THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Case No.: 2016-001247

Thomas Contreras, Claimant, ... Appellant,

v.

St. Johns Fire District Commission, Employer, and State Accident Fund, Carrier, Respondents.

RESPONDENTS' BRIEF

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The Appellate Panel was correct in finding that the Appellant did not suffer a wage loss under § 42-9-20.

The Appellate Panel was correct in finding that the Single Commissioner did not find the clavicle compensable and that this issue was not preserved on appeal.

Appellant failed to preserve any issue regarding payment of temporary partial disability and Appellant is not owed any temporary partial disability.

STATEMENT OF THE CASE

This matter arises out of a worker's compensation case. Appellant injured his right shoulder in the course and scope of his employment as a firefighter on October 8, 2008. Appellant filed a Form 50 in 2011 alleging injury to his right shoulder, right upper extremity, right glenohumeral ligament, right clavicle, right scapula, right lateral deltoid, right bicep and right distal clavicle. Respondents admitted an injury to the right shoulder and denied all other body parts. In March of 2012, the parties entered into a consent order that the Claimant admitted an injury to his right shoulder and that he was still being treated by Dr. DeMarco. (R. p.1). In February of 2013, Appellant filed another Form 50 claiming injury to right shoulder, right upper extremity, right glenohumeral ligament, right clavicle, right scapula, right lateral deltoid, right bicep and right distal clavicle. Respondents filed a Form 51 admitting to the right shoulder only.

On May 14, 2013, a hearing was held on Forms 50/51. Appellant took the position that he suffered a permanent partial wage loss under §42-9-20 as a result of injuries to his right shoulder, right upper extremity, specifically the right bicep being the second body part that is affected. (R. p. 536). Alternatively, the Appellant took the

position that if the commissioner found that the case was a §42-9-30 case, then in addition to a finding of permanent impairment to the shoulder, the Appellant requests a finding as to permanency for the clavicle under Regulation 67-1101. (R. p. 541)

Respondents took the position that the claim was to the right shoulder only and the case should be controlled by § 42-9-30. (R. p. 539).

On August 27, 2013, the Single Commissioner issued an order finding that the Appellant suffered an injury to his right shoulder and right upper extremity. The Single Commissioner found that the Claimant cannot return to work as a firefighter. The Single Commissioner found that the Appellant suffered a permanent partial wage loss under § 42-9-20.

Respondents then filed a Form 30 appealing the order of the Single Commissioner. On December 16, 2013, the Appellate Panel reversed the order of the Single Commissioner and found that the Appellant only suffered an injury to this right shoulder and that the case should remanded to the jurisdictional commissioner for a hearing under §42-9-30.

Appellant appealed the December 16, 2013 order to the Court of Appeals on the following grounds: whether the Appellate Panel erred in reversing and remanding for a scheduled member disability award to the shoulder when the evidence showed disability should have been awarded under the loss of earning capacity statute and whether the Appellate Panel erred in holding that the Single Commissioner did not find the clavicle compensable. The Court of Appeals dismissed the appeal as being interlocutory.

The case was then remanded back to the Commission. On October 22, 2015, the Single Commissioner issued an order finding that Claimant suffered a 35% permanent partial disability to his right shoulder. The Single Commissioner also noted that his

review was limited to determining an award to the Claimant's right shoulder. Appellant then appealed to the Full Commission. The Full Commission issued an order on May 27, 2016 affirming the order of the Single Commissioner. Additionally, the Full Commission Panel ruled that the Appellant cannot challenge the order of the Full Commission dated May 5, 2014. This appeal was then timely filed.

STATEMENT OF THE FACTS

Appellant injured his right shoulder in the course and scope of his employment on October 8, 2008. Appellant was employed as a firefighter. Appellant had risen to the rank of captain. (R. p. 546). Appellant also worked at a bowling alley. (R. p. 557). Appellant also had a snack route stocking vending machines. (R. p. 558). Appellant initially went to the ER with complaints to the right shoulder. (R. p. 438). The first orthopedist to see the Appellant was Dr. Spearman. The initial complaint was that of right shoulder pain. (R. p. 177). Appellant's care was then taken over by Dr. Jaskwhich on December 19, 2008. Dr. Jaskwhich noted that Claimant was suffering from popping and catching in his right shoulder. A MRI showed a superior labral tear. (R. p. 175). Dr. Jaskwhich performed a right shoulder arthroscopic repair of superior labrum anterior-posterior (SLAP) tear on January 29, 2009. (R. p.144). In the follow up notes, Dr. Jaskwhich only discusses problems with the Claimant's shoulder. (R. pp. 170-174). Dr. Spearman performed the second arthroscopic procedure on Claimant's right shoulder in October of 2009.[1] (R. p. 166). Dr. Jaskwhich then took over the Claimant's follow up care post surgery. Dr. Jaskwhich noted in May of 2010 that Claimant's chief complaint was for right shoulder pain. (R. p. 164). Dr. Jaskwhich did not recommend

