. I reminded him that his weight worsen this problem. I've also reminded him that he needs to maintain compression therapy

every day. I have ordered him occur Velcro stockings. This may be easier to apply found his thigh-high stockings. We'll see him back in 6 months if not sooner for any new troubles.

Preventive Medicine

Follow Up
6 Months



Electronically signed by Brandy Price, PAC on 12/16/2013 at 01:41 PM EST

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 12/16/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient: Brown, Oshea L
DOB: 07/08/1974 Age: 38 Y Sex: Male
Phone: 843-356-9590
Address: 533 Taft Road, Salters, SC-29590
Pcp: Robert J Allen, MD

Provider: Edward C. Morrison, MD
Date: 05/16/2013

Subjective:**CC:**

1. Abi.

HPI:

Medical History: Derangement of posterior horn of medial meniscus tear.

Family History:**Social History:**

Medications: None

Allergies:**Objective:****Past Orders:****Examination:****Assessment:****Assessment:**

1. Pain in Limb - 729.5 (Primary)

Plan:

1. Pain in Limb

Diagnostic Imaging: Arterial Physiologic BLEAS - ABI (Single Level)

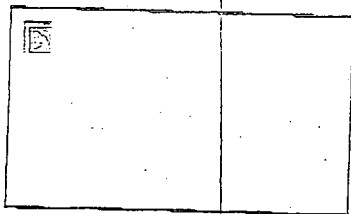
Immunizations:**Labs:**

Procedure Codes: 93922 Physiological studies of UE/LE arteries, single level, bilateral (e.g. ABIs, TcPO2)- Office

Preventive:

Provider: Edward C. Morrison, MD

Patient: Brown, Oshea L DOB: 07/08/1974 Date: 05/16/2013



Electronically signed by Rene Page on 05/29/2013 at 02:08 PM EDT
Sign off status: Completed

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

PCP: Robert J Allen, MD Referring: Harryrhett P

Rudolph, MD

Appointment Facility: CVVC Main Office

05/16/2013

Progress Note: Brandy E. Price, PA-C

Current MedicationsCompression Stockings 15-20 mm Hg as
directed During DayMedication List reviewed and reconciled with
the patient**Active Problem List**

459.81 Venous Insufficiency

Past Medical HistoryDerangement of posterior horn of medial
meniscus tear**Surgical History**right knee arthroscopy
VeneFit Closure RLE GSV 02-14-2013**Family History**Father: alive
Mother: alive**Social History**Tobacco Use:Tobacco Use/Smoking Are you a:
nonsmoker.Miscellaneous:

Marital status: married.

Occupation: Pt. on Workmens Compensation.

Allergies

N.K.D.A

Review of SystemsThe TIAs, amaurosis or stroke. No shortness
of breath or chest pain. No claudication or
rest pain. Remaining review of systems
negative.**Reason for Appointment**

1. 1MO FU/VSD/CHRONIC PAIN

History of Present IllnessGeneral:

Patient is here today for followup of his right leg. He admits he did not see Dr. Tavel as Dr. Morrison and I requested. He is back today stating his leg pain persists. He is walking a little better today. He is no longer ambulating with a cane. He states he is using the compression stockings but he did not wear them today. He reports no fever or chills. He's had no nausea or vomiting. No new complaints today.

Vital SignsHR 92 /min, BP 141/94 mm Hg, Ht 5 ft 11 in, Wt 290 lbs, BMI 40.44
Index.**Examination & Studies**General Examination:

Patient is alert and oriented in no apparent distress. Neurologically he is grossly intact. PERRLA, EOMI, or mucus reveals moist mucous membranes. Heart regular rate and rhythm. Abdomen remains obese. Right lower leg is edematous throughout. Stasis dermatitis noted in the lower leg. No active ulceration. Sensory and motor are intact in the foot. He's got good pedal pulses.

Vascular Labs:

ABIs were obtained today and showed no evidence of any peripheral arterial disease. ABI on the right is 1.13 and on the left is 1.16 with normal toe pressures.

Assessments

1. Pain in Limb - 729.5 (Primary)
2. VSD - 459.81

Treatment**1. Pain in Limb**

Pain and limb out of proportion to venous stasis disease. Again I will make another request to Dr. Tavel and I asked the patient to keep this appointment this time. Dr. Morrison and I would like his opinion on this patient's pain and whether or not he truly experiencing RSD.

2. VSD

Status post venous closure on the right leg. Patient was advised to continue moisturization a compression stockings. Diet exercise and weight loss Open encourage. We will refer the patient again for the lymphatic pump. See him back after he sees pain management.

Preventive Medicine

Follow Up
6 Weeks

Brandy E. Price

Electronically signed by Brandy Price, PAC on 05/16/2013 at 01:10 PM EDT

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L. DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 05/16/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

PCP: Robert J Allen, MD Referring: Harryrhett P
Rudolph, MD

Appointment Facility: CVVC Main Office

04/18/2013

Progress Note: Brandy E. Price, PA-C

Current Medications

Compression Stockings 15-20 mm Hg as
directed During Day

Medication List reviewed and reconciled with
the patient

Active Problem List

459.81 Venous Insufficiency

Past Medical History

Derangement of posterior horn of medial
meniscus tear

Surgical History

right knee arthroscopy
VeneFit Closure RLE GSV 02-14-2013

Family History

Father: alive
Mother: alive

Social History

Tobacco Use:
Tobacco Use/Smoking Are you a:
nonsmoker.

Allergies

N.K.D.A.

Review of Systems

Subjective fever but no reported elevated
temperatures. No nausea or vomiting. No
shortness of breath or chest pain. No
abdominal pain or bowel change. No
claudication or rest pain. No ulceration.
Remaining review of systems negative.

Reason for Appointment

1. 2MO FU/VSD

History of Present Illness

General:

Patient is being seen back today for reevaluation of his right leg. He states he has felt chilled over the last several days. He also reports warmth from the right leg and persistent discoloration of the skin. He is also having blisters develop on the back of his leg. He is unable to wear shoes. He continues to walk with a limp. He was let go from his job due to his medical condition. He is a workman's comp case and again was injured on his job hitting his head on a tractor-trailer. He is currently employed. He is going to physical therapy and achieving results and making progress. He is worried that he has cellulitis of the leg. He is convinced there is something more significant going on and then venous reflux disease and meniscal tear of the right knee.

Vital Signs

HR 106 /min, BP sitting: 145/97, Ht 5 ft 11 in, Wt 294 lbs, BMI 41.00
Index.

Examination & Studies

General Examination:

Patient is alert and oriented in no apparent distress. Neurologically noted to be grossly intact. PERRLA, EOMI and oral mucosa reveals moist mucous membranes. Neck is soft and supple with no cervical bruits noted. Heart is regular rate and rhythm without murmurs or gallops. Lungs are clear to auscultation bilaterally without wheezes rales or rhonchi. Abdomen is soft nontender nondistended without bruit. Patient has 2+ radial pulses. Right leg has stasis dermatitis throughout. There is no skin breakdown. The edema actually has improved since his last visit. PERRLA hand held Doppler he has triphasic dorsal pedal and posterior tibial Doppler signals.

Assessments

1. VSD - 459.81 (Primary)
2. Pain in Limb - 729.5

Treatment

1. VSD

I spent a great deal of time with the patient and his caseworker for the

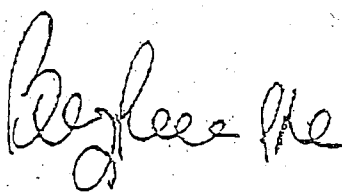
Workmen's Comp. component of his care. I explained to him that I did speak with his physical therapist/chiropractor who felt this could be RSD and is also worried about arterial ischemia. I explained to the patient he is perfectly normal Doppler signals however pedal pulses are difficult to palpate but this edema. His clinical picture fits that of significant venous reflux disease and actually I think his leg looks better today. It is less edematous than it has been since he was initially evaluated. He is status post VNUS Closure and undergone aggressive physical therapy with lymphatic massage and I feel he has achieved good results. I reassured him the skin changes are chronic stasis dermatitis and not cellulitis. He continues to reiterate that he is worried about infection. I have agreed to get him doxycycline 100 mg 1 by mouth twice a day explained to him I do not feel he'll get much improvement with an antibiotic. As far as his pain and the suggestion that this is RSD I do not think he fits the clinical picture however this is not my specialty and therefore I would like Dr. Tavel's opinion on this. We'll make the referral. I think long-term venous intervention has helped significantly as well as physical therapy. I will also refer him for evaluation for his candidacy for a flexitouch lymphatic pump. I think weight loss, compression stockings, lymphatic massage and lymphatic pump are the best option to try to improve his situation get him back to work. We will see him back in 4 weeks to track his progress.

Preventive Medicine

Follow Up
4 Weeks

Addendum:

04/18/2013 12:51 PM Price, Brandy E >



Electronically signed by Brandy Price, PAC on 04/18/2013 at 12:50 PM EDT

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 04/18/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

Referring: Harryhett P Rudolph, MD

Appointment Facility: CVVC Main Office

03/14/2013

Progress Note: Brandy E. Price, PA-C

Current Medications

Compression Stockings 15-20 mm Hg as directed During Day
Medication List reviewed and reconciled with the patient

Active Problem List

Problem List has not been verified

Past Medical History

Derangement of posterior horn of medial meniscus tear

Surgical History

right knee arthroscopy
VeneFit Closure RLE GSV 02-14-2013

Family History

Father: alive
Mother: alive

Social History

Tobacco Use:
Tobacco Use/Smoking Are you a:
nonsmoker.

Allergies

N.K.D.A.

Review of Systems

No SOB or CP. No claudication or rest pain.
remaining ROS negative.

Reason for Appointment

1. 4 WK/VC RLE GSV

History of Present IllnessGeneral:

Patient is here today for f/u of his right leg. He already had his post op appt for his right leg intervention but social worker with workmans comp told him he needed to come today as well even though I told him I did not need to see him back until 3 months post op. He has no new complaints. He continues to have right hip pain, right knee pain, right leg edema and left foot pain. He is seeing ortho soon. He has lost weight.

Vital Signs

HR 91/min, BP sitting: 148/96, Ht 5 ft 11 in, Wt 294 lb 4 oz, BMI 41.04
Index.

Examination & StudiesGeneral Examination:

Patient is alert and oriented in NAD. Neurologically he is grossly intact. PERRLA, EOMI, oral mucosa reveals MMM. Heart is RRR. Lungs are clear. Abdomen is soft NT/ND but he has lost weight. Lower legs reveal 2+ DP pulses. Left leg is normal. Skin intact. Right leg is edematous throughout. No ulcerations. Stasis dermatitis.

Assessments

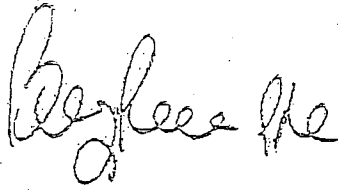
1. VV w/Other Complications (pain/swelling/edema) - 454.8 (Primary)

Treatment

1. VV w/Other Complications (pain/swelling/edema)
Stable s/p right GSV closure. Keep appt with ortho. return in 6 weeks.

Preventive Medicine**Follow Up**

keep f/u



Electronically signed by Brandy Price, PAC on 03/14/2013 at 01:42 PM EDT

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L. DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 03/14/2013

Note generated by eClinicalWorks EMP/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

Referring: Harryrhett P Rudolph, MD

Appointment Facility: CVVC Main Office

02/18/2013

Progress Note: Brandy E. Price, PA-C

Current Medications

Compression Stockings 15-20 mm Hg as directed During Day

Valium Tablet 10 MG bring with on day of procedure as needed

Loribab Tablet 5-500 MG bring with on day of procedure as needed

Medication List reviewed and reconciled with the patient

Active Problem List

Problem List has not been verified

Past Medical History

Derangement of posterior horn of medial meniscus tear

Surgical History

right knee arthroscopy

VeneFit Closure RLE GSV 02-14-2013

Family History

Father: alive

Mother: alive

Social History

Tobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Miscellaneous:

Marital status: married.

Occupation: Pt. on Workmens Compensation.

Allergies

N.K.D.A

Review of Systems

Patient to not actually check his temperature but states he was experiencing chills. No nausea vomiting shortness of breath or chest pain. No claudication or rest pain. No bowel change. Remaining review of systems negative.

Reason for Appointment

1. Post closure pain

History of Present IllnessGeneral:

The patient is here for followup ultrasound for his right leg closure. He asked to be seen as a working. He informs me he thought he had a fever the last couple days. His also had pain in his back right hip radiating down his lower leg. He's also had persistent swelling. He is curious if this is related to the procedure.

Vital Signs

HR 110 /min, BP 161/89 mm Hg, Ht 5 ft 11 in, Wt 288 lbs, BMI 40.16 Index.

