20526 THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM HORRY COUNTY
Court of Commons Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No.: 2012-213175

Gilbert Chavis,Employee, ... Employee,

v.

AVX Corporation, Employer, and Liberty Mutual Insurance, ... Carrier,

In Re: AVX Corporation and Liberty Mutual Insurance Company, ... Respondents,

v.

South Carolina Second Injury Fund,.....Appellant.

RECORD ON APPEAL

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VOLUME I

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ORDER AND AWARD

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 9826170 & 9927964

Gilbert Chavis

Employee/Claimant,

v.

AVX Corporation

Employer,

and

Liberty Mutual Insurance Corporation,

Carrier,

Defendant(s).

HEARING:	Date: March 30, 2006 Location: Columbia, South Carolina
APPEARANCES:	Claimant represented by Preston F. McDaniel, Esquire and Bruce G. Dew, Esquire Defendant(s) represented by Roy A. Howell, III, Esquire
PURPOSE OF HEARING:	This matter came before the Commissioner on a Form 50 and 51
COMMISSIONER:	J. Alan Bass
FILED:	August 31 2006.

STIPULATIONS

The parties have stipulated to jurisdiction and venue and that the Commission file with the exception of self-serving declarations and unstipulated medicals is made a part of the Record.

STATEMENT OF THE CASE

Pursuant to the Administrative Procedures Act and the Rules of this Commission at the time for the Hearing the parties have made records and reports from the following a part of the Record: Dr. Domenic DeMichele; Open MRI & CT; Dr. James R. Merikangas; Dr. L. Randolph Waid; Eastern Carolina Neurological Associates- Dr. Daniel B. Groblewki; Coastal Orthopedics-Dr. A. Jay Pressler, III, Dr. Jeffrey Wilkins, Dr. William Mills; Dr. Gregory Kang; Carolina Health Specialists; Strand Regional Specialty Associates Dr. Thomas J. Chambers; Pee Dee Orthopedics- Dr. Robert E. Elvington, Jr., Dr. W.S. Edwards, Jr.; Dr. Phillip Nicol; DISC Imaging; Grand Strand Medical Center; Doctors Care; Dr. Asbury Williams; Dr. Thomas Harden; Beach Rehabilitation and Injury Center; Power Rehabilitation at Work; Health South of South Carolina; C. Tucker Weston, M.D.; Dr. Richard W. Ward; Dr. Langdon A. Hartsock; Dr. Michael S. Green; Dr. Matthew E. Midcap; Brian West, Ph.D.; David Price, Ph.D.; Dr. Paul Pritchard; Dr. Keith Gawith; Fi-Fi Jubran, MA, CRC, CCM, CDMS, Employer Record-Injury Report; Claimant's 1999 W-2; South Carolina Workers'

Compensation Commission Form 20, Form 15 and two (2) Form 17s; and the deposition transcripts of Dr. Randolph Waid; Dr. A. Jay Preslar, III; and Dr. Jeffrey Wilkins.

The issues before this Commissioner for decision are: the benefits to which the Claimant is entitled in these accepted claims under the Act including whether or not he is entitled to an award for total and permanent disability or scheduled member awards and if he is entitled to an award of total and permanent disability whether or not he suffered physical brain damage as one of the injuries that resulted in total and permanent disability which would therefore entitle him to lifetime disability benefits. The average weekly wage and resulting compensation rate is an issue between the parties as well.

As to all disability award issues, based on a review of the testimony and evidence submitted and based on a review of the Commission File, it appears that the Claimant sustained a compensable injury on December 1, 1998 for which benefits were paid including a period of nine (9) weeks temporary total disability benefits including a period of temporary total paid from August 16, 1999 through September 26, 1999. The Claimant then sustained a second injury on December 27, 1999. Thereafter, the Claimant began to receive temporary total disability benefits on or about February 1, 2000 and has continued to be paid temporary total disability benefits from that date and continuing

at the time of the Hearing. The Defendants on the 1998 injury paid medical benefits including surgery to his right arm. The authorized treating physicians following the 1998 injury were Dr. A. Jay Preslar, III and Dr. Jeffrey C. Wilkins both of Coastal Orthopaedics. Then following the December 27, 1999 accident the Defendants have paid for medical care for the Claimant including medical care for his neck, low back, right shoulder and left shoulder and including treatment for depression, erectile dysfunction and other related conditions. This is based upon a review of the Commission File and the evidence submitted. While having paid for all of the above-referenced medical care and temporary total benefits from 2000 to 2003, when a request for Hearing was made on this case in 2003, the Defendants filed a Form 51 admitting injury to the back only as to the December 27, 1999 claim and injury to the back only in reference to the 1998 claim. The Defendants subsequently over two (2) years later (August 2005) filed Amended Form 51s without consent of the Claimant or leave of the Commission admitting injury to the right shoulder from the 1998 claim and admitting a minor injury in reference to the 1999 claim; again this was filed regardless of the fact that they had paid medical costs and temporary total disability benefits as set forth hereinabove.

Further, a review of the testimony and evidence submitted and the Commission File indicates that prior to the 1998 claim

that the Claimant had sustained compensable injury with the same employer in reference to his back and had received a prior award. Therefore, if it were determined that the Claimant were not entitled to an award for lifetime disability benefits for his injuries which includes a physical brain injury, the Defendants would be entitled to a credit.

A review of the Commission File and the evidence submitted establishes that the Claimant sustained injury on December 7, 1998 when a pot weighing approximately ninety (90) to one hundred (100) pounds tilted over and the Claimant attempted to catch it resulting in a stretching injury to his neck and right shoulder. The records and deposition testimony of Dr. Wilkins are clear that prior to and at the time of the injury in 1998 that the Claimant was being treated for low back pain. In December 1998 Dr. Wilkins referred the Claimant to Dr. Holgate for an L5-S1 facet block on the right. On January 11, 1999 the Claimant reported back to Dr. Wilkins as follows,

> "He returns today stating he does not know whether to hug us or hit us due to the fact that his facet has helped so much that he wishes he had it sooner."

The records from Dr. Wilkins and Dr. Preslar from that point (1/11/99) through December 27, 1999 show that the Claimant was treated only for continuing problems with pain in the right shoulder radiating into the right arm. There is no treatment between that date and the accident which occurred on December 27,

1999 for the low back. In fact, there is no mention of any problem in the records whatsoever with the low back prior to the 1999 accident. On August 18, 1999, the Claimant underwent a procedure on his right shoulder to repair a torn rotator cuff in the suprapinatus with a debridgement and decompression. Following the surgery the Claimant continued to have problems with the right shoulder and was being seen for that problem by Dr. Jay Preslar at the time of his injury on December 27, 1999.

On December 27, 1999 the Claimant was moving a pot of material which weighed approximately four hundred (400) pounds on what he described as a set of bad wheels at which time the pot came half way off the wheels. When the Claimant tried to keep the pot on the wheels and from turning over he began to feel immediate burning pain in his back after which at approximately 2:30 p.m. he reported his back was not burning but was hurting any time he tried to lift or pick up anything. The records of the employer on that date confirm that at the time of the accident the Claimant filed a written report of injury with his supervisor. This report of injury was placed in the Record.

Because of the ongoing problems that the Claimant was having in his right shoulder area prior to the December 27, 1999 accident and because of Dr. Preslar's recommendation that the Claimant undergo further surgery on the right shoulder in the Fall of 1999, the Defendants scheduled the Claimant to see Dr.

Robert E. Elvington, Jr. which was scheduled for December 29, 1999 two days after the second accident. In Dr. Elvington's evaluation of December 29, 1999 he agrees with Dr. Preslar that further surgery may help the Claimant with the continuing pain he was having. Dr. Elvington also recommended that the Claimant undergo a cervical MRI scan and when the Claimant returned to see Dr. Preslar on January 4, 2000 Dr. Preslar scheduled a cervical MRI scan which was performed by Dr. David Goltra, Jr. on January 8, 2000 which showed a central bulge at the C5-6. After the scan Dr. Preslar referred the Claimant for selective nerve root injection to see if this would help him with the problems that the Claimant was having in the neck and shoulder area. This procedure was performed on January 25, 2000 by Dr. David Goltra and during which the Claimant had a syncopal episode and was admitted to the hospital. Subsequent to discharge he came under the care of Dr. Daniel B. Groblewski who saw him on January 31, 2000 with an impression of syncope and persistent lethargy, ataxia and speech difficulty. An MRI was performed at Conway Hospital on February 7, 2000 which revealed an abnormal signal enhancement involving the right cerebral hemisphere and the right midbrain. Following the MRI Dr. Groblewski diagnosed the Claimant with a right cerebral infarct. Subsequently, after treatment Dr. Groblewski expressed the opinion that the Claimant had sustained permanent physical brain injury as a result of the cerebral

infact. Subsequent MRIs established that there was residual physical damage to the brain specifically including the MRI that was performed three (3) years later on December 16, 2003 which found an old infarct in the right cerebral hemisphere.

At the time of the injection and following the injection in March, April and May the Claimant continued to be followed for problems with his shoulder, neck and low back by Dr. Wilkins. He was referred for second opinions concerning the neck and shoulder pain that he was having to Pee Dee Orthopedics and after evaluation by both Dr. Edwards and Dr. Elvington, Dr. Elvington again recommended surgery on the shoulder to eliminate some of the shoulder pain that he was having. He also referred him back to Dr. Grobleski for treatment of the neck problems that he was having which Dr. Elvington stated in his notes his opinion that, "I think this is related to the stroke and/or the injection." He referred him back to Dr. Groblewski to give him pain medication and Neurotin to see if that would help with the neck pain. The Claimant continued under the care of and the records reflect that the Claimant's care was authorized by the carrier under Dr. Jeffrey C. Wilkins in the years 2000, 2001 and 2002 for treatment of the Claimant's right shoulder, neck and low back problems. The pain charts that were completed by the Claimant throughout 2000 record continuing problems with low back pain and in the Fall 2000 increasing low back pain.

According to the deposition of Dr. Wilkins and Dr. Preslar Dr. Wilkins referred the Claimant for a Functional Capacity Evaluation on November 1, 2001. When the Claimant was seen in follow up following that Functional Capacity Evaluation on January 21, 2002 the Claimant reported that he was having new complaints of left shoulder pain which he related to the FCE. There had been previous notations of some continuing left shoulder pain following the original cervical injection which resulted in the stroke but this had worsened by January 21, 2002 after the Functional Capacity Evaluation. Dr. Preslar in his deposition stated that the two (2) most likely causes of the Claimant's left shoulder problems were the cervical spine injection and stroke and/or injury occurring during the Functional Capacity Evaluation. The Claimant was followed by Dr. Preslar who recommended surgery in the Spring of 2002. On July 19, 2002 Dr. Wilkins who was the designated primary care physician by the insurance carrier, Liberty Mutual Insurance referred the Claimant to Dr. Gregory Kang for chronic pain management and according to the records on July 30, 2002 Carole Lovett the adjuster assigned by Liberty Mutual approved the referral to Dr. Kang. Since that time the Claimant has been treated and followed by Dr. Kang for his work-related problems. The Claimant testified as to his current medications and the treatment which he is being provided by Dr. Kang. According to

the records of Dr. Kang and the records of Dr. Chambers in 2003 Dr. Kang referred the Claimant for continuing left shoulder problems to Dr. Chambers with Strand Regional Specialty Associates.

As noted, the carrier has paid for all treatment specifically all the treatment provided by Dr. Jeffrey C. Wilkins and Dr. A. Preslar, III as the designated authorized treating physicians for the problems that the Claimant sustained with his right shoulder, his neck and his low back. The carrier has authorized the referral from Dr. Wilkins to Dr. Gregory Kang for continuing chronic pain management and according to Dr. Kang's records he is following the Claimant for lumbarspondlyosis with mechanical back pain and cervical degenerative disc disease and pain in his right and left shoulders. The pain charts submitted from Dr. Kang establish that the Claimant has consistently reported problems with pain in his low back and neck and shoulder areas.

Dr. Wilkins on February 20, 2001 stated that in his opinion the problems with the Claimant's neck and right shoulder were a direct result of the 1998 accident and that his low back pain and lumbar problems were as a direct result of the December 27, 1999 injury. Dr. Jay Preslar in a report dated May 31, 2005 stated the opinion that the problems with the cervical spine certainly could have been as a result of his December 27, 1999 accident.

In reference to physical injury to the brain which he suffered as a result of the failed injection and the stroke that occurred, Dr. Groblewski to whom the Claimant was referred as an authorized treating physician stated the opinion that Claimant had sustained permanent physical brain damage as a result of the stroke incident that occurred during the injection. Dr. James R. Merikangas, Neurologist and Director of Neuropsychiatry at Georgetown University Hospital stated the opinion that the Claimant suffered physical brain damage as a result of the injection which resulted in a stroke. Both the MRI performed on February 7, 2000 and the follow-up MRI that was performed December 16, 2003 found that the Claimant had an infarct in the right cerebral hemisphere as a result of the stroke. Dr. Randolph Waid stated the opinion that the Claimant had sustained physical brain damage as a result of the stroke. Dr. Kang stated the opinion that the Claimant had sustained residual physical injury to the brain as a result of the CVA. Dr. Domenic J. DeMichele stated the opinion that the Claimant had suffered physical brain damage as a result of the treatment necessary to treat his work-related injuries. The specialists to whom the Claimant was referred for Independent Evaluations by the Defendants agreed that the Claimant sustained physical brain injury but were either of the opinion that it had little or no effect or residual impairment to the Claimant's functioning. Again, all agree that

the Claimant suffered physical brain injury as a result of the accident and that he continues to have that at this time and at the time of the evaluations. The only disagreement is the effect of the brain injury on the Claimant's impairment and disability.

The authorized treating physician who coordinated the Claimant's medical care prior to transferring his medical care to Dr. Jeffrey Kang, that being Dr. Jeffrey C. Wilkins expressed the opinion on October 29, 2002 that Mr. Chavis was permanently disabled from his previous job at AVX. On November 8, 2002 and repeatedly since that time Dr. Gregory Kang the authorized treating physician for the Claimant's chronic pain management as authorized by the insurance carrier has stated the opinion that Mr. Chavis is permanently disabled due to the injuries that he suffered and that he is unable to work and that his condition is permanent. Dr. Domenic J. DeMichele to whom the Claimant was referred for an Independent Medical Evaluation and treatment on March 28, 2005 stated the opinion that the Claimant is totally and permanently disabled from gainful employment.

The Claimant testified in reference to the continuing problems that he has as a result of the injuries that he sustained. He testified as to the continuing problems that he has with pain, his inability to lift and the weakness he has from pain in his back. He described the continuing problems he has with pain and use of his right and left shoulders and his

inability to sleep. He gave examples of the types of activities that he tries to do around the house that he just can no longer do. He also testified as to his work background and experience and described how he is not able to do these jobs and the physical limitations and problems that he had with doing those types of jobs. He also testified as to the residual problems that he has had ever since the stroke that occurred during the injection which includes pain in his neck, memory loss, problems with severe depression, balance and weakness in his upper extremities. The Claimant testified that he is aware of no job in which he has a background, experience or any job that is available in the economy that he can do in his current condition. The vocational expert of the Claimant expressed the opinion that the Claimant is disabled from gainful employment. The Defendants have been paying total disability benefits since 2000 and have not offered evidence contrary to the opinion of the authorized treating physician that the Claimant is totally disabled from gainful employment.

The other issue involved in this case is the applicable average weekly wage and resulting compensation rate. The Record establishes that the Claimant's first injury occurred on December 7, 1998 and his second injury occurred on December 27, 1999. Therefore, the Claimant worked almost exactly one year or a little over a year between the date of the first injury and the

date of the second injury. It is also very clear that the Claimant was treated for problems with his right shoulder between the 1998 and 1999 injury. As noted the Claimant worked the entire year. It was not until after the December 27, 1999 injury and the subsequent stroke that the Claimant began to miss work and was treated for chronic pain in his back. When the Defendants resumed compensation following the 1999 injury, the Defendants resumed compensation at the rate at which he had been paid for the 1998 injury which is at the rate of $263.69. It is my opinion that the Claimant's total disability resulted from the injury that occurred in December of 1999 and the stroke with resulting physical brain damage which occurred in 2000. It was only after the subsequent 1999 accident that he became disabled due to chronic back pain and the physical brain injury that he sustained. Based on the amount of money that his employer reported to the Federal Government on his W-2 and based on the Form 20 for the 1999 accident which is based on the four (4) quarters that the Claimant worked prior to the injury, that being the first quarter of 1999 through the fourth quarter which would be December 26, 1999 the Claimant made $23,432.46. This is the amount of money that is set forth that was reported to the Commission on the Form 20 as being the correct amount of money that the Claimant earned during that period of time. On the Form 20 however, the employer and the insurance carrier used forty-

nine (49) weeks as the amount of time that the Claimant worked during .that period. This is obviously incorrect as the carrier paid the Claimant nine (9) weeks of temporary total disability benefits. Therefore the appropriate number of weeks that the Claimant worked between the two (2) injuries and specifically in the four quarters of 1999, would be forty-three (43). Dividing that into the amount of money that he made in 1999 excluding the nine (9) weeks of temporary total (which would not be calculated into his earnings for Federal Tax purposes), would result in an average weekly wage of $544.94 with a resulting compensation rate of $363.31. The Claimant obviously made more in a shorter period of time in 1999. I believe that the Form 20 is wrong as to the number of weeks he worked and that this establishes exceptional circumstances for going outside of the normal method of calculating the average weekly wage and I find that the appropriate average weekly wage and compensation rate is the amount of $544.94 with a resulting compensation rate of $363.31. It must be remembered that the Claimant's loss of earning capacity stretches into the future and it is quite obvious from the Record that his income was increasing and it is this figure that I believe is fair and reasonable to all parties concerned.

Wherefore, based upon a review of the testimony and evidence which is summarized hereinabove I find that the Claimant has established by a preponderance of the evidence that he is

entitled to the benefits sought that being that he is entitled to an award for total and permanent disability and having suffered physical brain damage he is entitled to weekly benefits payable for the Claimant's lifetime. In addition, the Claimant is entitled to continuing payment for all medical care on a lifetime basis for treatment of his back and right shoulder. Wherefore I have made the following findings of salient fact:

FINDINGS OF FACT

1. That both injuries are admitted accidents occurring on December 1, 1998 and December 27, 1999.

2. That as to the accident on December 1, 1998, I find that the Claimant suffered a compensable injury-by-accident to his right shoulder. Claimant's right shoulder injury affected use of Claimant's right arm (triceps involvement).

3. That because the Claimant's persistent right shoulder pain was thought to be radicular, Claimant was sent for a cervical epidural block (Dr. Jervey's report dated 6/1/04; Dr. Preslar's notes of 1/7/00 and 2/1/00). As a direct result of this cervical selective block, Claimant suffered a stroke which, in turn, led to a physical brain injury (Dr. Waid's report).

4. That the Claimant reached MMI for the right shoulder injury on August 7, 2001. Claimant reached MMI as to the physical brain injury on May 18, 2005.

As for the right shoulder injury, Claimant received a 5%

rating to the right upper extremity from Dr. Green. This impairment rating is a poor reflection of the extent to which the Claimant's use of his right shoulder has been affected.

Claimant has suffered some residual deficit from the work-related stroke in January 2000. This deficit is reflected in retardation of cognitive processing (Dr. Waid's depo, p. 38). Clearly, Claimant's deficit due to the stroke is minor. Moreover, Claimant's chronic pain serves as more of a factor in Claimant's difficulty with cognitive processing. The residuals from the stroke do contribute, however and I found Dr. Waid's opinions more persuasive than those of Drs. Price and Pritchard. Dr. Waid actually saw, examined and tested Claimant.

Also, I find Claimant successfully passed a GED exam only after the examiners allowed him to choose the subject matter for testing. This was after the stroke-second try also after stroke. Did worse on second test than on the first.

5. That as to the accident of December 27, 1999, I find that Claimant suffered a compensable injury-by-accident to his lower back.

It is import to note that Claimant suffered a lower back injury in 1996. Claimant received treatment for the 1996 low back injury through January 11, 1999. On that date, Claimant reported to Dr. Wilkins that a recent facet block injection had afforded him "marked improvement" of his lower back pain. There is no

medical evidence to suggest that Claimant's lower back pain returned until his accident on December 27, 1999.

It is equally important to note that the Defendants accepted the lower back as having been injured in the December 27, 1999 accident. This is important to note because counsel for the Defendants seemed to raise the issue of causation in Dr. Wilkins depo (see page 19)... This is in spite of the fact that Claimant filled out a contemporaneous accident report and in spite of the fact the Defendants had accepted the claim. I found this line of questioning to be ~~disingenuous~~ curious.

Counsel for the Defendants also raised the issue of the absence in Dr. Wilkins' notes of reference to low back pain. Claimant did report low back problems via pain diagram (see pages 35-40 of Dr. Wilkins' 2nd depo for discussion of "reporting").

That line of questioning I found somewhat disingenuous

6. That on December 27, 1999, Claimant suffered a compensable injury-by-accident to his lower back. No other injuries relative to that accident. I specifically find that there is no persuasive evidence establishing a causal link between either accident and Claimant's left shoulder problems.

7. That I find the Claimant experienced erectile dysfunction prior to the first of his two accidents. I find that the Claimant has not proven his current erectile dysfunction is related to his accidents, as opposed to a continuation of prior problems.

8. That the Claimant at times suffered from depression prior to

December 1, 1998. I find that his depression was exacerbated from chronic pain, chronic pain according to Dr. Kang's records, stems primarily from left shoulder and neck, neither of which is compensable. Depression not compensable (see Dr. Kang's note when he first prescribed Wellbutrin).

9. That the Claimant reached maximum medical improvement as to his lower back on May 18, 2005, last date seen at Pain, Spine & Sports Medicine.

10. That I find the Claimant's hands, feet most probably caused by diabetes-related neuropathy.

11. That the average weekly wage for the accident on December 1, 1998 is $395.51 with a resulting compensation rate of $263.69. The average weekly wage for the 1999 claim is $544.94 with a resulting compensation rate of 363.31. The Claimant worked 43 weeks in 1999. the W-2 reflects wages of $23,432.46. This would be the fairest way to calculate the average weekly wage. I find it would not be fair to add in temporary total disability benefit payments for nine (9) weeks out of work. Those amounts are based on 1998 income, which was less than 1999. Also based on .6667 x AWW, not from earnings. I find that nine (9) weeks out of work is an extraordinary circumstance which justifies calculation in the manner stated.

12. That I am convinced that the Claimant is totally and permanently disabled. I am equally convinced that the Claimant's

physical brain injury contributes-albeit a very slight contribution-to his permanent and total disability. I find that the Claimant's right shoulder injury, low back injury, and residual cognitive deficits render Claimant permanently and totally disabled under §42-9-10. I find that the primary cause of the permanent and total disability is the Claimant's low back pain. The average weekly wage from the 1999 accident applies.

13. That I found the Claimant to be a very credible witness.

14. That the parties have stipulated to jurisdiction and venue and that the Commission File with the exception of self-serving declarations and unstipulated medicals is made a part of the Record.

CONCLUSIONS OF LAW

Wherefore as provided in South Carolina Code §42-17-40 (1976, as amended), the following Conclusions of Law are made:

1. That both the 1998 and 1999 accidents are accepted and that the Defendants have specifically accepted the injury to the back and to the right shoulder. In addition, the Defendants have paid for medical treatment over the years since these accidents for treatment of the Claimant's right shoulder, treatment of his brain injury, treatment of his low back and neck problems and depression.

2. Under §42-1-40 the decision is made as to the applicable average weekly wage and compensation rate and particularly under

paragraph 2 and under Commission Rule 67-1603. I find that the Claimant having worked for approximately a year before the 1999 accident, missing roughly nine (9) weeks for surgery during that time period and considering the amount of money that he made in 1999 during this limited period of time as compared to 1998 establishes exceptional circumstances for determining the average weekly wage. Further, in determining the average weekly wage and compensation rate it is fair to both parties to take note of the holdings of the Supreme Court that the disability and loss of earning capacity in a workers' compensation case reaches into the future not the past and that his loss as a result of the injury must be thought of in terms of its impact on probable future earnings for purposes of calculating the Claimant's average weekly wage. Bennett vs. Gary Smith Builders, 271 S.C. 94, 245 S.E.2d 129 (1978); Sellers vs. Pinedale Residential Center, 350 S.C. 183, 564 S.E.2d 694 (SC App. 2002).

3. That the parties have stipulated to jurisdiction and venue and that the Commission File with the exception of self-serving declarations and unstipulated medicals shall be made a part of the Record.

4. Under §42-9-10 and §42-1-120 the determination is made as to the Claimant's entitlement to an award for total and permanent disability and the Claimant having suffered physical brain injury, under Paragraph 3 of §42-9-10 the Claimant having been,

"determined to be totally and permanently disabled who as a result of a compensable injury ...has suffered physical brain damage is not subject to the five hundred week (500) limitation and shall receive the benefits for life." Pearson v. Jay P.S. Converter & Industrial Corp., 327 S.C. 393, 489 S.E2d 219 (SC App. 1997) rehearing denied, certiorari denied.

5. Under S.C. Code §42-15-60 the determination concerning medical care is made.

ORDER AND AWARD

THEREFORE IT IS ORDERED that the Claimant is found to be totally and permanently disabled and having suffered physical brain damage is entitled to compensation at the rate of $363.31 per week payable weekly for the balance of the Claimant's life. The Claimant has previously been paid workers' compensation benefits from 2000 through the time of this Hearing at the rate of $263.69. The Defendants shall begin making payments at the new compensation rate and the difference or underpayment due to the Claimant for all payments at the lower rate made prior to the time that payment is started at the new compensation rate shall be paid to the Claimant in a lump sum.

IT IS FURTHER ORDERED that having been found to be entitled to an award for total and permanent disability the Claimant is entitled to lifetime medical care for all conditions causally related to the accident specifically including treatment to the

right shoulder and back and such other medical conditions as shall be determined to be causally related to the injury and for which treatment is needed as determined by the authorized treating physician. The Defendants have authorized and are paying for treatment for the Claimant's disabling symptoms through Dr. Gregory Kang and Dr. Kang is hereby authorized to continue as the authorized treating provider and such other medical providers as he deems necessary to fully and completely treat the Claimant's disabling symptoms and conditions stemming from the injuries suffered as a result of the work-related accident.

No hearing costs are assessed in this matter.

AND IT IS SO ORDERED

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Commissioner J. Alan Bass

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 31 day of August, 2006.

By Elaine M. Boyd.

Administrative Assistant to the Commissioner

BGD
PFM
RAH

APPELLATE PANEL

DECISION AND ORDER

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 9826170 & 9927964

GILBERT R. CHAVIS, EMPLOYEE, CLAIMANT/RESPONDENT/APPELLANT,

- V -

AVX CORPORATION, EMPLOYER,

AND

LIBERTY MUTUAL INS. CO., CARRIER, DEFENDANTS/APPELLANTS/RESPONDENTS.

Appellate Panel Review held in Columbia, South Carolina on May 21, 2007 per notices timely and properly served on all parties of interest.

Appellate Panel Decision and Order filed June 18, 2007.

APPEARANCES:

Claimant/Respondent/Appellant represented by Preston F. McDaniel, Esquire, of Columbia, South Carolina.

Defendants/Appellants/Respondents represented by Roy Howell, III, Esquire, of Mt. Pleasant, South Carolina.

STATEMENT OF CASE

The parties were heard by Commissioner J. Alan Bass on March 30, 2006 in Columbia, South Carolina. On August 31, 2006, he issued the following Order:

> THEREFORE, IT IS ORDERED that the Claimant is found to be totally and permanently disabled and having suffered physical brain damage is entitled to compensation at the rate of $363.31 per week payable weekly for the balance of the Claimant's life. This Claimant has previously been paid workers' compensation benefits from 2000 through the time of this Hearing at the rate of $263.69. The Defendants shall begin making payments at the new compensation rate and the difference or underpayment due to the Claimant for all payments at the lower rate made prior to the time that payment is started at the new compensation rate shall be paid to the Claimant in a lump sum.
>
> IT IS FURTHER ORDERED that having been found to be entitled to an award for total and permanent disability the Claimant is entitled to lifetime medical care for all conditions causally related to the accident specifically including treatment to the right shoulder and back and such other medical conditions as shall be determined to be causally related to the injury and for which treatment is needed as determined by the authorized treating physician. The Defendants have authorized and are paying for treatment for the Claimant's disabling symptoms through Dr. Gregory Kang and Dr. Kang is hereby authorized to continue as the authorized treating provider and such other medical providers as he deems necessary to fully and completely treat Claimant's disabling symptoms and conditions stemming from the injuries suffered as a result of the work-related accident.
>
> AND IT IS SO ORDERED.

Within the statutory period, counsel for both parties filed Applications for Review in the case setting forth their reasons, copies of which were furnished to all interested parties, prior to oral argument presented before the Appellate Panel on May 21, 2007. All proffered testimony has been taken. Such, together with all documentary

evidence, has been delivered by oral argument to the individual members of the Full Commission and has since been under study and consideration.

By appeal, Defendants respectfully submit the following:

1. The single commissioner erred in awarding lifetime benefits in this case, as the overwhelming weight of the medical evidence shows Claimant's low back strain from December 1999 did not render him permanently and totally disabled.

2. The single commissioner erred in awarding lifetime benefits in this case, as the overwhelming weight of the medical evidence shows Claimant's minor cerebellar stroke caused no residual impairment rending [him] permanently and totally disabled.

3. The single commissioner erred in awarding Claimant benefits under the 1999 compensation rate, as the greater weight of the evidence shows that any problems Claimant is currently experiencing are the result of his 1998 claim and therefore should be paid according to the 1998 compensation rate.

By appeal, Claimant respectfully submits the following:

1. Are the Defendants, who have paid for all medical care through the authorized treating physicians, estopped from denying benefits and have they accepted benefits for the injuries to the neck, left shoulder, anxiety and depression, and sexual dysfunction?

2. The hearing commissioner erred as a matter of law based on the substantial evidence in the record by denying Claimant continuing medical care and lifetime medical care, and by failing to find that the following injuries were related to the

accident, specifically including the neck, left shoulder, anxiety and depression and sexual dysfunction.

In an appellate review, the Panel shall, pursuant to S.C. Code Ann. §42-17-50 (1985), review the Award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner. After careful review in the instant case, the Panel, by unanimous vote, has determined all of the Hearing Commissioner's Findings of Fact and Rulings of Law are correct as stated. Accordingly, they shall become, and hereby are, the law of the case, and; therefore, the Order is sustained in its entirety. The Hearing Commissioner's decision is incorporated by reference as if set forth verbatim herein.

ORDER

IT IS, THEREFORE, ORDERED the Order of the Single Commissioner filed in the above-captioned matter on August 31, 2006 is hereby affirmed by the Panel, and the same shall constitute the Decision and Order of the Appellate Panel.

AND IT IS SO ORDERED.

S. C. WORKERS' COMPENSATION COMMISSION

Andrea Pope Roche, Commissioner

FULL AFFIRMATION

CONCUR:

Derrick L. Williams, Commissioner

George N. Funderburk, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties. PFM RH BGD

This 18th day of June, 2007.

By Pamela DB. Cheesebero

Administrative Assistant to the Commissioner

(L:\9826170.apr.app)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Gilbert Chavis,	)	W.C.C. FILE NO. 9927964
	)	W.C.C. FILE NO. 9826170
Employee,	)	
-vs-	)	
	)	
AVX Corporation,	)	
	)	
Employer, and	)	**DECISION & ORDER**
	)	
Liberty Mutual Insurance Co.	)	
	)	
Carrier,	)	
In Re:	)	
	)	
AVX Corporation and Liberty Mutual Insurance Company,	)	
	)	
Claimants,	)	
	)	
-vs-	)	
	)	
South Carolina Second Injury Fund,	)	
	)	
Defendant.	)	
	)	

Statement of the Case

The South Carolina Workers' Compensation Commission awarded Gilbert Chavis lifetime medical and indemnity benefits for a traumatic brain injury by Decision and Order dated August 31, 2006. This award was based on two separate, yet inextricably intertwined, claims: the first involving injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, psyche, and "whole body" on December 7, 1998; the second involving injuries to the back on December 27, 1999. On January 25, 2000, Chavis underwent a cervical injection, which resulted in a cerebellar stroke and injury to the brain. The award of lifetime indemnity and medical benefits was based on a combination

of both the December 7, 1998 and the December 27, 1999 accidents.

Following affirmation of the Hearing Commissioner's Order by the Commission's Appellate Panel on June 18, 2007, the matter was settled by a Final Lump Sum and Release Agreement on October 31, 2008. Under the terms of the agreement, Chavis was paid $348,000.00 in full settlement and satisfaction of every liability arising out of the December 7, 1998 and December 27, 1999 accidents.

AVX and Liberty Mutual (hereinafter, "the Claimants") now seek reimbursement from the Second Injury Fund for these medical and indemnity benefits pursuant to S.C. Code Ann. § 42-9-400. The Second Injury Fund (hereinafter "the Fund") concedes that all of the requirements for reimbursement set forth in S.C. Code Ann. § 42-9-400 have been satisfied for both the 1998 and the 1999 claim. A Consent Order was issued on July 28, 2010 by which the Fund agreed that the only issue in dispute relative to the reimbursement claim was the statue of limitations; "the Second Injury Fund agreed that the Employer/Carrier satisfied the requirements for full reimbursement in both cases pursuant to S.C. Code Ann. §42-9-400."

The Fund has stipulated that the 1999 claim is timely and otherwise not barred by S.C. Code Ann. § 15-3-600. (1/13/2011 Hrg. Transcript p.16, lines 2-5). However, the Fund argues that the 1998 claim is barred by S.C. Code Ann. § 15-3-600, which is the general statute of limitations for "civil actions." The Claimants submit that S.C. Code Ann. § 15-3-600 was satisfied for both the 1998 and 1999 claims no later than July 23, 2009 when the Second Injury Fund Claim Form was filed, commencing both reimbursement claims. The Claimants also argue that the Fund has forfeited its right to assert the statute of limitations as a defense, as it failed to file its Form 55 within thirty

days[1] after the Claimants filed their Form 54 on February 8, 2010, as required by S.C. Code Reg. 67-605(D). The Claimants further argue that the Fund should be estopped to deny this administrative reimbursement claim based upon an overly-strict construction of S.C. Code Ann. § 15-3-600.

This matter came before the undersigned Commissioner for a hearing on January 13, 2011. Roy A. Howell, III appeared on behalf of the Claimants and Latonya Edwards appeared on behalf of the Fund. Both parties presented pre-hearing briefs and documentary evidence. After considering the respective legal arguments and the record in this case, I find that the Claimants are entitled to reimbursement, as set forth below.

Evidence

The following documents were submitted into evidence at the time of the hearing, without objection, pursuant to the Administrative Procedures Act and S.C. Code Reg. 67-612:

SUBMISSIONS BY AVX & LIBERTY MUTUAL

APA #	DESCRIPTION	DATES	PAGES
1	Dr. Dominec DeMichele	3/28/05-6/20/05	1-10
2	Open MRI & CT	12/16/03	11
3	Dr. James R. Merikangas	6/19/03	12-15
4	Dr. Randolph L. Waid	5/2/02-3/29/05	16-24
5	Eastern Carolina Neurological	1/31/00-2/12/01	25-40
6	Coastal Orthopaedics	5/31/05	41-43a-z
7	Dr. Gregory Kang	7/9/02-5/18/05	44-111
8	Carolina Health Specialists	8/1/02-2/16/05	112-148
9	Strand Regional Specialty	11/18/02-4/2/04	149-169
10	Pee Dee Orthopaedics	12/29/99-6/2/00	170-174
11	Dr. Phillip Nicol	10/1/02-12/3/04	175-199
12	DISC Imaging	10/23/99-5/10/00	200-208
13	Grand Strand Medical Center	10/21/02	209-210

[1]The Fund did not file a Form 55 regarding the 1998 claim until June 2, 2010.

14	Doctor's Care	1/28/00	211
15	Fi-Fi Jubran, MA, CRC, CCM, CDMS	8/21/03-10/20/03	212-222
16	Employer Record-Injury Report and Claimants 1999 W-2	12/27/99	223-224
17	SCWCC, Form 20, Form 15 and Form 17	6/1/04	225-228

18	Asbury H. Williams, M.D.	6/7/96	229-230
19	William L. Mills, M.D.	6/12/96 – 3/22/01	231-236
20	Thomas P. Harden, M.D.	12/27/96 – 2/7/97	237-238
21	Jeffrey C. Wilkins, M.D.	3/18/97 – 7/8/02	239-261
22	Beach Rehabilitation and Injury Center	5/7/97 – 5/16/97	262-266
23	Power Rehabilitation at Work	5/15/97	267-271
24	C. Tucker Weston, M.D.	1/20/98	272-278
25	MRI reports	6/7/99 – 3/31/03	279-283
26	A. Jay Preslar, III, M.D.	7/1/99 – 7/9/02	284-299
27	Richard W. Ward, M.D.	3/11/00 – 3/30/00	300
28	Langdon A. Hartsock, M.D.	9/15/00	301
29	EMG Nerve Conduction Study – Right Upper extremity	3/29/01	302
30	Michael S. Green, M.D.	8/7/01	303-305
31	Matthew E. Midcap, M.D.	9/28/01	306-307
32	Functional Capacities Evaluation	1/8/02	308-316
33	C. Gregory Kang, M.D.	9/4/02 – 3/3/04	317-324
34	Charles S. Jervey, M.D.	6/1/04	325-327
35	Brian West, Ph.D.	6/21/04	328-329
36	David Price, Ph.D.	7/27/05	330-375
37	Paul Pritchard, M.D.	3/18/06	376-379
38	Keith Gawith, M.D.	5/29/97 – 6/20/97	380-383

EXHIBITS

39	Form 20 - #1 correct	Undated	384-385
40	Form 20 #5 correct	Undated	386-387
41	Payroll records	12/29/96 – 12/26/99	388-401
42	Deposition of Dr. Randolph Waid	9/20/05	
43	Deposition transcript of Dr. Wilkins	1/27/06	

SUPPLEMENTAL APA SUBMISSIONS

APA #	DESCRIPTION	DATES	PAGES
44	Jeffrey C. Wilkins, M.D.	2/20/01 – 7/8/02	402-403
45	Jay Preslar, III, M.D.	5/31/05	404-405
46	Statement – Jeffrey C. Wilkins, M.D. 1998 injury	5/30/09	406
47	Statement – Randolph Waid, Ph.D. 1998 injury	4/8/10	407

EXHIBITS #	DESCRIPTION	DATES	PAGES
48	Statement – Gilbert R. Chavis	5/20/09	408
49	Statement – Cheryl Keel – 1998 injury	4/7/10	409
50	Statement – Cheryl Keel – 1999 injury	4/7/10	410
51	Impairment Ratings & Restrictions	undated	411

SUPPLEMENTAL EXHIBITS

EXHIBITS #	DESCRIPTION	DATES	PAGES
52	"A – Letter to Marla Rehborn at Second Injury Fund	7/23/09	412
53	"B: - Notice of Possible Second Injury Fund Claim (WCC File No. 9826170)	7/23/09	413-414
54	"C" – Letter to Marla Rehborn at Second Injury Fund	7/28/09	415
55	"D" – Notice of Possible Second Injury Fund Claim (WCC File No. 9927964	7/28/09	416
56	"E" – Letter from Second Injury Fund	8/10/09	417
57	"F" – Letter to Phillip Johnson at Second Injury Fund	8/14/09	418
58	"G" – Letter from Second Injury Fund	11/10/09	419

SIF'S APA SUBMISSIONS

APA #	DESCRIPTION	DATES	PAGES
1	Carrier's Refiling of Forms 54	5/17/2010	1-2
2	SC Second Injury Fund Form 55	6/2/2010	3-5
3	Consent Order	7/28/2010	6-9

Discussion

S.C. Code Ann. § 15-3-600 provides that an "action for relief not provided for in this chapter must be commenced within ten years after the cause of action shall have accrued." Pursuant to S.C. Code Ann. § 15-3-20(B), a civil action is brought in a court and is "commenced when the summons and complaint are filed with the clerk of court..." Of course, S.C. Code Ann. § 15-3-20 does not apply to claims for reimbursement against the Fund. Instead, such administrative actions under the Workers' Compensation Act are commenced with the filing of a "claim."[2] Therefore, the question before the Commission is whether the Claimants commenced its reimbursement claim against the Fund within 10 years after placing the Fund on notice of their claim, which according to the South Carolina Supreme Court, is when the reimbursement claim accrued. Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010).

[2] In determining what constitutes the filing of a claim, it is almost universally held that the law "does not contemplate the filing of a claim having the same particularity as a formal pleading or stating 'all elements of a cause of action;' and that the law would be sufficiently complied with if the claim in whatsoever form sets forth enough facts to apprise the [defendant] of the time, place, and character of the accident, and the general nature of the injury, so that it may be understood that the claimant expects to receive the benefits provided by the Act." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 78, 518 S.E.2d 599, 602 (Ct. App. 1999).

In the present case, the Claimants served the Fund with notice of their reimbursement claim on August 4, 1999 in accordance with S.C. Code Ann. § 42-9-400, at which time the Fund assigned a SIF claim number: "67417."[3] (*See* Exhibit #2 to Claimant's Memorandum of Law). It is untenable for the Fund to assign claim numbers or to otherwise acknowledge or investigate "claims," yet argue that a claim has not yet commenced. The assignment of claim numbers is evidence that the reimbursement action actually commenced at the time the Fund was placed on notice of the claim.

Furthermore, S.C. Code Ann. § 42-9-400(f) requires that:

> "*An employer or his carrier shall notify the Industrial Commission and the Director of the Second Injury Fund in writing of any possible claim against the fund as soon as practicable but in no event later than after the payment of the first seventy-eight weeks of compensation.*"

According to the South Carolina Supreme Court,

> " *The primary purpose of § 42-9-400(f) is to establish a deadline for perfecting* ***actual claims*** *for reimbursement with the Fund ... Once a claim is submitted, the Fund may agree to reimburse an employer or carrier. In such a case, the Fund must submit the agreement to reimburse to the Commission for its approval. § 42-8-310(b). If the Fund denies a* ***claim*** *for reimbursement, the employer or carrier may request a hearing before the Commission on the* ***claim.*** *25A S.C. Code Reg. 67-208(D)...:Additionally, a purpose of § 42-9-400(f) is to provide* ***notice*** *to the Fund and the Commission of potential* ***claims*** *for reimbursement.*" S.C. Second Injury Fund v. American Yard Products, 330 S.C. 20, 21, 496 S.E.2d

[3] The SIF reimbursement claim number for the 1999 accident is "100406."

862, 863 (1998). (emphasis added).

Therefore; the primary purpose of the correspondence dated August 4, 1999 was to perfect an "actual claim" for reimbursement with the Fund in accordance with S.C. Code Ann. § 42-9-400(f). In fact, the Fund acknowledged that an actual claim for reimbursement had been made by correspondence dated September 11, 2003, wherein SIF Claims Analyst Phillip L. Johnson advised that SIF Claim #067417 (for date of accident 12/1/98) was "pending investigation." (*See* Exhibit #2 to Claimant's Memorandum of Law). Only if the reimbursement claim had commenced would it be deemed "pending" by the Fund and it would be unreasonable to suggest otherwise.[4]

Over the years, the underlying claim for medical and compensation benefits was actively and aggressively litigated, with final payment of compensation being made pursuant to a clincher agreement on July 23, 2009 after multiple motions and appeals.[5] During this time, the Claimants relied on the Fund's statement of September 11, 2003 that their reimbursement claim for the 1998 was "pending," as the Fund did not submit any agreement to reimburse the claim, the Fund did not formally deny the claim, and the claim was not finally adjudicated.[6] Also during this time, the Fund had sufficient information regarding the reimbursement claim to investigate the

---

[4] *See* BLACK'S LAW DICTIONARY, 6th Ed. (1990) (defining the term "pending" as "[b]egun, but not yet completed; during; before the conclusion of; prior to the completion of; unsettled; undetermined ... an action or suit is 'pending' from its inception until the rendition of final judgment.").

[5] In fact, a lump sum of indemnity benefits in the amount of $261,500.00 was paid on July 23, 2009 pursuant to the settlement agreement. Prior to that time, the Claimants could not have legally reduced their reserves pursuant to S.C. Code Ann. § 42-9-400(l); therefore, were not legally entitled to reimbursement prior to July 23, 2009.

[6] "A claim for compensation lawfully constituted and pending before the commission may not be dismissed without a hearing and without some proper form of final adjudication. No statute of limitations runs against a litigant while his case is pending..." Halks v. Rust Engineering Co., et al., 208 S.C. 39, 46, 36 S.E.2d 852, 855 (1946) (internal citations omitted).

same and certainly had sufficient information to understand that the Claimants expected reimbursement to the extent allowed by S.C. Code Ann. § 42-9-400.

In addition to the correspondence of August 4, 1999, the Claimants further filed a formal claim for reimbursement with its correspondence of September 5, 2003 and July 23, 2009, by which the Claimants supplied the Fund with detailed information regarding every element of their reimbursement claim. (*See* Exhibit #4 and #5 to Claimant's Memorandum of Law; APA pp. 412-419). A reimbursement claim against the Fund, like any other a workers' compensation claim, may also be commenced pursuant to S.C. Code Reg. 67-206(C):

> *A letter filed with the Commission also files a claim. The letter should include the information listed in items (1) through (12) below:*
>
> *(1) Claimant's name (and worker's name, if different);*
>
> *(2) Claimant's address (and workers' address if different);*
>
> *(3) Claimant's home and work telephone numbers (and workers' home and work telephone numbers, if different);*
>
> *(4) Claimant's social security number (and workers' social security number, if different);*
>
> *(5) Employer's name;*
>
> *(6) Employer's address;*
>
> *(7) Employer's telephone number;*
>
> *(8) Employer's insurance carrier, if known;*
>
> *(9) Date of injury;*
>
> *(10) The county in which the injury occurred;*
>
> *(11) Type of injury (to which area of the body);*
>
> *(12) Description of the accident.*
>
> *(13) Failure to include any of the information above does not bar the claim if the information necessary to an issue in a claim is given to the Claims Department on request.*

In the present case, the Claimants served the Fund with all information necessary to file a claim under S.C. Code Reg. 67-206 well before the expiration of the ten year statute of limitations applicable to civil claims.

Furthermore, our Courts have universally held that the Commission "will accept as the equivalent of a statutory claim any paper that contains the substance usually supplied by a formal claim, although the form may be defective." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 86, 518 S.E.2d 599, 606 (1999). The rationale is that a claim, as contemplated by the Workers' Compensation Act, is not necessarily a formal pleading, but must simply set forth enough facts to apprise the defendant of "the time, place, and character of the accident and the general nature of the injury" so that it may be understood that the claimants (which in this case is AVX and Liberty Mutual) expect to receive the benefits (*e.g.*, reimbursement) provided by the Act. Here, the Fund fully understood that the Claimants expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400 no later than July 23, 2009 -- before the expiration of any 10 year statute of limitations[7] -- by virtue of the Claimant's communications and Reimbursement Request Form, which were served upon the Fund and detailed their reimbursement claim and its merits, including the following statement:

> *The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed a workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 1997, 1998, and 1999. The Claimant had a subsequent work-related injury in 1998 when he was lifting a pot at work in which he injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 2000. During the injection, he sustained a minor cerebral stroke. Prior to the 1998 accident, the Claimant also received treatment for erectile dysfunction, diabetes, and depression.*

[7] Assuming the 10 year statute of limitations began to run on August 9, 1999, then a claim filed or perfected on or before July 23, 2009 is timely under S.C. Code Ann. § 15-3-600, even if the statute was not tolled by the conduct of the Fund upon which the Claimants relied.

The Claimant had multiple preexisting problems that were agitated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone.

It is clear that the present action against the Fund was commenced by the filing of a claim for reimbursement within ten years after it accrued in accordance with S.C. Code Ann. § 42-9-400 and S.C. Code Reg. 67-206 and; therefore, it is not time-barred by S.C. Code Ann. § 15-3-600.

Findings of Fact

1. All parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act.
2. The South Carolina Workers' Compensation Commission has jurisdiction over this claim
3. Gilbert Chavis sustained injures to his back and right shoulder in an accident arising out of and in the course of his employment with AVX Corporation on April 8, 1996, which resulted in permanent, physical impairment of his back and right shoulder and which was known to AVX. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Claimants have satisfied this requirement.
4. Prior to December 7, 1998, Gilbert Chavis suffered from permanent pre-existing diabetes and depression, which constituted a hindrance and obstacle to re-employment, and Gilbert Chavis made these permanent pre-existing conditions known to AVX. This

finding is based upon the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Claimants have satisfied this requirement.

5. In addition, Gilbert Chavis suffered permanent physical impairments of his neck, back, arms, hands, shoulders, brain, reproductive system, and psyche as a result of an accident arising out of and in the course of his employment with AVX Corporation on December 7, 1998 and AVX was award of these permanent physical impairments. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Claimants have satisfied this requirement.

6. The December 7, 1998 injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, and psyche aggravated and combined with Gilbert Chavis's pre-existing permanent impairment to the spine and right shoulder, as well as his pre-existing diabetes and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 7, 1998 accident alone. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Claimants have satisfied this requirement.

7. Gilbert Chavis sustained additional injuries to his back by accident arising out of and in the course of his employment with AVX Corporation on December 27, 1999. The December 27, 1999 injury to the back aggravated and combined with Gilbert Chavis's pre-existing permanent impairment to the spine, right shoulder, diabetes and depression, resulting in substantially greater disability and medical expenses than would have

resulted from the December 27, 1999 accident alone. This finding is supported by the greater weight of the evidence in this record, including the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Claimants have satisfied this requirement.

8. Gilbert Chavis incurred a subsequent disability from accidental injuries to his back on December 27, 1999, resulting in compensation and medical payments liability for disability that was substantially greater (and was caused by aggravation of the pre-existing impairments) than that which would have resulted from December 27, 1999 accident alone. This finding is based on the greater weight of the evidence in this case, the Commission's file, and the Second Injury Fund's stipulation that the Claimants have satisfied this requirement.

9. Gilbert Chavis was awarded medical and weekly compensation benefits for the remainder of his lifetime based on the combination of both the December 7, 1998 and December 27, 1999 accidents. AVX and its insurance carrier, Liberty Mutual Insurance, subsequently settled both the 1998 and the 1999 claims with a Final Lump Sum Agreement and Release on October 31, 2008, which was approved by the Workers' Compensation Commission on October 31, 2008. By the Agreement, the Claimant was paid Three Hundred Forty-Eight Thousand and no/100 ($348,000.00) Dollars in full settlement and satisfaction of every liability under the Act, for any injuries arising out of his December 7, 1998 and December 27, 1999 accidents. Two Hundred Sixty-One Thousand Five Hundred and no/100 ($261,500.00) Dollars of the settlement was allocated to the Claimant's injuries sustained in the December 7, 1998 accident. Thirty Thousand and no/100 ($30,000.00) Dollars was allocated to the injuries the Claimant sustained on

December 27, 1999. The remaining Fifty-Six Thousand Five Hundred and no/100 ($56,500.00) Dollars was allocated to future medical expenses. The Commission finds that this Agreement is reasonable and has heretofore adopted this Agreement as an Order of the Commission.

10. The Fund has stipulated that the Claimants gave timely notice of their intent to seek reimbursement for both the December 7, 1998 and December 27, 1999 accidents. The Fund was placed on notice with regard to the December 7, 1998 claim by correspondence dated August 4, 1999 and the claim "accrued" at that time.

11. The Fund has stipulated that the claim for reimbursement related to the December 27, 1999 accident was timely filed.

12. The greater weight of the evidence in the record indicates that the Claimants filed a claim for reimbursement against the Fund on July 23, 2009 when it filed a properly completed and filed a "SC Second Injury Fund Reimbursement Request Form," with supporting documents, at the request of the Fund. The Claimants' filing on July 23, 2009 served the Fund with all information necessary to file a claim under S.C. Code Reg. 67-206 because it fully informed the Fund as to the time, place, and character of the accident and the general nature of the injury and made it clear to the Fund that the Claimants expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400.

13. The reimbursement claim filed on July 23, 2009 was filed within ten years after the Claimants gave notice of their intent to seek reimbursement and the claim accrued (August 4, 1999).

Conclusions of Law

1. Pursuant to Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the cause of action for reimbursement by the Fund related to the December 7, 1998 accident began to accrue on August 4, 1999 when the Claimants provided notice to the Fund in accordance with S.C. Code Ann. § 42-9-400(f).
2. Pursuant to S.C. Code Reg. 67-206(C), the Claimants filed a claim for reimbursement and otherwise commenced action against the Fund regarding the December 7, 1998 accident on July 23, 2009 when it filed a detailed claim form and supporting documentation with the Fund, which adequately informed the Fund as to the time, place, and character of the accident and the general nature of the injury and made it clear to the Fund that the Claimants expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400. *See also* Hamilton v. Bob Bennett Ford, 336 S.C. 72, 86, 518 S.E.2d 599, 606 (1999).
3. Pursuant to S.C. Code Ann. § 15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the Claimants filed a claim against the Fund seeking reimbursement for the December 7, 1998 accident under S.C. Code Ann. § 42-9-400 within ten years after the claim accrued and; therefore, the claim for reimbursement is timely.
4. Pursuant to S.C. Code Ann. § 42-9-400(f), the Claimants gave timely notice of their claim for reimbursement related to the December 27, 1999 accident, as stipulated by the Fund.
5. Pursuant to S.C. Code Ann. § 15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010); the claim for the December 27, 1999

accident was timely filed, as stipulated by the Fund.

6. Because the Fund has stipulated that all other requirements for reimbursement under S.C. Code Ann. § 42-9-400 have been met for both the December 7, 1998 and December 27, 1999 accidents, the Claimants are entitled to, and the Fund is liable for, the following in accordance with S.C. Code Ann. § 42-9-400(a):

    a. reimbursement of all compensation benefits payments payable subsequent to those payable for the first seventy-eight weeks following both the December 7, 1998 and December 27, 1999 injuries, which totals Three-Hundred Eighty Four Thousand Seven Hundred Thirty-Eight and 15/100 ($384,738.15) Dollars; and

    b. reimbursement of fifty percent of medical payments in excess of Three Thousand Dollars during the first seventy-eight weeks following both the December 7, 1998 and December 27, 1999 injuries; and

    c. reimbursement of reimbursement of all medical benefits payments payable subsequent to the first seventy-eight weeks following the December 7, 1998 and December 27, 1999 injuries.

    The amount to be reimbursed specifically includes the payments made by the Claimants pursuant to the October 2008 clincher agreement with Gilbert Chavis, which has heretofore been found reasonable and adopted as a binding order of the Commission.

Order

IT IS, THEREFORE, HEREBY ORDERED that the South Carolina Second Injury Fund shall reimburse AVX Corporation, Inc. and Liberty Mutual Insurance Company in the amount of

Three-Hundred Eighty Four Thousand Seven Hundred Thirty-Eight and 15/100 ($384,738.15) Dollars for compensation paid to the Claimant following his 1998 and 1999 work-related injuries;

IT IS FURTHER ORDERED that the South Carolina Second Injury Fund shall reimburse AVX Corporation, Inc. and Liberty Mutual Insurance Company for all causally related medical expenses in accordance with S.C. Code Ann. § 42-9-400;

IT IS SO ORDERED!

Commissioner Andrea C. Roche

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.
June 28, 2011

By: Barbara Cheeseboro, Administrative Assistant to Commissioner Roche

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION'S APPELLATE PANEL

Gilbert Chavis, Employee, -vs- AVX Corporation, Employer, and Liberty Mutual Insurance Co. Carrier, ***In Re:*** **AVX Corporation and Liberty Mutual Insurance Company,** **Respondents,** **-vs-** **South Carolina Second Injury Fund,** **Appellants.**	W.C.C. FILE NO. 9927964 W.C.C. FILE NO. 9826170 **DECISION & ORDER**

Statement of the Case

The South Carolina Workers' Compensation Commission awarded Gilbert Chavis lifetime medical and indemnity benefits for a traumatic brain injury by Decision and Order dated August 31, 2006. This award was based on two separate, yet inextricably intertwined, claims: the first involving injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, psyche, and "whole body" on December 7, 1998; the second involving injuries to the back on December 27, 1999. On January 25, 2000, Chavis underwent a cervical injection, which resulted in a cerebellar stroke and injury to the brain. The award of lifetime indemnity and medical

benefits was based on a combination of both the December 7, 1998 and the December 27, 1999 accidents.

Following affirmation of the Hearing Commissioner's Order by the Commission's Appellate Panel on June 18, 2007, the matter was settled by a Final Lump Sum and Release Agreement on October 31, 2008. Under the terms of the agreement, Chavis was paid $348,000.00 in full settlement and satisfaction of every liability arising out of the December 7, 1998 and December 27, 1999 accidents.

AVX and Liberty Mutual (hereinafter, "the Respondents") now seek reimbursement from the Second Injury Fund for these medical and indemnity benefits pursuant to S.C. Code Ann. § 42-9-400. The Second Injury Fund (hereinafter "the Fund") concedes that all of the requirements for reimbursement set forth in S.C. Code Ann. § 42-9-400 have been satisfied for both the 1998 and the 1999 claim. A Consent Order was issued on July 28, 2010 by which the Fund agreed that the only issue in dispute relative to the reimbursement claim was the statue of limitations; "the Second Injury Fund agreed that the Employer/Carrier satisfied the requirements for full reimbursement in both cases pursuant to S.C. Code Ann. §42-9-400."

The Fund has stipulated that the 1999 claim is timely and otherwise not barred by S.C. Code Ann. § 15-3-600. (1/13/2011 Hrg. Transcript p.16, lines 2-5). However, the Fund argues that the 1998 claim is barred by S.C. Code Ann. § 15-3-600, which is the general statute of limitations for "civil actions." The Respondents submit that S.C. Code Ann. § 15-3-600 was satisfied for both the 1998 and 1999 claims no later than July 23, 2009 when the Second Injury Fund Claim Form was filed, commencing both reimbursement claims. The Respondents also argue that the Fund has forfeited its right to assert the statute of limitations as a defense, as it

failed to file its Form 55 within thirty days[1] after the Respondents filed their Form 54 on February 8, 2010, as required by S.C. Code Reg. 67-605(D). The Respondents further argue that the Fund should be estopped to deny this administrative reimbursement claim based upon an overly-strict construction of S.C. Code Ann. § 15-3-600.

This matter came before Hearing Commissioner Andrea C. Roche for a hearing on January 13, 2011. Roy A. Howell, III appeared on behalf of the Respondents and Latonya Edwards appeared on behalf of the Fund. Both parties presented pre-hearing briefs and documentary evidence. After considering the respective legal arguments and the record in this case, Commissioner Roche concluded that the Respondents are entitled to reimbursement, by Decision and Order dated June 28, 2011. The Second Injury Fund filed a Form 30, seeking review by the Commission's Appellate Panel, based on the following:

1. Did the Hearing Commissioner err in finding as fact (Finding of Fact No. 12) that the greater weight of the evidence in the record indicates that the carrier filed a claim for reimbursement against the Fund on July 23, 2009 when it filed a "SC Second Injury Reimbursement Request Form." With supporting documents when such finding is against the greater weight of the substantial evidence in the record?
2. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No.13) that the reimbursement claim filed on July 23, 2009 was filed within ten years after the carrier gave notice of his intent to seek reimbursement and the claim accrued (August 4, 1999) when such finding is against the greater weight of the substantial evidence in the record?

[1]The Fund did not file a Form 55 regarding the 1998 claim until June 2, 2010.

3. Did the Hearing Commissioner err in concluding (Conclusions [sic] of Law No. 3) that pursuant to §15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the carrier filed a claim against the Fund seeking reimbursement for the December 7, 1998 accident under S.C. Code Ann. § 42-9-400 within ten years after the claim accrued and therefore the claim for reimbursement was timely when such finding is against the greater weight of the substantial evidence in the record and is clearly erroneous in light of the applicable statutes and case law?

Following the Fund's appeal, both parties prepared Briefs for the Commission's Appellate Panel and oral arguments were held on October 25, 2011. Following the Hearing, the majority of the Appellate Panel determined that the Hearing Commissioner's Decision and Order should be affirmed in its entirety, as it is supported by the greater weight of the evidence and the applicable law, as described more fully, below.

Discussion

S.C. Code Ann. § 15-3-600 provides that an "action for relief not provided for in this chapter must be commenced within ten years after the cause of action shall have accrued." Pursuant to S.C. Code Ann. § 15-3-20(B), a civil action is brought in a court and is "commenced when the summons and complaint are filed with the clerk of court..." Of course, S.C. Code Ann. § 15-3-20 does not apply to claims for reimbursement against the Fund. Instead, such administrative actions under the Workers' Compensation Act are commenced with the filing of a

"claim."[2] Therefore, the question before the Commission is whether the Respondents commenced its reimbursement claim against the Fund within 10 years after placing the Fund on notice of their claim, which according to the South Carolina Supreme Court, is when the reimbursement claim accrued. Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010).

In the present case, the Respondents served the Fund with notice of their reimbursement claim on August 4, 1999 in accordance with S.C. Code Ann. § 42-9-400, at which time the Fund assigned a SIF claim number: "67417."[3] (*See* Exhibit #2 to Respondents' Memorandum of Law). It is untenable for the Fund to assign claim numbers or to otherwise acknowledge or investigate "claims," yet argue that a claim has not yet commenced. The assignment of claim numbers is evidence that the reimbursement action actually commenced at the time the Fund was placed on notice of the claim.

Furthermore, S.C. Code Ann. § 42-9-400(f) requires that:

> *"An employer or his carrier shall notify the Industrial Commission and the Director of the Second Injury Fund in writing of any possible claim against the fund as soon as practicable but in no event later than after the payment of the first seventy-eight weeks of compensation."*

According to the South Carolina Supreme Court,

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[2] In determining what constitutes the filing of a claim, it is almost universally held that the law "does not contemplate the filing of a claim having the same particularity as a formal pleading or stating 'all elements of a cause of action;' and that the law would be sufficiently complied with if the claim in whatsoever form sets forth enough facts to apprise the [defendant] of the time, place, and character of the accident, and the general nature of the injury, so that it may be understood that the claimant expects to receive the benefits provided by the Act." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 78, 518 S.E.2d 599, 602 (Ct. App. 1999).