[1] Appellant's brief erroneously states that Dr. DeMarco performed all 4 surgeries that the Appellant underwent on his right shoulder. (Appellant's Brief, p. 5).

additional surgery. On July 14, 2010, Dr. Jaskwhich noted that although the Claimant still had right shoulder pain, he was at maximum medical improvement. (R. p. 162). Dr. Jaskwhich assigned a 10% rating to the right shoulder based on his persistent pain, soreness and weakness in his right shoulder.

Appellant's care was then transferred to Dr. DeMarco. On the new patient information form, Claimant indicated the location of his pain was the right shoulder. (R. p. 134). Dr. DeMarco first saw the Claimant on August 6, 2010. The chief complaint listed was a right shoulder injury. (R. pp. 124-125). On October 11, 2010, Dr. DeMarco performed the third surgery on Claimant's shoulder, a sub-acromial decompression and excision of glenohumeral ligament with previous SLAP repair and debridement. (R. p. 122).

Appellant's last surgery was on March 29, 2012. (R. pp. 138-139). Appellant contends that this specifically was intended to alleviate arm pain. However, prior to the surgery on March 19, 2012, the parties had agreed to a consent order that Appellant had an injury to his right shoulder and was to return to Dr. DeMarco for more surgery. The consent order does not mention the arm, bicep or clavicle. (R. p. 1). It seems logical that had the Appellant felt that this surgery was really intended for his arm as oppose to his shoulder that the consent order entered into mere weeks before surgery would address this. Surgery was performed on March 29, 2012. The preoperative diagnosis was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions, right shoulder subacronial impingement with adhesions and right shoulder long head of biceps tendinopathy. The post operative diagnosis was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions,

right shoulder subacronial impingement with adhesions and right shoulder long head of biceps tendinopathy. (R. p. 138).

August 7, 2012 was the last time Appellant was seen by Dr. DeMarco. Under history of present illness, the right shoulder was listed. The examination was to the Appellant's right shoulder. Shoulder pain was listed under the assessment section and treatment section. Dr. DeMarco also stated that:

> At this point the patient is at MMI and has permanent partial restrictions of less than 40 pounds of overhead lifting with both hands and no more than 20 pounds with his right arm overhead. Less than 50 pounds of two handed carrying and pushing and pulling. He can do a medium level job. **He has a permanent partial impairment of 9%.** 3% for biceps atrophy, 3% for loss of internal rotation, 2% for loss of forward flexion and 1% for pain muscles spasm. I do not predict any further surgical intervention in the next year however if he regresses with his pain he may need repeat corticosteroid injections, anti-inflammatories and/or physical therapy.

(R. pp. 103-104).

STANDARD OF REVIEW

The Administrative Procedures Act ("APA") provides the standard for judicial review of decisions by the Commission. Pierre v. Seaside Farms, Inc., 386 S.C. 534, 540, 689 S.E.2d 615, 618 (2010); Lark v. Bi-Lo, Inc., 276 S.C. 130, 133-34, 276 S.E.2d 304, 306 (1981). Under the APA, this court can reverse or modify the decision of the Commission if the substantial rights of the appellant have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. S.C. Code Ann. § 1-23-380(5)(d), (e) (Supp. 2011); Transp. Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 427, 699 S.E.2d 687, 689-90 (2010).

The Commission is the ultimate factfinder in workers' compensation cases. Shealy v. Aiken Cnty., 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). As a general rule, this court must affirm the findings of fact made by the Commission if they are supported by substantial evidence. Pierre, 386 S.C. at 540, 689 S.E.2d at 618. "Substantial evidence is that evidence which, in considering the record as a whole, would allow reasonable minds to reach the conclusion the Commission reached." Hill v. Eagle Motor Lines, 373 S.C. 422, 436, 645 S.E.2d 424, 431 (2007). "The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission's finding from being supported by substantial evidence." Id.

