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

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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.

BRIEF OF APPELLANTS

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STATEMENT OF ISSUES ON APPEAL

I. WHETHER THE COMMISSION ERRED IN FAILING TO FIND THAT CLAIMANT'S CURRENT CLAIM FOR PERMANENT DISABILITY BENEFITS IS BARRED BY THE DOCTRINE OF *RES JUDICATA*?

II. WHETHER CLAIMANT'S CURRENT CLAIMS ARE BARRED BY THE DOCTRINE OF LACHES?

III. WHETHER THE COMMISSION ERRED IN AWARDING PERMANENT DISABILITY BENEFITS TO CLAIMANT BASED ON UNAUTHORIZED MEDICAL BENEFITS UNDER THE ACT?

IV. WHETHER THE COMMISSION ERRED IN HOLDING THAT APPELLANTS ARE NOT ENTITLED TO A CREDIT FOR TTD PAID TO CLAIMANT DURING THE PERIOD FEBRUARY10, 2010 THROUGH AUGUST 16, 2011?

STATEMENT OF THE CASE

This case, which has a complicated procedural history, presents the issue of whether a claimant, who is represented by counsel, is entitled to permanent partial disability based on surgery performed by an unauthorized surgeon when he neither asked the employer for the surgery nor was denied any treatment by the employer, and where unbeknownst to the employer or even to his own counsel, he simply went ahead and had surgery performed by a surgeon of his own choosing.

The claimant, Timothy Hannah ("Claimant") sustained compensable injuries in an 18-wheeler rollover accident that occurred on July 14, 2009. Claimant was employed by MJV/Butler Trucking Inc. at the time of the accident. Appellants MJV/Butler Trucking Inc. and Palmetto Timber S.I. Fund c/o Walker, Hunter & Associates, Inc. provided appropriate medical treatment for his cervical spine and left elbow, which body parts were accepted.

Claimant sustained an intervening accident on August 24, 2009 when he fell on steps at his home and hit his face on a railing. (R. p. 200, lines 8-25). Although Claimant initially alleged injury to only his cervical spine and left elbow, he later alleged a compensable injury to his lumbar spine. (Commission Order filed July 25, 2011, R. pp. 65-66) ("2011 Commission Decision"). After an initial hearing,[1] the Hearing

[1] At the July 30, 2010 hearing, the Hearing Commissioner stated Claimant's position as, "that as a result of this accident he injured his cervical spine, that he injured his elbow. That after the accident ... he's got problems with the cervical spine, with his elbow and also with his lumbar spine that's affecting his legs as a result of this accident. It's the position of the Claimant that he has not reached maximum medical improvement and in particular would request a finding that the lumbar spine ... would be found compensable and that he is in need of additional medical treatment for his lumbar spine. In the alternative if I find that the lumbar spine is not related to this accident 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 ..." (R. p. 193, lines 4-24).

Commissioner held that Claimant's cervical spine and elbow injuries, as well as his lumbar spine injury, were compensable, that he had not reached MMI and that he was entitled to additional treatment from Dr. Mark Triana. (Decision & Order filed Jan. 13, 2011, R. pp. 59-60).

Appellants appealed to the Full Commission which reversed, finding Claimant suffered compensable injuries only to his cervical spine and left elbow, and that he was not entitled to any future treatment for his lumbar spine/lower back. In addition, based on a Form 14B filled out by Dr. Bethea, the Commission found as a matter of fact that Claimant had been placed at MMI on February 2, 2010 for both his cervical spine and left elbow, and that Dr. Bethea had opined that Claimant sustained 0% impairment to both his cervical spine and left elbow. The Commission also held that, "Claimant has received all proper medical care that will tend to lessen his period of disability." (2011 Commission Decision, R. pp. 59-61) (Form 14B, dated Feb. 10, 2010, R. p. 76).

Claimant appealed the 2011 Commission Decision to this Court which, in an unpublished opinion, affirmed the 2011 Commission Decision in all respects. (Unpublished Opinion No. 2012-UP-535, Appeal No. 2011-197631, filed Sept. 26, 2012, R. pp. 49-51). Although Claimant's Brief to this Court 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, Appeal No. 2011-197631, filed March 21, 2012, R. pp. 105, 119, 132).

Claimant's counsel did not dispute this summary of his position, only adding that Claimant believed he had not reached MMI for his neck or back. (R. p. 194, line 24 – p. 195, line 23).

