THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

APPEAL FROM SOUTH CAROLINA
WORKER'S COMPENSATION COMMISSION

Supreme Court Opinion No. 27708
(filed March 8, 2017)

HENTON T. CLEMMONS, JR., EMPLOYEE,.....PETITIONER,

v.

LOWE'S HOME CENTERS, INC.-HARBISON, EMPLOYER, AND
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.,
CARRIER,.....RESPONDENTS.

PETITION FOR REHEARING AND REQUEST FOR ORAL ARGUMENT

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Pursuant to Rules 221(a) and 240, SCACR, Respondents Lowe's Home Centers, Inc.-Harbison, and Sedgwick Claims Management Services, Inc. hereby petition this Court for rehearing of its Opinion No. 27708. This Court not only overlooked and misapprehended the proper statutory interpretation of S.C. Code Ann. § 42-9-30(21), but also usurped the Commission's fact finding role. In particular, this Court engaged in impermissible fact finding based on arguments that are not preserved for appellate review and rendered a medical conclusion/opinion based on evidence not in the Record. In addition, this Court's interpretation of Section 42-9-30(21) is based on a flawed and incorrect statutory interpretation, which will produce absurd and unintended results. Finally, even assuming for the sake of argument that claimant Henton T. Clemmons, Jr., ("Claimant") met his burden of proving a greater than 50% loss of use of his back, this matter must be remanded to the Commission to determine whether Employer can rebut the presumption of total and permanent disability, in light of this Court's overruling of Watson v. Xtra Mile Driver Training, Inc., 399 S.C. 455, 732 S.E.2d 190 (Ct. App. 2012), and, if so, what Claimant's disability rating between 50% and 100% should be.

1. **This Court erred by basing its Opinion on an argument that is unpreserved for appellate review.**

The issue of whether and/or how Dr. Drye's whole person rating should be converted to a rating for Claimant's back – the core foundation of this Court's entire decision – is not preserved for appellate review. "Only issues raised and ruled upon by the commission are cognizable on appeal." Stone v. Roadway Express, 367 S.C. 575, 582, 627 S.E.2d 695, 698 (2006). Neither this Court nor Claimant can point to any evidence that Claimant raised to the Commission the argument or theory that Dr. Drye's

whole person rating converted to a regional spine rating. In fact, at the Commission level, Claimant argued that the Commission should not rely on Dr. Drye's medical reports and ratings ***at all***. Instead, he argued the Commission should focus ***only*** on the expert opinions submitted by Claimant. The entire basis of Claimant's argument at the Commission was that the expert opinions offered up by Claimant were stated in terms of "loss of use" or "loss of function," of the back," whereas Dr. Drye's were not. (Appx. pp. 329-330; p. 432, lines 16-21; p. 434, lines 4-8). Not once did Claimant suggest to the Commission that Dr. Drye's rating should be converted or that Dr. Drye's rating actually supported a finding of 50% or greater loss of use of the back. In fact, because Claimant apparently understood that Dr. Drye's rating supports a finding of less than 50% loss of use of the back, he quickly obtained two other medical opinions, (Appx. pp. 233-240), and opinions from a vocational rehabilitation manager, (Appx. pp. 241-263), and from a physical therapist, (Appx. pp. 208-232), which he offered ***in opposition*** to Dr. Drye's ratings.

The first time Claimant raised the "conversion" argument in any context was at oral argument before the Court of Appeals. In fact, Claimant's counsel prefaced his entire argument before the Court of Appeals with a statement to the effect that this "conversion" argument "had just occurred" to him. And, when he raised the issue of conversion in his Petition for Rehearing to the Court of Appeals, (Appx. pp. 479-509), it was with respect to his argument that Dr. Drye should have provided Claimant a separate rating for his myelopathy and lower back, and ***not*** that Dr. Drye's converted rating really supported a finding of 50% or greater loss of use of the back. (Appx. pp. 501-504). Instead, Claimant continued to argue that, "[t]he only evidence submitted on the

functional loss of use of the Claimant's back to do work requiring the use of his back was that of the Claimant and two (2) doctors." (Appx. p. 539). Mazloom v. Mazloom, 392 S.C. 403, 403-404, 709 S.E.2d 661, 661 (2011) (an issue not addressed by the Court of Appeals and not raised in a party's petition for rehearing is not preserved for appellate review). Claimant did not assert that Dr. Drye's 25% whole person rating converted to a 71% regional "spinal rating" as part of his argument regarding Section 42-9-30(21) until his Cert Petition and Brief to this Court. (Pet. for Writ of Cert. p. 18) (Pet. Br. p. 18).

It is axiomatic that an argument or theory of a case that is raised for the first time on appeal is not preserved for appellate review. Herron v. Century BMW, 395 S.C. 461, 465, 719 S.E.2d 640, 645 (2011); *see also* Foster v. Foster, 393 S.C. 95, 99, 711 S.E.2d 878, 880 (2011) (an argument not raised to the lower courts is not preserved for this Court's appellate review); Rodney v. Michelin Tire Corp., 320 S.C. 515, 517, 466 S.E.2d 357, 358 (1996) (issues not raised to the Commission or to the lower appellate court are not preserved for appeal). In addition, an argument raised by an appellant based on different grounds from the argument presented to the trial court is not preserved for appellate review. Creighton v. Coligny Plaza Ltd. P'ship, 334 S.C. 96, 108, 512 S.E.2d 510, 516 (Ct. App. 1998). Nonetheless, this Court has adopted as the very core of its ruling an argument that clearly was not raised until Claimant's Cert Petition to this Court.

While a respondent who prevailed below can argue, and an appellate court can affirm a lower court decision, on the basis of any ground or fact supported by the Record, Rule 220(c), SCACR; I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 419-420, 526 S.E.2d 716, 723 (2000), the opposite is not the case. "[D]ifferent preservation rules apply to an appellant – the losing party in the lower court." Preservation rules, which this Court

appears to have ignored in Opinion No. 27708, prevent "a party from keeping an ace card up his sleeve – intentionally or by chance – in the hope that an appellate court will accept that ace card ..." Id. at 422, 526 S.E.2d at 724.

Importantly, in addition, "[a]n appellate court may not, of course, reverse for any reason appearing in the record." Id. at 421-422, 526 S.E.2d at 724 (emphasis in original); *see also* Mercer v. Phillips, 318 S.C. 453, 455, 458 S.E.2d 427, 429 (1995) (an appellate court cannot address an issue that was not raised to the lower tribunal). The reason an appellate court can "affirm the lower court's judgment for any reason appearing in the record on appeal," is because an "affirmance promotes judicial economy and finality in private and public affairs, which are important public policies." I'On, 338 S.C. at 420-421, 526 S.E.2d at 723. This Court's willingness to entertain and adopt as the centerpiece of its Opinion an argument that was not raised to the Commission or to the Court of Appeals violates all of these principles and, in the end, reaches a conclusion that is not only unfair but, as is discussed below, also is incorrect.