ARGUMENT

I. The Appellate Panel was correcting in reserving the Single Commissioner's decision and in remanding this case under §42-9-30 for a determination of permanent partial disability to the shoulder.

Appellant argues that the issues on appeal in this case are the same as the issues on appeal in Gilliam v. Woodside Mills, 461 S.E.2d 818, 319 S.C. 385 (1995). In Gilliam, claimant had a total hip replacement and the issue on appeal was whether the hip was part of the leg. Appellant's claim that as the Gilliam case addressed whether hip was part of the leg; the same analysis should be applied to the shoulder and arm, specifically the biceps in the case at bar. On the 14B completed by Dr. DeMarco on September 4, 2012, he indicated that Claimant injured his right shoulder. The September 4, 2012, 14B has a right shoulder rating and a conversion of the rating to the right upper extremity but there are not two separate ratings to two different body parts. (R. p. 449). Although the biceps are referenced in the medical records pertaining to the fourth surgery, all of the Claimant's treatment was to the shoulder and all of Dr.

DeMarco's treatments are clearly to the shoulder. Furthermore, the Gilliam case was decided prior to the hip becoming a separately listed scheduled injury and should not apply in this case. Both the shoulder and arm are already separate scheduled members. The substantial evidence in this case makes it clear that injury was only to the shoulder. Therefore, the Gilliam case clearly does not apply to this matter.

The Appellate Panel was correct in finding that the injury to the Appellant was limited to the shoulder and thus any award for disability should be made pursuant to S.C. Code § 42-9-30 not S.C. Code § 42-9-20. The only injury was to the Claimant's right shoulder. Claimant did not suffer an injury to his right upper extremity. As outlined in the statement of facts, Appellant underwent a total of four **shoulder** surgeries. The Appellant's argument that the Claimant suffered an injury to his right upper extremity or biceps relies entirely on questionnaires drafted by Claimant's attorney as oppose any of the actual medical records. Furthermore, this issue was addressed in the 2014 order of the Full Commission when the Commission found that it was more appropriate to give weight to the opinions given in the various reports as oppose to the check box reports cited by the Appellant. Although medical evidence "is entitled to great respect," the Commission is not bound by the opinions of medical experts and may disregard medical evidence in favor of other competent evidence in the record. Potter v. Spartanburg Sch. Dist. 7, 395 S.C. 17, 23, 716 S.E.2d 123, 126 (Ct. App. 2011). The actual treatment records show that the injury was to the Appellant's shoulder and the questionnaires should not be given any weight in a review of the evidence.

The evidence is clear that the claimant suffered from only a shoulder injury. Dr. DeMarco completed two 14B's during the tenure of his treatment of the Appellant. On the 14B from May 16, 2011, Dr. DeMarco indicated that Claimant injured his right

shoulder. (R. p. 100). On the second 14B completed by Dr. DeMarco on September 4, 2012, he again indicated that Claimant injured his right shoulder. On the Form 14B dated September 4, 2012, it has a right shoulder rating and a conversion of the rating to the right upper extremity but it does not have two separate ratings for two different body parts. (R. p. 449). Therefore, as the injury was just to the shoulder as reflected by the impairment ratings any award should have been limited to §42-9-30.

Appellant quotes part of a medical record dated November 22, 2011 in trying to assert that the fourth surgery was specifically for arm pain. The November 22, 2011 note is the last note in the record prior to the Claimant's last surgery on his shoulder and states:

> At this point, Mr. Contreras continues to complain persistently of long head biceps[2] and bicipital groove pain. **There is approximately a 5 cm section of the long head of the biceps that we are unable to visualize arthroscopically on a routine arthroscopy; however, on selected patients with persistent pain in this area, we will go ahead take down the transverse ligament and the bursal sac in the area and visualize the long head of the biceps and certainly at this point do a biceps tenodesis on him. I would also do a coracoid decompression to take off the impingement that he is getting from his coracoid onto the anterior suscapularis and bicipital groove area.** He has failed injections, it has been over a year, he continues having pain, and the 1 thing about him is that he has been completely consistent with where his pain is, directly over the bicipital groove. We looked at his biceps in the intraarticular position. I pulled in as much of the biceps into the joint, and this is typically what we do, and in that region it appeared normal and so I did not decide to look further release anything. We did remove his previous sutures from his previous repair and did a bursectomy and decompression, an AC joint resection. This did help with some of the other pain, but he is left with biceps pain which now needs to be addressed. This is still a worker's comp injury as directly and causally related to his injury on 10/08/2008. **This is absolutely the last thing that can be done in the shoulder, and after doing a tenodesis, a coracoid decompression, I told him whatever pain or discomfort is left in the shoulder he will have to live with.** We will need to get clearance from worker's comp, and his postoperative course would be similar with physical therapy a couple times a week starting around 4-5 weeks postoperatively and going for

[2] The long head biceps is the tendon that attaches the biceps to the bones in the shoulder. Orthoinfo.aaos.org. Website for the American Academy of Orthopaedic Surgeons.

about 6 or 8 weeks. If we can get this done, I will see him in the end of December for surgery. (R. p .114). Emphasis added on portions omitted from Appellant's brief.

The statement in Appellant's brief that this record confirms that the fourth surgery was intended to specifically alleviate arm pain is incorrect. The surgery was clearly done to address ongoing issues with the Appellant's shoulder. Moreover, under the chief complaint section of the record from November 22, 2011, it lists "pain over the anterior aspect of the shoulder even when he just hangs it down or reaches behind him in extended position. It gets flared up by the simplest procedures, whether it is lifting or doing light yard work; even if he comes off the Celebrex, he continues to have pain and discomfort." (R. p. 114). The arm or bicep is not mentioned in the chief complaint portion or in the physical exam portion of this record.

The Commission was correct in finding that the Claimant's injury was limited to the Appellant's shoulder. Appellant argues that the August 27, 2013 Single Commissioner order was correct in finding the Claimant injured his right upper extremity. The Single Commissioner's order was not supported by substantial evidence. The findings made by the Single Commissioner do not rely on the medical records from treating physicians but instead rely on questionnaires and on an IME. Appellant cites to the Single Commissioner's reference to Dr. Hughes' opinion. Dr. Hughes was hired by the Appellant's attorney for purposes of an IME and saw the Appellant once on October 6, 2011. Dr. Hughes' IME report notes that the Claimant injured his right shoulder. (R. p. 97). Furthermore, Dr. Hughes did not see the Appellant after his fourth and final surgery.

Appellant makes the conclusory statement in his brief that the Appellate Panel substituted its own medical opinion for the opinions of the doctors. Appellant asserts

that Burnette case is on point and that the Appellate Panel substituted its own medical opinion for that of the doctors. In Burnette, the court found that prior orders were not supported by substantial evidence. There was no evidence that the findings made by the commission originated from a medical provider and was forced to conclude that it was the medical opinion of the single commissioner. Burnette v. City of Greenville, 401 S.C. 417 737 S.E.2d 200 (Ct. App. 2012). In the case at bar, the medical evidence clearly supports the findings of the Appellate panel as discussed at length in the facts section of this brief. Furthermore, it appears that the Appellant is substituting his opinion of that of the doctor's opinion by asserting that the fourth surgery was to alleviate arm pain.

Additionally, there seems to be an assumption that because the word biceps is used that this automatically means that the arm is involved. No medical testimony was elicited by either side and there is no evidence that use of the term biceps refers to the arm. The biceps attaches to the shoulder and arguable the term is being used as part of the shoulder. The operative note from October 11, 2010, gives a lengthy description of the procedure which is clearly a procedure on the Claimant's shoulder and references the bicep tendon as it attaches to the shoulder joint not as separate injury. (R. pp. 140-141). Furthermore, as noted in the November 22, 2011, the pain and treatment was for the Appellant's shoulder. (R. p. 114).

The rating from Dr. DeMarco states that Appellant has an 9% impairment to the shoulder and that this rating includes 3% biceps atrophy, 3% loss of internal rotation, 2% for loss of forward flexion and 1% for pain and muscle spasm. (R. p. 104). The reference to the biceps is included as part of the shoulder in the rating assigned by Dr. DeMarco.