In the meantime, Claimant signed a Form 17, stating that he agreed he "was able to return to work on 2/10/10." (Form 17, dated Aug. 19, 2011, R. p. 99). Appellants paid Claimant temporary total disability ("TTD") benefits from the date of the July 14, 2009 accident through August 16, 2011. (R. p. 228, lines 21-23).

On November 7, 2012, Appellants filed a Form 21 request for hearing, noting that temporary benefits had been stopped properly pursuant to the Form 17, "but there remains a large overpayment of temporary benefits after MMI." (Form 21, dated Nov. 7, 2012, R. p. 155). In response, Claimant filed an Amended Form 50 seeking "payment of medical expenses related to a cervical spine cervical procedure which took place on June 5, 2012; payment of weekly wages from the date of the change of circumstance December 1, 2011 and additional medical care and treatment for cervical spine injury." Attached to the Amended Form 50 was an Addendum that stated, "[t]his is an action for review of award on change of conditions, §42-17-90," and referenced "attached medical reports." However, the only attachment to the Amended Form 50 was an affidavit by Claimant stating that, following this Court's 2011 decision affirming the Commission, he sought medical treatment including surgery to his cervical spine. He stated that he did not tell his lawyer he was seeking additional medical care because he "thought it would be of no use," since he had lost his appeal. The Addendum also stated that, relying on Dr. Bethea's opinion, the Commission had "found a 0% medical impairment to the cervical spine and 0% impairment to his left elbow ..." (Amended Form 50, dated Jan. 8, 2013, R. pp. 159-166).

Appellants filed a Form 51, raising the defenses of *res judicata*, collateral estoppel, laches, unauthorized treatment, no medical evidence to support his change of

condition claim, among other defenses, and seeking a credit for overpayment of TTD. (Form 51, dated Jan. 16, 2013, R. pp. 167-168).

A hearing was held on January 18, 2013 and the Hearing Commissioner issued a decision on December 5, 2013, granting Claimant both temporary total disability payments and additional medical treatment for his cervical spine. However, that order was vacated because Appellants were not provided sufficient notice of the "Form 50" hearing and the issues raised on Claimant's Amended Form 50. The matter was remanded to the Hearing Commissioner for a determination on all issues set forth in Form 21, Form 50 and Form 51. (Commission Decision, filed July 17, 2014, R. pp. 41-48).

A remand hearing was held on September 25, 2014, after which the Hearing Commissioner issued an order finding that, "[w]hen the Claimant chose to proceed on his own, he took himself out from under the Workers' Compensation Act." The Hearing Commissioner also found Claimant reached MMI as of February 10, 2010, that he did not suffer any permanent partial disability to either his neck or left arm, and that he was not entitled to any temporary total disability benefits or further medical treatment. As to Appellants' request for a credit for overpayment of TTD, the Hearing Commissioner noted that "pursuant to S.C. Code Ann. § 42-9-210, a credit is to be deducted from the amount to be paid to Claimant as compensation," and found that, "[s]ince there is no compensation in this case, none exists from which to deduct a credit." (Decision & Order, filed July 2, 2015, R. pp. 26-39) ("Hearing Commissioner Decision").

Claimant appealed this Decision to the Full Commission, which affirmed in part and reversed in part the Hearing Commissioner Decision. (Commission Decision, filed

Feb. 23, 2016, R. pp. 15-25) ("2016 Commission Decision"). In particular, the Commission held that, "[w]hen the Claimant chose to proceed on his own he did not take himself out from under the Workers' Compensation Act and the Claimant had a right to assert he had a permanent injury and resulting impairment for which he was entitled to compensation," that Claimant had reached MMI, and that he had suffered a "28% permanent partial disability to the cervical spine based upon a fusion of C6-7 and the Claimant's testimony." (2016 Commission Decision, R. pp. 23-24).

Appellants moved for reconsideration seeking, among other things, a ruling that they were entitled to a credit for TTD benefits paid to Claimant from February 10, 2010 (the date of Dr. Bethea's Form 14B) to August 16, 2011, representing 79 weeks of benefits. Appellants also sought reconsideration of the finding that Claimant had sustained a 28% permanent partial disability to the cervical spine based both on Dr. Bethea's conclusion that Claimant reached MMI in 2010 with no permanent impairment of the spine. Appellants also requested that any award be made to the back (as opposed to the cervical spine) because the Act provides disability awards to the back and not to specific segments of the spine. (Motion for Reconsideration, dated Feb. 29, 2016, R. pp. 174-177).

The Commission issued an Amended Decision on July 6, 2016, denying Appellants' request for credit for overpayment of TTD benefits and denying their request to reconsider the permanent partial disability award, but granting Appellants' request that any award be termed as an award to the back. (Commission Decision, filed July 6, 2016, R. pp. 3-14).