[3] The SIF reimbursement claim number for the 1999 accident is "100406."

agreement on July 23, 2009 after multiple motions and appeals.[5] During this time, the Respondents relied on the Fund's statement of September 11, 2003 that their reimbursement claim for the 1998 was "pending," as the Fund did not submit any agreement to reimburse the claim, the Fund did not formally deny the claim, and the claim was not finally adjudicated.[6] Also during this time, the Fund had sufficient information regarding the reimbursement claim to investigate the same and certainly had sufficient information to understand that the Respondents expected reimbursement to the extent allowed by S.C. Code Ann. § 42-9-400.

In addition to the correspondence of August 4, 1999, the Respondents further filed a formal claim for reimbursement with its correspondence of September 5, 2003 and July 23, 2009, by which the Respondents supplied the Fund with detailed information regarding every element of their reimbursement claim. (*See* Exhibit #4 and #5 to Claimant's Memorandum of Law; APA pp. 412-419). A reimbursement claim against the Fund[7], like any other a workers' compensation claim, may also be commenced pursuant to S.C. Code Reg. 67-206(C):

> *A letter filed with the Commission also files a claim. The letter should include the information listed in items (1) through (12) below:*

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[5] In fact, a lump sum of indemnity benefits in the amount of $261,500.00 was paid on July 23, 2009 pursuant to the settlement agreement. Prior to that time, the Respondents could not have legally reduced their reserves pursuant to S.C. Code Ann. § 42-9-400(l); therefore, were not legally entitled to reimbursement prior to July 23, 2009.

[6] "A claim for compensation lawfully constituted and pending before the commission may not be dismissed without a hearing and without some proper form of final adjudication. No statute of limitations runs against a litigant while his case is pending..." Halks v. Rust Engineering Co., et al., 208 S.C. 39, 46, 36 S.E.2d 852, 855 (1946) (internal citations omitted).

[7] The Fund argues that the only way in which claim against the Fund can be perfected is by the filing of a Form 54; however, the Fund offers no authority for this argument, which is otherwise without merit. There is no statute or regulation that mandates the filing of a Form 54 or any specific procedure for commencing a reimbursement claim against the Fund. There is no reason why there should be a more strict filing requirement for reimbursement claims than any other claim under the Workers' Compensation Act and in the absence of a specific statute or regulation to the contrary, the Commission will not imply such a strict requirement on the Respondents.

(1) Claimant's name (and worker's name, if different);

(2) Claimant's address (and workers' address if different);

(3) Claimant's home and work telephone numbers (and workers' home and work telephone numbers, if different);

(4) Claimant's social security number (and workers' social security number, if different);

(5) Employer's name;

(6) Employer's address;

(7) Employer's telephone number;

(8) Employer's insurance carrier, if known;

(9) Date of injury;

(10) The county in which the injury occurred;

(11) Type of injury (to which area of the body);

(12) Description of the accident.

(13) Failure to include any of the information above does not bar the claim if the information necessary to an issue in a claim is given to the Claims Department on request.

In the present case, the Respondents served the Fund with all information necessary to file a claim under S.C. Code Reg. 67-206 well before the expiration of the ten year statute of limitations applicable to civil claims.

Furthermore, our Courts have universally held that the Commission "will accept as the equivalent of a statutory claim any paper that contains the substance usually supplied by a formal claim, although the form may be defective." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 86, 518 S.E.2d 599, 606 (1999). The rationale is that a claim, as contemplated by the Workers' Compensation Act, is not necessarily a formal pleading, but must simply set forth enough facts to apprise the defendant of "the time, place, and character of the accident and the general nature

of the injury" so that it may be understood that the claimants (which in this case is AVX and Liberty Mutual) expect to receive the benefits (*e.g.*, reimbursement) provided by the Act. Here, the Fund fully understood that the Respondents expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400 no later than July 23, 2009 -- before the expiration of any 10 year statute of limitations[8] -- by virtue of the Respondents' communications and Notice of Claim Form, which were served upon the Fund and detailed their reimbursement claim and its merits, including the following statement:

> *The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed a workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 1997, 1998, and 1999. The Claimant had a subsequent work-related injury in 1998 when he was lifting a pot at work in which he injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 2000. During the injection, he sustained a minor cerebral stroke. Prior to the 1998 accident, the Claimant also received treatment for erectile dysfunction, diabetes, and depression.*
>
> *The Claimant had multiple preexisting problems that were agitated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone.*

It is clear that the present action against the Fund was commenced by the filing of a claim for reimbursement within ten years after it accrued in accordance with S.C. Code Ann. § 42-9-400 and S.C. Code Reg. 67-206 and; therefore, it is not time-barred by S.C. Code Ann. § 15-3-600.

[8] Assuming the 10 year statute of limitations began to run on August 9, 1999, then a claim filed or perfected on or before July 23, 2009 is timely under S.C. Code Ann. § 15-3-600, even if the statute was not tolled by the conduct of the Fund upon which the Respondents relied.

Findings of Fact

1. All parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act.
2. The South Carolina Workers' Compensation Commission has jurisdiction over this claim
3. Gilbert Chavis sustained injures to his back and right shoulder in an accident arising out of and in the course of his employment with AVX Corporation on April 8, 1996, which resulted in permanent, physical impairment of his back and right shoulder and which was known to AVX. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Respondents have satisfied this requirement.
4. Prior to December 7, 1998, Gilbert Chavis suffered from permanent pre-existing diabetes and depression, which constituted a hindrance and obstacle to re-employment, and Gilbert Chavis made these permanent pre-existing conditions known to AVX. This finding is based upon the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Respondents have satisfied this requirement.
5. In addition, Gilbert Chavis suffered permanent physical impairments of his neck, back, arms, hands, shoulders, brain, reproductive system, and psyche as a result of an accident arising out of and in the course of his employment with AVX Corporation on December 7, 1998 and AVX was award of these permanent physical impairments. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The

Fund has stipulated that the Respondents have satisfied this requirement.

6. The December 7, 1998 injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, and psyche aggravated and combined with Gilbert Chavis's pre-existing permanent impairment to the spine and right shoulder, as well as his pre-existing diabetes and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 7, 1998 accident alone. This finding is supported by the greater weight of the evidence in the record, including the May 30, 2009 statement of Dr. Jeffrey Wilkins and the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Respondents have satisfied this requirement.
7. Gilbert Chavis sustained additional injuries to his back by accident arising out of and in the course of his employment with AVX Corporation on December 27, 1999. The December 27, 1999 injury to the back aggravated and combined with Gilbert Chavis's pre-existing permanent impairment to the spine, right shoulder, diabetes and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 27, 1999 accident alone. This finding is supported by the greater weight of the evidence in this record, including the May 20, 2009 statement of Gilbert Chavis. The Fund has stipulated that the Respondents have satisfied this requirement.
8. Gilbert Chavis incurred a subsequent disability from accidental injuries to his back on December 27, 1999, resulting in compensation and medical payments liability for disability that was substantially greater (and was caused by aggravation of the pre-existing impairments) than that which would have resulted from December 27, 1999 accident alone. This finding is based on the greater weight of the evidence in this case,

> *" The primary purpose of § 42-9-400(f) is to establish a deadline for perfecting actual claims for reimbursement with the Fund ... Once a claim is submitted, the Fund may agree to reimburse an employer or carrier. In such a case, the Fund must submit the agreement to reimburse to the Commission for its approval. § 42-8-310(b). If the Fund denies a claim for reimbursement, the employer or carrier may request a hearing before the Commission on the claim. 25A S.C. Code Reg. 67-208(D)....Additionally, a purpose of § 42-9-400(f) is to provide notice to the Fund and the Commission of potential claims for reimbursement."* S.C. Second Injury Fund v. American Yard Products, 330 S.C. 20, 21, 496 S.E.2d 862, 863 (1998). (emphasis added).

Therefore; the primary purpose of the correspondence dated August 4, 1999 was to perfect an "actual claim" for reimbursement with the Fund in accordance with S.C. Code Ann. § 42-9-400(f). In fact, the Fund acknowledged that an actual claim for reimbursement had been made by correspondence dated September 11, 2003, wherein SIF Claims Analyst Phillip L. Johnson advised that SIF Claim #067417 (for date of accident 12/1/98) was "pending investigation." (*See* Exhibit #2 to Claimant's Memorandum of Law). Only if the reimbursement claim had commenced would it be deemed "pending" by the Fund and it would be unreasonable to suggest otherwise.[4]

Over the years, the underlying claim for medical and compensation benefits was actively and aggressively litigated, with final payment of compensation being made pursuant to a clincher

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[4] *See* BLACK'S LAW DICTIONARY, 6th Ed. (1990) (defining the term "pending" as "[b]egun, but not yet completed; during; before the conclusion of; prior to the completion of; unsettled; undetermined ... an action or suit is 'pending' from its inception until the rendition of final judgment.").

the Commission's file, and the Second Injury Fund's stipulation that the Respondents have satisfied this requirement.

9. Gilbert Chavis was awarded medical and weekly compensation benefits for the remainder of his lifetime based on the combination of both the December 7, 1998 and December 27, 1999 accidents. AVX and its insurance carrier, Liberty Mutual Insurance, subsequently settled both the 1998 and the 1999 claims with a Final Lump Sum Agreement and Release on October 31, 2008, which was approved by the Workers' Compensation Commission on October 31, 2008. By the Agreement, the Claimant was paid Three Hundred Forty-Eight Thousand and no/100 ($348,000.00) Dollars in full settlement and satisfaction of every liability under the Act, for any injuries arising out of his December 7, 1998 and December 27, 1999 accidents. Two Hundred Sixty-One Thousand Five Hundred and no/100 ($261,500.00) Dollars of the settlement was allocated to the Claimant's injuries sustained in the December 7, 1998 accident. Thirty Thousand and no/100 ($30,000.00) Dollars was allocated to the injuries the Claimant sustained on December 27, 1999. The remaining Fifty-Six Thousand Five Hundred and no/100 ($56,500.00) Dollars was allocated to future medical expenses. The Commission finds that this Agreement is reasonable and has heretofore adopted this Agreement as an Order of the Commission.

10. The Fund has stipulated that the Respondents gave timely notice of their intent to seek reimbursement for both the December 7, 1998 and December 27, 1999 accidents. The Fund was placed on notice with regard to the December 7, 1998 claim by correspondence dated August 4, 1999 and the claim "accrued" at that time.

11. The Fund has stipulated that the claim for reimbursement related to the December 27,

1999 accident was timely filed.

12. The greater weight of the evidence ~~in the record~~ indicates that the Respondents filed a claim for reimbursement against the Fund on July 23, 2009 when it filed a ~~properly completed and filed a~~ "Notice of Possible Second Injury Fund Claim," with supporting documents, ~~at the request of the Fund.~~ The Respondents' filing on July 23, 2009 served the Fund with all information necessary to file a claim under S.C. Code Reg. 67-206 because it fully informed the Fund as to the time, place, and character of the accident and the general nature of the injury and made it clear to the Fund that the Respondents expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400.

13. The reimbursement claim filed on July 23, 2009 was filed within ten years after the Respondents gave notice of their intent to seek reimbursement and the claim accrued (August 4, 1999). The claim filed by the Respondents on July 23, 2009 set forth more than sufficient facts to apprise the Second Injury Fund of the nature of its claim so that the Fund clearly understood that the workers' compensation carrier expected to receive reimbursement under §42-9-400.

Conclusions of Law

1. Pursuant to Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the cause of action for reimbursement by the Fund related to the December 7, 1998 accident began to accrue on August 4, 1999 when the Respondents provided notice to the Fund in accordance with S.C. Code Ann. § 42-9-400(f).

2. Pursuant to S.C. Code Reg. 67-206(C), the Respondents filed a claim for reimbursement and otherwise commenced action against the Fund regarding the December 7, 1998 accident on July 23, 2009 when it filed a detailed claim form and supporting

documentation with the Fund, which adequately informed the Fund as to the time, place, and character of the accident and the general nature of the injury and made it clear to the Fund that the Respondents expected to receive reimbursement provided by S.C. Code Ann. § 42-9-400. *See also* Hamilton v. Bob Bennett Ford, 336 S.C. 72, 86, 518 S.E.2d 599, 606 (1999). There is no reason why there should be a more strict filing requirement for reimbursement claims than any other claim under the Workers' Compensation Act. In the absence of a specific statute or regulation that explicitly requires that only the filing of a Form 54 can commence a claim against the Fund, the Commission will not imply such a strict requirement on the Respondents.

3. Pursuant to S.C. Code Ann. § 15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the Respondents filed a claim against the Fund seeking reimbursement for the December 7, 1998 accident under S.C. Code Ann. § 42-9-400 within ten years after the claim accrued and; therefore, the claim for reimbursement is timely.
4. Pursuant to S.C. Code Ann. § 42-9-400(f), the Respondents gave timely notice of their claim for reimbursement related to the December 27, 1999 accident, as stipulated by the Fund.
5. Pursuant to S.C. Code Ann. § 15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010); the claim for the December 27, 1999 accident was timely filed, as stipulated by the Fund.
6. Because the Fund has stipulated that all other requirements for reimbursement under S.C. Code Ann. § 42-9-400 have been met for both the December 7, 1998 and December 27, 1999 accidents, the Respondents are entitled to, and the Fund is liable for, the following

in accordance with S.C. Code Ann. § 42-9-400(a):

a. reimbursement of all compensation benefits payments payable subsequent to those payable for the first seventy-eight weeks following both the December 7, 1998 and December 27, 1999 injuries, which totals Three-Hundred Eighty Four Thousand Seven Hundred Thirty-Eight and 15/100 ($384,738.15) Dollars; and

b. reimbursement of fifty percent of medical payments in excess of Three Thousand Dollars during the first seventy-eight weeks following both the December 7, 1998 and December 27, 1999 injuries; and

c. reimbursement of reimbursement of all medical benefits payments payable subsequent to the first seventy-eight weeks following the December 7, 1998 and December 27, 1999 injuries.

The amount to be reimbursed specifically includes the payments made by the Respondents pursuant to the October 2008 clincher agreement with Gilbert Chavis, which has heretofore been found reasonable and adopted as a binding order of the Commission.

Order

IT IS, THEREFORE, HEREBY ORDERED that the South Carolina Second Injury Fund shall reimburse AVX Corporation, Inc. and Liberty Mutual Insurance Company in the amount of Three-Hundred Eighty Four Thousand Seven Hundred Thirty-Eight and 15/100 ($384,738.15) Dollars for compensation paid to the Claimant following his 1998 and 1999 work-related injuries;

IT IS FURTHER ORDERED that the South Carolina Second Injury Fund shall reimburse

AVX Corporation, Inc. and Liberty Mutual Insurance Company for all causally related medical expenses in accordance with S.C. Code Ann. § 42-9-400;

IT IS SO ORDERED!

December ___, 2011

Avery B. Wilkerson, Commissioner

I CONCUR:

G. Bryan Lyndon, Commissioner

I DISSENT: The Flagstar Corp. case is directly on point and the carrier did not file a Form 54 within the required ten (10) year statue.

Derrick L. Williams, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 29 day of December, 2011

By Valerie D Boller

Administrative Assistant to the Commissioner

LaTonya Edwards

Roy A. Howell III

Preston F. McDaniel

STATE OF SOUTH CAROLINA)
)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS

South Carolina Second Injury Fund)
Plaintiff(s))

vs.)

Liberty Mutual Insurance Company)
Defendant(s))

CIVIL ACTION COVERSHEET

2012-CP-26-699

(Please Print)
Submitted By: Latonya Dilligard Edwards, Esq.
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FILED
2012 JAN 30 PM 2:39
CLERK OF COURT
HORRY COUNTY, SC

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (*Check all that apply)*

***If Action is Judgment/Settlement do not complete*

☐ **JURY TRIAL** demanded in complaint. ☐ **NON-JURY TRIAL** demanded in complaint.
☐ This case is subject to **ARBITRATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to **MEDIATION** pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

Torts - Professional Malpractice
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☐ Medical Malpractice (220)

Previous Notice of Intent Case # 20____-CP-_____-_____

- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

Torts – Personal Injury
- ☐ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☐ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☐ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

Real Property
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

Inmate Petitions
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

Judgments/Settlements
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Transfer of Structured Settlement Payment Rights Application (760)
- ☐ Other (799)

Administrative Law/Relief
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture—Consent Order (850)
- ☐ Other (899)

Appeals
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☒ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

Special/Complex /Other
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Motion to Quash Subpoena in an Out-of-County Action (660)
- ☐ Sexual Predator (510)

Submitting Party Signature: Latonya Edwards **Date: 1/30/12**

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

COPY

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY	)	
South Carolina Second Injury Fund,	)	
Defendant/Appellant,	)	
vs.	)	CERTIFICATE OF EXEMPTION FOR ADR
Liberty Mutual Insurance Company,	)	
Plaintiff/ Respondent.	)	DOCKET NO.: 2012-CP-___-_____

I certify that this action is exempt from ADR because:

12 JAN 30 PM 2:39

☐ this is a special proceeding or action seeking extraordinary relief such as mandamus, habeas corpus of prohibition.

☒ this action is appellate in nature;

☐ this is a post-conviction relief matter;

☐ this is a contempt of court proceeding

☐ this is forfeiture proceeding brought by the State;

☐ this is a case involving a mortgage foreclosure; or

☐ the parties submitted the case to voluntary medication with a certified mediator prior to the filing of this action.

Plaintiff/Attorney(s) for Plaintiff(s)

Defendant/Attorney(s) for Defendant(s)/Appellant

Latonya Dilligard Edwards, Esquire
Boykin & Davis, LLC
220 Stoneridge Drive, Suite 100
Columbia, South Carolina, 29210

Dated: January 27, 2012

COPY

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF HORRY	)	
	)	
South Carolina Second Injury Fund	)	DOCKET NO.: 2012-CP-____-_____
	)	
Defendant/Appellant,	)	
	)	
vs.	)	NOTICE OF INTENT TO APPEAL
	)	
Liberty Mutual Insurance Company,	)	
	)	
Plaintiff/Respondent.	)	
	)	

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TO: ROY A. HOWELL, III, ESQUIRE, ATTORNEY FOR LIBERTY MUTUAL INSURANCE COMPANY AND AVX CORPORATION; AND THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION.

YOU WILL KINDLY NOTE that the South Carolina Second Injury Fund (the Fund), pursuant to S. C. Code Ann. §§1-23-380 and 42-17-60, petitions the Court of Common Pleas of Horry County, South Carolina, to reverse the Decision and Order of the Appellate Panel of the South Carolina Workers' Compensation Commission in WCC File No. 9826170 dated December 29, 2011, a copy of which is attached hereto. The grounds for the Fund's petition are as follows:

1. The Commission's Decision and Order was filed on December 29, 2011, and received by the Fund on December 29, 2011, and, therefore this Appeal is timely.

2. The Commission's Decision and Order is final and the Fund has exhausted all available administrative remedies.

3. The Commissioner committed a reversible error in finding that the greater weight of the evidence indicates that the Respondents filed a claim for reimbursement against the Fund on July 23, 2009, when it filed a "Notice of Possible Second Injury Fund Claim", with supporting documents, the error being that the appropriate inquiry is whether the Carrier commenced a claim within ten (10) years per S.C. Code Ann. § 15-3-600.

4. The Commissioner committed a reversible error in concluding that pursuant to S.C. Code Reg. 67-206(C), the Respondents filed a claim for reimbursement and otherwise commenced action against the Fund regarding the December 7, 1998 accident on July 23, 2009, when it filed a detailed claim form and supporting documentation with the Fund.

5. The Commissioner committed a reversible error in concluding that pursuant to S.C. Code Ann. § 15-3-600 and Transp. Ins. Co. v. S.C. Second Injury Fund, 389, S.C. 422, 699 S.E. 2d 687 (2010), the Respondents filed a claim against the Fund seeking reimbursement for the December 7, 1998 accident under S.C. Code Ann § 42-9-400 within ten (10) years after the claim accrued and, therefore, the claim for reimbursement was timely.

6. The Commissioner committed a reversible error in concluding that because the Fund stipulated that all other requirements for reimbursements under S.C. Code Ann. § 42-9-400 have been met for both the December 7, 1998 and December 27, 1999 accidents, the Respondents are entitled to reimbursement per S.C. Code Ann. § 42-9-400(a), the error being Carrier's claim was untimely pursuant to S.C. Code Ann. § 15-3-600.

7. The Commissioner committed a reversible error in ordering the South Carolina Second Injury Fund to reimburse AVX Corporation, Inc. and Liberty Mutual Insurance Company for compensation paid to the Claimant following his 1998 and 1999 work-related injuries, the error being that the 1998 work related injury was not timely filed pursuant to § 15-3-600 and the prevailing case law.

8. The Commissioner committed a reversible error in failing to find that Carrier's request for reimbursement was barred by the ten (10) year statute of limitation per § 15-3-600 and the SC Supreme Court's decision in Transp. Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010).

9. The Commissioner committed a reversible error in ordering the South Carolina Second Injury Fund to reimburse AVX Corporation, Inc. and Liberty Mutual Insurance Company for all causally related medical expenses in accordance with S.C. Code Ann. § 42-9-400.

Respectfully submitted,

By: _____

Latonya Dilligard Edwards, Esquire
Boykin & Davis, LLC
220 Stoneridge Drive, Suite 100
Columbia, South Carolina 29210
(803) 254-0707

January 27, 2012

STATE OF SOUTH CAROLINA **HORRY COUNTY**	) **IN THE COURT OF COMMON PLEAS**) **FOR THE FIFTEENTH JUDICIAL CIRCUIT**
Gilbert Chavis, Employee, -vs- AVX Corporation, Employer, and Liberty Mutual Insurance, Carrier ***In Re:*** **AVX Corporation and Liberty Mutual Insurance Company,** **Respondents,** **-vs-** **South Carolina Second Injury Fund,** **Appellants.**	2012-CP-26-00699 W.C.C. FILE NO. 9826170 & 9927964 **ORDER**

HORRY COUNTY
12 AUG 20 PM 1:41
MELANIE HUGGINS-WARD
CLERK OF COURT

STATEMENT OF THE CASE

The South Carolina Workers' Compensation Commission awarded Gilbert Chavis lifetime medical and indemnity benefits for a traumatic brain injury by Decision and Order dated August 31, 2006. This award was based on two claims: the first involving injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, psyche, and "whole body" on December 7, 1998; the second involving injuries to the back on December 27, 1999. On January 25, 2000, Chavis underwent a cervical injection, which resulted in a cerebellar stroke and injury to the brain. The award of lifetime indemnity and medical benefits was based on a combination of both the December 7, 1998 and the December 27, 1999 accidents.

Following affirmation of the Hearing Commissioner's Order by the Commission's Appellate Panel on June 18, 2007, the matter was settled by a Final Lump Sum and Release

/MHC

Agreement on October 31, 2008. Under the terms of the agreement, Chavis was paid $348,000.00 in full settlement and satisfaction of every liability arising out of the December 7, 1998 and December 27, 1999 accidents.

AVX and Liberty Mutual (hereinafter, "the Respondents") then claimed reimbursement from the Second Injury Fund for these medical and indemnity benefits pursuant to S.C. Code Ann. § 42-9-400. The reimbursement claim was acknowledged by the Second Injury Fund (hereinafter "the Fund") in writing. The Fund further conceded that all of the requirements for reimbursement set forth in S.C. Code Ann. § 42-9-400 were satisfied for both the 1998 and the 1999 claims. A Consent Order was issued on July 28, 2010 by which the Fund agreed that the only issue in dispute relative to the reimbursement claim was the statue of limitations; "the Second Injury Fund agreed that the Employer/Carrier satisfied the requirements for full reimbursement in both cases pursuant to S.C. Code Ann. §42-9-400." The Fund subsequently stipulated that the statute of limitations was satisfied for the 1999 claim.

The reimbursement claim originally came before Commissioner Roche for a hearing on January 13, 2011. By Order dated June 28, 2011, Commissioner Roche found that "Pursuant to S.C. Code Ann. 15-3-600 and Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010), the Respondents filed a claim against the Fund seeking reimbursement for the December 7, 1998 accident under S.C. Code Ann. 42-9-400 within ten years after the claim accrued and; therefore, the claim for reimbursement is timely." The Fund was ordered to reimburse the Employer/Carrier $384,738.15 of compensation paid to the Respondents as well as all causally-related medical expenses as provided by S.C. Code Ann. 42-9-400. The Fund appealed to the Commission's Appellate Panel, which affirmed Commissioner Roche's Order in its entirety by final Decision and Order dated December 29, 2011.

/mhc

A hearing was held in Conway, South Carolina on July 24, 2012 pursuant to the Fund's appeal to the Court of Common Pleas from the Workers' Compensation Commission. Latonya D. Edwards of Dilligard Edwards, LLC, appeared on behalf of the Second Injury Fund and Kirsten L. Barr of Trask & Howell, LLC, appeared on behalf of the Respondents, AVX and Liberty Mutual.

On appeal, the Fund argues that the Commission erred as a matter of law by concluding that an "action for relief" is commenced with the filing of a claim. According to the Fund, an "action for relief," as contemplated by S.C. Code Ann. § 15-3-600, can only be commenced with the filing of a "Form 54 Request for Hearing." After considering the briefs and oral arguments presented by the parties, the December 29, 2011 Decision and Order of the South Carolina Workers' Compensation Commission is hereby AFFIRMED.

DISCUSSION

The Workers' Compensation Commission found that the Respondents filed a claim for reimbursement under S.C. Code Ann. § 42-9-400 on July 23, 2009, in accordance with S.C. Code Reg. 67-206. Because the claim accrued on August 4, 1999 when the Respondents provided notice to the Fund, the Commission concluded that the action for reimbursement was timely and properly commenced within the 10 year statute of limitations for civil claims, S.C. Code Ann. § 15-3-600.

Title 15, Chapter 15 governs the "Limitation of Civil Actions" and S.C. Code Ann. § 15-3-600 requires that "[a]n action for relief not provided for in this chapter must be commenced within ten years after the cause of action shall have accrued." The Fund argues that a Form 54 Hearing Request must be filed in order to "commence" an "action for relief" under § 42-9-400. The Workers' Compensation Commission rejected this argument and concluded that a

reimbursement claim or "action" under § 42-9-400 is "commenced" with the filing of a claim for reimbursement. The Commission explained, "[t]here is no reason why there should be a more strict filing requirement for reimbursement claims than any other claim under the Workers' Compensation Act." *See* Rogers v. Spartanburg Regional Medical Center, 328 S.C. 415, 491 S.E.2d 708 (Ct. App. 1997) (*rehearing denied, certiorari granted*) (holding that "The statute of limitations applicable to workers' compensation claims, like the Workers' Compensation Act as a whole, should be given liberal construction, and any reasonable doubts should be resolved in favor of coverage."). The Workers' Compensation Act contains no time limitations for hearing requests, only claims. *See* S.C. Code Ann. § 42-15-40.

According to the Fund, Transportation Insurance Company v. South Carolina Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010) requires that a "Form 54 Request for Hearing" must be filed to satisfy S.C. Code § 15-3-600. However, there is no mention of a "Form 54" or a "Hearing Request" in the Transportation Insurance case. Instead, the Supreme Court held that "section 15-3-600 applies to *claims* for reimbursement." 389 S.C. 422, 430, 699 S.E.2d 687, 691. (emphasis added). Neither Transportation Insurance, nor any other reported appellate case explains what commences an "action for relief" in the administrative context, such as a workers' compensation reimbursement claim.

According to S.C. Code Ann. § 15-3-20(B), "a civil action is commenced when the summons and complaint are filed with the clerk of court." However, S.C. Code Ann. § 15-3-20 does not directly apply to workers' compensation claims, which are administrative matters for which there is no summons or complaint filed with the clerk of court. There being no case law, statute, or regulation defining what commences an "action for relief" in the context of a workers' compensation claim, the Workers' Compensation Commission committed no error in concluding

that administrative "actions" under the Workers' Compensation Act are commenced with the filing of a "claim" pursuant to S.C. Code Reg. 67-206. Because the Respondents filed their claim within ten years after their claim accrued, the Commission committed no legal error in concluding that the reimbursement claim was not barred by S.C. Code Ann. § 15-3-600.

CONCLUSION

In accordance with the Administrative Procedures Act, the Workers' Compensation Commission's Decision and Order dated September 23, 2011 is hereby AFFIRMED in its entirety because the Commission committed no legal error in concluding that an action for relief under S.C. Code Ann. § 42-9-400 is commenced with the filing of a claim for reimbursement.

IT IS SO ORDERED!

Benjamin H. Culbertson

The Honorable Benjamin H. Culbertson
Circuit Court Judge

Date: August 13, 2012
Conway, SC.

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Gilbert Chavis, Employee, -vs- AVX Corporation, Employer, and Liberty Mutual Insurance Co. Carrier, *In Re:* **AVX Corporation and Liberty Mutual Insurance Company,** **Claimants,** **-vs-** **South Carolina Second Injury Fund,** **Defendant.**	W.C.C. FILE NO. 9927964 W.C.C. FILE NO. 9826170 **MEMORANDUM OF LAW**

Statement of the Case

The South Carolina Workers' Compensation Commission awarded Gilbert Chavis lifetime medical and indemnity benefits for a traumatic brain injury by Decision and Order dated August 31, 2006. This award was based on two separate, yet inextricably intertwined, claims: the first involving injuries to the neck, back, arms, hands, shoulders, brain, reproductive system, psyche, and "whole body" on December 7, 1998; the second involving injuries to the back and neck on December 27, 1999. Following the December 27, 1999 accident, Chavis underwent a cervical injection, which resulted in a cerebellar stroke and injury to the brain. The award of

lifetime indemnity and medical benefits was based on a combination of both the December 7, 1998 and the December 27, 1999 accidents.

Following affirmation of the Hearing Commissioner's Order by the Commission's Appellate Panel on June 18, 2007, the matter was settled by a Final Lump Sum and Release Agreement on October 31, 2008. Under the terms of the agreement, Chavis was paid $348,000.00 in full settlement and satisfaction of every liability arising out of the December 7, 1998 and December 27, 1999 accidents.

AVX and Liberty Mutual (hereinafter, "the Claimants") now seek reimbursement from the Second Injury Fund for these medical and indemnity benefits pursuant to S.C. Code Ann. § 42-9-400. The Second Injury Fund (hereinafter "the Fund") concedes that all of the requirements for reimbursement set forth in S.C. Code Ann. § 42-9-400 have been satisfied for both the 1998 and the 1999 claim. However, the Fund argues that the 1998 claim is barred by S.C. Code Ann. § 15-3-600, which is the general statute of limitations for "civil actions."[1] The Claimants submit that S.C. Code Ann. § 15-3-600 was satisfied for both the 1998 and 1999 claims no later than July 23, 2009 when the Second Injury Fund Claim Form was filed, commencing both reimbursement claims. Perhaps more importantly, the Fund has forfeited its right to assert the statute of limitations as a defense, as it failed to file its Form 55 within thirty days[2] after the Claimants filed their Form 54 on February 8, 2010, as required by S.C. Code Reg. 67-605(D). Furthermore, the Fund should be estopped to deny this administrative reimbursement claim based upon an overly-strict construction of S.C. Code Ann. § 15-3-600.

[1] The Fund has stipulated that the 1999 claim is timely and otherwise not barred by S.C. Code Ann. § 15-3-600.
[2] The Fund did not file a Form 55 regarding the 1998 claim until June 2, 2010.

Arguments

I. The Fund has forfeited its right to raise the statute of limitations as a defense.

The Fund acknowledges that the Claimants filed a Form 54 Hearing Request on February 8, 2010. (Exhibit #1). Pursuant to the express terms of S.C. Code Reg. 67-605, the "Fund shall file and serve a Form 55 ... within thirty days of service of the Form 54." However, the Fund failed to file or serve a Form 55 with regard to the 1998 claim until June 2, 2010, which is 114 days after the Form 54 was filed. Therefore, pursuant to S.C. Code Reg. 67-605(D), "the Second Injury Fund by the failure to respond within the period allowed in Section B shall forfeit each special and affirmative defense." Whether the reimbursement claim for the 1998 accident is barred by the statute of limitations is clearly and "special and affirmative defense." *See* Rule 8(c), S.C.R.C.P.. Of course, because the regulation employs the term "shall," the forfeiture of the statute of limitations defense is mandatory. Charleston Co. Parents for Public Schools, Inc. v. Mosley, 343 S.C. 509, 541 S.E.2d 533 (2001). For this reason, the Fund's arguments with respect to statute of limitations should be dismissed and reimbursement should be awarded in accordance with S.C. Code Reg. 42-9-400. *See* Case v. Hermitage Cotton Mills, 236 S.C. 285, 113 S.E.2d 794 (1960) (explaining that a statute of limitations defense may be waived by the failure to invoke it at the appropriate stage of the proceedings).

II. The reimbursement claim is not barred by S.C. Code Ann. § 15-3-600.

S.C. Code Ann. § 15-3-600 provides that an "action for relief not provided for in this chapter must be commenced within ten years after the cause of action shall have accrued." Pursuant to S.C. Code Ann. § 15-3-20(B), a civil action (as opposed to an administrative claim) is brought in a court (as opposed to an administrative agency) and is "commenced when the

summons and complaint are filed with the clerk of court..." Of course, S.C. Code Ann. § 15-3-20 does not apply to claims for reimbursement against the Fund. Instead, such administrative matters under the Workers' Compensation Act are commenced with the filing of a "claim."[3] Therefore, the question before the Commission is whether the Claimants commenced its reimbursement claim against the Fund within 10 years after placing the Fund on notice of their claim, which according to the South Carolina Supreme Court, is when the reimbursement claim accrued. Transportation Ins. Co. v. S.C. Second Injury Fund, 389 S.C. 422, 699 S.E.2d 687 (2010).

In the present case, the Claimants served the Fund with notice of their reimbursement claim on August 4, 1999 in accordance with S.C. Code Ann. § 42-9-400, at which time the Fund assigned a SIF claim number: "67417."[4] S.C. Code Ann. § 42-9-400(f) requires that:

> "*An employer or his carrier shall notify the Industrial Commission and the Director of the Second Injury Fund in writing of any possible claim against the fund as soon as practicable but in no event later than after the payment of the first seventy-eight weeks of compensation.*"

According to the South Carolina Supreme Court,

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[3] In determining what constitutes the filing of a claim, it is almost universally held that the law "does not contemplate the filing of a claim having the same particularity as a formal pleading or stating 'all elements of a cause of action;' and that the law would be sufficiently complied with if the claim in whatsoever form sets forth enough facts to apprise the [defendant] of the time, place, and character of the accident, and the general nature of the injury, so that it may be understood that the claimant expects to receive the benefits provided by the Act." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 78, 518 S.E.2d 599, 602 (Ct. App. 1999).

[4] The SIF reimbursement claim number for the 1999 accident is "100406." It would seem illogical for the Fund to assign claim numbers or to otherwise acknowledge or investigate claims that have not yet "commenced." For this reason, the Claimants respectfully contend that the reimbursement action actually commenced at the time the Fund was placed on notice of the claim.

> *" The primary purpose of § 42-9-400(f) is to establish a deadline for perfecting actual claims for reimbursement with the Fund ... Once a claim is submitted, the Fund may agree to reimburse an employer or carrier. In such a case, the Fund must submit the agreement to reimburse to the Commission for its approval. § 42-8-310(b). If the Fund denies a claim for reimbursement, the employer or carrier may request a hearing before the Commission on the claim. 25A S.C. Code Reg. 67-208(D)....Additionally, a purpose of § 24-9-400(f) is to provide notice to the Fund and the Commission of potential claims for reimbursement."* S.C. Second Injury Fund v. American Yard Products, *330 S.C. 20, 21, 496 S.E.2d 862, 863 (1998) (emphasis added).*

Therefore; the primary purpose of the correspondence dated August 4, 1999 was to perfect an **actual claim** for reimbursement with the Fund in accordance with S.C. Code Ann. § 42-9-400(f). In fact, the Fund acknowledged that an actual claim for reimbursement had been made by correspondence dated September 11, 2003, wherein SIF Claims Analyst Phillip L. Johnson advised that SIF Claim #067417 (for date of accident 12/1/98) was **"pending investigation."** (Exhibit #2). Only if the reimbursement claim had commenced would it be deemed "pending" by the Fund.[5]

Over the following years, the underlying claim for medical and compensation benefits was actively and aggressively litigated, with final payment of compensation being made pursuant

---

[5] *See* BLACK'S LAW DICTIONARY, 6th Ed. (1990) (defining the term "pending" as "[b]egun, but not yet completed; during; before the conclusion of; prior to the completion of; unsettled; undetermined ... an action or suit is 'pending' from its inception until the rendition of final judgment.").

to a clincher agreement on July 23, 2009 after multiple motions and appeals[6]. (Exhibit #3). During this time, the Claimants relied on the Fund's statement of September 11, 2003 that their reimbursement claim for the 1998 was "pending," as the Fund did not submit any agreement to reimburse the claim, the Fund did not formally deny the claim, and the claim was not finally adjudicated.[7] Also during this time, the Fund had sufficient information regarding the reimbursement claim to investigate the same and certainly had sufficient information to understand that the Claimants expected reimbursement to the extent allowed by S.C. Code Ann. § 42-9-400.

In addition to the correspondence of August 4, 1999, the Claimants further filed a formal claim for reimbursement with its correspondence of September 5, 2003 and July 23, 2009, by which the Claimants supplied the Fund with detailed information regarding every element of their reimbursement claim. (Exhibits #4 and #5). A reimbursement claim against the Fund, like any other a workers' compensation claim, may also be commenced pursuant to S.C. Code Reg. 67-206(C):

> *A letter filed with the Commission also files a claim. The letter should include the information listed in items (1) through (12) below:*
>
> *(1) Claimant's name (and worker's name, if different);*
>
> *(2) Claimant's address (and workers' address if different);*
>
> *(3) Claimant's home and work telephone numbers (and workers' home and work telephone numbers, if different);*

[6] In fact, a lump sum of indemnity benefits in the amount of $261,500.00 were paid on July 23, 2009 pursuant to the settlement agreement. Prior to that time, the Claimants could not have legally reduced their reserves pursuant to S.C. Code Ann. § 42-9-400(l); therefore, were not even entitled to reimbursement prior to July 23, 2009 as a matter of law.

[7] "A claim for compensation lawfully constituted and pending before the commission may not be dismissed without a hearing and without some proper form of final adjudication. No statute of limitations runs against a litigant while his case is pending..." Halks v. Rust Engineering Co., et al., 208 S.C. 39, 46, 36 S.E.2d 852, 855 (1946) (internal citations omitted).

(4) Claimant's social security number (and workers' social security number, if different);

(5) Employer's name;

(6) Employer's address;

(7) Employer's telephone number;

(8) Employer's insurance carrier, if known;

(9) Date of injury;

(10) The county in which the injury occurred;

(11) Type of injury (to which area of the body);

(12) Description of the accident.

(13) Failure to include any of the information above does not bar the claim if the information necessary to an issue in a claim is given to the Claims Department on request.

In the present case, the Claimants served the Fund with all information necessary to file a claim under S.C. Code Reg. 67-206 well before the expiration of the ten year statute of limitations applicable to civil claims.

Furthermore, our Courts have universally held that the Commission "will accept as the equivalent of a statutory claim any paper that contains the substance usually supplied by a formal claim, although the form may be defective." Hamilton v. Bob Bennett Ford, 336 S.C. 72, 86, 518 S.E.2d 599, 606 (1999). The rationale is that a claim, as contemplated by the Workers' Compensation Act, is not necessarily a formal pleading, but must simply set forth enough facts to apprise the defendant of "the time, place, and character of the accident and the general nature of the injury" so that it may be understood that the claimants (which in this case is AVX and Liberty Mutual) expect to receive the benefits (*e.g.*, reimbursement) provided by the Act. Here, the Fund fully understood that the Claimants expected to receive reimbursement provided by

S.C. Code Ann. § 42-9-400 no later than July 23, 2009 -- before the expiration of any 10 year statute of limitations[8] -- by virtue of the Claimant's communications and Reimbursement Request Form, which were served upon the Fund detailing their reimbursement claim and its merits, including the following statement:

> *The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed a workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 1997, 1998, and 1999. The Claimant had a subsequent work-related injury in 1998 when he was lifting a pot at work in which he injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 2000. During the injection, he sustained a minor cerebral stroke. Prior to the 1998 accident, the Claimant also received treatment for erectile dysfunction, diabetes, and depression.*
>
> *The Claimant had multiple preexisting problems that were agitated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone.*

It is clear that the present action against the Fund was commenced by the filing of a claim for reimbursement within ten years after it accrued in accordance with S.C. Code Ann. § 42-9-400 and S.C. Code Reg. 67-206 and; therefore, it is not time-barred by S.C. Code Ann. § 15-3-600.

II. <u>The Fund should be estopped to deny the claim, which was otherwise tolled during the Claimant's period of reliance on the Fund's affirmations.</u>

According to legal counsel for the Fund, the statue of limitations is not tolled until the Claimants file a "Request for Reimbursement." (Exhibit #1). While there is an official form

[8] Assuming the 10 year statute of limitations began to run on August 9, 1999, then a claim filed or perfected on or before July 23, 2009 is timely under S.C. Code Ann. § 15-3-600, even if the statute was not tolled by the conduct of the Fund upon which the Claimants relied.

entitled "Reimbursement Request," which is designated as a Second Injury Fund Form 2, the very face of the SIF Form 2 states that the "Fund will provide Reimbursement Request forms when the case is accepted for reimbursement." (Exhibit #6). For this reason, the Fund's argument that a reimbursement claim is not commenced until a "Reimbursement Request" is filed is wholly untenable.

In addition, without any supporting authority, the Fund argues that a reimbursement claim is not commenced until a Form 54 is filed and a hearing is requested. This is incorrect. As discussed more fully above, the Claimants gave the Fund notice of their reimbursement claim on August 4, 1999, after which the Fund stated, in writing, that the claim was "pending investigation." Thereafter, the Fund requested additional information regarding the pending reimbursement claim on their own form, which the Fund captioned, "Notice of Possible Second Injury Fund Claim," and which requested essentially the same (albeit far more detailed) information as the Form 54. The Claimants completed this form, with exacting detail and supporting documentation, on July 23, 2009. Again, during this period, the Fund acknowledged in writing that the reimbursement claim was "pending" and; therefore, the reimbursement claim had commenced according to the Fund itself. Therefore, the Fund should not now be heard to complain that the necessary information should have been submitted on a different form than that specifically requested by the Fund itself in order to commence the reimbursement claim process.

Furthermore, it is well-settled that a hearing need not be requested for a claim to be commenced under the Workers' Compensation Act. *See* Muir v. C.R. Bard, Inc.,336 S.C. 266, 519 S.E.2d 583 (Ct. App. 1999) (holding that a Form 50 that does not request a hearing "initiate[s] the claim" for purposes of S.C. Code Ann. § 42-15-40). *See also,* Halks v. Rust Engineering Co., et al., 208 S.C. 39, 36 S.E.2d 852 (holding that a hearing request is not

necessary to toll the statute of limitations and explaining that, after a claim is filed, the "situation is analogous to that of a case pending in court for a long period of time without either party making any effort to secure a final determination."). Like all administrative claims, hearings are the exception and not the rule and; therefore, a hearing request is not necessary to commence a claim.

Even after providing exhaustive information regarding every required element of S.C. Code Ann. § 42-9-400, the Fund refused to accept the claim for reimbursement, yet the only defense raised by the Fund at this juncture is the statute of limitations. However, this is not a long-delayed demand for which a statute of limitations is generally imposed. *See* Hamilton v. Bob Bennett Ford, 336 S.C. 72, 518 S.E.2d 599 (Ct.App. 1999). To the contrary, the Claimants could not have been entitled to reimbursement as a matter of law (S.C. Code Ann. § 42-9-400(l)) until the claim was paid on July 23, 2009. Immediately thereafter, the Claimants began actively negotiating with the Fund and providing all of the detailed documentation requested by the Fund. (Exhibits #7, #8, and #9). It was only after the Fund failed to respond to the detailed information that the Claimants had provided at the Fund's request that the Claimants filed a Form 54 Request for Hearing, but this was well after the claim for reimbursement had commenced. Therefore, because "Statutes of limitation which are susceptible to judicial construction should not be applied mechanically but rather construed in the manner most consistent with both their underlying purposes and the requirements of substantial justice for all parties involved," the Claimants respectfully contend that the present claim for reimbursement should not be barred by S.C. Code Ann. § 15-3-600. White v. MUSC, 355 S.C 560, 586 S.E.2d 157 (Ct. App. 2003) (internal citations omitted).

Finally, the actions and correspondence of the Fund led the Claimants to believe that the claim

for reimbursement had commenced as was "pending" without the necessity of any further forms being filed. Our Courts have that the doctrine of equitable estoppel applies against parties invoking the statute of limitations as a defense. Hucks v. Green's Fuel of S.C., 247 S.C. 457, 148 S.E.2d 149 (1966). Equitable estoppel applies when one party "by his actions, conduct, words or silence which amounts to a representation, or concealment of material facts, causes another to alter his position to his prejudice or injury." Rushing v. McKinney, 370 S.C. 280, 293, 633 S.E.2d 917, 924 (Ct. App. 2006). In the instant case, the employer/carrier justifiably relied on the Fund's representation that the 1998 reimbursement claim was "pending" and their request for further claim information on a form of their own making, as opposed to a Form 54. Therefore, the doctrine of equitable estoppel applies in the instant case. At the very least, the Commission should conclude that the statute of limitations was tolled after the Commission's correspondence of September 11, 2003 (Exhibit #2), until such time as the Fund first denied the claim with their untimely Form 55 on June 2, 2010 – a period of nearly seven years.

Conclusion

For all of the reasons set forth above, AVX Corporation and Liberty Mutual Insurance Company respectfully request reimbursement from the Second Injury Fund pursuant to S.C. Code Ann. § 42-9-400 for both the 1998 and 1999 claims.

Respectfully submitted,

TRASK & HOWELL, L.L.C.
P. O. Box 2167
Mt. Pleasant, SC 29465

By _____
Roy A. Howell, III, Esq.
Kirsten L. Barr, Esq.
Attorneys for the Defendants

January 11, 2011

Roy Howell

To: Edwards, Latonya; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

As per our motion we believe that the filing of the Notice of Claim Forms in July 2009 constituted the filing of a claim which means both cases were filed within the 10 years. We filed a request for reimbursement in July 2009 not February 2010. February 2010 is simply when we requested a hearing.

From: Edwards, Latonya [mailto:ledward@sif.sc.gov]
Sent: Thursday, October 14, 2010 10:50 AM
To: Roy Howell; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

Good Morning Barbara:

The Carrier has filed for reimbursement based on 2 claims. The first claim is based on a December 7, 1998 date of injury and the Fund received notice of that claim on August 4, 1999. Carrier filed a request for reimbursement on this claim on February 10, 2010, which is clearly more than 10 years of when the Fund received notice of the claim. The Fund denies that it is responsible for providing Carrier reimbursement on the 1998 claim as a Form 54 was not filed within the 10 year time period prescribed in Transportation Ins. Co. v. SC Second Injury Fund.

The second claim is based on a December 27, 1999 claim and the Fund received notice of this claim on September 9, 2003. A Form 54 was filed on this claim in February 2010 as well. The 1999 claim was filed within the applicable statute of limitations period.

We believe that since there are two separate claims with two separate dates of injury, and a Form 54 was filed in each claim, then each claim must stand on its own for purposes of interpreting the SC Supreme Court's recent ruling. Thus, the Fund is not required to reimburse Carrier for the 1998 claim.

Sincerely,

Latonya
Latonya Dilligard Edwards
General Counsel
SC Second Injury Fund
100 Executive Center Drive, Suite 101
Santee Building
Columbia, South Carolina 29210
(803) 798-2722 ext. 129 (phone)
(803) 798-5290 (fax)

From: Roy Howell [mailto:RHowell@trask-howell.com]
Sent: Thursday, October 14, 2010 10:17 AM
To: Cheeseboro, Barbara

Roy Howell

To: Edwards, Latonya; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

How is it that you can file a claim for benefits in an underlying claim without filing a 50 but for some reason an SIF claim is different? You can toll the statute of limitations by simply writing a letter. There is no requirement of filing a Form 54 to toll this mythical statute of limitations that the Court has now created outside of the Act. Clearly, the Notice of Claim Form gives the fund all the information it needs to let them know the carrier is filing a claim for reimbursement. To argue otherwise is meritless.

From: Edwards, Latonya [mailto:ledward@sif.sc.gov]
Sent: Thursday, October 14, 2010 11:00 AM
To: Roy Howell; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

We believe that a Request for Reimbursement is a Form 54. We disagree that submitting file materials to the Second Injury Fund is a Request for Reimbursement, but rather a submission for the Fund to determine whether the case will be accepted or denied. So we disagree with Roy's interpretation and would be happy to have a telephone conference at a time that is mutually agreeable to everyone.

Thanks.

Latonya

From: Roy Howell [mailto:RHowell@trask-howell.com]
Sent: Thursday, October 14, 2010 10:55 AM
To: Edwards, Latonya; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

As per our motion we believe that the filing of the Notice of Claim Forms in July 2009 constituted the filing of a claim which means both cases were filed within the 10 years. We filed a request for reimbursement in July 2009 not February 2010. February 2010 is simply when we requested a hearing.

From: Edwards, Latonya [mailto:ledward@sif.sc.gov]
Sent: Thursday, October 14, 2010 10:50 AM
To: Roy Howell; Cheeseboro, Barbara
Cc: Calamas, Pete; Deal, Gail
Subject: RE: Gilbert Chavis

Good Morning Barbara:

The Carrier has filed for reimbursement based on 2 claims. The first claim is based on a December 7, 1998 date of injury and the Fund received notice of that claim on August 4, 1999. Carrier filed a request for reimbursement on this claim on February 10, 2010, which is clearly more than 10 years of when the Fund received notice of the claim. The Fund denies that it is responsible for providing Carrier reimbursement on the 1998 claim as a Form 54 was not filed within the 10 year time period prescribed in Transportation Ins. Co. v. SC Second Injury Fund.

The second claim is based on a December 27, 1999 claim and the Fund received notice of this claim on September 9, 2003. A Form 54 was filed on this claim in February 2010 as well. The 1999 claim was filed within the applicable statute of limitations period.

1

The South Carolina Second Injury Fund

DOUGLAS P. CROSSMAN
DIRECTOR

WINTHROP BUILDING, SUITE 119
220 EXECUTIVE CENTER DRIVE
COLUMBIA, S.C. 29210

(803) 798-2722
FAX: (803) 798-5290

09/11/2003

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORPORATION

SIF NUMBER: 067417
WCC NUMBER: 9826170

CARRIER CLAIM NUMBER: WC 510-192314

Dear ROY A. HOWELL:

Thank you for your letter received 08/04/1999 .

Enclosed is a Notice of Claim Form. Please complete and return it and all requested documents as soon as possible.

Please note that during the course of our investigation, we may be in contact with the employer. Should you have any questions or objections, please advise accordingly.

The above captioned case is pending investigation.

Sincerely,

PHILLIP L. JOHNSON
CLAIMS ANALYST
Telephone Extension: 118

W.C.C. No. 9826170
Carrier Code 00055
Employer Code 330379007
Carrier File No. WC 510-192314
S.I.F. No. 067617

NOTICE OF POSSIBLE SECOND INJURY FUND CLAIM

Employee: GILBERT CHAVIS
Social Security No. 248-04-2224
Address:
Date of Accident: 12/01/98

Employer: AVX CORPORATION
Carrier: LIBERTY MUTUAL INSURANCE CO.
Location:
Address:

Employee's Attorney:
Carrier's Attorney:
Address:
Address:

SUBSEQUENT INJURY:

Nature of Second Injury:

Current Status:

Treating Physicians:

Average Weekly Wage: Compensation Rate:
Date of First Temporary Total: Date Returned to Work:
Weeks of All Benefits Paid: Medical Costs to Date:

NATURE OF PRIOR IMPAIRMENT: Refer to Section 42-9-400,Paragraph (d)

☐ Listed Impairment (1-33):
☐ Other (34 a or b):

KNOWLEDGE REQUIREMENT:

☐ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)
☐ Employee withheld existence of pre-existing condition from employer. (Please attach application, pre-employment physical, etc.)
☐ Employee was unaware of existence of pre-existing condition (Please attach affidavit)

[redacted]

Signature:
Mailing Address:
Date of Claim:

In support of such notice and without precluding the right to establish further facts as may be developed, the preceding allegations are set forth subject to proof at a Hearing.

PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE WORKERS' COMPENSATION COMMISSION.

Revised 3/90

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9826170
Carrier File # WC550-441515
Carrier Code #
Employer FEIN

Gilbert Chavis	248-04-2224	AVX Corporation	
Claimant's Name	SSN	Employer's Name	
6160 McKinley Way	Conway, SC 29526	P.O. Box 867	Myrtle Beach, SC 29578-0867
Address	City State Zip	Address	City State Zip
unknown	unknown	Liberty Mutual Insurance Co.	
Home Phone	Work Phone	Insurance Carrier	

Roy A. Howell, III — Preparer's Name
(843) 881-4228 — Phone #

Compensation Paid	Number of Weeks	From	To	Amount
1. Number of weeks T.T.	463	8/16/99-10/19/08		$ 121,824.75
2. Number of weeks T.P.				$
3. Number of weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$ 261,500.00
Total Compensation Paid				$ 383,076.33
6. Total Medical Benefits* Paid				$ 156,790.10
7. Funeral Benefits				$

☐ Case Denied

Date of Injury: 12/7/98 (month day year)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: Gilbert R Chavis — Claimant
By: [signature] — Employer's Representative
Date: 7/23/09

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By:

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party ..... $
B. Attorney's Fee Paid by Employer ..... $
C. Attorney's Fee Paid by Claimant ..... $
(Non contingent fees, only)

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied

WCC FORM # 19 REV. DATE 3/96 **19** STATUS REPORT AND COMPENSATION RECEIPT

3306

TRASK & HOWELL, L.L.C.
ATTORNEYS AT LAW
763 JOHNNIE DODDS BOULEVARD
P. O. BOX 2167
MT. PLEASANT, SC 29465

HAROLD E. TRASK
ROY A. HOWELL, III

KIRSTEN L. BARR
ANDREW D. SMITH
J. STEVEN RODENBERG
JANIE C. GUERRERO
R. KEVIN RICHEY

PHONE
(843) 881-4228

FAX
(843) 881-8784
E-MAIL
RHOWELL@TRASK-HOWELL.COM

September 5, 2003

CERTIFIED/RETURN RECEIPT REQUESTED

Mr. Douglas P. Crossman
S. C. Second Injury Fund
Koger Center
Winthrop Building, Suite 119
220 Executive Center Drive
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170
Carrier File No.: WC550-441515
Date of Accident: December 7, 1998

Dear Mr. Crossman:

This office represents the employer and their insurance carrier in the above-named workers' compensation claim filed by Gilbert Chavis. The Defendants are hereby placing you on notice that, should the appropriate benefits be paid out in this matter, they will seek reimbursement from the Second Injury Fund.

For your information, our records indicate the Claimant allegedly sustained his injury by accident in Horry County.

Yours very truly,

Roy A. Howell, III

RAHIII/AJB/lk
cc: Carol Lovett, Liberty Mutual
Cheryl Keel, AVX
S. C. Workers Compensation Commission (Certified/RRR)
3019\1625\l-sif not

5095 appeal

SCWCC
SEP 11 2003
JUDICIAL

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR

JAIME C. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
LORI B. KING

TRASK & HOWELL, L.L.C.
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PHONE
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(843) 881-8764

E-MAIL
RHOWELL@TRASKHOWELL.COM
DIRECT DIAL: (843) 881-2236

July 23, 2009

Marla Rehborn
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170
Carrier File No.: WC550-441515
Date of Accident: December 7, 1998

Dear Marla:

Enclosed please find the SC Second Injury Fund Reimbursement Request Form accompanied by the corresponding medical records. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Boundage, Liberty Mutual Insurance Co.
3019\1625\ltr re reimbursement 98 claim

"A"

W.C. No. 9826170
Carrier Code
Employer Code
Carrier File No.WC550-441515

NOTICE OF POSSIBLE SECOND INJURY FUND CLAIM

S.I.F. No.

Employee: Gilbert Chavis	Social Security No. 248-04-2224
Address: 6160 McKinley Way, Conway, SC 29526	Date of Accident: December 7, 1998
Employer: AVX Corporation	Carrier: Liberty Mutual Insurance Co.
Location: Horry	Address: P.O. Box 867, Myrtle Beach, SC 29578-0867
Employee's Attorney Preston McDaniel, Esq.	Carrier's Attorney: Roy A. Howell, III
Address: 1315 Elmwood Ave., Columbia, SC 29201	Address: P. O. Box 2167, Mt. Pleasant, SC

SUBSEQUENT INJURY: Nature of Second Injury: Claimant injured his back and shoulder lifting pots in the course of his employment. As a result of that injury, the Claimant underwent an epidural injection during which time he had a cerebral stroke.

Current Status: The claim was litigated and ultimately settled for $261,500.00

Treating Physicians: Dr. Wilkins, Dr. Mills, Dr. Kang, Dr. Presslar

Average Weekly Wage: Compensation Rate$263.12

Date of First Temporary Total: 8/16/99 Date Returned to Work:

Weeks of All Benefits Paid: Medical Costs to Date: $155,790.10

NATURE OF PRIOR IMPAIRMENT:

_X_ Listed Impairment (1-33): (2) diabetes; (4) arthritis

_X_ Other (34a or b): (b)

The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed a workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 1997, 1998, and 1999. The Claimant had a subsequent work-related injury in 1998 when he was lifting a pot at work in which he injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 2000. During the injection, he sustained a minor cerebral stroke. Prior to the 1998 accident, the Claimant also received treatment for erectile dysfunction, diabetes, and depression.

The Claimant had multiple preexisting problems that were agitated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone.

KNOWLEDGE REQUIREMENT:

_X_ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)

___ Employee withheld existence of pre-existing condition from employer. (Please attached application, pre-employment physical, etc.)

___ Employee was unaware of existence of pre-existing condition (Please attach affidavit)

[redacted]

Signature: [signature] Date of Claim: 7/23/09

Mailing Address: Tusk & Howell, L.L.C., P. O. Box 2167, Mt. Pleasant, SC 29465-2167

In support of such notice and without precluding the right to establish further facts as may be developed, the Preceding allegations are set forth subject to proof at a Hearing.

PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE

WORKERS' COMPENSATION COMMISSION.

Revised 3/90

STATEMENT

To whom it may concern:

I evaluated Gilbert Chavis for injuries he sustained in a work-related accident on December 7, 1998.

Prior to 1998, I had treated the Claimant for lower back and right shoulder injuries. The Claimant injured his lower back and right shoulder in an accident on April 8, 1996. The injuries the Claimant sustained in the 1996 accident resulted in permanent physical impairment. Additionally, the Claimant suffered from problems related to his preexisting diabetes, depression, and impotence prior to 1998.

It is my opinion within a reasonable degree of medical certainty that the accident of December 7, 1998 aggravated and combined with Mr. Chavis' preexisting permanent impairment to the lumbar spine and right shoulder, as well as his preexisting diabetes, impotence, and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 7, 1998 injury alone.

Also, it is my opinion, within a reasonable degree of medical certainty that Mr. Chavis' December 1998 accident aggravated these preexisting conditions and were a hindrance or obstacle to his reemployment.

Sincerely,

Jeffrey C. Wilkins, M.D.

Dated: 5/3/7

STATEMENT

To Whom It May Concern:

I, Gilbert C. Chavis, was involved in a work-related accident on December 7, 1998 and injured my right shoulder. Prior to December 1st 1998, I was treated by an orthopaedist for right shoulder pain on multiple visits beginning in 1996 which continued until December 7, 1998. I also was treated for impotence, depression, and diabetes prior to the 1998 accident. As a result of ongoing problems with my right shoulder, a cervical injection was recommended. As a result of a reaction to the cervical injection I suffered a cerebellar stroke. The injection was recommended because of ongoing problems with my right shoulder related to the December 7, 1998 accident.

My employer, AVX Corporation, was aware of my prior right shoulder injury, as it occurred while working for AVX. AVX was also aware of my prior treatment for impotence, depression, and diabetes.

Gilbert R Chavis

Gilbert R. Chavis

Dated: 5-20-09

Form L

S.C. SECOND INJURY FUND REIMBURSEMENT REQUEST FORM

Mail To:
S.C. Second Injury Fund
220 Executive Center Drive
Winthrop Building, Suite 119
Columbia, S.C. 29210

Second Injury Fund No.
Carrier No.
Date of Accident
Compensation Rate

PLEASE REVIEW INSTRUCTIONS ON REVERSE SIDE

Employee:	Employer:	Carrier

Date of first payment of compensation:

Date for 100% Medical Reimbursement: *(1st Day of 79th Week after accident)*

Type of Comp Paid	Date Beginning	Date To	Weeks	Amount
TEMPORARY TOTAL				
TEMPORARY PARTIAL				
PERMANENT PARTIAL				
PERMANENT TOTAL				
DEATH OR OTHER *(SPECIFY)*				
		TOTAL INDEMNITY TO DATE		
LESS 78 WEEKS	WEEKS / AMOUNT Wks at Full Compensation Rate Wks at Temporary Partial Rate			
		NET REIMBURSABLE INDEMNITY REIMBURSEMENT		
LESS ANY PRIOR INDEMNITY REIMBURSEMENT				
TOTAL INDEMNITY REIMBURSEMENT REQUESTED				
TOTAL MEDICAL REIMBURSEMENT REQUESTED *(ENCLOSED ITEMIZED LIST - SEE INSTRUCTIONS)*				
TOTAL REIMBURSEMENT REQUESTED				

I hereby certify, that to the best of my knowledge and belief, the information as indicated above is true and correct as of this date: _____

MAIL REIMBURSEMENT TO:

_____
NAME

_____
ADDRESS

_____

_____
NAME OF CARRIER OR EMPLOYER, IF SELF-INSURED

SIGNED BY _____

TITLE _____ DATE _____

I. MEDICAL REIMBURSEMENT:

A. Reimbursement for all medical bills incurred during the first 78 weeks will be 50% of any amount over $3,000.
(Example: $5,000 les $3,000 = $2,000 x 50% = $1,000 Reimbursement)

B. Reimbursement for all medical bills incurred after the first 78 weeks will be 100% of any amount.
(Example: $1,000 x 100% = $1,000 Reimbursement)

C. Recommend you request reimbursement when it reaches $5,000 and quarterly thereafter until the 78th week.

D. Or, file on completion of the 78th week.

E. Medical after 78 weeks will be reimbursed quarterly beginning 91st week.

II. REIMBURSEMENT REQUESTS:

A. The Second Injury Fund will provide Reimbursement Request forms when the case is accepted for reimbursement:

1. A completed Reimbursement Request form will be returned to the Second Injury Fund for each request. Both indemnity and medical may be included on the same form.