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition ("AMA Guides") on which both Claimant and this Court rely for converting Dr. Drye's 25% whole person impairment rating were not part of the Record before the Commission and are not part of the Record before this Court.[1] However, even if the AMA Guides were part of the appellate Record,[2] this Court's conversion is not proper because, among other reasons, Claimant failed to argue or assert that Dr. Drye's whole person impairment

[1] Respondents attach the relevant pages from the AMA Guides hereto as Exh. A for purposes of this rehearing argument.

[2] The significance of the fact that the AMA Guides are not part of the Record in this case is discussed in more detail below in Section 2.

rating converted to a 71% "cervical spinal rating" to the Commission or, for that matter, to the Court of Appeals.

In short, this Court has overruled a factual determination made by the Full Commission and affirmed by the Court of Appeals on the basis of a conversion calculation/argument that was never raised to either forum and based on evidence that is not in the Record. As a result, this Court should reconsider and reverse its Opinion No. 27708.

2. This Court engaged in impermissible fact finding in order to overturn the Commission's Finding of Fact that Claimant sustained a 48% permanent partial disability to his back.

"It is axiomatic that in a Workmen's Compensation case the [Commission] is the fact-finding body, and that in their review of a factual finding by the Commission the courts may not weigh the evidence, their function being limited to determination of whether or not such finding is supported by [substantial] evidence." Walker v. City of Columbia, 247 S.C. 241, 247, 146 S.E.2d 856, 859 (1966). Based on the medical evidence as a whole, the Commission found as a factual matter that Claimant had sustained a 48% partial disability to his back. As a result of that finding of fact, the Commission did not address the issue of whether the employer had rebutted the presumption of total and permanent disability that arises when a claimant has proven he sustained a 50% or greater loss of use of his back.[3] Relying on evidence that is not in the Record – in effect, offering a medical conclusion/opinion of its own – this Court converted Dr. Drye's "25% whole person impairment based on [Claimant's] injury to the cervical spine" to a regional spine impairment rating and concluded that that meant

[3] However, the Commission did address Claimant's separate argument that he was entitled to total and permanent disability under Section 42-9-10, (*see* Resp. Br. pp. 17-20), and held that he was not.

Claimant had lost 50% or greater use of his back. To do so constitutes reversible error for a number of reasons.

First, as noted above, this converted rating was not argued below and the issue is not preserved for appeal. Second, this converted rating is not supported in the Record. The AMA Guides are not in evidence. Although Claimant inappropriately attempted to submit portions of the 1958 AMA Journal in his briefing to this Court, even at that point, he did not attempt to submit any portion of the AMA Guides into the Record. Helms Realty, Inc. v. Gibson-Wall Co., 363 S.C. 334, 339, 611 S.E.2d 485, 487-88 (2005) (the appellant or petitioner bears "the burden of providing a sufficient record" for appellate review); Windham v. Honeycutt, 290 S.C. 60, 63-64, 348 S.E.2d 185, 187 (Ct. App. 1986) (same, and advising that appellate courts, "will not consider facts that do not appear in the transcript of record"). Any failure to provide a sufficient Record should fall on Claimant, as appellant and petitioner. Argument and advocacy by counsel – or the Court itself – do not constitute evidence. *See, e.g.*, Bowers v. Bowers, 304 S.C. 65, 68, 403 S.E.2d 127, 129 (Ct. App. 1991).

There is not one shred of evidence that either Dr. Drye or any other expert took Dr. Drye's whole person rating and converted it to a regional spine rating, much less to a rating for the whole back. Accepting that it is impermissible for commissioners to offer medical opinions that have not been rendered by an expert in the case, Burnette v. City of Greenville, 401 S.C. 417, 428, 737 S.E.2d 200, 206 (Ct. App. 2012) (rejecting a finding regarding an MRI "because no evidence indicates this opinion originated from a medical provider"), it is equally inappropriate for appellate courts to create and/or rely on medical conclusions that are not rendered by an expert. This Court either must overrule Burnette

and hold that the Commission and/or appellate courts may offer their own medical conclusions, or it must grant rehearing and agree that it is improper for an appellate court to offer its own medical opinion and then decide a case based on that opinion.

Third, setting aside the fact that there is no medical opinion, conclusion or Record evidence to support the conversion of Dr. Drye's whole person rating, the conversion that this Court performed rendered a ***whole person*** rating to a ***regional spine*** rating. As this Court pointed out, the scheduled member statute does not address impairment to the whole body. However, this Court overlooked or misapprehended the critical fact that the scheduled member statute does not address impairment to a ***region*** of the spine either. It does not address impairment to the cervical spine, or the thoracic spine or the lumbar and sacral spine, or even to the spine itself but to the ***back as a whole***. As a result, awards are not made to the cervical region, the thoracic region or the lumbar/sacral region. Awards are made to the back. *See, e.g.*, S.C. Code Ann. § 42-9-30(21) (providing compensation for "loss of use of the back ..."); Medlin v. Greenville County, 303 S.C. 484, 488, 401 S.E.2d 667, 669 (1991) (discussing proper award for successive injuries to a listed body part, "in this case, his back"); Fishburne v. ATI Syst. Int'l, 384 S.C. 76, 681 S.E.2d 595 (Ct. App. 2009) (award for loss of use of the back); Lyles v. Quantum Chem. Co., 315 S.C. 440, 434 S.E.2d 292 (Ct. App. 1993) (same).

There is no simple mathematical formula by which the Commission or this Court can convert a whole person rating to a whole back rating under the AMA Guides. Instead, the conversion calculation set forth on page 427 of the AMA Guides, which this Court apparently employed, converts "a whole person estimate" to "a regional estimate" for different parts of the spine. The cervical spine comprises only seven of the total 24

vertebrae that make up the cervical, thoracic and lumbar regions. (AMA Guides, p. 427, Exh. A). As a result, the conversion, which is not in the Record but which this Court holds is conclusive, simply and clearly does not correlate to loss of use of the back pursuant to Section 42-9-30(21). Critically and tellingly, neither Claimant nor this Court can point to any expert or medical evidence or opinion in this Record that supports a conversion of Dr. Drye's whole person impairment based on the injury to Claimant's cervical spine to a whole back impairment rating.[4] Instead, the Commission is the entity that is statutorily authorized to weigh impairment ratings under the AMA Guides, along with other medical/expert opinions and lay evidence, and determine a claimant's disability or loss of use rating.