Appellants timely appealed to this Court.

FACTUAL BACKGROUND

Claimant testified that he was injured when the steering mechanism on the truck he was driving locked up and he lost control. He alleges he injured his neck, chest, elbow and lower back. (R. p. 236, line 21 – p. 237, line 10). He initially was treated at Georgetown Memorial for his neck and elbow. (R. p. 237, lines 1-8). Next he was treated at Doctor's Care, and then referred to Dr. Triana. (R. p. 240, lines 2-24). Claimant testified that, before he began seeing Dr. Triana, he fell on some stairs and "scarred [his face] up against the railing and had a little gash in it." (R. p. 242, lines 9-21). Although he downplayed the impact of this fall, he agreed that he felt it was significant enough to report to both his occupational therapist and his physical therapist. (R. p. 271, lines 7-25). The first MRI of his neck was performed after this fall. (R. p. 243, lines 11-17).

Dr. Triana noted a small disc protrusion at C5-6 and ordered an MRI of Claimant's lumbar spine. (R. pp. 181-184).

In December 2009, Claimant was sent to Dr. Bethea for treatment. (R. p. 245, lines 20-25). Dr. Bethea operated on his elbow and performed physical examinations of Claimant's cervical spine. (R. p. 273, lines 10-15). On January 6, 2010, Dr. Bethea determined that Claimant was at MMI for both his left arm and cervical spine. (R. pp. 187-188).

Claimant agreed that, at the July 30, 2010 hearing, in which he was seeking to have his lower back ruled compensable, he testified that he could deal with his neck, stating, "It doesn't bother me as bad as my back." However, he also testified that, when

he stopped seeing Dr. Triana in April 2010, he wanted to have the neck surgery Dr. Triana recommended. (R. p. 256, lines 11-24; p. 273, line 20 – p. 274, line 22). That recommendation was to address disc herniation at C5-6 to the left. (R. p. 189).

After his elbow surgery, Claimant began seeing Dr. Triana again on his own. (R. p. 255, lines 7-24). He testified that he stopped seeing Dr. Triana in April 2010 because he could not pay for the medical treatment and there was no insurance. (R. p. 256, lines 3-6).

Claimant testified that, after the Commission issued its 2011 Commission Decision, holding Claimant's lower back was not compensable, he went to his counsel's office and signed a Form 17. (R. p. 258, lines 15-23). Claimant testified that he signed the Form 17, "because we had lost and I thought – you know, I wanted to stop them checks." (R. p. 258, line 24 – p. 259, line 13). However, he confirmed that the signature under the statement that he agreed he could return to work on February 10, 2010 was his signature. (R. p. 259, lines 14-20). He also confirmed that he signed the Form 17 after consulting and discussing it with his attorney. Although Claimant testified that his attorney told him the Form 17 "was the form to stop my check," he also confirmed that he is fully capable of reading the English language and that by signing his name to a document, that meant he agreed with what he was signing. (R. p. 269, line 16 – p. 271, line 5).

After signing the Form 17 agreeing he was able to return to work in February 2010, Claimant sought further medical care from Dr. Daniels, who referred him to Dr. James Brennan. He did not tell Appellants he wanted additional medical care, or request any further treatment. He attested that he did not tell his own attorney. (Affid. ¶ 10, R.

pp. 165-166) (R. p. 261, lines 13-18; p. 263, line 13 – p. 264, line 23; p. 265, lines 10-22). Dr. Brennan performed neck surgery on June 4, 2012. (R. p. 275, lines 22-25). Claimant agreed that, after he signed the Form 17, he did not ask Appellants for any further treatment for his neck. (R. p. 276, line 15 – p. 277, line 3).

At a deposition, Dr. Brennan confirmed that the area on which he performed surgery was Claimant's C6-7; however Dr. Triana's notes said C5-6 needed treatment. Dr. Brennan speculated that Dr. Triana's notes might have contained a typographical error or Dr. Triana just misspoke "and [C6-7 was] probably what Dr. Triana was looking at in his note." (R. p. 338, lines 4-20). Dr. Brennan acknowledged that he had not talked to Dr. Triana about this case, (R. p. 340, lines 8-10), and that he "[couldn't] get into his head on that." (R. p. 342, lines 6-14).