The medical records in this case clearly show that the years of medical treatment were all pertaining to the Appellant's shoulder. Other than the check the box questionnaires prepared by Claimant's attorney and presented to the doctors, there is little reference to any other body parts other than the Claimant's shoulder. Dr. DeMarco completed a questionnaire prepared by Claimant's attorney. As noted by the Commission, this was essentially a check the box questionnaire. (R. p. 49). This is the only reference in the medical records to the upper extremity being affected. The Commission has the ability to weigh and disregard medical evidence when there is other evidence in the record which is exactly what the Commission did in this case. The Commission clearly relied on the medical records and disregarded the medical questionnaires prepared by the Claimant's attorney.

Appellant relies on Singleton v. Young Lumber Co., 236 S.C. 454, 114 S.E. 2d 837 (1960), for the proposition that in order for a claimant to obtain compensation in addition to a scheduled member, the claimant must show that some other part of his body is affected. In Simmons v. City of Charleston, 349 S.C. 64, 76, 562 S.E.2d 476, 482 (Ct. App. 2002), this court held that if there is substantial evidence presented that shows that the claimant suffers additional complications to another part of the body, other than the scheduled member, the claimant is entitled to proceed under the general disability statute. However, as noted by the Simmons court, there still must be a showing of substantial evidence to demonstrate that additional body parts were affected. Substantial evidence must be a higher standard than just having a doctor sign off on a "check the box" questionnaire. The substantial evidence in the record does not support a finding that more than one body part was affected. The overwhelming evidence in this case is that Appellant only injured his right shoulder. More importantly,

there is substantial evidence in the record to support the findings of the Commission's order and it should be affirmed.

II. The Appellate Panel was correct in finding that the Appellant did not suffer a wage loss under § 42-9-20.

The Full Commission Order of May 2014 was correct in finding that case should be remanded to determine an awarded under the scheduled member statute as oppose to a wage loss case. The only injury was to the Claimant's right shoulder. Claimant did not suffer an injury to his right upper extremity. The medical evidence clearly supports this. Appellant initially went to the ER with complaints to the right shoulder. (R. p. 438). The first orthopedist to see the Appellant was Dr. Spearman. The initial complaint was that of right shoulder pain. (R. p. 177). Appellant's care was then taken over by Dr. Jaskwhich on December 19, 2008. Dr. Jaskwhich noted that Claimant was suffering from popping and catching in his right shoulder. A MRI showed a superior labral tear. (R. p. 175). Dr. Jaskwhich performed a right shoulder arthroscopic repair of superior labrum anterior-posterior (SLAP) tear on January 29, 2009. (R. pp. 144-145). In the follow up notes, Dr. Jaskwhich only discusses problems with the Claimant's shoulder. Dr. Spearman performed the second arthroscopic procedure on Claimant's right shoulder in October of 2009. (R. p. 166). Dr. Jaskwhich then took over the Claimant's follow up care post surgery. Dr. Jaskwhich noted in May of 2010 that Claimant's chief complaint was for right shoulder pain. (R. p. 164). Dr. Jaskwhich did not recommend additional surgery. On July 14, 2010, Dr. Jaskwhich noted that although the Claimant still had right shoulder pain, he was at maximum medical improvement. (R. p. 162). Dr. Jaskwhich assigned a 10% rating to the right shoulder based on his persistent pain, soreness and weakness in his right shoulder.

Appellant's care was then transferred to Dr. DeMarco. On the new patient information form, Claimant indicated the location of his pain was the right shoulder. (R. p. 134). Dr. DeMarco first saw the Claimant on August 6, 2010. The chief complaint listed was a right shoulder injury. On October 11, 2010, Dr. DeMarco performed the third surgery on Claimant's shoulder, a sub-acromial decompression and excision of glenohumeral ligament with previous SLAP repair and debridement. (R. p. 122).

Appellant's last surgery was on March 29, 2012. Appellant contends that this specifically was intended to alleviate arm pain. However, prior to the surgery on March 19, 2012, the parties had agreed to a consent order that Appellant had an injury to his right shoulder and was to return to Dr. DeMarco for more surgery. The consent order does not mention the arm, bicep or clavicle. (R. p. 1). It seems logical that had the Appellant felt that this surgery was really intended for his arm as oppose to his shoulder that the consent order entered into mere weeks before surgery would address this. Surgery was performed on March 29, 2012. The preoperative diagnosis was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions, right shoulder subacronial impingement with adhesions and right shoulder long head of biceps tendinopathy. The post operative diagnosis was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions, right shoulder subacronial impingement with adhesions and right shoulder long head of biceps tendinopathy. (R. p. 138). Clearly, all of the treatment was for the right shoulder and that any award should be issued under § 42-9-30 not § 42-9-20.