2. The Reimbursement Request form must be accompanied by an itemized list of all medical expenses, if medical reimbursement is requested.

B. The itemized list must be in the following format:

	DESCRIPTION	DATE INCURRED	AMOUNT
1.	General Hosp.	1-14-75 to 1-24-75	$3,470.14
2.	Dr. Hanson	1-24-75	$384.20
3.	Jones Boot Store Orthopedic Boots	3-6-75	$47.20
4.	Drug Bills*	1-4-75 to 4-4-76	$327.84

NOTE: Copies of all medical bills attached and numbered to correspond with itemized list. Also use the date incurred to place these bills in chronological order.

* One entry may be made for all drug bills incurred during 1st 78 weeks and one entry after the 78th week, **BUT DO NOT** combine the two entries.

The South Carolina Second Injury Fund

WILLIAM E. GUNN
INTERIM DIRECTOR

100 EXECUTIVE CENTER DRIVE, SUITE 101
SANTEE BUILDING
COLUMBIA, S.C. 29210
www.scsif.sc.gov

(803) 798-2232
FAX: (803) 798-5291

August 10, 2009

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORP.
SIF #: 100406 CARRIER CLAIM NUMBER: WC550-448871
WCC #: 9927964

DEAR ROY A. HOWELL:

WE HAVE REFERENCES TO INJURIES IN 1996, '98, AND '99. WE HAVE NO 12A'S OR ACCORD FORMS. CLAIMS ARE BEING MADE THAT THE '99 INJURY LED TO SUBSTANTIALL INCREASED COSTS DUE TO THE PRIOR CONDITIONS. THE MEDS DO NOT REFLECT THIS. ACTUALLY, THE MEDS DON'T REFERENCE AN INJURY IN DEC OF '99. PLEASE SEND THE SIF DOCUMENTATION OF A DECEMBER '09 INJURY.

SINCERELY,

PHILLIP L. JOHNSON
SENIOR CLAIMS ANALYST

"E"

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR

JAMIE C. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
LORI B. KING

TRASK & HOWELL, L.L.C.
ATTORNEYS AT LAW
763 JOHNNIE DODDS BOULEVARD
P. O. BOX 2167
MT. PLEASANT, SC 29465

PHONE
(843) 881-4228

FAX
(843) 881-8784

E-MAIL
RHOWELL@TRASK-HOWELL.COM
DIRECT DIAL: (843) 881-2236

August 14, 2009

Mr. Phillip Johnson
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9927964
Carrier File No.: WCS50-441515
Date of Accident: December 27, 1999

Dear Phillip:

Pursuant to your letter dated August 10, 2009 in regard to the above matter, I have enclosed a copy of Jeffrey C. Wilkins, M.D.'s Statement dated 2/20/01; the deposition transcripts of Dr. Jeffrey C. Wilkins dated October 21, 2006 and January 27, 2006; First Report of Injury dated 12/27/99 and Decision and Order dated August 31, 2006 from J. Alan Bass. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Bourdage, Liberty Mutual Insurance Co.
3019\1625\l-johnson re slf reimbursement 99 claim

"F"

The South Carolina Second Injury Fund

WILLIAM E. GUNN
INTERIM DIRECTOR

100 EXECUTIVE CENTER DRIVE, SUITE 101
SANTEE BUILDING
COLUMBIA, S.C. 29210
www.scsif.sc.gov

(803) 798-2722 •
FAX: (803)798-5290

November 10, 2009

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORP.
SIF #: 100466 CARRIER CLAIM NUMBER: WC550-448871
WCC #: 9927964

DEAR ROY A. HOWELL:

I TALKED WITH MICHELLE AND, AS OUR FILE CURRENTLY STANDS, I CAN EVALUATE THIS CLAIM FOR THE LUMBAR INJURY AND NOT THE SHOULDER. ANY ROLE DIABETES OR PSYCHONUROTIC DISABILITY PLAYS WILL BE DISCOUNTED. IF THIS IS ACCEPTABLE, PLEASE LET ME KNOW AND I WILL PROCEED ALONG THOSE LINES. IF NOT, I STILL NEED KNOWLEDGE INFO FOR DIABETES AND PSYCHONUROTIC DISABILITY.

SINCERELY,

PHILLIP L. JOHNSON
SENIOR CLAIMS ANALYST

"G"

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR

JAMIE C. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
LORI B. KING

TRASK & HOWELL, L.L.C.
ATTORNEYS AT LAW
763 JOHNNIE DODDS BOULEVARD
P.O. BOX 2167
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PHONE
(843) 881-4228

FAX
(843) 881-0764

E-MAIL
RHOWELL@TRASKHOWELL.COM
DIRECT DIAL: (843) 881-2236

July 28, 2009

Marla Rehbom
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9927964
Carrier File No.: WC550-441515
Date of Accident: December 27, 1999

Dear Marla:

Enclosed please find the SC Second Injury Fund Reimbursement Request Form accompanied by the corresponding medical records. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Boudage, Liberty Mutual Insurance Co.
3019\1625\l-elf re reimbursement SIF claim

"C"

415

9927964
Carrier Code
Employer Code
Carrier File No. WC550-448871

NOTICE OF POSSIBLE SECOND INJURY FUND CLAIM

S.I.F. No.

Employee: Gilbert Chavis	Social Security No. 248-04-2224
Address: 6160 McKinley Way, Conway, SC 29526	Date of Accident: December 27, 1999
Employer: AVX Corporation	Carrier: Liberty Mutual Insurance Co.
Location: Horry	Address: P.O. Box 867, Myrtle Beach, SC 29578-086
Employee's Attorney Preston McDaniel, Esq.	Carrier's Attorney: Roy A. Howell, III
Address: 1315 Elmwood Ave., Columbia, SC 29201	Address: P. O. Box 2167, Mt. Pleasant, SC

SUBSEQUENT INJURY: Nature of Second Injury: Claimant injured his back and shoulder lifting pots in the course of his employment.

Current Status: The claim has been settled for $30,000.00
Treating Physicians: Dr. Wilkins, Dr. Mills, Dr. Kang, Dr. Presslar

Average Weekly Wage: $478.21	Compensation Rate $318.82
Date of First Temporary Total: N/A	Date Returned to Work: N/A
Weeks of All Benefits Paid:	Medical Costs to Date: N/A

NATURE OF PRIOR IMPAIRMENT:

_X_ Listed Impairment (1-33): (2) diabetes; (4) arthritis
___ Other (34a or b):

The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 199 1998, and 1999. The Claimant had a subsequent work-related injury in 1999 when he was lifting a pot at work in which h injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 200 During the injection, he sustained a minor cerebral stroke. Prior to the 1999 accident, the Claimant also received treatment fo erectile dysfunction, diabetes, and depression.

The Claimant had multiple preexisting problems that were agitated and/or combined with the 1999 injury resulting i substantially greater disability and medical payment than that which would have resulted from the December 27, 1999 injur alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexistin diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would hav resulted from the 1999 injury alone.

KNOWLEDGE REQUIREMENT:

_X_ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)
___ Employee withheld existence of pre-existing condition from employer. (Please attached application, pre-employment physical, etc.)
___ Employee was unaware of existence of pre-existing condition (Please attach affidavit)

[redacted]

Signature: [signature] Date of Claim: 7/28/09

Mailing Address: Trask & Howell, L.L.C., P. O. Box 2167, Mt. Pleasant, SC 29465-2167

In support of such notice and without precluding the right to establish further facts as may be developed, the preceding allegations are set forth subject to proof at a Hearing.

PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE WORKERS' COMPENSATION COMMISSION.

Revised 3/90

"D"

416

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9927964
Carrier File # WC550-448871
Carrier Code #
Employer FEIN

Gilbert Chavis	248-04-2224	AVX Corporation	
Claimant's Name	SSN	Employer's Name	
6160 McKinley Way	Conway, SC 29526	P.O. Box 867	Myrtle Beach, SC 29578-0867
Address	City State Zip	Address	City State Zip
unknown	unknown	Liberty Mutual Insurance Co.	
Home Phone	Work Phone	Insurance Carrier	

Roy A. Howell, III — (843) 881-4228
Preparer's Name — Phone #

Check applicable claims and complete all blanks.

1. The Employee sustained a compensable accidental injury to the Back/neck and right shoulder and a cerebral stroke as a result of a spinal injection (Part of the Body)
on December 27, 1999 (Date) in Horry County (County), South Carolina (State)

2. That the Second Injury Fund was put on notice of the claim on September 5, 2005 (Date)

3. That the Carrier concluded the disability claim by Agreement on October 21, 2009 (Date)

4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. code §42-9-40 (d): (2) diabetes; (4) arthritis
a. Listed Impairment - (1) - (33):
b. (34) (a)
c. (34) (b)

5. ☒ a. That the impairment pre-existed;
☒ b. That the impairment was permanent; and
☒ c. That the impairment is a physical condition.
6. ☒ That the prior impairment combined with or was aggravated by the subsequent injury
7. ☒ That the combination/aggravation substantially increased the liability of the Carrier for (disability), (medical) or (both);
8. ☒ That the prior impairment was a hindrance of obstacle to employment or re-employment.
9. ☒ a. That the Employer has knowledge of the prior impairment;
☐ b. That the impairment was unknown to the Employee and the Employer; or
☐ c. That the Employee concealed the prior impairment from the employer.
10. ☒ That the subsequent injury would not have occurred "but for" the prior impairment.
11. That the above claim qualifies for reimbursement under S.C. code §42-9-4100. The Claimant had multiple preexisting problems that were aggravated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone. All of these conditions combined with the Claimant's work-related injury to result in substantially greater disability and medical expenses.

Signature — February 8, 2010 (Date)

PROOF OF SERVICE

I hereby certify that on this 9th day of February 2010, I served a copy of the attached Form 54, Request of Employer/Carrier for a Hearing solely between the Employer and the Second Injury Fund to determine entitlement to reimbursement, by mailing a copy of the same first-class, postage prepaid, to the S. C. Second Injury Fund addressed as follows:

Phillip Johnson
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Ste. 101
Columbia, SC 29210

Roy A. Howell, III
TRASK & HOWELL, L.L.C.
Mt. Pleasant, South Carolina

3019\1626\POS-54

South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, South Carolina 29202-1715

WCC I No. 9826170
Carrier Claim No. WC 510-192314
Carrier Code No. 00055
Employer FEIN

AVX CORPORATION
Employer's Name — Address

LIBERTY MUTUAL INSURANCE CO.
Insurance Carrier's Name — Address

GILBERT CHAVIS
Employee's Name — Address

The Second Injury, in answer to the claim, respectfully shows:

1. It is denied that the employee sustained a compensable accident:
   The claim is being investigated.

2. It is denied that the notice was given to the Second Injury Fund:

3. It is denied that the disability claim has been concluded.
4. It is denied that the impairment is:
   As alleged or any permanent physical impairment serious enough to be a hindrance or obstacle to employment.

5a. It is denied that the impairment pre-existed.
b. It is denied that the impairment was permanent.
c. It is denied that the impairment is physical.
6. It is denied that the impairment combined with or was aggravated by the subsequent injury.
7. It is denied that the combination/aggravation substantially increased the carrier's liability for disability, medical, or both:

8. It is denied that the impairment was a hindrance or obstacle to employment or re-employment.
9a. It is denied that the employer had knowledge of the impairment.
b. It is that the impairment was unknown to the employee and employer.
c. It is that the employee concealed the impairment.
10. It is denied that the subsequent injury would not have occurred 'but for' the prior impairment.
11. It is that the claim qualifies for reimbursement under S.C. Code Section 42-9-410;

12. Other grounds for denial:
    All affirmative defenses including estoppel, statute of limitation per 15-3-600, intervening trauma, laches, fraud, negligence, injuries not work related and not compensable, intoxication; and if mental injury, it didn't arise from unusual or extraordinary circumstances of employment; failed to pay its assessment per § 42-7-310.

LaTonya D'Edwards — June 2, 2010
Signature on behalf of the Second Injury Fund — Date

WCC Form 55 Rev 6/90 — Second Injury Fund's Answer to Employer's Request for Hearing

STATE OF SOUTH CAROLINA *
* CERTIFICATE OF SERVICE
COUNTY OF RICHLAND *

The undersigned employee of the South Carolina Second Injury Fund, 100 Executive Center Drive, Suite 101, Columbia, South Carolina, 29210, does hereby certify that he or she has served the following named individual(s) with a copy of the pleading indicated below by mailing a copy of same to them in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

COUNSEL SERVED:

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

PLEADING: FORM 55 - SECOND INJURY FUND'S ANSWER TO REQUEST FOR HEARING

Shona C. Bethea
SHONA C BETHEA

June 2, 2010

Columbia, South Carolina

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Gilbert Chavis,	W.C.C. FILE NO. 9927964
	W.C.C. FILE NO. 9826170
Employee,	
-vs-	
	CONSENT ORDER
AVX Corporation,	
Employer,	
-and-	
Liberty Mutual Insurance Co.	
Carrier,	
Defendants.	
In Re:	
AVX Corporation and Liberty Mutual Insurance Company,	
-vs-	
South Carolina Second Injury Fund	

The above matters were set for a hearing on July 27, 2010, before the undersigned Commissioner to determine the issues set forth in the Employer/Carrier's Form 54 hearing request.

Prior to the hearing, the Second Injury Fund agreed that the Employer/Carrier satisfied the requirements for full reimbursement in both cases pursuant to S.C. Code Ann. §42-9-400. However, the Fund maintains that the ten year statute of limitations set forth in S.C. Code Ann. §15-3-600 bars these claims for reimbursement.

The parties have agreed that the only issue to be determined by the Commissioner is whether or not the ten year statute of limitations set forth in §15-3-600 bars these claims. The parties

have each agreed that a hearing is no longer necessary. Instead, the parties have agreed to submit a Memorandum of Law in support of their respective positions on the application of the ten year statute of limitations. The Defendants request that the undersigned Commissioner issue an Order awarding full reimbursement as the ten year statute of limitations is not applicable to claims arising under the South Carolina Workers' Compensation Act. The Fund requests an Order denying reimbursement based upon §15-3-600.

IT IS, THEREFORE, HEREBY ORDERED that pursuant to agreement of the parties, the employer/carrier has satisfied the requirements for full reimbursement pursuant to S.C. Code Ann. §42-9-400 for both WCC File No. 9927964 and WCC File No. 9826170.

IT IS, FURTHER ORDERED that the only issue before the undersigned Commissioner is whether or not the ten year statute of limitations set forth in S.C. Code Ann. §15-3-600 bars the Employer/Carrier from obtaining reimbursement from the Second Injury Fund;

IT IS, FURTHER ORDERED that both parties shall submit a Memorandum of Law in support of their relative positions on or before August 10, 2010.

IT IS, FURTHER ORDERED that upon receipt of the aforementioned Memorandum of Law from the parties, the record shall be closed and the undersigned Commissioner will issue a ruling as to the application of the ten year statute of limitations and the Employer/Carrier's entitlement to reimbursement from the Second Injury Fund.

IT IS SO ORDERED.

_____
Commissioner Andrea C. Roche
S. C. Workers' Compensation Commission

_____, 2010

WE CONSENT:

TRASK & HOWELL, L.L.C.

By: _____
Roy A. Howell, III, Esq.
Attorney for ~~Defendants~~

By: _____
Latonya Edwards, Esq.
Attorney for South Carolina Second Injury Fund

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. - 9826170
WCC FILE NO. - 9927974

LIBERTY MUTUAL INSURANCE COMPANY,	
VS.	HEARING
SOUTH CAROLINA SECOND INJURY FUND,	BEFORE COMMISSIONER ANDREA C. ROCHE
IN RE: GILBERT CHAVIS,	**TRANSCRIPT**
CLAIMANT,	
VS.	
AVX CORPORATION,	
EMPLOYER,	
AND	
LIBERTY MUTUAL INSURANCE COMPANY,	
CARRIER, DEFENDANTS.	

THIS WORKERS' COMPENSATION COMMISSION HEARING TAKEN BEFORE CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 1:34 PM ON THURSDAY, JANUARY 13, 2011, SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION, 1333 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202.

APPEARANCES

FOR THE SOUTH CAROLINA SECOND INJURY FUND
LATONYA D. EDWARDS, ESQUIRE
100 EXECUTIVE CENTER DRIVER, SUITE 101
COLUMBIA, SOUTH CAROLINA 29210
803-798-2722

FOR THE EMPLOYER/CARRIER
ROY A. HOWELL, III, ESQUIRE
TRASK & HOWELL, LLC
POST OFFICE BOX 2167
MOUNT PLEASANT, SOUTH CAROLINA 29465
843-881-4228

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

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(EXHIBITS)

No Exhibits Proffered

THE COURT: Today's date is January the 13th, 2011. These are WCC File Nos. 9826170 and 9927964. These are the cases of Liberty Mutual Insurance Company versus The South Carolina Second Injury Fund; In Re: Gilbert R. Chavis versus AVX Corporation. Latonya Edwards is here on behalf of The Second Injury Fund and Roy A. Howell, III is here on behalf of the Carrier.

Are there any objections to APAs, jurisdiction, venue or any other items?

MS. EDWARDS: None.

MR. HOWELL: None from the Employer/Carrier.

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

All right, Mr. Howell, I'll hear from you.

BY MR. HOWELL: Thank you.

Your Honor, again, we're here in connection with two Second Injury Fund claims that arise out of two underlying claims from 1998 and 1999. And to background these, both of these cases were consolidated because of the -- even though they were separate claims the injuries were very intertwined and so the parties agreed to consolidate the cases for a

single hearing. Following the hearing Commissioner Bass issued an Order finding that the combination of both the injuries from the 1998 claim and the 1999 claim the Claimant was permanently and totally disabled and entitled to lifetime compensation and lifetime medical based upon the brain injury that arose out of the action of cervical injection that came from the 1998 injury. Subsequent to that we appealed to the Full Commission, the Full Commission affirmed and then we got into the Court system which took quite some time. And I think after oral arguments but before a decision was made the parties settled the case for $348,000, both -- both cases combined for $348,000. The settlement was approved on July 23rd, 2009. That very same day we filed a Notice of Claim Form that's required by the Fund to seek reimbursement in both cases. After the Fund investigated the claim and it was clear that they were not going to accept both claims we filed a Form 54 on December -- excuse me, February 8th, 2010 requesting a hearing. As you recall the case was set for a hearing last year and before the hearing The Second Injury Fund agreed we had met all of the requirements for reimbursement in both cases and that their only remaining defense for both cases was a Statute of

Limitations defense. The Statute of Limitations defense, of course, that they are arguing is the ten years Statute of Limitations in Section 15-3-600 for General Civil Actions. At that time five cases were pending for Supreme Court on the Statute of Limitations issue. We agreed to submit Memorandum of Law and you agreed ruled -- you originally ruled that the Statute of Limitations did not apply because it was a -- there was nothing in the Act that provided a Statute of Limitations. Unfortunately the Supreme Court has ruled that the Statute of Limitations -- the ten year Statute of Limitations does apply and this case was now reset for a hearing to determine whether or not a claim was filed timely. All the Court did in the transportation insurance company cases and the cases -- is all they did is, said, "Number 1, that Section 15-3-600 does apply to claims for reimbursement from The Second Injury Fund." And then it said, "Claims accrue when the notice of claim" -- "when the notice within 78 weeks is filed." What the Court didn't address, however, is how does one go about filing a claim for purposes of tolling the Statute of Limitations. We have provided you with a Memorandum of Law and some exhibits and our argument -- we have several arguments. Number one, we believe

that the Fund has forfeited its right to raise the Statute of Limitations as -- well, let me back up a little bit. Again, we think because these claims were consolidated for a -- an underlying hearing and having consolidated for Second Injury Fund purposes that if we've met the Statute of Limitations for one claim we met it for both claims for reimbursement purposes because they -- that's how the cases were decided -- the underlying cases and that's how we believe these claims should be decided as well. The Second Injury Fund concedes that the Statute of Limitations was met for the 1999 claim. They -- their argument is that we didn't meet it for the '99 claim because we didn't file our Form 54 until February the 8th, 2010. They concede that they were put on notice properly for the 1998 claim. The notice was filed in August of 1999. We believe that the Statute of Limitations was met because we filed certain things within the ten years. But we also believe that they forfeited their right to even raise the defense. Again, we filed our Form 54 requesting a hearing on February 8th, -- excuse me, February 10th, 2010 and The Fund did not file a 55 until June the 2nd, 2010. Pursuant to South Carolina Code Regulation 67-605(d), "The Second Injury Fund by failure to respond within the period allowed in

Section (b) shall forfeit each special and affirmative defense." Clearly the Statute of Limitations is a special and affirmative defense. The language of the regulation speak -- refers -- uses the term "shall" and so it's our position that since the Form 55 raised in the Statute of Limitations was not filed within 30 days of our filing the Form 54 that they -- The Second Injury Fund forfeited the defense and so we're entitled to reimbursement as a matter of Law. Secondly, we believe that an action was commenced within the ten year timeframe. Again, we're dealing -- because we're dealing with a Second Injury Fund claim for reimbursement we're not in -- we're not in a Court of Law so we don't have a Summons and Complaint situation here and of course the Court did not tell us how you go about satisfying the claim filing requirement. But in an administrative matter such as workers' compensation claims or Second Injury Fund claims for reimbursement a claim -- an action is commenced by a filing of a claim. Therefore the question before you is whether the Claimant, in this case the Employer/Carrier commenced its reimbursement claim against the Fund within ten years after placing the Fund on notice of their claim, which according to the South Carolina Supreme Court is when the

reimbursement claim accrued.

In the present case the Employer/Carrier served the Fund with notice of their reimbursement claim on August 4, 1999 which was within 78 weeks of first payment of compensation. At that time the Fund assigned a Second Injury Fund Claim Number of 67417. Now it's illogical for them to establish a claim number on one hand and then on the other hand argue that no claim has been filed. In addition South Carolina Code Annotated Section 42-9-400(f) requires "That an Employer or its Carrier shall notify the Commission and the Director of The Second Injury Fund in writing of any possible claim against the Fund as soon as practicable; in no event later than after the payment of the first 78 weeks of compensation." According to the Supreme Court in The Second Injury Fund versus American Yard Products, "The primary purpose of Section 42-9-400(f) is to establish a deadline for perfecting actual claims for reimbursement with The Fund. Once a claim is submitted The Fund may agree to reimburse an Employer/Carrier. In such case The Fund must submit the agreement to reimburse to the Commission for its approval. If The Fund denies a claim for reimbursement the Employer or Carrier may request a

hearing before the Commission on the claim. Additionally a purpose of 42-9-400(f) is to provide notice to The Fund and the Commission of a potential claim for reimbursement." Accordingly our Court has said the primary purpose of the correspondence that we sent the Commission -- or actually the Carrier sent the Commission on August 4, 1999 was to perfect an actual claim for reimbursement with The Fund in accordance with 42-9-400(f). The fact The Fund acknowledged the claim for reimbursement had been made by correspondence dated September 11, 20(inaudible) wherein Phillip Johnson advised The Second Injury Fund Claim Number was 67417 and that a -- there was a pending investigation. The only way for reimbursement claims to be commenced would be deemed appropriate for The Fund to say that a claim was in fact pending. Over the next several years after we received the letter from Phillip Johnson, of course the case was in litigation, and it wasn't appropriate to actually -- to take any further action with The Second Injury Fund claim until after the claim was resolved.

In addition to the correspondence of August 4, 2009 the Claimants further filed a formal claim for reimbursement with correspondence of September 5, 2003 and July 23, 2009 by which the Claimant supplied the

Fund with detailed information regarding every element of reimbursement for the claim when we filed the Notice of Claim form. And again, when you look at the Notice of Claim form which is one of the exhibits; it's Exhibit 5 which was filed on July 23, 2009 you'll see that it requires more detailed information even than the Form 54 requires. And everything that The Second Injury Fund would have required to give them notice of a claim that we were seeking reimbursement is set forth in that claim form. In fact, this is the form that The Fund requires that you submit if you are filing a claim. So on the one hand they want to argue that the only way you can file a claim is to request a hearing with a Form 54, they actually give you the form and say this is the form you have to complete to file a claim. They can't have it both ways. On page two of the form it requires a signature and then it actually, on the form that they created, "Date of claim, 7-23-09." Why would they have that on there if this did not constitute the filing of a claim? Furthermore, the Courts have universally held that the Commission, "Will accept the equivalent of a statutory claim any paper that contains the substance usually supplied by a formal claim although the form may be defective." The rational as they claim as

contemplated by the Workers' Compensation Act is not necessarily a formal pleading but simply -- but must simply set forth enough facts to apprise the Defendant of the time, place and character of the accident and the general nature of the injury so that it may be understood that the Claimants, which in this case is AVX and Liberty Mutual, expect to receive benefits; in this case reimbursement provided under The Second Injury Fund Statute. Here The Fund fully understood that the Employer/Carrier expected to receive reimbursement provided by Section 42-9-400 no later than July 23, 2009 before the expiration of the ten year Statute of Limitations by virtue of the Employer/Carrier's communications and a claim form that they required which was served detailing their reimbursement claim and its merits, including the following statement which I'll -- I'll let you read. And it's clear that the action -- the present action against The Fund was commenced by the filings of the Claim for Reimbursement within the ten years after it accrued and for that reason the Statute of Limitations Defense should be dismissed.

Finally, Your Honor, we also would argue that The Fund should be estopped from raising the Statute of Limitations as a defense. Again, after the original

Notice of Claim from was filed in August of 1999 and then we wrote them again in September of 2003 The Fund sent a letter to me saying, we got your letter, there's a pending investigation going on with regards to this claim, we'll let you know what's going on. And the case -- the underlying case proceeded. Nothing -- they can't be heard now to argue that they didn't have -- they didn't know that a claim was filed. And then after, of course, we filed the actual claim form in July of 2009, sent them all the information. There was communication back and forth from Phillip Johnson to my office and back and forth regarding the status of both of these claims and at no time did they indicate the claim was -- was being denied. They said it was under investigation so there was actually no reason for the Employer/Carrier to believe that they needed to do anything else other than continue to -- to provide The Fund information that they said they needed in order to make a decision whether to accept or deny the claim. So again, the Employer/Carrier relied upon The Second Injury Fund's conduct in the way they handled the claim and the -- an equitable estoppel should prevent them from raising the Statute of Limitations as a defense. For all of these reasons we believe the Statute of Limitations

defense should fall and ask that you issue an order in our favor.

Thank you.

THE COURT: Thank you. Ms. Edwards.

BY MS. EDWARDS: Thank you.

Let me address first the Carrier's allegation about us not timely filing the Form 54(sic). Of course we dispute that. At Fund APA pages 102 this is a very detailed note from Mr. Howell on May 17th, 2010 outlining that various people who obviously did not receive a copy of their original Form 54. He addresses it to the Judicial Director, Ms. Crocker. And more importantly at the end of that letter. "In order to expedite a hearing I am re-filing my Forms 54 that were previously filed on February 8th", the one that apparently everybody didn't receive, including the Judicial Department because they didn't schedule the hearing. And then he's enclosing a $25 fee for each case. In response to that, because that's when we received the Form 55 on the '98 claim, which is this one, we filed a Form 55 on June 2nd, which is well before the 30 days outlined in the statute. So certainly we would dispute that our Form 55 is not timely filed. From May 17th to June 2nd, that's well within 30 days. Fund APA page 3 and also let me -- on

the estoppel argument at Fund APA page -- pages 7, 8 and 9. This is a Consent Order that was prepared by Mr. Howell on July 28th, 2010 agreeing that the only issue in the case was on the Statute of Limitations, so certainly we would assert that he's estopped from raising that argument now when his Consent Order that he signed in July 2008, well after our first responsive pleadings consented. So first, we deny that the 55 was filed untimely. Second, even if it was I think his Consent Order after that date indicates that he was consenting to us having the Statute of Limitations being the only issue. So I think he's estopped from asserting that -- on -- as it relates to the ten year Statute of Limitations and is applicable to this case. In our Brief to the Supreme Court which I've given a copy to both the Commissioner and to Mr. Howell, pages 15 through 17; in that particular portion of the argument the Fund specifies to the Court the beginning -- what it thinks should be the beginning of the time period of the ten years and what it thinks should be the end of the time period. Our argument on when the time period should begin was when the date of injury was. The Supreme Court disagreed with that. And so while they disagreed with when the time period began I think they agreed with

when it ended and that is when the Form 54 was filed. Also if you look at -- it's footnote 3 -- footnote number -- I think it's number 3 in the Supreme Court's Decision; it's not numbered. But it's footnote 3. It's a few pages in. In that footnote the Supreme Court Opinion finds that as a result -- this is what they're saying. "As a result of the accrual beginning when notice is provided the result of that is that Great American", which is one of the six cases, "Great American's claim is the only one that is not precluded from receiving reimbursement." And that -- I think that affirms that they bought our argument on when the time period ended, because our argument on all of them was that the time period ended when the Form 54 was filed. So there's no dispute as to when it ends. So I think the Supreme Court spoke very clear on that. They disagreed with when we said it began, which they decided it began on the date we received notice, but I think everybody's clear on when it ends, and that's when the Form 54 is filed. As it relates to the consolidation of the cases our position, and I think case law has affirmed this as well; consolidating cases for judicial economy and expediency has absolutely nothing to do with the issue of reimbursement. Because case law clearly indicates

that compensability and reimbursement are two separate issues. In this case there are two separate injuries. Each case stands on its own. Now we accepted that we are going to be responsible for the 1999 case because they gave notice and they filed their Form 54 within the ten years. Not so on the 1998 and so we deny that we owe anything on that. And so let me say this also; if there's somehow Mr. Howell is arguing that because the case is consolidated then it has one date of injury, then certainly we would assert that the first date of injury would count and we wouldn't owe any of it. And so if the cases are being merged and for some reason if this Commissioner finds that there's only one date of injury, we would certainly assert that that one date for consolidation purposes is the 1998 injury and we don't owe any -- the 1999 or the 1998. Certainly we think that that's not the case, because they're two separate injuries, same Claimant, but two separate injuries and each of those cases and those injuries stand on their own merit as far as reimbursement is concerned.

Let me make sure there isn't anything -- and also Carrier has spoken extensively about us setting up a claim; it has nothing to do with whether the claim is reimbursable, it's -- we set up file numbers for all

claims. It's for purposes of accepting material and evaluating the claim. Just because we set up a claim number doesn't mean that the Carrier is going to receive reimbursement for it; that's why the investigation is required. Let me see. I think those are all the reasons. Based on the Supreme Court's decision I think they've made it very clear when the time period begins and when it ends. It begins on the date of notice, it ends when you file your Form 54. Conversations in between they're -- based on, you know, I think Mr. Howell is saying setting up a claim, you know, we've been sending in material, all of that sending in material is part of the investigation. It has absolutely nothing to do with whether -- with when the Statute of Limitation period ends for purposes of 15-3-600. So based on the Supreme Court's decision we believe the Carrier is barred from reimbursement. Our 55 was not filed untimely; it was filed on June 2nd after the May 17th re-filing of their 54. Consolidation of claims for judicial economy we don't believe had anything to do with whether the claims are reimbursable. They're still two separate injuries and so we believe that an Order denying reimbursement per the Supreme Court's decision is in order and we appreciate that Order.

Thank you.

THE COURT: Mr. Howell.

BY MR. HOWELL: Thank you.

If you'll look in Exhibit 1 to our Memorandum of Law, it's an email from Latonya to Barbara with a copy to me. It says, "The Carrier has filed for reimbursement based on two claims. The first claim is based on the December 7th, 1998 date of injury and The Fund received notice of that claim on August 4, 1999 and Carrier filed a request for reimbursement on that claim on February 10, 2010." So she's telling us right there that they received the Form 54 that we filed in February of 2010. Whether the Commission had it in their file I don't know, but clearly the Fund had the 54 that we filed on February 10, 2010 and should have responded within 30 days. And with regard to the Consent Order, all we were consenting to is that the only issue was the Statute of Limitations. Whether it applies, whether there are any defenses to them raising the Statute of Limitations is totally a separate issue.

Now with regards to the Supreme Court's decision, maybe I'm missing something but I have not seen a single thing in this decision that -- that says what constitutes a filing of a claim for The Second Injury

Fund purposes. It makes absolutely -- again, when you look at the -- the Act in its entirety and you can't just look at one section compared to another section. And if you look at how administrative matters are handled in general hearings are the exception and not the rule. If a claim could not be filed in any administrative case until a hearing reviewed the question, you'd have all sorts of Statute of Limitations issues unless there was a regulation that dealt with it. The problem that we've got -- have here, of course, is we have a Supreme Court decision, we have no statute and no regulation that tells any Employer and any Carrier when and how to actually file a Second Injury Fund claim except for 42-9-400(f) which our Supreme Court has interpreted and which I spoke to earlier in which the Court has said, look, the primary purpose of 42-9-400(f), the notice requirement is to establish a claim for reimbursement and then The Fund can investigate and accept it or they can investigate it and deny it. And like in the other case if it's denied then you request a hearing. They're suggesting that a claim was never established -- they're suggesting that -- that only if we request a hearing was a claim ever established for Second Injury Fund reimbursement. Those are totally separate

issues. The Commission decides if -- unless there's an agreement whether a claim is reimbursable or not. Those are the facts that are set forth and presented at a hearing. Whether or not the Carrier has actually established a claim is a totally separate issue. And in this case the Carrier established a claim way back on August 4th, 1999 and if they didn't establish one then they certainly established it in 2003 and at the very latest July 23, 2009 when a claim form that The Fund actually created and requires before they will even consider a claim for reimbursement. They won't even consider your claim for reimbursement unless and until you file that form that we filed on July 23, 2009 which sets forth in detail all of the requirements for reimbursement. And as the Supreme Court has said on many occasions and it has universally held that when you're dealing with cases in administrative matters, cases before the Commission and any other administrative procedure formal pleadings are required. You can file a claim in any number of ways. In this case the claim was filed in a number of different ways and all of them were filed within the ten year Statute of Limitations.

THE COURT: All right. Anything in addition, Latonya?

BY MS. EDWARDS: Just one thing.

A claim, whether they sent a notice of a claim is irrelevant in computing the Statute of Limitations. We don't deny that they sent a form. Everybody has to send a form to set up a claim at our agency. Does that mean that that meets the -- when you submit that paper that that's when the Statute of Limitations is? No, that doesn't mean that. I think when we made the argument that the statute ends when you file the 54 in our Brief and the fact that the Supreme Court determined that based on our definition of when it ends that only one of those claims, one of those six claims was eligible for reimbursement because they didn't file their 54 Form ten years from the date they received notice. And that's in -- that's the case that I cited in the footnote on my Brief and page -- from page 15 through 17 when you review those you'll under -- you'll see what I'm saying. Nobody -- nobody -- the Supreme Court to me clearly indicated when -- indicated when the ten years ended and that's when you file a 54. Sending paper over to The Second Injury Fund that -- that doesn't cut it. And so we certainly would dispute that sending a notice of a claim form to The Second Injury Fund ends -- is when you mark when the end of the ten year period begins. And so I'll

let that be my final comment and I'll let Roy have the rest.

THE COURT: All right. Mr. Howell.

BY MR. HOWELL: What's the purpose of that form that they require if it's not to file a claim? In an underlying case you can file a claim by writing a letter as long as it has all the information on there and that constitutes the filing of a claim. What does that do; it tolls the Statute of Limitations. Or you can file a Form 50 and not request a hearing. What does that do? It tolls the Statute of Limitations. The Statute of Limitations is tolled when a claim is filed. That's when the Statute of Limitations is tolled, not when you ask for a hearing, it's tolled when a claim is filed. There's absolutely no purpose in this form that The Fund requires if it's not to file a claim. How else do you file a claim? How else is a claim set up? How else do you get the -- the process started to determine whether you get reimbursement or not? You file a claim. That's what was done in this case, a claim was filed. That tolled the Statute of Limitations. And while they're investigating it and we're doing everything we can to give them information so they can make a decision regarding whether they're going to pay the claim or

not, that tolls the Statute of Limitations. It's just like in an underlying case where you've got medical being paid before a 12-A is filed. Medical is being paid, the Claimant's going to the doctor. If they do that for two or three years and then the Carrier says oh, we're not -- we're denying the claim, well the statute is tolled during that period in which the Carrier paid benefits, in which the Carrier did things that the Claimant could rely on to say I don't need to do anything else. In this case The Fund said we're investigating the claim and then after July 23, 2009, we're investigating the claim, here, we got your information, we need some more information and then they quit communicating which caused us to file for a hearing. The claim had been established long before that and tolled the Statute of Limitations.

THE COURT: All right. That concludes the hearing.

(The hearing concluded at 2:07 p.m.)

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)

CERTIFICATE

BE IT KNOWN THAT I TOOK THE FOREGOING WORKERS' COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF **23** TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT THE TIME AND PLACE AFORESAID TO THE BEST OF MY SKILL AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 2ND DAY OF JUNE, 2011.

_____

CORA ELLIS BRUTON
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES JANUARY 18, 2015

STATE OF SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
CASE NUMBER - 9826170

GILBERT R. CHAVEZ,	)	
	)	
CLAIMANT,	)	FULL COMMISSION HEARING
	)	
VS.	)	BEFORE
	)	
AVX CORPORATION,	)	PANEL B
	)	
EMPLOYER,	)	COMMISSIONER WILLIAMS
	)	
LIBERTY MUTUAL,	)	COMMISSIONER LYNDON
	)	
DEFENDANTS.	)	COMMISSIONER WILKERSON
	)	

WORKERS' COMPENSATION FULL COMMISSION HEARING TAKEN BEFORE SARA L. QUATTLEBAUM, A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 9:45 AM ON WEDNESDAY, OCTOBER 25, 2011, WORKERS' COMPENSATION COMMISSION, 1333 MAIN STREET, COLUMBIA, SOUTH CAROLINA.

COPY

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COURT REPORTER: Today is October 25, 2011. This is South Carolina Workers' Compensation Case No. 9826170.

This is the case of Gilbert Chavez, Claimant versus AVX Corporation, Employer. And Liberty Mutual is the Carrier.

The appellant is the Defendant represented by Latonya Edwards. The Respondent is represented by Roy Howell. Each side is allowed ten minutes for oral arguments and the appellant three minutes in reply. You are requested to argue the grounds of exception and stay within the record.

COMMISSIONER LYNDON: Ms. Edwards, you are recognized.

MS. EDWARDS: Thank you. Good morning. For my appeal, the Second Injury Fund is appealing the single commissioner order because we believe that the order violates the Transportation Insurance Company and Flagstar decision which held that the tenure of statute of limitations outlined in 15-3-600 apply to reimbursement cases and that the cause of action accrued on the date the Second Injury Fund received notice.

COMMISSIONER WILLIAMS: Can I just ask you one question?

MS. EDWARDS: Yes, sir.

COMMISSIONER WILLIAMS: There were two claims, the '98 and '99 claims.

MS. EDWARDS: WE accepted one, that's correct. We accepted -

COMMISSIONER WILLIAMS: So only the '98 claim?

MS. EDWARDS: Yes, sir. The only - because clearly the '99 claim met all of the requirements. And their Form 64 was filed timely. So we don't have any problem with that.

COMMISSIONER WILLIAMS: Let me ask you this. I know what this says, a red flag starts, and I know what it says, but it appears that part of the ruling is based on our statute and our regulation. Can that trump what the Supreme Court said in Flagstar? Because they're pretty clear it has to be done within ten years. And I think Commissioner Roche found that our regulation, that it was one of the reasons was for the timeliness. But I could be wrong, so I don't want to muddy this up. But it seems that Regulation 67-2-06 is psych. How can that supersede what the court has told us in Flagstar? Because it has to be done within ten years. It talks about cause of action, which to me is pretty clear. The cause of action is when the case is connected, which to me the filing of

a Form 54, or am I missing something here?

MS. EDWARDS: I'm sorry, are you asking me or Mr. Howell?

COMMISSIONER WILLIAMS: Yes.

MS. EDWARDS: I'm sorry, I thought you were asking Mr. Howell.

COMMISSIONER WILLIAMS: He's going to answer that too when he gets up here.

MS. EDWARDS: I certainly think that the Supreme Court trumps a workers' comp regulation. I think that the Supreme Court's decision was clear in my mind, that they have to file a Form 54 within that ten-year period. In this case, they submitted documents. We are not disputing that they submitted documents.

COMMISSIONER WILLIAMS: That is by the cause of action.

MS. EDWARDS: Right. And submitting documents is not in a cause of action -

COMMISSIONER WILLIAMS: Right, we are not arguing what that is, right?

MS. EDWARDS: Right.

COMMISSIONER WILLIAMS: We definitely know what the cause of action is.

MS. EDWARDS: Right. I totally agree with that.

COMMISSIONER WILLIAMS: Prior to filing a Form 50

to the Commission requesting it be heard by a hearing commissioner on the Claimant's side -

MS. EDWARDS: Right.

COMMISSIONER WILLIAMS: In effect an injury claim reversed is filed with a Form 54.

MS. EDWARDS: I certainly agree with that.

COMMISSIONER WILLIAMS: So was the 54 filed within ten years for the '98 -

MS. EDWARDS: It was not. And I don't think they dispute that. I think they are asserting that because they submitted their reimbursement request form to the Fund, that that allowed them within the ten years. I don't think they are disputing that. The Form 54 was filed outside of ten years. I think they are just using another date to commence a claim to allow them to get within the ten years. But my -

COMMISSIONER WILLIAMS: But if they could just amend the document they have given you all, and that would be the time period. And wouldn't that undo what they are trying to do?

MS. EDWARDS: I certainly think it is. But I don't even think it applies because our agency is not one that - even if we conducted hearings it would be different. Our agency - like you have this entity, of course. And you have a lot of other administrative

agencies that conduct hearings. We don't conduct hearings. So I think they would probably have a fair argument that sending documents to us commences the claim if our agency actually conducted some type of administrative hearing; which we don't do. And so I don't think that applies in this case.

And one of the cases that they cited in their response was Hamilton versus Bob Bennett Ford. And I want to address that because there are various reasons why that case is not applicable to this one. That case is not applicable for various reasons. First, that case applies to the underlying cases where there is a two-year statute of limitations, which is outlined in 42-15-40. Also, that case also talked about a Form 15, which satisfies the written notice requirement to the Employer.

In this particular case there is no form that satisfies all the requirements for notice to the Second Injury Fund of your claim and for meeting all of the statutory requirements.

But more importantly, the reason it doesn't apply is because on August 22, 2011 that case was partly reversed and modified before then at 714 SE2d 22 547 to the extent that it pulled a question of the executive agency's authority to hear an appeal as of

the subject matter jurisdiction. And it was also modified in 2000 at 339 S.C.68.

So - go ahead, I'm sorry.

COMMISSIONER LYNDON: Go ahead and finish your thought. Your time has expired.

MS. EDWARDS: To the extent that - I don't really know based on those two decisions that have modified and probably reversed the case, how much meat that case still has on its bones. But to the extent that it has any meat left, I would certainly think that the Transportation case would supersede it because it is directly on point.

COMMISSIONER LYNDON: So was this based on a late 54 being filed?

MS. EDWARDS: No, actually - we did not actually file a 54 late. We didn't. And I argued that, as well. So didn't file it late. We actually filed it - they updated their 54 again and refilled it with the Worker's Comp Commission, and we filed it again in response to that. We did not file that late. And certainly - and I argued that. All that is in the record. We did not file our 55 late. It was not late. And so it certainly is - I can rehash all of that if the Commission wants, but I don't really think that that was something that the Carrier raised or

preserved for review at this stage. But if it is, we deny that we filed it late, and we certainly indicated the date that we filed it. And clearly it was within 30 days of when they filed their Form 54.

Anything else, Your Honors?

COMMISSIONER LYNDON: Thank you.

MS. EDWARDS: Thank you very much.

MR. HOWELL: I will get right to the point. The only issue that Transportation carrier had to decide was whether the ten-year statute of limitation applied. The issue did not address how do you perfect a claim. To begin, number one -

COMMISSIONER WILLIAMS: Mr. Howell, let me ask you this. You're a very good lawyer so I know you can answer this. Generally when we think of a simple question, if you have a four-year statute of limitations, when does that statute end, when the claim is filed, right; when the claim is filed?

MR. HOWELL: Right.

COMMISSIONER WILLIAMS: And if it's not timely filed, then that's when the statute runs.

MR. HOWELL: But we are not in civil court.

COMMISSIONER WILLIAMS: No, we are not in civil court. Just from a general legal basis, a cause of action, that stops that statute from running. And at

the outside of it, even if it is one day, then if you haven't met it, fine. I think we can kind of muddy it all we want to, but it does talk about a ten-year statute, the time period running when the cause of action accrues. When does the cause of action accrue in this case? Is it when you all submit documents to the Fund or when you file the 54 with us?

MR. HOWELL: The cause of action accrues, okay, the statute of limitations begins to run when we file, according to the Transportation case, when we file our notice within the 78 weeks, okay?

COMMISSIONER WILLIAMS: No, no.

MR. HOWELL: That's when the time accrues. Now, the question becomes - okay, after that - the next question is how do we then file a claim to satisfy the statute of limitations after that, okay? And of course - and our problem is is that there is no statute or regulation that specifically speaks to how you file a claim for purposes of satisfying the statute of limitations because there is no statute of limitations in the Act that deals with the Second Injury Fund reimbursement. So what we have to do -

COMMISSIONER WILLIAMS: There is not anything in the Act, but the complaint takes notice that it's ten years. So for when you all placed it on notice, the

clock starts to run; do you agree with that?

MR. HOWELL: I agree with that.

COMMISSIONER WILLIAMS: All right. And you just file a 54 within ten years, is that -

MR. HOWELL: The question is, is the 54 the only way to satisfy the statute of limitations?

COMMISSIONER WILLIAMS: Tell me why the 54 is not -

MR. HOWELL: Because our Court has said over and over in cases dealing with statute of limitations with respect to claims before administrative - specifically claims before the Worker's Compensation Act is that law does not contemplate the filing of a claim having the same peculiarity as a formal pleading or stating all elements of a cause of action, which is what you're talking about. You're saying, okay, the cause of action is -

COMMISSIONER WILLIAMS: And we know before the filing of a worker's compensation claim, the Claimant can send a letter in to us and ask us to - send a letter to us that would toll the statute in this case.

MR. HOWELL: Absolutely. And that was - well, there were several letters sent. The first letter was sent on August 4, 1999 when the notice of claim was sent. Okay, that's number one.

COMMISSIONER WILLIAMS: That is a claim to the Fund?

MR. HOWELL: That is a claim to the Fund, which is copied to the Commission. Okay. The second -

COMMISSIONER WILLIAMS: What I'm getting at is when is the Commission placed on notice that - when is the claim filed with us? When was the claim filed with us? Because a copy notice on a letter to them isn't filing a claim with us. I don't agree with that. The point I was making in the Claimant's case was they filed a letter with us and then they copy the Carrier. They sign a letter directly with us. We are being copied on a letter to the Fund. Is that correct what you're telling me?

MR. HOWELL: All right. Okay. Again, the second question, again, if I can finish answering the first question.

COMMISSIONER WILLIAMS: All right. I'm sorry. Yeah, go ahead. That was August 4.

MR. HOWELL: Again, the second letter was sent September 5, 2003, which again the Fund responded to with a letter saying we acknowledge your claim and we are investigating it.

COMMISSIONER WILLIAMS: That's what the Fund said.

MR. HOWELL: That's what the Fund said. The third form that was filed, and we think is the most significant, is the notice of possible Second Injury Fund claim form that was filed on July 23, 2009. And what I would ask you to do is compare that form, and you should have it in -

COMMISSIONER WILLIAMS: What is the date on that again?

MR. HOWELL: July 23, 2009.

COMMISSIONER WILLIAMS: All right.

MR. HOWELL: Now, if you compare this form with the Form 54 there is absolutely no difference between the two forms. And again, going back to the case I would cite the case earlier sets up enough facts to apprise the Defendant in this case, The Second Injury Fund, of the time, place and character of the accident and general nature of the injury so that it may be understood that the Claimant in this case, the Employer/Carrier, expects to receive benefits under the Act. And the benefits in this case is reimbursement. So the Second Injury Fund cannot complain that they were not provided sufficient information to know that we were seeking reimbursement for benefits. And we would argue that that was done in September of 2003. But at the latest it was done

was in July of 2009. And no formal pleading need be filed to do that.

COMMISSIONER WILLIAMS: But is it the - I hear your argument, but the cause of action with the filing of the claim is with us. You have to place them on notice, but we're the ones who decide whether reimbursement is proper if they don't pick it up. So from my standpoint and, you know, I haven't asked you this, but why did the Carrier just sit on it?

MR. HOWELL: Why did the Carrier just sit on it? The Carrier did not just sit on it. Again, this was a strongly litigated claim. If you look at the nature of the claim, it was a -

COMMISSIONER WILLIAMS: When did it - did the case settle?

MR. HOWELL: It settled in July of 2009. We filed a claim for - we sent the notice of claim form, the form we just gave you, the same day the 19 was filed with the Commission.

COMMISSIONER LYNDON: July 23.

MR. HOWELL: And in that case there were a number of litigated issues, including whether or not -

COMMISSIONER WILLIAMS: When was the hearing held on the case?

MR. HOWELL: Gosh, several years before 2009

because -

COMMISSIONER WILLIAMS: I'm sorry, when was the Second Injury Fund reimbursement made?

MR. HOWELL: Less than a year ago.

COMMISSIONER WILLIAMS: Go ahead. I can find that.

MR. HOWELL: Anyway, the point being we didn't just sit on it. We sent them another letter in 2003, we sent a letter back saying we got your claim and we are investigating it. Now, that tells us they neither accepted it nor denied it. They said they were investigating it. Well, that tells us, that gives us reasonable reliance that we can go forward with the underlying claim and we don't need to do anything with the Second Injury Fund claim at that point. Even after we filed the notice of claim form in July of 2009 they wrote a letter back to me saying okay, we are still investigating it. We need more information in order to make a decision on whether to accept it or deny it. So even if you argue that the notice of claim form wasn't sufficient to satisfy the statute of limitations, which I believe it was, their conduct in not making a decision whether they accepted it or denied it, tolled the statute of limitations further.

COMMISSIONER WILLIAMS: Hold on now. Isn't it

then your client's duty to go file a form 54 for that claim that -

MR. HOWELL: Well, we did.

COMMISSIONER WILLIAMS: But a claim form is not our Form 54 form. So the problem with it is you all are asking for reimbursement from them.

MR. HOWELL: Exactly.

COMMISSIONER WILLIAMS: We are the ones that they don't provide reimbursement. We are the ones that when a claim is filed we decide whether you all will get reimbursement or not. So you all really don't know if the claim form should probably remain as it will be gone by year's end, pretty much. But the claim form really is a request for reimbursement from them, it's not the filing of the claim. And that's the problem I have with it even before the claim form came out.

MR. HOWELL: Well, why does it have a claim -

COMMISSIONER WILLIAMS: Why didn't you fill us out a form 54?

MR. HOWELL: When?

COMMISSIONER WILLIAMS: When you said you wanted reimbursement. Whenever you think that -

MR. HOWELL: Well, why would - everything is not whenever, whenever, whenever. Whenever you filed the

COMMISSIONER WILLIAMS: I'm just trying to figure out so I can - Flagstar says what it said.

MR. HOWELL: All Flagstar said is that you've got ten years to file a claim.

COMMISSIONER WILLIAMS: The question is how did you file a claim?

MR. HOWELL: We filed a claim three or four different times.

COMMISSIONER WILLIAMS: No, no, no. They are not the Worker's Comp Commission though, Mr. Howell. We are the Worker's Comp Commission. You file a claim with us. You can ask them for reimbursement. You can provide them notice. But the claim is filed with us. I'm just trying to figure that out. If a Claimant sends you - let's just take it out of the Second Injury Fund. If a Claimant sends you a notice of the claim, is that filing a claim with the Commission? I don't think it is. And you would be arguing the same as Ms. Edwards is arguing if they did that outside of the two years. It's the same argument to me.

MR. HOWELL: Well, your next question is -

COMMISSIONER WILLIAMS: Why is not filing a Form 54 not filing a claim?

MR. HOWELL: It is filing a claim. The question

is can a claim a claim be filed any other way? And in this case was the statute of limitations tolled by the information that we sent them. And they are basically telling us we are investigating the claim. We are not denying the claim.

COMMISSIONER WILLIAMS: But who said the statute of limitations was tolled? It should be the Worker's Comp Commission. That's the problem I have with it. You can say anything to them all day. If you think you are entitled to reimbursement and they aren't providing it, then you file a 54. The statute is tolled and we don't have a problem.

MR. HOWELL: Let's change the facts a little bit. Okay. Let's say the farthest you got is the underlying claim. And if the Claimant reports an accident and the Insurance Carrier sends information to the Claimant and says, we need more information to make a decision whether or not to deny the claim. And this goes on for a period of time. There is no question that that conduct is conduct the Claimant can reasonably rely upon in deciding whether or not to file a claim. And our Court has said that conduct on the part of an Employer or a Carrier tolls the statute of limitations during the period of reasonable reliance. My point is that even if you say these

things didn't toll the statute, certainly when we filed that notice of claim form in July of 2009 and provided them information, every bit of that information that is on that Form 54, when they send us information back saying we got everything, we need more information, we are investigating the case, even as late as November of 2009 they are still investigating the claim. They are asking for additional information. They haven't denied the claim. There is no reason for us to file a 54 and request a hearing because they haven't denied the claim. Doesn't that conduct allow us to reasonably rely that we don't need to do anything if we don't need to file a 54 and request a hearing, specifically when there is no regulation or statute that tells us otherwise? And again -

COMMISSIONER LYNDON: Your time has run. You need to wrap it up. Go ahead.

MR. HOWELL: And again, if you look at - again, the Supreme Court in dealing with this, .29400(f), the primary purpose of 49-400(f) is to establish a deadline for perfecting actual claims for reimbursement with the Fund. Once a claim is submitted the Fund may agree to reimburse the Employer or Carrier. In such case the Fund must submit the

agreement to reimburse the Commission for its approval. If the Fund denied the claim, and this is our court saying this, for reimbursement the Employer or Carrier may request a hearing before the Commission on the claim.

So again, that's what happened in this case. We did everything we were supposed to do. What they did was -

COMMISSIONER WILLIAMS: You didn't file a Form 54 within ten years.

MR. HOWELL: Well, there was nothing in the Act or the regulations that said that is the only way to file a claim.

COMMISSIONER LYNDON: Your time has run. Thank you.

MS. EDWARDS: I'm going to let Roy have the last word.

COMMISSIONER LYNDON: Okay. Thank you. That will conclude this proceeding.

(The hearing concluded at 10:06 AM)

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF HORRY	)	2012-CP-26-00699
South Carolina Second Injury Fund,	)	
Plaintiff,	)	Transcript of Record
vs.	)	Hearing
Liberty Mutual Insurance,	)	July 24, 2012
Defendant.	)	

B E F O R E :

Honorable Benjamin H. Culbertson
Horry County Courthouse
Conway, South Carolina

A P P E A R A N C E S:

Latonya Dilligard Edwards, Esquire
Attorney for Plaintiff

Kirsten L. Barr, Esquire
Attorney for Defendant

Grace L. Hurley, CVR-CM-M
Circuit Court Reporter

(There were no exhibits marked during the hearing.)

(On the record, July 24, 2012.)

THE COURT: All right, 2012-CP-26-699, South Carolina Second Injury Fund versus Liberty Mutual Insurance Company.

MS. BARR: Your Honor, may I approach? I'm Kirsten Barr on behalf of Liberty Mutual and I have a brief and a record on appeal for you. The commission no longer sends up the ---

THE COURT: Okay.

MS. BARR: --- whole file.

THE COURT: And you represent who?

MS. BARR: I represent Liberty Mutual and AVX Corporation.

THE COURT: And ma'am, your name?

MS. EDWARDS: My name is Latonya Dilligard Edwards and I represent the Appellant and we sent a copy of the entire record when we filed our appeal in January. So, the Court should have that.

THE COURT: All right.

MS. EDWARDS: In addition, I do have another copy of my brief to the court because I believe it was sent to your Beaufort P.O. box. I don't know if you would have gotten it if it was sent there.

THE COURT: Not if it was sent to Beaufort.

MS. EDWARDS: I have another copy.

THE COURT: I'm in Georgetown.

MS. EDWARDS: I apologize, I apologize.

THE COURT: All right.

MS. EDWARDS: I have another copy of that.

THE COURT: All right, and this is - you represent the Second Injury Fund?

MS. EDWARDS: Yes, I'm the Appellant, Your Honor.

THE COURT: All right, let me hear from you.

MS. EDWARDS: Okay, Your Honor, the South Carolina Second Injury Fund is appealing the decision of the Workers' Comp Commission based on various errors that the Workers' Comp panel committed in its decision upholding reimbursement in this particular case. Now ---

THE COURT: All right, now is this - why is this appealed to the Circuit Court? Does it predate the ---

MS. EDWARDS: This is a pre, pre-2007 case. This is a 1998 case.

THE COURT: Okay, okay, all right. Go ahead.

MS. EDWARDS: Okay, and the Workers' Comp Commission and I'll say a majority because the attorney on the panel dissented and found that the decision in Transportation Insurance Company was directly on point. The other non-attorney members did not, okay? And so, we are appealing based on three, at least three errors. The first is that the - in the decision below the - it regarded whether the ten-year statute of limitations outlined in 15-3-600 applied to

reimbursement cases. That case was decided in 2010. I argued that case before the Supreme Court and the Supreme Court held that it did, in fact, apply to reimbursement cases. I have a copy of that if you would like that as well. I can hand that up for Your Honor.

THE COURT: So the statute of limitations is what?

MS. EDWARDS: Ten years from when the carrier places the Second Injury Fund on notice of a potential reimbursement claim.

THE COURT: So they've got ten years ---

MS. EDWARDS: Ten years.

THE COURT: --- to?

MS. EDWARDS: To perfect their claim and ---

THE COURT: Okay.

MS. EDWARDS: --- to file a Form 54 requesting a hearing.

THE COURT: Okay.

MS. EDWARDS: Okay?

THE COURT: All right.

MS. EDWARDS: In this particular case, the Workers' Comp Commission and I'm just going to quote for you what the majority said. The opening statement or one of the statements in the majority's opinion is that, "Of course," this is a quote. This is on page four of the decision below. "Of course South Carolina annotated 15-3-600 does not apply to

claims for reimbursement against the Second Injury Fund." That's on the discussion at page four. Now, that pronouncement is clearly erroneous in light of the Transportation case that I just passed up to the Court. So we first believe that their failure to apply the prevailing case law in the state was erroneous.

THE COURT: Well, and I'm assuming just because of the nature of your argument that they did not perfect their claim within the ten-year ---

MS. EDWARDS: That's correct.

THE COURT: --- period.

MS. EDWARDS: That's absolutely correct, Your Honor.

THE COURT: Okay.

MS. EDWARDS: The second assignment of error is the majority's reliance on a Workers' Comp regulation which is inapplicable to this particular situation. The regulation that they applied was regulation 67-206. That particular regulation applies to underlying issues of compensability, does not address Forms 54's and Form 55's which, which is what commences a reimbursement claim and it does not deal with statute of limitations issues; and so, that's the second error and I also would point out that the majority failed to even reference the Workers' Comp regulation that does address how you commence a claim. That section was 67-208, subsection D. That section in the Workers' Comp regs indicates that the

carrier commences a claim by filing a Form 54 with the Judicial Department and serving a copy to the Second Injury Fund. Now, I think that's important because I think the carrier's assertion has been that all they have to do to commence a claim is send a copy of documents to the Defendant, which in this case would be the Second Injury Fund. I don't know of any other cause of action that's commenced by just filing a copy of documents to the Defendant. You have to - in this particular case the regs even say you have to file a Form 54 and they didn't do that within the ten years that the Supreme Court says they're allowed.

The final assignment of error was the majority's reliance on a case that's been modified in part and reversed in part. That case was Hamilton versus Bob Bennett Ford. The citation is 336 S.C. 72, 518 S.E.2d 599 and that's a 1999 case. That case, setting aside the fact that it's been modified and or reversed on other issues, it's not applicable to reimbursement issues and it talks about when a claim is filed versus when a cause of action is commenced. In this particular case, the Supreme Court talks about when a cause of action is commenced. The regulation I believe supports that it's commenced against the Second Injury Fund when you file a Form 54, not when you submit documents to the Second Injury Fund.

THE COURT: All right, so the Hamilton case, what was reversed and what was remanded? What were the ---

MS. EDWARDS: A part, a part of the case talked about - it talked about when an agency files a claim, I think, with another agency, okay, and this, this - that was not the question that was being litigated. The question was when you commence a cause of action; and so, I think carrier is asserting that by their filing, giving documents or requesting reimbursement from the Second Injury Fund commences a claim, the Supreme Court and other laws clearly - you don't commence a claim by just sending a copy of documents to a Defendant. You have to ---

THE COURT: Well, what documents did they send?

MS. EDWARDS: They submitted their - what they believe supported their reimbursement. They submitted medical questionnaires from doctors and medical records as well as one of the criteria outlined, criterion outlined in 42-9-400 which is the Second Injury Fund enabling statute is that you submit knowledge, evidence that a preexisting condition is a hindrance to employment, substantially increased liability. I believe that what they submitted was all of their documents they believe supported their claim for reimbursement. So, that's what they submitted to the Defendant, the Second Injury Fund. Okay?

