THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

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

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W.C.C. File No. 0908371

Timothy Hannah, Employee, Claimant ..... Respondent,

v.

MJV, Inc./Butler Trucking, Employer, and
Palmetto Timber S.I. Fund c/o
Walker, Hunter & Associates, Inc., Carrier, ... Appellants.

INITIAL REPLY BRIEF OF APPELLANTS

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I. Claimant's version of the facts contains glaring misstatements

Instead of addressing the issues properly raised by Appellants, Respondent Timothy Hannah, Claimant below, attempts to create an aura of misdeeds and denials of treatment that are based on readily demonstrable misstatements of fact. For example, Claimant asserts that, when Dr. Bethea released him at maximum medical improvement ("MMI"), he imposed a five-pound lifting limit, no bending, climbing or stooping. (Resp. Br. pp. 2, 22). While this is technically true, what Claimant omits is that these limitations were put in place for three weeks only. (CL APA pp. 103-104 ("[a]s far as his left elbow is concerned, I think that he has reached maximum medical improvement. **For the next three weeks** he should avoid any pushing, pulling, lifting or carrying with the left upper extremity over 5 lb.") (emphasis added)) (Bethea Dep. p. 48, lines 8-10 ("I think what I said was for three weeks after I saw him, he is going to have to limit use of left upper extremity to five pounds")). Thus, Claimant's characterization of Dr. Bethea's limitations as permanent is patently false.

More concerning, however, is that Claimant refers throughout his Brief to the fact that Appellants would not pay for and Dr. Bethea was unable to review a "2009 MRI" that Claimant later "obtained on his own." (Resp. Br. pp. 2, 4, 18, 21). What Claimant fails to mention, but is readily apparent from the medical records and testimony in this case, is that the "2009 MRI" was of his lower back/lumbar spine, (CL APA pp. 81-84) (Triana Dep. p. 23, lines 16-18; p. 24, lines 11-14; p. 33, lines 20-21 (discussing desire to have an MRI done of Claimant's lower back, which Appellants did not authorize)), which Appellants never accepted as causally related to the July 14, 2009 accident – a position

which both the Commission and this Court have affirmed. In fact, Claimant goes so far as to imply that Appellants' denial of the 2009 lumbar spine MRI constituted a denial of authorized treatment of his cervical spine, somehow justifying his failure to even request additional medical treatment to his neck. (Resp. Br. pp. 14, 15, 19, 23).[1]

Equally concerning is Claimant's assertion that he continued "to treat his chronic neck/back pain with Dr. Triana" and later with Dr. Brennan because Appellants refused to provide medical care. (Resp. Br. pp. 3, 4, 18, 19, 20). Claimant implies in some places and flatly asserts in other that Appellants denied his request for medical treatment to his cervical spine, thereby justifying his going "outside the Act" and seeking medical care on his own. (Resp. Br. pp. 14, 15, 19, 20, 23). The reality is that, following the July 25, 2011 Commission Decision, Claimant did not ask for any further treatment of his cervical spine from Appellants. In fact, Claimant concedes that his "worsening pain and resulting treatment for the neck *had not yet occurred* at the time of the prior appeal ..." (Resp. Br. p. 12). Because Claimant did not request additional treatment to the cervical spine, there was no denial of same. Claimant's blatant attempts to re-write the facts of this case are easily debunked and must be rejected. Moreover, his efforts to mischaracterize the facts indicate just how baseless and unjustified his opposition is to this appeal.

Claimant incorrectly asserts that, "[i]t is undisputed that Mr. Hannah has never been able to return to work ..." (Resp. Br. pp. 2). However, Claimant's signature on not

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[1] The transcript references contained in Claimant's Brief for this point all refer to the lumbar spine, not the cervical spine. (CL APA p. 81-82 (Dr. Triana's medical records discussing MRI and treatment of the lumbar spine)) (July 30, 2010 Tr. p. 21, line 25 – p. 26, line 8 (discussing treatment with Dr. Triana for his lower back complaints and Dr. Bethea's treatment of his left elbow)). Other testimony Claimant relies on was stricken. (Sept. 25, 2014 Tr. p. 41, lines 3-9 (stricken hearsay testimony by Claimant that Dr. Triana stopped seeing him in 2010 because his "insurance" stopped paying)).

one but two Form 17s demonstrates that he, himself disputed that fact. (Form 17 dated August 19, 2011; Form 17 dated August 31, 2011). Appellants reasonably and justifiably relied on Claimant's statement that he was able to return to full-time employment.