The Appellate Panel of May 5, 2014 did explain the reversal of the Single Commissioner's disability award by finding that the case was limited to recovery under

§42-9-30. Appellant argues that there is evidence of the loss of earnings capacity. No doubt in a lot of work compensation cases, the claimant could argue that they suffered a loss of earnings capacity; however, this in and of itself does not make a loss of earnings capacity case. The mere fact that the Appellant cannot return to work as a firefighter also does not make it a loss of earnings capacity case. The Appellate Panel made findings of fact that are supported by the substantial evidence in the record. Nothing requires a detailed explanation as to how the panel arrived at its findings, the issue on the appeal is whether the findings are supported by the evidence or if there is an error of law. The Appellate Panel found after a *de novo* review of the record which included extensive medical records that the Appellant only suffered an injury to the shoulder. If the Appellant only suffered an injury to one body then, he is only entitled to an award under §42-9-30.

III. The Appellate Panel was correct that the clavicle was not found compensable and that this issue was not preserved on appeal.

Appellant argues that the Single Commissioner's order did not making a specific finding as to the clavicle and that this issue has never been addressed. Had the Appellant wanted to preserve the issue of the whether the clavicle was compensable and felt that the Single Commissioner should have addressed it, he should have appealed this issue to the Appellate Panel. Issues not raised on appeal are not preserved for review. Rodney v. Michelin Tire Corp., 320 S.C. 515, 466 S.E.2d 357 (S.C. 1996).

However, if the Court believes that the Appellant did properly preserve this issue on appeal, it is clear that the Appellant's clavicle was not injured as a result of this accident. Appellant tries to argue that the terminology distal clavicle resection and right

shoulder acromioclavicular joint means that the clavicle or collarbone is involved. There is no medical evidence to support this. Specifically, Appellant references the third surgical procedure that was done as proof that his clavicle was injured. The post surgical note of October 20, 2010 lists the chief complaint as status post right shoulder SAD and excision of glenohumeral ligament with previous SLAP repair and debridement. (R. p. 122).[3] On January 21, 2011, Dr. DeMarco assigns an impairment rating of 7% to the right upper extremity which converts to an 11% shoulder impairment. (R. p. 119). This rating is prior to Appellant's fourth surgery. There is no mention of the clavicle or collarbone as being involved when Dr. DeMarco assigned an impairment rating following the third surgery.

Dr. Hughes, who only saw the Appellant once, is the only doctor who found that the clavicle was injured. Dr. Hughes, an orthopedist who performed an IME issued a 14% rating to the shoulder and did not issue a separate rating to Claimant's upper extremity. On the check the box questionnaire supplied to Dr. Hughes by the Claimant's attorney, Dr. Hughes left it blank when asked if there was any impairment to the upper extremity. (R. p. 95). Dr. Hughes wrote in the words "distal" and "A-C joint" next to clavicle when asked about ratings. The distal clavicle and the A-C joint are different from the clavicle. This is the only reference to the clavicle being injured. Neither Dr. DeMarco nor Dr. Jaskwhich the primary treating physicians ever reference an injury to the clavicle.

[3] A SLAP tear is an injury to the labrum of the shoulder, which is the ring of cartilage that surrounds the socket of the shoulder joint. www.orthoinfo.aaos.org

IV. Appellant failed to preserve any issue regarding payment of temporary partial disability benefits.

Appellant argues that the Single Commissioner would have been within the remand instructions for the Single Commissioner to order TPD. The Single Commissioner found that he could not address any other issues beyond PPD as the remand was clearly just for a determination under §42-9-30. As the Single Commissioner's order doesn't address TPD, this issue isn't properly before the Appellate Panel and therefore this Appellate Panel is without jurisdiction to address this issue. If the Court does address this issue, the calculation presented by the Appellant is not supported by the record.