THE COURT: Okay.

MS. EDWARDS: But they didn't commence their claim within the ten years that the Supreme Court says that they're

required to do that.

THE COURT: Which is the filing the Form 54 with the commission?

MS. EDWARDS: Right, and serving a copy on the Second Injury Fund, and while we're on that, Your Honor, let me bring something up because as the carrier raised this ancillary and I call it ancillary because I don't believe it's a primary issue which is whether the Fund waived affirmative defenses by failing to form its Form 55 within 30 days of when the carrier filed a 54 request for hearing. First, let me just say that's not correct, and I also have a document from carrier where there was some - the Workers' Comp Commission had contacted the parties indicating that the Form 54 on - they filed, it's two cases, 1999 and 1998. The only one at issue today is the 1998. There was some question about whether or not, the commission indicated they did not receive the Form 54 for - you want a copy of it?

MS. BARR: I have it.

MS. EDWARDS: Okay, that they did not file a 54 for the 1999 case which is this case and ---

MS. BARR: What? That's not what it says.

MS. EDWARDS: Okay, I'll let the judge determine what it says. The Workers' Comp Commission indicated that they had not received a Form 55, a Form 54 in the 1999 case. In this or in this letter it says quote, "In order to expedite a

hearing on Second Injury Fund claims I'm re-filing a Form 54," that they allege was previously filed on February 8th, 2008, but that's 2010 and enclosing the $25 filing fee. So, on this date, May 17th, 2010, they refiled the Form 54 in the 1999 case. Okay? And I think they're alleging we didn't respond in 30 days, but on June 2nd, which that's well within 30 days, we did file a Form 55 response to their request, and the only reason I raise that is because it's in the opening facts of the order, and though it hasn't been ruled on I certainly would assert that it hasn't been preserved for review, but I wanted to point it out that that's not factually correct. We did respond within 30 days; therefore, we did not waive any affirmative defenses, and so for those reasons, Your Honor, we believe that the Workers' Comp Commission's decision is error of law because they did not follow the Supreme Court's decision in Transportation and we believe that because of that, because of these errors, their decision warrants a reversal.

THE COURT: All right, all right, Ms. Barr, let me hear from you.

MS. BARR: Thank you, Your Honor. With all due respect, I believe that the Fund has rather grossly misrepresented the state of the law in South Carolina. The South Carolina Workers' Compensation Commission did address the question before them and applied the statute as required

by the South Carolina Supreme Court's decision in Transportation Insurance. They held that 15-3-600, which is the general statute of limitation for civil actions, applies in administrative claims for reimbursement against the Second Injury Fund. 15-3-600 simply requires that an action for relief be commenced within ten years. Now, in the civil setting you're accustomed to a summons and complaint; and of course, we don't file summons and complaints in Workers' Comp administrative proceedings. We file claims and Liberty Mutual and AVX Corporation filed a claim within ten years. The commission made a finding to that effect that the greater weight of the evidence indicates that we filed a claim, in other words, commenced an action for reimbursement against the Fund within ten years.

THE COURT: How did you file the claim?

MS. BARR: Well, we notified the commission of a potential claim, excuse me, the Fund of a potential claim, copied the commission. The claim was then assigned a claim number by the Second Injury Fund. We have correspondence from the Second Injury Fund saying the claim number had been assigned, that the claim was pending investigation and that they required additional information, including a claim form, to investigate our claim.

THE COURT: But did the commission assign it a case number as though they - did they consider ---

MS. BARR: The commission's case ---

THE COURT: --- it as a filed claim?

MS. BARR: Yes, I mean everything's filed with the commission that - there's a Workers' Compensation claim number and then the Second Injury Fund reimbursement claim has its own number which is assigned by the Second Injury Fund. So ---

THE COURT: So, you're saying that they do not require a Form 54?

MS. BARR: No, there is absolutely no requirement of a Form 54 anywhere in the statutes or regulations whatsoever.

THE COURT: Okay.

MS. BARR: The Form 54 requests a hearing. What commences the reimbursement action is the filing of a claim, which is what we did, and they kind of tiptoed around it, Ms. Edwards did in her argument, but in addition to all the supporting documentary evidence that was specifically requested by the Fund during their investigation of our pending claim was the claim form, the claim form that details the entire basis for our claim for reimbursement, all the seminal facts. In fact, all the information that would have been required on a 54, if the 54 was in fact required, which it's not. The Fund points to no statute or regulation that requires a 54 for anything other than the hearing request, but by the time a hearing's requested in an administrative claim it's been ongoing and litigated for years with information

going back and forth. So, we took the position, which the majority of the commission, lawyers or not, I'm not sure how a non-lawyer commissioner's opinion is entitled to less respect, but the majority of the commissioners found that we did, in fact, file a claim within the ten-year statute of limitations, cited this evidence. Again, it smacks of hypocrisy for the Second Injury Fund to say no claim was filed yet they assigned it a number, told us they were investigating it, said that the claim was pending and requested all this information and accepted it in ongoing negotiations. So, we believe that the commission's finding that the claim was form - filed within ten years is supported by substantial evidence in the record and should be affirmed under the Administrative Procedures Act. We further believe that the commission committed no error of law in construing 15-3-600 for purposes of administrative claims. I think it's a matter of first impression how you commence an action for relief under a Workers' Compensation claim but heretofore it's always been the filing of a claim.

Now, in her brief the Second Injury Fund argues somehow that Transportation Insurance requires the filing of a Form 54 hearing request to commence the action.

THE COURT: She's saying that that's what reg 67-208(D) requires, that the carrier ---

MS. BARR: Regulations - I'm sorry, Your Honor.

THE COURT: Well, that's all right. Does anybody have that regulation?

MS. BARR: Yes, Your Honor, I've got it right here if you'd like me to show you, but ---

THE COURT: Yeah.

MS. BARR: --- regulation 67-208, if I may approach, is how you request a hearing. If you'll look at regulation 67-206 that's how you file a claim.

THE COURT: All right, go ahead.

MS. BARR: So, we believe we did, in fact, not only file an actual claim, we gave them all the requisite information, we complied with regulation 206 as the commission found. There's no form required for a filing of a claim in Workers' Compensation. It's sufficient that you put the Fund on notice that you seek reimbursement and here their actions belie the argument they did not know we were seeking reimbursement. They requested the information, we gave it to them in a timely fashion.

With respect to the Fund's argument that the Transportation Insurance case requires a Form 54 hearing request to comply with the statute of limitations, that argument is wholly without merit. She's handed up the copy of that case. You'll see that the commission - the court in that case does not even cite when claims were filed in that case, when hearings were requested in that case. There's no mention

of a hearing request. There's no mention of a 54 anywhere on any page of that entire order. So, for her to suggest this is wholly without merit. The sum total of the Transportation Insurance holding was that the statute applied and find when it accrued and they found it accrued when you give notice. The question of when the action for relief commences, when the claim commences, we would submit to you, is a factual question for the commission which was answered with substantial evidence and no error of law was committed. We'd ask, therefore, that this matter be affirmed and that reimbursement be granted as ordered by the majority of the Workers' Compensation Commission.

THE COURT: All right, anything in reply?

MS. EDWARDS: Your Honor, yes, yes, just briefly. In Transportation, in holding that the ten-year statute of limitations applied, the court indicated, quote, this is at footnote three, "The result in this case of accrual beginning when notice is provided is that Great American's claim is the only one that is not precluded by the running of the ten-year statute." In that particular case, Great American was the only carrier that had filed a 54 within ten years of when they provided notice.

THE COURT: Yeah, but I mean, 67-206 reg, that reg clearly states to file a claim ---

MS. EDWARDS: Right, and ---

THE COURT: --- you file a form 50, 52 or a letter to the commission.

MS. EDWARDS: Right, now, and let me say, commencing a cause of action, I think, you know, we, we ---

THE COURT: No, this says not a cause of action. This is to file a claim.

MS. EDWARDS: Right, and filing a claim is not what the issue is. The issue is commencing a cause of action per 15-3-600 and in every, and, you know, Ms. Barr indicates that when we assign a case number that files a claim. So what? People - I can - you - somebody sends me a piece of paper, I file a case number to open up a file to begin an investigation. That does not commence a cause of action.

THE COURT: So, you're saying that the cause of action ---

MS. EDWARDS: That simply opens a file. I'm sorry, go ahead, Your Honor.

THE COURT: --- the cause of action is only commenced when they request a hearing?

MS. EDWARDS: That's absolutely correct, Your Honor.

THE COURT: Have you got anything that states that?

MS. EDWARDS: Other than the, what we believe the Transportation Insurance Company case stands for, no, and regulation 67-208(D) indicates when you commence a cause of action.

THE COURT: No, 208(D) says to request a hearing ---

MS. EDWARDS: Right, and ---

THE COURT: --- you filed a Form 54.

MS. EDWARDS: --- I'm sorry, and I'm using, I'm using the two synomously because my position is and the Fund's position is and we believe what the Transportation decision's position is that when you commence a cause of action that's what you have to do, request a hearing, that's when you commence a cause of action when you're requesting a hearing. Otherwise, you're just shuffling paper to a Defendant or a state agency or whomever, that does not commence a cause of action. It does not.

THE COURT: Okay, all right.

MS. BARR: Your Honor, may I reply briefly? Your Honor ---

THE COURT: Well, no, that's fine. Does anybody have 15-3-600? Let me look at that statute. Oh, wait a minute. It might be in here.

MS. BARR: Your Honor, I think it's block quoted in that Transportation Insurance case.

THE COURT: Oh, it might be. You've got it right here?

MS. BARR: Your Honor, page six of the Transportation Insurance case, paragraph two, it block quotes and says, "An action for relief not provided for in this chapter must be

commenced within ten years after the cause of action shall accrue." That's the sum total of 15-3-600.

THE COURT: Yeah. I'm assuming based upon you all's argument that there is no appellate decision that states when a cause of action is commenced, whether it's with the filing of a Form 54 or whether it's the filing of the letter of the Form 50 or 52. One says claim, one says request for hearing. Is there anything that says - what is the language used in the - I've got it right here. An action, there's nothing that says when an action is commenced.

MS. EDWARDS: Your Honor, Your Honor ---

MS. BARR: No, Your Honor, and, and part of the way I've looked at this situation, 42-15-40 has been treated as a statute of limitations for claims between an employee and an employer under the Workers' Compensation Act and those actions are commenced by the filing of claim in accordance with that regulation 67-206 that you just looked at. If you're to accept the Fund's argument that the general statute of limitations, 15-3-600, is only satisfied when a hearing is requested then that general statute, 15-3-600, would apply in all Workers' Compensation claims because there is no statute under Title 42 that governs the timing of a hearing request. That was because in every single case we've ever seen come up from the Workers' Compensation Commission the action commenced with the filing of the claim and that's obvious. It's an

administrative proceeding. A hearing is not necessary. This is an administrative, an informal proceeding. It's simple - it's enough to simply put the opposing - the opponent on notice that you seek the compensation and here we did more than just shuffle papers towards a state agency. We filed and perfected a claim.

THE COURT: All right.

MS. EDWARDS: Your Honor, just briefly, first of all, 42-15-40 does not apply to Second Injury Fund cases because that's a case that applies a two-year statute of limitations. 15-3-600, the Supreme Court has already said that applies; and so, and Your Honor correctly appointed out that 67-206 doesn't even address Second Injury Fund issues, it talks about the 50 and 52, neither of which are filed when you request reimbursement. There's a 54 filed by the carrier and a 55 in response. So, it doesn't even address the statute of limitations nor ---

THE COURT: Well, that's, that's basically the same thing as saying that 67-208 only addresses requesting a hearing because nothing in there says ---

MS. EDWARDS: Well, and the ---

THE COURT: I mean, the problem we've got here is you've got a statute of limitations that says an action shall be filed.

MS. EDWARDS: Well, it says commenced, the cause of

action commenced.

THE COURT: Shall be commenced.

MS. EDWARDS: Right.

THE COURT: Now, is it commenced when you file the claim or is it commenced when you request the hearing, and as I understand from you all there's no appellate decision that says whether it's commenced when you file the claim pursuant to 67-206 or when you request a hearing pursuant to 67-208.

MS. EDWARDS: I, Your Honor, and, and while that may be - certainly we believe Transportation supports that because commencing a claim like Ms. Barr appropriately pointed out in all other venues you would file a summons and complaint. That's what you would file and that starts your claim, that's the road to your hearing. In this particular case a 54 is the only way you get a hearing in a Workers' Comp case on a reimbursement cause of action.

THE COURT: So, you're saying that when they file a claim pursuant to 67-206, it just sits out there to infinity ---

MS. EDWARDS: When they sent ---

THE COURT: --- with no action?

MS. EDWARDS: --- and it can because, quite frankly, let's just, let's just point out that's the reason we're here in the first place. That's the reason why we had to go to the Supreme Court because we've had cases sitting for 15 years ---

THE COURT: But I mean what is ---

MS. EDWARDS: --- then somebody just decided they wanted to request reimbursement for.

THE COURT: When somebody submits a claim to the Second Injury Fund ---

MS. EDWARDS: That's right.

THE COURT: --- pursuant to 67-206 ---

MS. EDWARDS: Uh-huh.

THE COURT: --- does the Second Injury Fund have a timeline when they have to take action to respond to that claim?

MS. EDWARDS: No, but what that does is that simply evaluates the claim to determine whether we're going to accept it or deny it.

THE COURT: So, but you never have to notify them that you're accepting it ---

MS. EDWARDS: Yes, we do.

THE COURT: --- or denying it?

MS. EDWARDS: Yes, we send them information saying either, one, we need more information, two, we're accepting it, or three, we're denying it.

THE COURT: And do you have a timeline on when you have to do that?

MS. EDWARDS: No, no, well, well, now since, since there has been new legislation ---

THE COURT: I'm ---

MS. EDWARDS: --- but no, not, not at that time.

THE COURT: --- in this case ---

MS. EDWARDS: No.

THE COURT: --- in this case.

MS. EDWARDS: No.

THE COURT: So, you could have just never responded ---

MS. EDWARDS: No.

THE COURT: --- to them.

MS. EDWARDS: But that wasn't the case though. That wasn't the case.

MS. BARR: Yes, Your Honor, they responded and kept saying, "If you just send us this, if you just send us this, if you just send us this," and we kept sending what they asked for, actively negotiating it. It was only after we had exhausted every possible shred of evidence we could give them ---

THE COURT: Okay.

MS. BARR: --- to voluntary accept our claim that a hearing was required to be filed.

THE COURT: But I mean did, did you ever notify them that you were denying the claim?

MS. EDWARDS: They were notified that the claim was denied.

THE COURT: Okay.

MS. EDWARDS: Now, I can't tell you when that was but they were notified. Otherwise they wouldn't have requested a hearing.

THE COURT: Okay. Well, did they request the hearing within ---

MS. EDWARDS: No.

THE COURT: --- the ten years?

MS. EDWARDS: No, that's, that's what I'm saying, no they didn't.

THE COURT: Within ten years of the denial of the claim?

MS. BARR: But Your Honor, with all due respect ---

MS. EDWARDS: I'm sorry, repeat your question, Your Honor.

THE COURT: When you notified them that you were denying the claim did they request a hearing within ten years of that denial?

MS. EDWARDS: No, it's not within ten years of the denial. It's within ten years ---

THE COURT: Well, I mean, if you wait nine years and 364 days to notify them that you're denying ---

MS. EDWARDS: No, no, and ---

THE COURT: --- or let's say you don't even, let's say you ---

MS. EDWARDS: That's not the case.
THE COURT: --- let's say you ---
MS. EDWARDS: That's not the case, Your Honor.
THE COURT: Well, let's say this ---
MS. EDWARDS: That's not the case.
THE COURT: --- you're saying that under the regs you don't have to take any action. What happens if you don't notify them that you're denying the claim until the ten years has expired?
MS. EDWARDS: Well, and let me just say that the ten years is a new phenomenon, that's only something that the Supreme Court's decided since 2010. So, it hadn't been an issue ---
THE COURT: Okay.
MS. EDWARDS: --- before then; okay?
THE COURT: All right, all right.
MS. BARR: And Your Honor, you'll see from ---
THE COURT: I've heard enough, that's fine.
MS. BARR: But, Your Honor, I just point you to the correspondence.
THE COURT: I've heard enough. I'm fine. Thank you.
All right, Ms. Barr, if I could get you to prepare an order that affirms the decision of the commission and put in there specifically that my ruling, so that if they want to appeal it, the Appellate Court will answer the question that

the - I find that the filing of a claim pursuant to 67-206 satisfies the requirements, that I disagree with the Appellant's contention that it requires a request for a hearing on a Form 54 to file the claim. The statute of limitations says commence an action. 67-206 says filing a claim, 67-208 says request a hearing. So, put it on there where they're going to have to say commencing an action pursuant 15-3-600 commences. I'm affirming the decision saying that it commences when you file the claim pursuant to reg 67-206. I'm either right or wrong.

MS. EDWARDS: I understand, Your Honor.

MS. BARR: Thank you, Your Honor.

THE COURT: All right, so they'll make that decision.

MS. BARR: Thank you.

THE COURT: All right, thank you.

(Adjourned.)

C E R T I F I C A T E

I, the undersigned, Grace L. Hurley, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the hearing held in the case of South Carolina Second Injury Fund versus Liberty Mutual Insurance Company, held in the Court of Common Pleas for Horry County, Horry County Courthouse, Conway, South Carolina, on July 24, 2012.

I do hereby certify that I am neither of kin, counsel, nor interest to any party hereto.

_____

Grace L. Hurley, CVR-CM

Official Reporter

October 30, 2012.

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

GILBERT CHAVIS, Employee/Claimant, vs. AVX CORPORATION, Employer, and LIBERTY MUTUAL INSURANCE CO., Carrier, Defendants.	W.C.C. File No. 9826170 9927964 DEPOSITION OF: L. RANDOLPH WAID, Ph.D.

COPY

DATE: Tuesday, September 20, 2005

TIME: 3:12 p.m.

LOCATION: Medical Offices of L. Randolph Waid, Ph.D.
222 West Coleman Boulevard
Mt. Pleasant, South Carolina 29464

REPORTER: Deborah Horsley

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No exhibits were proffered during this deposition.

DEBORAH HORSLEY
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It was stipulated by and between counsel for the parties that this deposition is taken for the purpose of discovery; that all objections, save as to the form of the question, are reserved until the time of trial; that the deponent was explained his right to read and sign the deposition and waived that right.

(L. RANDOLPH WAID, Ph.D., being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MR. HOWELL:

Q. If you will state your full name for the record, please?

A. Louis Randolph Waid. Waid is spelled W-A-I-D.

Q. Okay. Dr. Waid, as you know, I'm Roy Howell, and I represent AVX Corporation and Liberty Mutual Insurance Company, and I'm here today to ask you some questions regarding your neurological evaluation that you did back in May and June of 2002, and particularly in regards to a letter that you wrote Mr. McDaniel on March 29, 2005. If you could, just for the Commission's benefit, give us the benefit of your educational background, your professional training, and kind of tell us what you do now?

A. Sure. I got a bachelor's degree in psychology from Temple University in 1974, a master's degree in

psychology from the University of Richmond in 1977. I attained a Ph.D. in clinical psychology from the University of North Texas in 1982, and that followed an internship here at the Medical University of South Carolina. I returned to Charleston in 1982 and joined the faculty of the Medical University of South Carolina, which I remain on as an associate professor. I was full-time faculty and director of the Assessment Neuropsychological Center and trained people in neuropsychological evaluations and forensic evaluations.

I left the university on at least a full-time basis in 1998. I remain on the faculty and in research involved with that, and I have maintained a practice in Mt. Pleasant where I do clinical psychology as well as specializing in forensic and neuropsychological evaluations and currently -- currently negotiating about going back into the university, but we'll see.

Q. Okay. And when you say that you -- obviously I understand clinical psychology, but when you say you do forensic and neuropsychological assessments, are those simply evaluations?

A. Neuropsychological evaluations is a specialized area in clinical psychology where you do intervention, assessment, evaluations, and research in the areas of brain behavior dysfunction. So neuropsychologists are

heavily involved within the patient population such as Alzheimer's, head injury, toxic injuries, learning disabilities, attention deficit, the things that affect brain functioning and the impact on intellectual cognitive and emotional functioning.

Forensic really has to do with a lot of whether it relates to interfacing with law, personal injury, but I also do a lot of criminal work-ups and sexual predator evaluations and, you know, competency to stand trial, and those sorts of things.

Q. Okay. Now, you were asked to do a neuropsychological consult/evaluation in May of 2002, and it looks like your testing went all the way through some time in June of 2002; is that correct?

A. That is correct.

Q. All right. And is that the only time you've seen Mr. Chavis?

A. I believe those are the only times I've seen Mr. Chavis. Those were four different therapeutic and evaluative contacts. I do believe for the most part that I saw him in the Murrells Inlet Office, and that's where we did most of the evaluative and therapeutic contacts.

Q. Okay. And so any opinions you would give in the case are based upon your evaluation that was done I

guess now almost two and a half years ago?

A. That is correct.

Q. Okay. You do not know what his current medical condition is?

A. No, I have not had any recent contact with Mr. Chavis or evaluations conducted on him.

Q. Okay. Now, at that time back in 2002, you were asked to assess his neuropsychological problems related to a cerebellar stroke that he had sustained; is that correct?

A. That is correct.

Q. Okay. And, again, by neuropsychology, we're talking about the function of the brain?

A. That is correct.

Q. All right. Tell me what memory functions are located in the cerebellar?

A. The cerebellar is really an area involved more in the subtleties of motor coordination, balance, in these sorts of areas. It's an area of the brain that sometimes gets affected particularly. For example, the toxin of alcohol can cause cerebellar dysfunction where people aren't as well coordinated, but on the good note, it's not the more involved cortical areas of the brain such as the frontal temporal parietal lobes and even the occipital lobe that are much more involved with the

functions of executive processing, attention, concentration, memory, and somatosensory processes. So to a certain extent it does not impact on higher reasoning or memory or learning capacities as a functional component. It's not a bad place to hurt it if you had to hurt something in the brain.

Q. Okay. Most people do not have problems with memory function related to this type of stroke; is that correct?

A. That would be correct. You would expect perhaps after the acute stage, where there would be good recovery without any lasting impairment affecting memory functioning.

Q. Okay. The other parts of the brain that you talked about, the cerebral, the temporal frontal lobes, those types -- those areas of the brain, if you had a stroke there, that would be more likely to cause problems with memory function, correct?

A. They would be. The more interior portions of the brain, the temporal and frontal lobes in particular, would be much more implicated.

Q. And in this case, Mr. Chavis' stroke was in the cerebellum?

A. That is correct in terms of the neuroradiographic studies revealing the evidence, the

pathology in that area.

Q. Okay. And as you note, its main function -- the main function of the cerebellum is to control and coordinate movement; is that correct?

A. That's correct, motor movement functional aspects, balance to a certain extent.

Q. Okay. Now, when you tested Mr. Chavis in 2002, May of 2002, I think he reported to you that -- that the acute problems he had following his stroke had significantly improved; is that correct?

A. He had indeed as one would expect.

Q. All right. And in terms of the testing itself -- and let's just go I guess one by one.

A. Sure.

Q. I'm not going to rehash all of this. But in terms of the language function, I'm just going to summarize, and you tell me if I'm right or not. His conversational speech was prosodic, fluent, of normal rate and tone without evidence of --

A. Dysarthria.

Q. And what is that?

A. No slurring of speech. Basically his expressive language was fine.

Q. Okay. And, again, when you have a stroke involving the cerebellum, that's one of the concerns is

that you can have problems with your speech, correct?

A. You could, but it would be primarily due to the motor component involved in speech.

Q. All right.

A. And we did not see that in this --

Q. Right.

A. -- in this set of testing.

Q. All right. And you noticed that he had no evidence of receptive language dysfunction; is that correct?

A. He understood language perfectly fine.

Q. All right. On the Intellectual/Academic Achievement portion of the test -- and let me back up a little bit. In the history he gave you, it appears that he had a tenth grade education; is that correct?

A. That is correct, I believe.

Q. And apparently he had to do the sixth grade over; is that correct?

A. That is correct.

Q. And apparently before his stroke, he attempted to get his GED twice and failed, and then apparently after his stroke, he finally passed and got his GED?

A. He was able to apply himself and finally passed it. That is correct.

Q. Okay. So obviously -- and I think there was

some vocational testing done at some point that indicated that he had a reading disorder?

A. In my opinion, he likely did have some reading and spelling difficulties that did not get appropriately identified as a learning disability growing up.

Q. Okay. And obviously that's premorbid; that's before his stroke?

A. That would be correct.

Q. All right. The results of his -- of the intellectual academic achievement portion of your testing, was that consistent with his poor education and learning disability?

A. Yeah, actually he had a higher performance IQ. I mean, the visual-spatial skills were much better than the verbal education lowering it, which would be consistent with some history of learning disabilities or lack of educational attainment. And as you well know, some of the academic achievement skills like spelling are reflective of potentially a fifth grade level. So I would see that all as premorbid and not related to the insult that he suffered as a result of the incident that occurred.

Q. Okay. And, again, on his -- on the Executive/Higher Reasoning Skills --

A. Yes, sir.

Q. -- it says Mr. Chavis had no difficulties inhibiting and sequencing fine motor movements on go-no go types of tasks?

A. That is correct.

Q. That's a good finding?

A. Yeah, it's more of a frontal lobe sequential motor movement type task, and he wasn't grossly impaired with regard to that type of task.

Q. Okay. And he was able to meet demands of word generativity tests?

A. Yeah, it was a letter fluency test that he actually did quite well on, another frontal lobe based executive task.

Q. Okay.

MR. HOWELL: And, Preston, just for your information, I'm on what will be I guess Page 22 of the APAs.

MR. McDANIEL: Is that Page 6 of the report?

THE WITNESS: It is, Preston, yeah.

MR. HOWELL: Correct. Correct.

BY MR. HOWELL:

Q. And then on I guess the WAIS-III, Mr. Chavis was variable and generally scored in the average range on tasks demanding higher reasoning and problem solving skills?

A. Yes, that is correct.

Q. So he did fairly well on that?

A. He did fairly well on that.

Q. All right. It says he was efficient in his performance on the Wisconsin Card Sorting Test. He showed good ability to methodically generate hypotheses, to discern the correct hypotheses, as well as to shift the basis of his responding when the externally imposed demands of the task necessitated this?

A. That's right. He did not look impaired on that particular task involving set-shifting skills and reasoning abilities.

Q. Okay. And, again, that's a very good finding?

A. Yeah. Again, we would anticipate that would be poor if you had frontal lobe damage. That's not the area where he has damage.

Q. He attained the expected categories on this test with a low rate of perseverative errors?

A. Perseverative errors.

Q. And one failure to maintain set.

A. That's correct.

Q. And, again, on the sensory motor functions, the evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile, auditory, or visual modalities during unilateral or

bilateral stimulation paradigms, correct?

A. Right. He could hear and see and discriminate touch effectively.

Q. Okay. Apparently he did have some problems with the right hand, which would be expected given his injury?

A. Yes, he certainly continues to have some pain and some physical limitations associated with his pain syndrome.

Q. Okay. And, again, he was noted to ambulate without difficulty or complaint; is that correct?

A. That's correct. We just found some slowness with regard to fine motor speed and dexterity, which might be related to cerebellar function, or it might be related to his pain difficulties.

Q. Okay. Now, in your summary, again, you go on to note that after sustaining the stroke, he experienced confusion and other neurocognitive difficulties that would be expected. He has shown significant improvement with the passage of time; is that correct?

A. Right. He would have some acute symptoms related to the edema and residual effects of the cerebellar stroke, but once that clears, you would expect recovery of function, and he demonstrated recovery of function.

Q. Okay. You go on to note that the neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency?

A. Yes, sir, I would see those as pre-existing and not related to this recent neurological insult.

Q. Okay. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills; is that correct?

A. As we discussed, yeah.

Q. Okay. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as a result of the cerebellar stroke; is that --

A. In my opinion, he has made a good recovery.

Q. Okay. And this would be expected considering the location of the stroke?

A. That is correct.

Q. And that's, again, what we were talking about earlier. Because it was a stroke involving the cerebellum, you would not expect him to have any significant problems with memory function from that stroke?

A. He wouldn't expect long-term impairment in those

type of thinking and concentration skills in terms of chronic.

Q. And your findings on testing confirmed that?

A. That is correct.

Q. Okay. You go on to say there is no compelling evidence for impairment affecting visual-spatial skills, receptive or expressive language functions, or sensory perceptive functions; is that correct?

A. That is correct. No evidence of impairment there. My only concern really was some immediate learning memory, and that was somewhat variable. So it might have a little reduced capacity there, but, again, I don't think there's compelling evidence of any other impairment in higher cortical functions.

Q. Okay. And the problems with immediate learning, you're talking about if you read something, retaining it?

A. Hear it, retain it. See it, retain it immediately. It's not a matter of forgetting. It's about effectively encoding it. And my point would be anything that happens to the brain can affect that a little bit, plus, you know, he still has some pain, and things that can interfere with that too.

Q. Right, which was going to be my next question. That his problems with, as you say, sort of encoding

that information, that could very well simply be related to the effects of his chronic pain?

A. That's correct. Chronic pain can definitely impact on that particular function.

Q. All right. He also apparently had some symptoms of depression. That can also impact those -- that as well?

A. I would really see pain as a bigger player because he wasn't very depressogenic when we were testing him, but I would agree depression/anxiety can do that, but I really believe pain is the bigger player in terms of interfering with that.

Q. Okay. With the learning and encoding?

A. With encoding and processing of information.

Q. And that's what you were talking about when you talked about him having some residual impairments affecting his capacity for learning/memory function --

A. Yeah.

Q. -- you're talking about related to his pain, correct?

A. Yeah, I am talking about that. I do believe that's affected. It might be residual, but certainly pain particularly affects the encoding, getting it to the hard disc so to speak.

Q. Okay. Do you know whether or not since you last

saw him, whether he's had a repeat MRI or CT scan of the brain that showed -- apparently he had -- and let me back up. Apparently he had an MRI of the brain four, five, six months after his stroke that showed that the place where he had the stroke in the cerebellum had gotten a lot smaller. It had improved considerably; is that correct?

A. Yeah. Basically improvement may be the wrong word, but you would expect some tissue changes. It's kind of like even with a bad head injury, you ultimately see the kind of dead tissue, but it doesn't look as rich, and you would expect this not to look as rich acutely as when Dr. Wenzel first got the MRI.

Q. Okay.

A. But, you know, even the CT scan didn't see it acutely because a CT scan wouldn't be the best method for getting at this kind of phenomena, but the MRI did, but you would expect that to show improvement as it related to how it is demonstrated on the MRI in time.

Q. All right. If he has any permanent impairment related to the stroke, those impairments would be more on the nature of, again, problems with affecting his control, his motor control, and that sort of thing? Like problems with balance and maybe his speech, and that sort thing?

A. Yes. In my opinion, it would be more of the oral motor aspect of speech but even balance, which acutely was very off, but at the point I saw him, it was off but much improved, and I would imagine those are the kind of more of the balance, discoordination of things you might see. You know, if this guy was out playing baseball or basketball, you know, you might see it more under that high demand for that coordination of multiple motor components, but, otherwise, you wouldn't expect a lot of residual impairments from a cerebellar stroke of this size.

Q. Okay. And, again, in terms of who would be best suited to address those types of impairments, would you agree that that would be more appropriate for a neurologist?

A. Well, a neurologist can speak to it conceptually, yeah. Actually when you get right down to it, sometimes an occupational therapist or a physical therapist could talk more about those particulars. I mean, if you put this guy on a -- I wouldn't put this guy on a beam walk right now and some of those really high demand, but I'm not sure a lot of us do tandem walking, and those sorts of things --

Q. Right.

A. -- in realty unless we're stopped for drunk

driving or something.

Q. Right.

A. And those would be the kind of tests that might be off for him.

Q. All right. But as far as you're concerned, when you evaluated him, he did not show any significant impairment related to those things either, I mean, in terms of his balance or his speech or anything like that?

A. They were minor. The speech definitely wasn't a problem. Expressive language, there was no evidence of slurring or what we call oral-muscular structure problems. Mainly there were complaints of some balance. You might consider a little dizziness. But all in all, again, I thought he had made a good recovery, and I did not give him a diagnosis of cognitive disorder, which I would have given him if I thought more of the higher cortical aspects were affected permanently.

Q. Okay. Thank you, sir. Please answer any questions that Mr. McDaniel may have for you.

A. Sure.

CROSS-EXAMINATION BY MR. McDANIEL:

Q. Dr. Waid, first off, would it be a fair statement that as Mr. Howell went through the results of your tests, that he hit all the good points and none of

the bad results?

A. Well, Mr. Howell did sometimes go through the good points. I did indicate some potential slowness and the speed of processing and some reduced capacity for immediate learning. He did point out that some of that could be pain related, but also it could be related to the contributions of some of the cerebellar stroke, but, otherwise, he is correct. The higher reasoning, abstract thinking, and true memory functioning would not and was not in my opinion significantly impaired.

Q. But he had some impairment, did he not?

A. Yeah. I would see this as more of a reduced capacity in real life multiprocessing, mild reduction, and, again, to be expected because of the location of the stroke being in the cerebellar, which is just not intimately involved in those functions.

Q. Let me ask you a question about that. How would that show up in his day-to-day functioning?

A. In the day-to-day functioning, primarily it would show up more in the high demand multiprocessing. We live in a world where we have to keep up with multiple things at the same time, and he would likely comment that there is some forgetfulness going on. It's really not true memory disturbances as much as not being able to effectively process lots of data all at once.

It can be of akin to sitting at a round table where there is ten people at a meeting, and often individuals like this will say they have a hard time keeping up with the multiple conversations going on. That would probably be more of a residual impact that almost any brain injury or any type of neurological injury will affect that high level of multiprocessing.

Q. Let me ask you before we go any further about that because I want to ask you some questions about Page 6 on that memory functioning. We know from the MRI, that this gentleman had a stroke in the cerebral area of the brain; is that correct?

A. In the cerebella area of the brain; that is correct.

Q. Do you know whether -- is it your understanding that what occurred was that during an injection, the injection was made in such a way that it affected the brain and resulting in a stroke? Are you aware of that?

A. It certainly seemed to be related to the procedure that was being conducted. The mechanism of that I wouldn't be an expert on. I think the MRI that was subsequently requested clearly involved the right cerebellar hemisphere and a bit of the right mid-brain. That's where I get into a little bit of the slowness may be involved with that mid-brain area being affected, but

other than that, there was no other findings of physical brain damage.

Q. In reference to the -- you deal in many -- many times in your capacity as a clinical psychologist specialize in the area of assessment of physical brain damage --

A. Yes, sir.

Q. -- in reference to close -- what could better be -- better be referred to as closed head trauma injury?

A. Yeah, closed head injury.

Q. All right. Caused by various types of insults --

A. Right.

Q. -- including chemical encephalopathies of some nature?

A. Yes, sir.

Q. Can your testing tell whether or not there was additional damage to the brain outside of or give us any direct data as to whether or not there was any damage to the brain outside of the stroke area affected that will show up on the MRI?

A. It can, and I believe in this case, there isn't because I think the stroke is a discreet phenomena, very localized. Even in the major strokes, when you have one

of the major arteries get clogged, if you will, embolic strokes, you have to understand those major arteries feed to an arterial network, and all that tissue gets injured, but a minor stroke results in rather minor impairment that we see in the age. This is clearly a very discreet stroke in the cerebellar and affecting some of the vessels leading to the mid-brain. There's always a feed system.

Even Dr. Groblewski's impression was that it was a right cerebellar CVA and likely what we call thromboembolic. He felt both a clot or even some trauma due to the injection might have done it. So my point, it's not clear if it was totally embolic or thrombotic. Thrombotic would, again, be some impact on the system by a blow. But a head injury from a car accident is going to be much more damaging to the brain because of the forces involved, the way the brain is going to get sheared and moved about. So this is a very discreet but true physical injury to the brain.

Q. What's the significance of -- you said that this is in the cerebellum, and you also said that there was some evidence involving the mid-brain. What's the significance of that?

A. The mid-brain probably represents some aspect of how the infarct or the vascular injury that occurred had

a little bit of a feed to some vessels in the mid-brain, and they showed up acutely. You know, this is a huge network of vessels in the brain, and obviously any time you clog or cause damage here, it's going to affect peripherally some of the inner veins that feed out from it kind of like an oil feed kind of thing. And so my take on that, and I would certainly defer to a neurologist or a neuroradiologist, is you're looking at some spread of how that vessel that really was hurt may have hurt the feeding vessels just a little bit.

Q. Okay. And what in reference to -- what does the mid-brain do?

A. The mid-brain is really what we call the subcortical regions. Again, the cerebellar is way down here, so the feed would be into the subcortical regions. Again, cortical is what we consider the higher reasoning, truly where Alzheimer's hits, and where most of our higher reasoning and thinking and memory capacities. The subcortical region is involved in speed of processing and multiprocessing, and sometimes when it's involved more, some of the fibers that lead to the frontal lobe will show a person with frontal effects, which we didn't get in this case because of how posterior it was. The cerebellar is as far back as you can get. So, again, the more you have a posterior

injury to the brain, in the back of the brain, the less you affect the higher reasoning and thinking capacities.

Q. What area of the brain is affected with emotions?

A. Emotions are very much frontal temporal.

Q. All right. Let's go to your report on Page 6.

A. Yes, sir.

Q. The second paragraph, could you just explain to me -- and this has been placed -- I believe Mr. Howell referred to it as being placed in the AMA -- the APAs, but on the second -- that first full paragraph, Mr. Chavis was administered the Wechsler Memory Scale --

A. Yes.

Q. -- to assess different components of anterograde memory functioning?

A. That's correct.

Q. Mr. Chavis demonstrated significant impairment in his performance across the WMS-III tasks --

A. Right.

Q. -- attaining a general memory. Can you tell me what --

A. Well, basically --

Q. -- what that test told you?

A. Yeah. One of the things about the Wechsler Memory Scale-III is that we give you the material one

time to process. We read the story to you, or we show you the pictures, or we do other types of verbal, visual, memory tasks one time. And when we did that with Mr. Chavis, he showed us immediately an inability to fully process and learn that information, so he was low on his immediate memory scores. However, on the delayed memory scores, how much did he remember 30 minutes later, he showed good retention, so he doesn't show forgetting.

As I pointed out to Mr. Howell, there is a deficient ability to immediately learn something under one trial learning. When I gave him the California Verbal Learning Test, which is a task where we give you five tries to learn a list, he actually scores at the 48th percentile. What that demonstrates is with repetition, with repeating the material, Mr. Chavis catches up. So this is where he's having problems in his life.

You throw something by him once, he may not be getting it as well, but you throw it by him a few other times, he shows an excellent learning curve and profits from repetition. This is what I mean by an immediate encoding problem. So that's where his forgetfulness is coming.

If his wife just says something to him once real

quickly in passing, he's not going to be as sharp maybe in remembering what his wife said, but, you know, all of us can do that to a certain extent, but with repetition, he shows the ability to learn. It would be a far more superior problem if he does not profit from repetition. That would be a true memory disturbance or learning disturbance.

So this is like somebody now who has to read the book twice rather than once to learn as much as he might have used to learn once, and that is the processing problem that we amply talked about. And I believe any injury to the brain sometimes affects that, but he doesn't have a true forgetfulness. What he learns, he retains.

Q. Okay. And would it be a good example that it would be a good idea to make sure you told Mr. Chavis something that you wanted him to remember several times instead of just once?

A. Yes, repetition will help him. Obviously this is my point about the GED is one of the things I've learned is because he was off, he was able to study more than he used to. I think he would have been capable of probably passing that GED, but this man was working. And one of the things we talked about with his GED was failing. That's all he had to do, and I think the

repetition allowed him to pass the GED more than him gaining or losing in the abilities that he had beforehand.

Q. Based on -- based on your evaluation of Mr. Chavis and in reference to your conclusion, of course, there's no question that as you've already previously stated, your opinion is that he has physical brain damage as a result of the accident?

A. Well, this is clearly at the tissue level --

Q. Right.

A. -- in the radiographic evidence, and so it does ante up to a physical injury to the brain and renders him somewhat less efficient to recover if he were to hurt his brain again, but it is in an area of the brain that -- I don't know if anything is ideal, but I would consider it ideal from functioning in our human way, but it is a physical injury to the brain. Very similar to a man I once evaluated for workers' comp who for some reason misfired a nail gun, and it penetrated the skull and hit the tissue, but his really only deficit was he suffers from bad migraines, but it was a physical injury to the brain, and so he does have that. I just think because of the location, he is not as impaired as we would see with somebody who had more of a frontal injury like we do see in car accidents or falls or these sorts

of things that are more commonly what we assess in these work related incidents.

Q. Based on your assessment of him in the areas of the brain, the cerebellum is the major part of the brain that was injured, and also it's my understanding there's some involvement of the mid-brain. Can you sort of tell me from your report and your conclusions the type -- the particular symptoms and problems that he's had that you would relate that are either directly -- that are definitely related or could be related to the injury he sustained in reference to the brain?

A. I think in reference to the brain injury, again, some fine coordination, balance issues. Maybe those were not -- they showed a little bit up on motor speed and dexterity. Like a grooved peg board test, he didn't do that as well. Maybe some slowness in processing. And as I talked about it, some need to repeat material to learn it effectively. Otherwise, I don't believe there is any other evidence of significant cognitive impairment directly related to his cerebellar infarct in the residual localized problem. I think those are kind of as I pointed out some inefficiencies in learning that affect him, and, again, having to go over material more than once or not processing it well, but, otherwise, I don't see any demonstrative evidence of impairment.

Q. You also gave him a diagnoses based on your testing, that pain disorder associated with both psychological factors and a general medical condition?

A. That's correct. I mean, this all was due to his first primary issue was chronic pain, and he actually was seeking this procedure in reference to that pain difficulties, and the pain disorder is real. I put the psychological factors or depressive disorder down because I think it's very common for chronic pain patients to have some mood and sleep disturbance and depression. I actually thought some of that was getting better, but this man still lives with some depression, some sleep disturbance, and some irritability, some psychological comorid problems that are not atypical for people who have to live in pain, and actually I felt that's where his care needed to be. I thought he had shown what recovery. We didn't have much to offer him from a brain point of view, and he needed to continue to have care directed toward his chronic pain syndrome.

Q. If Mr. Chavis is having problems with erectile dysfunction, in reference to the part of the brain that's involved, and I know you talked about his speech and the other fine motor skills, is the damaged area of the brain, could that be involved with that as well?

A. Well, I think possibly I would have to refer to

a urologist there. I'm much more concerned about pain and his medications as causing his erectile dysfunction than I would be about the direct injury. When there's more cortical involvement or even subcortical involvement, thermal regulation, getting hot or cold too easy, erectile dysfunction, and some of those can come on board, but I do not believe he has the extent of that subcortical involvement. And I would much more be concerned about pain and medication as causing his erectile dysfunction, particularly at his age, and unfortunately Viagra, at least by his report, wasn't working.

Q. Just a minute.

A. Sure.

(Whereupon there was a pause in the proceedings.)

Q. I'm going to refer to the head of the Neuropsychological/Psychiatric Department to a Dr. James Merikangas, M-E-R-I-K-A-N-G-A-S, and he reviewed the Claimant from a neurological standpoint and stated in his report, and I just want to see if this concurs with your impressions after your neuropsychological testing. He said that Mr. Chavis will continue to suffer impairments caused by this stroke for the rest of his life. He will remain in chronic pain. He is depressed

and suffers from dizziness and unsteadiness.

A. I think the dizziness and unsteadiness is really the area that you'd be most concerned from a cerebellar point of view. That could be activated under conditions that might put any of us in less balance or dizziness, but he's going to be more susceptible to that. I particularly think that is true. The pain, there is some intensification of pain. I don't know if that's directly the cerebellar. He obviously has a lot of orthopaedic difficulties. And also, you know, obviously this is a man with diabetes, and I don't think the cerebellar stroke is going to interface with his diabetes well. I mean, obviously he might not age as well with his diabetic condition now too, but I would agree with those in principle particularly the dizziness and the unsteadiness.

Q. No further questions.

REDIRECT EXAMINATION BY MR. HOWELL:

Q. When you saw him in May and June of 2002, you didn't find any significant problems in regards to dizziness or unsteadiness, correct?

A. Some balance being off, Roy. I didn't run him through any gamut of tests to activate dizziness, but some in stating as in some less than efficient performance on motor testing, but clearly much better

compared to the acute symptoms, which he remarked on, but I would still see the unsteadiness as potentially there for him particularly considering the cerebellar involvement in that too. I mean, it makes medical sense.

Q. And on Page 3 of your report, when you talk about that, it says acutely following the stroke, there was significant balance problems, but he describes them as, quote, minor now?

A. Yeah, relative to that they were minor, and I would see unsteadiness as the kind of word that you would use rather than, you know, disequilibrium or more of a -- I mean, even the neuropsychiatrist term unsteadiness I think puts that at a minor level.

Q. Okay. And I think you were trying to speak to this when you were answering Mr. McDaniel's questions, but in terms of the nature of this stroke, this was a mild stroke, correct?

A. Oh, yes, it's a very discreet stroke relative to a major arterial feed being blocked or something more thrombotic where somebody received a huge blow by a baseball bat, and you end up busting up some vessels. I mean, this is fairly discreet and very localized.

Q. Okay. And in terms of the location of the stroke itself, all of the medical records show that it

was in the cerebellum?

A. That's correct.

Q. It was localized in the cerebellum?

A. It was localized in the cerebellum. When it says a little bit mid-brain, they're really just talking about some vessels that are extending toward that mid-brain area as probably being affected by it, but the infarct itself was in the cerebellar area.

Q. Okay. And I think you said earlier in response to one of Mr. McDaniel's questions, that you would defer to a neurologist as to whether some other part of the brain was affected?

A. Yeah. I really think most all of this is posterior, and in general, I need to tell you guys, posterior is better than anterior. The higher order of functions of the brain are all in the anterior. The frontal temporal area are much more -- just like car accidents are much more damaging because you have so much more involvement here in the frontal. So if I had any choice, even when you talk about a shunt being put in, where do they put it in, posterior because you stay away from language, and this is probably the most benign area to put in an intraperitoneal shunt.

Q. And in regards to what you described as sort of a slowness in the ability to retain things that he

immediately reads, again, you would agree that he probably had a learning disability before the stroke, correct?

A. Right. My only problem with not totally supporting that is that the visual memory also showed the same kind of thing, and the visual memory would be in his strength.

Q. Okay.

A. So I think there's some reduction in immediately getting information but very good ability to profit from hearing it twice.

Q. And as you note, he doesn't have a problem with retaining information?

A. Once effectively learned, he does not forget. He doesn't show amnestic amps. Really his complaints of forgetfulness has to do with not getting it in not actually forgetting.

Q. And, again, as you pointed out, he actually took the GED a couple of times before his stroke, and he didn't pass?

A. Right.

Q. And then he passed after the stroke?

A. Yeah. I think, again, trivial to the fact of being able to go over the material more and profit from repetition. He is capable of learning.

Q. Okay. And you would agree that in -- and, again, in reference to his neurocognitive problems, as you said on an earlier question, you did not give him a specific diagnosis of a neurocognitive disorder; is that correct?

A. No, I did not. I think there is some inefficiency there, but I did not see this as affecting those higher order functions to the extent that I gave him that diagnosis.

Q. Okay. And in that regard in reference to the stroke itself, you wouldn't see any problems with him going back to work in terms of a learning -- in terms of his cognitive problems?

A. It may take him longer to learn a new job. I can't speak for his premorbid educational skills. There would be some restrictions. I wouldn't let this guy up in the air; I need to tell you that. I think that's where your disequilibrium might get into more play. I certainly wouldn't doubt it, but obviously in and of itself, I thought the greater obstacles toward him returning back to light pursuits in general with pain and the physical limitations.

Q. Okay. Thank you, sir. That's all I have.

RECROSS EXAMINATION BY MR. McDANIEL:

Q. The area of the brain that's affected, would

that affect nerve conduction studies? Would that show up on nerve conduction studies?

A. I do not believe it would, and I don't believe -- I believe he was assured that the EMG conduction studies and some of those pains that he was experiencing in the forearm and hand were not due to the cerebellar stroke, and I would agree with that in principle.

Q. If he was found to be unstable on examination, would that be in reference to the unsteadiness that you referred to?

A. Yeah. If somebody, again, did tandem walking or, you know, those sorts of high motor coordination things, again, that we all might do in a field sobriety test, he probably might fail those. This guy probably needs to have a note in his back pocket saying that if he failed such a test, it's not because of alcohol, but those would be the kinds of tests that he might fail.

Q. And the last question in reference to Mr. Howell's question about going back to work, if he had a job that required him to receive instructions from a supervisor to go do a particular job and those instructions varied, not a repetitious type job where he was able to have repetitious getting instructions over and over again to do the same task, would he have

problems with that type of instruction?

A. Well, he's going to have problems, but, again, in due respect to Mr. Howell's point, again, there's going to be some interference with learning also because of his pain and physical limitations in day-to-day functioning. Neuropsych testing, we won't capture as much of that because it's an ideal situation.

When you're out in a plant or having to listen to your boss and have noise and interference, you know, pain and physical limitations are going to start to interfere too as well as any residuals of a cerebellar stroke, so now you're going to see more interference due to those other factors that are definitely on board. Pain definitely interferes with cognitive capacity, and it's more in real life than they do in our testing situation. And I do believe pain would certainly compromise this man's ability to be effective in learning a new job also.

Q. And that leads me to one other question, and I said I was going to ask you one more, but now I got to ask you this.

MR. HOWELL: No, Preston, you can't ask him.

BY MR. McDANIEL:

Q. In reference to that type of functioning out in the workplace, am I hearing you say that both -- that

these both could cause -- the pain and the injury that he had could both cause those problems -- give him problems, and that the bottom line, do these actually -- can they augment each other for a better term?

A. Oh, absolutely. My issue is, as I've indicated in many depositions, chronic pain is clearly a major interferer with cognitive processing in day-to-day pursuits more so than depression and anxiety. Any of us can sit here and see if you have a bad headache. None of you guys are going to sit down and do an affidavit. I mean, you just can't focus. You can't concentrate. Pain interferes with cognitive capacities.

In a lot of ways, when we really talk about this man's ability to get back successfully in life, I would see his chronic pain and physical limitations to be the biggest player of that even at a cognitive level. If he had nothing but this discreet cerebellar stroke, he'd be much more functional in his ability to return to pursuits, so the chronic pain is a very real thing, and the cerebellar stroke doesn't help, but the chronic pain is really a major issue. And, again, it can be a major issue with learning a new job and being able to prolong the cognitive capacities for an eight hour day, much more than that even. You know, some jobs are more. So it's a big player for him.

Q. And so no question that the chronic pain as you said, but the stroke adds to it?

A. It doesn't help it at all because it does create some inefficiency that will only be further exacerbated to a more disruptive level by the interfering effects of chronic pain, sleep disturbance, fatigue, and so forth.

REDIRECT EXAMINATION BY MR. HOWELL:

Q. And the test results, again, on your learning, that portion of the test, that apparently showed some mild deficits that could very well just be related to pain disorder?

A. Pain definitely can contribute, Roy. In real life, it's even going to contribute more. And the reason I say that, in ideal testing, we give a lot of breaks, and we try to, if we can, get rid of the interference effects of pain and fatigue. As you saw, I saw this guy -- as you well know, it's very untypical. I saw him over three different testing sessions, so we even limited the amount of testing we did to get an ideal understanding of the brain function as that was the pertinent question, so the 2nd, 15th, and 29th. I generally get most people tested in two half days, and we even gave him a third to try to avoid the pain and fatigue factor interfering.

Q. Okay. And all of your opinions today are based

upon a report and evaluation that was done I guess almost two and a half years ago?

A. Yes, sir, that is correct.

Q. Okay. If you'll just bear with me one second.

A. Sure.

(Whereupon there was a pause in the proceedings.)

A. I would add that the stroke happening January 2002, I would have expected a full recovery obviously from that by then, but they are based on having only seen this man in 2002.

Q. Right. And I guess -- I guess my point there, assuming a full recovery by that time, you wouldn't expect his symptoms to regress after that, correct?

A. Correct.

Q. Whatever condition you found him in then, he ought to be at now?

A. That's correct. I would consider the other factors of pain or how he's doing in those aspects of life associated with some normal aging to be the factors not the cerebellar stroke.

Q. Okay. So if he told you then that his acute symptoms from the stroke had significantly improved, then you wouldn't expect them to get worse after that?

A. That's correct; I would not. As a matter of

fact, if they hadn't gotten better, I would wonder about that because they should get better compared to acutely.

Q. Do you happen to have a copy of the first MRI or CT that was done? I'm trying to find it, and I can't find it.

A. You know, Roy, I don't know if I have it or not. I can't remember if the radiographic study is from DISC Imaging. I have records that reveal that a CT scan was reportedly conducted at the facility where he underwent the nerve block, which would probably indicate that I didn't have a copy of that because I used the word reportedly. I would have told you if I had a copy.

Q. All right. So you actually haven't the MRI of the brain that was done?

A. Well, the MRI of the brain, I did have a copy of that, the one conducted on February 7th of 2000, that I think was ordered by --

Q. Do you have a copy of the report?

A. I do, yeah.

Q. Okay.

A. Now I got to find the report. I mean, the way I wrote it, I will tell you that I was able to look at the radiographic studies but --

MR. McDANIEL: I didn't ask that question, so don't blame it on me.

Q. I just want to look at it myself before I leave. It looks like I got portions of it, but I can't find the whole --

A. All right. Here it is. Well, I got the -- yeah, abnormal signal and enhancement involving the right cerebellar hemisphere and right mid-brain.

MR. McDANIEL: Where was that done?

THE WITNESS: 2/7/2000.

MR. McDANIEL: Where? Where?

THE WITNESS: DISC Imaging, I believe. Roy, does that say that?

MR. HOWELL: No, this appears to have been done at Conway Hospital.

THE WITNESS: Okay.

BY MR. HOWELL:

Q. That's all I have. Thank you, sir.

RECROSS-EXAMINATION BY MR. McDANIEL:

Q. And we didn't note for the record, that actually, Dr. Waid, he was referred to you by Dr. Wilkins, his treating orthopaedic?

A. Yeah, he was referred by Jeff Wilkins. Yeah.

Q. That's it.

MR. HOWELL: Thank you, sir.

(Deposition concluded at 4:07 p.m.)

STATE OF SOUTH CAROLINA)

: C-E-R-T-I-F-I-C-A-T-E

COUNTY OF CHARLESTON)

I, Deborah Horsley, Court Reporter and Notary Public, certify that I did have L. Randolph Waid, Ph.D. to appear before me at 3:12 p.m. on Tuesday, September 20, 2005, at the Medical Offices of L. Randolph Waid, Ph.D., 222 West Coleman Boulevard, Mt. Pleasant, South Carolina; that the witness was sworn and cautioned to tell the truth, the pages constitute a true and accurate transcript of the testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 27 day of September, 2005.

COPY

Deborah Horsley

Notary Public for South Carolina

My Commission Expires 12/29/2009

DEBORAH HORSLEY
Independent Court Reporter
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BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

GILBERT CHAVIS, Employee/Claimant, -vs- AVX CORPORATION, Employer, and LIBERTY MUTUAL INSURANCE COMPANY, Carrier, Defendant.	W.C.C. File No. 9826170 & 9927964 DEPOSITION OF: DR. JEFFREY C. WILKINS COPY

DATE: Friday, January 27, 2006

TIME: 12:16 p.m.

LOCATION: Coastal Orthopaedic Associates, PA
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Conway, SC 29526

REPORTER: Ryan P. Alderman

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It was stipulated by and between counsel for the parties that this deposition is taken for the purpose of discovery; that all objections, save as to the form of the question, are reserved until the time of trial; that the deponent was explained his right to read and sign the deposition and waived that right.

(Dr. Jeffrey C. Wilkins, having been duly sworn, testified as follows:)

DIRECT EXAMINATION BY MR. HOWELL:

Q. Dr. Wilkins, this is a continuation of your deposition that we started on Friday, October 21, 2005. When we stopped your deposition, we were talking about -- we had talked about the March 24, 1999, report. And I believe you had indicated that that was the first time he had mentioned this incident on December 1, 1998, in which he had injured his arm; is that correct?

A. March 24th, 1999. These must have gotten out of order. Excuse me for a second. What's it look like?

Q. I made a -- I made a set, so this might be easier for you to follow through. Let's see, --

A. Oh, I got it. I got it.

Q. Okay.

A. It's just out of order. Here we go.

Q. And I think in your earlier testimony you had indicated that that was the first time he had mentioned this incident at work that had occurred on December 1, 1998; is that correct?

A. That's correct.

Q. All right. And we had -- you had also talked about -- you began talking about some pain diagrams from January '99, and December '98. And you were beginning to talk about a pain diagram from November 16, 1998, and I guess that's where we need to start. If you could tell us what was -- what he reported was bothering him in regards to the pain diagram of November 16, '98.

A. Okay, November 16th, 1998, again, the pain diagram is a front and back silhouette of the human body, which the patient's asked to fill out. We have a key up top of the various symbols the patient can use for aching, numbness, et cetera. And on the bottom is what's called a visual analog scale from between no pain and the worst pain, and they're asked to put a line which determines their pain.

Gilbert has put "X"s, which mean burning, in his right lower back, left posterior thigh. He has diamonds, which means aching, in his right lower back. And then circle symbols for pins and needles in his left foot. And dashes, meaning numbness, of his right foot.

There is no markings anywhere on his upper body, front or back, above that of his low back.

Q. Okay. And, again, that was -- that was before December 1, 1998?

A. That's correct. That is 11/16/98.

Q. All right. Now, going back to his complaints that he related to this incident, the complaints that he gave to you were that he was having pain in the triceps area, which is the upper arm between the elbow and the shoulder?

A. That's correct, on the back.

Q. Okay. He didn't complain that he had injured any other part of his body; is that correct?

A. Not that I recall.

Q. All right. You then followed him up on April 21, 1999; is that correct?

A. Yes.

Q. And he was continuing to complain of triceps pain at that point?

A. Yes.

Q. All right. And obviously you recommended some conservative care?

A. Yes.

Q. And also told him that he perhaps should consider getting an MRI of the shoulder?

A. Yes. And we also wanted a BTE exam, which is sort of like a Cybex machine you might see athletes use. It's a computerized weight machine so to speak that can look for muscle comparisons from side to side.

Q. Okay. And then he returned on May 13, 1999; is that correct?

A. Yes.

Q. And was continuing to complain of pain in the right, right triceps region?

A. Yes. And he also says he has -- he had pain in the subdeltoid region, which would be more on the upper and side of the arm.

Q. Okay. Consistent with a shoulder problem?

A. Correct.

Q. All right. And at that point, you sent him for an MRI of the shoulder?

A. That is correct.

Q. And then he came back on June the 10th, 1999; is that correct?

A. Yes.

Q. All right. And what did his MRI show?

A. Here we go. June 7th, correct? MRI, right shoulder, from DISC Imaging was done, and their interpretation -- Beverly Genez, who is quite possibly the greatest radiologist that's ever resided in the

State of South Carolina. Was a -- probably a partial tear in the underside of the rotator cuff, or tendonosis was her other diagnosis.

Q. Okay. And as a result of that, it looks like you recommended some additional physical therapy and then saw him back on June 30 and recommended that Dr. Preslar evaluate him for a possible surgical intervention?

A. Yes, that appears correct.

Q. Okay. And, again, at this point in time had Mr. Chavis reported any injury arising out of this incident on December 1, 1998, other than to the right shoulder and arm?

A. Not to my knowledge.

Q. Okay. You don't have any record of him reporting any other injury?

A. No, sir. I can look at that. Again, the pain diagrams, even after the injury of 1/11/99, he did not mark his shoulder at all.

Q. All right. And I think we discussed that in your first dep -- in the first deposition.

A. Right. On 3/24/99, is when he first marks his shoulder, and it's -- he has his right arm and some burning in his neck that says sometimes next to it written down. The same on 4/21. And no other part of

his silhouette is marked.

Q. Okay. Now, it looks like he saw Dr. Preslar for an initial evaluation on July 1, 1999; is that correct?

A. Yes, that is correct.

Q. Okay. And, again, his complaints at that time were right shoulder pain?

A. Yes.

Q. And he apparently also had given a history at that time that he had had some sort of injury to his back and his shoulder several years back; is that correct, under the past medical history?

A. Yes.

Q. And he indicated that his back had been treated, and this his shoulder had also been treated at one time and got better but apparently got worse with this incident?

A. It says here the shoulder was not really treated or diagnosed, and it eventually got better.

Q. Okay. But in fact you had actually treated his shoulder --

A. That's correct.

Q. -- in the past? Okay. And it looks like Dr. Preslar eventually recommended that the Claimant undergo surgery; is that correct?

A. Yes, that's correct.

Q. Okay. And surgery was done on August 18, 1999?

A. Yes.

Q. All right. And at least according to Dr. Preslar's records, he did not get much relief, if any, following the surgery at least by report?

A. It looks like -- yeah, it says August 30th, 1999, he's doing much better, excellent motion. Then September 23rd, 1999, he's now six week post-op, and he reports continuing problems. He states it's no better than before surgery.

Q. Okay. And at that time, he was complaining of some intermittent numbness problems I assume in his -- in his arm?

A. Burning in the shoulder, has one episode of numbness in the middle digit but has not recurred on September 23rd by Dr. Preslar.

Q. And then Dr. Preslar saw him back on October 12th, 1999; and at least the diagnosis says ongoing pain, right shoulder, uncertain etiology?

A. Yes.

Q. Okay. And it looks like at that point, Dr. Preslar placed him at maximum medical improvement; is that correct?

A. That appears correct, yes, sir.

Q. Okay.

A. Well, it says if it does not show --

Q. Oh, okay. I'm sorry.

A. If the MRI does not show anything new, he would consider him MMI.

Q. Okay. And he also ordered an injection in the shoulder?

MR. MCDANIEL: Let me just place --

A. Yes.

MR. MCDANIEL: Object to the testimony of the Doctor concerning Dr. Preslar. We have Dr. Preslar's deposition sch --

MR. HOWELL: Okay. I'm just trying to move through it, and then I'll --

MR. MCDANIEL: Yeah.