As he did below, Claimant intimates that the transfer of his medical care from Dr. Triana to Dr. Bethea, is somehow nefarious. (Resp. Br. pp. 2). As he did below, he presents no evidence of any "sinister reason behind that." (March 22, 2011 Tr. p. 7, lines 5-12). Dr. Triana had seen Claimant only three times when his care was transferred to a general orthopedist, Dr. Bethea, who specializes in "[n]ecks, backs, shoulders, elbows, feet, hands." (Bethea Dep. p. 4, lines 10-18).

II. The law of the case doctrine does not bar Appellants' current arguments but, instead, binds Claimant.

Claimant mistakenly argues that the law of the case doctrine bars Appellants from arguing that, in the 2011 Commission Decision, the Commission implicitly found that Claimant reached MMI and that he was not entitled to any permanent disability award. His suggestion that this argument is waived or barred because Appellants did not make it in the prior appeal to this Court is completely backwards. In the first appeal of the 2011 Commission Decision (Appellate Case No. 2011-197631), Appellants herein were the "Respondents," having prevailed at the Commission. As "Respondents" in Appellate Case No. 2011-197631, Appellants were not compelled to raise the issues they had won before the Commission. Indeed, it was incumbent on Claimant, the losing party and Appellant in Appellate Case No. 2011-197631, to raise every issue he desired to contest in that prior appeal.

"Under the law-of-the-case doctrine, a party is precluded from relitigating, after an appeal, matters that were either not raised on appeal, but should have been, or raised

on appeal, but expressly rejected by the appellate court." Atkins v. Wilson, 417 S.C. 3, 17, 88 S.E.2d 228, 235 (Ct. App. 2016); *see also* Dreher v. South Carolina Dep't of Health & Envtl. Control, 412 S.C. 244, 250, 772 S.E.2d 505, 508 (2015) ("should the appealing party fail to raise all of the grounds upon which a lower court's decision was based, those unappealed findings – whether correct or not – become the law of the case"). Although Claimant's Brief to this Court in Appellate Case No. 2011-197631 focused on the compensability of his lower back, Claimant also argued that he had not reached MMI for his cervical spine and left elbow, and disputed the Commission's finding "that he "has no remaining impairments from the truck wreck." (Appellant's Final Brief, filed March 21, 2012, pp. 2, 16, 29). This Court affirmed the 2011 Commission Decision and, as a result, those earlier Commission findings, including the conclusion that Claimant had "received all proper medical care that will tend to lessen his period of disability," (2011 Commission Decision, pp. 9-10), are the law of this case and cannot be disturbed on appeal.

Conversely, "it is not necessary for the party who prevailed below to object to or appeal from the trial court's ruling in order to raise such grounds." Dreher, 412 S.C. at 250, 772 S.E.2d at 508, *citing* I'On, LLC v. Town of Mt. Pleasant, 338 S.C. 406, 417-418, 420 S.E.2d 716, 722 (2000). Thus, as the prevailing party in the 2011 Commission Decision, and "Respondents" in Appellate Case No. 2011-197631, Appellants were not compelled to raise any issue decided by the Commission, and particularly not those portions of the 2011 Commission Decision that were decided in their favor, in order to preserve them for this appeal.

Citing Nettles v. Spartanburg Sch. Dist. #7, 341 S.C. 580, 535 S.E.2d 146 (Ct. App. 2000), Claimant suggests that, because this Court did not remand to the Commission for more specific findings and rulings, the Commission's 2011 findings are somehow voided or of no effect. However, this Court previously has approved similar implicit findings by the Commission without remand. Cranford v. Hutchinson, 399 S.C. 65, 77, 731 S.E.2d 303, 309 (Ct. App. 2012) (affirming an implicit finding that the claimant had reached MMI based on findings in agreement with the treating physician's 0% impairment rating and that "no further medical treatment will lessen [the claimant's] period of disability"). As was the case in Cranford, no remand was necessary in this case.