Appellant alleges that the Claimant should be entitled to 80 weeks of TPD from January 20, 2011 through August 7, 2012. As noted by the Appellant, a Form 17 was signed by the Appellant. (R. p. 71). The Form 17 reflects that TT was paid from October 18, 2010 through September 4, 2011. Temporary total benefits actually continued until September 25, 2011 as the Form 17 wasn't filed until September 30, 2011. The Full Commission found that the Claimant was paid temporary total benefits from October 18, 2010 through September 25, 2011 and that benefits were suspended as a result of a signed Form 17 filed on September 30, 2011. (R. p. 48). Finding of Fact #25 was not part of the 2013 Single Commissioner's order. This finding is critical as it shows that temporary total benefits were properly suspended as a result of the Form 17 being signed.

Claimant argues that Finding of Fact #27 of the Full Commission order dated May 5, 2014 requires the Single Commissioner to order temporary partial disability. Finding of Fact #27 was in the 2013 Single Commissioner's order and clearly was just

left in the Full Commission order as there was no directive to remove it. Finding of Fact # 27 which is the same in both the Single Commissioner's order and the Full Commission's order was not appealed which is why it remained in the Full Commission's order. As Claimant signed a Form 17, there was no reason for his weekly benefits to resume. Furthermore, Claimant was paid the maximum comp rate for 2008 and would not be entitled to any other temporary total benefits for this period. There was never a request to restart weekly benefits by the Claimant. Appellant contends that he should receive 80 weeks of TPD benefits but provides no basis for this calculation. It appears that Appellant is alleging that TPD benefits should start from January 20, 2011 however clearly, based on the dates of the Form 17, Appellant was receiving TT benefits until September 25, 2011. Furthermore, the carrier overpaid TT benefits from June 21, 2011 and should be awarded a credit for this time. Claimant would receive a windfall if this is ordered.

Appellant alleges that in May 5, 2014 Appellate Panel order (R. pp. 35-51), the omission of the Single Commissioner's finding of fact #28 on temporary partial wage loss is an error. Appellant raises issues from the Appellate Panel order filed May 5, 2014, that were not previously raised on Appellant's first appeal to the Court of Appeals and the Appellate should be barred from arguing these issues on appeal. On May 5, 2014, the Appellate Panel reversed the order of the Single Commissioner and found that the Appellant only suffered an injury to his right shoulder and that the case should remanded to the jurisdictional commissioner for a hearing under §42-9-30. Appellant then filed their first appeal and raised the following issues: whether the Appellate Panel erred in reversing and remanding for a scheduled member disability award to the shoulder when the evidence showed disability should have been awarded

under the loss of earning capacity statute and whether the Appellate Panel erred in holding that the Single Commissioner did not find the clavicle compensable. The Court of Appeals dismissed the appeal as being interlocutory. Appellant can not decided that they now want to appeal additional issues from that order. Issues not raised on appeal are not preserved for review. Rodney v. Michelin Tire Corp., 320 S.C. 515, 466 S.E.2d 357 (S.C. 1996).

CONCLUSION

For all of the foregoing reasons, the order of the Commission should be affirmed in its entirety.

Respectfully Submitted,

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March 1, 2017

THE STATE OF SOUTH CAROLINA
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Workers' Compensation Commission

Case No.: 2016-001247

Thomas Contreras, Employee, ... Appellant

v.

St. Johns Fire District, Employer, and State Accident Fund, Carrier, ... Respondent

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PROOF OF SERVICE

I certify that I have served the Respondents' Brief and Certificate of Counsel upon the Appellant by mailing a copy of the same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below address as follows:

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Charleston, South Carolina
March 2, 2017

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
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I certify that I have served the Respondents' Brief and Certificate of Counsel upon the Appellant by mailing a copy of the same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below address as follows:

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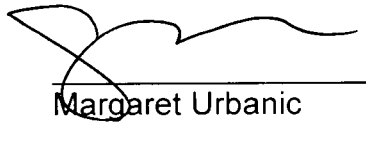

Margaret Urbanic

Charleston, South Carolina
March 2, 2017

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Case No.: 2016-001247

Thomas Contreras, Employee, ... Appellant

v.

St. Johns Fire District, Employer, and State Accident Fund, Carrier, ... Respondent

---

PROOF OF SERVICE

I certify that I have served the Respondents' Brief and Certificate of Counsel upon the Appellant by mailing a copy of the same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below address as follows:

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CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Final Brief complies with Rule 211(b), SCACR.

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