STANDARD OF REVIEW

Judicial review of a Commission decision is directed by the substantial evidence rule of the Administrative Procedures Act, S.C. Code Ann. § 1-23-380(5) (Supp. 2016). Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981). A reviewing court should affirm the decision of the Full Commission unless it is clearly erroneous in view of the substantial evidence of the whole record. Lark, 276 S.C. at 136, 276 S.E.2d at 307. The reviewing court may not substitute its own judgment for that of the Full Commission as to the weight of the evidence on a question of fact, but may reverse if the decision is affected by an error of law. S.C. Code Ann. § 1-23-380(5).

Review of the Commission's factual findings is governed by the substantial evidence standard. "A reviewing court may reverse or modify a decision of an agency if the findings, inferences, conclusions, or decisions of that agency are 'clearly erroneous in

view of the reliable, probative and substantial evidence on the whole record.'" Bass v. Isochem, 365 S.C. 454, 467, 617 S.E.2d 369, 376 (Ct. App. 2005). In particular, Workers' Compensation awards "must not be based on surmise, conjecture or speculation." Tiller v. Nat'l Health Care Ctr., 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999). In addition, a reviewing court should reverse, remand or modify a decision of the Workers' Compensation Commission if it is affected by an error of law. Etheredge v. Monsanto Co., 349 S.C. 451, 562 S.E.2d 679 (Ct. App. 2002).

ARGUMENT

I. The Commission erred in failing to find that Claimant's current claim for permanent disability benefits is barred by the doctrine of *res judicata*.

As a threshold matter, the Commission's implicit finding of MMI in its 2011 decision, that "[p]ursuant to S.C. Code Ann. §42-15-60, which governs the periods within which medical treatment shall be furnished, we conclude that the Claimant has received all proper medical care that will tend to lessen his period of disability," (2011 Commission Decision, R. p. 73), is the law of the case. The 2011 Commission Decision was affirmed by the Court of Appeals. Claimant did not appeal this Court's 2011 Order. Charleston Lumber Co. v. Miller Housing Corp., 338 S.C. 171, 175, 525 S.E.2d 869, 871 (2000) (because respondent did not appeal the ruling of the reviewing court, the courts on remand were bound by the ruling as the law of the case).

Furthermore, the 2011 Commission Decision was not limited solely to the lumbar spine, but also made Findings of Fact that "Claimant suffered an admitted work related accident on July 14, 2009 which resulted in injury to his cervical spine and left elbow," that he suffered an unrelated fall at home on August 25, 2009," that "Claimant was placed at maximum medical improvement for injuries to his cervical spine and left elbow

on February 2, 2010, by his authorized treating physician, Dr. James Bethea," and that "Dr. Bethea opined that Claimant has sustained 0% medical impairment to the cervical spine and 0% medical impairment to his left elbow." (2011 Commission Decision, R. pp. 70-72). In fact, Conclusion of Law No. 8, in which the Commission held that Claimant was "not entitled to medical treatment and/or supplies ... for his alleged low back/lumbar spine injury," is separate from Conclusion of Law No. 6, which states that "Claimant has received all proper medical care that will tend to lessen his period of disability." (2011 Commission Decision, R. p. 73). Conclusion of Law No. 8 is limited to the lower back whereas Conclusion of Law No. 6 is not.

The doctrine of *res judicata* applies to workers' compensation cases. Under that doctrine, a claim may be precluded if it is shown: "(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).

In Johnson, the claimant filed a workers' compensation claim and sought benefits based on the belief that the chemicals she was exposed to in her employment caused a fatal skin condition. The treating physician opined that the claimant's condition was unrelated to her employment. As a result, the single commissioner found that the claimant's condition was not compensable. She did not appeal the single commissioner decision. 317 S.C. at 250, 452 S.E.2d at 833. Subsequently, the claimant began treating with a different physician who opined that the claimant's condition was most probably related to chemicals to which she was exposed in the workplace. Based on this opinion, the claimant filed a second Form 50 claiming occupational exposure. The Supreme Court

held that the claimant's second claim was barred by *res judicata*, reasoning that, "[a]lthough Claimant was unaware of the causal relationship between her disease and her employment at the time of the first adjudication, the issue was nonetheless litigated." 317 S.C. at 251, 452 S.E.2d at 833.

Here, clearly, the parties to the proceeding that resulted in the 2011 Commission Decision and to the present proceeding are the same. In addition, the subject matter is the same. Claimant clearly argued at the 2010 hearing that, in the event the lumbar spine was not compensable, he was seeking a permanent partial disability award that "would far exceed any rating in the record, including that of Dr. Bethea," and that Claimant believed he had not reached MMI for his neck. (R. p. 193, lines 4-24; p. 194, line 24 – p. 195, line 23). Thus, the issue of whether Claimant had reached MMI for his cervical spine and, if so, what his disability award should be was raised in 2010.