Examination & StudiesGeneral Examination:

Patient is alert and oriented in no apparent distress. Neurologically he is grossly intact. Heart regular rate and rhythm. Right lower leg reveals edema throughout. There are a few areas where there is some skin abrasions noted but no ulcerations or evidence of infection. The foot is warm and appears well perfused. Gait is intact and stable. He is walking with a crutch.

Vascular Labs:

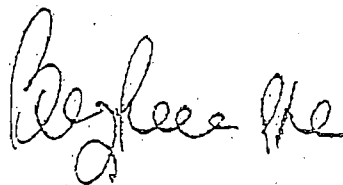
Successful right GST closure but no postoperative complications.

Assessments

1. VV w/Other Complications (pain/swelling/edema) - 454.8 (Primary)

Preventive Medicine**Follow Up**

2 Months



Electronically signed by Brandy Price, PAC on 02/18/2013 at
03:28 PM EST

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 02/18/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

Referring: Harryrhett P Rudolph, MD

Appointment Facility: CVVC Main Office Vascular Lab

02/18/2013

Thomas C. Appleby, MD

Current MedicationsCompression Stockings 15-20 mm Hg as
directed During DayValium Tablet 10 MG bring with on day of
procedure as neededLortab Tablet 5-500 MG bring with on day of
procedure as needed**Active Problem List**

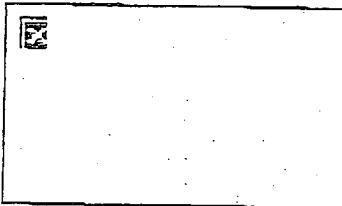
Problem List has not been verified

Past Medical HistoryDerangement of posterior horn of medial
meniscus tear**Surgical History**right knee arthroscopy
VeneFit Closure RLE GSV 02-14-2013**Social History****Reason for Appointment**

1. P/VC RLE GSV

History of Present Illness**Examination & Studies****Assessments**1. Aftercare following surgery of the circulatory system, NEC - V58.73
(Primary)**Treatment**1. Aftercare following surgery of the circulatory system, NEC
Diagnostic Imaging: Venous Duplex Unilateral**Preventive Medicine****Procedure Codes**

93971 Duplex scan of UE or LE veins, unilateral or limited study- Office

Electronically signed by Kimberly, CPC Collins on
02/26/2013 at 12:04 PM EST

Sign off status: Completed

CVVC Main Office Vascular Lab

1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4531
Fax: 843-577-8868

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Thomas C. Appleby, MD 02/18/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Surgeon: Edward C. Morrison, MD

Assistant: Hinckley, Jodi, RTR

02/14/2013

Edward C. Morrison, MD

OPERATIVE REPORT

Pre-op. Diagnosis:

1. Venous Insufficiency Lower Extremity with Painful Varicose Veins and Swelling
2. Severe Venous Reflux Disease of Right Greater Saphenous Vein

Operation:

1. FAST Cath VINUS Closure

Anesthesia:

Lortab and Valium P.O. as well as intradermal local.

Indications:

Mr. Brown is a 38 year old female with a several month history of right leg swelling due to an accident at his work. He has been complaining of leg pain, tightness, and swelling. Patient has been compliant with wearing prescription-grade compression stockings, elevating his legs and walking when his leg is not so swollen and painful. Venous duplex study shows venous reflux of his right greater saphenous vein. Despite failed conservative therapy, it was recommended for radiofrequency ablation of his right greater saphenous vein.

Details of Procedure:

The side site of surgery was discussed and confirmed with the patient before administration of Lortab and Valium, and before the informed consent was obtained. This was confirmed verbally by the patient as the right side. The patient was placed supine on the procedure room table. The right leg was prepped and draped in a sterile fashion then pre-screened.

Using ultrasound guidance with micropuncture technique, 1% Xylocaine was instilled in the skin. A #7 French sheath was placed in the greater saphenous vein.

The FAST Cath device was brought into the operative field and prepared sterilely. It was flushed appropriately. It was then placed through the sheath and without difficulty imaged to the saphenofemoral junction. It was withdrawn 2 cm proximal to the epigastric vessel. Tumescence anesthesia was injected in a perivenous standard from sheath up to the groin using ultrasound guidance. The FAST Cath Device was utilized with the assistance of manual pressure. The proximal segment was treated 2 times.

At this point, the FAST catheter was removed sequentially at 6.5 cm per removal. Before the catheter was exited from the skin, the sheath was removed. Great care was taken to make sure that there was no contact of the catheter with the skin. Ultrasound revealed full closure of the vein. The catheter was removed.

Pressure was held and dressing was applied once hemostasis was achieved. The procedure was terminated. The patient tolerated the procedure well. Aftercare instructions were provided.

Notes:

Estimated blood loss: Minimal

Total Treatment time: 3 Minutes :40 Seconds - Greater Saphenous Vein Access Site: Below Knee

Estimated amount of Tumescence used: 280 cc

Vascular Asst.: Edie Panzarella, RVT

cc: Dr. Harrythett P. Rudolph

Procedure Codes:

1.36475 Endovenous ablation therapy of each incompetent vein, RLE, inclusive of all imaging guidance & monitoring, percutaneous, radiofrequency; 1st vein treated- Office. Modifiers: RT

Edward C. Morrison MD

Electronically signed by Edward Morrison MD, MD on 02/18/2013 at 03:12 PM EST
Sign off status: Completed

CVVC Vein Center
1327 Ashley River Rd
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Edward C. Morrison, MD 02/14/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974

Account Number: 126756

533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

PCP: Robert J Allen, MD Referring: Edward C Morrison, MD

Appointment Facility: CVVC Vein Center

02/14/2013

Edward C. Morrison, MD

Current Medications

None

Reason for Appointment

1. VC RLE GSV

Past Medical History

Derangement of posterior horn of medial meniscusl tear

Electronically signed by Edward Morrison MD, MD on
07/09/2014 at 05:44 PM EDT

Sign off status: Pending

CVVC Vein Center
1327 Ashley River Rd
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Edward C. Morrison, MD 02/14/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L38 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L Insurance: Gallagher and

Bassett Services Payer ID: 00000

Referring: Harryrhett P Rudolph, MD

Appointment Facility: CVVC Main Office Vascular Lab

01/09/2013

Thomas C. Appleby, MD

Current Medications

None

Active Problem List

Problem List has not been verified

Past Medical HistoryDerangement of posterior horn of medial
menisul tear**Social History****Reason for Appointment**

1. RLE PAIN AND EDEMA

History of Present Illness**Examination & Studies****Assessments**1. Varicose veins of the lower extremities with other complications -
454.8 (Primary)**Treatment**1. Varicose veins of the lower extremities with other
complications

Diagnostic Imaging: Venous Duplex Unilateral

Preventive Medicine**Procedure Codes**

93971 Duplex scan of UE or LE veins, unilateral or limited study- Office

Electronically signed by Kimberly, CPC Collins on 01/31/2013
at 03:59 PM EST

Sign off status: Completed

CWC Main Office Vascular Lab
1827 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-577-8868

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Thomas C. Appleby, MD 01/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

COASTAL VASCULAR & VEIN CENTER

Brown, Oshea L

38 Y old Male, DOB: 07/08/1974
533 Taft Road, Salters, SC-29590

Home: 843-356-9590

Guarantor: Brown, Oshea L

Referring: Harryrhett P Rudolph, MD

Appointment Facility: CVVC Main Office

01/09/2013

Progress Note: Brandy E. Price, PA-C

Current Medications

Compression Stockings 15-20 mm Hg as directed During Day

Medication List reviewed and reconciled with the patient

Active Problem List

Problem List has not been verified

Past Medical History

Derangement of posterior horn of medial meniscus tear

Surgical History

right knee arthroscopy

Family History

Father: alive

Mother: alive

Social History

Tobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Miscellaneous:

Marital status: married.

Occupation: Pt. on Workmens Compensation.

Allergies

N.K.D.A.

Review of Systems

Patient denies fever chills shortness of breath or chest pain. He denies claudication or rest pain. Remaining review of systems is negative.

Reason for Appointment

1. H.Rudolph/ RLE EDEMA -DVT.

History of Present Illness

General:

Patient is here today for Workmen's Comp case for evaluation of right leg swelling. He informs me several months ago he had his knee on his tractor trailer while trying to unload it and torn meniscus and had it surgically repaired. Ever since that point he's had severe lotion the swelling pain and tightness. He is here for our opinion. He has been in compression stockings little relief.

Vital Signs

HR 87 /min, BP 148/85 mm Hg, Ht 5 ft 11 in, Wt 288 lbs, BMI 40.16 Index.

Examination & Studies

General Examination:

Patient is alert and oriented in no apparent distress. Neurologically he is grossly intact. Neck is soft and supple no cervical bruits noted. There is no JVD. There is an cervical adenopathy. Heart is regular rate and rhythm. Lungs are clear to auscultation bilaterally. Abdomen is soft nontender nondistended but obese. Right lower leg is edematous throughout. There are no ulcerations. The foot is warm and appears well perfused. Therapy. The normal limits. Left leg is stable and has good pedal pulses. Patient walks with a cane.

Vascular Labs:

Right great saphenous vein reflux. No evidence of DVT.

Assessments

1. VSD - 459.81 (Primary)

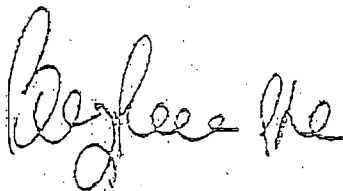
Treatment

1. VSD

For Dr. Morrison and I both the patient together and both agree at this point the patient should proceed with a right great saphenous vein closure. The procedure was explained to the patient in detail including the risks benefits realistic outcomes and possible complications. He's agreed to proceed at this time. Also written a prescription for Viagra impression socks. We have encouraged diet and exercise.

Preventive Medicine

Follow Up
scheduled for right great saphenous vein closure.



Electronically signed by Brandy Price, PAC on 01/09/2013 at
02:09 PM EST

Sign off status: Completed

CVVC Main Office
1327 Ashley River Rd Bldg B
Charleston, SC 294075384
Tel: 843-577-4551
Fax: 843-606-8030

Patient: Brown, Oshea L DOB: 07/08/1974 Progress Note: Brandy E. Price, PA-C 01/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

6/19/2014 2:49 PM FROM: FAX PAIN SPECIALISTS OF CHARLESTON TO: STP-1117 PAGE: 002 OF 006
Summary View for BROWN, OSHEA L

Page 1 of 3



Pain Specialists of Charleston, P.A.

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 31501

538 TAFT RD, SALTERS, SC 29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L Insurance: GALLAGHER

RASSETT

Referring: MD EDWARD C MORRISON

Appointment Facility: PAIN SPECIALISTS OF CHARLESTON

03/13/2014

Progress Note: Amanda McFann, NP

Reason for Appointment

1. Low Back Pain
2. Leg Pain

History of Present Illness

Response to Treatment since last visit:

DOI: 4/30/2012

work status: not working since the injury.

Mr. Brown is here today for a follow up. On the patient's last visit, we provided him with TENS unit and compounding cream. He receives compound cream in the mail. He states TENS and compound cream providing him with some relief. He also takes Hydrocodone and is satisfied with the medication. He needs more pads for TENS unit.

Patient states he has been getting the hydrocodone from Dr. Rudolph, but that it's a 14 day supply and that he's running out. Currently he takes 2-4/day (q4-6h).

Med Follow Up:

The relief that the medication provides 30%. The onset of the relief provided by the medication is less than 30 minutes. The duration of the effect of the medication is 3-4 hours. Compliance with the medical regimen has been as prescribed. Side effects of the medication include none.

Patient needs Hydrocodone refill today. Patient takes Hydrocodone 2-3 times a day and sometimes takes it every 4-5 hours.

Pain Management

Patient rates pain 6-9 on the pain scale. Patient complains of low back pain at L5 that is radicular from RIGHT hip down into the RIGHT foot. He also complains of swelling to RLE. He states he has pain in his LEFT knee to LEFT foot intermittently since he is compensating on that side. He walks with a cane. Patient c/o numbness/tingling to low back and RLE. Pain is aggravated by nothing in particular, his pain is constant. Pain is improved by compound cream and Hydrocodone.

Current Medications

Taking

- Hydrocodone-Acetaminophen 7.5-500 MG Tablet as directed BID PRN
- Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

Knee surgery
Vein Closure

Family History

Father: alive
Mother: alive
2 daughter(s) - healthy.
Non-Contributory

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: Amanda McFann, NP 03/13/2014
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

07/10/2014 9:49 PM FROM: PAIN SPECIALISTS OF CHARLESTON TO: 177-0127 PAGE: 003 OF 004
Summary View for BROWN, OSHEA L

Page 2 of 3

Social History

no Alcohol
Children: yes.
Married: yes.
Smoking Smoking Status: Never Smoker.