Furthermore, the findings at issue in Nettles are substantively different than those at issue here. In Nettles, the treatment for the claimant's work-related injury to her spine involved a bone graft utilizing bone from her iliac crest, part of the hip. The site where the bone was harvested later experienced chronic pain, for which she was prescribed non-steroidal anti-inflammatory medications. Those medications, in turn, caused stomach problems. The Commission awarded benefits based on the spine and stomach injuries but not specifically for the hip. This Court held that the Commission's "implicit" ruling that "although the hip problem was causally connected to the injury, it did not cause Nettles any permanent disability thereby justifying an award of 25% permanent partial disability for the spine, 10% for the stomach, but nothing for the hip," was too attenuated and indefinite for appellate review. As a result, this Court remanded for more specific findings of fact regarding Claimant's disability rating. Nettles, 341 S.C. at 590, 535

S.E.2d at 151. In contrast, in the prior appeal in this case, there was no problem with indefinite findings of fact and, therefore, no need to remand.

III. Claimant's claim is barred by *res judicata*.

Claimant argues that his claims are not barred by *res judicata* because the subject matter of the first Commission proceeding and the 2011 Commission Decision and the Commission Decision now on appeal are not the same. He argues that the only issue raised and ruled on by the Commission in 2011 was the compensability of his lower back. However, there cannot be any serious question that the issues of whether Claimant had reached MMI and whether he was entitled to any award for permanent disability for his cervical spine and elbow were at issue at the first hearing at the Commission. Claimant's 2010 Form 58 identified the "neck, left shoulder, left elbow and back" as relevant body parts and argued that "Claimant has not reached MMI and needs further medical treatment." (CL Form 58, dated April 8, 2010).

At the July 30, 2010 hearing, Claimant took the position that he had injured his lower back in addition to his cervical spine and elbow, and that he had not reached MMI. Alternatively, Claimant argued that, if it was determined that the lumbar spine was not compensable and that he had reached MMI, "it would be the position of the Claimant that his permanent disability would far exceed any rating in the record, including that of Dr. Bethea ..." (July 30, 2010 Tr. p. 4, lines 4-24; p. 5, line 24 – p. 6, line 23). In addition, Claimant testified that he wanted additional medical treatment for his neck, although his lower back was his major problem. "I can deal with the neck, it doesn't bother me as bad as my back." (July 30, 2010 Tr. p. 37, line 15 – p. 38, line 23).

On appeal to the Full Commission, Appellants clearly raised the issues of whether Claimant had reached MMI, whether he was entitled to further medical treatment and whether the Hearing Commissioner erred in not assigning a permanent disability rating. (App. Form 30, dated Jan. 17, 2011) (Appellants' Brief to the Full Commission, dated Feb. 23, 2011, pp. 13-15).

At the first Appellate Panel hearing, it was clarified that the initial Form 21 hearing did not go forward so that Claimant's claim that the lumbar spine was causally related could be addressed. Instead, "the issues were consolidated ... **to decide everything at once** including the lumbar spine." (March 22, 2011 Tr. p. 9, line 16 – p. 10, line 1) (emphasis added). Claimant did not dispute that the subject matter of the first hearing included his neck and elbow – arguing to the Commission that Claimant injured his neck, elbow and lower back in the accident. (March 22, 2011 Tr. p. 10, lines 7-21). In fact, the 2011 Commission Decision explains that, "[i]n an **effort to avoid bifurcation of the issues** of the claim, the Hearing Commissioner ordered a continuance to allow Claimant to file a Form 50 adding Claimant's lumbar spine as an alleged body part so that **all issues could be heard together** in a single hearing." (2011 Commission Decision, p. 2) (emphasis added). The initial hearing was set to determine all of the issues raised "on Forms 21, 50 and 51." (Id.).[2] Importantly, the 2011 Commission Decision noted Claimant had been placed at MMI by the authorized treating physician with 0% impairment to his neck and elbow, did not award him any permanent benefits,

[2] Appellants' Form 21 sought a stop payment order based on the fact that Claimant had reached MMI, and requested credit for overpayment of benefits. (Form 21, dated April 29, 2010). Appellants' Form 51 asserted that Claimant had reached MMI and that he did not suffer any permanent disability as a result of the accident. (Form 51, dated June 3, 2010).

found he had received all medical treatment "that will tend to lessen his period of disability" and, importantly, did not hold any issue in abeyance.