BY MR. HOWELL:

Q. And then October 29th, 1999, he came back, and he was continuing to complain of shoulder pain; is that correct?

A. Yes.

Q. All right. And there was some discussion about doing an open exploration and distal clavicle resection?

A. Yes.

Q. Okay. And at least -- and it looks like that Mr. Chavis was going to consider that, but until then

Dr. Preslar placed him at MMI?

A. Yes.

Q. With a 30 pound -- it looks like a permanent 30 pound lifting restriction?

A. Yeah. It says go ahead and release him to full duties with 30 pound lifting -- but that was permanent at that time.

Q. Okay. Now, --

MR. MCDANIEL: Object to the question and the answer on the basis that permanent is not listed in the -- in the referenced note.

MR. HOWELL: Okay, objection noted.

BY MR. HOWELL:

Q. Now, do you have any notes in your file from Dr. Preslar between October 29th, 1999, and January 17th, 2000?

A. Yes, I have one in January 4th.

Q. Okay. Is your --

A. It should be on your same page as the October 29th.

Q. Okay. I don't have that one. Is there any between October 29th and January 4th?

A. I don't believe so.

Q. Okay.

A. Again, those two are stuck on the same piece of

paper, so that would usually mean they're consecutive visits.

Q. All right. And what was the -- what was contained in the January 4th, 2000, report?

A. Dr. Preslar of January 4th states he comes in. He's doing worse. He went to see Dr. Ernst apparently on December 7th of '99, and Dr. Preslar had that report available. He recommended continuing conservative management. He also has seen Dr. Elv -- it should be Elvington instead of Allington (ph), who's at Pee Dee Orthopaedics in Florence. And he apparently recommended surgical intervention.

Q. Okay. What were Mr. Chavis' complaints on January 4th? Were they still in the right shoulder?

A. It said -- well, all the subjective part says he's doing worse. All of Dr. Preslar's exam appears related to the right shoulder.

Q. Okay. And what were Dr. Preslar's recommendations at that point?

A. He -- going along with Dr. Elvington agreed for an MRI of the cervical spine. He wanted to see Dr. Elvington's note, and that he wanted a specific X-ray view of his shoulder upon return, and he wanted to look as his MRIs of his shoulder.

Q. Okay. Let me show you -- and I'm going to have

this marked as Defendant's 1 to your deposition.

(DOCUMENT MARKED FOR IDENTIFICATION AS DEFENDANT'S EXHIBIT NO. 1.)

BY MR. HOWELL:

Q. That's the report from Dr. Elvington dated December 29, 1999. According to that report, what were Mr. Chavis' complaints to Dr. Elvington?

MR. MCDANIEL: Objection, the record speaks for itself. And we're not here at Dr. Elvington's deposition; we're here at Dr. Wilkins' --

BY MR. HOWELL:

Q. You can answer.

A. His chief complaint is right shoulder pain.

Q. Okay. Are there any complaints of low back pain contained in that report?

A. No.

Q. Is there any indication in that report of any recent injury or accident that the Claimant may have had at work?

A. No.

Q. Okay. The only accident that's referenced in that report is the December 1, 1998, accident?

A. That is correct.

Q. All right. And going back to Dr. Preslar's

report of January 4, 2000, is there any indication in that report of any sort of new accident that he was involved in --

A. No.

Q. -- prior to that visit?

A. No, sir.

Q. Are there any complaints of low back pain?

A. No.

Q. Okay. Now, --

A. Again, remembering he had low back pain about his pain diagram before.

Q. Right. Going back -- all the way back to 1996 apparently; is that correct?

A. I believe that's correct, yes, sir.

Q. All right. Now, --

A. Yeah.

Q. Apparently Mr. Chavis did have the cervical MRI on January 8th of 2000; is that -- is that correct?

A. Yes, that's correct.

Q. All right. And then he returned to Dr. Preslar apparently on January 17, 2000?

A. Yes.

Q. All right. And at that time, Dr. Preslar recommended he have a cervical selective nerve root injection?

A. Yes.

Q. All right. And apparently that was done in Mt. Pleasant or Charleston some time thereafter?

A. Oh, yes.

Q. Okay. Let me ask you to take a look at Dr. Preslar's reports. Well, it looks like the next time you saw Mr. Chavis was on August the 1st of 2000?

A. That appears correct.

Q. Okay. And in between he was seeing Dr. Preslar for his shoulder, correct?

A. Yes, that is correct.

Q. Okay. And apparently he had also had reaction to the cervical injection and possibly a stroke?

A. Well, actually it -- I saw him July 5th, 2000, was the first time I saw him back.

Q. All right. Between -- what I'd ask you to do, if you would take a look at Dr. Preslar's records between February of 2000, and July 2000, when you saw him back. After you've had a chance to look at them, just let me know.

A. What was the last part of that? And do what?

Q. Well, let me ask you -- if you'll look at his records between February 1, 2000, and July I think you said 5th --

A. Yes.

Q. -- when you saw him back and tell me whether or not there's any indication in those records that the Claimant had suffered a new injury at work.

A. No, not that I see.

Q. Okay. And when Mr. Chavis came back to see you on July 5th, 2000, what were his complaints?

A. Torn rotator cuff in right shoulder and bulging disc in neck.

Q. Okay.

A. And he had pain below his elbow to his fourth and fifth digits, would be his pinkie and ring finger, on his right hand, continued shoulder pain.

Q. All right. Were there any complaints of low back pain?

A. Not that I see. Let me check this. He does have identical to the previous referenced pain diagrams aching in his low back, same location.

Q. Is there any history when you saw Mr. Chavis on July 5, 2000, of any new injury at work in which he injured his low back?

A. Not by the record and I have no independent recollection of that either.

Q. Okay. And then you saw him again on August 1, 2000, and August 15, 2000; is that correct?

A. That's correct.

Q. All right. And were there any complaints, specific complaints, of low back pain on any of those visits?

A. Not that I noted.

Q. Okay. Is there any indication in those records of any new injury or accident involving his low back?

A. No, sir. His pain diagram of August 1st of 2000, there's no notation to the low back.

Q. All right. And then you saw him back on September 22, 2000, and again on October 2, 2000; is that correct?

A. Yes, that's correct.

Q. All right. And were there any specific complaints on either of those visits involving the low back?

A. Yeah, on September 22nd it states returns today having some increased pain in low back.

Q. Okay. Is there any indication of any new injury or accident involving his low back at that time?

A. No.

Q. All right. Was it your impression that that was a continuation of the low back problem he had had for years?

A. Yes.

Q. All right. Let me show you sort of the reason

we're here today, and I'm sure you're glad we've gotten around to that. Let me show you two questionnaires that were apparently sent to you by Mr. Chavis' attorneys back in 2001. And the specific question that I'm concerned about is Question 2.

A. Yes.

Q. All right. And on these questionnaires, it asks you to answer whether or not Mr. Chavis injured his low back in an accident on December 27, 1999, and you indicate in response that he did.

A. Yes.

Q. And my question is if there's no record of him reporting such an injury to you, how did you answer that question?

A. I have no idea.

Q. Okay. After reviewing your records, would you like to change your answers to --

A. Yeah, I like No. 2 better. I like this page better, aggravation of low back pain.

Q. Okay. But my question is do you have any record or independent recollection of any sort of accident occurring on December 27, 1999, at all?

A. No, I don't.

Q. Okay. And, again, he saw Dr. Preslar several times and you several times between December 27, 1999,

and at the time of this -- that this questionnaire was sent to you, and apparently there's no record of him reporting such an incident to you guys?

A. To the best of my knowledge, that is correct.

Q. Okay. So, again, would you like to change your response to that question given the fact that he gave -- never gave you any history of injury --

MR. MCDANIEL: Asked --

BY MR. HOWELL:

Q. -- to the low back?

MR. MCDANIEL: Objection, asked and answered.

A. Yes.

Q. Okay. And what would your response be given that there's no history of such an injury?

A. That his back pain was related to his chronic history of low back pain.

Q. Okay. Now, you continued to follow Mr. Chavis up until July of 2002; is that correct?

A. Yes.

Q. Okay. And at that time, you referred him to Dr. Kang?

A. Kang, that's correct.

Q. For --

A. K-A-N-G.

Q. -- chronic pain management?

A. Yes.

Q. Okay. And do you have a copy of Dr. Kang's report from his initial evaluation on July 9, 2002? I think the letter was actually addressed to --

A. Yes.

Q. Okay. And what is the history that Mr. Chavis gave to Dr. Kang?

A. All right. It's a 47 year old gentleman with a history of chronic neck and shoulder pain since 1998. He suffered an injury to the right rotator cuff. Underwent long-term conservative treatment without success. Had an MRI that showed it was a tear. Arthroscopic surgery, which -- with improvement in function and symptoms. Then developed recurring shoulder pain, second opinion in Florence by Dr. Elvington who recommended evaluation at the Spine Institute in Mt. Pleasant.

Some type of spinal injection there in 2000. He apparently had a small CVA during that period. He developed some speech difficulties as well as weakness in the left arm. He is seen by Dr. Grabowski, which should be Dr. Keblesky (ph), in Conway, a neurologist, who eventually diagnosed him with a stroke. Currently most of Mr. Chavis' neurologic symptoms have resolved.

He no longer has speech, any residual weakness. He does complain of dysesthesias and paresthesias in the hands and feet, which he is convinced is due to the stroke. He also reports concurrent development of pain in the left shoulder. He's been treated with physical therapy, trigger point injections, some success. Poor sleep, migraine headaches.

Q. Okay. Is there any indication in Dr. Kang's report of a history of an injury to his low back in December 1999?

A. Not that I see on this report.

Q. Okay. The only injury or accident, work injury or accident, that's referenced in Dr. Kang's record, and this is July of 2002, is the 1998 accident; is that correct?

A. That is correct.

Q. All right. Now, there's also apparently some indication of a left shoulder problem. Did Mr. Chavis ever report to you that he had injured his left shoulder at work in this accident in December 1998?

A. Let me see. I see -- let's see, left shoulder, left shoulder. The first notation I have of anything with the left is on February, February 13th of 2002. From my physical exam, it says left impingement. I don't see any specific notation to the left before then.

Everything was chronic in that, you know, --

Q. Okay.

A. I know we treated him for his right. I don't know when the left popped up. We gave him an injection then.

Q. Assuming that that was the first time that he complained to you about the problems with his left shoulder and assuming that his injury to the right shoulder occurred in December 1998, do you have an opinion within a reasonable degree of medical certainty as to whether or not the left shoulder problems have any connection with the accident of December 1, 1998?

A. Well, I don't think he should have had any, and from his, his therapeutic misadventure on his injection -- no, I don't think it would be related to his accident.

Q. Okay. Now, Dr. Kang's report of July 2002, also makes mention of the stroke that was diagnosed following the cervical injection and makes note that the residual problems from the stroke had pretty much resolved. From your evaluation of Mr. Chavis after the stroke, would you agree with Dr. Kang that the symptoms of the stroke resolved?

A. Well, he -- I could say that all the signs of his stroke resolved, being objective evidence. He

cont -- as the chart noted, he continued to complain of, of numbness of which we, you know, we can't really document the presence, having some numbness. But there is no objective evidence of the CVA.

Q. Okay. Now, I believe there was a functional capacity evaluation done at some point, at some time.

A. That's a pretty fair guess.

Q. Let's see, it looks like it was done in January of 2002.

A. 2002, okay. Here we go, okay.

Q. Okay. And what did the functional capacity show in terms of his -- Mr. Chavis' ability to go back to work?

A. Let's see, that it appears to be an acceptable FCE since he appeared to give full effort. Just double check that. Appears to be a valid FCE on the base of effort. They grade him out as a medium physical category, which can go from sedentary to heavy. He's medium. His floor to knuckle and 12 inch knuckle lift were 54 pounds. Knuckle to shoulder and shoulder to overhead were 35 pounds.

Q. Okay. And do you have an opinion within a reasonable degree of medical certainty as to whether or not he could return to work in those restrictions?

A. Based on the results, he should be able to

return to work within the restrictions on this FCE.

Q. Okay. Now, going back to the, the stroke for a second, let me turn your attention to your report of February 13, 2002, which is on Page 255 of the APA submissions.

A. February 15th?

Q. February 13th.

A. February 13th, okay. 2002 okay?

Q. Yes. And just, if you could, just read your recommendations.

A. We injected him today. He noticed some improvement after the subacromial injection. And I put an "L" to designate that was the left. We'll see him back in two to three weeks time. He's asked about ending his case. We discussed with him that we're unable to relate any cognitive complaints to his CVA as brain stem should lead to absolutely no cognitive or memory issues at all.

Q. Okay. And why did you give that opinion?

A. I could -- I don't have any independent recollection. I imagine that Gilbert was complaining of some sort of cognitive or memory deficit.

Q. Okay. His stroke apparently was in the cerebellar region; is that correct?

A. Cerebellar or brain stem as I recall.

Q. Okay.

A. And that's not near the cortex; so there should be no personality, memory, cognitive changes.

Q. Okay. So if he has complained of problems with his memory, in your opinion would those problems be related to his stroke?

A. No.

Q. And is that your opinion within a reasonable degree of medical certainty?

A. Yes.

MR. MCDANIEL: Object to the answer. Object to the question on the basis that the Doctor had been qualified as an expert in the area of orthopedic surg -- or actually as a physical medicine specialist.

MR. HOWELL: Okay.

BY MR. HOWELL:

Q. I think when your deposition was originally started, I asked you some questions about your background in treating people who have been involved in strokes?

A. Yes.

Q. Could you go over that again for us, please?

A. For seven years, I was the medical director of Med Star Subacute Care Unit. And I'm currently medical

director of Waccamaw Rehabilitation Center. A large percentage of our patients are post-CVA.

Q. Okay. Thank you, Doctor. Please answer any question that Mr. McDaniel might have for you.

CROSS-EXAMINATION BY MR. MCDANIEL:

Q. Dr. Wilkins, first off you've been seeing Gilbert Chavis a long time?

A. Yes, indeed.

Q. Before we started the deposition, you expressed some frustration over this case; is it -- is it -- is that frustration related to us, or is it related to Mr. Chavis?

A. That would be both.

Q. Okay. Can you tell me when your frustration with Mr. Chavis began?

A. No.

Q. It appears to me based on review of your records that you had a very good relationship with Mr. Chavis until after this stroke incident. Would that be a fair statement?

A. Yeah, again, I don't recall the stroke -- I recall the stroke. Again, I couldn't tell you when the frustration began. It was -- it's just the whole ongoing nature of this.

Q. You've been -- you've been knowing Gilbert, you

know, since 1996. I mean, it's --

A. Correct.

Q. -- actually like you had actually treated him for that, and he had returned to treat with you as a patient on numerous occasions.

A. Yes.

Q. And have you noticed -- did you notice a change in Gilbert over the last couple -- over the last few years?

A. Change how?

Q. Let's say the last four. Well, I mean, would you say he's more argumentative, more belligerent, more demanding on --

A. No, he's not -- he's not belligerent.

Q. Okay.

A. I wouldn't use that. Has Gilbert changed over the last few years. No, I don't think he -- I don't think there's any sort of fundamental change in his personality or anything like that. Yeah, I -- no, again, I would -- certainly wouldn't call him belligerent.

Q. Okay. I'm just trying to figure out the source of your frustration as to, you know, --

A. Well, I mean, I could tell you that -- I could -- I could tell you, and this doesn't certainly

unfortunately in America pull Gilbert in to any sort of minority. In fact anymore I think he's the -- this is what normal Americans are all about. But I -- let's put it this way. I think Gilbert, as do many Americans, have, and, and, and me personally, would have a difference in the levels of control.

I think that it's -- Gilbert strikes me as someone that anything that's ever happened in his life has happened because of somebody's else fault of negligence. Or bad things have happened, and none of its his issues. As we've gone through this and his prior claim and the, the -- and the legal issues that have gone with the prior claim, it's -- it just strikes me as a never ending saga where there's always new injuries, new conditions, new fault, new blame, new suits, new everything. That's the best I can put it.

Q. Okay.

A. Again, unfortunately that's not a minority anymore.

Q. All right. Let's go -- you referenced the fact there was a pain chart on numerous occasions. It looks like every time you have to see a patient, you have them fill out a pain chart.

A. That's correct, we try to get them fill -- just me, not my other partners, just me.

Q. I was going to say. In other words, that's something you do, not your other -- that your other partners don't necessarily do?

A. Correct.

Q. Okay. And I guess that you do that because of your background in physical medicine and --

A. Correct. 'Cause a lot of my outpatient practice is pain, so. Often can be very helpful with --

Q. I was going to say. I mean, what's your actual position within the practice? I mean, is that what you do? You deal all -- with all the non-surgical chronic pain types as --

A. That's part of it. Again, I could see anywhere from the -- I could be the first person the patient's seen, or I could see them after they've been evaluated surgically, or I could see them post-surgically. It can fall anywhere in the -- sometimes I just see them to just do EMGs, and that's the only time I ever lay eyes on them.

Q. Okay. Let's go back to January of let's say 1998. I believe first off one of the records I have -- January the 11th of 1998.

MR. HOWELL: Of '99?

A. '99?

Q. 19 --

A. Yes.

Q. All right. After the 1998 injury, I know that Dr. Mills had treated him regarding to -- I'm not going to go back through your records, but Dr. Mills had treated Gilbert. And then you saw Gilbert after Dr. Mills referred him to you for treatment of pain in reference to his lumbar spine. And there was a period of time in there that you didn't reference any problems with the back. You were more focusing on the neck or, excuse me, on the shoulder.

Then it looks like you were trying to resolve Gilbert's pain. And then you, on December 23rd of 1998, you report that, you know, he had chronic back pain, and you referred him for some injections to Dr. Holgate?

A. Yes.

Q. Okay. In the lumbar spine?

A. Correct.

Q. If you would, just publish the first line of your January 11th, 1999, report for the record.

A. He returns today stating he does not -- it should be does not know whether to hug us or hit us due to the fact his facet helped so much that he wishes he had it sooner.

Q. Okay. Based on your recollection and your records -- and we can go back through them after that,

but basically did that facet injection resolve his, his low back problem?

A. Assuming that wasn't the focal area of our treatment.

Q. Okay. Look -- it may help to look at your -- and I know basically your testimony today -- we're talking about 1999 and the year 2000.

A. Yes.

Q. Is your testimony basically today on your records?

A. Yes.

Q. Looking at March 24th, 1999, the first two sentences, says he returns, and the second one says back still doing very well.

A. March 24th.

Q. Would it be helpful to have one that's in order? I have a set here that's in order.

A. Yes, please. Oh, I got it. I got it. I got it. Yes.

Q. And that's when he came in complaining about the triceps tendon area?

A. Yes.

Q. Okay. And then April 21st, 1999, was triceps pain?

A. Uh-huh.

Q. No mention of any problems with the back?
A. Correct.
Q. Then May 13th was impingement syndrome?
A. Correct.
Q. No mention of the back?
A. Correct.
Q. June 10th, 1999, impingement syndrome, partial rotator cuff tear?
MR. HOWELL: What's the appointment --
MR. MCDANIEL: June 10th, 1999.
A. Correct.
Q. All right. You can just follow right along. June 30th, I believe that's when they were -- you made a referral to Dr. Preslar?
A. Yes.
Q. Then you got -- you testified to Dr. Preslar's records; but July 1st, 1999, chronic right shoulder pain?
A. Yes.
Q. Back doing pretty good?
A. Doesn't say.
Q. Okay. Then Dr. Preslar saw him on July 22nd and basically involved an injection?
A. Correct.
Q. And he's treating him in reference to his shoulder?

A. Correct.

Q. Okay. August 18th, 1999?

A. The surgery, yes.

Q. Okay. Then August 30th, 19 -- 1999, treating him for his shoulder?

A. Yes.

Q. September 23rd, still treating for his shoulder?

A. Yes.

Q. October 12th, 1999, shoulder?

A. Yes.

Q. October 14th, injection in the back, excuse me, in the shoulder?

A. Correct.

Q. Then had another MRI of the right shoulder done on October the 23rd. And then October 29th saw him back, again he was treating him for his shoulder?

A. Yes.

Q. And then the next visit is January 4 of 2000, according to my --

A. Next visit here, correct.

Q. Next visit you have there, okay. Based on your records, how was Gilbert's back doing throughout 1999?

A. I could tell you that it apparently wasn't Gilbert's primary concern.

Q. I mean, do you have any indication from your records that he was having any ongoing problem with his back; or that as he stated earlier, he didn't know whether to kiss you or hit you in reference to how much relief he had gotten from the previous back problems he had?

A. Yeah, I, I don't -- I don't recall any conversations regarding his back.

Q. Okay. Now, the next time you saw Gilbert was on, I believe, -- I'm going to flip through these myself with you. And the next time you saw him was in reference to --

A. July 5th, 2000?

Q. July 5th, 2000?

A. Yes.

Q. And he was referred back to you then in reference to his cervical problem?

A. Correct.

Q. Where did those cervical problems according to your records extend?

A. Ask that again?

Q. Where were they extending? Where all areas was he having pain in at that time?

A. Oh, let's see, he had pain he states is below his elbow to his fourth and fifth digits of his right

hand, continued shoulder pain. That's the only notations I have.

Q. He didn't specify what area of his shoulder, did he?

A. Not that -- not that I noted.

Q. Okay. Not if it was in the shoulder blade or below, below the shoulder blade or whatever, just in the shoulder?

A. Correct.

Q. Okay. And I assume that that was the right shoulder?

A. Yes, right shoulder.

Q. All right. Now, didn't you tell me that you did a pain -- you had him fill out a pain survey that day there?

A. Yes.

Q. Where was he having pain?

A. Most of the right upper extremity and he had aching in his low back.

Q. So he was reporting problems with his low back again at that point in time?

A. He noted it on his pain diagram.

Q. And, Doctor, in fairness to you you're really -- your recollection as far as what your patient was telling you, what's going on, is what's recorded in

those records? You're limited --

A. That's correct.

Q. -- strictly -- I mean, you don't have any independent recollection of how much you and Gilbert were talking about, problems? You don't know of any -- if he and Dr. Preslar were talking about, for example, that we're going to treat the shoulder, we're going to treat your neck, and we'll deal with the other problems; we're going to treat the major problems first? You don't have any recollection of --

A. No more than what I'd have access to in the chart.

Q. Right. And just like anybody else, you don't record everything you say to a patient and everything a patient says to you when you deal with them; is that a fair statement?

A. Correct.

Q. You're mainly interested, not -- just documenting their complaints and also then your -- what they need to have treated; is that a fair statement?

A. Yes, that's fair.

Q. All right. Now, Doctor, I want to note something to you that Counsel didn't note. The Defendants have accepted both the 1998 claim and the 1999 claim. For your information and the rest of your

testimony, I want you to understand that they have accepted the accident of 1998 and 1999.

Have you ever been made aware of, of this document, which is a -- which is going to be -- which has been put in to evidence with the Commissioner where Mr. Gilbert Chavis on December the 27th, 1999, filled out an accident report wherein he reported his injury and the problems that he was having to his employer?

A. Yeah, this is something that -- I don't think this ever got to me from any of his injuries that I recall. I don't usually see accident reports.

Q. Right. Okay. And this is the 1999 injury?

A. Yes, it says his name and then 12/27/99.

Q. Okay. Just for purposes -- I can read that. I don't know if you can. If you can read that 'cause I want to ask you some questions about --

A. Moving pot of work on a set of bad wheels. Pot came halfway off wheels. And when I tried to keep the pot on the wheels, my back began to burn. Now 2:30, back is not burning but hurts when I pick up something.

Q. All right. Mr. Chavis was on medications for his -- let me ask you that. That's a good question. What medication was he on, if we can flip back to Dr. Preslar's last record in October, or do y'all keep a separate medication chart as to what medication --

A. We'll have a separate thing for -- they call in for meds.

Q. Okay.

A. That's usually in the chart. What am I looking at?

Q. What I'm trying to find out is what medication was he on in the fall of 1999, just prior to this accident?

A. Looking at Dr. Preslar's notes, he doesn't make any notation of medication. He does not have carbon copies like I do, so I don't think I'd be able to tell for you unless -- let's see, it looks like a couple times in October and November of '99, he called in and received Vioxx.

Q. Okay. Which is what type of medication?

A. An anti-inflammatory. And in 8/31 he received Talacen, which is a -- an opioid.

Q. Pain medication?

A. Pain medication.

Q. Okay.

A. Then before that, it was June he received some medicine as well.

Q. So would it be safe to say -- and you don't have records as to whether Dr. Elvington or the other doctors that they -- the Defense sent him to for other

opinions in reference to Dr. Preslar -- I know you noted in your previous testimony Dr. Elvington saw him.

A. Yes.

Q. And I believe they sent him somewhere else also at that time for a second opinion, whatever, a third opinion, prior to that accident of December 27th of 1999. And my question is, is that we do know, though, however that he was given a prescription in the late fall for an anti-inflammatory?

A. That's correct.

Q. All right. What type of effect -- and those, those medications were given to him in reference to obviously his -- the ongoing shoulder treatment. But would they affect the pain that he was having in his back if he also developed injury in his back later on?

A. They could.

Q. And in his cervical spine area?

A. Yes.

Q. Now, I note that in your previous pain surveys Mr. Chavis would be reporting areas of pain let's say for example in his low back and in his shoulder and in his neck, but then in your notes you would actually just talk about the specific injury that you were treating; is that -- if that a fair statement in --

A. Well, we'd usually just deal with whatever was

his major complaint that day.

Q. So for example it's like I tell people a lot of times. If you stick a pin in your finger, it hurts; but if you stick a cigarette in your elbow, you're going to feel that cigarette a lot more. So in other words, you would deal with the major problem?

A. Correct.

Q. And you're recording what was the focus of the treatment at that, that --

A. Right, and it's -- and the patients often times won't even write down about the finger even though it hasn't really changed.

Q. Uh-huh. And so -- and a lot of times when they're coming in, they know they're coming and being treated for this particular acc -- so they may be reporting what they're seeing you about and what you're asking about?

A. Yes.

Q. Okay. If we can flip forward, I believe you said that Mr. Chavis in the fall of 2000, -- and I believe if I remember correctly you -- it was in September.

A. September 2000.

Q. You were actually seeing him at that time in reference to his cervical radiculopathy; am I correct?

A. His neck and shoulder pain, yes.

Q. Exactly. And yet you made note on that date that he returns today having some increased pain in the low back?

A. Yes.

Q. All right. Would it be a fair statement then that that was another complaint, even though he was seeing you for his cervical and his shoulder pain, to report to you the increase in pain that he was noting in his low back?

A. Yes, 'cause that's something I wouldn't have asked about.

Q. Okay. And so would that be significant in your opinion having treated Mr. Chavis over the years that he would report that to you?

A. Well, significant enough for me to note.

Q. That's a fair statement. Let's go forward to -- and Counsel said he had two reports. I don't know if we made -- marked those as exhibits.

MR. HOWELL: There are two of them. There's, there's one in January, and there's one in February. They're the same exact questionnaires, but they -- they appear to be anyway.

MR. MCDANIEL: I think there may be some

reference to some aggravation due to his second injury concern. But anyway are these additional copies we could make a part of --

MR. HOWELL: That's fine.

MR. MCDANIEL: We can make those part of the record, Plaintiff's -- Claimant's 1. We'll just make those both Claimant's Exhibit 1.

BY MR. MCDANIEL:

Q. And let me ask you if you can identify -- is that your -- is that your --

A. Just this one or both?

Q. All right. You can answer both.

MR. MCDANIEL: We'll make that Claimant's 1 and Page 1 of 2.

(DOCUMENTS MARKED FOR IDENTIFICATION AS PLAINTIFF'S EXHIBIT NO. 1.)

A. Yes, those are both my handwriting.

Q. All right. And you, of course, read those questions at that time?

A. Yes.

Q. And answered those to the best of your ability at that time in reference to your treatment as you understood of your patient at that time; is that correct?

A. Yes.

Q. All right. Now, Doctor, and I'm trying to be as fair to you as I can. Is your ability to remember what was going on, what types of problems Mr. Chavis was having, what he was reporting to you at that time, what you knew about his situation in January and February of 2001, and -- when you answered those questions originally, is it -- was it better then or better now?

A. I would hope better then.

Q. Okay. I mean, do you have any reason to believe that it wouldn't have been?

A. No.

Q. All right. And based on the way you try to -- I know -- and I know you just like all physicians try to truthfully answer the questions that you respond to, and I've had both positive and negative responses to those questions. Did you try to answer those truthfully at that time?

A. Yes.

Q. And do you believe that that constituted your opinion at that point in time?

A. Yes.

Q. All right. And based on the fact that you're now being asked questions in 2005, four years later, do you believe that you properly and fairfully and truthfully answered those questions to the best of your

ability based on your medical training and treatment of Mr. Gilbert Chavis and your knowledge of his situation at that time?

A. Yes, but I think I was smarter on Page 2.

Q. Okay.

A. I think the issue was probably if I'm just -- you know, we have stacks and stacks of paperwork, and I'm reading through -- it says your diagnosis likely a result of work accident, his low back. So I probably just said oh, the time he injured his back. And this one it's like wait a minute, I -- it may have been this one was just a more thorough review of my records, but that's, that's just a guess.

Q. And in all fairness to both sides, there's no question that Mr. Chavis had preexisting back problems?

A. Right.

Q. That there's no question about that. But are there many patients that you see that have had treatment over the years for various back problems, and then they come to another incident and it results in extenuating or --

A. Oh, yes. Yes. Yes. Absolutely.

Q. -- damage to the back? All right. By the way, something I didn't tell you. But in reference to that, that second injury, that pot that Mr. Chavis was talking

about and he was talking about the pushing of the pot wheels, that pot weighed about 450 to 500 pounds and was on casters.

MR. HOWELL: Objection, that assumes facts not in evidence.

BY MR. MCDANIEL:

Q. I, I -- and, of course, based on that. But when it tipped over, he tried to catch it and to prevent it from falling over. And that's when he felt that immediate burning sensation. What is the significance of a burning sensation in the back?

A. Not much. It usually means muscular.

Q. All right. What about the pain radiating down his leg?

A. Well, it depends how far down his leg.

Q. Okay.

A. If it's not -- if it's below the knee, you worry about a pinched nerve. If it's not below the knee, it usually means a joint.

Q. Okay. And I believe you already answered this, but in your opinion you were in a better position to truthfully testify about -- to answer those questions and to express your opinions in 2001 than you are today based on just a review of records?

A. Assuming that I reviewed the records equally

throughout those times, yes.

Q. Now, let's go to the -- I'd like to go to the -- let's talk about the cervical spine a little bit. Have you had a chance to observe -- to review that MRI that was performed on January -- I believe it was --

MR. HOWELL: January 8 of 2000.

MR. MCDANIEL: January 8 of 2000?

MR. HOWELL: Here it is right here.

A. Okay, do you mean did I review it then, or did I look at the report now?

Q. No, if, if you could -- if you could just look at it.

A. Oh, okay.

Q. By the way, in your practice here do y'all rely on the radiologist reports, or do you independently review the MRIs?

A. Depending on where it is we -- more often than not we review the MRI ourselves.

Q. Okay. In reference to the MRI, and I believe David Goltra is the one who performed that MRI --

A. Yes.

Q. -- on January 8? Who was the person that you said you felt like was one of the best radiologists around?

A. Oh, Dr. Genez.

Q. Dr. Genez, okay.

A. I think she read his original shoulder.

Q. Okay.

A. And I believe she -- the last I heard she was at the VA, so I don't know where she's at.

Q. Okay. We can focus in on the findings at the C4-5 and the C5-6. It says bilateral annular osteophytes (ph) on present, left greater than right, with moderate left and right -- mid right neuroforaminal stenosis. First off what's the significance of the bilateral annular osteophytes?

A. That would be an arthritic or degenerative change.

Q. Okay. Then it says that there was neuroforaminal stenosis.

A. Yes.

Q. What is the importance of stenosis or -- in reference to causing a patient problems?

A. Well, neuroforaminal stenosis would mean that the -- that the essentially tube of bone that leads from the spinal cord to the arm is being constricted usually from either bone, disc, or a combination thereof and could lead to irritation or injury to the nerve that goes through the foramen.

Q. All right. If you then superimpose injury on

that, what effect does that injury have on it if you have preexisting stenosis?

A. If you get additional inflammation, the swelling that occurs can make stenosis that was previously asymptomatic become symptomatic.

Q. Okay. Now, and, of course, various nerves exit the spinal cord at certain times, and you'll have symptoms in reference to those nerve roots if pressure is being placed on them as they leave the spinal cord; is that correct?

A. Yes.

Q. All right. Looking at C5-6, it says there is a right parasagittal disc protrusion which contacts, contacts and flattens the spinal cord. Tell me what the significance of that finding is.

A. That means that it could possibly be causing mylopathic or spinal cord symptoms.

Q. Okay. That means it's actually pushing in on the spinal cord, right?

A. Yeah, it's actually causing a change in the shape of the cord to MRI appearance.

Q. Okay. If you have that kind of involvement at the C5-6 level, what's it going to do to everything below that?

A. Usually nothing depending on the degree of

deformation. In severe circumstances, you could be quadriplegic.

Q. Okay. And for example if you cut it or completely compress the --

A. Correct.

Q. But also it can cause neurological findings in the feet and legs, can't it?

A. If severe enough, yes.

Q. Okay. Such as causing tingling?

A. Again, if it's severe enough.

Q. Okay. At that level, C5-6, is -- am I right that that's where the ulnar and the radial nerve both exit?

A. No.

Q. Okay.

A. No, ulnar -- his complaints of fourth and fifth digit, you'd be concerned with Cervical Root 8 or Thoracic Nerve No. 1, which would be a couple -- which would be, be down a couple.

Q. Below, okay.

A. Below.

Q. All right. But since they're below, if you were having spinal cord involvement above that level could it cause -- could it cause problems with numbness and tingling in the fingers and also in the legs?

A. It could. But, again, typically, typically the patient's level of compression correlates fairly strong with the level of radicular or nerve root level involved.

Q. Correct me if I'm wrong, though. That it is not until after this CT scan was performed on January the 8th of 2000, that Mr. Chavis began to report -- and I -- you've already testified to this earlier -- problems with tingling and numbness and problems in both hands and both feet? Take time and review your records but --

A. Well, again, the first time I started seeing him in this was July 5th of 2000, so that's the first time I would have known about it. He complained of pain below his elbow to his fourth or fifth digits of his right hand, so that's all I'm aware of at that time.

Q. Okay. And I believe you did a pain chart. You were referencing some pain charts, and he was having problems in those -- in the fall of 2000; is that right?

A. Fall of 2000.

Q. Well, actually July 5th would be the first pain chart we've got since you're the only one of your partners that does that, so. That'd be fair, wouldn't it?

A. 8-1. 8-1 I have has got his -- throughout

most of his right upper extremity. Nothing else is marked. From the July 5th, it's his -- also his right upper extremity; although, the majority of the markings are actually outside of the arm itself. And then some notations to his low back.

Q. Doctor, I think you testified that you were involved with stroke patients?

A. Yes.

Q. In reference to our function of our -- the good 'ole bodies that the Lord gave us, in reference to the cerebellum and in the mid-brain where do those -- what do those affect?

A. The cerebellum most commonly affects the ability to do repetitive tasks gracefully so to speak. Cerebellar -- if you were to whack your cerebellar it would make you look like a drunk. You'd have to walk wide-based, and you wouldn't be able to put your finger to your nose. It's called ataxia. There's no -- that's not really part of the cerebrum; so there's no cortex where personality, memory, all that stuff occurs.

Brain stem, all of the nerves that go from your brain to your -- out to your spinal cord all go through a very tight area in your mid-brain, the brain stem. And you can have effects of any of the systems that, that go through there directly. The things that

would --

Q. Sexual dysfunction?

A. Well, if you were to get -- the problem with sexual dysfunction is that tends to be multi-factorial. And if you're going to have a direct nerve injury that makes you unable to form an erection for instance, that tends to be just a small part of a much bigger problem.

Q. Okay. And but it also -- it affects like you said both their cerebellum and the mid-brain? Both affect for example the use of your extremities, your legs and --

A. They can, correct.

Q. And can it result in some tingling nerve sensations if it's not -- you know, like we're not talking about total paraplegia. I'm --

A. Right. Not the cerebellum.

Q. What about the mid-brain?

A. That would be -- if you were going to have both hands, both feet, it would have to be a bilateral injury, which would -- which would, one, tend to be very unlikely except in the course of -- except like with a, a tumor.

If it's a vascular condition, typically you have bilateral -- you have, you know, arteries on each side. So if you damage one artery, have a clot, it's

going to tend to preferentially involve the right or left half of your brain stem, which is going to give you fairly asymmetric findings. They're going to be either numb and weak on one side or numb and weak on the other as opposed to both.

If you're -- if you look at the spread of the nerves of the brain stem, if you have an injury that's bad enough to get both sides for the patient numbness is the least of their problems. They're going to have some pretty substantial motor deficits, muscle function deficits.

Q. But, I mean, the, the, the effects from a brain injury in both their cerebellum and in the mid-brain can be -- I mean, there's 0 to 100. I mean, you know, you're talking about the worst but --

A. Yes, you can be -- you could go anywhere from nothing to what's called locked in syndrome where all the patient can do is lift their eyes up and down.

Q. Okay. And are you aware that the stroke, the actual place that we can -- find that the stroke actually occurred on Mr. Chavis, was in the mid-brain and in the cerebellum?

A. Yes, I do recall that.

Q. Okay. And, again, it was after this accident on December the 27th of 1999, and this finding on the MRI

of the cervical spine problems and the subsequent unfortunate event in reference to the stroke that he began to report problems with tingling and numbness, problems with his hands and feet; is that correct?

A. Yes.

Q. Counsel asked you about the, the FCE; and he asked you about your treatment, I believe. Although you treat chronic pain patients, you found it to the best interest of Mr. Chavis to transfer him for somebody for long-term chronic care, Dr. Kang; is that -- is that why you transferred him?

A. Do you know what date that was?

Q. 2002.

A. Well, I mean, at that -- let me go back and see. I mean, at that point he really had -- you know, he had been extensively imaged. And we had as I recall documented, you know, pathology of "X" and yet we were giving Gilbert what I would consider to be much more pain medicine than the average person for what we had objective evidence of. And therefore I just wanted Dr. Kang to give his assessment on the -- whether it was a reasonable amount of opiates for that. Not that Dr. Kang does more as doing -- just to get sort of another thumbs up from a compatriot.

Q. And then for whatever reason, I -- this has

been made part of the APAs. But is that -- did you make that referral to --

A. Yes, that's me.

Q. Okay. So on July 30th of 2002, you referred him to Dr. Kang for chronic pain management? Is that something that you -- like you said that you more generally do, sent -- if it is a chronic pain situation, you refer them out?

A. No. No. In fact I very rarely refer them out. I do most of that myself.

Q. Okay. But on this particular occasion, you -- at least it was for a second opinion?

A. Correct.

Q. For whatever reason, he wound up staying with Dr. Kang?

A. Correct.

Q. Okay.

MR. MCDANIEL: Let me ask you to mark this as a Claimant's Exhibit.

(DOCUMENT MARKED FOR IDENTIFICATION AS PLAINTIFF'S EXHIBIT NO. 2.)

BY MR. MCDANIEL:

Q. Do you have any records where you saw Mr. Chavis after?

A. No. I have two -- I have a note from 10/02,

where I did a letter. But that's -- assuming these are in order, that's the last notes I have that I saw him in the off -- you know, as a --

Q. All right. And throughout the years you treated Mr. Chavis, at the first incident, I believe, way back in the early '90s?

A. Mid '90s, yes.

Q. Okay. And then after that, you saw him in 1996 again and originally it was some kind of a little thumb injury or something, I believe, way, way, way back when?

A. It may have been -- he saw my partner, Dr. Haskin, back in '91.

Q. Right, that's what it was. I'm sorry, I didn't mean to --

A. That's okay.

Q. I apologize. In other words, then you saw him in 1996. You consistently -- as a matter of fact, at one point after this unfortunate incident with, with the situation with the injection down in Charleston Mr. Chavis thought enough of you to come back to you to get your advice, and I believe that's when you referred him back to Dr. Preslar. He actually at one point wanted you to pull him from Dr. Preslar because he was --

A. That's correct.

Q. And after that, though, you continued to -- he

continued to seek your advice, and you continued to treat him?

A. Yes.

Q. And so from 1996 up until 2002, you treated him throughout that period of time?

A. Off and on, yes.

Q. And you knew his condition, and you knew what he did for work. You were there when he came in and asked for you to try to be able to get him back to his second job and -- back after in 1998 and 1999. Remember that?

A. Yeah. I know when I first saw him, he had two jobs. I definitely recall that.

Q. All right. And he wanted to keep working those jobs; you kept him in those jobs as long as you could; is that -- and helped him get back to those work -- get back to work?

A. That was certainly our agenda.

Q. All right. And there's no question that you knew his, his condition and knew him and had been treating him from 1996 up until 2002 when you referred him to Dr. Kang?

A. Yes.

Q. All right. What's been marked as Claimant's Exhibit No. 2, I'm going to ask you if that is your

signature or your initial on that there?

A. That's me.

Q. Okay. Would you publish in to the record what your opinion was in reference to Mr. Chavis' ability to return to work at that time?

A. Says please note Mr. Chavis is permanently disabled from his previous job at AVX.

Q. Okay. Thank you, Doctor. I have -- and that constituted your opinion at that time?

A. Yes, that's me.

Q. Okay.

REDIRECT EXAMINATION BY MR. HOWELL:

Q. You did not say in that report that he was totally disabled, did you?

A. No. No, it was specific to that job if that's what you --

Q. Okay. And do you stand by your earlier testimony that he could probably return to work in accordance with the functional capacity evaluation that was done?

A. Yes, that's correct.

Q. All right. Mr. McDaniel asked you some, some questions about, again, about the low back problems and --

A. Yes.

Q. -- after December of 1999. And, again, as we discussed earlier he apparently saw Dr. Elvington just two days after this incident. If we assume this incident at AVX occurred on December 27, 1999, --

A. Yes.

Q. -- he saw Dr. Elvington just two days later; is that correct?

A. That's correct.

Q. And apparently it wasn't significant enough to tell Dr. Elvington --

MR. MCDANIEL: Objection. Objection. This is going back in to direct examination. You're doing redirect. It's improper questioning not subject to redirect examination and assumes facts not in evidence. We don't know what he told Dr. Elvington. Dr. Elvington --

BY MR. HOWELL:

Q. According to the report, he did not mention the alleged accident that occurred two days earlier involving his low back; is that correct?

A. That's correct.

Q. All right. And when he saw Dr. Preslar on January 4, 2000, which would have been just a week later, he didn't tell -- at least by report didn't say anything to Dr. Preslar about injuring his low back; is

that correct?

A. That's correct.

Q. And throughout the entire period of time between January of 2000, and July 2000, when he was seeing Dr. Preslar apparently at least by report did not mention anything about this incident at work on December 27, 1999; is that correct?

A. That's correct.

Q. And even when he came back to see you on July 5th, 2000, and apparently on the pain diagram indicated some aching in his low back, he didn't mention anything about this incident on December 27, 1999; is that correct?

A. That's correct.

Q. All right. And after that, I think you said you saw him back on August 1 of 2000?

A. Yes.

Q. And the pain diagram at that time didn't reference the low back, did it?

A. That is correct.

Q. Okay. And when he was seen back on August 15th, 2000, he didn't complain of any problems with his low back either, did he?

A. That is correct.

Q. Okay. And then while he complained of some

problems with increased low back pain on September 22nd, 2000, it wasn't any different than the type of low back pain he had had ever since '96, was it?

A. I don't know I can say that. I don't see where I provided any treatment or anything like that. I don't recall the specific nature of the back pain. All I guess I could say, that at that point it wasn't high enough on the priority list for us to address.

Q. Okay. And then he came back in October of 2000; and there were no complaints of low back pain at that time, correct?

A. None listed. That's Dr. Mills, correct.

Q. Okay. And then you saw him on April 20th of 2001; is that correct?

A. Yes.

Q. All right. And there were no complaints of the low back at that time, correct?

A. Correct.

Q. All right. Then you saw him on September 13th, 2001; is that correct?

MR. MCDANIEL: I'm going to object because I believe this has already been gone through on direct examination.

MR. HOWELL: No, it's in response to your questions on cross.

MR. MCDANIEL: You're on redirect, and you've already covered on direct -- anyway note the objection. I'll move to strike at the --

A. That's correct.

Q. Okay. And, again, you saw him on January 21, 2002; is that correct?

A. Yes.

Q. Okay. And there were no complaints of low back pain on that date?

A. Correct.

Q. And then again on February 13th, 2002?

A. Correct.

Q. And there were no -- and there were no complaints of low back pain on that occasion; is that correct?

A. That's correct.

Q. Okay. And again on March 7th, 2002, and March 15th, 2002. Were there any complaints of low back pain on any of those dates?

A. None that I noted.

Q. Okay. And how about on May 31, 2002; were there any complaints of low back pain?

A. No.

Q. Okay. And how about June 21, 2002; were there any complaints of low back pain?

A. No.

Q. And, again, when you last saw him on July 8, 2002, before the referral to Dr. Kang, did he complain of any problems with his low back?

A. Not that I had noted.

Q. And would it be a fair statement to say that since 1996, Mr. Chavis has had bouts of off and on back pain?

A. Yes.

Q. Okay. Sometimes they were merely in the right -- in the lower part of the back; at other times they radiated into the left?

MR. MCDANIEL: I'm going to object on the basis that we're on redirect, and I'm going to move to strike at the hearing. You can go ahead and answer, Doctor, but --

A. Yes, that's correct.

MR. MCDANIEL: And I'd like to make that just a running objection.

MR. HOWELL: Okay.

BY MR. HOWELL:

Q. And, again, today obviously we've been through all of your records in significant detail; is that correct?

A. Yes, we have.

Q. Okay. And you would agree there is no record that Mr. Chavis ever reported to you or Dr. Preslar of this injury of December 27, 1999, correct?

A. Other than what the Defense presented as --

MR. MCDANIEL: Claimant.

A. I'm sorry, Plaintiff, Plaintiff, Plaintiff.

MR. MCDANIEL: Claimant.

A. The Claimant.

Q. Are you talking about the incident report?

A. Correct.

Q. Right. But you didn't have that?

A. No, not to my knowledge. I have not seen that before.

Q. Okay. That's all I have. Thank you.

THE WITNESS: Come on, you got to have something.

MR. MCDANIEL: One question.

RECROSS-EXAMINATION BY MR. MCDANIEL:

Q. Counsel asked you about all of your reports, but -- after 2000, 2001, 2002. He went through those meticulously again; but he did not go through your pain diagrams that you fill out each time, did he?

A. Correct.

Q. Nothing further.

REDIRECT EXAMINATION BY MR. HOWELL:

Q. Okay. Do you have pain diagrams after August of 2000?

A. Yes.

Q. Okay. When he came in on August 1 of 2000, --

A. August 1, 2000.

MR. MCDANIEL: Off the record.

(Whereupon there was a pause in the proceedings.)

A. August 15th, 2000, yes, I have one for that.

Q. Okay.

A. We discussed -- we talked about those, didn't we?

Q. All right.

A. In 9/22/00, I have one. 10/2/2000, I have one.

Q. Okay. What did the one on 10/2/2000, show?

A. He's got some notations in his low back and neck and right upper extremity.

Q. Okay. And what I'd like to do with your permission is get -- just get copies of all the pain diagrams --

A. You may.

Q. -- rather than go back through all of them but --

A. Do our part to support IP.

Q. Okay. But would it be fair to say, Doctor,

that since April of 1996, when you started seeing Mr. Chavis that he's had off and on problems with his low back?

A. Of '97, yes.

Q. Of '97, okay. And, again, --

MR. MCDANIEL: Objection again. This is on redirect, redirect. I object to the questions.

BY MR. HOWELL:

Q. I don't have anything else.

(Deposition concluded at 1:45 p.m.)

(DOCUMENTS MARKED FOR IDENTIFICATION AS DEFENDANT'S EXHIBIT NOS. 2-4.)

RYAN P. ALDERMAN
Independent Court Reporter
Tele: 843.971.5867 Fax: 843.971.6509

STATE OF SOUTH CAROLINA)

: C-E-R-T-I-F-I-C-A-T-E

COUNTY OF HORRY)

I, Ryan P. Alderman, Court Reporter and Notary Public, certify that I did have Dr. Jeffrey C. Wilkins to appear before me at 12:16 p.m. on Friday, January 27, 2006, at Coastal Orthopaedic Associates, PA, 2376 Cypress Circle, Conway, South Carolina; that the witness was sworn and cautioned to tell the truth, the pages constitute a true and accurate transcript of the testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 21st day of February, 2006.

COPY

Ryan P. Alderman

Notary Public for South Carolina

My Commission Expires: 06/01/2010

RYAN P. ALDERMAN
Independent Court Reporter
Tele: 843.971.5867 Fax: 843.971.6509

3306

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P. O. BOX 2167
MT. PLEASANT, SC 29465

HAROLD E. TRASK
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KIRSTEN L. BARR
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J. STEVEN RODENBERG
JAMIE C. GUERRERO
R. KEVIN RICHEY

PHONE
(843) 881-4228

FAX
(843) 881-8784
E-MAIL
RHOWELL@TRASK-HOWELL.COM

September 5, 2003

CERTIFIED/RETURN RECEIPT REQUESTED

Mr. Douglas P. Crossman
S. C. Second Injury Fund
Koger Center
Winthrop Building, Suite 119
220 Executive Center Drive
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170
Carrier File No.: WC550-441515
Date of Accident: December 7, 1998

Dear Mr. Crossman:

This office represents the employer and their insurance carrier in the above-named workers' compensation claim filed by Gilbert Chavis. The Defendants are hereby placing you on notice that, should the appropriate benefits be paid out in this matter, they will seek reimbursement from the Second Injury Fund.

For your information, our records indicate the Claimant allegedly sustained his injury by accident in Horry County.

Yours very truly,

Roy A. Howell, III

RAHIII/AJB/lk
cc: Carol Lovett, Liberty Mutual
Cheryl Keel, AVX
S. C. Workers Compensation Commission (Certified/RRR)
3019\1625\l-sif not

5095 angela

SCWCC
SEP 11 2003
JUDICIAL

The South Carolina Second Injury Fund

DOUGLAS P. CROSSMAN
DIRECTOR

WINTHROP BUILDING, SUITE 119
220 EXECUTIVE CENTER DRIVE
COLUMBIA, S.C. 29210

(803) 798-2722
FAX: (803) 798-5290

09/11/2003

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORPORATION

SIF NUMBER: 067417
WCC NUMBER: 9826170

CARRIER CLAIM NUMBER: WC 510-192314

Dear ROY A. HOWELL:

Thank you for your letter received 08/04/1999 .

Enclosed is a Notice of Claim Form. Please complete and return it and all requested documents as soon as possible.

Please note that during the course of our investigation, we may be in contact with the employer. Should you have any questions or objections, please advise accordingly.

The above captioned case is pending investigation.

Sincerely,

PHILLIP L. JOHNSON
CLAIMS ANALYST
Telephone Extension: 118

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR

JANE C. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
LORI B. KING

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DIRECT DIAL: (843) 881-2236

July 23, 2009

Maria Rehborn
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170
Carrier File No.: WC550-441515
Date of Accident: December 7, 1998

Dear Maria:

Enclosed please find the SC Second Injury Fund Reimbursement Request Form accompanied by the corresponding medical records. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Bourdage, Liberty Mutual Insurance Co.
3019\1625\l-sif re reimbursement 98 claim

"A"

W.C. No. 9826170
Carrier Code
Employer Code
Carrier File No.WC550-441515

NOTICE OF POSSIBLE SECOND INJURY FUND CLAIM

S.I.F. No.

Employee: Gilbert Chavis — Social Security No. 248-04-2224
Address: 6160 McKinley Way, Conway, SC 29526 — Date of Accident: December 7, 1998

Employer: AVX Corporation — Carrier: Liberty Mutual Insurance Co.
Location: Horry — Address: P.O. Box 867, Myrtle Beach, SC 29578-
0867

Employee's Attorney Preston McDaniel, Esq. — Carrier's Attorney: Roy A. Howell, III
Address: 1315 Elmwood Ave., Columbia, SC 29201 — Address: P. O. Box 2167, Mt. Pleasant, SC

SUBSEQUENT INJURY: Nature of Second Injury: Claimant injured his back and shoulder lifting pots in the course of his employment. As a result of that injury, the Claimant underwent an epidural injection during which time he had a cerebral stroke.

Current Status: The claim was litigated and ultimately settled for $261,500.00
Treating Physicians: Dr. Wilkins, Dr. Mills, Dr. Kang, Dr. Presslar
Average Weekly Wage: — Compensation Rate$263.12
Date of First Temporary Total: 8/16/99 — Date Returned to Work:
Weeks of All Benefits Paid: — Medical Costs to Date: $155,790.10

NATURE OF PRIOR IMPAIRMENT:

_X_ Listed Impairment (1-33): (2) diabetes; (4) arthritis
_X_ Other (34a or b): (b)

The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed a workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 1997, 1998, and 1999. The Claimant had a subsequent work-related injury in 1998 when he was lifting a pot at work in which he injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 2000. During the injection, he sustained a minor cerebral stroke. Prior to the 1998 accident, the Claimant also received treatment for erectile dysfunction, diabetes, and depression.

The Claimant had multiple preexisting problems that were agitated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone.

KNOWLEDGE REQUIREMENT:

_X_ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)
___ Employee withheld existence of pre-existing condition from employer. (Please attached application, pre-employment physical, etc.)
___ Employee was unaware of existence of pre-existing condition (Please attach affidavit)

[redacted]

Signature: [signature] Date of Claim: 7/23/09

Mailing Address: Tusk & Howell, L.L.C., P. O. Box 2167, Mt. Pleasant, SC 29465-2167
In support of such notice and without precluding the right to establish further facts as may be developed, the Preceding allegations are set forth subject to proof at a Hearing.
PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE
WORKERS' COMPENSATION COMMISSION.
Revised 3/90

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9826170
Carrier File # WC550-441515
Carrier Code #
Employer FEIN

Gilbert Chavis	248-04-2224	AVX Corporation	
Claimant's Name	SSN	Employer's Name	
6160 McKinley Way	Conway, SC 29526	P.O. Box 867	Myrtle Beach, SC 29578-0867
Address	City State Zip	Address	City State Zip
unknown	unknown	Liberty Mutual Insurance Co.	
Home Phone	Work Phone	Insurance Carrier	

Roy A. Howell, III — Preparer's Name
(843) 881-4228 — Phone #

Compensation Paid	Number of Weeks	From	To	Amount
1. Number of weeks T.T.	463	8/16/99-10/19/08		$ 121,824.75
2. Number of weeks T.P.				$
3. Number of weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$ 261,500.00
Total Compensation Paid				$ 383,076.33
6. Total Medical Benefits* Paid				$ 155,790.10
7. Funeral Benefits				$

☐ Case Denied

Date of Injury: 12/7/98 (month day year)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: Gilbert P. Chavis — Claimant
By: [signature] — Employer's Representative
Date: 7/23/09

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By:

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party ..... $
B. Attorney's Fee Paid by Employer ..... $
C. Attorney's Fee Paid by Claimant ..... $
(Non contingent fees, only)

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied

WCC FORM # 19 REV. DATE 3/96 19 STATUS REPORT AND COMPENSATION RECEIPT

HAROLD E. TRASK
ROY A. HOWELL, III
KRISTEN L. BARR

JANIE C. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
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DIRECT DIAL: (843) 881-2236

July 28, 2009

Marla Rehborn
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9927964
Carrier File No.: WCS50-441515
Date of Accident: December 27, 1999

Dear Marla:

Enclosed please find the SC Second Injury Fund Reimbursement Request Form accompanied by the corresponding medical records. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Boundage, Liberty Mutual Insurance Co.
3019\1625\l-slf re reimbursement 99 claim

415

9927964
Carrier Code
Employer Code
Carrier File No. WC550-448871

NOTICE OF POSSIBLE SECOND INJURY FUND CLAIM

S.I.F. No.

Employee: Gilbert Chavis	Social Security No. 248-04-2224
Address: 6160 McKinley Way, Conway, SC 29526	Date of Accident: December 27, 1999
Employer: AVX Corporation	Carrier: Liberty Mutual Insurance Co.
Location: Horry	Address: P.O. Box 867, Myrtle Beach, SC 29578-086
Employee's Attorney Preston McDaniel, Esq.	Carrier's Attorney: Roy A. Howell, III
Address: 1315 Elmwood Ave., Columbia, SC 29201	Address: P. O. Box 2167, Mt. Pleasant, SC

SUBSEQUENT INJURY: Nature of Second Injury: Claimant injured his back and shoulder lifting pots in the course of his employment.

Current Status: The claim has been settled for $30,000.00
Treating Physicians: Dr. Wilkins, Dr. Mills, Dr. Kang, Dr. Presslar

Average Weekly Wage: $478.21	Compensation Rate $318.82
Date of First Temporary Total: N/A	Date Returned to Work: N/A
Weeks of All Benefits Paid:	Medical Costs to Date: N/A

NATURE OF PRIOR IMPAIRMENT:

_X_ Listed Impairment (1-33): (2) diabetes; (4) arthritis
___ Other (34a or b):

The Claimant initially sustained an injury to his lower back and shoulder in an accident which occurred in 1996. He filed workers' compensation claim for the lower back injury and continued to receive medical treatment for this injury in 1996, 199 1998, and 1999. The Claimant had a subsequent work-related injury in 1999 when he was lifting a pot at work in which h injured his right shoulder and back. As a result of the right shoulder injury, the Claimant had an epidural injection in 200 During the injection, he sustained a minor cerebral stroke. Prior to the 1999 accident, the Claimant also received treatment fo erectile dysfunction, diabetes, and depression.

The Claimant had multiple preexisting problems that were agitated and/or combined with the 1999 injury resulting i substantially greater disability and medical payment than that which would have resulted from the December 27, 1999 injur alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1999 injury alone.

KNOWLEDGE REQUIREMENT:

_X__ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)
___ Employee withheld existence of pre-existing condition from employer. (Please attached application, pre-employment physical, etc.)
___ Employee was unaware of existence of pre-existing condition (Please attach affidavit)

[redacted]

Signature: [signature] Date of Claim: 7/28/09
Mailing Address: Trask & Howell, L.L.C., P. O. Box 2167, Mt. Pleasant, SC 29465-2167
In support of such notice and without precluding the right to establish further facts as may be developed, the Preceding allegations are set forth subject to proof at a Hearing.
PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A COPY TO THE WORKERS' COMPENSATION COMMISSION.
Revised 3/90

"D"

416

The South Carolina Second Injury Fund

WILLIAM E. GUNN
INTERIM DIRECTOR

100 EXECUTIVE CENTER DRIVE, SUITE 101
SANTEE BUILDING
COLUMBIA, S.C. 29210
www.scsif.sc.gov

(803) 798-2222
FAX: (803) 798-5291

August 10, 2009

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORP.
SIF #: 100406 CARRIER CLAIM NUMBER: WC550-448871
WCC #: 9927964

DEAR ROY A. HOWELL:

WE HAVE REFERENCES TO INJURIES IN 1996, '98, AND '99. WE HAVE NO 12A'S OR ACCORD FORMS. CLAIMS ARE BEING MADE THAT THE '99 INJURY LED TO SUBSTANTIALL INCREASED COSTS DUE TO THE PRIOR CONDITIONS. THE MEDS DO NOT REFLECT THIS. ACTUALLY, THE MEDS DON'T REFERENCE AN INJURY IN DEC OF '99. PLEASE SEND THE SIF DOCUMENTATION OF A DECEMBER '09 INJURY.

SINCERELY,

PHILLIP L. JOHNSON
SENIOR CLAIMS ANALYST

"E"

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR

JAMIE G. GUERRERO
KATHRYN C. THOMPSON
ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
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DIRECT DIAL: (843) 881-2236

August 14, 2009

Mr. Phillip Johnson
S. C. Second Injury Fund
Santee Building
100 Executive Center Dr., Suite 101
Columbia, SC 29210

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9927964
Carrier File No.: WC550-441515
Date of Accident: December 27, 1999

Dear Phillip:

Pursuant to your letter dated August 10, 2009 in regard to the above matter, I have enclosed a copy of Jeffrey C. Wilkins, M.D.'s Statement dated 2/20/01; the deposition transcripts of Dr. Jeffrey C. Wilkins dated October 21, 2006 and January 27, 2006; First Report of Injury dated 12/27/99 and Decision and Order dated August 31, 2005 from J. Alan Bass. Please let me know if you need any additional information to issue reimbursement in the above-referenced claim.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co.
Cheryl Keel, AVX
Michelle Bourdage, Liberty Mutual Insurance Co.
3019\1625\l-johnson re slf reimbursement 99 claim

"F"

The South Carolina Second Injury Fund

WILLIAM E. GUNN
INTERIM DIRECTOR

100 EXECUTIVE CENTER DRIVE, SUITE 101
SANTEE BUILDING
COLUMBIA, S.C. 29210
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November 10, 2009

ROY A. HOWELL
TRASK & HOWELL
PO BOX 2167
MT. PLEASANT, SC 29465

RE: GILBERT CHAVIS VS. AVX CORP.
SIF #: 100406 CARRIER CLAIN NUMBER: WC550-448871
WCC #: 9927964

DEAR ROY A. HOWELL:

I TALKED WITH NICHELLE AND, AS OUR FILE CURRENTLY STANDS, I CAN EVALUATE THIS CLAIM FOR THE LUMBAR INJURY AND NOT THE SHOULDER. ANY ROLE DIABETES OR PSYCHONUROTIC DISABILITY PLAYS WILL BE DISCOUNTED. IF THIS IS ACCEPTABLE, PLEASE LET ME KNOW AND I WILL PROCEED ALONG THOSE LINES. IF NOT, I STILL NEED KNOWLEDGE INFO FOR DIABETES AND PSYCHONUROTIC DISABILITY.