The impact of this Court's ruling cannot be overstated. Under this Court's application of "converted ratings" under the AMA Guides, there will never be a case where an employee who has undergone an anterior cervical discectomy with a fusion can ever be awarded anything less than 50% loss of use under Section 42-9-30(21). Per the example on page 394 of the AMA Guides, those facts result in a 25% impairment rating of the whole person based on the cervical spine which, according to this Court, automatically converts to a 71% loss of use/impairment rating. In the referenced example, the subject "[h]ealed uneventfully and returned to work 4 months after the injury." (AMA Guides, p. 394, Exh. A). However, under this Court's analytical

[4] This Court also "converted" Dr. Forrest's impairment ratings (30% to the neck and 10% to the lower back) to a 99% "regional impairment to [Claimant's] back," even though Dr. Forrest did not indicate which version of the AMA Guides to the Evaluation of Permanent Impairment, if any, he was using to rate Claimant. The Fourth and Sixth Editions of those Guides do not contain the same "conversion" calculations as does the Fifth Edition of the AMA Guides.

framework, the subject would not only be presumed, but conclusively deemed totally and permanently disabled.[5]

Fourth, if this Court believes Dr. Drye's impairment rating does not support the Commission's finding of 48% disability to Claimant's back, the proper remedy is to remand to the Commission for a factual determination of the degree to which Claimant has lost the of use of his back. The Commission's determination of the degree of loss of use under Section 42-9-30 is "an issue of fact; and the Commission's determination of that issue is conclusive" when it is supported by substantial evidence. Roper v. Kimbrell's of Greenville, Inc., 231 S.C. 453, 455, 99 S.E.2d 52, 53-54 (1957). And, as this Court is aware, in making this determination the Commission has "discretion to weigh and consider all the evidence, including both lay and expert testimony." Ballenger v. Southern Worsted Corp., 209 S.C. 463, 467, 40 S.E.2d 681, 682-683 (1946); *see also* Lyles, 315 S.C. at 443-445, 434 S.E.2d at 294-295 ("[t]he commission may find a degree of disability different from that suggested by expert testimony"); Fishburne, 384 S.C. at 87-88, 681 S.E.2d at 600 (the Commission "is not bound by the opinion of medical experts and 'may find a degree of disability different from that suggested by expert

[5] Respondents note, for frame of reference, that professional football player Peyton Manning underwent successive cervical surgeries, ending with a fusion. He later went on to win Super Bowl 50, evidencing his functional capability to use his back. *See*, https://www.washingtonpost.com/sports/redskins/peyton-manning-on-his-neck-surgeries-rehab--and-how-he-almost-didnt-make-it-back/2013/10/21/8e3b5ca6-3a55-11e3-b7ba-503fb5822c3e_story.html?utm_term=.629578dd2045; http://www.cbssports.com/nfl/news/peyton-mannings-super-bowl-stats-are-really-close-to-another-great-qb/

testimony'" by considering both lay and expert testimony), *citing* Tiller v. National Health Care Ctr. of Sumter, 334 S.C. 333, 340, 513 S.E.2d 843, 846 (1999).[6]

In the instant case, there was substantial lay testimony that Claimant was able to stand for most of an 8-hour shift, for 40 hours per week, for nearly two years, without needing a chair to sit in, without seeking additional medical treatment, and without any prescription pain medications. (Appx. p. 368, line 4 – p. 369, line 18) (Appx. p. 371, lines 2-23) (Appx. p. 407, lines 2-17) (Appx. p. 409, line 19 – p. 410, line 15) (Appx. p. 415, line 23 – p. 416, line 1). This evidence demonstrates Claimant's functional capability to use his back. Therefore, if this Court believes Dr. Drye's medical records do not support the Commission's disability award then, because the determination of Claimant's loss of use of his back is not limited strictly to expert medical evidence, the Commission should be allowed to re-evaluate the record as a whole and determine Claimant's loss of use in the first instance.

Once that determination has been made and, if it is determined that Claimant has lost 50% or greater of the use of his back, then the Commission must decide, in the first instance, whether the presumption has been rebutted. Given the 48% disability award, the Commission did not reach this issue, and it is the Commission's role as the "ultimate factfinder" in workers' compensation cases, *e.g.,* Ross v. American Red Cross, 298 S.C. 490, 492, 381 S.E.2d 728, 729 (1989), to make this finding of fact.

If the Commission finds that the presumption has been rebutted, the Commission then should determine the precise degree of loss of use between 50% and 100% and make an award accordingly. Any other process usurps the Commission's fact finding role. *See*

[6] The Dissent properly points out the concern that the Majority opinion may well be read as holding that only expert medical evidence is relevant to a disability award for loss of use of the back.

Burnette, 401 S.C. at 428, 737 S.E.2d at 206 (in workers' compensation cases "this court does not have the authority to find facts; that authority belongs to the Commission"); Sigmon v. Dayco Corp., 316 S.C. 260, 262, 449 S.E.2d 497, 498 (Ct. App. 1994) (explaining that the Commission, not the courts, is authorized to make factual findings).

This Court should reverse its erroneous factual findings and, if it believes Dr. Drye's impairment rating does not support the Commission's disability rating, remand for the Commission to make the proper findings of fact regarding loss of use and, if necessary, whether the presumption has been rebutted.

3. The Commission's finding that Claimant sustained a 48% permanent partial disability to his back is supported by substantial evidence and should be upheld.

This Court overlooked or misapprehended that substantial evidence supports the Commission's Finding of Fact that Claimant sustained a 48% permanent partial disability/loss of use to his back which should be upheld. As discussed above, there is no medical opinion converting Dr. Drye's 25% whole person impairment rating to loss of use of the cervical spine, let alone to loss of use of the whole back. Taking the medical evidence as a whole, the Commission's finding on this point must be upheld. Where there is a conflict in the evidence, either by different witnesses or the testimony of the same witness, the factual findings of the Commission are conclusive. Anderson v. Baptist Med. Ctr., 343 S.C. 487, 492-93, 541 S.E.2d 526, 528 (2001).

The medical reports provided Claimant with conflicting impairment ratings: Dr. Drye, Claimant's neurosurgeon and treating physician assigned Claimant "a 25% whole person impairment based on his injury to the cervical spine," (Appx. pp. 177-179); Dr. Margalit, with Sunset Family Practice, opined that Claimant had "lost more than 50% of

the functional capacity of his back to work," (Appx. p. 237), and, responding to a questionnaire drafted by Claimant's counsel, agreed that "from a physical capacity standpoint and his physical ability to use his back to do full time work, has he lost more than 50% of the use of his back to do work with his back," (Appx. p. 238); Dr. Forrest also opined that Claimant sustained "over 50% loss of his functional capabilities," (Appx. p. 240); Dr. Howard Mandell indicated that the injury to Claimant's cervical spine "resolved very nicely after urgent surgical decompression and [Claimant] has made a remarkably good recovery, though not recovered to his preinjury level of functioning," and that Claimant did not need further treatment beyond, perhaps, physical therapy, and "will certainly need his future work adjusted and be selective in which jobs he can and cannot do," (Appx. pp. 206-207); and physical therapist Tracy Hill opined that Claimant qualified for a 28% whole person impairment rating, which she converted to an 80% cervical spine impairment, and an 8% whole person impairment rating which she converted to an 11% lumbar spine impairment. (Appx. 208-209).[7] Given the conflicting medical evidence, some of which addresses the cervical spine separately from the whole back, and some of which is couched in terms of loss of use to do work or loss of functional capability, it was the Commission's role as fact finder to resolve this conflicting evidence and, along with the other evidence in the Record,[8] determine

[7] The fact that Tracy Hill felt compelled to provide two separate whole person ratings, one she converted to a regional impairment rating to the cervical spine and one she converted to a regional impairment rating to the lumbar spine, supports Respondents' position that the regional impairment ratings are not "whole back" ratings but only relate to a specific region of the spine.