Allergies

NKDA

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of SystemsConstitutions:

Patient denies fever, loss of appetite, insomnia.

Gastroenterology:

Patient denies nausea/vomiting, diarrhea, constipation.

Neurology:

Patient complaining of poor balance, RIGHT leg weakness and tingling, numbness.

Vital Signs

Pain Scale 8-9/10, Ht 71, Wt 298, BMI 41.56, BP 158/90, HR 89, RR 18.

Assessments

1. Other noninfectious lymphedema - 457.1 (Primary)
2. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4
3. Encounter for long-term (current) use of other medications - V58.69, Risk: Low

Treatment**1. Other noninfectious lymphedema**

Refill Hydrocodone-Acetaminophen Tablet, 7.5-325 MG, as directed, Orally, BID PRN, 30 days, 60, Refills 0
Start Opana ER Tablet Extended Release 12 Hour, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60, Refills 0

Notes: After talking with the patient, we will refill Hydrocodone 7.5-325 mg BID PRN and start Opana 10 mg every 12 hours for pain management. Patient was given prescriptions today. We will see the patient back in 4 weeks for medication management. We feel very strongly that his unilateral right sided lymphedema is not solely based on his weight. Patient referred for a EXO 631 back brace to support weak spinal muscles. Total time spent with patient in excess of 15 minutes with 50% of time spent counselling patient regarding treatment options. Electronic records being sent to referring provider. As always, thank you for allowing me the opportunity to work with this patient.

Referral To:

Reason: EXOS 637 Back Brace to support weak spinal muscles/Low back garment to help with pad placement due to large treatment area

2. Thoracic or lumbosacral neuritis or radiculitis, unspecified**Referral To:**

Reason: EXOS 637 Back Brace to support weak spinal muscles/Low back garment to help with pad placement due to large treatment area

3. Encounter for long-term (current) use of other medications

Notes: UDS performed in the office today and sent to in office lab. Screening performed for confirmation that the current prescribed pain medications including Hydrocodone and Opana are present and taken as prescribed. We will also confirm that no illicit drugs are present. Urine sample sent to Aegis lab for confirmation.

Procedure Codes

81003 URINALYSIS, AUTO, W/O SCOPE
82542 COLUMN CHROMATOGRAPHY, QUANT
82570 ASSAY OF URINE CREATININE

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: Amanda McFann, NP 03/13/2014
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Summary View for BROWN, OSHEA L
6/19/2014 2:45 PM FROM: PAIN SPECIALISTS OF CHARLESTON TO: 843-818-1127 PAGE: 004 OF 004

Page 3 of 3

83955 ASSAY OF BODY FLUID ACIDITY
84311 SPECTROPHOTOMETRY
G0431 DRUG/SCR QUAL; SINGLE CLASS METH EA

Follow Up

4 Weeks (Reason: Medication Follow Up)

Electronically signed by AMANDA MCFANN on 06/19/2014 at 01:36 PM EDT
Sign off status: Pending

PAIN SPECIALISTS OF CHARLESTON
3695 ELMS PLANTATION BLVD
NORTH CHARLESTON, SC 29405017
Tel: 843-818-1181
Fax: 843-818-1145

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: Amanda McFann, NP 03/13/2014
Note generated by eClinicaWorks EMR/PM Software (www.eClinicaWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

02/19/2014

HARRY P RUDOLPH, MD

Current Medications

Cane -- Miscellaneous as directed as directed
Compression Stockings (15-20 mmHg) 15-20
mm/Hg Knee length as directed as directed
Medications reported as directed by the
ordering provider
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a:
nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink
containing alcohol in the past year?: No,
Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night
sweats denies. Sleep disturbance denies.
Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at
night denies. Pain at rest denies.

Reason for Appointment

1. rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

Patient returns today for his right lower leg edema. He had his 2nd opinion by Dr. Stamm a sports medicine physician who tells him that he may actually have a new meniscal tear in the knee but he would not suggest surgery at this time secondary to the ministry of what exactly happened to the leg postoperatively from the last surgery. He is concerned as I would be that the surgery might create more difficulty with this leg that is already significantly swollen to the point where he is getting some blistering of the skin. From what I see on his MRI he does have some lateralization of the patella but I believe that's from his gait and the deconditioning of the leg. I think if the swelling in the leg will go away the patella could be lined better. Otherwise he may want to consider a lateral release of his patella in the future but I would be very cautious about considering surgical intervention considering his history. The medial meniscus may or may not be a problem. I truly believe his biggest problem is the swelling in his leg that basically is going from his upper thigh all the way down to the foot. This has not improved over time. The knee range of motion is limited secondary to the swelling in the leg. Unfortunately he has now seen 2 vascular surgeons and 2 orthopedic surgeons none of which really have given him any really good ideas as to what to do beyond this point. He is getting some epidural injections but this doesn't seem to be helping his leg as much as it is back.

I think he has definitely reached maximum medical improvement. Obviously he has had the worst result that he can have status post a medial meniscal tear as far as mobility and swelling are concerned. And we will evaluate him accordingly. We will fill out a 14 B with the appropriate numbers once we looked them up. In the future as stated above he may need further surgery in this knee with possible debridement of the medial meniscus and release of the patella. Physical therapy I think would be necessary first to see how well therapy could realign the patella with strengthening. All this is predicated upon the fact of getting the swelling out of the leg first. If the swelling in the leg persists I don't think any type of therapy to the knee is going to really help him.

Examination

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 02/19/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Weakness denies.

Neurologic:

Radiating pain denies.

Tingling/Numbness denies.

General Examination:

Assessments

1. Medial Meniscus Tear-Knee (new) - 836.0 (Primary)

Treatment

1. Medial Meniscus Tear-Knee (new)

Start Norco Tablet, 7.5-325 MG, 1 to 2 tablets, Orally, every 4 to 6 hours, 14 days, 50, Refills 0

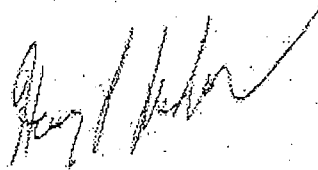
2. Others

Continue Medications reported as directed by the ordering provider

Treatment Notes: **NOTE** This document was created using voice recognition software. Inadvertent typographical errors, word omissions, and/or word substitutions may exist. Occasionally, this may alter the intended meaning of the document.

Follow Up

prn



Electronically signed by HARRY RUDOLPH MD on
02/20/2014 at 09:32 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 02/19/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

01/08/2014

HARRY P RUDOLPH, MD

Current Medications

Cane -- Miscellaneous as directed as directed
Compression Stockings (15-20 mmHg) 15-20
mm/Hg Knee length as directed as directed
Medications reported as directed by the
ordering provider
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive

Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a:
nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink
containing alcohol in the past year?: No.
Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night
sweats denies. Sleep disturbance denies.
Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at
night denies. Pain at rest denies.

Reason for Appointment

1. rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

Patient returns today status post right leg swelling. He is over a
year out from his knee surgery. There is no sign of infection. He still
has significant swelling in his right lower extremity. He continues to
use the vascular pump as well as the TENS unit. The TENS unit helps
some while he is using it. He knee stills feel something is "stabbing" him
in hte knee as well as the giving away and catching on him. We discuss
him getting a second opinion from another orthopedist or vascular
surgeon to see if they can think of what could be causing this swelling.

We reviewed his lumbar MRI with him today and also his second
knee MRI with him to try to gain some understanding of where this
pain and discomfort is coming from. He has back pain and knee pain
along with this unusual swelling in his leg. Even though the MRI does
show some changes in the meniscus I don't really see anything that
would explain the pain that he has throughout the knee. We have are
debrided the meniscus arthroscopically. The MRI of his back was fairly
unremarkable except for arthritic changes and some disc bulging but
really doesn't give a great explanation for the radiculopathy has down
his leg. I still see no obvious source of the swelling that he has
throughout his leg that extends all the way up into the upper thigh.
Both his current vascular surgeon and I unfortunately have really not
been able give him any answers for at least a year. I do think that a
fresh set of eyes may help him and at least establish some solution to
his significant problem. Am happy to see him back at any time. No
change in his current disability status.

Examination

General Examination:

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Derangement of posterior horn of medial meniscus

Start Norco Tablet, 7.5-325 MG, 1 to 2 tablets, Orally, every 4 to 6

Weakness denies.

Neurologic:

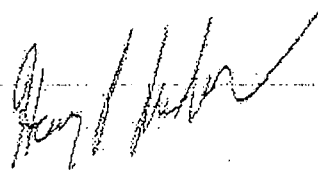
Radiating pain denies.
Tingling/Numbness denies.

hours, 14 days, 50, Refills 0

2. Others

Treatment Notes: ****NOTE**** This document was created using voice recognition software. Inadvertent typographical errors, word omissions, and/or word substitutions may exist. Occasionally, this may alter the intended meaning of the document.

Follow Up
p 2nd opinion



Electronically signed by HARRY RUDOLPH MD on
01/09/2014 at 11:20 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 01/08/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

12/11/2013

HARRY P RUDOLPH, MD

Current Medications

Cane -- Miscellaneous as directed as directed
Compression Stockings (15-20 mmHg) 15-20
mm/Hg Knee length as directed as directed
Medications reported as directed by the
ordering provider
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive

Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a:
nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink
containing alcohol in the past year?: No,
Points: 0.

Allergies

N.K.D.A

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night
sweats denies. Sleep disturbance denies.
Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at
night denies. Pain at rest denies.

Reason for Appointment

1. rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

Patient returns today to review his MRI results. The patient MRI of his knee shows horizontally oriented tear at the body and posterior horn of the medial meniscus of the right knee. Patellar tendinitis with a 15 mm remotely fractured enthesophyte from remote Osgood Schlatter disease.

The MRI of his lumbar spine shows L5-S1 disc desiccation with contained circumferential annular tear in the mild broadly bulging disc without significant foraminal or canal stenosis.

Neither of these findings in the knee nor the back really explain the amount of pain that he is having in most especially no explanation for the swelling in this leg. I still believe that swelling in the leg is the biggest concern and detractor from his ability to improve. The meniscal injury in the knee has been dealt with arthroscopically. He debrided back to a stable area. I don't think this is the source of his pain. Some of his hip pain could be coming from the findings in his back but certainly does not explain all the pain and swelling he has in his leg.

The swelling in his leg is no better. His MRI does not show anything that would suggest the swelling in his leg. He is going back to see Dr. Morrison on Monday for the swelling in his leg. He tells me that he has blisters on the posterior aspect of his calf due to the swelling. We discuss physical therapy to work on getting his knee moving again. We will wait to see what Dr. Morrison suggest before he starts physical therapy again for the 2 nd time.

Examination

General Examination:

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Derangement of posterior horn of medial meniscus

Start Norco Tablet, 7.5-325 MG, 1 to 2 tablets, Orally, every 4 to 6 hours, 14 days, 50, Refills 0

Weakness denies.

Neurologic:

Radiating pain denies.

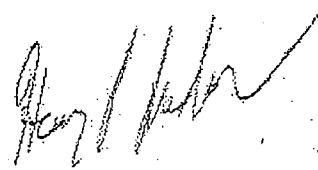
Tingling/Numbness denies.

2. Others

Treatment Notes: **NOTE** This document was created using voice recognition software. Inadvertent typographical errors, word omissions, and/or word substitutions may exist. Occasionally, this may alter the intended meaning of the document. **NOTE** This document was created using voice recognition software. Inadvertent typographical errors, word omissions, and/or word substitutions may exist. Occasionally, this may alter the intended meaning of the document.

Follow Up

prn



Electronically signed by HARRY RUDOLPH MD, MD on
12/12/2013 at 09:22 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 12/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

39 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

10/30/2013

HARRY P RUDOLPH, MD

Current Medications

Compression Stockings (15-20 mmHg) 15-20 mm/Hg Knee length as directed as directed
Medications reported as directed by the ordering provider
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink containing alcohol in the past year?: No, Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies. Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies. Weakness denies.

Reason for Appointment

1. Lumbar Radiculopathy

History of Present Illness

Symptom(s):

Patient returns today for his right leg. He is 1 year out from his surgery. He continues to have a significant amount of swelling in his leg even after a year out from surgery. He has been using a lymphedema pump for the past 3 months that does not help with the swelling in his leg. He has also undergone vascular surgery that did not seem to improve the swelling in his leg. Because of its failure Dr. Morrison referred him to Dr. Tavell who evaluated him for reflex sympathetic dystrophy. Dr. Tavell did not feel that the patient had RSD. He was concerned that he might have a lumbar spine radiculopathy. He felt as if this may be part of his pain. Furthermore since I've seen him last he has not gotten the MRI that we ordered back in June. Therefore we are requesting an MRI of his lumbar spine and an MRI of his right knee to assure that there is no other pathology that may explain this significant swelling. We'll see him back after the MRIs.