SINCERELY,

PHILLIP L. JOHNSON
SENIOR CLAIMS ANALYST

"G"

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9826170
Carrier File # WC550-441515
Carrier Code #
Employer FEIN

Gilbert Chavis	248-04-2224	AVX Corporation	
Claimant's Name	SSN	Employer's Name	
6160 McKinley Way	Conway, SC 29526	P.O. Box 867	Myrtle Beach, SC 29578-0867
Address	City State Zip	Address	City State Zip
unknown	unknown	Liberty Mutual Insurance Co.	
Home Phone	Work Phone	Insurance Carrier	

Roy A. Howell, III — (843) 881-4228
Preparer's Name — Phone #

Check applicable claims and complete all blanks.

1. The Employee sustained a compensable accidental injury to the Back\neck and right shoulder and a cerebral stroke as a result of a spinal injection (Part of the Body) on December 7, 1998 (Date) in Horry County (County), South Carolina (State)
2. That the Second Injury Fund was put on notice of the claim on September 5, 2005 (Date)
3. That the Carrier concluded the disability claim by Agreement on October 21, 2008 (Date)
4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. code §42-9-40 (d):
   a. Listed Impairment - (1) - (33): (2) diabetes; (4) arthritis
   b. (34) (a)
   c. (34) (b)
5. ☒ a. That the impairment pre-existed;
   ☒ b. That the impairment was permanent; and
   ☒ c. That the impairment is a physical condition.
6. ☒ That the prior impairment combined with or was aggravated by the subsequent injury
7. ☒ That the combination/aggravation substantially increased the liability of the Carrier for (disability), (medical) or **(both).**
8. ☒ That the prior impairment was a hindrance of obstacle to employment or re-employment.
9. ☒ a. That the Employer has knowledge of the prior impairment;
   ☐ b. That the impairment was unknown to the Employee and the Employer; or
   ☐ c. That the Employee concealed the prior impairment from the employer.
10. ☒ That the subsequent injury would not have occurred "but for" the prior impairment.
11. That the above claim qualifies for reimbursement under S.C. code §42-9-4100. The Claimant had multiple preexisting problems that were aggravated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone. All of these conditions combined with the Claimant's work-related injury to result in substantially greater disability and medical expenses.

Signature — February 8, 2010 (Date)

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9927964
Carrier File # WC550-448871
Carrier Code #
Employer FEIN

Gilbert Chavis	248-04-2224	AVX Corporation	
Claimant's Name	SSN	Employer's Name	
6160 McKinley Way	Conway, SC 29526	P.O. Box 867	Myrtle Beach, SC 29578-0867
Address	City State Zip	Address	City State Zip
unknown	unknown	Liberty Mutual Insurance Co.	
Home Phone	Work Phone	Insurance Carrier	

Roy A. Howell, III — (843) 881-4228
Preparer's Name — Phone #

Check applicable claims and complete all blanks.

1. The Employee sustained a compensable accidental injury to the Back/neck and right shoulder and a cerebral stroke as a result of a spinal injection (Part of the Body) on December 27, 1999 (Date) in Horry County (County), South Carolina (State)
2. That the Second Injury Fund was put on notice of the claim on September 5, 2005 (Date)
3. That the Carrier concluded the disability claim by Agreement on October 21, 2009 (Date)
4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. code §42-9-40 (d): (2) diabetes; (4) arthritis
   a. Listed Impairment - (1) - (33):
   b. (34) (a)
   c. (34) (b)
5. ☒ a. That the impairment pre-existed;
   ☒ b. That the impairment was permanent; and
   ☒ c. That the impairment is a physical condition.
6. ☒ That the prior impairment combined with or was aggravated by the subsequent injury
7. ☒ That the combination/aggravation substantially increased the liability of the Carrier for (disability), (medical) or **(both).**
8. ☒ That the prior impairment was a hindrance of obstacle to employment or re-employment.
9. ☒ a. That the Employer has knowledge of the prior impairment;
   ☐ b. That the impairment was unknown to the Employee and the Employer; or
   ☐ c. That the Employee concealed the prior impairment from the employer.
10. ☒ That the subsequent injury would not have occurred "but for" the prior impairment.
11. That the above claim qualifies for reimbursement under S.C. code §42-9-4100. The Claimant had multiple preexisting problems that were aggravated and/or combined with the 1998 injury resulting in substantially greater disability and medical payment than that which would have resulted from the December 7, 1998 injury alone. The Claimant had pre-existing injuries to his lower back and right shoulder, as well as problems resulting from preexisting diabetes, depression, and erectile dysfunction, resulted in substantially greater disability and medical payments than would have resulted from the 1998 injury alone. All of these conditions combined with the Claimant's work-related injury to result in substantially greater disability and medical expenses.

Signature — February 8, 2010 (Date)

South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, South Carolina 29202-1715

WCC File No. 9927964
Carrier File No. WC550-448871
Carrier Code No. 00055
Employer FEIN

AVX CORP.	PO BOX 867, MYRTLE BEACH, SC 29578 0867
Employer's Name	Address
LIBERTY MUTUAL INSURANCE CO.	
Insurance Carrier's Name	Address
GILBERT CHAVIS	
Employee's Name	Address

The Second Injury, in answer to the claim, respectfully shows:

1. It is denied that the employee sustained a compensable accident:
   The claim is being investigated.

2. It is denied that the notice was given to the Second Injury Fund:

3. It is denied that the disability claim has been concluded.
4. It is denied that the impairment is:

5a. It is denied that the impairment pre-existed.
b. It is denied that the impairment was permanent.
c. It is denied that the impairment is physical.
6. It is denied that the impairment combined with or was aggravated by the subsequent injury.
7. It is denied that the combination/aggravation substantially increased the carrier's liability for disability, medical, or both:

8. It is denied that the impairment was a hindrance or obstacle to employment or re-employment.
9a. It is denied that the employer had knowledge of the impairment.
b. It is that the impairment was unknown to the employee and employer.
c. It is that the employee concealed the impairment.
10. It is denied that the subsequent injury would not have occurred 'but for' the prior impairment.
11. It is that the claim qualifies for reimbursement under S.C. Code Section 42-9-410;

12. Other grounds for denial:
    All affirmative defenses including estoppel, statute of limitation per 15-3-600, intervening trauma, laches, fraud, negligence, injuries not work related and not compensable, intoxication; and if mental injury, it didn't arise from unusual or extraordinary circumstances of employment; failed to pay its assessment per § 42-7-310.

Latonya D. Edwards — 3-15-10
Signature on behalf of the Second Injury Fund — Date

HAROLD E. TRASK
ROY A. HOWELL, III
KIRSTEN L. BARR
JAMIE C. GUERRERO

ALLISON C. NUSSBAUM
JILL W. KING
WILLIAM H. LYON
D. ALAN WESTERLUND, JR.

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DIRECT DIAL: 843-881-2236

p2

67417
100406
LED

May 17, 2010

CERTIFIED

Ms. Virginia Crocker
Judicial Director
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, SC 29202-1715

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170 & 9927964
Carrier File No.: WC550-441515 & WC550-448871
Date of Accident: December 7, 1998 & December 27, 1999

Dear Ms. Crocker:

On February 8, 2010 we filed a Form 54 with the Commission requesting hearings in the above-referenced Second Injury Fund claims. The Form 54s were filed separately for each claim. On March 15, 2010, the Second Injury Fund filed a Form 55 in connection with WCC File No. 9927964 denying the Second Injury Fund claim. No Form 55 was filed in connection with the December 7, 1998 claim, WCC File No. 9826170.

On March 31, 2010, I wrote the Commission explaining the nature of these cases and asked that both cases be set for a single Second Injury Fund hearing since both cases were consolidated by Commissioner Bass with regard to the underlying claims.

Last week, I asked my paralegal to follow-up with the Commission regarding the status of these cases being set for a hearing. She was advised that the Commission had no record of receiving the Form 54s in either case. This is interesting as the Second Injury Fund filed a Form 55 in connection with the 1999 claim.

In order to expedite a hearing on the Second Injury Fund claims, I am re-filing the Form 54s that were previously filed on February 8, 2010. I am also enclosing a $25.00 filing fee for each case. In addition, I am renewing my request that both cases be consolidated for a single hearing on the Second Injury Fund issues.

By Proof of Service to the Second Injury Fund, I am serving a copy of our Request for a Hearing in both cases as required by the Rules of the Commission.

Thank you for your assistance in this matter.

Yours very truly,

Roy A. Howell, III

RAHIII/hcj/lk
Enc.
cc: Chris Vitto, Liberty Mutual Insurance Co. (w/enc.)
Cheryl Keel, AVX (w/enc.)
Phillip Johnson, S. C. Second Injury Fund (w/enc.)
Latonya Edwards, Esq. SIF (w/enc.)
Michelle Bourdage, Liberty Mutual Insurance Co. (w/enc.)
3019\1625-1626\I-F54#2

South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, South Carolina 29202-1715

WCC I No. 9826170
Carrier Case No. WC 510-192314
Carrier Code No. 00055
Employer FEIN

AVX CORPORATION
Employer's Name — Address

LIBERTY MUTUAL INSURANCE CO.
Insurance Carrier's Name — Address

GILBERT CHAVIS
Employee's Name — Address

The Second Injury, in answer to the claim, respectfully shows:

1. It is denied that the employee sustained a compensable accident:
   The claim is being investigated.
2. It is denied that the notice was given to the Second Injury Fund:
3. It is denied that the disability claim has been concluded.
4. It is denied that the impairment is:
   As alleged or any permanent physical impairment serious enough to be a hindrance or obstacle to employment.
5a. It is denied that the impairment pre-existed.
   b. It is denied that the impairment was permanent.
   c. It is denied that the impairment is physical.
6. It is denied that the impairment combined with or was aggravated by the subsequent injury.
7. It is denied that the combination/aggravation substantially increased the carrier's liability for disability, medical, or both:
8. It is denied that the impairment was a hindrance or obstacle to employment or re-employment.
9a. It is denied that the employer had knowledge of the impairment.
   b. It is that the impairment was unknown to the employee and employer.
   c. It is that the employee concealed the impairment.
10. It is denied that the subsequent injury would not have occurred 'but for' the prior impairment.
11. It is that the claim qualifies for reimbursement under S.C. Code Section 42-9-410;
12. Other grounds for denial:
    All affirmative defenses including estoppel, statute of limitation per 15-3-600, intervening trauma, laches, fraud, negligence, injuries not work related and not compensable, intoxication; and if mental injury, it didn't arise from unusual or extraordinary circumstances of employment; failed to pay its assessment per § 42-7-310.

Latonya D Edwards — June 2, 2010
Signature on behalf of the Second Injury Fund — Date

WCC Form 55 Rev 6/90 — Second Injury Fund's Answer to Employer's Request for Hearing

EASTERN CAROLINA MEDICINE

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Dr. W. L. Coleman
Physical Medicine

Dr. Joseph Carter
Acupuncture

June 07, 2005

Mr. Preston McDaniel
McDaniel Law Firm
Attorneys and Counselors at Law
1315 Elmwood Avenue
Columbia, SC 29201

Re: Gilbert Chavis

Dear Preston:

Gilbert comes in for his first follow-up visit. Unfortunately, he hasn't had any of his database done so there is a limited amount I can do for him today. However, he is getting worse. His meds aren't holding him. I don't want to increase his narcotic load or Tylenol load. I am putting him on Ultracet. I explained the gate theory of pain to him and how he is using his TENS unit wrong. I am getting him set up for acupuncture, deep massage, aquatic therapy. I am starting him on Ultracet, Cymbalta. He states that he is staring at the clock until 5:00 in the morning. He is being treated for apnea. It may be that his C-PAP unit is leaking or he now has apnea plus disorder of initiating and maintaining sleep. I have asked him to take his C-PAP machine to the vendor, have it checked for leaks. If it is leaking, we will start him on Ambien. Further workup and evaluation will await the database. At this point, I am not doing anything invasive until I have a database to work with. I will let you know how he is doing from here.

I hope you are doing well.

Sincerely,

Domenic J. DeMichele, M.D., Ph.D.

DOMENIC J. DeMICHELE, M.D., Ph.D.

DJD/tb

NERVE CONDUCTION STUDY
PATIENT: Gilbert Chavis
DATE: 6/20/05

The right median is normal throughout with the exception of decreased overall conduction velocity seen at the wrist. Left median is normal throughout except that there is decreased latency onset at the wrist with five percent decrement in overall nerve conduction velocity. Left ulnar is normal throughout except overall conduction velocity is decreased. Right ulnar (ABD) dig min is normal throughout.

Sensory: Right median anti (second) is normal throughout. Left ulnar anti (fifth) is normal throughout. Right median anti (second) is normal throughout. Right ulnar anti (fifth) is normal throughout.

IMPRESSION: Abnormal upper extremity nerve conduction study, consistent with right median, left median and an emerging left ulnar neuropathy of unknown etiology. Clinical correlation is indicated.

Domenic J. DeMichele, M.D., Ph.D.

DOMENIC J. DeMICHELE, M.D., Ph.D.

DJD/tb

F-WAVE LATENCY EXAMINATION
PATIENT: Gilbert Chavis
DATE: 6/20/05

F-wave latencies are normal for the bilateral ulnar and median nerves.

IMPRESSION: Normal F-wave latency test. Clinical correlation is indicated.

DOMENIC J. DeMICHELE, M.D., Ph.D.

DJD/tb

NERVE CONDUCTION STUDY
PATIENT: Gilbert Chavis
DATE: 6/7/05

Motor latencies are normal throughout. Sensory latencies are normal throughout.

Peroneal and posterior tibial motor latencies are normal with normal nerve conduction velocities seen. Sural potentials are unremarkable and F-wave latencies are normal throughout.

IMPRESSION: Normal lower extremity nerve conduction study. Clinical correlation is indicated.

Domenic DeMichele M.D. Ph.D.

DOMENIC J. DeMICHELE, M.D., Ph.D.

DJD/tb

F-WAVE LATENCY EXAMINATION
PATIENT: Gilbert Chavis
DATE: 6/7/05

F-wave latencies are normal for the bilateral peroneal, and posterior tibial nerves.

IMPRESSION: Normal F-wave latency test. Clinical correlation is indicated.

Domenic DeMichele D. Ph.D.

DOMENIC J. DeMICHELE, M.D., Ph.D.

DJD/tb

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Dr. W. L. Coleman
Physical Medicine

Dr. Joseph Carter
Acupuncture

March 28, 2005

Mr. Preston McDaniel
McDaniel Law Firm
Attorneys and Counselors at Law
1315 Elmwood Avenue
Columbia, SC 29201

Re: Gilbert Chavis

Dear Preston:

I have seen Gilbert and then went through his chart which took approximately two hours. He is a long and complicated case. I am taking the history from him after and then looked at the chart. In summarizing this plethora of information, some of which is right-on and some of which is disparate: This is a fifty year old, white male who, in 1998, was lifting a ninety-six pound pot for a coworker. He immediately developed right shoulder pain, neck pain, low back pain and reported it. It continued to get worse. He, ultimately, had rotator cuff surgery on the right, rested the shoulder for six weeks and was back to work on light duty and in therapy. He noted every time he picked up something, he would get burning dysesthesias in his neck. He sought medical care and ultimately, had the rotator cuff area re-explored when the entire time, the problem was in his neck. He ultimately had cervical ESI's during which he had a CVA. This left him with a speech disorder, stuttering, problems with balance and memory, disorientation and the CVA by MR initially showed a cerebellar infarct. The right shoulder, in the meantime, froze and he had to go through manipulation under anesthesia to break up adhesions. During all of this, he developed a major clinical depression which was not addressed. His brain injury, the result of the initial work accident, also was not addressed and still hasn't been. He continues to have neck pain, low back pain, radicular pain in the right upper extremity to the elbow and nothing has changed except it is getting worse.

(Continued)

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He is having marital problems at home. He has lost all interest in sex. He has mood swings, periods of disorientation still, problems with short-term memory. He has gained weight and has lost all interest in any ADL's secondary to elicitation of pain which limits his ability to do anything. He has also developed dysesthesias in both feet. This occurred after the stroke. After the stroke, his right shoulder also became worse, probably secondary to immobility. He has had multiple ESI's. The last MRI of his brain was a year ago. I don't actually have the films. He has found that the only thing that works for pain is Bextra. Now, for the past five years, his left knee has begun giving him trouble and this is secondary to poor body mechanics secondary to favoring the right side over the left.

CURRENT MEDICATIONS: He is currently on Glipizide, Glucophage, Neurontin, Bextra, Roxicodone, Levitra, ASA, MVI, Liver Oil, Hydrochlorothiazide, Lipitor, Actos, Lidoderm Patches and a TENS unit which he is not using properly.

VITALS: He states that he does not have hypertension. However, on today's exam, BP is 170/110. He is 5'5", 215 lbs. Pulse is 76. Respiratory rate was 14 unlabored, afebrile.

ALLERGIES: Codeine.

PHYSICAL EXAMINATION: Uncomfortable, constantly in motion, but pleasant, fifty year old, white male, obviously in moderate discomfort and moving around the room throughout the history which took approximately one hour. HEENT: Atraumatic. Normocephalic without lymphadenopathy. Trachea is midline. Thyroid is non-palpable. TM's are clear. Neck is supple with normal ROM. Lungs are clear to auscultation and percussion.

(Continued)

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March 28, 2005

Mr. Preston McDaniel
Re: Gilbert Chavis
Page Three

Heart - regular rate and rhythm; no rubs, murmur, gallop, or click. Abdomen, benign. Extremities - no clubbing, cyanosis, or edema; decreased range of motion passively and actively in abduction/adduction, circumduction with pain elicited both actively and passively. The left knee shows a stable tibial plateau with no crepitation. Vascular pulses - full, symmetric without carotid or cranial bruits.

NEUROLOGICAL EXAMINATION: Cranial nerves II-XII within normal limits. PERRLA. EOM's are full. Fields, full. Fundi are benign except for early retinopathic changes which are noted bilaterally. Motor 5:5 with - 5:5 in the right upper extremity secondary to pain elicited in the shoulder and neck, 5:5 in all muscle groups on the left, 5:5 in the lowers with subtle loss of power in the left lower extremity secondary to knee pain which is elicited. 2+ symmetric DTR's. No pathological reflexes. Sensory examination is intact to primary and cortical modalities without Romberg or Drift. However, there is decreased pin-prick, light touch, hot/cold and vibratory in both feet in a stocking/glove distribution. Cognitive senses are within normal limits except in the feet. Cerebellar testing; he is having some problems with rapid, alternating movements, diadochokinesia, finger to nose, heel to shin bilaterally. Some of this is from the infarct and some is from no proprioceptive sense in both lowers. Cognitive: A/O x three. Thought content and process is linear, non-tangential. Thought content is appropriate. He is not delusional, paranoid or malingering. Short-term and intermediate term memory are moderately impaired. Long-term memory is intact. However, I have no way of verifying the facts that he is giving me but he comes up with them lucidly and quickly and I assume that they are accurate.

(Continued)

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IMPRESSION: Fifty year old, white male with multiple problems including obstructive sleep apnea which is untreated and leads to cardiomyopathy and pulmonary hypertension, both of which are uniformly fatal. This is a result of his injuries at work. A brain injury which resulted from the treatment necessary to treat his work-related injuries and which is non-static, getting progressively worse and based on the known fact that we have a loss of one million neurons a day, with this and normal aging; this is only expected to get worse with time. Right shoulder; this is a wasp's nest that has been disrupted x two and will only get worse with time. Left knee; not a new, but relatively new, problem secondary to poor body mechanics.

PLAN: This needs to be scanned and looked at to see if any intervention is necessary. The patient also needs formal neuropsych testing to parcel out brain sections and determine a quantitative estimate on the degree of impairment for each area. The patient also needs a SPECT scan of the brain to look for crossed cerebellar diaschisis, dying back of the crossed cerebellar pathways to the opposite cerebral hemisphere. NICS/TCD. He needs the second half of the sleep study as he does have apnea which was documented and never treated and this is a carrier responsibility. Hypertension; unaddressed. He has been told to start taking his blood pressure on a regular basis, writing it down, and if it continues to be in this range, to report it to Dr. Milton in Conway.

Ultimately, this patient has multisystem damage. He is going to be in need of medical care for the rest of his life from several subspecialists. He also reports, reluctantly, impotence which is not primarily due to his injuries but is due to a major clinical depression, probably sustained/undiagnosed hypertension, and diabetes which was preexisting but exacerbated. He has thought about a pump.

(Continued)

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Specializing In Interventional Pain Management

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March 28, 2005

Mr. Preston McDaniel
Re: Gilbert Chavis
Page Five

I am advising against this as they are prone to mechanical failure. I would go with an implant. He is a candidate because he has failed Levitra. He is currently not on any antidepressant and needs to be. However, since this is a CME, I cannot do anything. Being on Roxicodone, this is a depressant and is only going to make matters worse including his memory.

Overall, he has a plethora of medical problems and taken in sum, based on AMA Guidelines for Impairment, this patient has a greater than fifty-one percent total body impairment rating, is totally disabled from gainful employment and should receive lifetime medical care and the further testing, as indicated, along with a MRI of the C-spine as I know without even seeing the films that he has disc and bone disease; MRI of the LS-spine, bone scan.

Thank you for allowing me to evaluate this patient.

Sincerely,

DOMENIC J. DeMICHELE, M.D., Ph.D.
DJD/tb
cc: Dr. Milton in Conway

OPEN MRI & CT OF MYRTLE BEACH

OPEN MRI & CT OF MYRTLE BEACH
900 21st Avenue North
Myrtle Beach, SC 29577
(843)916-1700 fax (843)916-9460

PATIENT NAME: Chavis, Gilbert
DATE OF BIRTH: 12/07/54
REFERRING PHYSICIAN: Dr. Bunn

DATE OF EXAM: 12/16/03

MRI OF THE BRAIN AND PITUITARY WITH AND WITHOUT CONTRAST

INDICATION: Hypogonadotrophic hypogonadism.

TECHNIQUE: Sagittal T1, axial T2, FLAIR images were performed. This was followed by sagittal and axial coronal T1 pre- and post-gadolinium sequences through the pituitary glands. Axial T1 post-gadolinium images were then acquired through the entire brain. The study was performed on a 1.5 Tesla closed magnet.

FINDINGS: The thin sections through the pituitary gland show no evidence for pituitary adenoma or macroadenoma. There is no mass within the suprasellar cistern. The cavernous sinus and optic chiasm are normal.

Images through the posterior fossa reveal a small area of previous infarction within the right cerebellar hemisphere within the posterior inferior cerebellar artery distribution. There is mild prominence to the subarachnoid space throughout the supratentorial and infratentorial compartment, consistent with mild age-appropriate atrophy. The ventricular system is of normal size and in the midline. There is no supratentorial mass or infarct seen. There are normal flow voids maintained within the internal carotid and basilar artery at the skull base. The visualized orbits and paranasal sinuses are remarkable for mild mucosal thickening within the ethmoid air cells on the right. Nasal septum is also seen to be deviated towards the left. Post-gadolinium images through the entire brain show no area of pathologic enhancement.

IMPRESSION:
1. THERE IS NO ADENOMA IDENTIFIED WITHIN THE PITUITARY GLAND.
2. THERE IS A SMALL OLD INFARCT IN THE RIGHT CEREBELLAR HEMISPHERE WITHIN THE PICA DISTRIBUTION.

Steven Epstein, M.D./rg
Dictated on 12/17/03

good MRI OK

James R. Merikangas, M.D., L.L.C.
Neurology, Psychiatry, Neuropsychiatry

June 19, 2003

J. Edward Bell, III
232 King Street
P.O. Box 2590
Georgetown, SC 29442

RE: GILBERT R. CHAVIS
SOCIAL SECURITY NO: 248-04-2224
DATE OF BIRTH: 12/7/54

Dear Mr. Bell:

Mr. Chavis is an unfortunate gentleman who suffered a stroke as the result of an improperly performed cervical spine injection. A misplace needle injured a vertebral artery, causing a cerebrovascular accident involving his cerebellum and brainstem. As a result he is left with permanent neurological and psychological impairments. Mr. Chavis had sustained various work related injuries to his back and shoulder and was in chronic pain. He had been treated in a number of places including: Primary Medical Associates from September 8, 1994 to January 24, 2000; Strand Regional Specialty Associates from May 5, 1998 to June 1, 1998; Disc Imaging from January 5, 1999 to April 13, 2000; Atlantic Physical Therapy and Rehab from August 30, 1999 to December 3, 1999 and from March 19, 2002 to April 25, 20003; Pee Dee Orthopedic Associates from December 29, 1999 to June 2, 2000; East Cooper Regional Medical Center from January 25, 2000 to January 26, 2000; Doctors Care Conway from January 28, 2000 to May 18, 2002; Eastern Carolina Neurosurgical Associates of Conway from January 31, 2000 to February 21, 2001; Coastal Orthopedic Associates from February 7, 2000; Conway Hospital February 7, 2000; Palmetto Health from February 7, 2000 to September 28, 2000; Midlands Orthopedic on August 7, 2001; and by L Randolph Waid, Ph.D., from December 5, 2002 to June 12, 2002.As part of my evaluation I reviewed all these medical records.

Mr. Chavis had lifted a heavy pot at work and had pain in his right shoulder down to his elbow. An x-ray taken on December 8, 1998, showed mild spurring of the right acromioclavicular joint. He was noted to have chronic back pain, which resulted in him being sent to Dr. Holgate for an L5-S1 facet block on the right. A note of January 11,

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1999, reveals that he had a marked improvement in his pain as a consequence of that procedure.

Richard C. Holgate, M.D. on January 5, 1999, under fluoroscopic control, performed this successful block of the right S1-S2 joint. An MRI of the right shoulder performed on June 7, 1999, by Beverly M. Genez, M.D., Ph.D., revealed abnormal signal of the rotator cuff, representing a partial tear on the undersurface and a possible tendinosis. Another MRI on October 23, 1999, for his chronic right shoulder pain revealed "Heterogeneous fluid within the subacromial subdeltoid bursa most likely resulting from prior decompression. Abnormal signal intensity within the distal rotator cuff may represent... tendinosis. No focal full thickness of the rotator cuff is identified on the current examination".

An MRI scan of the cervical spine on January 8, 2000, showed a large number of osteophytes with neural foraminal stenosis at C3-4. At C4-5 there was also seen a small shallow central disc protrusion and at C5-6 there is a parasagittal disc protrusion, which "Contacts and flattens the spinal cord" and "This is superimposed on a diffuse disc bulge which narrows both neural foramina, slightly more so on the right than on the left, but there is moderate right neural foraminal stenosis. At C6-7 and C7-T1 the MRI showed normal discs and normal foramina.

Dr. Goltra then performed a lateral selective epidural block in the cervical area on January 25, 2000. It was noted "Upon removing the needles a small amount of blood returned (sic) was obtained and direct compression was applied to the lateral neck. At approximately the time that the needle was removed the patient had an episode of syncope, which lasted for approximately one minute. When he awakened, he was nauseated and mildly disoriented. When he recovered from this he stated that his right shoulder pain was gone". Following that, a CT scan of the brain was performed with axial images showing no hemorrhage, edema or other abnormality. Unfortunately, subsequent MRI scans revealed the patient had a stroke. With reference to a prior examination of February 7, 2000 and an MRI of April 13, 2000, "There is a subtle area of signal abnormality in the right cerebellar hemisphere. Relative to the prior study the area of signal abnormality in the right cerebellar hemisphere is diminished in size, markedly. The lesion is not apparent on flair images and there is no abnormal enhancement, restrained or increased diffusion in this area. Small high signal focus in the right pons is again seen and is unchanged". This was also read by David D. Goltra, Jr., M.D.

It should be noted that the examination of May 25, 2000, by W. S. Edwards, Jr., M.D., at Pee Dee Orthopedic Associates revealed that he had arthroscopic surgery that "Did not lead to any significant improvement" and further "In the course of the work up it was determined that he had a disc bulge at C5-6 and given the radicular component of some of his symptoms, a spinal evaluation was requested". The doctor was reluctant to

Recommend surgery "Given his previous history of a 'stroke' from an epidural steroid injection done back in January". Furthermore, "He was cautioned, however, that some of his radicular symptoms conceivably could come from this (i.e., his cervical disc) and that he could not expect complete resolution of all of his symptoms from whatever type of shoulder surgery Dr. Elvington feels is required". It was further noted on June 2, 2000, by Robert E. Elvington, Jr. M.D., that "Gilbert is still having significant pain" and furthermore, "I think that this is related to the stroke and/or the injection".

Following the episode of syncope with his cervical injection, he was admitted to East Cooper Regional Medical Center under the care of David Wenzel, M.D., "For 23 hour observation following a complication related to a nerve block procedure". Dr. Wenzel noted "He was undergoing selective nerve root injection this afternoon for pain relief with a combination of Lidocaine and Depo-Medrol. Immediately after one of the injections was performed, he abruptly stopped talking, exhibited flexor posturing of both upper extremities and staring for perhaps two minutes, after which he became violently nauseated and vomited several times and was somewhat confused, reporting that he did not know where he was, why he was there, etc.". The impression was "Brief episode of unresponsiveness, followed by confusion and persistent nausea, likely due to inadvertent intra-arterial injection of Lidocaine".

He was subsequently seen on February 15, 2000, by Daniel B. Groblewski, M.D., who noted that he was complaining of imbalance and episodic diplopia and he had three days of bad headache. The MRI showed a right cerebellar stroke. Dr. Broblewski's note of April 18, 2000, states the impression "Right cerebellar cerebrovascular accident, probable thromboembolic or directly/indirectly related to injection". In his letter to Bruce G. Dew, Attorney at Law, dated April 18, 2000, Dr. Groblewski gives the opinion "Because of the association of his symptoms to the epidural injection, it is very possible that his stroke could have resulted from the epidural injection. This has been documented in previous literature as well. Also, I believe this could have caused his syncopal spell". He went on to state further "It is very unlikely that this represented a pre-existing condition and certainly could be a direct/indirect cause of the injection (sic)".

I subsequently personally examined Mr. Chavis at Georgetown University Medical Center. I also interviewed his wife on the same date.

Mr. Chavis was complaining of imbalance, neck and shoulder pain, headaches and depression.

A review of systems, physical examination and his history are all consistent with a cerebellar and brain stem stroke occurring from interference with the vertebral arterial system in the course of a cervical injection for pain relief as described in the previous reports.

The cervical segment of the vertebral artery courses through the intervertebral foramina. According to Frank H. Netter, M.D., writing on page 62 of Volume I of the Nervous System published by Ciba, West Caldwell, New Jersey, 1986, "The second (cervical) segment of the vertebral artery courses through the intervertebral foramina and is seldom the site of serious atherosclerosis. Minor ridges and plaques may develop at sites of indentation by the osteophytic spurs of cervical arthritis, but occlusion of this portion of the vertebral artery is rare".

As the vertebral arteries supply the pons and the posterior fossa through the basilar artery with its penetrating branches and the cerebellar branches, the symptoms of pain and ataxia and nausea can easily explained by the misplaced injection striking the vertebral artery. Again, according to Netter on page 62 of the cited volume "The artery is easily dissected or torn, which may cause clot formation within one or both vertebral arteries. Ischemia most often occurs at the time of injury and is limited to the ipsilateral cerebellum and lateral brain stem". The illustration on this page of Netter's book very clearly illustrates the anatomy of the region and how a misplaced needle could cause a stroke of this type.

In summary then, there was a deviation from the standard of care in the attempted nerve block, which injured a vertebral artery. Mr. Chavis will continue to suffer the impairments caused by this stroke for the rest of his life. He will remain in chronic pain. He is depressed and suffers from dizziness and unsteadiness.

The above is based upon my review of the medical records cited, my personal interview of Mr. Chavis and his wife and the relevant medical literature, as well as my experience and training as a board certified neurologist.

Please let me know if I may provide further information.

Sincerely yours,

James R. Merikangas, M.D.
Director, Neuropsychiatry Program
Georgetown University Hospital

JRM:mak

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist

Tidewater Executive Center
222 West Coleman Blvd.
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Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, SC 29201

Name: Gilbert Chavis
Age: 50 (DOB: 12/07/54)

Dear Mr. McDaniel:

Please accept this addendum in response to your inquiry as to whether or not in my opinion Mr. Gilbert Chavis has sustained physical brain damage. In my report, I state that there is neuroradiographic evidence of the sustainment of a cerebellar stroke as well as some residual impairments affecting Mr. Chavis' capacity for learning/memory functioning. A great obstacle for Mr. Chavis' return to life pursuits is continuing pain an physical limitations.

While I did not use the specific words that the Claimant had sustained physical brain damage, it is my opinion that Mr. Gilbert Chavis sustained physical brain damage as a result of is accidents and the treatment necessary therefor.

I hope this provides you with the information you need.

L. Randolph Waid, Ph.D
Licensed Clinical Psychologist

3/29/2005
Date

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist

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REPORT OF NEUROPSYCHOLOGICAL CONSULTATION/EVALUATION
Confidential-For Professional Use Only

Name: Gilbert R. Chavis

Age: 47(DOB: 12/07/54)

Sex: Male

Handedness: Right

Dates of Evaluation: May 2nd, 15th, 29th, and June 12th, 2002

Reason for Referral: Gilbert R. Chavis is a 47-year-old married male referred for neuropsychological evaluation by Jeffrey C. Wilkins, M.D. Mr. Chavis has been under Dr. Wilkins' care for chronic pain and was referred for neuropsychological evaluation due to concerns of having suffered a cerebellar stroke while undergoing conduction of a nerve block in January of 2000.

Mr. Chavis was seen in multiple evaluative contacts commencing on May 2nd, 2002. I also had the opportunity to conduct a separate interview of his wife on May 29th, 2002.

History of Presenting Difficulties: A review of records assisted in my understanding of Mr. Chavis' case. Records reviewed included the following:

1. Treatment records from PeeDee Orthopedic Associates.
2. Treatment records from Daniel P. Groblewski, M.D.
3. Radiographic studies from Disc Imaging.
4. Medical records from East Cooper Regional Medical Center.
5. Report of MRI study of the brain.
6. Evaluation report from Matthew E. Metcalf, M.D., The Center for Pain Management.
7. Report of psychological evaluation from Clay Drummond, Ph.D.
8. Treatment records from J. Preslar, III, M.D. and Jeffrey Wilkins, M.D.

Germane to the current evaluation, Mr. Chavis' difficulties commenced following a work related accident on 12/01/98 while employed for the AVX company in Myrtle Beach. Subsequent to this injury, he underwent arthoscopic rotator cuff debridement for a partial thickness tear and also a subracromial decompression by Dr. Preslar in August of 1999. Reportedly, prior to operative procedures, injections and physical therapy proved to be non-efficacious. Mr.Chavis underwent previous evaluations due to persistent pain and second opinion evaluation with regard to being a candidate for surgical procedures.

Germane to the current evaluation, Mr. Chavis underwent a procedure by David D. Goltra, Jr., M.D. for right shoulder pain. Reportedly, during the procedure, he experienced a "syncopal episode" necessitating transfer of his care to the East Cooper Regional Medical Center. Reportedly, following the injection, he "abruptly stopped talking, exhibiting flexor posturing of both upper extremities and staring for two minutes, after which he became violently nauseated and vomited several times and was somewhat confused and disoriented." At East Cooper, he underwent neurological evaluation and admission for observation. Upon arrival to the East Cooper facility, he remained persistently nauseated and vomited on at least one occasion. There was report of headache. Records reveal that a CT scan was reportedly conducted

at the facility where he underwent the nerve block without evidence of any difficulties. Evaluation by David Wenzel, M.D. resulted in an impression of episode of unresponsiveness followed by confusion and persistent nausea likely due to intra-arterial injection of Lidocaine.

Reportedly, family members stayed in communication with David Goltra, M.D. and subsequent care at the East Cooper Hospital. The following day, Mr. Chavis requested discharge. Per referral by Lewis Lawson, M.D., Mr. Chavis came under the care of Daniel B. Groblewski, M.D. Initial evaluation (1/31/00) was for assessment of syncope as well as persistent lethargy, ataxia, and speech difficulty. An MRI of the brain was requested (2/07/00) and revealed an abnormal signal enhancement involving the right cerebellar hemisphere and right mid-brain. Follow-up care with Dr. Groblewski (2/15/00) resulted in impression of right probable cerebellar infarct, right rotator cuff tear, diabetes, and headaches. Dr. Groblewski initiated care and scheduled other evaluative studies. Carotid ultrasound (4/05/00) failed to reveal any thermodynamically significant clot or lesion. As of 4/18/00, Dr. Groblewski's impression was one of right cerebellar CVA, probable thromboembolic or directly/indirectly related to injection. He anticipated that Mr. Chavis would improve over the course of the next six months. He provided opinions regarding Mr. Chavis' difficulties to inquiries posed by attorneys representing Mr. Chavis' Workers' Compensation case. Mr. Chavis continued to experience right upper extremity discomfort affecting the forearm and hand, though was reassured that the cerebellar stroke "should not cause the discomfort." He was to undergo EMG nerve conduction studies and was encouraged to advance his Neurontin as tolerated to 2-3 times a day. Nerve conduction studies (6/16/00) failed to reveal any evidence of radiculopathy or carpal tunnel syndrome.

Mr. Chavis has continued under orthopedic evaluation and diagnostic studies. Dr. Langdon A. Hartsock's assessment (9/15/00) was one of right shoulder impingement, subacromial bursitus, and decreased range of motion. He also assessed cervical spondylosis. Mr. Chavis also underwent evaluation with Michael S. Green, M.D. at Midland Orthopedics who provided work restrictions as well as impairment ratings.

Mr. Chavis was referred to the Pain Management Program at Palmetto Health Facility. This was conducted while he was under the care of Dr. Wilkins. Dr. Metcalf's assessment was one of peripheral neuropathy and he noted that imaging studies of the shoulder failed to demonstrate any abnormality of the rotator cuff. Recommendation was to wean Mr. Chavis down off Oxycodone and initiate use of Gavatril. He also recommended conduction of a functional capacities evaluation. Dr. Metcalf also recommended neuropsychological testing for assessment of Mr. Chavis' memory post-CVA. Clay Drummond, Ph.D. conducted psychological testing revealing moderate depression as well as a diagnosis of a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

In interview, I reviewed with Mr. Chavis the series of treatments and operative procedures he has undergone since suffering injury at his place of employment on 12/01/98. Subsequently, the series of interventions led up to the nerve block that was conducted resulting in the cerebellar infarct. I reviewed with him the acute difficulties following the procedure, as he has improved significantly since that period of time. I reviewed with him how he did not want to stay in the East Cooper facility and subsequently sought care with his family physician leading to the referral to Dr. Groblewski, neurologist.

With regard to current complaints, Mr. Chavis reported continuing pain in the left shoulder, offering that pain occurs in both extremities. He reported an impingement of the right upper extremity and muscle spasms affecting the left arm. He reported that headaches persist, though they have significantly improved since acutely following the procedure that led to cerebellar stroke. Headaches continue to be somewhat frequent with migrainous type symptomatology. He reported that his wife complains that he is very forgetful with decreased concentration. As he reported, "I can tell you about ten years ago, but I have trouble remembering things from yesterday."

During the course of my contacts with Mr. Chavis, he remained under the care of Jeffrey Wilkins, M.D. Reportedly, as of June 12th, he had undergone an injection to his left shoulder muscle with improvement in pain.

In separate interview on 5/29/02, I interviewed Mr. Chavis' wife. In interview, I reviewed the series of events that led to her husband's acute confusion and subsequent hospitalization at the East Cooper facility. She acknowledged that her husband has "been through a lot" since the work related injury. Currently, she views her husband as irritable and "ill a lot." She described him as emotional with crying spells. There is also an easy fatiguability. She stated that "he is not the same since the stroke," but also reported that he has improved significantly since acutely following the incident. Mr. Chavis reported some continuing language difficulties, stating "he still stutters if he gets excited." There was complaint of decreased capacity for attention and concentration. Ms. Chavis reported that her husband continues to experience pain in the shoulder region. She also stated, "he has aged so much." She further stated, "he hurts all the time." Of particular disappointment for Mr. Chavis was his loss of job at AVX as he could only return to light duty and "they didn't accept that." Ms. Chavis stated that her husband is "depressed about not working" and it has limited the couples ability "to do the things we want to do." Ms. Chavis remains employed with the Horry County Finance Office.

In initial evaluation, a structured symptom review failed to reveal any complaints by Mr. Chavis with regard to olfactory or gustatory processes. He reported episodic blurred vision that he related to his diabetes, thought stated, "it has been worse since the stroke." He further offered that blurred vision especially manifests "when reading." He denied diplopia. With regard to auditory acuity, there was no complaint of significant difficulties. There are infrequent episodes of tinnitus.

With regard to motor functioning, there was no evidence of paralysis, though Mr. Chavis complained of general weakness affecting his upper extremities. Acutely following the "stroke" there were significant balance problems, but he describes them as "minor now." He reported numbness in the 4th and 5th digits of the left and right hand. There was also report of paresthesias affecting his feet.

Mr. Chavis' primary complaint is of pain in the left arm as well as the right shoulder region. He reported burning pain in his feet likely related to peripheral neuropathy. Pain is aggravated by any physical exertion and particularly reaching over head. He obtains relief via use of medication.

Acutely following the injection and subsequent stroke, Mr. Chavis reported experiencing intense headache activity. Currently, headaches have significantly improved.

There was report of occasional dizziness, but no report of vertigo, blackout spells, or seizure activity.

With regard to cognitive processes, there were complaints of decreased capacity for concentration, easy distractibility, and an inability to think as quickly as before (bradyphrenia). Mr. Chavis reported that his wife specifically believes that he is having memory problems.

With regard to psychological functioning, Mr. Chavis admitted to problems with sadness/depression. Sleep was characterized as disturbed with difficulty falling asleep and middle of the night awakenings. There was no report of nightmare activity or specific symptomatology associated with the Posttraumatic Stress Disorder. Mr. Chavis did not currently view himself as disruptively anxious or tense. Nor did he report episodes of anger dyscontrol. There was report of excessive fatigue. There is concern regarding a potential to lose his wife, but no other evidence of paranoid ideation or delusional thinking. There was no report of phobic symptomatology. Mr. Chavis denied hallucinatory activity. He was without report of appetite disturbance. He was significantly concerned regarding erectile dysfunction, stating, "my sex life is gone" and further stating "Viagra doesn't even work."

Mr. Chavis, at the time of initiation of the evaluation was on Oxycodone with attempt to decrease his dosage regimen. He was also on Lipizid and Glucophage for a diabetic condition that was diagnosed approximately nine years ago.

Medical History: Significant for positive loss of consciousness in a motor vehicle accident in 1979. Mr. Chavis denied any serious after effects following his involvement in the motor vehicle accident. Mr. Chavis underwent a tracheotomy at age 10 months. Reportedly, he suffered an injury to his back while employed at AVX in 1996. He underwent shoulder surgery in 1999.

Other than diabetes, Mr. Chavis denied history of medical problems such as hypertension, serious infections, or cardiovascular difficulties. Mr. Chavis denied a history of migraine or tension headaches prior to the stroke.

There was no report of a history of psychiatric illness or need for formal treatment. Mr. Chavis denied lifelong problems with his nerves, depression, or mood swings. He denied any history of alcohol or illicit drug usage. He denied history of formal substance abuse treatment. He denied history of DUI or criminal arrest. He denied ever being the victim of sexual or physical abuse. He does not utilize tobacco products.

Family History: Significant for a father who had alcohol problems but has been recovering during the past 19 years. Mr. Chavis is unaware of any other family history for psychiatric illness or substance abuse problems.

Psychosocial Review: Mr. Chavis reported attending formal education through the 10th grade and subsequently attained his GED. Reportedly, there were three attempts to obtain his GED, and he passed it six to seven months after the cerebellar stroke. Reportedly, there was repetition of the 6th grade. Reportedly, he underwent evaluation at South Carolina Vocational Rehabilitation Department and received a report that he had a reading disorder. Reportedly, Vocational Rehabilitation Services assisted him with attaining the GED.

Mr. Chavis reported being employed with AVX for approximately 13 years. Reportedly, he was employed as a paste processor for a ten year period.

Mr. Chavis has been married to his current wife since 1988. Reportedly, he has been married on three previous occasions. Reportedly, there is one child in the home setting. Mr. Chavis reported being saved and converting to Christianity approximately 2 ½ years ago.

Procedures: Germane to the current evaluation was the conduction of a neuropsychological evaluation to determine if Mr. Chavis suffers from any neurocognitive impairments associated with brain behavior dysfunction. Test procedures included the Wechsler Adult Intelligence Scale-III, Wechsler Memory Scale-III, California Verbal Learning Test-II, Wide Range Achievement Test-Revision 3, Wechsler Test of Adult Reading, Aphasia Screening Exam, Sensory Perceptual Exam, Trail Making Test, Finger Tapping Test, Grooved Pegboard Test, Seashore Rhythm Test, Speech Sounds Perception Test, Controlled Oral Word Association Test, Stroop Test, Paced Auditory Serial Addition Test, Judgment of Line Orientation Test, Wisconsin Card Sorting Test, Behavioral Dyscontrol Scale, Multi Dimensional Pain Inventory, and Personality Assessment Inventory (PAI).

Examination Results:

Neurobehavioral Status: Mr. Chavis was on time for each of his scheduled appointments. He interacted well with the examiner and was pleasant in his interactions. Affect was euthymic and sensorium was clear. He was open and engaging in discussing his history of difficulties as well as his recent

improvement in overall functioning. There was no evidence of psychomotor retardation or excitation. Mr. Chavis had no difficulty with test instructions and worked in a straight forward, diligent fashion. He was observed to put forth good effort throughout the evaluative process. Specific assessment of effort was undertaken via administration of the Test of Memory Malingering (TOMM). Mr. Chavis' performance on the TOMM including his errorless performance on trial 2 was consistent with our observation of providing good effort. The obtained test results are viewed as a valid depiction of his current functioning.

Language Functions: There was no aphasic or agnostic symptomatology. Conversational speech was prosodic, fluent, of normal rate and tone without evidence of dysarthria. Mr. Chavis did not demonstrate any word finding difficulties in conversational speech. His performance on a formal test of verbal fluency was well within the average range (87th percentile). There was no evidence of receptive language dysfunction.

Intellectual/Academic Achievement: Mr. Chavis' performance on the Wechsler Adult Intelligence Scale-III (WAIS-III) classified his intellectual functioning to be in the average range with a Full Scale I.Q. of 91, a Verbal I.Q. of 88, and a Performance I.Q. of 99. Mr. Chavis' Full Scale I.Q. places him at the 27th percentile compared to age related peers. There was a significant discrepancy in his performance on verbal, educationally oriented tasks (21st percentile) compared to visual spatial integration tasks (47th percentile), a finding likely reflective of his lack of full educational attainment.

WAIS-III analysis revealed Mr. Chavis to score in the average range on tasks assessing working memory (66th percentile) and perceptual organizational skills (58th percentile). He was also in the average range on tasks assessing processing speed (39th percentile). He demonstrated significant weakness on verbal comprehension tests (9th percentile), again a finding likely related to his lack of profiting from formal educational experiences.

Analysis of separate WAIS-III scale performance was consistent with his lack of formal educational attainment as he was deficient with regard to his performance on tests assessing vocabulary skills (9th percentile) and general fund of information (5th percentile). In contrast, Mr. Chavis demonstrated strength on tests assessing letter/number sequencing (84th percentile) and matrix reasoning (84th percentile).

Mr. Chavis' academic achievement skills were assessed via administration of the Wide Range Achievement Test-Revision 3 (WRAT-3). He demonstrated deficient performance across the assessed tasks. Below are the standard scores, percentiles, and grade scores for each of the assessed academic areas:

	Standard Score	Percentile	Grade Score
Reading/Word Recognition	81	10	08
Spelling	70	02	05
Arithmetic	91	27	08

Mr. Chavis' performance on the Wechsler Test of Adult Reading provided a prediction of intellectual functioning that was consistent with that obtained in the current evaluation.

Attention/Memory Functioning: In addition to suffering from chronic pain, Mr. Chavis' primary complaint as the result of a cerebellar stroke was one of decreased capacity for attention/concentration and memory functioning.

In the current evaluation, Mr. Chavis demonstrated mildly slowed processing speed for word (T=42) and color (T=44) stimuli. He remained mildly slow but without added decrement on a divided [illegible]al task (T=41). Mr. Chavis scored in the average range on an attentional task demanding [illegible]rhythmic sounds (T=57). In contrast, he was impaired on a task demanding discrimination

of speech sounds and matching them to their phonemes (T=39). Mr. Chavis was able to meet the demands of the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed, attention/concentration, and immediate learning. He demonstrated a good initial trial performance with expected decrements in his performance as the trials became more rapid and demanding. His total recall performance on the PASAT was within average limits (T=46).

Mr. Chavis was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory functioning. Mr. Chavis demonstrated significant impairment in his performance across WMS-III tasks, attaining a general memory index score of 78 placing him at the 7th percentile. Mr. Chavis was deficient in his performance on WMS-III tasks assessing immediate auditory memory (6th percentile) as well as immediate visual memory (7th percentile). Mr. Chavis' performance on delayed auditory memory tasks fell at the 9th percentile with performance on delayed visual memory tasks falling at the 14th percentile. Mr. Chavis performed efficiently on WMS-III tasks assessing working memory (88th percentile).

Analysis of separate WMS-III scale performance revealed Mr. Chavis to be below average across a variety of immediate learning tasks including recall of orally presented story material and free recall of family pictorial stimuli. Mr. Chavis had difficulties retaining and recalling orally presented story material after a period of delay (percent retention =50). Immediate learning and reproduction of visual designs placed him at the 63rd percentile. Yet, Mr. Chavis had difficulties retaining and reproducing visual designs after a period of delay (16th percentile).

Mr. Chavis was administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Chavis' total recall score after five administrations of the word list placed him at the 48th percentile compared to age related peers. Observation of test performance revealed mild impairment in his initial learning trial, but a good ability to profit from repetitive administrations as he demonstrated the expected learning curve. Mr. Chavis showed a generally good ability to retain and recall word list information in a short and long delay, free and cued recall process. There was evidence of mildly excessive intrusive errors. Mr. Chavis performed efficiently on a recognition task demanding that he discriminate target from non-target words.

Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Chavis' performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 58th percentile. Mr. Chavis was less efficient in his performance on a task demanding fine discriminations of lines in space (9th percentile). On a visuographic sequencing test involving the serial processing of numbers, he was within average limits (T=59). When the task became more demanding, involving alternations between numbers and letters in sequential fashion, he remained within average limits (T=61).

Executive/Higher Reasoning Skills: Mr. Chavis had no difficulties inhibiting and sequencing fine motor movements on go-no go types of tasks. He was able to meet the demands of a word genertivity test as well as the set shifting skills associated with Trail Making Test-Part B.

On the WAIS-III, Mr. Chavis was variable in his performance but generally scored in the average range on tasks demanding higher reasoning and problem solving skills.

Mr. Chavis was efficient in his performance on the Wisconsin Card Sorting Test. He showed a good ability to methodically generate hypotheses, to discern the correct hypotheses, as well as to shift the basis of his responding when the externally imposed demands of the task necessitated this. He attained the expected categories on this test with a low rate of perseverative errors and one failure to maintain set.

Sensory/Motor Functions: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile, auditory, or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Chavis performed errorlessly on a tactile finger recognition test. He had no difficulty recognizing tactile forms in his extremities.

Mr. Chavis reports being right hand dominant. There has been obvious pain and physical limitations affecting his upper extremities, particularly with regard to physical exertion and reaching overhead. On a test demanding fine motor speed (Finger Tapping Test), Mr. Chavis performed within average limits. He was less efficient, scoring in the impaired range bilaterally, on a test demanding fine motor speed and dexterity (Grooved Pegboard Test). Mr. Chavis was noted to ambulate without difficulty or complaint.

Emotional/Mood State Functioning: This has obviously been a very difficult course of events for Mr. Chavis since he sustained his work related injury in December of 1998. It appears that while undergoing a nerve block, he suffered a cerebellar stroke with acute difficulties that have significantly cleared with the passage of time. Multiple medical problems as well as stressors associated with unemployment and financial concerns have certainly impacted significantly on Mr. Chavis as well as his wife. He remains suffering from chronic pain and has experienced episodes of depression and continuing sleep disturbance (difficulty falling asleep and middle of the night awakenings). Mr. Chavis remains quite fragile and vulnerable with concerns that his wife will leave him due to his failure to be a full partner both financially and sexually. There have been difficulties getting along with his spouse, and he has experienced a significant decline in his ability to pursue social and recreational activities. Previous evaluations have confirmed depression as well as chronic pain associated with psychological factors and a general medical condition.

In the current evaluation, Mr. Chavis' responses to psychological testing revealed him to have a negative view of himself and a tendency to view his current situation in a negative manner. The response set is indicative of a "cry for help."

The corresponding clinical profile is consistent with clinical interview in revealing an individual who views his life as being severely disrupted by a variety of medical/physical problems. There is complaint of chronic pain, somatic difficulties, and physical problems that have left him unhappy, with little energy or enthusiasm with which to concentrate on important life tasks, and little hope for improvement in the future.

Separate scale elevations are consistent with ongoing pain and somatic difficulties in a person who is depressed, anxious, and somewhat wary and sensitive with regard to interpersonal relations.

Mr. Chavis denied being disturbed by thoughts of self harm. He reported his temper as being within the normal range.

On the Multi Dimensional Pain Inventory, Mr. Chavis reported experiencing intense pain on a daily basis that extremely interferes with his ability to work and to attain satisfaction and enjoyment from participation in social and recreational activities.

Ms. Chavis completed a Symptom Checklist regarding her husband's current functioning. She viewed her husband as having severe difficulties with headaches, nausea, numbness or tingling on parts of his body, forgetfulness, fatigue, sleep disturbance, feeling depressed or sad, irritability/easily annoyed, and poor frustration tolerance/feeling easily overwhelmed by things.

Summary/Integration: I had the opportunity to provide Mr. Chavis feedback regarding the neuropsychological evaluation. The course of his medical difficulties as well as the manifestation of a cerebellar infarct have been well documented in the medical records. Acutely after sustaining the stroke, he

experienced confusion and other neurocognitive difficulties that would be expected. He has shown significant improvement with the passage of time.

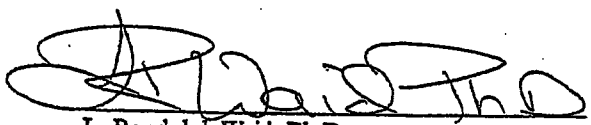
Neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected considering the location of the stroke. Attention/concentration appears to be intact, though there was notable variability in his performance on memory/learning tasks. Indeed, there is compelling evidence of reduced capacity for immediate learning/memory, but no evidence of rapid forgetting or amnestic syndrome. There is no compelling evidence for impairment affecting visual spatial skills, receptive or expressive language functions, or sensory perceptual functions. Mr. Chavis was generally efficient and commensurate with his intellectual/educational level in his performance on tasks assessing executive/higher reasoning skills.

Assessment of emotional functioning reveals an individual who continues to suffer from chronic pain and comorbid depressive and anxious difficulties. This has been a highly stressful period for Mr. Chavis and his wife, and it certainly has affected the quality their life.

In summary, there is neuroradiographic evidence of the sustainment of a cerebellar stroke as well as some residual impairments affecting Mr. Chavis' capacity for learning/memory functioning. A great obstacle for Mr. Chavis' return to life pursuits is continuing pain and physical limitations. I would agree with previous diagnoses of Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89) as well as Depressive Disorder, NOS (311). Mr. Chavis likely experiences a mild reduction in overall neurocognitive functioning consistent with the location of stroke. There is not extreme interference in his overall cognitive processing.

Mr. Chavis remains in need of care directed toward his chronic pain syndrome and comorbid psychological problems. Clearly, pain and physical limitations serve as the primary obstacle with regard to his successful return to vocational and social pursuits. These difficulties also serve as an obstacle to efficient neurocognitive functioning.

Thank you for allowing me to participate in the evaluative care of Mr. Gilbert Chavis. If you have any questions regarding the evaluation or report, please feel free to contact me.



L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist
Clinical Associate Professor in Psychiatry/Neurology, MUSC

LRW/emf

Re: Gilbert Chavis, Employee
S.C.W.C.C.#9826170
AVX, Employer

1) Based on the history you took, your testing and treatment, and your medical knowledge and background, was the right cerebellar infart Mr. Chavis sustained most likely caused by the C6 nerve root block injection he had done on that date?

Yes ✓ No ____

2) Has Mr. Chavis reached Maximum Medical Improvement from that injury/condition?

Yes ✓ No ____

3) Did he most likely sustain any permanent brain damage as a result of the right cerebella infart?

Yes ✓ No ____

4) Did he sustain any permanent bodily impairment as a result of the right cerebella infart? If so, how much?

Yes ✓ → Has not been seen in a while Current level?
No ____

5 %

5) What is his prognosis? Any further treatment necessary? Good Not re stroke

Date 2/12/01

Daniel B. Groblewoski, M.D.

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NERVE CONDUCTION STUDY

DATE: June 16, 2000

PATIENT: Gilbert Chavis

REFERRING PHYSICIAN: Daniel B. Groblewski, M.D.

HISTORY: Mr. Chavis is a 45-year-old male, diabetic, known to have a rotator cuff tear on the right, who is having pain in the right arm and hand.

Motor nerve conduction velocity over the right median nerve is normal at 41.1 meters per second. The distal latency is normal at 3.8 milliseconds. Sensory latency is normal at 3.5 milliseconds. Sensory velocity is normal at 56.1 meters per second.

Motor nerve conduction velocity over the right ulnar is normal at 52.3 meters per second. Distal latency is normal at 2.8 milliseconds. Sensory latency is normal at 3.0 milliseconds. Sensory velocity is normal at 57.5 meters per second and around the elbow at 63.0 meters per second.

Late latency using the ulnar F-wave response is normal at 30.1 milliseconds.

EMG right upper extremity including cervical paraspinous normal.

IMPRESSION:
Normal study. No evidence of radiculopathy or carpal tunnel syndrome.

Michael L. Hodge, M.D.
Clinical Professor of Neurology, MUSC

MLH/mdh

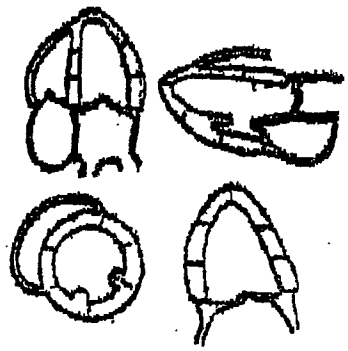
6/20/00

CONWAY HOSPITAL
ECHOCARDIOGRAPHIC REPORT

Patient Info

Patient: Chavis, Gilbert
Patient ID: 5114980 188399
Birthdate: 12-7-54
Sex: M
Weight: . lbs Height: . in
BSA: m^2
Referring doctor: Dr. D. Grabowski
Operator ID: SWB

Examination date: 3-22-00
Referral reason: C.O.A



M-Mode Measurements w/ Normals

Ao = 3.30cm	(2.2-3.7)
AV = 1.90cm	(1.5-2.6)
LAOs = 3.10cm	(2.5-4.0)
IVSd = 1.67 cm	(.7-1.3)
LVPWd = 1.61 cm	(.7-1.3)
LVDd = 3.62 cm	(4.0-5.8)
LVDs = 2.31 cm	(2.0-3.8)
LVEF = 66 %	(>50%)
RVDd = 1.19 cm	(<2.6)

2-D & Doppler

Interpretation

Normal EF
Normal wall motion
MVP
Trace MR
No Pericardial Effusion

DATE RECEIVED: 3-27-00

Signature

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RE EVALUATION NOTE

DATE: June 9, 2000

PATIENT: Gilbert Chavis

The patient is well known to myself from my initial evaluation for a cerebellar stroke who is now being followed by Pee Dee Orthopedics for possible impingement syndrome in the right shoulder. The patient has been experiencing increasing pain beyond his shoulder and arm area now into the forearm and hand. He was evaluated by Dr. Edwards for an MRI scan of the cervical spine which was performed to rule out radiculopathy, which showed some disc bulging at C5-6 but no significant entrapment or impingement on nerve roots. He is referred on for a neurological evaluation of his hand and forearm pain. The patient tells me that the pain below his elbow into the forearm and hand started following his stroke. Basically it is an aching type discomfort that sometimes is sharp and extends through the medial aspect of the forearm and into the hand involving digits four and five completely and part of three. There is no numbness, loss of sensation, dysesthesias and really denies any significant weakness. He has recently been started on Neurontin which seems to help some and is at a dose of 300 mg t.i.d. He is still taking Oxycodone two tablets every four to six hours. He is complaining of some episodic imbalance with no falls as well as constipation. His other medications include Glipizide, Glucotrol.

PHYSICAL EXAMINATION: Blood pressure 128/98. In general, he is a well-developed, well nourished white male, no apparent distress, not demonstrating any pain type behavior, though he is guarding the right arm. HEENT: normocephalic atraumatic. Neck is supple. Cranial nerves II-XII are intact. Motor examination shows no wasting or fasciculations in the extremities. He has incomplete abduction at the shoulder to about 45 degrees, but the biceps and triceps strength is about +4. Wrist extension, flexion, intrinsic hand muscle abduction, finger opposition, grip are all 5/5 on the right. The remainder of his extremities are easily 5/5 proximal to

distal. Reflexes in the upper extremities are about 2 symmetrical as well as in the lower extremities. He has a flexor plantar response bilaterally. Finger to nose and heel to shin testing are intact and his gait shows a good toe, tandem and heel walk. Sensory testing of the upper extremities shows only a mild decrease to pain of the dorsum of the hand medially. Otherwise no significant deficits to primary modalities. He has a negative Tinel's sign at the elbow and wrist. There is minimal tenderness to deep palpation in his metacarpal joints. He has some mild tenderness to the right paracervical region as well as over the shoulder in a non-trigger point fashion.

IMPRESSION:
Right upper extremity discomfort to the forearm and hand, will consider ulnar neuropathy, less likely radiculopathy with normal MRI scan.

I reassured the patient that his cerebellar stroke should not cause this discomfort. He is going to be scheduled for an EMG nerve conduction study right upper extremity. I encouraged him to advance his Neurontin as tolerated to two three times a day. I added a Catapres patch and encouraged him to cut back on his Oxycodone as much as possible. I also explained that his constipation was a result of the narcotics and he should be taking Milk of Magnesia at bedtime, pushing plenty of fluids. I will see him back after the electrical studies.