[8] As noted above, there was substantial testimony and evidence that Claimant was able to stand for 8 hours a day, 40 hours per a week for nearly two years with minor accommodations (never asking to use the chair provided for him and never asking for additional medical care), no pain prescription medication and no missed time. (Appx. p. 368, line 4 – p. 369, line 18) (Appx. p.

Claimant's disability/loss of use rating under Section 42-9-30(21). Both Dr. Drye's impairment rating and lay testimony in the record constitute substantial evidence that supports the Commission's loss of use determination, which should be affirmed.

As a result, this Court should reconsider its Opinion and hold that substantial evidence supports the Commission's finding that Claimant sustained a 48% permanent partial disability to his back.

4. This Court's statutory interpretation of Section 42-9-30(21) is flawed and must be reversed.

This Court's statutory interpretation of Section 42-9-30(21) is both legally and logically flawed, and must be reconsidered. While this Court correctly notes that, generally under the scheduled member statute, the ability to work or earn wages is not relevant, the presumption under Section 42-9-30(21) carves out an exception to that general rule. Recognizing that our Workers' Compensation Act is premised on two competing models of compensation – the so-called "economic" and "medical" models – this Court's following analysis presumes, erroneously, that ***all*** of the subsections of Section 42-9-30 are based strictly on the medical model and that, therefore, evidence that a claimant is able to earn the same wages and perform the same physical job duties after an injury as before the injury can never rebut the presumption of total and permanent disability that arises under Section 42-9-30(21).

This Court's Opinion relies heavily on Wigfall v. Tideland Utils., Inc., 354 S.C. 100, 580 S.E.2d 100 (2003). As noted by this Court in Wigfall, "[t]he two models are distinct in parts of the *S.C. Workers' Compensation Act* and intertwined in other parts." 354 S.C. at 104, 580 S.E.2d at 102. For example, while Subsection 42-9-10(A) follows

371, lines 2-23) (Appx. p. 407, lines 2-17) (Appx. p. 409, line 19 – p. 410, line 15) (Appx. p. 415, line 23 – p. 416, line 1).

the economic model, requiring proof of "the incapacity for work," Subsections 42-9-10(B)&(C) follow the medical model, providing compensation regardless of a claimant's ability to work. In other words, Section 42-9-10, although premised on the economic model, contains provisions that are "intertwined" with the medical model.

This Court's conclusion that the method of compensation under Section 42-9-30 "conclusively relies upon the medical model with its presumption of lost earning capacity," 354 S.C. at 105, 580 S.E.2d at 102, was correct at the time Wigfall was decided. However, the rebuttal language in what is now Section 42-9-30(21) was not part of the Act in 2003. *See* Act No. 111, Pt. I § 18, eff. July 1, 2007. In light of the 2007 changes to Section 42-9-30(21), this Court's analysis and conclusion are not accurate.

In fact, following the quotation in Wigfall cited by this Court, to the effect that a claimant can be deemed disabled and receive compensation "even though the claimant is able to work," (which is entirely true under the all of the subsections of Section 42-9-30 except for Subsection 21), this Court observed, "South Carolina has never recognized that a claimant can suffer a single scheduled injury and as a result become totally, permanently disabled." 354 S.C. at 109, 580 S.E.2d at 104. Clearly, the presumption of total and permanent disability under the current version of Section 42-9-30(21), as well as the ability to rebut that presumption, was not under consideration in Wigfall. Therefore, the language from Wigfall that underpins this Court's statutory analysis simply does not apply to the current version of Section 42-9-30(21).

Instead, as is described in more detail below, under the proper analytical framework, the initial determination of loss of use is made under the medical model, relying on both expert and lay evidence. Then, if it is determined a claimant has lost 50%

or greater of the use of his or her back, the presumption of total and permanent disability arises, and the analysis to determine whether that presumption is rebutted is made under the economic model. Then, if the presumption is rebutted successfully, the analysis returns to the medical model to determine the claimant's disability award, between 50% and 100%, if that has not already been determined.

Under all of the subsections of Section 42-9-30 except for Subsection 21, "the disability in each case is considered to continue" as listed in the various subsections. In other words, the inability to earn wages is conclusively established based on the degree of loss of use. Under Section 42-9-30(21), however, "where there is fifty percent or more loss of use of the back the injured employee shall be ***presumed*** to have suffered total and permanent ***disability***," which "***presumption*** ... is rebuttable." S.C. Code Ann. § 42-9-30(21) (emphasis added). The word presumption clearly is tied to the phrase "total and permanent disability," which informs what kind of evidence should be probative to rebut the presumption. Any other reading produces an absurd result. Kiriakides v. United Artists Commc'ns, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994).

Key to this analysis is the term "disability," which is defined in the Act. "The General Assembly has power to prescribe legal definitions of its own language, and such definitions are generally binding upon the Courts, and should prevail." Brown v. Martin, 203 S.C. 84, 88, 26 S.E.2d 317, 318 (1943). "[S]tatutory definitions should be followed in interpreting [a] statute." Weston v. Carolina Research & Dev. Found., 303 S.C. 398, 404, 401 S.E.2d 161, 164-165 (1991), *citing* Bell Fin. Co. v. South Carolina Dept. of Consumer Affairs, 297 S.C. 111, 114, 374 S.E.2d 918, 920 (Ct. App. 1988). "What a legislature says in the text of a statute is considered the best evidence of the legislative

intent or will." Wigfall, 354 S.C. at 110, 580 S.E.2d at 105. Here, the Legislature has defined the term "disability" – "***'disability' means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment***," S.C. Code Ann. § 42-1-120 – and courts are not free to ignore that definition.

"When interpreting a statute, the Court must read the language in a sense which harmonizes with its subject matter and accords with its general purpose." Allen v. South Carolina Pub. Emp. Ben. Auth., 411 S.C. 611, 769 S.E.2d 666 (2015). As stated in Stephenson v. Rice Servs., Inc., the purpose of the Act is "to compensate workers for reductions in their earning power caused by work-related injuries or accidents." 323 S.C. 113, 116, 473 S.E.2d 699, 700 (1996). Because the Act is "in derogation of the common law," it must be strictly construed. Wigfall, 354 S.C. at 110, 580 S.E.2d at 105. Thus, the use of the term disability, which inherently and inarguably includes the capacity to earn wages, to describe the presumption that arises once a claimant proves a 50% or greater loss of use of the back, dictates what kind of evidence is probative and sufficient to rebut that presumption, *i.e.*, evidence of a claimant's capacity or "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment."