Examination

General Examination:

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)
2. Lumbar Radiculopathy - 724.4

Treatment

1. Derangement of posterior horn of medial meniscus

Start Cane Miscellaneous, --, as directed, as directed, as directed, lifetime, Refills 0

Start Lortab Tablet, 7.5-500 MG, 1 to 2 tablets, by mouth, every 4 to 6 hours PRN pain, 07 days, 50, Refills 0

Treatment Notes:.

2. Lumbar Radiculopathy

IMAGING: MR SPINE LUMBAR W/O CONTRAST MRI

Treatment Notes:.

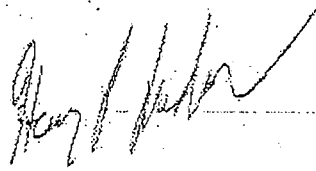
Neurologic:

Radiating pain denies.
Tingling/Numbness denies.

3. Others

Treatment Notes: **NOTE** This document was created using voice recognition software. Inadvertent typographical errors, word omissions, and/or word substitutions may exist. Occasionally, this may alter the intended meaning of the document.

Follow Up
after MRI



Electronically signed by HARRY RUDOLPH MD, MD on
11/01/2013 at 08:27 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCK'S CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 10/30/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

38 Y Old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

06/26/2013

HARRY P RUDOLPH, MD

Current Medications

Compression Stockings (15-20 mmHg) 15-20 mm/Hg Knee length as directed as directed
Medications reported as directed by the ordering provider
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink containing alcohol in the past year?: No, Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies. Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies. Weakness denies.

Reason for Appointment

1. rt knee MMT DOI 04/30/12 DOS 10-02-12 (WC)

History of Present Illness

Symptom(s):

Patient returns today status post right knee medial meniscus tear. He is 8 months out from his knee surgery. He continues to have lower extremity swelling. He has not received his lymphedema pump. He tells me that he now has swelling from his low back and hip to his foot. He also has the tingling and prickling feeling in the knee. He also has joint line tenderness in the knee suggesting some continued pathology in the knee itself. He is now as stated above 8 months status post his surgical intervention of the knee and continues to have problems with this knee. We discussed with him that at this point in time my concern is that the knee is as good as is going to get. I still am unsure how much pain is coming from his knee and how much of it may be coming from his lymphedema. We will order another MRI of the knee to make sure there is not a re-tear or something new causing him the tingling and prickling sensation in the knee.

We did discuss that his swelling is more of a problem than his knee and his vascular doctor may be the more appropriate primary care physician for his present problem if the MRI turns out to be negative.. We will see him back after his MRI.

Examination

General Examination:

Patient still has full range of motion to the knee. He still has tenderness along the medial joint line to deep palpation. There is no real significant change in the exam of his knee. The patella itself is not ballotable. He has pitting edema throughout the lower extremities that is also if not a little worse about the same.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Derangement of posterior horn of medial meniscus
Diagnostic Imaging:MR KNEE WITHOUT CTRST MRI

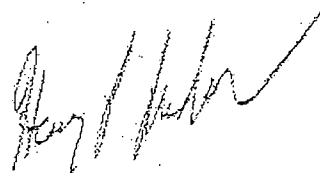
2. Others

Continue Medications reported as directed by the ordering provider

Neurologic:

Radiating pain denies.
Tingling/Numbness denies.

Follow Up
after MRI



Electronically signed by HARRY RUDOLPH MD, MD on
06/27/2013 at 08:45 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29451-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 06/26/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Neurologic:

Radiating pain denies
Tingling/Numbness denies.

Electronically signed by HARRY RUDOLPH MD, MD on
04/25/2013 at 09:47 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCK'S CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 04/24/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

03/20/2013

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the ordering provider
 Compression Stockings (15-20 mmHg) 15-20 mm/Hg Knee length as directed as directed
 Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
 Son(s): alive

Social HistoryTobacco Use:

Tobacco Use/Smoking Are you a nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink containing alcohol in the past year?: No,
 Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present IllnessSymptom(s):

Patient returns today for his right knee. He still has swelling in his leg. He tells me that the pain is now radiating up to his hip and back. The pain that radiates up his thigh follows the path of his saphenous nerve. He did have that vein surgery by Dr. Appleby. He may have had his saphenous vein ablated. I am unsure of exactly what he had done but he still has a great deal of swelling. He is still fully convinced that this is coming from his knee. His patella is not ballotable. There is no increased swelling in the knee. His pain in his leg is global as is the pain around his knee. He is walking with a significant limp. He feels like the knee wants to give out on him. We will get him started with some physical therapy to work on gait training. I am worried by the fact that he has very little incentive to get better at this time. I think he has qualified at this point in time for sedentary work and if we could find some activities for him to do this would probably be beneficial. Other than that physical therapy should be strongly encouraged to get him back to ambulating without a limp which should gain strength in his leg which in turn should decrease the amount of swelling in his leg. He was not wearing his TED hose today but he tells me that because he was coming to visit us.

Patient has very adequate range of motion to the knee. There is no instability to the knee. He has a global pain with no one specific area of tenderness.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment**1. Derangement of posterior horn of medial meniscus**

Continue to work on gait. We will get physical therapy involved at this point in time to try to accelerate his improvement. He is now 6 months out from his arthroscopy. By observation of his gait, his swelling in his leg and his extension of the pain all way into his hip at this point in time I feel like the knee is a very minor contributor to his pain. We'll see him back again in 3 more weeks hopefully to see some improvement with physical therapy.

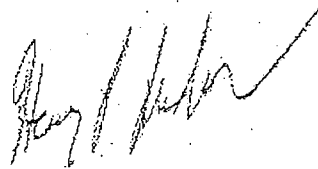
Referral To:

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 03/20/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Reason:

Follow Up
4 Weeks



Electronically signed by HARRY RUDOLPH MD, MD on
03/21/2013 at 09:31 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 03/20/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

01/16/2013

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the ordering provider

Compression Stockings (15-20 mmHg) 15-20 mm/Hg Knee length as directed as directed
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive

Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking Are you a nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink containing alcohol in the past year?: No, Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

----- Patient returns today for his right knee. He still has a significant amount of swelling in his leg. He has seen a vascular surgeon and is going to have an ablation surgery at the saphenous vein to see if we can get this to drained better. Apparently a repeat ultrasound did show significant decreased flow in this saphenous vein.. He still has some medial joint line tenderness. He has good extension of the knee. It is still somewhat difficulty for him to flex his knee due to his swelling. I would like to see him back after his surgery to see how his knee is feeling at that time. If he is doing well we will release him at that time. I think until we get rid of the swelling in the leg we cannot determine how well the knee is doing. Once the swelling in the lower extremity clears I think she will be doing a lot better.

Examination

General Examination:

The patient has very adequate range of motion to the knee. He comes to full extension and flexes to at least under 10 degrees. There is a woody chronic swelling appearance all the way up to the knee of the lower extremity. There is no increased warmth. There does not appear to be any cellulitis.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Derangement of posterior horn of medial meniscus

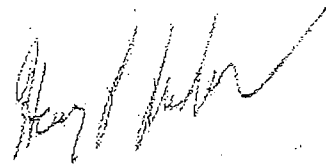
We will see the patient back in about 6 weeks. At that point in time if the swelling in his lower extremity has improved enough to observe the knee only been hopefully we will see some improvement in his knee motion and strength. We did begin to discuss his MMI at that time.

Follow Up

3 Weeks

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 01/16/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Electronically signed by HARRY RUDOLPH MD, MD on
01/17/2013 at 11:40 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCK'S CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 01/16/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL

12/19/2012

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the ordering provider
 Compression Stockings (15-20 mmHg) 15-20 mm/Hg Knee length as directed as directed
 Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
 Son(s): alive

Social HistoryTobacco Use:

Tobacco Use/Smoking Are you a nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink containing alcohol in the past year?: No,
 Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present IllnessSymptom(s):

Patient returns today for his right leg. He still has a significant amount of swelling going up his leg. He has swelling from his thigh to his ankle. We are still awaiting approval from his workman's compensation for an evaluation by a Vascular surgeon. I continue to be very concerned over the swelling. I am concerned that he may develop some type of chronic ulcers in his leg and/or have some type of vascular problem that is causing the swelling. DVT testing a couple of months ago proved out to be within normal limits without signs of any significant clotting. This does not rule out other problems however. He did not have the swelling until after the surgery. I do think that it's important that we get this worked up to make sure that he does not have any major medical issues with this leg. We're still awaiting Workmen's Compensation approval for evaluation of this leg.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)
2. Ankle edema - 782.3

Treatment**1. Derangement of posterior horn of medial meniscus**

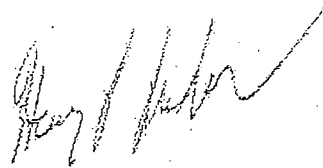
Patient is status post meniscectomy. After the meniscectomy the patient developed severe swelling in this leg. DVT testing about 3 or 4 weeks after the surgery showed no obvious venous clotting. The swelling if anything is getting worse. He does have some skin changes from the chronic swelling. I think it's important for a vascular surgeon to see him to see if there are any other issues that need to be addressed concerning the swelling. We're awaiting approval for evaluation of this leg via Workmen's Compensation.

Follow Up

3 Weeks

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 12/19/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



Electronically signed by HARRY RUDOLPH MD, MD on
12/20/2012 at 02:56 PM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 12/19/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEAL L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEAL L

11/28/2012

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the
ordering provider
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social HistoryTobacco Use:

Tobacco Use/Smoking Are you a:
nonsmoker.

Drugs/Alcohol:

Alcohol Screen Did you have a drink
containing alcohol in the past year?: No,
Points: 0.

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present IllnessSymptom(s):

Patient returns today status post right knee medial meniscus tear. He is 8 weeks out from his knee surgery. There is no sign of infection. He still has a significant amount of edema in his right lower leg. This has not improved since weeks ago. At that point in time we requested a consult to her primary care physician. Apparently his Workmen's Compensation insurance has not been able to approve this. I believe there must be some miscommunication. He has had a negative ultrasound for DVT already.. He was unable to see his primary care physician. This leg causes him a great deal of pain and it doesn't seem to be centered around the knee seems to be centered around the swelling in the lower extremity. He has adequate range of motion to the knee in the ankle so I don't think this is an RSD type problem but with a negative Doppler and not really sure what is causing the swelling. The right leg is definitely significantly larger than left. I would like for him to see a vascular doctor regarding his edema. It is certainly causing a great deal of pain.

ExaminationGeneral Examination:

The patient has significant edema in the right leg below the knee. It appears to be the same as it was 4 weeks ago. He is still not full weightbearing on the leg because of the pain. He has adequate pulses distally. There is slight discoloration of the leg. There is no increased density to the skin as is typical for chronic swelling as of yet.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Derangement of posterior horn of medial meniscus

Start Compression Stockings (15-20 mmHg) Knee length, 15-20

mm/Hg, as directed, --, as directed

Plan is for a vascular consult and TED hose for the right leg to see if we
can figure out how to decrease the swelling.

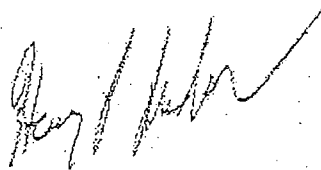
Referral To: Edward Morrison Vascular Surgery

Reason: right leg edema with negative DVT study

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 11/28/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Follow Up
3 Weeks



Electronically signed by HARRY RUDOLPH MD, MD on
11/30/2012 at 08:43 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCK'S CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 11/28/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

Appointment Facility: Chas Bone And Joint Moncks Cor

11/14/2012

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the ordering provider
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? No

Points 0

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies. Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies.

Weakness denies.

Neurologic:

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

Patient returns today for his left knee medial meniscus tear. He is 6 weeks out from his surgery. He still has a lot of swelling in both legs and feet. There is significant pitting edema. He has already had a Doppler study that shows no DVT in his lower extremity. I have suggested for him to go see his primary care doctor with the suggestion that this is some type of cardiovascular problem. I did suggest that maybe he should get put on fluid pill for fluid overload or perhaps this could be a result of one of his antihypertensives. Nonetheless I am concerned about the amount of swelling he has in his lower extremities. I think it's keeping him from getting better because of the increased pain that he has in his legs from the swelling.. He tells me that he is still having some pain in his knee. I did explain to him that the pain is at least partially coming from the swelling.