Thus, Appellants are not relying only on what Claimant characterizes as "contextual findings of fact" to demonstrate that the issues of whether he had reached MMI and whether he was entitled to any permanent disability award were raised to the Commission in the first hearing. Those issues clearly were and Claimant is now bound by the Commission's findings relating to MMI, impairment rating and medical care.

Claimant cites Stone v. Roadway Express, 367 S.C. 575, 582, 627 S.E.2d 695, 698 (2006) in an effort to assert that this Court recognized that the prior appeal was limited to issues regarding his lower back and, therefore, he is not barred by *res judicata* from litigating issues now that he either abandoned or lost in Appellate Case No. 2011-197631. However, this Court's reference to Stone was in relation to Claimant's argument regarding "doctor shopping" and not whether he had been found to be at MMI with a 0% impairment rating. Those latter issues, decided by the Commission in Appellants' favor, were and are the law of this case.

Finally, Claimant argues that, because his "worsening" neck pain had not occurred at the time of the prior appeal, that issue could not have been raised then.[3] However, his attempt to allege entitlement to compensation based on the June 2012 cervical fusion as a "change of condition" implicitly assumes and agrees with the Commission's prior adjudication of MMI and no permanent disability. Furthermore, Claimant's Amended Form 50 was ineffective as a change of condition as it was not

[3] Claimant fails to recognize the disconnect between relying on Dr. Triana's recommendation for a cervical fusion as "justifying" Dr. Brennan's intervention, and his argument that his need for surgery had not arisen at the time of the prior appeal. One or the other may be true, but they cannot both be true.

accompanied by any medical opinion. (Claimant's Amended Form 50, dated Jan. 8, 2013, alleging a change of condition but containing no medical opinion).[4]

This Court should hold Claimant's claim is barred by *res judicata*, because "(1) the identities of the parties is the same as a prior litigation; (2) the subject matter is the same as the prior litigation; and (3) there was a prior adjudication of the issue by a court of competent jurisdiction." Johnson v. Greenwood Mills, 317 S.C. 248, 250-251, 452 S.E.2d 832, 833 (1994).

IV. Claimant's claim is barred by laches.

Claimant's response to Appellants' laches argument is based, by and large, on the late notice provisions in S.C. Code Ann. § 42-15-20. However, laches is an equitable doctrine, not a statutory construct. Section 42-15-20 addresses a claimant's failure to timely notify his employer of a work-related accident. *E.g.*, Lizee v. South Carolina Dep't of Mental Health, 367 S.C. 122, 129, 623 S.E.2d 860, 864 (Ct. App. 2005). Here, in contrast, there is no issue with regard to notice of the accident, and Claimant's pontifications regarding same are beside the point. Appellants had notice of the accident and have never claimed otherwise. What Appellants did not know, and what Claimant readily admitted he kept to himself, (Sept. 25, 2014 Tr. p. 61, line 15 – p. 62, line 3), was that he was embarking on a path of serious medical intervention without asking for treatment or advising Appellants of same.

Even if Section 42-15-20 was applicable or even analytically relevant, which Appellants do not concede, the disability award based on Claimant's unauthorized, unknown and unrequested medical treatment would still be barred. Section 42-15-20

[4] Appellants properly opposed Claimant's Amended Form 50 by pointing out, among other things, that it was an "[i]mproper filing of change of condition claim; No medical evidence to support change of condition claim." (Form 51, dated Jan. 16, 2013).

involves a burden shifting analysis under which, once the initial determination has been made that a claimant failed to give timely notice of a work-related injury, the claimant bears the burden of demonstrating he had a reasonable excuse for failing to give notice to his employer. It is only after a claimant meets the burden of demonstrating a reasonable excuse that the burden shifts to the employer to demonstrate prejudice resulting from the lack of notice. *See* Nero v. South Carolina Dep't of Transp., 2017 S.C. LEXIS 62 I (2017); *citing* Gray v. Laurens Mills, 231 S.C. 488, 492, 99 S.E.2d 36, 38 (1957) for the proposition that, "lack of prejudice does not justify compensation unless the requirement of reasonable excuse is also satisfied." Here, Claimant has not provided any reasonable excuse that would switch the burden to the employer to demonstrate prejudice.