This Court points to Stephenson, for the proposition that claimants can (and do) continue to work after being deemed totally and permanently disabled under "one of the specific statutory presumptions of total disability." 323 S.C. at 118 n.1, 473 S.E.2d at 701 n.1, *citing* Lyles v. Quantum Chem. Co., 315 S.C. 440, 434 S.E.2d 292 (Ct. App. 1993). While this is true, all of the cases on which this Court relies for the proposition

that the ability to earn wages cannot be considered under any subsection of the scheduled member provision were decided before the presumption and rebuttal language was added to Section 42-9-30(21). Lyles (1993); Fields v. Owens Corning Fiberglas, 301 S.C. 554, 393 S.E.2d 172 (1990); Jewell v. R.B. Pond Co., 198 S.C. 86, 15 S.E.2d 684 (1941). Therefore, the analyses contained in Lyles, Fields, and certainly in Jewell, which were decided under substantively different language, are inapplicable to the question of what kind of evidence is sufficient to rebut the presumption that arises under current Section 42-9-30(21).[9]

Under the proper statutory analysis, the initial determination under Section 42-9-30(21), the degree of loss of use of the back, is made strictly under the medical model. Both expert and lay testimony is relevant. If the degree of loss of use is determined to be 50% or greater, the claimant is entitled to a presumption of total and permanent disability and is entitled to the same compensation that a claimant who lost "both hands, arms, shoulders, feet, legs, hips or vision in both eyes, or any two thereof," is entitled to under Section 42-9-10(B). Note that in Section 42-9-10(B) total disability, and for all of the subsections of Section 42-9-30 other than Subsection 21 partial disability, is deemed or conclusively "considered" to exist for the prescribed period of time. In contrast, in Section 42-9-30(21), under certain circumstances, total and permanent disability is merely presumed, which presumption is rebuttable.

Once the presumption of total and permanent disability arises, the employer has an opportunity to rebut it by presenting evidence showing the claimant is capable of earning the same wages he was earning at the time of the injury, which can include the

[9] As the Dissent correctly points out, Wigfall and Stephenson were decided before the rebuttable presumption was added, while Watson was decided under the current version of the statute.

same types of lay and expert testimony that are probative under Section 42-9-10(A) and the economic model. Any other reading of the statute impermissibly disregards the use of the defined term "disability" to describe the presumption to be rebutted. Brown, 203 S.C. at 88, 26 S.E.2d at 318 (statutory definitions are binding on courts); Weston, 303 S.C. at 404, 401 S.E.2d at 164-165 ("statutory definitions should be followed in interpreting [a] statute"); Bell Fin., 297 S.C. at 114, 374 S.E.2d at 920 (same). It is "presumed that the General Assembly intended to accomplish something by its choice of words and would not do a futile thing." Beaufort County v. South Carolina State Elec. Comm'n, 395 S.C. 366, 376, 718 S.E.2d 432, 438 (2011). Then, if the employer successfully rebuts the presumption of total and permanent disability, the analysis returns to the medical model to determine the applicable loss of use between 50% and 100%, if that precise number has not already been determined.

Although the Act must be construed liberally in favor of coverage, this "does not empower the courts to employ semantics to stretch the Act or its attendant regulations and extend benefits" where they are not warranted under the Act. *See* Johnson v. Beauty Unlimited Landscape Co., 379 S.C. 403, 410, 665 S.E.2d 656, 660 (Ct. App. 2008); Ashe v. Rock Hill Hardware Co., 219 S.C. 159, 167, 64 S.E.2d 396, 400 (1951) (courts are not justified in construing the Act so "as to do violence to a specific requirement ... 'Such Statutes apply with full force to the most meritorious claims'"). Indeed, the Act "must not be construed so as to work a hardship on the employer and/or the carrier by the interpolation of words or conditions not found in the act .... The act must be construed in justice to both parties and must not impose a burden on either." Hill v. Skinner, 195 S.C. 330, 340, 11 S.E.2d 386, 390 (1940). This Court's construction of Section 42-9-30(21)

erroneously expands and contorts the Act to reach a result that is neither fair nor just, and is, in fact, in conflict with the Legislature's stated intent.

Without explicitly stating what kind of evidence is probative or sufficient to rebut the presumption set out in Section 42-9-30(21), this Court's Opinion cryptically holds that a "mere ability to return to work" within restrictions and "the mere fact a claimant continues to work" are both insufficient. The Opinion then refers back to the medical reports, stating that, "Dr. Drye's reports were the only other relevant evidence" beyond Claimant's return to work.[10] It is unclear whether this Court would consider both a return to work ***and*** medical evidence sufficient to rebut the presumption or whether it considers medical evidence ***alone*** sufficient to rebut the presumption. Since, the lay evidence overwhelmingly supports a finding that Claimant is not totally and permanently disabled – where Claimant not only returned to the exact same position (cashier) that he held prior to his injury, but he performed his job successfully working a regular 8-hour a day, 40-hour a week schedule, for nearly two years with minor accommodations[11] (never asking to use the chair provided for him; having lifting assistance available if needed, as does any Lowe's employee; and never requesting additional medical treatment), no

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[10] This Court misapprehends that there is no other medical evidence that Claimant is not totally and permanently disabled. In fact, Dr. Forrest, who agreed with Dr. Drye's work restrictions, opined that "customer service and/or cashier work ... would be best" for Claimant. (Appx. p. 240). Dr. Mandell noted that Claimant had "made a remarkably good recovery," and that he would "need his future work adjusted and be selective in which jobs he can and cannot do." (Appx. pp. 206-207). Claimant's vocational expert, Fowler, indicated that he had lost only 76% of access to light or sedentary jobs. (Appx. p. 262).

[11] Respondents note that this Court's findings that Claimant's work "duties were significantly reduced in light of his condition," and that he returned to work in "a less demanding position" are additional instances of judicial fact-finding. These findings are not supported by the evidence in the Record, and are contrary to the Commission's Findings of Fact that Claimant "returned to work full duty with the employer for almost two years," and that "the employer has accommodated him if needed," but that "Claimant has not made any complaints to the employer nor asked for additional medical treatment." (Appx. p. 107).

prescription pain medication and no missed time (Appx. p. 368, line 4 – p. 369, line 18) (Appx. p. 371, lines 2-23) (Appx. p. 407, lines 2-17) (Appx. p. 409, line 19 – p. 410, line 15) (Appx. p. 415, line 23 – p. 416, line 1) – the only logical reading of this Court's Opinion is that it requires medical evidence to rebut the presumption.

Ironically, it is this Court's interpretation that "renders the presumption meaningless." Under this Court's reasoning, only medical evidence is probative in the initial determination of the degree of loss of use and, where that loss of use is determined to be 50% or greater raising the presumption of total and permanent disability, apparently only medical evidence is probative with regard to whether the presumption has been rebutted. In essence, this Court's reading results in a battle of expert ratings and means, effectively, that the Section 42-9-30(21) presumption will never be rebutted. If the Commission relies on medical evidence, or as it appears the Court has done, solely on the ratings provided by physicians, to determine a claimant has lost 50% or greater of the use of his back, it is unlikely to look at that same medical evidence and find that the employer has rebutted the presumption of total and permanent disability.[12] *See* Florence County Democratic Party v. Florence County Republican Party, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012) (courts "should seek a construction that gives effect to every word of a statute rather than adopting an interpretation that renders a portion meaningless"). This Court's interpretation renders the use of the term "disability" to describe the rebuttable presumption meaningless.