Examination

General Examination:

The patient has 2+ pitting edema in the left leg and about 3+ pitting edema in the right. The swelling extends all the way up to both knees. There is no increased warmth. There is no chronic skin change. He has adequate pulses distally in both feet. The knee has good range of motion and the patella is not ballotable. There is no increased warmth around the knee. There is good stability about the knee.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Status post medial meniscus tear debridement via arthroscopy x6 weeks ago. He has some residual pain with contributing factors including the surgery itself and also very significant lower extremity edema in both legs. I'm not sure what the source of the lower extremity swelling is good would strongly suggested he discuss this with his primary care physician to see if he is a candidate for either changing his blood pressure medicines or considering a diuretic.

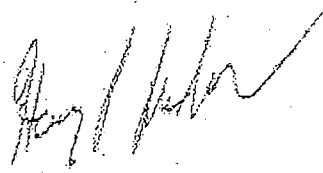
Follow Up

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 11/14/2012

Note generated by eClinicalWorks EHR/PM Software (www.eClinicalWorks.com)

Radiating pain denies.
Tingling/Numbness denies.

2 Weeks



Electronically signed by HARRY RUDOLPH MD, MD on
11/16/2012 at 10:58 AM EST

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 11/14/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

10/31/2012

HARRY P RUDOLPH, MD

Current Medications

Medications reported as directed by the ordering provider
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? No
Points 0

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies. Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies. Weakness denies.

Neurologic:

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

Patient returns today status post right knee medial meniscus tear. He is 4 weeks out from his knee surgery. There is no sign of infection. He has a significant amount of swelling all the way down to his foot. I will order an ultrasound to see if he may have a possible DVT. He does have some tenderness in his knee but this could be from all the swelling.

Examination

General Examination:

Patient has swelling all way down to the foot. There is deathly difference between the right leg and the left leg. The knee itself appears to be doing better but the leg below the knee is a problem. He does have a positive Homans sign. Got tenderness along the medial border of the calf. There is no tenderness more proximally in the thigh.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)
2. Deep Venous Thrombosis, LE - 453.40

Treatment

1. Deep Venous Thrombosis, LE

Diagnostic Imaging: SP VEN EXTREMITY UNILAT Please call report stat to 693-3334 verbal auth from Linda rivera @2:15 pm 10/31/12

2. Others

Continue Medications reported as directed by the ordering provider

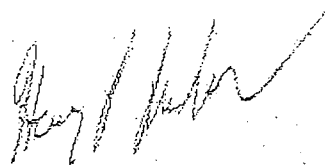
Follow Up

3 Weeks

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 10/31/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Radiating pain denies.
Tingling/Numbness denies



Electronically signed by HARRY RUDOLPH MD, MD on
11/01/2012 at 10:56 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 10/31/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



ROPER ST. FRANCIS

PHYSICIAN PARTNERS

PCP: Raymond K Allen, MD

BROWN, OSHEA L

38 Y old Male, DOB: 07/08/1974

Account Number: 00003775178

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

Appointment Facility: Chas Bone And Joint Moncks Cor

10/10/2012

HARRY P RUDOLPH, MD

Current Medications

Lortab 7.5-500 MG Tablet 1 tablet as needed every 4 to 6 hours, stop date 10/15/2012
Medications reported as directed by the ordering provider
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Daughter(s): alive
Son(s): alive

Social History

Tobacco Use:

Tobacco Use/Smoking
Are you a *nonsmoker*

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? No
Points 0

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies. Weight gain denies. Weight loss denies.

Cardiovascular:

Edema admits.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies.

Reason for Appointment

1. S/P rt knee MMT DOI 04/30/12 DOS 10-02-12

History of Present Illness

Symptom(s):

The patient returns today status post right knee arthroscopy. He is 8 days out from his surgery. Pictures were viewed with the patient. We explained the procedure and the findings. On examining her no signs of infection. Swelling is a little more than expected. The patient can weight-bear as tolerated to the knee. He is still using crutches. He still has a significant amount of swelling in his knee. There is no increased warmth. There is no induration. There is no instability. He did have a bucket-handle meniscus tear in the posterior horn of the medial meniscus. We debrided this intraoperatively. There was a fragment in his intercondylar notch. Hopefully the swelling will go down over the next 2 weeks. If no better we will address that at that time.

Assessments

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)

Treatment

1. Others

Continue Medications reported as directed by the ordering provider
Refill Lortab Tablet, 7.5-500 MG, 1 tablet as needed, Orally, every 4 to 6 hours, 14 days, 1 bottle of 50, Refills 0

Follow Up

3 Weeks

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 10/10/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Weakness denies.
Neurologic:
Radiating pain denies.
Tingling/Numbness denies.

Electronically signed by HARRY RUDOLPH MD, MD on
10/11/2012 at 08:46 AM EDT.

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCKS CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 10/10/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



BROWN, OSHEA L

38.Y old Male, DOB: 07/08/1974

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA L

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Moncks Cor

09/12/2012

HARRY P RUDOLPH, MD

Current Medications

None

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

No Family History documented.

Social HistoryTobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? No

Points 0

Allergies

N.K.D.A

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Review of SystemsGeneral/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies.

Weight gain denies. Weight loss denies.

Cardiovascular:

Edema denies.

Musculoskeletal:

Joint stiffness denies. Pain at night denies. Pain at rest denies.

Weakness denies.

Neurologic:

Radiating pain denies.

Tingling/Numbness denies.

Reason for Appointment

1. rt knee MMT DOI 04/30/12 MRI results

History of Present IllnessSymptom(s):

Patient comes today and does continue to have medial joint line tenderness on the right knee. At this point in time the patient desires surgical intervention secondary to continued pain along the medial joint line. We reviewed the MRI with the patient and the MRI does in fact show a fairly obvious medial meniscus tear. There is a grade 3 signal in the posterior horn of the medial meniscus. We explained the surgical intervention and expectations. Patient seems to have realistic expectations.

ExaminationGeneral Examination:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

HEAD: normocephalic, atraumatic.

EYES: pupils equal, round, reactive to light.

EARS: normal.

ORAL CAVITY: mucosa moist.

THROAT: clear.

NECK: neck supple, full range of motion, no cervical lymphadenopathy.

LYMPH NODES: no axillary, supraclavicular or inguinal adenopathy.

HEART: no murmurs, normal rate and regular rhythm, S1, S2 normal.

LUNGS: clear to auscultation bilaterally.

ABDOMEN: no hepatosplenomegaly, no masses palpable, soft, nontender, nondistended.

RECTAL EXAM: not examined.

BACK: normal, no scoliosis, spine nontender to palpation, no signs of pilonidal disease.

SKIN: no suspicious lesions, warm and dry.

MUSCULOSKELETAL: full range of motion.

EXTREMITIES: no edema, clubbing or cyanosis.

PERIPHERAL PULSES: palpable in all 4 extremities.

NEUROLOGIC: nonfocal, motor strength normal upper and lower extremities, sensory exam intact.

Patient: BROWN, OSHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 09/12/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

PSYCH: alert, oriented, cognitive function intact, judgment and insight good, mood/affect appropriate.

CARDIOVASCULAR no pedal edema or varicosities, good peripheral pulsations.

LUMBAR PARASPINAL MUSCLES tenderness to palpation, bilateral.

The patient has pain on attempted extension of the knee. There is a positive McMurray's exam. The patient is unable to fully weight-bear on the knee. Patient has full flexion with pain at the extremes of range of motion. Patient has a negative Lachman's exam. Patient has a negative Apley's exam. There is no lateral tenderness. The patella is slightly ballotable. There is no increased warmth to the knee. There is no varus or valgus instability. There is no pitting edema in the lower extremity. The skin is intact. The foot is neurovascularly intact.

The hip has no pain on internal or external rotation. The patient has a negative straight leg raise exam. There is no back pain to palpation or motion.

Assessments

1. Medial Meniscus Tear-Knee (new) - 836.0 (Primary)

The patient has classic medial meniscus tear symptoms.

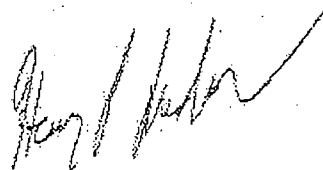
Treatment

1. Medial Meniscus Tear-Knee (new)

We discussed medial meniscus tear and the pathophysiology of the injury. We explained through drawings and the model of the knee to explain the injury. We explained the possibility of surgery. I further explained that an MRI would give us the best idea of the exact pathology in the knee. We reviewed the MRI with the patient and explained the pathology again. We discussed surgical intervention with the patient and explained to the process of arthroscopy. The patient seems to understand the risks and benefits of surgery. Plan is for arthroscopic debridement of the medial meniscus.

Follow Up

10-14 days after sx



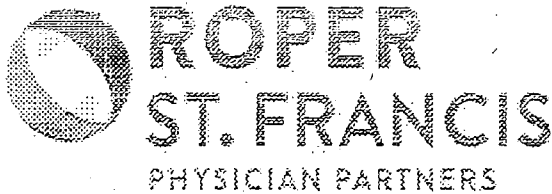
Electronically signed by HARRY RUDOLPH MD, MD on 09/13/2012 at 10:46 AM EDT

Sign off status: Completed

Chas Bone And Joint Moncks Cor
2061 HWY 52
MONCK'S CORNER, SC 29461-5017
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, OSHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 09/12/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



BROWN, O'SHEA L

38 Y old Male, DOB: 07/08/1974
533 TAFT ROAD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, O'SHEA L

PCP: Raymond K Allen, MD

Appointment Facility: Chas Bone And Joint Johnnie Dodds

07/24/2012

Progress Notes: HARRY P RUDOLPH, MD

Current Medications

None

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

No Family History documented.

Social HistoryMarital and Family status:

Marital Status: Married.

Tobacco Use:

Tobacco Use/Smoking

Are you a nonsmoker

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? No

Points 0

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

No Hospitalization History.

Review of SystemsGeneral/Constitutional:

Night sweats denies. Night sweats denies. Sleep disturbance denies.

Weight gain denies. Weight loss denies.

Endocrine:

Take insulin? No. Thyroid problem No.

Diabetes No.

Respiratory:

Asthma No. TB or exposure to TB No.

Coughing up blood No. Emphysema No.

Cardiovascular:

Stroke No. Cardiac pacemaker or defibrillator No. Heart problems No.

Circulatory problems No. Edema denies.

Gastrointestinal:**Reason for Appointment**

1. rt knee MMT DOI 04/30/12

History of Present IllnessSymptom(s):

A very nice 38 year old gentleman comes in today for his right knee. He injured his knee on April 30 at work. He was trying to get up on a trailer and hit his knee on the metal part of the trailer. He did go see his work comp doctor. He is wearing a knee brace today. He has been taking lortab for the pain. He says he does have swelling in his thigh and in his ankle. His whole knee hurts. He says it feels like his knee "locks up" on him. He does not recall any previous knee injury or trauma to this knee. His xrays does show an old Osgood Schlatter lesion. He does have some popping in the knee. He also has tenderness along the medial joint line. The patient comes today complaining of medial knee pain. The tenderness is directly over the medial joint line. Full extension of the knee increases his pain. It will give way and catch on him at times. There are times when he cannot fully straighten the knee out. Patient denies any previous problems up until this current problem. Patient admits to occasional swelling. Problem seems to be slowly getting worse. He has never had an MRI. He has classic medial meniscal symptoms. Tenderness over the medial parapatellar region. He is now 3 months out and still no better. I think at this point in time it's worth getting an MRI for an answer to his pain. His pain has not improved for a couple months.

ExaminationGeneral Examination:

The patient has pain on attempted extension of the knee. There is a positive McMurray's exam. The patient is unable to fully weight-bear on the knee. Patient has full flexion with pain at the extremes of range of motion. Patient has a negative Lachman's exam. Patient has a negative Apley's exam. There is no lateral tenderness. The patella is slightly ballotable. There is no increased warmth to the knee. There is no varus or valgus instability. There is no pitting edema in the lower extremity. The skin is intact. The foot is neurovascularly intact.

The hip has no pain on internal or external rotation. The patient has a negative straight leg raise exam. There is no back pain to palpation or motion. Tenderness medially is right near the medial parapatellar region. It extends up into the vastus medialis area.

Assessments

Patient: BROWN, O'SHEA L DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 07/24/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Jaundice No. Stomach ulcers No.
Hematology
 AIDS/HIV No. Anemia No.
Women Only
 Regular menses No. Pregnant No.
Genitourinary
 Kidney problems No.
Musculoskeletal
 Joint stiffness denies. Pain at
 night denies. Pain at rest denies.
 Arthritis No. Weakness denies. Gout No.
Neurologic
 Radiating pain denies. Seizures No.
 Tingling/Numbness denies.
Psychiatric
 Depression No.
Cancer Self-Management
 Cancer No.
General
 Hearing problems No.