Finally, these issues have been addressed in a prior Commission decision. The 2011 Commission Decision found as a matter of fact that, "Claimant was placed at maximum medical improvement for injuries to his cervical spine and left elbow on February 2, 2010, by his authorized treating physician, Dr. James Bethea," and that "Dr. Bethea opined that Claimant has sustained 0% medical impairment to the cervical spine and 0% medical impairment to his left elbow." In addition, the Commission concluded as a matter of law that, "Claimant has received all proper medical care that will tend to lessen his period of disability." (2011 Commission Decision, pp. 9-10). Together, these findings constitute an implicit finding of MMI with no permanent disability. *See* 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"), *citing* O'Banner v. Westinghouse Elec. Corp., 319 S.C. 24, 28, 459 S.E.2d 324, 327 (Ct. App. 1995) for the proposition that MMI "is a term used to indicate that a person has reached such a plateau that in the physician's opinion *there is no further medical care or treatment which will lessen the degree of impairment.*" The 2011 Commission Decision was affirmed by this Court.

Therefore, this Court should hold that Claimant's current claims that he had not reached MMI in 2010 and/or that he is entitled to a permanent disability award are barred by *res judicata*.

II. Claimant's current claims are barred by the doctrine of laches.

Like *res judicata*, the theory of laches applies in workers' compensation claims. *See* McMillan v. Midlands Human Res, 305 S.C. 532, 533, 409 S.E.2d 443, 444 (Ct. App. 1991) (noting that a "claimant must prosecute his claim in a timely fashion or it may be barred by the doctrine of laches"). "Laches is neglect for an unreasonable and unexplained length of time, under circumstances affording opportunity for diligence, to do what in law should have been done." Muir v. C.R. Bard, Inc., 336 S.C. 266, 296, 519 S.E.2d 583, 598 (Ct. App. 1999). Put another way, laches is the negligent failure to act for an unreasonable period of time. The party asserting laches bears the burden of showing "negligence, the opportunity to have acted sooner, and material prejudice." 336 S.C. at 297, 519 S.E.2d at 599. Laches is a "highly fact-specific" determination and each case must be decided on its own facts. Mid-State Trust, II v. Wright, 323 S.C. 303, 307-308, 474 S.E.2d 421, 424 (1996) (finding that, although the party had been "at least

slightly prejudiced" by the failure to timely assert a claim, there was no evidence of the other party's knowledge of its claim).

Here, Claimant timely brought his claim and argued at the July 30, 2010 hearing, that he sustained compensable injuries to his cervical spine and his left elbow (in addition to his lower back), that he had not reached MMI for any of his injuries, and that his permanent disability far exceeded the rating in the record provided by Dr. Bethea. (R. p. 193, lines 4-24; p. 194, line 24 – p. 195, line 23). The Hearing Commissioner ruled in his favor but the Commission reversed, and that decision was affirmed in September 2012 by this Court. Prior to this Court's Decision, Claimant signed a Form 17, with the advice of counsel, affirming that he was able to return to work as of February 10, 2010. Thereafter, without notifying Appellants or his own attorney, he began seeking medical care for his cervical spine, including ultimately surgical fusion of his C6-7. (Affid. ¶ 10, R. pp. 165-166) (R. p. 261, lines 13-18; p. 263, line 13 – p. 264, line 23; p. 265, lines 10-22). Over a year and a half pass. It was not until after Appellants filed a Form 21 seeking only credit for TTD benefits paid to Claimant from February 10, 2010 through August 16, 2011, that Claimant revealed that he had taken it upon himself to seek medical care. Critically, there was no denial of or refusal to provide appropriate care. Claimant simply failed to request any additional medical care for either of his compensable conditions.

"Generally, a claimant may obtain compensation only by accepting services from the employer's choice of providers." Hall v. United Rentals, Inc., 371 S.C. 69, 86, 636 S.E.2d 876, 885 (Ct. App. 2006). And, while Appellants do not dispute that a claimant need not forgo necessary medical care, here, there was no denial or refusal to provide. Furthermore, the Act "does not give a unilateral right to claimants to select their treating

physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature." Turner v. South Carolina Dept. of Health & Envtl. Control, 377 S.C. 540, 546, 661 S.E.2d 118, 121 (Ct. App. 2008).