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[12] As explained above in footnote 8, looking at the medical records as a whole, there are conflicting statements as to whether Claimant is totally and permanently disabled. *See* Appx. pp. 206-207, 240, 262) As a result, this Court's resolution of the conflicting medical evidence with respect to whether the presumption was rebutted constitutes another instance of improper appellate fact finding. Nettles v. Spartanburg Sch. Dist. #7, 341 S.C. 580, 590, 535 S.E.2d 146, 151 (Ct. App. 2000).

There is no valid statutory or policy reason to conclude that the ability to work – particularly where, as here, the claimant not only "can work" but was working for two years in the same position he was in prior to the accident with only minor accommodations – is insufficient to rebut the presumption of total and permanent disability under Section 42-9-30(21). The addition of the presumption and the ability to rebut it transforms Subsection 21 from a strictly medical model provision to an "intertwined" or hybrid provision, Wigfall, 354 S.C. at 104, 580 S.E.2d at 102, as is the case with Section 42-9-10. Given the clear statutory definition of "disability," which is the presumption to be rebutted, there simply is no valid reason to discredit any of the types of evidence that normally are employed to prove or disprove disability.

Regardless of this Court's attempt to provide Claimant relief because his return to work for two years "is something to be commended, rather than to be used to deny him benefits," the Legislature's use of the defined term "disability" in relation to the presumption under Section 42-9-30(21) cannot be ignored. This Court has recognized that some inequities are inevitable under the Act, but that they "are the province of the Legislature to correct by balancing the interests, risks and rewards of such a large, comprehensive program. This Court may only take such equitable arguments into account where legislative intent and statutory language are not clear .... Equity cannot prevail over a positive legislative enactment." Wigfall, 354 S.C. at 116, 580 S.E.2d at 108. In short, courts cannot apply "the 'chancellor's foot' notions of equity" where, as here, the legislature has enacted a clear statutory choice. Id.

Finally, based on a proper statutory analysis of Section 42-9-30(21), Respondents believe this Court erred in overruling Watson. However, even if this Court sustains its

overruling of Watson, in that a "mere ability to return to work within her restrictions was *alone* sufficient to rebut the presumption of total permanent disability under section 42-9-30(21)," that case is factually distinguishable from the instant case. There, the claimant's work restrictions were much more severe than are Claimant's in this case,[13] and when she tried to return to work within her restrictions, she was sent home. 399 S.C. at 460, 732 S.E.2d at 193. Here, in contrast, the rebuttal evidence establishes that Claimant not only could but did return to his former job, which he performed successfully working a regular 8-hour a day, 40-hour a week schedule, for two years with minor accommodations, no pain medication, no complaints or requests for medical care, and no missed time. The rebuttal evidence in this case is demonstrably stronger than that in Watson, where the claimant was sent home because the employer could not accommodate her restrictions.

This Court should reconsider its Opinion No. 27708 and hold that the same types of evidence that are relevant to a determination of total and permanent disability under Section 42-9-10(A) are probative in determining whether an employer has rebutted the presumption of total and permanent disability when it arises under Section 42-9-30(21).

5. If this Court does not reverse its holding with respect to Issues 1, 2, 3 and 4, *supra*, this Court must remand to the Commission for additional rebuttal evidence.

As is discussed above, when this case was litigated and decided by the Commission, Watson was binding precedent as to what constituted acceptable rebuttal evidence under Section 42-9-30(21). Unlike Wigfall 2003); Stephenson (1996); Lyles,

[13] For example, the claimant in Watson could lift and carry no more than 10 pounds, could stand no longer than 12 minutes, could sit no longer than three minutes, and could walk no farther than a tenth of a mile. 399 S.C. at 459, 732 S.E.2d at 192. In contrast, Claimant's work restrictions were "no standing or walking for more than an hour without [the] ability to sit for a brief period of time ... [no] climbing heights or repetitively combing steps, [he] should avoid any repetitive overhead reaching and should lift or carry less than 30 pounds only occasionally." (Appx. 177, 179).

(1993); Fields, (1990); and Jewell (1941), all of which were decided before the rebuttal language was added to what is now Section 42-9-30(21), at the time this case was litigated, Watson was the only case interpreting the rebuttal provision.[14] Accordingly, Respondents presented evidence that not only met but exceeded the standard set in Watson – that is, not only was Claimant able to work within assigned restrictions, but he was working and had worked for nearly two years in his prior position with minor accommodations. Because there is no indication in the statute itself,[15] and there was no indication from the courts that such evidence would not be sufficient to overcome the presumption, there was no reason for Respondents to present other or additional rebuttal evidence to the Commission. Litigants should not be held to a standard of "guessing" whether valid case law might be overturned in the future and be required to submit evidence that would meet multiple, as-yet unstated standards.

In light of this Court's reversal of Watson while this case is on appeal, the matter must be remanded to the Commission and the Respondents must be allowed the opportunity to meet whatever standard is articulated by this Court. As the Dissent points out, that task is made particularly difficult by the Majority's refusal "to identify what type of evidence would be germane." The Majority has side-stepped the difficult question of articulating to the parties and the Commission what kind of evidence is sufficient to rebut the presumption. The only direction provided by the Majority is that "evidence of subsequent employment is insufficient by itself to rebut the presumption of total and

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[14] Although the Court of Appeals' decision in Watson was appealed to this Court, the parties settled their dispute and the Petitioner withdrew the appeal. Therefore, at the time the parties presented their cases before the Commission, Watson was good law.

[15] As discussed above, Section 42-9-30(21) uses the statutorily defined term "disability" to describe the presumption that is to be rebutted. As a result, an employee's ability to return to work within their restrictions should be probative in rebutting that presumption.

permanent disability under section 42-9-30(21)," and that medical evidence may be relevant, if not conclusive. In light of the Respondents' reasonable reliance on Watson, which was good case law, in fact, the only case law concerning rebuttal evidence, at the time this case was presented to the Commission, it would be a denial of due process to prohibit Respondents from at least attempting to submit evidence to meet whatever new standard is set by this Court.

The Majority suggests that it would be both "inequitable and contrary to precedent to afford Respondents a second opportunity to litigate this issue." That statement is wrong for at least two reasons. First, there is nothing that would prohibit this Court from ordering the Commission to take limited additional testimony and evidence on the limited issue of whether Claimant is totally and permanently disabled based on whatever standard this Court believes is appropriate to rebut the presumption, assuming a clear standard is articulated on rehearing. Indeed, it would be inequitable to Respondents not to do so. Second, there is no precedent applicable to posture of this case that would prohibit allowing Respondents an opportunity to present additional evidence. In this respect, Parker v. South Carolina Pub. Serv. Comm'n, 288 S.C. 304, 342 S.E.2d 403 (1986), is not controlling. There is no indication that, in Parker, the law or standard that the power company had to meet with respect to its rate filing changed from the time of the first hearing to the remand hearing. Here, in contrast, Respondents reasonably relied on the plain language and defined terms in the Act, as well as the ruling in Watson, which this Court has overruled.