1. Derangement of posterior horn of medial meniscus - 717.2 (Primary)
2. Knee pain - 719.46

The patient has medial joint line tenderness with a positive McMurray's and catching and locking in his knee. I'm concerned he has a medial meniscus tear. He has never received an MRI. X-rays are unremarkable for significant arthritic changes.

Treatment

1. Derangement of posterior horn of medial meniscus
 Start Lortab Tablet, 7.5-500 MG, 1 tablet, by mouth, 4-6 hours as needed for severe post-op pain, 30 days, 40, Refills 0
 Diagnostic Imaging: MR LOWER EXTREMITY JOINT (ANKLE, KNEE, HIP) WITHOUT CONTRAST Right knee MMT WKC/ADJUST
 CALLED AND WILL SCHEDULE

2. Knee pain
 Diagnostic Imaging: XR KNEE 3 VIEWS

3. Others

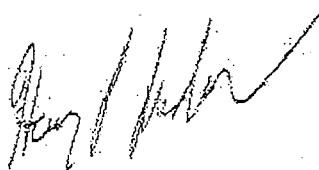
The patient has classic medial meniscus symptoms. His exam is also classic for medial meniscus tear. I would suggest an MRI of the knee. The patient has classic medial meniscus symptoms. His exam is also classic for medial meniscus tear. I would suggest an MRI of the knee. The patient has classic medial meniscus symptoms. His exam is also classic for medial meniscus tear. I would suggest an MRI of the knee. The patient has classic medial meniscus symptoms. His exam is also classic for medial meniscus tear. I would suggest an MRI of the knee. The patient has classic medial meniscus symptoms. His exam is also classic for medial meniscus tear. I would suggest an MRI of the knee.

Procedure Codes

73562 X-RAY EXAM OF KNEE, 3

Follow Up

after MRI



Electronically signed by HARRY RUDOLPH MD, MD on
 07/25/2012 at 08:48 AM EDT

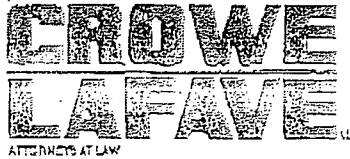
Sign off status: Completed

Chas Bone And Joint Johnnie Dodds
767 JOHNNIE DODDS BLVD
MT PLEASANT, SC 29464-3027
Tel: 843-853-3474
Fax: 843-606-8056

Patient: BROWN, O'SHEAL DOB: 07/08/1974 Progress Note: HARRY P RUDOLPH, MD 07/24/2012

Note generated by eClinicalWorks EMP/PM Software (www.eClinicalWorks.com)

Danny C. Crowe, Esq.
danny@crowelafave.com
803-724-5726
Matthew C. LaFave, Esq.
matt@crowelafave.com
803-724-5727



P.O. Box 1149
Columbia, SC 29202
contact@crowelafave.com

June 5, 2014

Dr. Harry Rudolph
Charleston Bone and Joint
255 E. Bay Street
Charleston, South Carolina 29401

RE: O'Shea Brown v. Steel Technologies and The Hartford Accident and Indemnity Co.
SCWCC No.:
Claim No.: 00196-WC-01
C/L File No.: 406-00044

Dear Dr. Rudolph:

Please be advised that I am presenting you with this questionnaire as counsel for the Defendants in the above workers' compensation claim. It is my understanding that you were brought into this matter due to a tear in his meniscus, which eventually required surgical intervention. I understand that this is a medically complex case, but I am writing to inquire as to some questions in regard to your impairment rating as well as the Physician's Statement completed. In each question below I am asking for your opinion within a reasonable degree of medical certainty based upon your expertise as a vascular surgeon.

1. Please identify the specific surgical procedure you performed on Claimant. arthroscopy
lateral meniscus
2. Please set forth the prescribed impairment rating, pursuant to the AMA Guides for Evaluation of Permanent Impairment 5th Edition for the surgical procedure identified in Answer Number 1. Table 16-3 Meniscus injury. It is the highest manual number I could give. He however has a higher number because of his vascular injury.
3. Please set forth, with specificity the additional elements considered in reaching your impairment of 13% in light of the impairment rating referenced in Answer Number 2. For each additional element please identify the applicable page, table, and/or chart relied upon from the AMA Guides for Evaluation of Permanent Impairment 5th Edition to support the increase.
4. Do you believe Claimant has permanent work restrictions? ☒ Yes ☐ No
 - a. If yes, please identify the work restrictions you would place upon Claimant.
He cannot stand or walk more than 15 min at a time because of his swelling and pain

Medical Questionnaire to Dr. Rudolph
Page Two
June 5, 2014

5. Do you believe Claimant will need any future medical care, from an orthopedic standpoint, related to his injury? ☒ Yes ☐ No

a. If yes, please identify the future medical care you believe Claimant will need.

Both / either procedure and orthopedic exam

orthopedic vs total knee possible

These are my opinions within a reasonable degree of medical certainty as evidenced by my signature below:


Harry Rudolph, MD

7/17/14
DATE

We certainly understand that your time is valuable and are amenable to paying for your time to complete this questionnaire. If you require payment please provide an invoice, with your Federal Tax Identification Number with your completed questionnaire.

With kindest regards, I remain

Yours very truly



Matthew C. LaFave
Crowe LaFave, LLC

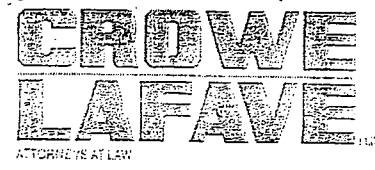
MCL

cc: Joe Ann Calvy, Esquire
Linda Cannon-Rivera, Gallagher Bassett (via email)
Michelle Harper, Steel Technologies (via email)
Rebecca Murphy, Steel Technologies (via email)

f21

why should claimant wear the blame equity (lag in time)

Danny C. Crowe, Esq.
Columbia, SC 29202
803-724-5728
Matthew C. LaFave, Esq.
Columbia, SC 29202
803-724-5727



P.O. Box 1149
Columbia, SC 29202
crowelafave.com

March 19, 2014

Dr. Edward C. Morrison
Coastal Vascular & Vein Center
1327 Ashley River Rd., Bldg. B
Charleston, South Carolina 29407

RE: O'Shea Brown v. Steel Technologies and The Hartford Accident and Indemnity Co.
SCWCC No.:
Claim No.: 00196- -WC-01
C/L File No.: 406-00044

Dear Dr. Morrison,

Please be advised that I am presenting you with this questionnaire as counsel for the Defendants in the above workers' compensation claim. It is my understanding that you were brought into this matter due to some excessive swelling Claimant was experiencing in his lower extremity, which was first noticed by Dr. Rudolph. Due to the medical complex nature of this case I am seeking clarification on the conditions for which you are treating Claimant and the treatment that has been undertaken at your direction. In each question below I am asking for your opinion within a reasonable degree of medical certainty based upon your expertise as a vascular surgeon.

1. Please identify the specific diagnoses for which you are treating Claimant. VENOUS STASIS disease and edema
 - a. For each diagnosis referenced in response to #1 please indicate whether or not said diagnosis is related, in any way, to Claimant's workers' compensation claim/injury and if related please specify how it/they are related. yes the injury likely exacerbated his underlying venous reflux disease
2. Please set forth the specific basis and/or condition for which Claimant underwent the right great saphenous vein closure. because the patient has VENOUS STASIS disease
3. Was the right great saphenous vein closure related to Claimant's workers' compensation claim wherein he injured his right knee. "eventually requiring arthroscopic intervention to repair a torn medial meniscus?" ☒ Yes ☐ No
 - a. If yes, please explain how this procedure was related to Claimant's workers' compensation claim/injury. THE VENOUS CLOSURE PROCEDURE WAS DONE TO HELP IMPROVE HIS PAIN & SWELLING WHICH WAS CAUSED BY HIS KNEE INJURY

crowelafave.com

4. Do you believe Claimant's lymphedema is related to Claimant's workers' compensation claim?

☒ Yes ☐ No

a. If yes, please explain how this condition is related to Claimant's workers' compensation claim/injury.

The lymphedema is a vascular disease was exacerbated by knee injury. However he likely had malfunctioning venous valves prior to injury.

5. Please set forth the basis for your referral to Dr. Tavel.

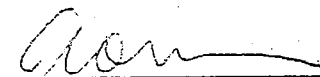
for pain management, and to rule out BPD

a. Was your referral to Dr. Tavel in related, in any way, to Claimant's workers' compensation claim/injury? ☒ Yes ☐ No

i. If yes, please explain how this referral is related to Claimant's workers' compensation claim/injury?

Injury can cause BPD & sympathetic dystrophy (LSD)

These are my opinions within a reasonable degree of medical certainty as evidenced by my signature below:



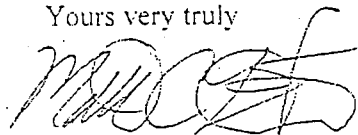
Edward C. Morrison, MD

03/13/14
DATE

We certainly understand that your time is valuable and are amenable to paying for your time to complete this questionnaire. If you require payment please provide an invoice, with your Federal Tax Identification Number with your completed questionnaire.

With kindest regards, I remain

Yours very truly



Matthew C. LaFave
Crowe LaFave, LLC

MCL

cc: O'Shea Brown, Pro-se Claimant
Linda Cannon-Rivera, Gallagher Bussett (via email)
Michelle Harper, Steel Technologies (via email)
Rebecca Murphy, Steel Technologies (via email)

Gabor A. Winkler, MD
3312 Trenton Street
Florence, SC 29501

Medical Expert Report

Florence, November 14th, 2014

I am preparing a medical expert report of the Worker's Compensation Case O'Shea Brown vs. Steel Technologies AND Hartford Accident & Indemnity Co.

This report is based on review of the following documents:

- Records from Clair Orthopedics, PA, Dr. Mason Ahearn
- Records from Rehabilitation Consultant Feryal Jubran, CRC
- Records from Carolina Orthotics & Prosthetics
- Records from Lowcountry Orthopedics, Dr. Eric S. Stem
- Records from Clarendon Memorial System, Dr. Noel Phipps
- Records from Pain Specialist of Charleston, PA, Kinsey Knight
- Records from CPM Physical Therapy, Mary Harpell
- Records from Coastal Vascular and Vein Center, Dr. Edward Morrison
- Records from Dr. Harry Rudolph
- Records from Coastal Occupational Medicine, Dr. Byron Williams
- WCC Form 20
- Correspondence between Attorney LaFave and Dr. Rudolph
- Correspondence between Attorney LaFave and Dr. Morrison

Mr. Brown sustained a Right knee injury on April 30, 2012 in a work related accident. On May 2, 2012 he was examined by Dr. Byron Williams at Coastal Occupational Medicine and "mild effusion" of the knee was noted. On subsequent examinations at Coastal Occupational Medicine, swelling of the Right knee and leg was documented.

Mr. Brown then saw Dr. Harry Rudolph, an orthopedic surgeon, who on October 2, 2012 performed an arthroscopic Right knee surgery with partial medial meniscectomy. Following the operation Mr. Brown developed even more swelling in his Right leg and became increasingly debilitated by this. While a venous duplex did not demonstrate deep vein thrombosis, the swelling remained a concern both for Dr. Rudolph and the patient.

He was referred for a vascular surgical consultation but was only able to have this done on January 9, 2013. Going forward, he underwent Great Saphenous Vein ablation and compression therapy, as well as lymphedema treatments but remains greatly disabled from the chronic and ongoing swelling.

In essence, the tear in the medial meniscus of the Right knee resulted directly from the work injury that Mr. Brown sustained on April 30, 2012. He developed some swelling in his Right leg after the injury, which was not present before. It became necessary for him to undergo a Right knee arthroscopic surgery with partial meniscectomy, after which the swelling worsened significantly and remained a permanent issue despite multiple treatment attempts. At this point it is evident that this will be a permanent disability for him.

It is my opinion that it can be declared with a reasonable degree of medical certainty that Mr. Brown's chronic swelling is a direct result of the work injury to his Right knee that he sustained on April 30, 2012. Certainly the impact of the injury could have caused the immediate swelling, as well as the ultimately resulting permanent swelling. The swelling was further worsened by the arthroscopic knee surgery that became necessary as a result of the same injury. It is also clear with a reasonable degree of medical certainty that the impairment due to the swelling in his Right leg is and will remain a permanent problem and disability for Mr. Brown. While it is possible that with a variety of treatments (such as lymphedema therapy, lymphedema massage therapy, compression therapy, compression boot therapy, and weight loss therapy some level of improvement in his symptoms can be achieved, it is extremely unlikely that he will ever return to a normal function. In short, his permanent disability is a direct result of the injury he sustained on April 30, 2012.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Gabor A. Winkler', with a stylized, flowing script.