Claimant's "excuse" for not requesting additional medical treatment for his cervical spine – or even advising Appellants that he wanted medical treatment – does not hold water. Instead, Claimant attempts to justify his failure to seek additional medical treatment for his cervical spine by insinuating that Appellants denied treatment for that body part. (*See* Resp. Br. pp. 14, 15, 19, 20, 23). As noted above, this is a blatant misstatement of the evidence, as the evidence relied on by Claimant refers to Appellants' refusal to authorize treatment to Claimant's lower back – a refusal that this Court upheld.

Unlike the statutory concept of late notice, laches "is defined ... as unreasonable delay; neglect to do a thing or to seek to enforce a right at a proper time; and as neglect to do what in law should have been done, for an unreasonable and unexplained length of time and under circumstances permitting diligence." Hemingway v. Mention, 228 S.C. 211, 216, 89 S.E.2d 369, 371 (1955). Claimant either misunderstands or misconstrues the element of "knowledge" under laches. He asserts that he did not know he had any

responsibility to seek medical treatment from Appellants. However, the test is whether he knew or should have known he had a legal right to assert. In other words, where "the circumstances are such as to have put him upon enquiry and the means of ascertaining the truth were readily available had enquiry been made, the neglect of the party to make enquiry will charge him with laches the same as if he had known the facts." Arceneaux v. Arrington, 284 S.C. 500, 503-504, 327 S.E.2d 357, 359 (Ct. App. 1985). Here, Claimant not only had been through one workers' compensation claim in the past, (CL Dep. p. 11, lines 8-19), but he also was fully represented by counsel throughout this proceeding. The facts that he did not ask his attorney whether he had any further recourse and, in addition, that his counsel did not advise him that he could seek additional treatment for his cervical spine means either one of two things. Either both Claimant and his counsel understood the 2011 Commission Decision as having found him to be at MMI and not entitled to any disability award or treatment, or both failed to avail themselves of the opportunity to discover whether Claimant was entitled to further treatment for his neck. Clearly, both Claimant and his counsel had ample opportunity to inquire as to the status of his entitlement to further medical treatment prior to Claimant's June 2012 fusion surgery.

Claimant goes so far as to assert that he was "excused" from first seeking medical treatment from Appellants because they had refused treatment for his neck injury. As noted above, this is based on a clear misstatement of fact and should be disregarded. Concomitantly, giving notice that his condition had worsened and/or that he needed additional medical care would not have been a futile act, as Claimant suggests. McIntyre v. Cameron, 124 S.C. 232, 117 S.E. 515 (1923), does not provide differently.

Contrary to Claimant's assertions, this case is substantively and meaningfully distinguishable from Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct. App. 2006), which Claimant relies on to argue that laches should not apply. There, the claimant was treated at Doctor's Care for a lower back injury and discharged to full duty work. The claimant attempted to perform his job but was unable, due to crippling pain. His employer told him to return to Doctor's Care; however, Doctor's Care would not see him and the workers' compensation carrier refused to authorize treatment. In contrast, here there has been no refusal of treatment for either his neck or his elbow. The only refusal of treatment was for Claimant's lower back, which has been established to be not compensable.

In addition, Martin considered the provision in Section 42-15-60 that provides that, "[i]n case of a controversy arising between employer and employee, the Commission may order such further medical, surgical, hospital or other treatment as may bin the discretion of the Commission be necessary ..." S.C. Code Ann. § 42-15-60. This Court explained that it was "[t]he refusal by Doctor's Care to see Martin and Dr. Johnson's subsequent diagnosis [that] created the controversy contemplated by the statute." Here, because there was no refusal to provide treatment, because none was sought following the 2011 Commission Decision,[5] this provision simply does not apply.