Make no mistake, this Court's failure to specify what constitutes evidence sufficient to overcome the presumption makes Respondents' task on remand particularly

difficult. In all fairness, this Court must enunciate what kinds of evidence are probative and sufficient to rebut the presumption, and Respondents must be provided the opportunity to meet whatever standard is articulated by the Majority.

6. Oral Argument.

Finally, Respondents request oral argument given the exceptional importance and wide-ranging implications of this Court's Opinion. The proper application of impairment ratings based on the AMA Guides is of critical importance to both claimants and employers. The long-standing rules that appellate courts are bound to consider only evidence in the record and to not engage in resolving conflicting evidence have been turned on their heads. In addition, this Court's erroneous interpretation of Section 42-9-30(21) will have wide-reaching and deleterious consequences for both employers and claimants. For example, while this Court's interpretation works in Claimant's favor in this instance, a claimant who obtains medical impairment ratings below 50% will never be able to avail him or herself of the Section 42-9-30(21) presumption, or, if for some reason he or she does, will not be able to argue successfully against the rebuttal evidence since that too, apparently, will be based on the medical evidence. Very likely, this Court's Opinion No. 27708, should it stand, will draw the attention of the Legislature, which could provide an opening for broad and far-reaching changes to the Act, unintended by either party to this appeal. As is more fully discussed in the Brief of Amicus parties, the impacts of this Court's Opinion will negatively impact both employers and workers. It is inevitable that, in light of this Court's Opinion, premiums for workers' compensation coverage will increase significantly. For these reasons, Respondents request that this Court grant their request for oral argument on rehearing.

CONCLUSION

For all the reasons stated herein, this Court should reconsider its Opinion No. 27708, reverse its improper factual findings including, but not limited to: 1) that Dr. Drye's impairment rating converts to a 71% regional impairment to Claimant's spine/back, and 2) that, consequently, the Commission's 48% disability rating is not supported by substantial evidence. In addition, this Court must revise its statutory analysis of Section 42-9-30(21) to hold that evidence that a claimant is able "to earn the wages which the employee was receiving at the time of injury in the same or any other employment" is both probative and sufficient to rebut the Section 42-9-30(21) presumption. In the event this Court fails to reverse its improper factual findings and analysis as noted above, it must remand to the Commission for further proceedings as discussed herein. Respondents request that this Court order oral argument on the issues raised in this Petition for Rehearing, given the importance and far-reaching consequences of this Court's Opinion.

Respectfully submitted,
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Fifth Edition

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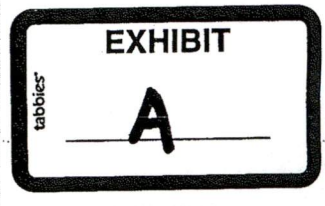


AMA press

15.6 DRE: Cervical Spine

15.6a Criteria for Rating Impairment Due to Cervical Disorders

For cervical problems localized to the cervical or cervicothoracic region, use Table 15-5. If the cervical spine problem also leads to isolated bowel and/or bladder dysfunction not due to corticospinal damage, obtain the appropriate estimates for bowel and bladder dysfunction from the gastrointestinal and urology chapters (Chapters 6 and 7) and combine these with the appropriate cervical spine DRE category from DRE I to V, listed in Table 15-5. If the cervical spine problem is due to corticospinal tract involvement, use Table 15-6 alone.

The DRE cervical categories are summarized in Table 15-5.

Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders

DRE Cervical Category I 0% Impairment of the Whole Person	DRE Cervical Category II 5%-8% Impairment of the Whole Person	DRE Cervical Category III 15%-18% Impairment of the Whole Person	DRE Cervical Category IV 25%-28% Impairment of the Whole Person	DRE Cervical Category V 35%-38% Impairment of the Whole Person
No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity, and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity *or* individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment *or* fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement	Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings *or* individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery *or* fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases the fracture is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition	Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity *or* fractures: (1) more than 50% compression of one vertebral body without residual neural compromise	Significant upper extremity impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction *or* fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement

DRE Cervical Category I
0% Impairment of the Whole Person

No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity, and no other indication of impairment related to injury or illness; no fractures

Example 15-12
0% Impairment Due to Cervical Injury

Subject: 37-year-old man.

History: Complaints of neck discomfort when painting.

Current Symptoms: Intermittent neck pain, occasionally extending into upper back bilaterally, moreso on the left side.

Physical Exam: Full neck motion, but pain at the extremes; some tenderness over the trapezius muscles; no spasm; no neurologic findings.

Clinical Studies: Radiographs: normal cervical spine.

Diagnosis: Intermittent cervical neck strain.

Impairment Rating: 0% impairment of the whole person.

Comment: No evidence of permanent impairment, without objective signs. Advised to do appropriate stretching and neck exercises regularly, before and after vigorous activity.

DRE Cervical Category II
5%-8% Impairment of the Whole Person

Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity

or

individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment

or

fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement

Example 15-13
5% to 8% Impairment Due to Cervical Injury

Subject: 37-year-old woman.

History: Pain in the neck and lateral right upper extremity extending to the thumb following a rear-end auto collision. An MRI showed a herniated disk at C6. She elected nonoperative treatment and recovered after 18 months.

Current Symptoms: Some residual neck pain with physical activity; upper limb symptoms have resolved.

Physical Exam: Slight loss of motion of the cervical spine. Neurologic examination is normal.

Clinical Studies: Initial MRI: right posterolateral disk herniation at C5. No additional imaging studies were done.

Diagnosis: Herniated disk C5-6 with resolved right C6 radiculopathy.

Impairment Rating: 5% impairment of the whole person.

Comment: The individual qualifies for DRE cervical category II because she had a radiculopathy caused by a herniated disk that responded to treatment. She has no significant residual signs.

DRE Cervical Category III
15%-18% Impairment of the Whole Person

Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings

or

individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery

or

fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases the fracture is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or by bone scans performed after the onset of the condition

Example 15-14
15% to 18% Impairment Due to Radiculopathy

Subject: 44-year-old man.

History: Sustained a blow to his posterior neck from a machine support that slipped. Unable to use his dominant left hand for ADL without considerable pain in neck, left upper back, and ulnar left upper limb. No discomfort in the lower extremities. Refuses surgery.

Current Symptoms: Neck pain, radiating to the ulnar hand with numbness of the ring and little fingers.

Physical Exam: Decreased range of motion in the neck with severe radiating pain to the left arm in a C6 distribution.

Clinical Studies: MRI: left posterolateral disk herniation C7-8.

Diagnosis: Radiculopathy due to disk herniation C6.

Impairment Rating: 18% impairment of the whole person.

Comment: Residual symptoms and functional limitations to perform ADL.

DRE Cervical Category IV
25%-28% Impairment of the Whole Person

Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity

or

fractures: (1) more than 50% compression of one vertebral body without residual neural compromise

Example 15-15
25% to 28% Impairment Due to Alterations of Motion Segment Integrity

Subject: 37-year-old woman.