Gabor A. Winkler, MD

Gabor Andras Winkler, M.D., F.A.C.S.

Office: McLeod Regional Medical Center
McLeod Vascular Associates
101 S. Ravenel Street
230
Tel: (843) 777 7043
Fax: (843) 777 7041

Home: 3312 Trenton Street
Florence, SC 29501
Cell: (609) 784 3001

e-mail: gawinkler@mac.com

PERSONAL

Date of Birth: July 4, 1968

Birth Place: Budapest, Hungary

Citizenship: German/USA dual citizenship

Language Skills	Hungarian	Native tongue
	German	Native tongue
	English	Fluent
	Russian	Intermediate
	French	Beginner

Hobbies: Tennis, Bridge

CURRENT PROFESSIONAL APPOINTMENTS

2014- Attending Surgeon
 McLeod Vascular Associates
 McLeod Regional Medical Center
 Florence, SC

ACADEMIC APPOINTMENTS

2011-2012 Assistant Professor of Surgery
 Thomas Jefferson University

MEDICAL STAFF APPOINTMENTS

2012-2014 Member of the Board of the Holy Redeemer Ambulatory Surgery Center

2011-2014 Medical Executive Committee Holy Redeemer Hospital

2009-2010 Surgical Clerkship Director for Medical Students
 Thomas Jefferson University

2005-2008 Medical Executive Committee Deborah Heart and Lung Center

2005-2008 Graduate Medical Education Committee Deborah Heart and Lung Center

2006-2007 Chair of Perioperative Task Force Committee Deborah Heart and Lung
 Center

EDUCATION

1974-1978 Elementary School in Vienna, Austria

1978-1986 Middle and High School Arany Janos Gimnazium in Budapest, Hungary

1986-1987 College for Foreign Students in Frankfurt, Germany

1987-1993 Johann-Wolfgang-Goethe University, Medical School in Frankfurt,
 Germany

ELECTIVE ROTATIONS DURING FINAL YEAR OF MEDICAL
SCHOOL

Gabor Andras Winkler, M.D., F.A.C.S.

Page 3 of 9

Oct92- Jan 93 Four Month Elective Rotation at Harvard University in Boston, MA
(Orthopedic Surgery)

Feb-May, 93 Four Month Elective Rotation at University of the Witwatersrand in
Johannesburg / South-Africa (General Surgery and Trauma Surgery)

Jun-Sep, 93 Four Month Elective Rotation at St.Markus-Krankenhaus in Frankfurt /
Germany (Internal Medicine)

THESIS

Basic science research at Department of Anatomy at Frankfurt Medical
School: *The prenatal proliferation of Merkel cells in rat vibrissae. An
autoradiographic study.*

This Thesis received the degree of Magna cum Laude.

1994-1995 Internship at Humboldt Hospital / Department of Trauma and
Reconstructive Surgery in Berlin, Germany

1995-1997 Research Fellowship in Orthopedic Oncology at the Musculoskeletal
Tumor Center in Bala Cynwyd, PA

1997-1998 Preliminary PGY-1 position in General Surgery at The Graduate Hospital
in Philadelphia, PA

1998-2000 General Surgery Residency PGY 1-2 at The Graduate Hospital in
Philadelphia, PA

2000-2003 General Surgery Residency PGY 3-5 at Temple University Hospital in
Philadelphia, PA

2003-2004 Vascular Surgery Fellowship at Pennsylvania Hospital / University of
Pennsylvania Health System in Philadelphia, PA

MEDICAL LICENSURE

Pennsylvania

New Jersey

Florida

South Carolina

BOARD CERTIFICATION

General Surgery

American Board of Surgery

P385

Vascular Surgery
American Board of Surgery
May 23, 2006

HONORS

Robert D. Smink Resident Teaching Award 2010

H. Taylor Caswell Award given to the senior resident, who in the opinion of the junior residents most significantly contributed to their education
2003

Pennsylvania Orthopedic Society Resident Paper Competition Award in
November, 1996

Mid-Atlantic Boxing Federation Appreciation Award for voluntary service
in amateur boxing in 1997

SPECIAL MENTION

Top Docs of South Jersey
South Jersey Magazine, 2007

PAST APPOINTMENTS

2013-2014 Vice President of Surgical Services
Holy Redeemer Health System
Meadowbrook, PA

2011-2014 Chairman, Department of Surgery
Holy Redeemer Hospital
Meadowbrook, PA

2008-2011 Attending Surgeon
Main Line HealthCare
Riddle Memorial Hospital
Media, PA

2008-2011 Attending Surgeon
Main Line HealthCare
Lankenau Hospital

Wynnewood, PA

- 2005-2008 Director of Division of Vascular and General Surgery
Department of Surgery
Deborah Heart and Lung Center
- 2005-2008 Program Director, General Vascular Surgery Residency
Deborah Heart and Lung Center
Browns Mills, NJ
- 2004-2008 Attending Surgeon, Deborah Heart and Lung Center
Browns Mills, NJ
- 2007-2008 Attending Surgeon, Southern Ocean County Hospital
Manahawkin, NJ
- 2004-2005 Surgical Specialists of New Jersey
Mount Holly, NJ
- 2004-2005 Director of Vascular Surgery Services Virtua Memorial Hospital
Mount Holly, NJ
- 2004-2005 Attending Surgeon, Virtua Memorial Hospital
Mount Holly, NJ

PROFESSIONAL SOCIETIES

Fellow of the American College of Surgeons

Delaware Valley Vascular Society

Peripheral Vascular Surgical Society

Society for Clinical Vascular Surgery

Eastern Vascular Society

Hungarian Medical Association of America

GRAND ROUNDS

History of Biliary Tract Surgery Grand Rounds given at Temple

Abdominal Aortic Aneurysm Surgery in the 21st Century
Grand Rounds given at Deborah Heart and Lung Center in April 2006

Aortic Aneurysm Repair in the 21st Century
Grand Rounds given at Lankenau Hospital on September 16, 2008

Peripheral Vascular Disease, An Update
Grand Rounds given at Riddle Memorial Hospital in May 2009

Workup of the contemporary Vascular Patient
Grand Rounds given at Holy Redeemer Hospital in October 2011

INVESTIGATIONS

Sub-investigator for SAPHIRE WW carotid stent post market analysis trial 2006-2008

Sub-investigator for CHOICE carotid stent post market analysis trial 2006-2009

Sub-investigator for CREATE (EV3) carotid stent post market analysis trial 2006-2008

Medical Monitor for Optiflow US trial Data Safety Monitoring Board 2014-Present

FACULTY PARTICIPATION

18th Annual Pennsylvania Vascular Symposium in Philadelphia, Pennsylvania in March 2009

19th Annual Pennsylvania Vascular Symposium in Philadelphia, Pennsylvania in April 2010

Co-Program Director of 1st Annual Current Approaches to Vascular Disease Symposium in Atlantic City, New Jersey in May 2006

Co-Program Director of 2nd Annual Current Approaches to Vascular Disease Symposium in Atlantic City, New Jersey in June 2007

PRESENTATIONS

Winkler, G.A.: *The Contemporary Work-up of the Vascular Patient*. Presented at the 44th Annual Meeting of the Hungarian Medical Association of America in Sarasota, Florida in October 2012

Samra, M.; Winkler, G.A.: *A single institution experience with carotid artery revascularization in the setting of severe coronary artery disease*. Presented at the 2008 Annual Meeting of the Delaware Valley Vascular Society Meeting in Philadelphia, PA in April 2008.

Winkler, G.A.: *AAA Surgery in 2007: An Update and Review of Institutional Data*. Presented at the 2nd Annual Current Approaches to Vascular Disease Symposium in Atlantic City, New Jersey in June 2007

Winkler, G.A.: *Endovascular Aortic Aneurysm Repair: Present and Future*. Presented at the 1st Annual Current Approaches to Vascular Disease Symposium in Atlantic City, New Jersey in May 2006

Winkler, G.A., Calligaro, K.D., Dougherty, M.J.: *Carotid stump pressure correlation with neurological function in 404 endarterectomies under cervical block anesthesia*. Paper accepted for presentation at the 20th Annual Vascular Fellows Abstract Presentation in New York City in April 2004.

Winkler, G.A., Calligaro, K.D., Dougherty, M.J.: *Carotid stump pressure revisited*. Paper presented at the Association of Program Directors in Vascular Surgery/Resident meeting in Bethesda, Maryland in April 2004.

Winkler, G.A.: *Aortic dissection, a comprehensive review*. Basic science lecture given to Pennsylvania Hospital Department of Surgery in May 2004.

Winkler, G.A.: *Mesenteric ischemia, a comprehensive review*. Basic science lecture given to Pennsylvania Hospital Department of Surgery in December 2003.

Heaton, T.E., Winkler, G.A., Calligaro, K.D., Doerr, K., McAfee-Bennett, S., Kutz, J., Dougherty, M.J.: *Duplex ultrasound vs. CT Scan for the detection of endoleaks and failing limbs following endovascular aortic aneurysm repair*. Paper presented at the 2003/September Delaware Valley Vascular Society Meeting in Philadelphia. This paper received 3rd prize in the Residents competition.

Winkler, G.A., Singhal, A., Cordova, F.C., Furukawa, S., Macha, M., Rolandelli, R.R., Parkman, H.P., Kuzma, A., Criner, G.J.: *Treatment of patients with gastroparesis following heart and lung transplantation with pyloroplasty*. Poster presented at the American Thoracic Society meeting in Atlanta in May 2002.

Schmidt, R.G., Winkler, G.A., Fisher, S.A., Staddon, A.H.: *Intraoperative radiation therapy in the treatment of soft tissue sarcomas of the extremities*. Abstract accepted at the International Society for Limb Salvage Surgery Meeting in September/1999 in New York, NY.

Winkler, G.A., Schmidt, R.G., Labs, K., Schunemann, S.F.: *The relative benefit of multi specialty care in the treatment of soft tissue sarcomas*; Paper presented at the annual meeting of the American Academy of Orthopedic Surgeons in February/1997 in San Francisco, CA.

Winkler, G.A., Schmidt, R.G.: *Osteoarticular allograft reconstruction versus modular segmental prosthetic replacement in the treatment of neoplastic conditions of the shoulder*; Paper presented at the Pennsylvania Orthopedic Society spring meeting in April/1996 in Aventura, FL.

Winkler, G.A., Schmidt, R.G.: *Surgical management of severely comminuted, non neoplastic distal femur fractures in the elderly, using a modular oncology system*; Paper presented at the Pennsylvania Orthopedic Society fall meeting in November/1996 in Pittsburgh, PA. (This paper won first prize in the "Pennsylvania Orthopaedic Society Resident Paper Competition.)

Winkler, G.A., Schmidt, R.G.: *Reconstruction following wide resection of neoplastic conditions in the extremities using the Howmedica Modular Oncology System. A review of the first 63 cases*; Paper presented at the "1st National Conference on the Use of the Modular Replacement System" in November/1996 in Chicago, IL.

Winkler, G.A., Klauser, H. and Kecskés, S.: *The early functional, non-operative treatment of fractures of the humeral shaft after Specht*; Poster presented at the Annual Meeting of the Hungarian Society of Trauma Surgery in Békéscsaba/Hungary in May/1995 (bilingual poster Hungarian-German).

PUBLICATIONS

Winkler, G.A., Calligaro, K.D., Kolakowski S., Doerr, K.J., McAfee-Bennett, S., Muller, K., Dougherty, M.J.: *Comparison of intraoperative completion flowmeter vs. duplex ultrasonography and contrast arteriography for carotid endarterectomy*; Vascular and Endovascular Surgery. 2007;40:482-6.

Klauser, G.J., Winkler, G.A., Lamberts, O., Winckler, J. and Korr, H.: *The prenatal proliferation of Merkel cells in rat vibrissae*; Article published in Anatomy and Embryology in 1994.

Winkler, G.A.: *Das pränatale Proliferationsmuster der Merkelzellen von Vibrissen von Ratten. Eine autoradiographische Studie*. Thesis book published at the Johann-Wolfgang-Goethe University, Frankfurt am Main/Germany in 1996.

BOOK CHAPTERS

Winkler, G.A., Calligaro, K.D., Doerr, K., McAfee-Bennett, S., Dougherty, M.J.:
Surveillance of tibial bypasses. In: Diabetic foot, tibial disease and limb salvage. Sidawy,
A.N. editor; 2006, Lippincott, Williams and Wilkins.

Schmidt, R.G., Winkler, G.A.: *Palliative Orthopedic Surgery*. In: Principles and
Practice of Supportive Oncology. Berger, A.M., Portenoy, R.K., Weissman, D.E. editors;
1998, Lippincott-Raven.