Finally, Claimant wrongly argues that Appellants failed to show any prejudice. First, relying on tests and standards that might apply under Section 42-15-20 does not speak to whether Appellants have shown prejudice under the equitable doctrine of laches. Second, as indicated in their Brief, Appellants were prejudiced because Claimant's

[5] In fact, at the time of the July 30, 2010 hearing, Claimant testified that he could deal with the neck "it doesn't bother me as bad as my back." (July 30, 2010 Tr. p. 38, lines 20-23).

actions deprived them of any ability to assert their rights under Section 42-15-60. That Section provides that "the employer, at his own option, may continue to furnish or cause to be furnished, free of charge to the employee, and the employee **shall** accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown." S.C. Code Ann. § 42-15-60 (emphasis added). Refusal by a claimant to comply with this mandatory provision "bars the employee from further compensation ..." Id; *see also* Hall v. United Rentals, Inc., 371 S.C. 69, 86, 636 S.E.2d 876, 885 (Ct. App. 2006) ("[t]he Worker's Compensation Act provides that the employer names the authorized treating physician once a case has been accepted. [citations omitted] Generally, a claimant may obtain compensation **only** by accepting services from the employer's choice of providers") (emphasis added); McKinney v. Kimberly Clark Corp., 376 S.C. 636, 638, 658 S.E.2d 112, 113 (Ct. App. 2008) (explaining that claimants do not have a right to "unilaterally" select a physician to provide treatment).

Because Appellants had no knowledge that Claimant had embarked on a course of medical treatment that involved a surgical fusion at the C6-7 level, they had no opportunity to consider or direct him to try more conservative treatment first. Note that, with regard to his C5-6 vertebrae, which Dr. Triana treated and for which he recommended possible surgery, Dr. Grant recommended a conservative course of treatment including physical therapy. (CL APA p. 148). Appellants had no chance to obtain a second opinion as to the advisability of surgery **prior** to the June 2012 fusion. Such opportunity is completely lost at this point. And, as a result of the fusion surgery, Claimant's impairment rating is inarguably higher than it would have been if his

symptoms could have been addressed through more conservative treatment. As a result of the Commission Decision, Appellants clearly have been prejudiced by being ordered to pay compensation based on an impairment rating that is a direct result of unauthorized and, indeed unknown to them, medical treatment that occurred almost two and a half years after Claimant signed a statement saying he could return to work without restrictions.

This Court should hold that Claimant's claim is barred by laches.

V. The Commission Decision should be reversed because it is based on unauthorized medical treatment.

Claimant incorrectly states that Appellants do not take issue with the Commission's legal conclusion that its denial of Claimant's request that Appellants pay for treatment by Dr. Brennan, "does not require and should not lead to the denial of the award of permanency based on the findings of Dr. Brennan." (Resp. Br. p. 7) (Amended 2016 Commission Decision, p. 8). In fact, Appellants argue strenuously that basing an permanent disability award on the results of unauthorized treatment is reversible legal error. (App. Br., Issue III, pp. 17-21).

As noted immediately above, Section 42-15-60 provides that the employer chooses the medical provider, "and the employee **shall** accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown." S.C. Code Ann. § 42-15-60 (emphasis added). Refusal by a claimant to comply with this mandatory provision "bars the employee from **further compensation** ..." Id (emphasis added); *see also* Hall, 371 S.C. at 86, 636 S.E.2d at 885 ("the employer names the authorized treating physician ... [and] a claimant may obtain compensation **only** by accepting services from

the employer's choice of providers") (emphasis added); McKinney, 376 S.C. at 638, 658 S.E.2d at 113 (claimants do not have a right to "unilaterally" select a physician to provide treatment). This is the employer's statutory right in the first instance.