Claimant's request for payment of permanent partial disability benefits is complicated by the fact that he sustained an intervening accident on August 25, 2009 when he fell on some steps at his home and hit his face on a railing. The first MRI of Claimant's cervical spine was not performed until three weeks after the August 25, 2009 incident. Dr. Triana's medical notes reference treatment to C5-6, (*see* R. pp. 181-184, 189), whereas the surgery Dr. Brennan performed was to C6-7. Although Dr. Brennan speculated that Dr. Triana's notes were the result of a typographical error or simply mistaken, (R. p. 338, lines 4-20; p. 340, lines 8-10; p. 342, lines 6-14), that is nothing more than mere speculation. As a result the disability award to Claimant's cervical spine based on Dr. Brennan's surgical intervention is speculative, adding prejudice to Appellants. *See* Tiller, 334 S.C. at 339, 513 S.E.2d at 845 (workers' compensation awards "must not be based on surmise, conjecture or speculation").

In this case, the Hearing Commissioner properly undertook a review of the records, including the testimony at the September 25, 2014 hearing, and made the determination that Claimant had not sustained any permanent disability as a result of his work accident. It would be impossible to determine Claimant's entitlement to permanent partial disability benefits without resorting to speculation. Therefore, the Hearing Commissioner correctly found that Claimant was not entitled to permanent disability benefits. Any other conclusion would result in material prejudice to Appellants, as they were unable to assert their rights under the Act prior to Claimant unilaterally choosing his

physician, undergoing treatment, which ultimately included a cervical fusion. It also would be patently unfair to hold Appellants responsible for events that occurred outside of their knowledge and control so far after the date Claimant reached MMI and agreed he could return to work.

It is widely held that ignorance of the law, or Claimant's alleged "confusion" in this claim, is no excuse. Claimant has slept on his rights and was not vigilant in asserting his claim. Hucks v. Green's Fuel of S.C., 247 S.C. 457, 464, 148 S.E.2d 149, 152 (1996) ("[a]ny lack of diligence on the part of the attorney for the [claimant] is attributable to and binding upon him").

Claimant's explanation regarding his alleged "confusion" regarding signing the Form 17 and seeking medical care on his own is inadequate. On the surface, Claimant's explanation appears sympathetic but that rationale does not survive even cursory scrutiny. First, he signed his Form 17 in the presence and on the advice of his own learned counsel, who is familiar with and knowledgeable of workers' compensation law. Thus, we are not dealing with a claimant who is proceeding *pro se* and who legitimately might have misunderstood the purpose or the effect of signing the Form 17. Any failure to explain or understand the Form 17, or even the status of the claim on remand from this Court, should fall on Claimant and his counsel, not on Appellants.

Second, Claimant acknowledged that he is fully capable of reading and understanding the English language. (R. p. 269, line 16 – p. 271, line 5). "A person who signs a contract or other written document cannot avoid the effect of the document by claiming that he did not read it." Wachovia Bank, N.A. v. Blackburn, 407 S.C. 321, 755 S.E.2d 437 (2014), *citing* Regions Bank v. Schmauch, 354 S.C. 648, 663, 582 S.E.2d

432, 440 (Ct. App. 2003). "Instead, when a person signs a document, he is responsible for exercising reasonable care to protect himself by reading the document and making sure of its contents." Wachovia Bank, 407 S.C. at 333, 755 S.E.2d at 443; *see also* Evans v. State Farm Mut. Auto. Ins. Co., 269 S.C. 584, 587, 239 S.E.2d 76, 77 (1977) (a person signing a written document "should read it and avail himself of every reasonable opportunity to understand its content and meaning"). Here, there is no reason to believe Claimant was incapable of understanding the agreement he was signing on the Form 17 and, as noted above, he was counseled by his own attorney prior to signing that form. Hucks, 247 S.C. at 464, 148 S.E.2d at 152 (claimant's failure to act, relying on advice from his own attorney, cannot be attributable to employer). Claimant's explanations for why he signed the Form 17, and why he failed to request additional medical treatment from Appellants for his compensable injuries are convenient excuses that do not survive basic scrutiny. In the end, Claimant's "unilateral mistake ... is unavailing absent proof of fraud, deceit, misrepresentation, concealment, or imposition of," the opposing party, Regions Bank, 354 S.C. at 662, 582 S.E.2d at 440, none of which have been alleged, much less shown, here.

Appellants have been materially prejudiced by Claimant's failure to act appropriately and timely. Appellants did not have the opportunity to accept or deny or even evaluate the treatment Claimant ultimately sought on his own. As a result, Appellants had no opportunity to investigate possible alternative, less intrusive treatments.