Daniel B. Groblewski, M.D.

DBG/mdh

cc: Pee Dee Orthopedics

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FOLLOW-UP NOTE

DATE: April 18, 2000

PATIENT: Gilbert Chavis

HISTORY: The patient is a 45-year-old white male with the diagnosis of diabetes, pending right shoulder rotator cuff repair with cerebellar CVA. He has had symptoms of ataxia and diplopia. Echocardiogram was performed at Conway Hospital 3/22/00 and was basically unremarkable. We obtained an MRI scan of the brain through disc imaging 4/13/00 and I understand previous films were available for comparison and the results of the MRI scan showed the right cerebellar infact has diminished in size. There was no abnormal enhancement or other abnormalities noted on the imaging. The patient follows up today and tells me that he has been doing much better. His walking is back to about 90%, still with occasional balance difficulty, but no falls. His diplopia has completely resolved. He still gets a little tired easily and his voice will occasionally stutter. But, overall he seems to be improving.

REVIEW OF SYSTEMS: Positive for constipation for about 2 months. He has had some decrease in his sex drive, but this is slowly starting to come back. He was on Elavil that I prescribed for him for about 3 to 4 weeks and once his prescription ran out, he has now been off the Elavil for about 2 weeks. He still takes occasional p.r.n. Oxycontin, Glipizide and another diabetic medication.

PHYSICAL EXAMINATION: Today, the patient is alert and oriented times 4. He is in no apparent distress or demonstrating any pain type behavior.

NEUROLOGICAL EXAMINATION: Cranial nerves II-XII are intact. There is no ophthalmoplegia. Good facial symmetry. Tongue is midline. Motor exam shows good strength, although limited in the right upper extremity. Coordination is intact finger-to-nose bilaterally as well as heel-to-shin. Gait is non-ataxic. He demonstrated an excellent tandem walk.

IMPRESSION AND PLAN:

1) Right cerebellar CVA, probable thromboembolic or directly/indirectly related to injection.

We have not received the results of the coagulopathy workup; however, there is certainly a clear association between the procedure and the symptoms. Coagulopathy is very unlikely. I still would recommend a coagulopathy panel be followed through, especially given his young age. Anti-platelet therapy, probably an Aspirin a day, should be sufficient at this point. I will release him to his orthopedic doctor so that they may proceed with surgery being that it is just about 3 months out and should be safe enough. He has demonstrated overall improvement and I anticipate that he should continue to show improvement over the next 6 months. I explained to Mr. Chavis that it was certainly possible that he could have some residual neurological deficit, although even at this point he has shown dramatic improvement being relatively close to his baseline. If there are any other questions regarding his neurological status, I would be glad to see him in follow-up for re-evaluation.

Daniel B. Groblewski, M.D.
DBG/hbc

RETURN TO WORK OR SCHOOL

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(803) 347-4196

Date: 4/18/00

This is to certify that:

Gilbert Chavis

has been under my care for the following:

STROKE

and is able to return to work / school on: _____

Remarks: Will release but no work until evaluation by orthopedics.

(SIGNATURE)

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CAROTID ULTRASOUND

DATE: April 5, 2000

PATIENT: Gilbert Chavis

The patient is a 45-year-old patient who was involved in a Workman's Compensation accident and injured his left shoulder. He has had Epidural injections. He has had black-outs during this period of time.

Carotid-duplex study was performed in multiple plains with an Ultramark 9 ATL with both Duplex and color.

Right side reveals interval thickening in the bulb. Doppler velocity is within normal limits. Diameter stenosis is estimated at 1 to 20%.

Left side reveals interval thickening in the bulb. Doppler velocity is within normal limits. Diameter stenosis is estimated at 1 to 20%.

IMPRESSION: No hemodynamically significant clot or lesion identified on either side.

Ashley D. Kent, MD
ASK/hbc

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FOLLOW-UP NOTE

DATE: March 7, 2000

PATIENT: Gilbert Chavis

HISTORY: The patient is a 45-year-old white male with diabetes and now with a cerebellar CVA in the process of being worked up. The patient was last seen by me on February 15th and we attempted to proceed with workup for CVA to include non-invasive carotid studies, coagulopathy panel and echocardiogram. Unfortunately, the patient did not follow through secondary to lack of approval by Workman's Compensation. The patient was started on Elavil for what I believed were musole contraction type and he was also given a prescription for Midrin, but could not afford this medication. He took the Elavil and he is now up to 50 mg and is still having headaches. Also, the patient complains of a fall times one, after bending over in his yard and losing his balance. He still has difficulty moving fast and has a tendency to lag behind his wife when out shopping. This causes him embarrassment. He loses his balance easily, although there has only been one interval fall, as described above. He is tired all the time. He complains of persistent shoulder pain and his sleep is only marginal. He had double vision while watching TV, but this has resolved, although he still has the double vision when he lays down. He has been complaining of decreased libido, which has happened since his syncopal spell. He has no new neurological complaints.

MEDICATIONS: Tylox 10-12 qd, Valium 5 mg t.i.d., Glyburide and Elavil 50 mg qd.

PHYSICAL EXAMINATION: In general, the patient is a well-developed, well-nourished white male who is in no apparent distress and not demonstrating any pain type behavior. HEENT, normocephalic, atraumatic. Neck is supple. Funduscopic exam is clear. Cardiac revealed a regular rate and rhythm.

NEUROLOGICAL EXAMINATION: The patient is alert and oriented times 4. Cranial II-XII appear to be intact. There is no ophthalmoplegia noted. Motor examination shows drifting in the right upper extremity, although he has okay resistance testing proximal to distal in all of his extremities. Reflexes are symmetric at about 2 and he has a flexor plantar response bilaterally. Coordination testing is intact, finger-to-nose and heel-to-shin. Gait was non-ataxic. He could do a good toe and heel walk. He had difficulty with tandem.

IMPRESSION AND PLAN:

1) Probable right cerebellar infarct. We will reattempt workup with Workman's Compensation approval.
2) Rotator cuff tear. Pending evaluation at Strand Orthopaedics.
3) Diabetes.
4) Headaches, probably muscle contraction type.

The patient is instructed to advance his Elavil by another 25 mg at bed time. He will be scheduled for physical therapy to help with balance and gait assistance. I do not recommend that he go back to work for another 6 weeks until he is re-evaluated. Also, he I suspect his shoulder will limit him in regards to his work performance. After another 6 weeks, I would recommend repeating the MRI scan of the brain for interval change. The patient had questions regarding work. Certainly, now with his persistent neurological complaints, especially balance difficulty, I would not recommend going back to work until we follow through with rehabilitation, stroke workup as well as orthopaedics.

Daniel B. Groblewski, MD
DBG/hbc

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FOLLOW-UP NOTE

DATE: February 15, 2000

PATIENT: Gilbert Chavis

HISTORY: The patient is a 45-year-old white male with diabetes who was sent to my office for evaluation of syncope on January 31st. Per my initial evaluation, his examination seemed to be non-lateralizing, although his complaints were of concern, which included imbalance and episodic diplopia, which may have suggested a posterior fossa problem. On Friday, 2/11/00, the patient called in with a bad headache, which had lasted for about 3 days in duration. Symptoms were slow in onset, but he seemed to complain of a pain that was coming from his neck area, up over the back of his head. Almost at the same time I received a report of his MRI scan, which showed a right cerebellar stroke. At that time the patient informed me that although he had been having a headache, his other neurological symptoms including imbalance and visual disturbance, seemed to be slowly getting better. He was instructed to report to the emergency room for evaluation of his headache, which seems to be a new complaint. In the emergency room, it was noted that he had some neck and occipital lobe discomfort, which was thought to be secondary to chronic neck pain, possibly tension. He also described interval improvement after taking a shower. He received some conservative treatment with IV medication and he was discharged from the emergency room in improved condition. The patient desired to leave the emergency room because he was to take a test on Saturday morning. He was instructed to follow up with my office today.

The patient tells me that his headache is somewhat improved today, although now he believes it started in the front. He through initially this was a sinus headache. He does not have any sinus type symptoms such as discharge or drainage. He has been taking Valium and other medication that he received from the emergency room that seems to help him sleep. He still feels episodically off-balance and occasionally has to grab on, his vision occasionally doubles primarily when lying back watching T.V.

There are no other new neurological complaints. No previous history of migraine headaches. He has had this type of headache in the past.

PHYSICAL EXAMINATION: The patient is in no apparent distress and he is not demonstrating any pain type behavior. Neck is supple. There is minimal tenderness over

the neck and upper back. TM's are clear bilaterally. Funduscopic exam shows no papilla edema. No carotid bruits. Cardiac exam is a regular rate and rhythm.

NEUROLOGICAL EXAMINATION: The patient is alert and oriented times 4. Cranial nerves II-XII are intact. No nystagmus is noted. There is good facial asymmetry. He has limitation of motion primarily in the proximal upper extremities secondary to discomfort, but going more distally, his strength is more intact. Intact proximal and distal lower extremities. Tone is normal. Reflexes are intact at about 2. Flexor plantar response bilaterally. There is no hypertonia. Coordination testing is intact, finger-to-nose and heel-to-shin. Gait shows a good tandem, toe and heel walk. Sensory testing is intact to pain and light touch, proprioseption throughout.

IMPRESSION:
1) Probable right cerebellar infarct, etiology unclear at this point.
2) Right rotator cuff tear.
3) Diabetes.
4) Headaches, probable muscle contraction type.

Certainly, the patient does have a risk factor for cerebrovascular disease, which would include diabetes. Association to his Epidural injection and syncopal spell is unclear.

The patient is encouraged to take 1 Aspirin per day. The patient will be scheduled for non-invasive carotid studies, coagulopathy panel and cardiogram. He is pending rotator cuff repair, but at this time I would recommend this procedure be delayed until we get a better idea of the source of his stroke. The imaging seems relatively convincing for CVA, although we may want to consider re-imaging in 3 months to rule out a neoplasm.

The patient is going to be started on Elavil 25 mg to advance to 2 tablets after one week as tolerated for his headaches. I have provided him with a prescription of Midrin to use for abortive therapy.

The patient will follow back up in 4 to 6 weeks.

Daniel B. Groblewski, MD

DBG/hbc
CC: Lewis Lawson, MD
J. Pressler, MD

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January 31, 2000

Lewis Lawson, MD

RE: Gilbert Chavis

Dear Dr. Lawson:

Thank you for referring Mr. Chavis to our clinic for evaluation of his syncopal spell.

HISTORY: As you recall, the patient is a 45-year-old male with a history of diabetes who now presents for evaluation of syncope.

According to the patient, one week ago this past Tuesday, he was at Mt. Pleasant Disc Imaging for what sounded like an Epidural nerve block. Supposedly, the patient has been having disc and shoulder discomfort. He remembered having two occasions of pain during the injection and somewhere just around the 2nd episode of pain in his neck, he supposedly blacked out. No records are available and there was no witnessed seizure activity. The patient has no recall of the event, no bowel or bladder incontinence was noted and no tongue biting. He was taken to Roper Hospital for evaluation and was admitted. To the best of his knowledge, the day after blacking out, he felt very weak and had difficulty talking. By the evening time, the patient could sit up, but had some difficulty. He was walking with assistance. He still felt somewhat groggy and sleepy the next day. Some time during the hospitalization, he had feelings as if something were crawling up his legs. His speech was supposedly also affected, more specifically having difficulty getting words out. I do not have records of this hospitalization, but supposedly he was discharged after about 24 hours.

Unfortunately, the patient has been complaining of persistent difficulty. He has felt sleepy and weak all week long. His speech is getting better, he still complains of difficulty getting words out. He feels off-balanced when he ambulates, but he has not fallen. Also, he complains of diplopia mainly on trying to focus on the TV. The only other visual disturbance was seeing bugs out the corner of his eyes crawling up the wall and this was during his 1st night of hospitalization, but this has not been a problem since that time.

Overall, there has been an interval improvement in the patient's symptoms. He is not taking any sedating type medications. The patient has never experienced a seizure, alteration of consciousness, oral facial automatism or syncope. He denies any chest pain, heart palpitations or shortness of breath.

PAST MEDICAL HISTORY: He is allergic to Codeine. The patient's history is positive for diabetes (approximately 8 years), right shoulder arthroscopy secondary to rotator cuff tear from a lifting accident, August 1999, resection of a growth from the rectum at the age of 13, paratracheal injury at 10 months of age. The patient's history is negative for hypertension, CVA, MI, migraine headaches, seizures and tobacco.

MEDICATIONS: Glipizide for diabetes.

FAMILY MEDICAL HISTORY: There are no significant familial conditions.

SOCIAL HISTORY: The patient is married. He is employed at the AVX Corporation as a paste processor.

PHYSICAL EXAMINATION: The patient's blood pressure is 140/90 and pulse is running in the 70's. In general, he is a well-developed, well-nourished white male in no apparent distress and not demonstrating any pain type behavior. HEENT, normocephalic, atraumatic. Neck is supple. Funduscopic examination is clear. No carotid bruits are noted. Cardiac exam shows a regular rate and rhythm without murmur or gallop.

NEUROLOGICAL EXAMINATION: The patient is alert and oriented times 4. Cranial nerves II-XII were intact. Speech was non-dysarthric or aphasic. There was no nystagmus. There was no ophthalmoplegia. Pupils were about 3 millimeters, reactive to light bilaterally. He has good facial symmetry. There is no speech difficulty. Motor examination shows normal bulk and tone throughout. No pronation or drift. Strength is symmetric proximal to distal with the exception of some give away in the right upper extremity secondary to discomfort. Reflexes are 2 symmetric. Flexor plantar response bilaterally. Coordination testing intact, finger-to-nose and heel-to-shin. Gait showed good toe and heel walk, but he had some difficulty on tandem. Sensory testing was intact to all primary modalities.

IMPRESSION:

1) Syncope. The most likely explanation is probably neurocardiogenic secondary to pain.
2) Persistent lethargy, ataxia, speech difficulty. Unclear.
3) Diabetes.

The patient's neurological examination appears to be intact. I reassured the patient regarding the syncope in that I doubt that this was an epileptic event. Most other records or information suggests otherwise. I do not have an explanation for his persistent neurological complaints and certainly cannot associate it to a direct effect of the Epidural injection.

The only other explanation would be some type of superimposed pre-existing brain lesion. Although my suspicion is low, I am going to have the patient imaged with an MRI scan. If the MRI scan is negative, I would not recommend any further evaluation, especially since his symptoms seem to be resolving.

If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

Daniel B. Groblewski, MD

DBG/hbc

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
Orthopaedic Surgery
Sports Medicine

J. Stewart Haskin, Jr., M.D.
Orthopaedic Surgery
Surgery of the Hand

A. Jay Preslar III, M.D.
Orthopaedic Surgery
Shoulder Surgery

William L. Mills, M.D.
Orthopaedic Surgery
Spinal Surgery

Jeffrey C. Wilkins, M.D.
Physical Medicine and Rehabilitation
Electrodiagnosis

Ross Taylor, M.D.
Orthopaedic Surgery
Surgery of the Foot and Ankle

C. Curtis Elliott, M.D.
Orthopaedic Surgery
Sports Medicine

May 31, 2005

Preston F. McDaniel
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, SC 29201

RE: GILBERT CHAVIS
DOB: 12/07/1954
Our Case No: 20347

Dear Mr. McDaniel:

I am writing in response to your letter of April 15, 2005, regarding Gilbert Chavis. I have reviewed the records available to me regarding Mr. Chavis. Based on the third MRI of that right shoulder done at Conway Hospital on 6/29/01 and including an arthrogram. I do not think there is any evidence that he re-injured his shoulder in his workman's comp accident of December 27, 1999.

With regard to the cervical spine, he had had some previous cervical spine complaints and had received a 5% whole person impairment rating related to the cervical spine by Dr. Wilkins on December 2, 1997. It is not clear to me if he had a preceding cervical MRI. We did order a cervical MRI which was done in January, 2000, showed multilevel disease with moderate central and right sided bulge at C5-6. This certainly could have been due to his work injury of December 27, 1999.

2376 Cypress Circle, Suite 300 • Conway, South Carolina 29526 • 843.347.7223 • fax 843.347.2205

RE: GILBERT CHAVIS

I hope this information is helpful in your evaluation of his case.

Sincerely,

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

A. Jay Preslar, III, MD

AJP/dsh
142146

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

SECTION A: TO BE COMPLETED BY THE SUPERVISOR

EMPLOYEE NAME: Gilbert Chavis SSN: 248-04-2224 TITLE: Past Processor

DEPT-SEC-SHIFT: 29-29-01 DATE OF HIRE: 12-3-87 TIME ON THIS JOB: _____

DATE/TIME OF ACCIDENT: 12-27-99 LOCATION OF ACCIDENT: Production floor

SECTION B: TO BE COMPLETED BY THE EMPLOYEE

Time 8:00-8:30

DESCRIBE THE ACCIDENT: Moving pot of work on a set of bad wheels. Pot came halfway off wheels. When I tried to keep the pot on the wheels my back began to burn. Now at 2:30 P.M. back is not burning but hurts when I pick up something

LIST ANY WITNESSES: Toni

EMPLOYEE SIGNATURE: Gilbert R. Chavis DATE: 12-27-99

SECTION C: TO BE COMPLETED BY THE SUPERVISOR

DESCRIBE THE ACCIDENT: _____

CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN: _____

COMPLETION DATE OR EXPECTED COMPLETION DATE: _____

SAFETY RULES VIOLATED? : YES/ NO DISCIPLINARY ACTION TAKEN: YES/NO

NAME : _____ _____ DATE: _____

(PRINT) (SIGNATURE)

SECTION D: TO BE COMPLETED BY THE INFIRMARY

NEAR MISS: _____ RECORDABLE: _____ INJURED BODY PART(S) : _____

_____ CODE(S): _____

MINOR : _____ LOST WORKDAY: _____ TYPE OF INJURY/ILLNES: _____

TREATMENT: _____ _____ CODE(S): _____

SECTION E: TO BE COMPLETED BY THE SAFETY DEPARTMENT

REMARKS: _____

ACCIDENT CAUSE: _____ (CODES) _____

NAME : _____ _____ DATE: _____

(PRINT) (SIGNATURE)

NOTE: THE SAFETY DEPARTMENT WILL COPY COMPLETED REPORT TO AREA MANAGEMENT AND SUPERVISOR

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
J. Stewart Haskin, Jr., M.D.
A. Jay Preslar III, M.D.
William L. Mills, M.D.
Jeffrey C. Wilkins, M.D.

MUSCULOSKELETAL EVALUATION

Gilbert Chavis

Date: July 5, 2000
Case No: 20347
Age Race Sex:
Referred By: Daniel Groblewski, M.D.

COMPLAINT: Torn rotator cuff in right shoulder and bulging disc in neck.

HISTORY: Mr. Chavis returns today, apparently suffered a stroke around the time of a selective nerve root block and his pain he states from that time is below his elbow to his fourth and fifth digits of his right hand. Continued shoulder pain. He is currently out of work. We reviewed a lumbar MRI which revealed a herniation at C5-6 with significant cord compression resulting in foraminal stenosis. No new bowel or bladder dysfunction, fever, chills or weight loss. He is on Neurontin, Glipizide and Glucophage. Denies smoking or ethanol use. No change in his medical problems.

ALLERGY TO HYDROCODONE.

PHYSICAL EXAM: Good internal rotation and strength with full range of motion passively. Reflexes are normal. Negative Spurling's sign. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted.
VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency.

X-RAYS / LAB:

IMPRESSION: C6 radiculopathy. Rotator cuff.

RECOMMENDATION: I agree with Dr. Elvington and I think improvement of his cervicogenic problem should be first. He apparently has been turned down for surgery by Dr. Edwards. We will proceed with a course of physical therapy focusing on ~~lumbar~~ traction. If this is not beneficial in two weeks, would give consideration to reblock if Mr. Chavis agrees which really enforces the matter in light of the previous circumstances.

Jeffrey C. Wilkins, M.D. dsh

CC: Daniel Groblewski, M.D. CC: WC

1400 Highway 544 Conway, SC 29526-8485 • (803) 347-7222 • FAX (803) 347-3305

Re: Gilbert Chavis
W.C.C. File No. 9826170

1) I am Gilbert's treating orthopedist for his work-related right arm and shoulder injury and I referred him for an injection in ~~the shoulder/arm~~ his neck on January 26, 2000, in Charleston, S.C. (Disc, Inc.).

Yes ✓ No____

2) During that procedure, he ~~developed a seizure that was caused by the injection; as a result, he had vertigo and ataxia, and had to have a Brain MRI.~~ had, by report, some type of reaction that may have been related to it.

Yes ✓ No____

As a result of that event we recommended a referral + evaluation by a neurologist

3) I postponed surgery on February 21, pending further testing, but he still needs the surgery.

Yes ✓ No____

4) He is still unable to work because of his arm/shoulder injury.

Yes ✓ No____

Any Other Comments:

Date: 3/2/00

Jay Preslar III, M.D.

February 25, 2000

A. Jay Preslar, III, M.D. /pmc

Gilbert Chavis
Case No.: 20347

Mr. Chavis apparently came in ~~today~~ the other day to see Dr. Wilkins and has apparently told Dr. Wilkins that he is no longer comfortable with me taking care of him orthopaedically. I would, therefore, recommend that he be referred to Dr. Elvington at Pee Dee Orthopaedics in Florence for his further orthopaedic care. We will arrange that appointment for him. We will give him pain medicines until the date of that appointment and after that he would need to get his medicines from Dr. Elvington. There have also been questions about his being evaluated by Dr. Groblewski and the relationship of that work up to his Workers Comp. Injury. He apparently had some type of episode when he was down at Disc, and this was related to a test that we recommended as part of work up and treatment of his Workers Comp. injury. Therefore, I feel that the evaluation and treatment by Dr. Groblewski is related to his Workers Comp. problem AT THIS POINT IN TIME. However, it is certainly possible that the ultimate decision would be that the changes seen on the brain MRI preexisted any of these problems, and it would at that point in time be determined that it is independent of his Workers Comp. case. I am not in a medical position to make that determination. That would need to be done by a neurologist, and we have referred him to Dr. Groblewski.

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

FAXED 2/25 to Tony

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

1400 Hwy. 544
Conway, South Carolina 29526

(843) 347-7522 FAX: (843) 347-3305

Work and/or School Release

Date 2-25-00 Chart 20347

RE Gilbert Chavis

Diagnosis (R) shoulder pn, partial rot cuff tear

Please be advised that the above named patient:
(✓) Was seen in this office on the following dates: 2-1-00

( ) May return to full duty on

(✓) May not return to work until further astive, and/or eval by DR. Groblesk.

( ) May return to light duty

( ) May not participate in

Return Appointment

☐ James W. Yates, Jr., M.D.
☐ A. Jay Preslar III, M.D.
☐ William L. Mills, M.D.
☐ J. Stewart Haskin, Jr., M.D.
☐ Jeffrey C. Wilkins, M.D.

CLK

CONWAY HOSPITAL
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

NAME: CHAVIS,GILBERT
PHYS: Preslar,Arthur J. III MD
DOB: 12/07/1954 AGE: 45 SEX: M
ACCT: V00005106890 LOC: PAT
EXAM DATE: 02/07/2000 STATUS: REG CL
RADIOLOGY NO: 00112659
UNIT NO: M000188399
PATIENT PHONE: (843)347-5748
CPT4 CODE: 70553

Arthur J. Preslar III MD
1400 Highway 544
Conway, SC 29526

(843)347-7222

ADMITTING DX: RT SHOULDER PAIN/ROTATOR CUFF TEAR
EXAMS: 00004470 BRAIN W/ AND W/O CONTRAST

STUDY: MRI OF THE BRAIN 2/7/00

HISTORY: ATAXIA AND SYNCOPE.

TECHNIQUE: Sagittal T1, axial double echo T2, axial flair, axial and coronal post Gadolinium T1 images of the brain and diffusion weighted images of the brain.

FINDINGS: The ventricles and sulci are of normal size and configuration for the patient's age. There are no abnormal extra-axial fluid collections, or evidence for intraparenchymal mass.

There is abnormal flair signal and enhancement in the right cerebellar hemisphere, measuring approximately 1 x 2 cm. It has a somewhat amorphous calcification, some of this is likely subcortical. There is an additional areas of abnormal T2, flair signal and enhancement involving the right mid brain immediately above the cerebellar peduncle on the right side, this measures 2-3 mm. in size. The diffusion weighted images are normal. Flow voids are identified within the major intracranial vessels.

IMPRESSION: ABNORMAL SIGNAL AND ENHANCEMENT INVOLVING THE RIGHT CEREBELLAR HEMISPHERE AND RIGHT MID BRAIN. THESE ARE LIKELY THE SEQUELLAE OF SUBACUTE ISCHEMIA. RECOMMEND REPEAT STUDY IN 3 MONTHS TO FURTHER CHARACTERIZE THESE LESIONS.

CONWAY HOSPITAL
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

NAME: CHAVIS,GILBERT
PHYS: Preslar,Arthur J. III MD
DOB: 12/07/1954 AGE: 45 SEX: M
ACCT: V00005106890 LOC: PAT
EXAM DATE: 02/07/2000 STATUS: REG CLI
RADIOLOGY NO: 00112659
UNIT NO: M000188399
PATIENT PHONE: (843)347-5748
CPT4 CODE: 70553

ADMITTING DX: RT SHOULDER PAIN/ROTATOR CUFF TEAR
EXAMS: 000042470 BRAIN W/ AND W/O CONTRAST
<Continued>

WW:VH
2/9/00

** REPORT SIGNATURE ON FILE 02/09/2000 **
REPORTED AND SIGNED BY: WILLIAM WEADOCK M.D

CC: Arthur J Preslar III MD

TECHNOLOGIST: JAMES TOMPKINS RT (R)(MR)
TRANSCRIBED DATE/TIME: 02/09/2000 (1057)
TRANSCRIPTIONIST: VHORN
PRINTED DATE/TIME: 02/09/2000 (1208)

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
1400 Hwy 544
Conway, South Carolina 29526
(843) 347-7222 FAX: (843) 347-3305

Work and/or School Release

Date 2-1-00 Chart 20347

RE Gilbert Chavis

Diagnosis Right Shoulder pain

Please be advised that the above named patient:

* Was seen in this office on the following dates: 2-1-00

( ) May return to full duty on

* May not return to work until further notice - Mr. Chavis to Scheduled for Surgery on

( ) May return to light duty 2-21-00

( ) May not participate in

Return Appointment

☐ James W. Yates, Jr., M.D.
~~☐~~ A. Jay Preslar III, M.D. ☐ William L. Mills, M.D. ☐ J. Stewart Haskin, Jr., M.D. ☐ Jeffrey C. Wilkins, M.D.

* has been out since 1-25-00

** had an injection on 1-26-00 on orders of treating doctor & had a seizure which partially paralyzed him.

January 17, 2000
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He comes back his cervical MRI which indeed shows moderate central bulge at C5-6, somewhat more eccentric to the right than the left.

DIAGNOSIS: (1) Unchanged. (2) I think some of his discomfort could be referred from this cervical spine lesion.

PLAN: I am going to try a selective nerve root injection and will see if this helps diagnostically/therapeutically. We will then re-evaluate him in a week or ten days after that and hopefully get the letter from Dr. Elmington and then make further decisions.

CC: WC

February 1, 2000
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

Mr. Chavis comes in still having severe pain in that right shoulder. He states the pain has gotten progressively worse and is now worse than it was before surgery. He went down to DISC for selective nerve root injection and apparently had some type of reaction and that has actually required further workup. He is scheduled for an MRI of his brain next week and followup by Dr. Groblewski. Today, we have the note from Dr. Elvington, Pee Dee Orthopaedics in Florence, who feels like, according to the note, the distal clavicle resection and assessment of the decompression is warranted. Mr. Chavis says, that while it is not in the note, verbally he recommended exploring the partial tear and reconstruction of that along with recommending further evaluation of the neck.

DIAGNOSIS: Ongoing right shoulder pain, probably related to a combination of distal arthrosis, partial rotator cuff tear and possibly residual impingement.

PLAN: I have had a long talk with Mr. Chavis today. I think it would be reasonable to do an open exploration distal clavicle resection, assess the decompression and debride the partial thickness tear and repair it. I would anticipate that this will give him some improvement. He understands, however, that it is very difficult to predict how much, and certainly there are no guarantees. Part of his concern at this time is popping in the shoulder which I think is related to scar tissue and certainly scar tissue will reform. In addition, with the problems related to the selective nerve root injection, we really don't know how much his symptoms might be referred from the cervical spine. He apparently got no relief with whatever portion of the injection they did. We discussed risks, including blood loss and nerve damage as well as unknown potential for improvement. He understands all of this and wishes to proceed. Dictation is done on the hospital line.

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/25/00
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: CT BRAIN
PT #: 01-95-91

CLINICAL INFORMATION: The patient has had syncopal episode.

TECHNIQUE: The patient is examined in the GE Highlight Advantage CT System. SERIES: 1) Lateral scout view; 2) AX 3 x 3 mm posterior fossa; 3) AX 5 x 5 mm brain; 4) AX 3 x 3 mm posterior fossa; 5) AX 5 x 5 mm brain.

CONTRAST: The last two series were carried out during and following an injection of 100 cc of Omnipaque 300.

SEDATION: None.

FINDINGS: Axial images through the brain demonstrate no evidence of intracranial mass, hemorrhage, edema or other abnormality. Bony structures are normal in appearance.

OPINION: CT of the brain is within normal limits.

DAVID D. GOLTRA, JR, M.D.

DDG/smt-12

DISC IMAGING

DIAGNOSIS • INSIGHT • SERVICE • CARE

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/25/00
REFERRED BY: A. JAY PRESLAR,III, M.D.
TYPE OF EXAM: LATERAL SELECTIVE EPIDURAL BLOCK,CERV
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 45-year-old male with right shoulder pain.

TECHNIQUE: After informed consent was obtained, the patient was placed on the fluoroscopy table in the supine position. The skin over the right neck was prepped and draped in a sterile fashion. Using fluoroscopic guidance, a 22 gauge Chiba needle was advanced toward the right C5-6 neural foramen. When the patient's radicular pain was reproduced, the stylet was removed from the needle. No blood return was obtained. Following this, a neurogram was performed, using a small amount of Omnipaque 240 documenting opacification of the nerve root sheath. 1 cc xylocaine and 80 mg Depo-Medrol were injected into the perineural space.

Upon removing the needle, a small amount of blood returned was obtained and direct compression was applied to the lateral neck. At approximately the time when the needle was removed, the patient had an episode of syncope, which lasted for approximately one minute. When he awakened, he was nauseated and mildly disoriented. When he recovered from this, he stated that his right shoulder pain was gone.

OPINION:

1. Selective right C6 nerve root block with alleviation of right shoulder pain.

2. Syncopal episode during procedure.

David D. Goltra Jr.

DAVID D. GOLTRA, JR, M.D.

DDG/smt-60

January 17, 2000
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He comes back his cervical MRI which indeed shows moderate central bulge at C5-6, somewhat more eccentric to the right than the left.

DIAGNOSIS: (1) Unchanged. (2) I think some of his discomfort could be referred from this cervical spine lesion.

PLAN: I am going to try a selective nerve root injection and will see if this helps diagnostically/therapeutically. We will then re-evaluate him in a week or ten days after that and hopefully get the letter from Dr. Elmington and then make further decisions.

CC: WC

February 1, 2000
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

Mr. Chavis comes in still having severe pain in that right shoulder. He states the pain has gotten progressively worse and is now worse than it was before surgery. He went down to DISC for selective nerve root injection and apparently had some type of reaction and that has actually required further workup. He is scheduled for an MRI of his brain next week and followup by Dr. Groblewski. Today, we have the note from Dr. Elvington, Pee Dee Orthopaedics in Florence, who feels like, according to the note, the distal clavicle resection and assessment of the decompression is warranted. Mr. Chavis says, that while it is not in the note, verbally he recommended exploring the partial tear and reconstruction of that along with recommending further evaluation of the neck.

DIAGNOSIS: Ongoing right shoulder pain, probably related to a combination of distal arthrosis, partial rotator cuff tear and possibly residual impingement.

PLAN: I have had a long talk with Mr. Chavis today. I think it would be reasonable to do an open exploration distal clavicle resection, assess the decompression and debride the partial thickness tear and repair it. I would anticipate that this will give him some improvement. He understands, however, that it is very difficult to predict how much, and certainly there are no guarantees. Part of his concern at this time is popping in the shoulder which I think is related to scar tissue and certainly scar tissue will reform. In addition, with the problems related to the selective nerve root injection, we really don't know how much his symptoms might be referred from the cervical spine. He apparently got no relief with whatever portion of the injection they did. We discussed risks, including blood loss and nerve damage as well as unknown potential for improvement. He understands all of this and wishes to proceed. Dictation is done on the hospital line.

DISC IMAGING

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

DIAGNOSIS • INSIGHT • SERVICE • CARE

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/08/00
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: MRI CERVICAL SPINE
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 45-year-old male with right-sided neck and shoulder pain; prior rotator cuff surgery.

TECHNIQUE: The patient is examined on the High Field GE Horizon LX Echo Speed MR System which functions at 1.5 Tesla. A dedicated spine coil is used to obtain high resolution images of the cervical spine. SERIES: 1) COR, T1, SE, 7 mm; 2) SAG, T2, FSE, 3 mm; 3) AX, T2*, GRE, 3 mm. Additional series: 1) AX, T1, SE, 5 mm.

CONTRAST: None. SEDATION: None.

FINDINGS:

OVERVIEW: Coronal T1 weighted images demonstrate normal appearance of the lung apices, paraspinous musculature and brachial plexus regions.

CERVICAL SPINE OVERVIEW: There is normal alignment of the cervical vertebral bodies. Craniocervical junction is normal in appearance and no abnormal signal is present within the cervical spinal cord.

C3-4. Mild annular osteophytes are present, resulting in mild neural foraminal stenosis.

C4-5. Bilateral annular osteophytes are present, left greater than right, with moderate left and mild right neural foraminal stenosis. A very small, shallow central disc protrusion is present.

C5-6. There is a right parasagittal disc protrusion which contacts and flattens the spinal cord. This is superimposed upon a diffuse disc bulge which narrows both neural foramina, slightly more so on the right than left, where there is moderate right neural foraminal stenosis.

C6-7, C7-T1. Axial images taken at these levels show normal disc space height and signal with no evidence of bulge or herniation of disc material, and no evidence of protrusion of disc material beyond its normal confines. The spinal cord and exit foramina are normal in their appearance.

OPINION:

(CONTINUED)

1136 Bowman Road, Mount Pleasant, SC 29464 • (800) 933-DISC • (843) 884-4MRI • FAX (843) 849-9326

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/08/00
REFERRED BY: A. JAY PRESLAR,III, M.D.
TYPE OF EXAM: MRI CERVICAL SPINE
PT #: 01-95-91

(CONTINUED - PAGE 2)

1. C3-4. Mild bilateral neural foraminal stenosis secondary to annular osteophytes.

2. C4-5. Moderate left and mild right neural foraminal stenosis secondary to annular osteophytes; shallow central disc protrusion.

3. C5-6. Right parasagittal disc protrusion superimposed upon a diffuse disc osteophyte protrusion with moderate right and mild to moderate left neural foraminal stenosis. Protruding disc contacts and flattens the spinal cord at this level.

DAVID D. GOLTRA, JR, M.D.

DDG/smt-60

October 29, 1999
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He comes in still complaining of pain. He states the injection did not help with his discomfort. He states he is having more popping in the shoulder and is having pain in the shoulder he is unable to live with. On exam, he does have a significant amount of subacromial crepitance with motion of the arm in abduction. He is somewhat tender at the AC joint.

I verbally discussed the MRI report with DISC Imaging and they do not see progression of the tear to a full thickness tear.
DIAGNOSIS: Ongoing right shoulder pain, uncertain etiology.

PLAN: At this point in time, I think his options are to live with it or consider open exploration with distal clavicle resection. He would need to understand that this may improve his symptoms but to the degree the popping is related to scar tissue, this certainly could recur. At this point in time, he is not sure he wants to undergo a procedure. We will go ahead and release him to full duties with a 30 pound lifting restriction and he will think about all of this and contact us.

CC: WC

January 4, 2000
A. Jay Preslar, III, M.D. /pmc

Gilbert Chavis
Case No.: 20347

He comes in stating he is doing worse. Of his own accord he went to see Dr. Ernst. We have his report from December 7. He recommended continuing conservative management. The patient also apparently has seen Dr. Elmington at the request of Workmens Comp. over at Pee Dee Orthopedics who recommended excision of the partial tear with repair and distal clavicle resection. On physical exam today he points to the deltoid insertion as the area of greatest tenderness. He has mild tenderness with palpation over the AC joint and mild subacromial tenderness. He has a positive impingement sign, a positive Hawkins sign. He reports lateral deltoid tenderness with adduction.

DX: 1. Ongoing pain possibly related to the distal clavicle and partial thickness rotator cuff tear.

PLAN: Dr. Elmington also apparently recommended a cervical MRI. Mr. Chavis does complain of some pain in that right trapezius, and I think that is not unreasonable, but I suspect that pain is related to primary trapezial muscle discomfort. We will go ahead and arrange the cervical MRI. We will see him back with that result. I would like to see Dr. Elmington's note prior to making any decisions about further surgery. On return Mr. Chavis needs a good preclinic Bigliani x-ray. Also please pull both of his shoulder MRI's for me to look at.

CC: WC

DISC IMAGING

DIAGNOSIS • INSIGHT • SERVICE • CARE

Richard C. Holgate, M.D., F.R.C.P.C.
Beverly M. Genez, M.D., Ph.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 10/23/99
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 44-year-old, 190-pound, 5'5" male with chronic right shoulder pain.

TECHNIQUE: The patient is examined on the High Field GE Horizon LX Echo Speed MR System which functions at 1.5 Tesla. A dedicated shoulder coil is used to obtain high resolution images of the shoulder. SERIES: 1) COR, T1, SE, 7 mm; 2) AX, T2*, GRE, 4 mm; 3) SAG, Oblique, FSE, Proton/Fat Sat, 4 mm; 4) SAG, Oblique, T2/Proton, SE, 4 mm.

CONTRAST: None. SEDATION: None.

FINDINGS:

The patient had a prior examination performed at Health South. If this examination becomes available for comparison, an addendum comparing the two will be issued to this report.

OVERVIEW: Views include the pulmonary apices and proximal brachial plexus, and no abnormality is seen in these structures. A survey view of the opposite shoulder shows no abnormality. There are multiple foci of magnetic susceptibility artifact within the soft tissues, resulting from surgical clip placement.

GLENOHUMERAL JOINT: The head of the humerus is well-seated within the glenohumeral joint. The glenoid labrum is intact showing normal signal and the biceps tendon is within its groove. There is no evidence of a Hill-Sachs deformity to indicate previous anterior dislocation. There is no evidence of a joint effusion.

ACROMIOCLAVICULAR JOINT: There is heterogeneous fluid signal intensity within the subacromial space; this fluid is contiguous with the acromioclavicular joint space and most likely is post-operative in nature. There is no evidence of rotator cuff impingement following decompression.

ROTATOR CUFF: The proximal muscle bellies of the elements of the rotator cuff demonstrate normal substance. There is abnormally-increased signal intensity within the distal supraspinatus tendon, which is slightly attenuated. Slightly higher signal intensity is noted along the articular surface; however, a full thickness tear is not identified.

(CONTINUED)

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 10/23/99
REFERRED BY: A. JAY PRESLAR,III, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

(CONTINUED - PAGE 2)

OPINION: Heterogeneous fluid within the subacromial subdeltoid bursa, most likely resulting from prior decompression. Abnormal signal intensity within the distal rotator cuff may represent a combination of edema and tendinosis. No focal, full thickness rotator cuff tear is identified on the current examination.

TARA NOONE, M.D.

BEVERLY M. GENEZ, M.D.

October 12, 1999
A. Jay Preslar, III, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Mr. Chavis comes in stating he is having more problems with the arm. He states he is having increased pain. He is also having popping with movement. He states the popping is not always associated with discomfort. On exam, clinically the shoulder looks fairly good with a 170 degrees of forward flexion. Negative impingement sign. No discomfort with Hawkins. It is difficult to elicit point tenderness with palpation. There is no major subacromial tenderness. He has occasional tenderness at the posterior aspect of the AC joint, but this is not reproducible. X-rays today, Bigliani, shows a nice decompression compared to his preop films.

DIAGNOSIS: Ongoing pain, right shoulder, uncertain etiology. I think the popping is probably related to scar tissue.

PLAN: I think it would be reasonable to try an injection. I will see if that helps his symptoms. I think this has the potential to benefit him, especially since he has had a decompression already to help open up the space. He has to leave at this time to go pick up his daughter from school and we will plan to have him come in Thursday for an injection. If that does not help him, the other option would be a repeat MRI. If that shows progression of his partial thickness tear, he would need an open procedure. If it does not show progression, I think he is at maximum medical improvement.

FORMS COMPLETED: 10/15/99

CC: WC

OFFICE MAILED: OR

October 14, 1999
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He comes in for his subacromial injection which is done (moderately difficult). We will see how thta does forhim and and re-evaluate him three weeks.

CC: WC

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

Pain, Spine & Sports Medicine

5046 US Hwy 17 Bypass Ste 201, Myrtle Beach, SC 29588 (843) 293-8868 FAX: (843) 293-8869

nt's Name: G Cleve Chavis Date: 05 18 05

T pa 2° T evelin · both Shoulders painful - ⇒ T neck p
of the joint per evelin

any current Side Effects to Medications:
Nausea Itching Vomiting Drowsiness Constipation Other:

cation(s) is/are helping with pain? Yes No Comments: Celebrex

meds enable what activities: pa limits exercise

PSS Medications: Bottles brought? Yes No			# Remaining	# Should Be Remaining	Refill Due Date
Celebrex 200mg po QD	4/20	30/-	1		
Neurontin 400mg po TID	4/20	90/1	105		
OxyContin 80mg po TID	4/24	180/-	6		
Levitra 20mg po QD	4/20	21/-	5		
Pt to ASA-325mg QOD					

Brochure given Instructed to bring in bottles each visit or prescriptions will not be refillable? Yes No

ctive: WD Obese Thin WD AA Other M F in NAD Mod Acute Distress

P R B/P 120/78 HT: WT BMI

NT Normocephalic/Atraumatic LUNGS: CTA CARDIAC: RRR Without MRG

CU Edema: Yes / No Location Peripheral Pulses: Equivalent & Bilateral Yes / No

o/Musculoskeletal: Posture: Erect Gait: Steady Speech Clear: Yes / No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

cal/Thoracic: ROM: Strength: Para spinal Tenderness: Spasms: Location: upper trapezius

r Extremity: ROM: Strength: Para spinal Tenderness: Spasms: Location:

Tinnels: + / - Phalens: + / - Finkelsteins: + / - ThenarAtrophy + / - pain Rom of both arms

Biceps: Triceps: Brachioradialis: Other:

r Extremity: ROM: Strength: Para spinal Tenderness: Spasms: Location:

Launchman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location:

Facet Joint Loading: + / - Patellar Achilles Other:

ssment,

1) Mechanical back pain
2) Lumbar spondylosis
3) CPDD
4) Erectile Dysfunction
5) Compliant with Meds: Yes / No
6) Aberrant Behavior: Yes / No

Refill all PSS Medications: Yes No D/C Following:

Meds

Celebrex, Oxycodone as above (# 1 RF) 4) Theravue Z-3x/wk - myalgia/myositis (# 1 RF)
Lidoderm patch 5% 1-2 on 12 hr/off 12 hr (# 60 0 RF) 5) Ergoflex + Motrin + Vicodin prn (# 1 RF)
Prochlorperazine 10mg - 5mg QD (# 30 1 RF) 6) Levitra 20mg PO QD (#4 3 RF)

ng Labs:

issed consequences of not taking meds as prescribed: Yes No Other:

n to Clinic in 1 Month Other: Constance Alger, FNP

ssed with Dr. Kang Seen by Dr. Kang Joy Kang, RN, BSN

August 30, 1999
A. Jay Preslar III, M.D. /we

Gilbert Chavis
Case No.: 20347

He comes in doing much better. He actually has excellent motion today. I can take him up to 170 degrees. His incisions are benign.

DIAGNOSIS: Unchanged.

PLAN: I think he is doing well. However, he really has not used it much overhead so we don't know how he will do ultimately. Today I want to start him on physical therapy working on aggressive rotator cuff strengthening protocol. He has excellent motion and we really don't need for the therapist to work on that. We will hold him out of work while we start on this rehab program. We will plan to see him again in 4 weeks. Plan to return him to regular or light duty at that time.

September 23, 1999
A. Jay Preslar, III, M.D. /we

Gilbert Chavis
Case No.: 20347

Mr. Chavis is now about 6 weeks postop and he reports continued problems with the shoulder. He states it is no better than it was before surgery. He has a complaint of pain with certain motions and also states he can only hold the arm in 1 position when he lays down at night. He describes a burning sensation in the shoulder as well as pain in the posteromedial aspect of the elbow. He had 1 episode of numbness in the middle digit but that has not recurred.

DIAGNOSIS: Unchanged.
PLAN: The numbness was an intermittent problem. Unless it recurs I would do nothing else with regard to that. The tenderness at the elbow is not really over the cubital tunnel or the medial epicondyle. It appears to be in the posteromedial triceps muscle region. I think we should watch that at this piont in time. With regard to the shoulder I do think he will get improvement as he works on rotator cuff strengthening and I recommend he continue with therapy for that. He should also continue to work on maintaining his range of motion. With regard to work we will get him back to a light duty status. We will see him again in 1 month and may be near the end of what we have to offer him.

CC: WC

FORMS COMPLETED: 10/1/99
OFFICE MAILED: KD

COASTAL ORTHOPAEDIC ASSOCIATES, P

July 22, 1999
A. Jay Preslar, III, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Mr. Chavis comes back stating the previous injection gave him good improvement in his pain for 6 days. The pain has now returned and is back t his baseline. His primary complaint is pain. It is worse with certain motions, especially overhead activity. In addition, he has had intermittant pain radiating down into the fingers. This is not constant. It can affect any of the five digits. On physical exam, he has some discomfort with impingement testing. No real pain with Hawkins. His greatest tenderness is in the lateral subacromial region with palpation. No real tenderness with palpation over the AC joint.
IMPRESSION: Unchanged.

PLAN: I think the response to the injection concurs with our diagnosis. In light of that, I think his options are to live with the discomfort or consider surgery. The anticipated surgical result would be improvement in pain that he got with the injection. I have told him the symptoms radiating into the hand are not coming from the shoulder. They are intermittent and variable and therefore don't appear to represent an ongoing nerve compression lesion. We have discussed the risks of an operation, which include primarily infection (the patient is diabetic). At this time we will plan an arthroscopic evaluation of the right shoulder with an arthroscopic subacromial decompression. Dictation is done on the hospital line.

CC: WC

August 18, 1999
A. Jay Preslar, III, M.D. /ajf

Gilbert Chavis
Case No.: 20347

OPERATIVE NOTE.

FINDINGS: 1. Partial thickness supraspinatous rotator cuff tear. 2. Subacromial impingement from the acromion as well as some impingement from the distal lateral clavicle.

PROCEDURE: Right shoulder evaluation under anesthesia, debridement of partial thickness rotator cuff tear, subacromial decompression and resection of lateral inferior clavicle. FINDINGS: No evidence of instability or an anterior inferior labral abnormality. He had a small partial thickness

rotator cuff tear in the supraspinatus which was debrided and decompression.

FOLLOW-UP PLAN: He will be seen back in the office in seven to ten days for a wound check.

FORMS COMPLETED: 8/25/99

OFFICE MAILED: @

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

1400 Hwy. 544
Conway, South Carolina 29526
(843) 347-7222 FAX: (843) 347-3305

Work and/or School Release

Date 8-30-99 Chart _____

RE Gilbert Chris

Diagnosis SP (R) Shoulder A/C

Please be advised that the above named patient:

~~( )~~ was seen in this office on the following dates: 8-30-99

( ) May return to full duty on _____

(X) May not return to work until recheck/eval in 4 wks

( ) May return to light duty _____

( ) May not participate in _____

Return Appointment _____

☐ James W. Yates, Jr., M.D.
☒ A. Jay Prestar III M.D.
☐ William L. Mills, M.D.
☐ J. Stewart Haskin, Jr., M.D.
☐ Jeffrey C. Wilkins, M.D.

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
J. Stewart Haskin, Jr., M.D.
A. Jay Preslar III, M.D.
William L. Mills, M.D.
Jeffrey C. Wilkins, M.D.

MUSCULOSKELETAL EVALUATION

Gilbert Chavis

Date: July 1, 1999
Case No: 20347
Age Race Sex:
Referred By:

COMPLAINT: Right shoulder pain.

HISTORY: The patient is a very pleasant 44-year-old right hand dominant gentleman who works in the lab at AVX. He does a lot of pushing and pulling and some lifting of weights, all less than 50 pounds. He apparently injured his right shoulder at work on December 1, 1998. He picked up a pot and had to extend his arms to set it down with immediate onset of pain in the right shoulder. He has been seen and nicely treated by Dr. Wilkins. He has had a trigger point injection in the area of discomfort in the triceps and a subacromial injection. He did not see significant improvement with either of these. He has had an MRI done that is felt to show a partial tear.

His primary complaint at this time is pain. It is constantly present in the day and night, occasionally will wake him up from sleep. The pain is worse if he does overhead activities. Overall, the pain is better than it was initially but it has stabilized and not improved from that point. He is back to work in a light duty position.

PAST HISTORY: Pertinent for some type of injury to the back and shoulder area two years ago. He states the back was treated. The shoulder was not really treated or diagnosed and it eventually got better.
ALLERGIES: None.
MEDICATIONS: Glipizide. MAJOR MEDICAL: Non-insulin dependent diabetes.
SURGICAL: Status post throat surgery as a child.
SOCIAL HISTORY: Denies cigarettes and alcohol.

PHYSICAL EXAM: He is an alert, pleasant, healthy appearing gentleman in no acute distress. I don't see any atrophy. No tenderness dorsally over the AC joint. He has some anterior lateral subacromial tenderness. His range of motion shows 170 degrees of forward flexion, internal rotation to T12,

1400 Highway 544, Conway, SC 29526-8485 • (803) 347-7222 • FAX (803) 347-3305

external rotation 35; compared to 165, T11 and 35 on the left. He has some pain with full forward flexion impingement but no real discomfort with Hawkin's sign. There is good strength in all three directions.

X-RAYS / LAB: Plain x-rays show slight type II acromion. MRI is felt to show a partial thickness joint side tear. I don't see any evidence of a full thickness tear.

IMPRESSION: I agree with Dr. Wilkins, he probably has some impingement and discomfort related to a partial tear.

RECOMMENDATION: I have recommended and done a diagnostic/therapeutic injection today. He has reported to Alison that he has no discomfort in the shoulder with the Lidocaine in place. We will let him monitor that over the next several weeks and we will re-evaluate him in 3-4 weeks.

A. Jay Preslar, III, M.D.

dsh

CC: WC

June 10, 1999
Jeffrey C. Wilkins, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He returns today for followup of his MRI. Physical examination reveals impingement sign, intermittently reproducible pain with abduction internal rotation. Neurologic, dermatologic and vascular normal. MRI does reveal partial rotator cuff tear. Also, opinion of Dr. Genez.

IMPRESSION: Impingement syndrome. Partial rotator cuff tear.

Aggressive physical therapy program for strengthening. Limitation with no overhead activity vocationally or recreationally. Patient will return in 3-4 weeks.

CC: WC

June 30, 1999
Jeffrey C. Wilkins, M.D. /dsh

Gilbert R. Chavis
Case No.: 20347

He returns today unimproved. Neurologic, dermatologic and vascular unchanged. Still positive impingement. For now, to Dr. Preslar for consideration of surgical opinion. Per therapy certainly Gilbert did not give maximum effort in therapy and we have little else to offer him from a conservative standpoint.

CC: WC

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

DISC IMAGING

Richard C. Holgate, M.D.
Beverly M. Genez, M.D., PhD

DIAGNOSIS • INSIGHT • SERVICE • CARE

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 06/07/99
REFERRED BY: JEFFREY WILKINS, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 197-pound, 5'5", 44-year-old male who presents with history of injury and subsequent pain. His physician suspects possible rotator cuff pathology.

TECHNIQUE: The patient is examined in the High Field Signa Horizon LX MR System which functions at 1.0 Tesla. The shoulder coil is used to obtain high resolution images of the shoulder. SERIES: 1) AX, T2*, GRE, 4 mm; 2) Oblique COR, T2, FSE, 4 mm; 3) Oblique COR, proton, FSE, 4 mm; 4) Oblique COR, T1, SE, 4 mm; 5) Oblique SAG, T2, FSE, 4 mm.

CONTRAST: None. SEDATION: None.

GLENOHUMERAL JOINT: There is normal alignment between the humeral head and the glenoid. No joint effusion is present. Axial images show no evidence for labral pathology.

BONES: There is prominent arthrosis of the acromioclavicular joint with a large osteophyte of the under surface of the distal clavicle. With this exception, the bones are normal.

ROTATOR CUFF: Evaluation of the rotator cuff shows abnormal high signal in the under surface of the distal cuff noted on coronal images #3 through #5 on page #3. The upper surface of the cuff appears to be intact. Consequently this most likely represents a partial thickness tear on the under surface of the distal anterior supraspinatus. The remaining cuff tendons are intact.

OPINION: MRI of the right shoulder demonstrates abnormal signal in the cuff, most likely representing a partial tear on the under surface or joint side. Tendinosis is also a second possibility.

Beverly M Genez MD

BEVERLY M. GENEZ, M.D.PHD

BMG/smt-60

March 24, 1999
Jeffrey C. Wilkins, M.D. /ajf

Gilbert Chavis
Case No.: 20347

Gilbert Chavis returns today. Back still doing very well. Now complaining of elbow pain. He points to the tricep tendon region. He says this begin 12/01/98. He was lowering an item at work. He still continues to work but he is having to restrict his weight somewhat. Physical exam reveals tenderness of the triceps with some myofascial dysfunction. He has full strength. Neurologic, dermatologic and vascular exams are normal.

IMPRESSION: Myofascial pain. PLAN: Tender trigger injection. Follow-up with Louise. Continue current work.

INJECTION NOTE: Three cc of celestone/lidocaine was injected into four separate injection sites using a clean technique, no significant grittiness. Some improvement in pain. No jump signs.

April 21, 1999
Jeffrey C. Wilkins, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Returns today without particular improvement. We examined him today in length with Louise from Physical Therapy. He has good strength. Negative impingement sign. Does have pain with resisted stretch to the triceps. Focal tenderness over the triceps tendon, as before.

IMPRESSION: Tricep pain.

PLAN: We expected better response. We will have the patient undergo a BTE evaluation to look for any muscle strength asymmetries. We would expect no permanent impairment from this condition. Give consideration to shoulder MRI. This would be the only diagnosis that could tie in all current complaints.

May 13, 1999
Jeffrey C. Wilkins, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Returns today says when he lifts his arm over his head he gets pain in the sub deltoid region as well as the triceps. Note, with the same maneuver, he has no firing of the triceps. Neurologic, dermatologic, and vascular exams are normal. Impingement sign laterally. Negative flexion.

IMPRESSION: Impingement syndrome.

PLAN: We will inject him today. Send him for an MRI of the shoulder, with treatment based on the results. 8 cc of Lidocaine and 2 cc of Celestone injected into the patient's right subacromial space with immediate improvement in some of the patient's symptoms.

November 16, 1998
Jeffrey C. Wilkins, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He returns today still having the pain in his arm, otherwise doing. He has been laid off once and now working at AVX. He saw Dr. Hayes who prescribed some medications, says it didn't help. But apparently per Dr. Hayes' notes, he was poorly compliant with it. He had an MRI ordered by Dr. Stengal. Neurologic, dermatologic and vascular normal. Restriction in extension greater than flexion. MRI essentially normal for patient's age. Disc architecture appears to be within normal limits. Some mild degenerative changes again appropriate for Gilbert's age, body habitus and occupational load.

IMPRESSION: Chronic back pain.

Will get a muscle stimulator, place him on some Remeron q.h.s. No restrictions with work.

CC: Dr. Asbury Williams

CC: NWWI

December 23, 1998
Jeffrey C. Wilkins, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Getting improvement in his back pain with the muscle stimulator. He has particular pains in a forward flexed position. He has some increased pain on extension greater than flexion.

IMPRESSION: Chronic back pain. Question facet syndrome.

PLAN: Send him down to Dr. Holgate for an L5-S1 facet block on the right. If he does have a facet hypertrophy on that side, this would fit with his symptoms. We will have him continue the muscle stimulator.

CC: Dr. Asbury Williams

CC: NWWI

January 11, 1999
Jeffrey C. Wilkins, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He returns today stating he does not whether to hug us or hit us due to the fact his facet has helped so much that he wishes he had it sooner. Neurologic, dermatologic and vascular normal. Marked improvement in extension.

IMPRESSION: Facet pain.

I discussed with him the fact that if it recurs we would repeat the block one more time and if the pain recurs after that, we will give consideration to facet rhizotomy. Note: Must be careful the numbering has he has a transitional vertebra.

CC: Dr. Asbury Williams

CC: NWWI

Pain, Spine & Sports Medicine

5046 US Hwy 17 Bypass Ste 201, Myrtle Beach, SC 29588 (843) 293-8866 FAX: (843) 293-8869

nt's Name. G Chard Chavis Date: 05 18 05

I per 2° T evelin - both Shoulders pain fwd - ⇒ T neck pain
upper back pain evelin

any current Side Effects to Medications:

Nausea ☐ Itching ☐ Vomiting ☐ Drowsiness ☐ Constipation ☐ Other: _____

cation(s) is/are helping with pain? Yes ☐ No ☐ Comments: Excedrine

meds enable what activities: pain limits exercise

SS Medications: Bottles brought? ☐ Yes ☐ No			# Remaining	# Should Be Remaining	Refill Due Date
Celebrex 200mg po QD	4/20	30/-	1		
Neurontin 400mg po TID	4/20	90/1	105		
OxyContin 80mg po TID	4/20	180/-	60		
Lasix 20mg po QD	4/20	30/-	5		
Rx ASA-325mg QD					

Prescribed % Instructed to bring in bottles each visit or prescriptions will not be refillable? ☐ Yes ☐ No

ctive: WD Obese ☐ Thin ☐ WD ☐ AA ☐ Other ☐ M ☐ F ☐ in NAD ☐ Mod ☐ Acute ☐ Distress

P R B/P 150/98 HT: WT BMI

NT Normocephalic/Atraumatic ☐ LUNGS: CTA ☐ CARDIAC: RRR Without MRG ☐

CUT Edema: Yes / No Location _____ Peripheral Pulses: Equivalent & Bilateral Yes / No

o/Musculoskeletal: Posture: Erect Gait: Slow Speech Clear: Yes / No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

cal/Thoracic: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: trapezius

r Extremity: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: _____

Tinnels: + / - Phalens: + / - Finkelsteins: + / - ThenarAtrophy + / - pain c Rom of both arms

Biceps: _____ Triceps: _____ Brachioradialis: _____ Other: _____

r Extremity: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: _____

Launchman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location: _____

Facet Joint Loading: + / - Patellar _____ Achilles _____ Other: _____

ssment.