Further, the evidence is not "uncontroverted" that the surgery performed by Dr. Brennan "was previously recommended by Dr. Triana ..." (Resp. Br. p. 7) (Amended 2016 Commission Decision, p. 9). In fact, Dr. Brennan operated on and fused the C6-7 vertebrae whereas Dr. Triana recommended possible surgery on C5-6. Indisputably, all of Dr. Triana's reports addressing the cervical spine refer to C5-6. (CL APA pp. 81, 85, 86, 148). Dr. Brennan "speculates" that Dr. Triana really meant C6-7 and/or had consistent typographical errors. (Brennan Dep. June 26, 2013, p. 5, lines 4-20 (Dr. Brennan stating C6-7 was "probably what Dr. Triana was looking at"); p. 16, line 21 – p. 17, line 10 (stating Dr. Triana "probably" made a typographical error but he had not asked him about it); p. 20, lines 6-14 (acknowledging he could not get into Dr. Triana's head)). Such a conclusion is not only speculation and conjecture, is fairly preposterous, given the consistent reference to C5-6 in Dr. Triana's medical records. Dr. Brennan's speculation as to what Dr. Triana meant in his medical notes is not "unrefuted medical evidence," (Resp. Br. p. 8), but only Dr. Brennan's guesswork. On one hand, Claimant asserts the surgery recommended by Dr. Triana in 2009 is the very surgery performed by Dr. Brennan but, on the other hand, suggests Dr. Triana consistently mis-identified the correct level of the cervical spine that needed treatment.[6]

Claimant alleges that Appellants knew or should have known he needed further medical treatment to his cervical spine. (Resp. Br. p. 18). In reality, Appellants had no

[6] As noted above, although Dr. Triana recommended a "decompression and fusion of the C5-6 disc," he also revealed that Dr. Grant suggested physical therapy. (CL APA p. 148).

indication that Claimant was seeking or allegedly was in need of additional treatment for the work-related injury to his cervical spine. In fact, at Claimant's deposition, taken March 30, 2010, he testified that his lower back was bothering him more than his cervical spine.

> Q: Between our left elbow, your neck, your left shoulder, and your lower back, what is bothering you the most at this point?
>
> A: Today?
>
> Q: Well, yeah, today and recently.
>
> A: My back. Yeah, my back.

(Hannah Dep. p. 37, lines 12-17). As noted above, he repeated this testimony at the July 30, 2010 hearing before the Hearing Commissioner. "I can deal with the neck, it doesn't bother me as bad as my back." (July 30, 2010 Tr. p. 37, line 15 – p. 38, line 23). Even now, Claimant continues to assert that his need for cervical surgery had not arisen at the time of the 2011 Commission decision. (*See* Resp. Br. p. 12 (Claimant asserting that his "worsening pain and resulting treatment for the neck *had not yet occurred* at the time of the prior appeal")).

The cervical spine surgery was performed some 847 days **after** Claimant signed a Form 17 agreeing he could return to work as of February 10, 2010. (Sept. 25, 2014 Tr. p. 60, line 22 – p. 61, line 14). He was represented by counsel when he signed the Form 17, indicating he could return to full work duty. He had the means and ability to find out whether his "assumption" that since he lost at the Commission level he was entitled to no more treatment for his cervical spine was in fact true. By failing to request additional medical care from Appellants first, Claimant deprived them of their statutory right under Section 42-15-60 to name the medical provider. Claimant has shown neither an emergency nor a failure or refusal to provide treatment.

VI. The Commission erred in denying Appellants' request for credit.

Respondent can point to no reasoning or rationale in the Commission Decision that supports its denial of Appellants' request for a credit of overpayment of TTD benefits. As explained in their Brief, the only reason stated by the Hearing Commissioner for denying Appellants a credit was because "a credit is to, 'be deducted from the amount to be paid as compensation' [and] [s]ince there is no compensation in this case, none exists from which to deduct a credit." (Hearing Commissioner Decision, p. 13).

On appeal, the Commission simply found, as a matter of fact, that Appellants "are not entitled to a credit for Temporary Total Disability benefits paid to the Claimant during the period of February 10, 2010 through August 16, 2011," with no explanation or support. The fact that Claimant offers his own self-serving rationale for why the Commission ruled against Appellants on this point does not constitute sufficiently detailed findings of fact made by the Commission. *See, e.g.*, Grant v. Grant Textiles, 372 S.C. 196, 202-203, 641 S.E.2d 869, 872 (2007) (reversible error where the Commission fails "to clearly set forth the underlying facts upon which it relied to support its conclusion"); Gray, 231 S.C. at 492, 99 S.E.2d at 492 (requiring Commission to "make such specific and definite findings upon the evidence reported as will enable this court to determine whether the general finding or conclusion should stand").