As a result, this Court should hold that the award of permanent disability benefits to Claimant is barred by the doctrine of laches, since Claimant has presented no rational

explanation for his failure to timely request medical treatment and Appellants have been materially prejudiced by Claimant's unilateral decision to pursue medical treatment.

III. The Commission erred in awarding permanent disability benefits to Claimant based on unauthorized medical benefits under the Act.

Even if this Court finds that Claimant's claim is not barred by the doctrine of *res judicata* and/or the equitable doctrine of laches, this Court should reverse the Commission's award of permanent partial disability benefits based on Claimant's unilateral selection and pursuit of medical treatment for an admitted compensable injury without requesting same or even notifying Appellants. Turner, 377 S.C. at 546, 661 S.E.2d at 121 (claimants do not have a unilateral right "to select their treating physician, and such an unencumbered right undermines the authority of the commission, as prescribed by the legislature").

Section 42-15-60 states, in pertinent part, that "[t]he employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty .... 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(A). The provision goes on to provide an exception to the employer's right to select the treating physician, which arises in emergency situations where the employer has failed to provide adequate medical

care: "If in an emergency, **on account of the employer's failure to provide the medical care as specified in this section**, a physician other than provided by the employer is called to treat the injured employee, the reasonable costs of such service shall be paid by the employer if so ordered by the Commission." Id. (emphasis added).

Accordingly, in Hall, this Court held that the Commission has the discretion to authorize medical treatment from an unauthorized medical provider under certain scenarios. 371 S.C. at 86, 636 S.E.2d at 885-886. There, the claimant was declared to be at MMI by the authorized treating physician. Believing he still needed medical treatment, the claimant sought a second opinion from another physician, who recommended surgical intervention. The claimant requested that the employer authorize the surgery and the employer refused. Nonetheless, the claimant proceeded with the surgery. 371 S.C. at 76-77, 636 S.E.2d at 880. The surgery provided beneficial results. This Court held that, under those facts, the Commission had discretion to authorize the medically necessary treatment and to require payment of the causally related medical expenses. 371 S.C. at 87, 636 S.E.2d at 886.

Here, in contrast, Claimant did not request authorization for the treatment through Dr. Brennan or file a Request for Hearing seeking entitlement to the same until after he had already received the treatment. In fact, it is undisputed that Claimant did not inform Appellants or even his own attorney about the treatment and subsequent surgery until after it had been performed. Appellants were deprived of the opportunity to decide whether or not to authorize the treatment through Dr. Brennan in the first place, resulting in prejudice after-the-fact.

Below, Claimant cited Gattis v. Murrells Inlet VFW #10420, 353 S.C. 100, 114 S.E.2d 191 (Ct. App. 2003) for the proposition that the Commission may override an employer's choice of medical provider. As noted above, Appellants agree that the Commission may override the employer's choice of medical care when the employer fails to provide adequate medical care. *See* S.C. Code Ann. § 42-15-60. However, Claimant has presented no evidence that the unauthorized surgical intervention performed by Dr. Brennan arose out of an emergency where Appellants failed to provide adequate medical care. In fact, as stated above, Appellants did not even have the opportunity to approve or deny the requested medical care, further bolstering their contention that any claim should be barred under the doctrine of laches based on material prejudice and Claimant's unreasonable delay in filing his claim.

Below, Claimant cited case law from North Carolina, Cash v. Lincare Holdings, 181 N.C. App. 259, 264, 639 S.E.2d 9, 14 (N.C. Ct. App. 2007), for the principle that the consideration of whether an employer must pay for medical treatment is a separate consideration from whether the employee is entitled to disability compensation. However, this discussion by the North Carolina Court of Appeals arose in the context of determining whether the appeal was interlocutory. Cash does not hold that a claimant can fail to request additional medical treatment for an compensable injury but, instead, go off on his own and direct his own treatment and then obtain a disability award based on unrequested, unauthorized and, at the time, unknown treatment. Hyler v. GTE Prods. Co., 333 N.C. 258, 425 S.E.2d 698 (NC 1993), also cited by Claimant, dealt with whether annual monitoring of the claimant's knee condition required that he show a change of condition or, instead, was part of the ordered medical care. In the context of determining

that the claimant did not need to show a change of condition, the North Carolina Supreme Court simply determined that "[m]edical and hospital expenses which employers must provide pursuant to N.C.G.S. § 97-25 are not part of 'compensation' as it always has been defined in the Workers' Compensation Act." 333 N.C. at 264, 425 S.E.2d at 702. However, neither Cash nor Hyler dealt with the issue before this Court, which is whether a claimant can simply fail to ask for medical care, then seek it on his own without the employer's knowledge or input, and then use that medical care, including serious back surgery, to obtain disability benefits. The question is especially critical in this context where the prior authorized medical provider released him years before with a 0% impairment to his neck, (Form 14B, R. p. 76) (R. pp. 187-188), and Claimant signed a Form 17 agreeing he could return to work. (Form 17, R. p. 99).