McLeod**Physician Associates****BROWN, OSHEA**

40 Y old Male, DOB: 07/08/1974

Account Number: e1034014

533 TAFT RD, SALTERS, SC-29590

Home: 843-356-9590

Guarantor: BROWN, OSHEA

PCP: Unknown Unknown

Appointment Facility: McLeod Vascular Associates

01/20/2015

Progress Notes: Gabor Winkler, MD

Current Medications**Taking**

- Meloxicam 7.5 MG Tablet 1 tablet Once a day
- Hydrocodone prn

Past Medical History

4/2012 RLE Meniscus Tear

Surgical History

R leg vein closure 2/14/13

R knee surgery d/t Meniscus Tear 10/2/2012

Family History

Father: alive

Mother: alive

2 daughter(s) - healthy.

Social History**Tobacco Use:**

Smoking

Are you a: never smoker

Miscellaneous:

Others at home: lives alone.

Occupation: bx of truck driver until 8/2012 injury.

Drug/Alcohol:

Drugs: Denies.

Alcohol

Did you have a drink containing alcohol in the past year? No

Points 0

Interpretation Negative

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

Denies Past Hospitalization

Review of Systems**General/Constitutional:**

General good general state of health but clearly disabled.

HEENT/Neck:**Reason for Appointment**

1. Expert witness opinion
2. "R leg pain with swelling, R side back and hip pain"

History of Present Illness**Constitutional:**

This is an independent medical evaluation for Mr. Oshea Brown. I had an opportunity to review his records in detail and I have prepared a separate report of that review previously.

The purpose of today's evaluation is to have a current physical exam on record in addition to the chart review that had already occurred.

Just to briefly recap, Mr. Brown sustained a work related injury to his Right knee on April 30, 2012. Subsequently he was first treated nonoperatively and later on October 2, 2012 he underwent arthroscopic medial meniscectomy of the right knee. He developed some swelling as a result of the original injury and then significantly more swelling after his operative procedure. Ever since then he has been battling swelling and chronic pain in his right leg.

Currently Mr. Brown is walking with a cane and a right knee brace as well as a back support girdle. He walks with a significant limp.

On exam he has no carotid bruits, palpable femoral pulses, palpable DP and PT pulses bilaterally.

He has very significant swelling and signs of chronic lymphedema of the right lower extremity, especially in the below-knee segment. There is sparing of the foot but the swelling reaches from just below the knee to all the way below the ankle. In addition there is some swelling of the right thigh as well.

Based on this examination today and the review of his records I maintain my previously given medical expert opinion that his right leg chronic swelling is a direct result of the work-related injury that he sustained and the subsequent surgery that was necessary. I also continue to believe that this represents a very significant disability that is permanent at this time.

Vital Signs

Temp 97.1, HR 98, BP L 144/98 R 164/104.

Examination**General Examination:**

GENERAL APPEARANCE: pleasant, in no acute distress.

Head no trauma. Nose no pain.
Throat no pain. Eyes normal vision.
Ears normal hearing.

Respiratory:

Shortness of breath no.

Cardiovascular:

Cardiovascular symptoms no current
anginal symptoms, no recent
coronary interventions.

Gastrointestinal:

General no reflux, no bleeding, no
ulcers.

Hematology:

Patient denies abnormal bleeding.

Genitourinary:

Urinary no hematuria, no stones,
no history of renal failure.

Musculoskeletal:

General chronic back pain & RLE
pain.

Peripheral Vascular:

General no claudication; RLE w/
extensive swelling; pt reports pain
on RLE w/ any weight-bearing.

Skin:

Patient denies sores or rash.

Neurologic:

Neurology no history of CVA, no
history of TIA.

Psychiatric:

Patient denies depression, anxiety.

HEENT: normal.

NECK/THYROID: no lymphadenopathy, supple.

CARDIOVASCULAR: normal S1S2, regular rate and rhythm, no
murmurs.

CHEST: clear to auscultation, good aeration.

GASTROINTESTINAL: normal without tenderness, masses, or
megaly.

SKIN: normal, no rash.

EXTREMITIES: warm and well perfused feet at rest Significant
circumferential swelling in Right lower leg starting at just below knee
all the way down to below ankle w/ exclusion of the foot - minimal
swelling in Right foot. Overall, showing signs of significant
lymphedema.

Vascular Examination:

Carotids Right normal, Left normal.

Bruits Right negative, Left negative.

Subclavian Right normal Left normal.

Brachial Right normal, Left normal.

Aorta normal.

Femoral Right normal, Left normal.

Popliteal Right normal, Left normal.

Dorsalis Pedis Right normal, Left normal.

Posterior Tibialis Right normal, Left normal.

Assessments1. Lymphedema - 457.1 (Primary)

Based on today's exam and the previous review of the records I
maintain my medical expert opinion that the chronic Right leg swelling
and lymphedema is a direct cause of his work related injury on
4/30/2012 and the subsequent surgery that was necessary due to the
injury.

I also maintain that his disability is permanent at this point.

Treatment1. Lymphedema

Notes: Continue lymphedema therapy & chronic pain management.

Follow Up

prn

Electronically signed by GABOR WINKLER, MD on

01/21/2015 at 10:09 AM EST

Sign off status: Completed

McLeod Vascular Associates
101 S RAVENEL ST, STE 230
FLORENCE, SC 295062611
Tel: 843-777-7043
Fax: 843-777-7041

Patient: BROWN, OSHEA DOB: 07/08/1974 Progress Note: Gabor Winkler, MD 01/20/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient name: O'Shea Brown
Date of birth: July 8, 1974
Date of evaluation: December 31, 2014
Date of injury: April 30, 2012

INDEPENDENT MEDICAL EXAMINATION

Mr. Brown was examined for independent medical exam on December 31, 2014, at the request of attorney Joe Ann Calvy for evaluation of work-related injury on April 30, 2012. His identity was confirmed with South Carolina Driver's license. Prior to the examination, I explained that no treatment would be rendered and no doctor-patient relationship would be established from this encounter.

I reviewed records provided by the attorney, and I obtained a history directly from the client. The history obtained from the client was consistent with the medical records provided.

Mr. Brown had a work injury on April 30, 2012. He described bumping his right knee while getting on the back of the trailer. At that time he was a truck driver for Steel Technologies. Initially his pain was localized to the right knee. He was able to drive, however the following day he had severe pain and swelling. He eventually saw an occupational health provider. X-rays did not show a fracture. He had a trial of non-operative management with medications, restrictions, and a brace. He was referred to an orthopedic surgeon. MRI showed a meniscus tear. On October 2, 2012 he had an arthroscopic partial medial meniscectomy. Postoperatively he developed pain and swelling in the leg. He was evaluated for DVT, but tests were negative. He had continued worsening pain and swelling and was referred to a vascular surgeon. He was diagnosed with lymphedema and was treated with mechanical devices. He later underwent venous ligation. Neither of these interventions provided relief of pain and swelling. He was referred for evaluation for possible reflex sympathetic dystrophy. His pain and swelling never resolved. He began having low back pain which was attributed to his abnormal gait. MRI of the lumbar spine showed L5-S1 disc bulging with a small annular tear. Second opinion evaluation of the knee demonstrated lateral patella tilt on MRI.

When I saw Mr. Brown he complained of low back pain with radiation into the right buttock and down the entire right lower extremity. He also complained of pain in the left lower extremity. He reported chronic pain of 8 to 9 out of 10, associated with giving out of the right leg. He also described aching and tingling in the right lower extremity, but denied bowel or bladder symptoms. He used a brace on the right lower extremity. He took hydrocodone, Opana, and Meloxicam for pain. He denied any of these symptoms prior to his injury on April 30, 2012.

When I examined Mr. Brown he was an overweight male in no acute distress. He was cooperative with examination. He used a cane to ambulate. He wore a brace on the right knee. He had an abnormal gait with a lurch. His lumbar spine had normal alignment. There was mild tenderness in the soft tissues of the lumbar spine. I did not detect any muscle spasm. He had pain and tightness of the hamstrings with straight leg raise on the right. He had a limited range of motion in the lumbar spine. Quadriceps atrophy was present in both lower extremities. There was no knee effusion. Range of motion of the right knee was 0 to 85° and the contralateral knee had 0 to 125° of motion. Lachman and drawer testing of the right knee revealed no instability. There was mild joint line tenderness in both knees and no crepitation. There was marked woody edema in the right lower extremity with hyperpigmentation of the skin. The swelling in the right

Patient name: O'Shea Brown
Date of birth: July 8, 1974
Date of evaluation: December 31, 2014
Date of injury: April 30, 2012

lower extremity was severe enough to restrict range of motion in the ankle. There was no erythema. There was diminished sensation in a stocking distribution on both lower extremities right side more diminished than the left.

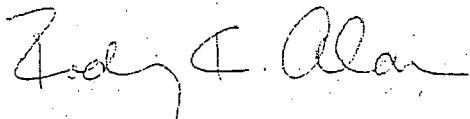
Based on my history and evaluation of Mr. Brown, he has persistent chronic knee pain after right knee arthroscopy for work-related meniscus tear, class 3 chronic vascular impairment of the right lower extremity following knee surgery, chronic pain with opioid dependency, and lumbar radiculopathy. His current knee condition is a direct result of his work injury. The vascular impairment of the right lower extremity is also causally related to the work injury as an unanticipated complication of the treatment for his injury. Lastly, Mr. Brown's lumbar radiculopathy is causally related to his work injury as an exacerbation and/or acceleration of the normal degenerative process of the lumbar spine secondary to severe gait impairment.

Mr. Brown's current impairment has been outlined in records provided. Mr. Brown has a 3% whole person impairment of her chronic pain, a 60% right lower extremity impairment for chronic lymphedema, a 7% impairment of the right knee for residual patellar instability, and a 2% impairment to the right lower extremity and for partial meniscectomy. He also has a DRE lumbar category II impairment of 5% whole person. His total whole person impairment is 33% using the combined values table.

Future treatments for Mr. Brown include ongoing lymphedema evaluation and treatment. He will need future treatment for knee arthritis status post meniscectomy. He will need ongoing pain management. He will need durable medical equipment including a cane, a brace for the knee, and lumbar support.

Recommended activity restrictions for Mr. Brown are limited to sedentary work as defined by the Social Security Code Of Federal Regulations § 404.1567 Physical exertion requirements. Sedentary work may not be feasible given Mr. Brown's chronic opioid dependence.

My opinions are given to a reasonable degree of medical certainty. The opinions are given based on my evaluation of the patient and reviewed the medical records made available to me as of December 31, 2014. Any additional information, or changes to the information, may or may not affect opinions.



Rodney K. Alan

Date of injury: April 30, 2012

SECRET

1985-05-24/84

single, 10/10/02



1. The first of these is the fact that the Commission has not yet received any information from the Government of the Republic of China (Taiwan) regarding the situation in the Republic of China (Taiwan) and the Republic of China (Taiwan) has not yet received any information from the Government of the Republic of China (Taiwan) regarding the situation in the Republic of China (Taiwan).

10-10-68

[illegible]

100-15819

Hydro-Land, Cape Cod, Mass.

1959 by *James O. R. L. L.*

2002

2516

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
Appellate Panel

SCWCC No.: 1205647

RECEIVED

MAR 08 2017

SC Court of Appeals

O'Shea L. Brown, Claimant.....Appellant

v.

Steel Technologies, Employer and

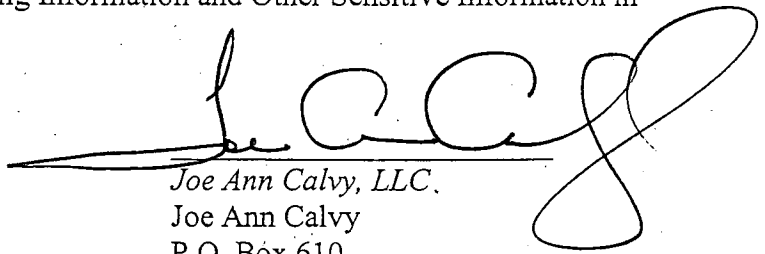
Twin City Fire Ins. Co., Carrier.....Respondents.

Appellate Case No. 2016-001992

CERTIFICATE OF COMPLIANCE

The undersigned certifies that the Record on Appeal filed in this matter contains all the material proposed to be included by the parties to this matter and does not include any other material. The undersigned further certifies that the Record on Appeal filed in this matter complies with the South Carolina Supreme Court's April 16, 2014 Order re: Revised Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings.

February 28, 2017



Joe Ann Calvy, LLC,
Joe Ann Calvy
P.O. Box 610
Kingstree, SC 29556
Telephone: (843) 354-5504
Facsimile: (843) 354-5845
Attorney for Respondent