History: Onset of pain in the neck and right arm along the radial aspect and into the thumb following a medium-speed rear-end auto collision. Individual failed conservative treatment, and an MRI showed a herniated disk at C6-7. Underwent a diskectomy of the sixth cervical disk and fusion of C6 to C7. Healed uneventfully and returned to work 4 months after the injury.

Current Symptoms: Occasional neck pain with physical activity. Upper extremity pain resolved.

Physical Exam: Slight loss of cervical spine motion. Neurologic examination is normal.

Clinical Studies: Radiographs: healed C6-7 fusion.

Diagnosis: Herniated disk C6-7 with C7 radiculopathy resolved following anterior cervical diskectomy and C6-7 fusion.

Impairment Rating: 25% impairment of the whole person.

Comment: This individual meets criteria for DRE cervical category IV because of alteration of motion segment integrity due to fusion.

DRE Cervical Category V 35%-38% Impairment of the Whole Person
Significant upper extremity impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction *or* fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement

Example 15-16
35% to 38% Impairment Due to Herniated Cervical Disk Postdiskectomy and Fusion

Subject: 37-year-old woman.

History: Individual fell and struck her posterior head and neck on a conveyor machine while working on an assembly line. She had severe and persistent pain in the neck and lateral right upper limb extending into the thumb. An MRI showed a herniated disk at C5-6. She failed nonoperative treatment and underwent a diskectomy of the sixth cervical disk and fusion of C6 to C7. She has continued neck and bilateral upper extremity pain. Unable to perform most ADL and uses assistive devices for gripping and turning objects.

Current Symptoms: Severe neck and bilateral upper extremity pain aggravated by movements of the neck and use of the upper extremities. Persistent numbness in the radial forearm, hand, and digits on both sides.

Physical Exam: Slight loss of cervical motion. Neurologic examination reveals decreased sensation in the thumb and index finger and weakness of the biceps and wrist extensors bilaterally. Diminished brachioradialis reflexes, right worse than left.

Clinical Studies: Radiographs: healed fusion.

Diagnosis: Herniated C5-6 disk treated with residual bilateral C6 radiculopathy.

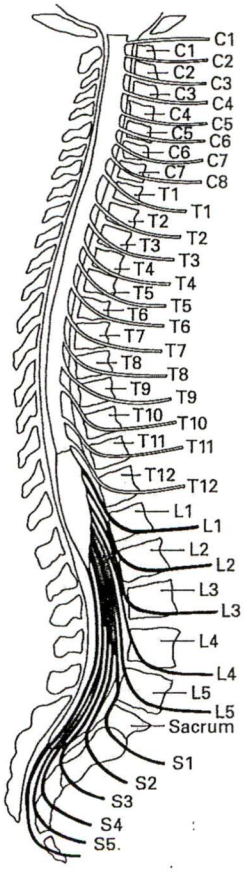
Impairment Rating: 38% impairment of the whole person.

Comment: This individual meets criteria for both DRE cervical category III, with a surgically treated radiculopathy, and DRE cervical category IV, because of alteration of motion segment integrity due to the fusion, and is placed in DRE category V because of objective findings supportive of significant upper extremity impairment requiring the use of adaptive devices.

15.7 Rating Corticospinal Tract Damage

The neurologic level of involvement is determined by identifying the level of cord involvement, not necessarily the same level as a fracture, because the root function at the fracture level frequently returns with time. The level of cord involvement is determined by identifying the lowest normally functioning nerve root. Identifying the level of nerve root function helps to determine the degree of residual function. Figure 15-5 illustrates the relationship of nerve roots to the vertebral level.

Figure 15-5 Relationship of Spinal Nerves to Vertebrae

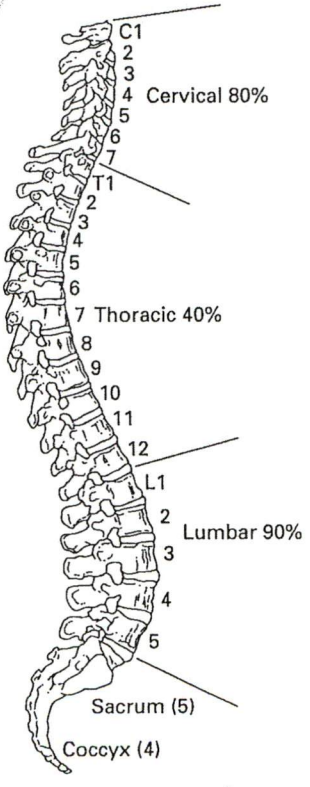


The level at which nerve roots exit the spine relative to the vertebrae. The neurologic level of involvement is determined by identifying the lowest normally functioning nerve root.

15.13 Criteria for Converting Whole Person Impairment to Regional Spine Impairment

In some instances, the evaluator may be asked to express an impairment rating in terms of the involved spine region rather than the whole person. This is done by dividing the whole person impairment estimate by the percent of spine function that has been assigned to that region. Under the DRE method, a whole person estimate being converted to a regional estimate would be divided by 0.35 for the cervical spine, 0.20 for the thoracic spine, and 0.75 for the lumbar and sacral spines. Under the ROM method, a whole person estimate being converted to a regional estimate should be divided by 0.80 for the cervical spine, 0.40 for the thoracic spine, or 0.90 for the lumbosacral spine (Figure 15-19). For example, a 24-year-old female office worker sustained a cervical injury that, after it was healed and stable, resulted in a whole body impairment, estimated by the DRE method, of 20%. Dividing the 20% by 0.35 results in 57% impairment of the cervical spine. An individual with multiple lumbar compression fractures was rated 25% whole body impairment by the ROM method. To obtain an estimate of lumbar spine impairment, the physician should divide the 25% by 0.9, resulting in a 27.7% rounded up to 28% lumbar spine impairment. Any values that exceed 100% are rounded down to 100% regional impairment.

Figure 15-19 Side View of Spinal Column



The whole spine divided into regions indicating the maximum whole person impairment represented by a total impairment of one region of the spine. Lumbar 90%, thoracic 40%, cervical 80%.

15.14 The Pelvis

Criteria for Rating Impairment Due to Pelvic Injury

The pelvis is composed bilaterally of three bones: the ilium, the ischium, and the pubis, forming a ringlike structure. Each ilium is attached to the sacrum via the sacroiliac synchondrosis. The pelvis, including the symphysis pubis, assists in transfer of body weight to the lower extremities. In females, the pelvic structure and function are also of paramount importance in pregnancy and delivery.

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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

APPEAL FROM SOUTH CAROLINA
WORKER'S COMPENSATION COMMISSION

Supreme Court Opinion No. 27708
(filed March 8, 2017)

HENTON T. CLEMMONS, JR., EMPLOYEE,.....PETITIONER,

v.

LOWE'S HOME CENTERS, INC.-HARBISON, EMPLOYER, AND
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.,
CARRIER,.....RESPONDENTS.

PROOF OF SERVICE

I certify that I have served the Respondents' **Petition for Rehearing and Request for Oral Argument** on Henton T. Clemmons, Jr. by depositing a copy of it in the United States Mail, postage prepaid, on April 7, 2017, addressed to his attorney of record:

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