Claimant also argued below that the award is proper because claimants often seek independent opinions from non-authorized physicians. Seeking an opinion from a non-authorized physician is factually and legally distinct from what occurred here. Here, as noted above, Claimant did not simply seek a second opinion and then seek authorization for the recommended course of treatment. Neither did he simply seek an evaluation and rating from an independent expert. Instead, he went out on his own, sought medical care that included a cervical spine fusion, without seeking authorization or even advising Appellants that that was what he was doing. And, while there are circumstances under which a claimant might be justified in "going outside the Act" to obtain necessary medical treatment, this case does not present one of those situations.

For the foregoing reasons, this Court should reverse the Commission Decision and hold that Claimant is not entitled to any permanent disability award.

IV. The Commission erred in holding that Appellants are not entitled to a credit for TTD paid to Claimant during the period February10, 2010 through August 16, 2011.

On rehearing, the Commission determined that Appellants were not entitled to a credit for TTD payments paid to Claimant from February 10, 2010 through August 16, 2011. This Finding of Fact is not supported by any explanation as to why the Commission denied the credit. As a result, this finding is not sufficiently detailed for appellate review, *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"), and must be reversed.

Although the Commission has discretion in awarding a credit under Section 42-9-210, which uses the permissive term "may," a failure to exercise discretion or basing the decision on improper considerations constitutes reversible error. Balloon Plantation, Inc. v. Head Balloons, Inc., 303 S.C. 152, 399 S.E.2d 439 (Ct. App. 1990) ("[i]t is an equal abuse of discretion to refuse to exercise discretionary authority when it is warranted as it is to exercise the discretion improperly"). Here, there were prior Findings of Fact that Dr. Bethea had found Claimant to have reached MMI as of February 10, 2010, and that he had rated Claimant at 0% for both his cervical spine and left arm. (2011 Commission Decision, R. pp. 71-73). Claimant signed a Form 17 in August 2011 agreeing he could return to work as of February 10, 2010. (Form 17, R. p. 99). As a result, the payments made from February 10, 2010 through August 16, 2011 "were not due and payable when made," S.C. Code Ann. § 42-9-210, and Appellants are entitled to the credit.

The Hearing Commissioner did not deny Appellants' request for a credit. Instead, he held that, "pursuant to S.C. Code Ann. § 42-9-210, a credit is to be deducted from the

amount to be paid to Claimant as compensation," but, since he was not awarding claimant any compensation, "none exists from which to deduct a credit." (Hearing Commissioner Decision, R. p. 38). On appeal and rehearing, the Commission has provided no explanation whatsoever for its denial of Appellants' legitimate and substantiated request for a credit for overpayment.

As a result, this Court should hold the Commission's denial of a credit to Appellants for overpayment of TTD is legal error and award the credit or, at a minimum, remand to the Commission for detailed findings of fact to support its conclusion.

CONCLUSION

For all the reasons stated 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 claimants cannot 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. Finally, this Court should award Appellants a credit for overpayment of TTD benefits paid from February 10, 2010 through August 16, 2011.

Respectfully submitted,

July 10, 2017

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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

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W.C.C. File No. 0908371

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

v.

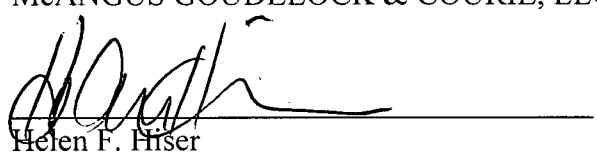
MJV, Inc./Butler Trucking, Employer, and
Palmetto Timber S.I. Fund c/o
Walker, Hunter & Associates, Inc., Carrier, ... Appellants.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Brief of Appellants MJV, Inc./Butler Trucking and Palmetto Timber S.I. Fund c/o Walker, Hunter & Associates, Inc. complies with Rule 211(b), SCACR. The undersigned also certifies that this Brief of Appellants complies with the South Carolina Supreme Court's April 15, 2014 Order re: Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings.

July 10, 2017

McANGUS GOUDELOCK & COURIE, LLC



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