As explained in Appellants' Brief, the 2011 Commission Decision included Findings of Fact that Dr. Bethea determined that Claimant reached MMI as of February

10, 2010. In August 2011, Claimant signed a Form 17 agreeing he could return to full-time work. Although on one hand, Claimant argues that the denial of a credit is proper because the Commission determined that he reached MMI following Dr. Brennan's cervical fusion, (Resp. Br. p. 24), on the other hand he asserts that his "worsening pain and resulting treatment for the neck *had not yet occurred* at the time of the prior appeal ..." (Resp. Br. p. 12). This latter concession is a tacit admission that his symptoms and alleged need for surgery did not exist at the time the Commission issued its 2011 Commission Decision. In other words, he had reached MMI, had knowingly signed a Form 17 with advice of counsel, and Appellants are entitled to a credit. This Court should reverse the Commission on this issue or, at a minimum, remand to the Commission for proper findings of fact on this issue.

CONCLUSION

For all the reasons stated in their Brief and herein, this Court should reverse the Commission Decision, hold that Claimant's claim for permanent disability benefits is barred by the doctrines of *res judicata* and/or laches, and that Section 42-15-60 does not allow claimants to unilaterally seek out medical treatment for admitted injuries without first requesting the same from the employer, and then effectively bootstrap a disability award on ratings provided by the unauthorized treating physician based on the unauthorized treatment. Finally, this Court should award Appellants a credit for overpayment of TTD benefits paid from February 10, 2010 through August 16, 2011 or, at a minimum, remand to the Commission for properly detailed findings of fact on this issue.

Respectfully submitted,

June 1, 2017

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Attorneys for Appellants

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

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

---

W.C.C. File No. 0908371

Timothy Hannah, Employee, Claimant ..... Respondent,

v.

MJV, Inc./Butler Trucking, Employer, and
Palmetto Timber S.I. Fund c/o
Walker, Hunter & Associates, Inc., Carrier, ... Appellants.

PROOF OF SERVICE

I certify that I have served the **Initial Reply Brief of Appellants** and Appellants' **Designation of Matter** on Respondent Timothy Hannah by depositing a copy of it in the United States Mail, postage prepaid, on the 1st day of June 2017, addressed to his counsel of record as follows:

W.E. Jenkinson, III, Esquire
Jenkinson, Jarrett & Kellahan, PA
Post Office Drawer 669
Kingstree, South Carolina 29556

Kathy Aldrich

Kathy Aldrich
Legal Assistant to Helen F. Hiser
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Attorneys for Appellants MJV, Inc./Butler Trucking and Palmetto Timber S.I. Fund c/o Walker, Hunter & Associates, Inc.

mgc

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

June 1, 2017

Via U.S. Mail
The Honorable Jenny Abbott Kitchings
Clerk of Court
South Carolina Court of Appeals
Post Office Box 11629
Columbia, South Carolina 29211

RE: Timothy Hannah v. MJV/Butler Trucking, Inc. and Palmetto Timber S.I. Fund c/o Walker, Hunter & Associates, Inc.
Date of Accident: July 14, 2009
WCC File No.: 0908371
Our File No.: 2069.10005
Claim No.: 0001-0593-09-0002
Appeal No.: 2016-001643

Dear Ms. Kitchings:

Enclosed for filing please find the following documents:

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

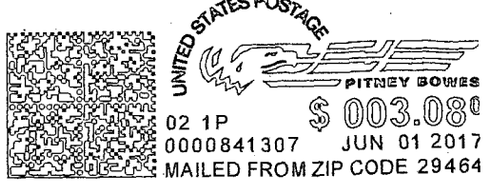
Please file these documents and return the clocked-in copies in the enclosed, self-addressed stamped envelope.

If you have any questions, please contact me.

Yours truly,

Helen F. Hiser

Enclosures
cc: W.E. Jenkinson, III, Esquire



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SC Court of Appeals

2069.10005/HFH/kea
The Honorable Jenny Abbott Kitchings
Clerk of Court
South Carolina Court of Appeals
PO Box 11629
Columbia, SC 29211