1) Mechanical back p
2) Lumbar spondylo
3) CPDD S/P CVA
4) Fibrositis Syndrome
5) Compliant with Meds: Yes / No
6) Aberrant Behavior: Yes / No

Refill all PSS Medications: Yes ☐ No ☐ D/C Following: _____

Meds			
Celebrex, Oxycodone acaba	(# 1 RF)	4) Therapy 2-3x/wk - myofascial	(# 1 RF)
Lasix 20mg 1-2 po 12th/yr 12th	(# 60 10 RF)	5) Ibuprofen + Robaxin + Vicodin	(# 1 RF)
Prescribed 15 - Sig QD	(# 30 15 RF)	6) Lasix 20mg po QD	(#24 3 RF)

ng _____ Labs: _____

issed consequences of not taking meds as prescribed: Yes ☐ No ☐ Other: _____

n to Clinic in 1 Month ___ Other: _____ Constance Alger, FNP _____

ssed with Dr. Kang ☐ Seen by Dr. Kang ☐ Joy Kang, RN, BSN _____

Pain, Spine & Sports Medicine

5046 US Hwy 17 Bypass Ste 201, Myrtle Beach, SC 29588 (843) 293-8868 FAX: (843) 293-8869

Patient's Name: Gilbert Chavis Date: 04 20 05

CC: Difficulty difficult to speak knows what to say - hard difficulty getting out
Hawk - Cold - Dizziness - Tears on medications - HCTZ Headaches

List any current Side Effects to Medications:

None Nausea Itching Vomiting Drowsiness Constipation Other: Sleepiness Headaches

Medication(s) is/are helping with pain? Yes No Comments:

Pain meds enable what activities: Can't ADL

PSS Medications: Bottles brought? Yes No	# Remaining	# Should Be Remaining	Refill Due Date
Levitra 20mg TPOQD 3/21 #21/-	6		
Lidoderm 700mg TPOMD 3/21 #90/2	Lots		
Oxycodone 30mg ½ po TID 3/21 #30/-	10		
Lidocaine patch			
Androgel 1% QD			

ASA 81mg PO QD Benicar 20mg TPOQD

Instructed to bring in bottles each visit or prescriptions will not be refillable? Yes No

Objective:

WN Obese Thin WW AA Other M F NAD Mod Acute Distress

T P R B/P 159/78 HT: WT BMI

ENT: Normocephalic/Atraumatic LUNGS: CTA CARDIAC: RRR Without MRG

SCULAR: Edema: Yes / No Location Peripheral Pulses: Equivalent & Bilateral: Yes / No

Musculoskeletal: Posture: Gait: Speech Clear: Yes / No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

Cervical/Thoracic: ROM: Strength: Para spinal Tenderness: Spasms: Location:

Upper Extremity: ROM: Strength: Para spinal Tenderness: Spasms: Location:

Tinnels: + / - Phalens: + / - Finkelsteins: + / - ThenarAtrophy + / -

Biceps: Triceps: Brachioradialis: Other:

Lower Extremity: ROM: Strength: Para spinal Tenderness: Spasms: Location:

Launchman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location:

Facet Joint Loading: + / - Patellar Achilles Other:

Assessment:

1) Mechanical Back pain 4) Tactile Dysfx

2) Lumbar Spondylosis 5) Compliant with Meds: Yes / No

3) CDDD S/P CVA 6) Aberrant Behavior: Yes / No

Plan: Refill all PSS Medications: Yes No D/C Following: Benicar

Meds:

Benicar oxycodone cr (# / RF) 4) Neuro Consult - (# / RF)

Lidoderm (# / RF) 5) Yes Speech difficulties (# / RF)

Lidocaine Androgel (# / RF) 6) S/P CVA (# / RF)

ASA-EC Celebrex 200mg TPOQD #30 2RF

Testing: Labs:

Discuss consequences of not taking meds as prescribed: Yes No Other:

Return to Clinic in 1 Month Other:

Discussed with Dr. Kang Seen by Dr. Kang — 30 minute appt —

Constance Alger, FNP

Joy Kang, RN, BSN

Pain, Spine & Sports Medicine

5046 US Hwy 17 Bypass Ste 201, Myrtle Beach, SC 29588 (843) 293-8868 FAX: (843) 293-8869

Pt's Name: Gilbert-Chavez Date: 03/01/05

did a lot of walk this week - Back + foot pain
before - hydrocodone pain helps shower

Any current Side Effects to Medications:
Nausea ☐ Itching ☐ Vomiting ☐ Drowsiness ☐ Constipation ☐ Other: ____

Medication(s) is/are helping with pain? Yes ☑ No ☐ Comments: ____

Pain meds enable what activities: clean

PSS Medications: Bottles brought? ☑ Yes ☐ No			# Remaining	# Should Be Remaining	Refill Due Date
Vicodin -			4		
Roxicodone 30mg TPO TID	2/21	120/-	6		
Baclofen 20mg TPO BID	2/21	60/-	27		
Lyrica 300mg TPO QD	2/21	30/-	4		
Neurontin 400mg TPO TID	2/17	90/3	12		
Androgel 1% Apply QD					
ASA 81 mg PO QD					

CTC

Instructed to bring in bottles each visit or prescriptions will not be refillable? ☑ Yes ☐ No

Objective:
☑ WN ☑ Obese ☑ Thin ☐ W ☑ AA ☐ Other____ M ☐ F ☑ In NAD ☐ Mod ☐ Acute ☐ Distress

____P____R____B/P____HT:____WT____BMI____

HENT: Normocephalic/Atraumatic ☐ LUNGS: CTA ☐ CARDIAC: RRR Without MRG ☐

EXT: R: Edema: Yes / No Location ____ Peripheral Pulses: Equivalent & Bilateral: Yes / No

Musculoskeletal: Posture: erect Gait: ____ Speech Clear: Yes / No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

Cervical/Thoracic: ROM: ____ Strength: ____ Para spinal Tenderness: ☐ Spasms: ☐ Location: ____

R Extremity: ROM: ____ Strength: ____ Para spinal Tenderness: ☐ Spasms: ☐ Location: ____

Tinnels: + / - Phalens: + / - Finkelsteins: + / - ThenarAtrophy + / -

Biceps: ____ Triceps: ____ Brachioradialis: ____ Other: Pain Lancen -

L Extremity: ROM: ____ Strength: ____ Para spinal Tenderness: ☑ Spasms: ☐ Location: L Shoulder

Lachman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / - Cramps -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location: ____

Facet Joint Loading: + / - Patellar ____ Achilles ____ Other: ____

Assessment:
1) Mechanical Back Pain 4) Erectile Dysfunction
2) Lumbar Spondylosis 5) Compliant with Meds: Yes / No
3) CDDD 6) Aberrant Behavior: Yes / No

Refill all PSS Medications: Yes ☑ No ☐ D/C Following: ____

Meds:
1) Cod as above (# / RF) 4) Ranitidine discuss (# / RF)
2) Lidocaine Flav Refer (# / RF) 5) ____ (# / RF)
3) ____ (# / RF) 6) ____ (# / RF)

Imaging: ____ Labs: ____

Discuss consequences of not taking meds as prescribed: Yes ☐ No ☐ Other: ____

Return to Clinic in 1 Month ☑ Other: ____ Constance Alger, FNP

Discussed with Dr. Kang ☑ Seen by Dr. Kang ☐ Joy Kang, RN, BSN ____

Pain, Spine & Sports Medicine

5046 US Hwy 17 Bypass Ste 201, Myrtle Beach, SC 29588 (843) 293-8866 FAX: (843) 293-8869

Date: 2 4 05

Patient's Name: Chavis Gilbert

CC: Back pain continues on normal

List any current Side Effects to Medications:
None ☐ Nausea ☐ Itching ☐ Vomiting ☐ Drowsiness ☐ Constipation ☐ Other: _____

Medication(s) is/are helping with pain? Yes ☐ No ☐ Comments: _____

Pain meds enable what activities: Lortab 5/500

PSS Medications: Bottles brought? ☐ Yes ☐ No			# Remaining	# Should Be Remaining	Refill Due Date
Vanacrex 400 mg TID	2/17	90/3	20ct = 18		
Benlux 20 mg tab BID	1/27	60/1	4		
Roxicodone 30 mg tab TID	1/21	90/0	2		
Levitra 20 mg	1/17	21/0			
Anuchael 1% apply QID	1/12	120 gm/0	1 tube	(Needs Rx Sent)	

Instructed to bring in bottles each visit or prescriptions will not be refillable? ☐ Yes ☐ No

Objective:
WD ☐ WN ☐ Obese ☐ Thin ☐ W ☐ AA ☐ Other ____ M ☐ F ☐ In NAD ☐ Mod ☐ Acute ☐ Distress

VS: T____ P____ R____ B/P____ HT:____ WT____ BMI____

CARDIAC: RRR Without MRG ☐

LUNGS: CTA ☐

ENT: Normocephalic/Atraumatic ☐

VASCULAR: Edema: Yes / No Location _____ Peripheral Pulses: Equivalent & Bilateral: Yes / No

Neuro/Musculoskeletal: Posture: Erect Gait: _____ Speech Clear: Yes / No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

Cervical/Thoracic: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: _____

Upper Extremity: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: _____

Tinnels: + / - Phalens: + / - Finkelsteins: + / - ThenarAtrophy + / -

Biceps: _____ Triceps: _____ Brachioradialis: _____ Other: _____

Lower Extremity: ROM: _____ Strength: _____ Para spinal Tenderness: ☐ Spasms: ☐ Location: _____

Launchman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / - Pain pain -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location: Shoulder -

Facet Joint Loading: + / - Patellar ____ Achilles ____ Other: Full ROM -

Assessment:
1) Mechanical Back pain
2) Lumbar Spondylosis
3) CDDD
4) Cervical Spondylosis
5) Compliant with Meds: Yes / No
6) Aberrant Behavior: Yes / No

D/C Following: _____

Plan: Refill all PSS Medications: Yes ☐ No ☐

New Meds:
1) Roxicodone 30 mg tab (# / RF)
2) Medrol dose pack + Benlux (# / RF)
3) Flexeril 10 mg tab (# / RF)
4) Celecoxib 200 mg tab (# / RF)
5) Lidoderm patch (# / RF)
6) Refill Roxicodone + Levitra as ever (# / RF)

Labs: _____

Imaging: _____

Other: _____

Discussed consequences of not taking meds as prescribed: Yes ☐ No ☐

Return to Clinic in 1 Month ____ Other: _____

Discussed with Dr. Kang ☐ Seen by Dr. Kang ☐

Constance Alger, FNP

Joy Kang, RN, BSN

Pa Spine & Sports Medicin

5046 Hwy 17 Bypass, #201, Myrtle Beach, SC 29577 (843) 293-8868 FAX: (843) 293-6689

ni ame: Gilbert Chavis Date: 1 RI 105

Loach pain continues meds - / Hernia surgery pending early Feb
of ACA fa Surg - will resume pain cm

my current side effects to medications:

Nausea ☐ Itching ☐ Vomiting ☐ Drowsiness ☐ Constipation ☐ Other: _____

cation(s) is/are helping with pain? Yes ☐ No ☐ Comments: _____

meds enable what activities: home rx

PSS Medications: Bottles brought? Yes ☐ No ☐		# Remaining	# Should Be Remaining	Refill Due Date
Ultram 4ca TID	11/29 (#90 / 5 RF)			
Protonix 20mg po TID pc	12/22 (#180 / 0 RF)			
Benicar 20mg po BID	9/— (#60 / 5 RF)			
	(# / RF)			
	(# / RF)			

Instructed to bring in bottles each visit or prescriptions will not be refillable? Yes ☐ No ☐

ctive:

WN ☐ Obese ☐ Thin ☐ W ☐ AA ☐ Other _____ M ☐ F ☐ In NAD ☐ Mod ☐ Acute ☐ Distress

T___ P___ R___ B/P_____ HT:___ WT___ BMI_____

NT: Normocephalic/Atraumatic ☐ **Lungs:** CTA ☐ **Cardiac:** RRR Without MRG ☐

ul Edema: Yes / No Location _____ Peripheral Pulses: Equivalent & Bilateral: Yes / No

ro/Musculoskeletal: Posture: Erect Gait: Ataxic Speech Clear Yes No

CN II-XII Intact: Yes / No Alert: Yes / No OX3: Yes / No Pt to Pt Movements Intact: Yes / No

ical/Thoracic: ROM:___ Strength:___ Paraspinal Tenderness: ☐ Spasms: ☐ Location:_____

er Extremity: ROM:___ Strength:___ Paraspinal Tenderness: ☐ Spasms: ☐ Location: _____

Tinnels: + / - Phalens: + / - Finkelsteins: + / - Thenar Atrophy: + / -

Bicepts: ___ Tricepts ___ Brachioradialis ___ Other: _____

er Extremity: ROM:___ Strength:___ Paraspinal Tenderness: ✓ Spasms:___ Location: lumbar

Lauchman: + / - Drawer: + / - Vargus: + / - Valgus: + / - Straight Leg: + / -

SI Joint Tenderness: + / - Muscular Atrophy: + / - Location: _____

Facet Joint Loading: + / - Patellar ___ Achilles ___ Other: _____

essment:

1) Mech Back pn
2) Lumbar spondylosis
3) CDDD
4) D/P (L) Rotator cuff tear / HRCM
5) Compliant with Meds: Yes ☐ No ☐
6) Abbernat Behavior: Yes ☐ No ☐

: Refil all PSS Medications: Yes ☐ No ☐ D/C Following: _____

Meds:

Ultram ER 300mg	(# / RF) 4)		(# / RF)
Lean out Voice Recognition	(# / RF) 5)		(# / RF)
Benicar HCT 20mg po QD	(# / RF) 6)		(# / RF)

ging: Portop Labs: _____

uss consequences of not taking meds as prescribed: Yes ☐ No ☐ Other: _____

rn to Clinic in 1 Month ✓ Other: _____

ussed with Dr. Kang ☐ Seen by Dr. Kang ☐

Constance Alger, FNP

Joy Kang, RN, BSN

CONSENT FORM

Date: 12-22-04

I, Gilbert Chavis, give Dr. Greg Kang permission to perform this procedure:

(R) C3, C4, C5 MBB

I understand the risks of the procedure which includes; Bleeding, Infection, Headache, Tendon Damage/Rupture, Nerve Damage, Paralysis - other, No More !!!

Gilbert R Chavis
Patient Signature

Physician Signature 12/22/04 70% Better

Witness Signature

Back of

PATIENT: GILBERT CHAVIS
DATE: 11/29/2004

Brief History:
This patient returns today for follow up. He reports the medial branch blocks were equivocal. It did not seem to help very much as far as his right-sided lower back pain. It did change though. The back pain went away and he developed some pain in the right lateral hip. The effects wore off in about a day. He reports his medicines give him some partial temporary relief. He is getting good relief of pain in the feet as well as in the neck with the Tens unit.

Examination:
On examination today the patient is alert and oriented. His speech is fluent. He still has positive facet loading maneuvers in the right side of his lower back. Neurologically he demonstrates no new focal deficits.

Diagnostic Impression:
1. Lumbar spondylosis with mechanical back pain.
2. Cervical degenerative disc disease.
3. Status post left rotator cuff repair.
4. History of CVA.

Recommendations:
1. Refilled Neurontin 400 mg t.i.d.
2. Roxicodone 30 mg t.i.d. p.r.n. pain.
3. Schedule for repeat medial branch block of the right lumbar spine.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 11/17/2004

Preoperative Diagnosis:
1. Right lumbar facet syndrome.

Postoperative Diagnosis:
1. Right lumbar facet syndrome.

Procedure:
1. Right L3, L4 and L5 medial branch blocks.

Brief History:
The patient is a 48-year-old gentleman with a longstanding history of right-sided lower back pain. He did previously respond to intraarticular facet joint injections back in August of 2004. The effects are starting to wear off and he continues to complain of right-sided lower back pain. He is here for diagnostic medial branch blocks to see if he is a candidate for radio frequency l[illegible]ning.

Procedure in Detail:
After the informed consent was obtained, the patient was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. Fluoroscopy was used to identify the right L3 medial branch location. A 3 1/2-inch, 22-gauge spinal needle was used to approach the medial branch. After appropriate AP and lateral views were checked one cc 0.5% Marcaine was injected. Next the needle was directed towards the right L4 medial branch. Once the needle position was confirmed in AP and lateral views one cc 0.5% Marcaine was injected after negative aspirate. Next the needle was directed towards the right sacral ala where the L5 medial branch lies. After AP and lateral views were checked one cc 0.5% Marcaine was injected after negative aspirate.

Post-injection the patient continued to complain of right-sided lower back pain. I will follow up with the patient in about one to two weeks to see if he had any type of relief from the medial branch blocks.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

cc: Workers Compensation

CONSENT FORM

Date: 11-17-04

I, Gilbert Chavis, give Dr. Greg Kang permission to perform this procedure:

(R) Lumbar Medial branch block

I understand the risks of the procedure which includes; Bleeding, Infection, Headache, Tendon Damage/Rupture, Nerve Damage, Paralysis - other, _____.

Gilbert R Chavis
Patient Signature

Physician Signature

Witness Signature

11/17/04 No sig. improvement in pain s/p block

PATIENT: GILBERT CHAVIS
DATE: 10/28/2004

Brief History:
This patient returns today for follow up. He reports the physical therapy seems to have helped him to some degree. He has somewhat plateaued. He is still having considerable pain in the neck and shoulder area. He is still getting headaches. He does report that Tens unit seems to help with the spasms and pain in the neck and also seems to help to some degree with his headaches. The Neurontin does not seem to work quite as well as it did before. He is still taking six Roxicodone a day for pain. He reports the right side of his lower back is starting to hurt again. The facet blocks seem to be wearing off.

Examination:
On examination today the patient has positive facet loading maneuvers on the right side. His mentation is clear. His speech is fluent. There is no slurring of speech. There are no signs of impairment. He is alert and oriented times three. The neck and upper shoulder areas have c[illegible]nued muscle spasms and tenderness.

Diagnostic Impression:
1. Cervical degenerative disc disease.
2. Tension headaches.
3. Lumbar facet syndrome.
4. History of CVA.
5. Chronic left shoulder pain status post arthroscopic surgery.

Recommendations:
1. Will try to pre-authorize a trial of lumbar medial branch blocks to see if he is a candidate for radio frequency lesioning.
2. We would like to order a Tens unit for him for neck and upper shoulder pain.
3. Refilled Roxicodone.
4. We increased Neurontin to 400 mg t.i.d.

C. Gregory Kang, M.D.
'hysiatrist

CGK/dhm

:c· Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 09/30/2004

Brief History:
This patient returns today for follow up. He reports significant improvement in back pain with physical therapy. He is able to function much better. The Neurontin seems to be helping with his headaches also. Roxicodone gives him enough relief so he can function and perform day-to-day activities. The Bextra seems to help with the back pain as well. He reports no significant side effects or cognitive impairment from current medication regimen.

Examination:
On examination today the patient has minimal tenderness in the lumbosacral spine. His hamstrings and lumbar paraspinals are still extremely tight. Lumbar flexion is still very limited due to muscular tightness. Neurologically he has no new changes.

Diagnostic Impression:
1. Cervical degenerative disc disease.
2. Status post left shoulder arthroscopic surgery.
3. Lumbar facet arthropathy with mechanical back pain.

Recommendations:
1. Refilled his medicines.
2. I have asked him to finish up physical therapy with emphasis on home exercise program.
3. Will check back in a month or as needed.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 09/02/2004

Brief History:
This patient returns today for follow up. He reports the facet injection on the right side gave him relief. The sharp pain down his right groin and leg has pretty much disappeared. Most of his discomfort is localized to the lower back now. It is worse with bending and stooping. He reports the physical therapy is helping him. He is making progress on a weekly basis.

Examination:
On examination today the patient still has very limited lumbosacral flexion. He has extremely tight hamstrings, especially on the left side. The lumbar paravertebral muscles are also very tight. Neurologically there are no new changes.

Diagnostic Impression:
1. Lumbosacral myofascial pain.
2. Lumbar facet arthropathy.
3. Cervical degenerative disc disease.

Recommendations:
1. I have asked the patient to continue with physical therapy for another 12 sessions to work on his flexibility. He is still extremely tight in the lumbar spine and hamstring muscles.
2. I will check back with the patient in about one month after he finishes rehabilitation.

C. Gregory Kang, M.D.
'hysiatrist

CGK/dhm

:c: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 08/10/2004

Preoperative Diagnosis:
1. Lumbar facet arthropathy.

Postoperative Diagnosis:
1. Lumbar facet arthropathy.

Procedure:
1. Right L3-4/L4-5/L5-S1 facet joint injection.

Brief History:
The patient is a 48-year-old gentleman with a history of a work-related lower back injury. He has had an MRI of the lumbosacral spine, which reveals facet joint disease. He has mechanical-type back pain mainly in the right side of his lower back and into the gluteal region. He failed a trial of epidural injections. He is now here for intraarticular facet joint injections.

Procedure in Detail:
After the informed consent was obtained, the patient was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. Fluoroscopy was used to identify the right L3-4/L4-5/L5-S1 facet joints. A 3 ½-inch, 22-gauge spinal needle was used to enter the right L5-S1 facet joint with fluoroscopic guidance. Then 20 mg Depo-Medrol and one-half cc 0.5% Marcaine was injected. Next the L4-5 facet joint was identified. The same needle was used to enter that joint. Then 20 mg Depo-Medrol and one-half cc 0.5% Marcaine was injected. Next the L3-4 facet joint was injected with the same needle under fluoroscopic guidance. Then 20 mg Depo-Medrol and one-half cc 0.5% Marcaine was injected without complications. He was sent to recovery in good condition.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 07/14/2004

Brief History:
This patient returns today for follow up. He reports continued pain in the neck and left upper shoulder. He also has pain in the lower back radiating into the groin and lateral thigh. He reports he is having increased muscle spasms in the neck and upper shoulder area and also in the lumbar spine. He also reports erectile dysfunction. His headaches seem to be under control with Neurontin.

Examination:
On examination today the patient has soft tissue tenderness and spasms in the cervical paraspinals and left upper trapezius. The lumbosacral spine is still tender to palpation. Extension seems to aggravate pain as well. Neurologically the patellar reflexes are 2+. Achilles reflexes are diminished bilaterally. Sensation is somewhat altered in the stocking glove distribution around the feet.

Diagnostic Impression:
1. Cervical degenerative disc disease with radiculitis.
2. Rotator cuff tendinopathy status post arthroscopic surgery.
3. History of CVA.
4. Chronic mechanical back pain.

Recommendations:
1. Refilled Roxicodone 60 mg t.i.d. p.r.n.
2. Bextra 20 mg t.i.d.
3. Neurontin 400 mg b.i.d.
4. Recommend a short course of physical therapy to address muscle tightness in the cervical paraspinals, left upper trapezius and also in the lumbosacral spine.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 06/14/2004

Brief History:
This patient returns today for follow up. He reports continued chronic pain in the neck and left shoulder and also in the lower back. He still has not gotten his MRI. He is getting some partial temporary relief with Roxicodone. The Bextra also seems to help some. His headaches also seem to be under good control.

Examination:
On examination today the patient has cervical paraspinal and left upper trapezius pain. He has excellent shoulder range of motion on the left side. Lumbosacral spine is tender primarily in the lumbar paravertebrals and over the sacroiliac joint region.

Diagnostic Impression:
1. Cervical degenerative disc disease with radiculitis.
2. Chronic rotator cuff tendinopathy status post arthroscopic surgery.
3. Tension headaches.
4. History of CVA.
5. Chronic mechanical back pain.

Recommendations:
1. Refilled Roxicodone and Bextra.
2. Continue current dose of Neurontin.
3. I have nothing further to offer. MRI of the lumbar spine has not been done.
4. Check back in a month.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 05/20/2004

Brief History:
This patient returns today for follow up. He reports increased pain in the hips. He still has pain in the left shoulder. He has had good days and bad days. His migraine headaches are under control but he still has some tension headaches in the back of the neck and head area. He has no side effects from his medicines yet.

Examination:
On examination today the patient has some lumbosacral tenderness. Extension seems to aggravate pain. He has muscle tightness in the upper trapezius muscle. He has some shoulder hiking in the left with abduction.

Diagnostic Impression:
1. Cervical degenerative disc disease with radiculitis.
2. Chronic shoulder pain status post arthroscopic surgery.
3. Tension headaches.
4. History of CVA.
5. Chronic mechanical back pain.

Recommendations:
1. He still has not gotten his MRI done.
2. Increased Bextra to 20 mg twice a day.
3. Refilled Roxicodone 30 mg two tablets three times a day as needed.
4. Continue current dose of Neurontin.
5. Check back in a month.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workers Compensation

PATIENT: GILBERT CHAVIS
DATE: 04/26/2004

Brief History:
This patient returns today for follow up. He reports that the epidural injection did not help his back pain. He still has centralized localized pain in the lower back on the left side.

Examination:
On examination today back extension aggravated his pain. Neurologically there are no new focal deficits and he is intact without any new changes. He has diminished reflexes in the ankles.

Diagnostic Impression:
1. Cervical degenerative disc disease with radiculitis.
2. Chronic shoulder pain status post arthroscopic surgery.
3. Tension headaches.
4. History of CVA.
5. Chronic mechanical back pain.

Recommendations:
1. We will schedule for a left lower lumbar facet block.
2. Get lumbar MRI.
3. Continue Bextra 10 mg twice a day and Neurontin 300 mg twice a day.
4. Roxicodone p.r.n. for pain.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Workman's compensation.

PATIENT: GILBERT CHAVIS
DATE: 04/06/2004

Preoperative Diagnosis:
1. Lumbar radiculitis.

Postoperative Diagnosis:
1. Lumbar radiculitis.

Procedure:
1. L5-S1 intralaminal epidural steroid injection.

Brief History:
The patient is a 48-year-old man with a history of lower back pain and radicular pain down the left leg. He had a caudal epidural injection last week with minimal relief. He is here now for a translaminal epidural injection.

Procedure in Detail:
After the informed consent was obtained, the patient was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. Fluoroscopy was used to identify the L5-S1 interspace then a 3 ½-inch, 18-gauge needle was used to enter the epidural space with fluoroscopic guidance using the loss of resistance technique. Both AP and lateral views were used to check the needle placement. Then one cc of Omnipaque dye was injected, which revealed a normal epidural flow pattern. Then after a negative aspirate, 80 mg of Depo-Medrol and two cc of 1% Xylocaine and then two cc of saline were all slowly injected. There were no apparent complications.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Worker's compensation.

PATIENT: GILBERT CHAVIS
DATE: 04/01/2004

Brief History:
This patient returns today for follow up. He reports that the first epidural injection did not help him very much. He is still having lower back pain and radicular pain down the left leg. He is having a lot of difficulty with sleep at the present time. Apparently he has been snoring quite a bit. He reports that he has never had sleep difficulties in the past but he has developed it since he has had these medical problems. He continues to have chronic pain in the neck and shoulder area and it tends to progress into headaches. The Neurontin seems to be addressing that particular problem.

Examination:
On examination today the patient has cervical paraspinal muscle tenderness and upper trapezius tenderness. The base of the skull is somewhat tender as well. He has lumbosacral tenderness mainly on the left side in the lower lumbar paravertebral muscles. Straight-leg testing is negative. Neurologically he is intact in the bilateral lower extremities with normal reflexes. His Achilles' reflexes are both diminished though. The left hand is unchanged.

Diagnostic Impression:
1. Cervical degenerative disc disease with disc bulge.
2. Tension headaches, probably related to his cervical disc disease.
3. History of cerebrovascular accident.
4. Sleep disorder. It might possibly be related to his history of stroke.
5. Chronic mechanical back pain with radicular pain to the left leg.

Recommendations:
1. We will definitely need to get an MRI of the lumbosacral spine.
2. Repeat lumbar epidural injection.
3. Bextra 10 mg twice a day.
4. Neurontin 300 mg twice a day.
5. Refill Roxicodone for pain.
6. We will check back after MRI.

C. Gregory Kang, M.D.
Physiatrist
CGK/dhm
cc: Worker's compensation.

Patient Name: Gilbert Chavis Date: 4/6/04

TODAY'S PROCEDURE : _____

BP _____ P _____ R _____ HT: _____ WT: _____

ASSESMENT

Allergies: Codeine

LATEX? YES NO SHELLFISH? YES NO

DYES? YES NO BETADINE? YES NO

WOMEN: PREGNANT? YES NO

PRIOR INJ.? YES NO if yes, what kind? Caudal

Pain Level (0-10) 9

Meds currently taking:

Aspirin B12

(circle meds taken today)

POST PROCEDURE ASSESMENT

Nurses Notes:

_____

_____

_____

_____

_____

BP _____ P _____ R _____

_____

Physician's Signature

_____

Nurse's Signature

PATIENT: GILBERT CHAVIS
DATE: 04/01/2004

Brief History:
This patient returns today for follow up. He reports that the first epidural injection did not help him very much. He is still having lower back pain and radicular pain down the left leg. He is having a lot of difficulty with sleep at the present time. Apparently he has been snoring quite a bit. He reports that he has never had sleep difficulties in the past but he has developed it since he has had these medical problems. He continues to have chronic pain in the neck and shoulder area and it tends to progress into headaches. The Neurontin seems to be addressing that particular problem.

Examination:
On examination today the patient has cervical paraspinal muscle tenderness and upper trapezius tenderness. The base of the skull is somewhat tender as well. He has lumbosacral tenderness mainly on the left side in the lower lumbar paravertebral muscles. Straight-leg testing is negative. Neurologically he is intact in the bilateral lower extremities with normal reflexes. His Achilles' reflexes are both diminished though. The left hand is unchanged.

Diagnostic Impression:
1. Cervical degenerative disc disease with disc bulge.
2. Tension headaches, probably related to his cervical disc disease.
3. History of cerebrovascular accident.
4. Sleep disorder. It might possibly be related to his history of stroke.
5. Chronic mechanical back pain with radicular pain to the left leg.

Recommendations:
1. We will definitely need to get an MRI of the lumbosacral spine.
2. Repeat lumbar epidural injection.
3. Bextra 10 mg twice a day.
4. Neurontin 300 mg twice a day.
5. Refill Roxicodone for pain.
6. We will check back after MRI.

C. Gregory Kang, M.D.
Physiatrist
CGK/dhm
Cc: Worker's compensation.

PATIENT: GILBERT CHAVIS
DATE: 03/23/2004

Preoperative Diagnosis:
1. Lumbar radiculitis.

Postoperative Diagnosis:
1. Lumbar radiculitis.

Procedure:
1. Caudal epidural steroid injection with fluoroscopic guidance.

Brief History:
The patient is a 48-year-old gentleman with a history of lower back pain and radicular pain down left leg. He previously responded well to a lumbar epidural steroid injection. His symptoms have now recurred and he is here for another epidural injection.

Procedure in Detail:
After the informed consent was obtained, the patient was placed in the prone position and Betadine was used to sterilely prep the back in the usual fashion. 1% Xylocaine was used for local anesthesia. Fluoroscopy was used to identify the sacrum on the lateral view. A 3 ½-inch, 22-gauge spinal needle was then used to enter the sacrococcygeal ligament and was slowly advanced to about the S3 level. AP and lateral fluoroscopy was used to confirm needle placement than one cc of Omnipaque dye was injected which revealed a nice epidural flow pattern and no vascular uptake was noted. Then after a negative aspirate 80 mg of Depo-Medrol and 11 cc of saline were all slowly injected without complication.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm

Cc: Worker's compensation.

PATIENT: GILBERT CHAVIS
DATE: 2/6/04

Brief History:
He returns today for follow up. He reports his shoulder is feeling much better. He has some restriction in motion but overall he is pleased with the results. He continues to have neck pain, some radiation into the upper shoulder region. He weaned himself off the Remeron. He did not think it was helping him rest at night. He is still taking 6 Roxicodone a day. He is complaining of now pain in the lower back and into the groin to the medial thigh.

Examination:
He has some increased groin pain with internal and external rotation of the hip. The lumbosacral spine reveals some focal tenderness at the L4/5 and L5/S1 area as well as over the SI joint region. Neurologically he has no new focal deficits. No clonus or spasticity.

Diagnostic Impression:
(1) Left rotator cuff tendonitis status post arthroscopic surgery, improved
(2) Cervical disc displacement with radiculitis
(3) Chronic back pain with some radicular pain, possibly associated with the groin pain

Recommendations:
(1) We will go ahead and x-ray the left hip as well as the lumbar spine
(2) Refill Roxicodone
(3) Continue Neurontin 400mg b.i.d.
(4) Started him on Bextra 10mg b.i.d.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0002
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 1/7/04

Brief History:
Mr. Chavis returns today for follow up. He reports that his medications were stolen by the Vocational Rehab nurse that he saw a few weeks ago. I had a long discussion with Mr. Chavis. I told him that I would give him this one chance as far as replacing his medications but should it happen again I will not replace them. He is still having pain in the neck and left shoulder, lower back, some radicular pain in the gluteal region.

Examination:
Unchanged.

Diagnostic Impression:
(1) Cervical disc displacement with radiculitis
(2) Chronic shoulder pain, status post arthroscopic surgery
(3) History of cerebellar CVA

Recommendations:
(1) I refilled Roxicodone 30mg 2 tabs t.i.d. for pain
(2) Continue current dose of Neurontin
(3) Weaning off Remeron
(4) Check back in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0003
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 12/22/03

Brief History:
Mr. Chavis returns today for follow up. He reports continued pain in the lower back. He cannot sleep well at night because of it. He says it is starting to radiate into his groin and lateral thigh and posterior thigh region. He reports he did have a prior injection in the past in the lower back which gave him considerable relief. He is not sure what kind of injection that was.

Examination:
He is extremely tender in the SI joint region on the left side. The lumbar paravertebral muscles are tight. Neurologically patella reflexes are 2+. Achilles reflexes are both absent. Straight leg testing is negative.

Diagnostic Impression:
(1) Chronic low back, some radicular symptoms left leg
(2) Left rotator cuff repair
(3) Cervical disc displacement with radiculitis

Recommendations:
(1) Decrease Roxicodone to 30mg 2 tabs b.i.d.
(2) Start OxyContin 40mg at nighttime
(3) Continue Remeron 30mg q hs
(4) Neurontin 400mg b.i.d.
(5) He probably needs to have an MRI of the lumbosacral spine. Considering facet and SI blocks on that left side. Much of the back pain seems mechanical in origin.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0004
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 12/1/03

Brief History:
He continues to report his pain primarily now in the left side of his lower back and posterior thigh area. His x-rays reveal evidence of sclerosis in the left SI joint region. He also has mild spondylitic changes. Neck and shoulder, left arm is without change. He reports the Remeron does not seem to help with sleep any more.

Examination:
He has continued tenderness in the left SI joint. Straight leg testing is equivocal. Patella reflexes are 2+. Both achilles reflexes are diminished. No clonus or spasticity. Left hand exam reveals continued sensory changes in the ulnar nerve distribution.

Diagnostic Impression:
(1) Chronic left shoulder pain, status post arthroscopic surgery
(2) Cervical disc displacement with radiculitis
(3) Sacroiliac joint dysfunction
(4) Insomnia

Recommendations:
(1) We will go ahead and increase Remeron to 30mg q hs
(2) We are waiting for a left SI and facet joint injection approval
(3) Continue Roxicodone for pain
(4) Vioxx 25mg once daily

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0005
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 11/17/03

Brief History:
Mr. Chavis returns today for follow up. He reports continued chronic pain in the neck, shoulder, left arm associated with paresthesias. Also, the right side of his lower back continues to be extremely painful.

Examination:
He is tender in the right SI joint and lower lumbar paravertebral muscles. Facet joint loading maneuvers aggravate the pain. The left arm is without change.

Diagnostic Impression:
(1) Left focal ulnar neuropathy at the elbow, status post transposition
(2) Bilateral mild carpal tunnel syndrome, non-worker's comp related
(3) Right SI joint dysfunction, possible involvement of facet joints

Recommendations:
(1) Still waiting for approval for the spinal injections
(2) Continue all current medications

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0006
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 11/3/03

Brief History:
Mr. Chavis returns today for follow up. He reports continued pain in the neck, left shoulder, radicular pain down the left arm, also in the lower back-mainly on the right side. It is mainly localized to the back area-worse with activities such as bending, stooping, and walking. He reports he is getting some temporary partial relief with Roxicodone. He reports the shoulder ROM is also improving.

No new changes. No numbness or tingling in the legs. His left foot is burning though and that seems to be from his diabetes.

Examination:
He has tenderness mainly in the right SI joint and lower lumbar paravertebral muscles. Extension seems to aggravate his pain. The left shoulder ROM is much better. He has about 180 degrees of abduction but he is still hiking the left shoulder. Neurologically there are no new changes. Patella and achilles reflexes are 2+. No clonus or spasticity is noted today.

Diagnostic Impression:
(1) Left rotator cuff tendinosis status post arthroscopic surgery
(2) Frozen shoulder is definitely improving
(3) Cervical disc displacement with radiculitis, no change
(4) Mechanical back pain possibly involvement of the SI joint and lumbar facets, unchanged

Recommendations:
(1) Continue Roxicodone for severe pain
(2) Vioxx 25mg q d
(3) Remeron 15mg q hs
(4) May benefit from a diagnostic therapeutic SI and facet block
(5) Follow up in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

0007
Gregory Kang, MD

PATIENT: GILBERT CHAVIS
DATE: 10/2/03

Brief History:
Mr. Chavis returns today for follow up. He reports continued pain in the lower back, radiation down his left leg. He thinks it has gotten worse. He reports that he previously had some type of spinal injection and that seemed to give him relief for over a year. He is tolerating his medicines well. Roxicodone continues to help him. Remeron helps him rest at night. Neurontin continues to help with neck pain and associated headaches.

Examination:
Most of his pain seems to be in the right SI joint region. He has positive facet maneuvers on that right side. Neurologically his reflexes are 2+ patella. Achilles reflexes are both diminished. The left shoulder ROM is significantly improved. He still has some shoulder hiking and shoulder external rotation also is restricted.

Diagnostic Impression:
(1) Rotator cuff tendinosis, status post arthroscopic surgery and repair
(2) Cervical disc displacement with radiculitis
(3) Right SI joint dysfunction
(4) Lumbar radiculitis

Recommendations:
(1) I have recommended we try a right SI joint injection and possibly the facet joint above that to see if that will give him pain relief. We will try to pre-authorize this with worker's comp
(2) Refill all other medicines

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

Pain,
Spine & Sports
Medicine

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Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

PATIENT: GILBERT CHAVIS
DATE: 9/18/03

Brief History:
Mr. Chavis returns for follow up. He reports the back pain has not improved significantly. In fact, he thinks it is getting worse. It is going down his left leg. He does report he previously had an epidural injection which gave him complete relief. He is afraid that there may be something abnormal in his back at this time.

Examination:
We palpated the lower back. He is tender in the lumbosacral spine. Extension and ROM aggravates his pain. Neurologically he has 2+ patella reflexes. Achilles reflexes are absent. Muscle strength is WNL.

Diagnostic Impression:
(1) Low back pain with radiculitis, previously responded well to epidural injections.

Recommendations:
(1) We will go ahead and x-ray his back
(2) Recommended either a course of therapy or a trial of epidural injections
(3) Continue current medications

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp
Attn: Carol Lovette

PATIENT: GILBERT CHAVIS
DATE: 9/10/03

Brief History:
He returns today for follow up. He reports increasing back pain with radicular pain down his leg. He says he has had this before on a prior worker's comp injury back in 1996. He remembers getting some type of injection in the back which relieved all of his pain. He is still having neck and shoulder pain down the left arm. He is attending aggressive physical therapy for the left shoulder for ROM. He still reports pain in the left arm and shoulder.

He reports his medications are effective. The only problem has been that he has been gaining weight from the Neurontin, he believes. We have decreased that to once daily now.

Examination:
He has about 180 degrees of abduction on the left side which is markedly better. He has still limited external rotation. He has tenderness in the greater tuberosity of the humerus. Some numbness in the index and fourth and fifth digits of the left hand. Otherwise there is no other change. In the back, he has tenderness in the right lower lumbar paravertebral muscles, mainly at L5/S1. Straight leg testing is negative.

Diagnostic Impression:
(1) Rotator cuff tear, status post repair
(2) Cervical disc displacement with radiculitis
(3) History of low back injury/radiculitis
(4) Chronic depression
(5) History of ulnar nerve transposition

Recommendations:
(1) Continue Neurontin at 400mg q hs
(2) Continue Remeron 15mg q hs for depression and sleep regulation
(3) Vioxx 25mg q d
(4) Continue current dose of Roxicodone
(5) As for the epidural injection in the back, he is currently hesitant with that. We will follow up in a month.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 8/27/03

Brief History:
Mr. Chavis returns today for follow up. He continues with physical therapy for the left shoulder. He continues to make progress. He is still having considerable neck and shoulder pain, radiating down his left arm. He had to stop taking the Zonegran because it was giving him severe headaches. He reverted back to Neurontin b.i.d. and is tolerating that well. Still requiring Roxicodone on a regular basis for pain control. He reports poor sleep and ongoing depression.

Examination:
He has cervical paraspinal, upper trapezius muscle tenderness. Shoulder ROM shows about 160 to 170 degrees of abduction. Still has some weakness in the left hand intrinsic muscles but much better than on previous exams. Continued sensory decrease in the left fourth and fifth digits.

Diagnostic Impression:
(1) Cervical disc displacement with radiculitis
(2) Rotator cuff tear status post repair

Recommendations:
(1) Discontinue Zonegran
(2) Continue Neurontin 400mg b.i.d.
(3) Refill Roxicodone
(4) Continue Vioxx
(5) Start Remeron 15mg q hs for sleep
(6) Follow up in 1 month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 8/7/03

Brief History:
Gilbert returns today in follow up. He is getting physical therapy at Strand Regional. Apparently he is developing a frozen shoulder. His ROM is limited. He continues to have pain in the neck with radiation into the left arm. The Neurontin is certainly helping with that and with the associated occipital headaches. However, he reports the Neurontin is making him gain weight. He has put on about 15 lbs. It is starting to effect his diabetes.

Examination:
He does look a little bit more overweight. He continues to have pain and tenderness in the cervical paraspinals and left upper trapezius muscle. He has shoulder ROM which is pretty poor at about 100 degrees of abduction. External rotation is very severely limited as well.

Diagnostic Impression:
(1) Frozen shoulder
(2) Rotator cuff tear, status post repair
(3) Cervical disc displacement with radiculitis

Recommendations:
(1) Start weaning off Neurontin. We will add Zonegran 100mg q hs and titrate up as a substitute for Neurontin
(2) Refill Roxicodone
(3) Continue Vioxx 25mg a day
(4) Follow up in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 6/16/03

Brief History:
Mr. Chavis returns today for follow up. He reports continuing ongoing pain in the lower left shoulder and arm. He still reports limited use of the left arm. He continues to have some radicular pain down the left arm starting from the neck. His pain is under fairly good control with the Roxicodone. Neurontin seems to help with the dysesthesias and the radicular type symptoms as well. He is due to have rotator cuff surgery in the next few weeks with Dr. Chambers.

His main complaint today is poor sleep. We have tried various medications in the past including Ambien. He reacted poorly to Trazodone.

Examination:
He is alert and oriented x 3. He has about 100 degrees of shoulder abduction on the left side with pain. He has a positive impingement sign. Neck and upper trapezius region still has tenderness and trigger points. Neurologically there are no new changes.

Diagnostic Impression:
(1) Rotator cuff tendonopathy with impingement syndrome
(2) Cervical disc displacement C5/6 with radiculitis
(3) Insomnia

Recommendations:
(1) Neurontin 400mg t.i.d.
(2) Continue current dose of Oxycodone
(3) Start Pamelor 25mg q hs and titrate up until effective for sleep

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 5/8/03

Brief History:
Mr. Chavis returns for follow up. His condition has not changed much. He still has severe pain in the left shoulder-worse with activity. Also neck and upper trapezius muscles are painful associated with muscle spasms. He is tolerating his medicines well. They seem to give him some temporary partial relief. No significant side effects. He has seen Dr. Chambers for the left shoulder. He has not had his surgery yet. I am not sure what the future plans are regarding that.

Examination:
He has continued cervical and thoracic myofascial trigger points. Left shoulder ROM is still restricted to about 90 to 100 degrees of abduction. Neurologically no changes.

Diagnostic Impression:
(1) Cervical disc displacement with radiculitis C5/6
(2) Chronic rotator cuff tendonopathy with impingement

Recommendations:
(1) Refill Oxycodone
(2) Continue Neurontin b.i.d.
(3) Follow up in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 4/23/03

Brief History:
Mr. Chavis returns today for follow up. The dizziness is significantly improved after stopping the Wellbutrin and the Lodine. However, Mr. Chavis is still having a lot of neck and shoulder pain associated with muscle spasms. The pain radiates down his left arm. He is still having significant difficulty using the left shoulder. He is having difficulty with lifting, overhead activities and overall use of the left arm. He recently saw Dr. Chambers who recommended what sounds like subacromial decompression for impingement syndrome. However, it appears that worker's compensation has not authorized surgery yet.

Mr. Chavis continues to suffer from chronic unremitting pain in the neck, shoulders, and down into the left arm. His condition has not significantly changed despite aggressive conservative treatment. He continues to require pain medications on a regular basis.

Examination:
He still has continued pain and tenderness in the cervicothoracic region and the left upper trapezius and shoulders. He has 90 degrees of abduction in the left shoulder. Forward flexion is also restricted to about 90 degrees. The subacromial bursa is tender. The shoulder overall is tender to palpation. Neurologically there are no new changes.

Diagnostic Impression:
(1) Chronic left rotator cuff tendonopathy with impingement syndrome
(2) C5/6 disc displacement with radiculitis
(3) Depression due to chronic pain

It is my medical opinion that Mr. Chavis has achieved maximal medical improvement for all practical purposes. He may make further improvements with regards to the left shoulder if he undergoes his surgery. Mr. Chavis will continue to require pain medications on a regular and long term basis. He may need intermittent sessions of therapy to address neck and shoulder pain. A cervical epidural in the future may also help him. Mr. Chavis, in my opinion, is unable to work due to his chronic pain condition.

Based on the AMA Guide's 5th edition Mr. Chavis receives a total of 12% left upper extremity impairment using the range of motion model. Shoulder abduction is 90 degrees. Forward flexion is 90 degrees. External rotation is 10 degrees. For the cervical spine, Mr. Chavis receives an 8% impairment using the DRE model.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Compensation

PATIENT: GILBERT CHAVIS
DATE: 4/2/03

Brief History:
Gilbert returns today for follow up. The dizziness is much improved now. He has weaned himself down to 1 Wellbutrin a day. He is still having a little bit of dizziness in the morning which does not last very long. He recently saw Dr. Chambers who is currently reviewing his MRI. He is having a lot of shoulder pain on the left side that radiates into the neck. He continues to have pain down his left arm. He is having muscle spasms around the periscapular region as well.

Examination:
The cervical paraspinals, upper trapezius muscles are still extremely tender with trigger points. He has limited ROM in the left shoulder to abduction and forward flexion. Neurologically there are no new changes.

Diagnostic Impression:
(1) Chronic rotator cuff tendonopathy with impingement syndrome
(2) Cervical disc displacement with radiculitis
(3) Left AC joint arthritis

Recommendations:
(1) We will start some Lodine XL 400mg b.i.d. with meals
(2) Continue Roxicodone
(3) Wean off Wellbutrin
(4) Follow up in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

4/17/03 Phone Call to MR Chan
Neurontin TID.
D/C Lodine

PATIENT: GILBERT CHAVIS
DATE: 3/21/03

Brief History:
Gilbert returns to my office complaining of severe pain in the left shoulder. He is also having a lot of nausea and dizziness. He thinks this happened after he increased the Wellbutrin. Otherwise he is without change. He is still taking his Roxicodone on a regular basis with some relief of his pain. He is due to see Dr. Chambers very soon.

Examination:
He only has about 90 degrees of abduction on the left side. Very little strength in the rotator cuff muscles.

Diagnostic Impression:
(1) Chronic rotator cuff tendonitis with impingement syndrome

Recommendations:
(1) Follow up with Dr. Chambers
(2) Continue Roxicodone
(3) Wean off Wellbutrin
(4) Follow up after visit with Dr. Chambers

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Worker's Comp

PATIENT: GILBERT CHAVIS
DATE: 3/12/03

Brief History:
Mr. Chavis returns today in follow up because he is out of pain medication. I had written #180 Roxicodone tablets but the pharmacist only filled #120 so he is out. He continues to complain of severe pain in the neck and shoulder area with radiation to the left arm. He cannot lift his arm above 90 degrees. Any type of use of the left arm aggravates his pain. Gilbert reports that basically the left arm he cannot use for any type of physical activity.

Examination:
He has about 90 degrees of forward flexion in the left shoulder. 90 degrees of abduction. He has diffuse tenderness over the subacromial bursa, upper trapezius, and around the deltoid muscles. Neurologically his biceps reflexes are 2+. Brachioradialis 2+ bilaterally. He has give away weakness in the left arm.

Diagnostic Impression:
(1) Chronic left rotator cuff tendonopathy with impingement syndrome
(2) C5/6 disc displacement with radiculitis
(3) Depression

Recommendations:
(1) Continue Roxicodone 30mg, 2 tablets t.i.d. for severe pain, refilled #180
(2) Continue Wellbutrin 150mg b.i.d.
(3) Neurontin 400mg t.i.d.
(4) Recommended seeing orthopedic surgeon regarding possible left shoulder arthroscopic surgery

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

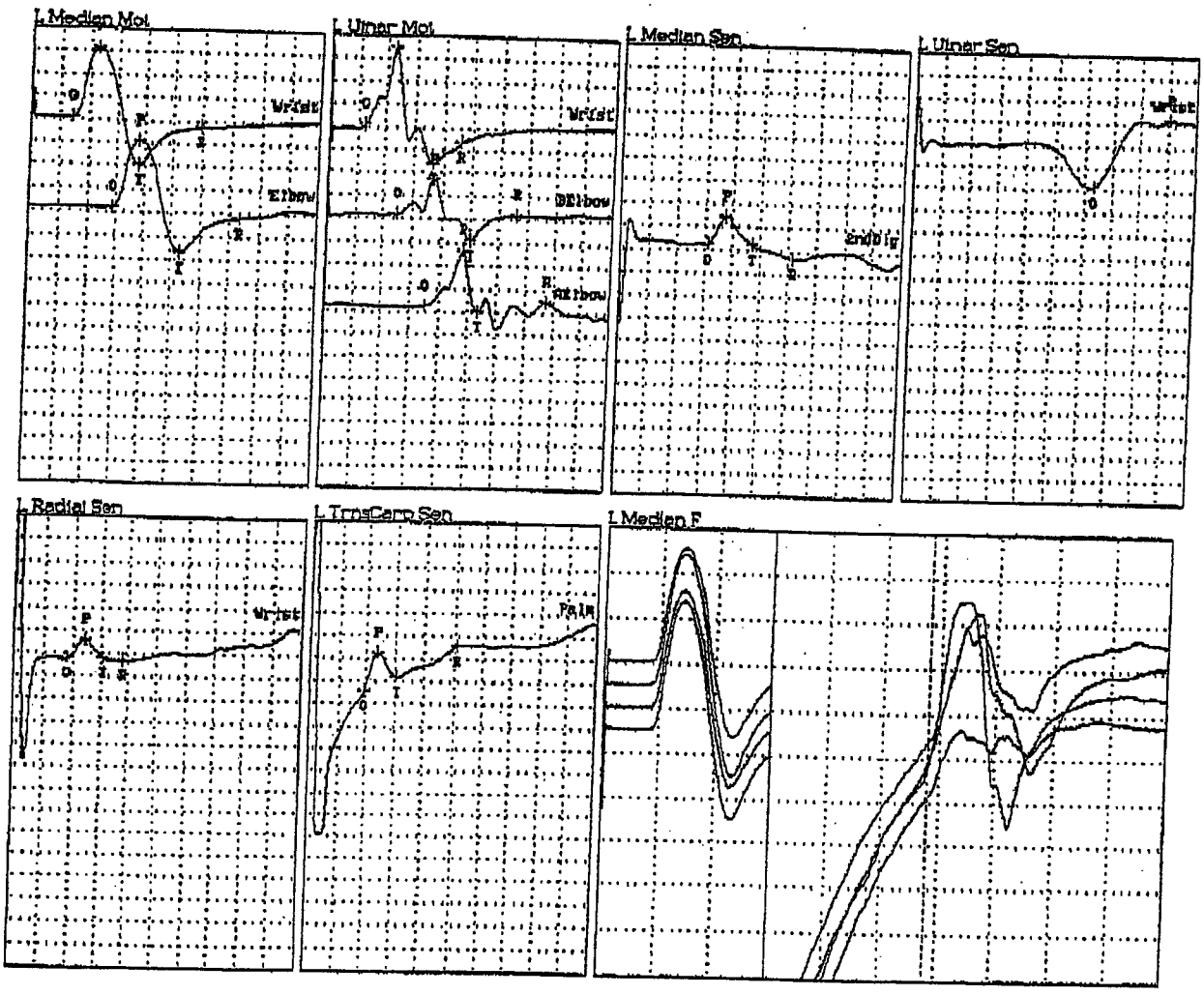
Cc: Worker's Compensation

Pain, Spine, and Sports Medicine 12/11/02 7:24 pm

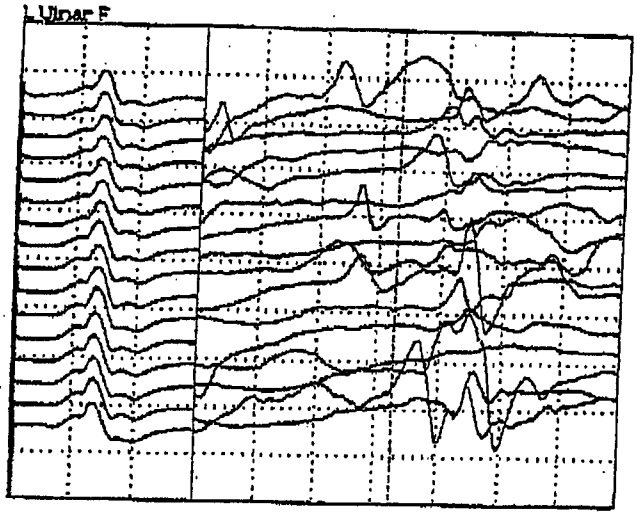
Patient: Chavis, Gilbert R.
Sex: Male

Age/DOB: 48 / 12-7-1954
Height: 5'5"
Weight: 195 lbs.

Physician: C.G.Kang,MD.
Tech DJB
Ref Phys: J.Wilkins,MD.



Chavis, Gilbert 12/11/02 7:24 pm 2



Nerve Conduction Report:

Motor Nerves

Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
L Median	APB					O-P (mV)					O			
	Wrist	4.22	<4.2			15.12	>5.0			Elbow-Wrist	4.41	22.75	51.6	>50.0
	Elbow	8.63				14.84								
L Ulnar	ADM					O-P (mV)					O			
	Wrist	3.75	<4.2			3.39	>3.0			BElbow-Wrist	3.66	20.00	54.7	>53.0
	BElbow	7.41				1.49				AElbow-BElbow	3.09	13.50	43.6	>53.0
	AElbow	10.50				2.38								

Sensory Nerves

Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
L Median	Wrist					P-T (µV)					P			
	2ndDig			3.70	<3.4	11.76	>10.0			2ndDig-Wrist	3.70	14.00	37.8	>40.0
L Ulnar	5thDig					P-T (µV)								
	Wrist	NR		NR										
L Radial	IDI					P-T (µV)					P			
	Wrist			2.41	<2.7	15.20	>18			Wrist-IDI	2.41	10.00	41.6	>40.0
L TmsCarp	Wrist					P-T (µV)					P			
	Palm			2.39	<2.2	21.16	>10			Palm-Wrist	2.39	8.00	33.5	40

Chavis, Gilbert

12/11/02 7:24 pm 3

F/H Report:

Nerve	Muscle	Lat1 (ms)	Lat2 (ms)	Lat2 - Lat1 (ms)	Amplitude (μV)
L Median F	APB	28.98		28.98	
L Ulnar F	ADM	31.33		31.33	

EMG Report:

Side	Muscle	Nerve	Root	INS	FIBS	PSW	AMP	DUR	Poly	REC	IP	Comment
L	Biceps	Musc	C5-6	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	Cerv Parasp	Rami	C1-T1	Inc	Nml	1+	Nml	Nml	2+	Nml	Nml	crd's
L	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	ExtCarRad	Radial	C6-7	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	PronatorTer	Median	C6-7	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	

PATIENT: GILBERT CHAVIS
DATE: 11/27/02

Diagnosis: Rotator Cuff Tendonitis Left Shoulder
Procedure: Left Shoulder Injection

The left shoulder was prepped under sterile fashion. 40mg of Depo-Medrol and 2cc of 1% Xylocaine was injected into the left shoulder joint after a negative aspirate. 25 gauge, 1 ½" needle was used. There were no complications.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Pain, Spine & Sports Medicine

C. Gregory Kang, M.D. • Phone: (843) 293-8868 • Fax: (843) 293-8869
Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 20 • Myrtle Beach, SC 29588

November 8, 2002

RE: GILBERT CHAVIS

To Whom It May Concern:

Mr. Gilbert Chavis has been a patient of mine. He is permanently disabled due to the injuries that he suffered. He is unable to work. He has been disabled from January 25, 2000 until the present. I do not see his condition changing in the future.

If you have any questions about Mr. Chavis please do not hesitate to contact me.

Sincerely,

C. Gregory Kang, MD
Physiatrist

CGK/ajw

Fax To: Betty Benton
365-6339

PATIENT: GILBERT CHAVIS
DATE: 11/8/02

Brief History:
Mr. Chavis returns for follow up. He reports that the left hand numbness is much better after the ulnar nerve release. However, he was in an arm sling for several weeks after surgery. When the sling was removed Mr. Chavis reports that his shoulder pain has dramatically worsened. He says the pain is much more severe. His pain medications are not quite as effective as before. The pain is mainly localized in the neck and upper shoulder area and into the humerus.

Of concern to Mr. Chavis today is that he has been getting regular testosterone injections. He is currently being followed by his urologist, Dr. Shore. Mr. Chavis reports that his sex drive has continued to diminish despite getting testosterone injections. Mr. Chavis feels that maybe his stroke in the past after the discography has something to do with this. He would like to have this situation evaluated.

Examination:
His rotator cuff muscles are weak. They are rated at 4-/5. Shoulder abduction is also decreased from prior exams. It is about 85 degrees abduction and about 100 degrees of forward flexion. He has improved sensation in the left hand. The elbow incision is healing very nicely at this time. He does have pain and tenderness in the muscles around the scapulothoracic region including the pectoralis minor, trapezius, levator scapulae and deltoid muscles.

Diagnostic Impression:
(1) Cervical degenerative disc disease
(2) Left rotator cuff tendonopathy with impingement syndrome, slightly worse due to long term use of a sling
(3) Erectile dysfunction with decreased sexual drive. I think this is most likely due to multi-factorial causes including chronic pain. I personally do not believe that this is a direct result of the stroke that he suffered after the discography. Nonetheless, I am going to ask for an opinion from a neurologist to see if there is any direct relationship between his prior CVA and his current erectile dysfunction.

Recommendations:
(1) In the meantime, he is to continue with his Zonegran 300mg q hs
(2) Percocet 10/325, 2 tablets 3 to 4 times a day for severe pain
(3) I think he will need another course of physical therapy to the left shoulder mainly for strengthening.
(4) I will address this with Mr. Chavis when he returns for follow up.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw
Cc: Worker's Compensation

Pain, Spine & Sports Medicine

935

C. Gregory Kang, M.D. • Phone: (843) 232-8118

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 29575

550-441515/317

PATIENT: GILBERT CHAVIS
DATE: 9/4/02

Brief History:
Mr. Chavis returns for follow up. These are his main complaints. He continues to have pain in the left side of his neck, upper shoulder. He also has continued paresthesias and tingling in the left 4th and 5th digits. He is also having elbow discomfort. He was recently seen and evaluated by Dr. White regarding ulnar neuropathy at the elbow.

Mr. Chavis reports that he is making progress as far as his physical therapy. The spasms in his neck and shoulder area seem to be a little better. He is still having a lot of problems with pain in that distribution, worse with use of the left arm.

Examination:
He continues to have myofascial tender points and trigger points in the upper trapezius and cervical paraspinals. He has a positive Tinel's sign in the left elbow. There is continued atrophy of the left hand intrinsic muscles as well as decreased sensation in the left 4th and 5th digits. Strength is also diminished in the hand intrinsics.

Laboratory Data:
I reviewed his cervical spine MRI. He has a mild cervical disc herniation at T5/6. We did an EMG/nerve conduction study of the upper extremities and this reveals bilateral carpal tunnel syndrome which was relatively mild. He also has a focal ulnar neuropathy on the left side at the elbow consistent with cubital tunnel syndrome/tardy ulnar palsy. He has evidence of de-enervation based on needle exam in the left first dorsal interossei muscle as well.

Diagnostic Impression:
(1) Left rotator cuff tendonitis, chronic
(2) C5/6 disc herniation
(3) Cervical myofascial pain
(4) Left focal ulnar neuropathy at the elbow with evidence of de-enervation of hand intrinsic muscles.
(5) Mild bilateral carpal tunnel syndrome

Recommendations:
(1) I have recommended Gilbert try another course of cervical traction and slowly work him up to about 25 to 30 lbs. if he can tolerate this.
(2) His other option is to undergo a cervical epidural steroid injection but he is not interested in this after what happened the last time he had a cervical spine procedure.
(3) Continue with left shoulder rehabilitation.

PATIENT: GILBERT CHAVIS

(4) Continue follow up with Dr. White and possibly surgical release of the ulnar nerve on the left side.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Dr. White
Worker's Compensation

Pain, Spine & Sports Medicine

C. Gregory Kang, M.D. • Phone: (843) 232-8118

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 2957

PATIENT: GILBERT CHAVIS
DATE: 8/12/02

Procedure Note: Left Shoulder Injection
Diagnosis: Chronic Rotator Cuff Tendonitis/Bursitis

The left shoulder was prepped with Betadine solution. Sterile technique was used. 40mg of Depo-Medrol and 1cc of 1% Xylocaine was injected into the left shoulder bursa without complications. Mr. Chavis tolerated the procedure well.

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Community Medical Center • South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 2957

PATIENT: GILBERT CHAVIS
DATE: 8/7/02

Procedure Note: Trigger Point Injections

Trigger point was identified in the right pectoralis minor muscle. 3cc of 1% Xylocaine was injected into the trigger point. 25 gauge, 1 ½" needle was used to infiltrate the medication. The patient tolerated the procedure well. There were no complications.

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Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 2957

PATIENT: GILBERT CHAVIS
DATE: 8/5/02

Brief History:
Mr. Chavis returns for follow up. The Duragesic seems to be ineffective for controlling his pain. The Roxicodone gives him temporary partial relief. He is having to take up to six a day at this time. He frequently wakes up at night with severe pain in the neck and upper shoulder area, especially on that left side. He still has paresthesias in his hands. Dysesthesias in the feet seem to be better with Topamax.

Examination:
Unchanged. He still has tenderness in the left upper trapezius and scalene muscles. Shoulder abduction causes pain. He is still tender in the subacromial bursa.

Diagnostic Impression:
(1) Chronic rotator cuff tendonitis with impingement syndrome
(2) AC joint arthritis
(3) Cervicothoracic myofascial pain
(4) Dysesthetic pain in the feet
(5) Bilateral carpal tunnel syndrome and left focal ulnar neuropathy

Recommendations:
(1) Increase Roxicodone to 1 tablet q 4 h, #180 a month
(2) Wean off Duragesic
(3) Continue Topamax 50mg q hs
(4) Schedule physical therapy to the left side of the neck and upper shoulder area

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Pain,
Spine & Sports
Medicine

C. Gregory Kang, M.D. • Phone: (843) 232-81

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 2

PATIENT: GILBERT CHAVIS
DATE: 7/31/02
STUDY: EMG/NERVE CONDUCTION STUDY

Brief History:
Mr. Chavis is a 47 year-old gentleman with a history of numbness, tingling and paresthesias especially in the left arm and hand and also to some degree in the right hand. He is here for electrodiagnostic testing.

Findings:

(1) Bilateral median motor distal latencies were slightly delayed with normal amplitudes and conduction velocities.
(2) Right ulnar motor distal latency, amplitude and velocity is normal.
(3) Left ulnar motor distal latency is normal. However, the conduction velocity across the elbow is markedly delayed when compared to the forearm. There is also an amplitude drop across the elbow.
(4) Bilateral median sensory and transcarpal studies are delayed. Left ulnar sensory response is absent.
(5) Repetitive nerve stimulation of the upper extremity reveals no significant decrement in amplitude.
(6) Needle EMG of select muscles of the upper extremities reveals increased insertional activity and positive sharp waves and fibrillation potentials in the left first dorsal interossei muscle. The left APB muscle is normal.

Conclusions:

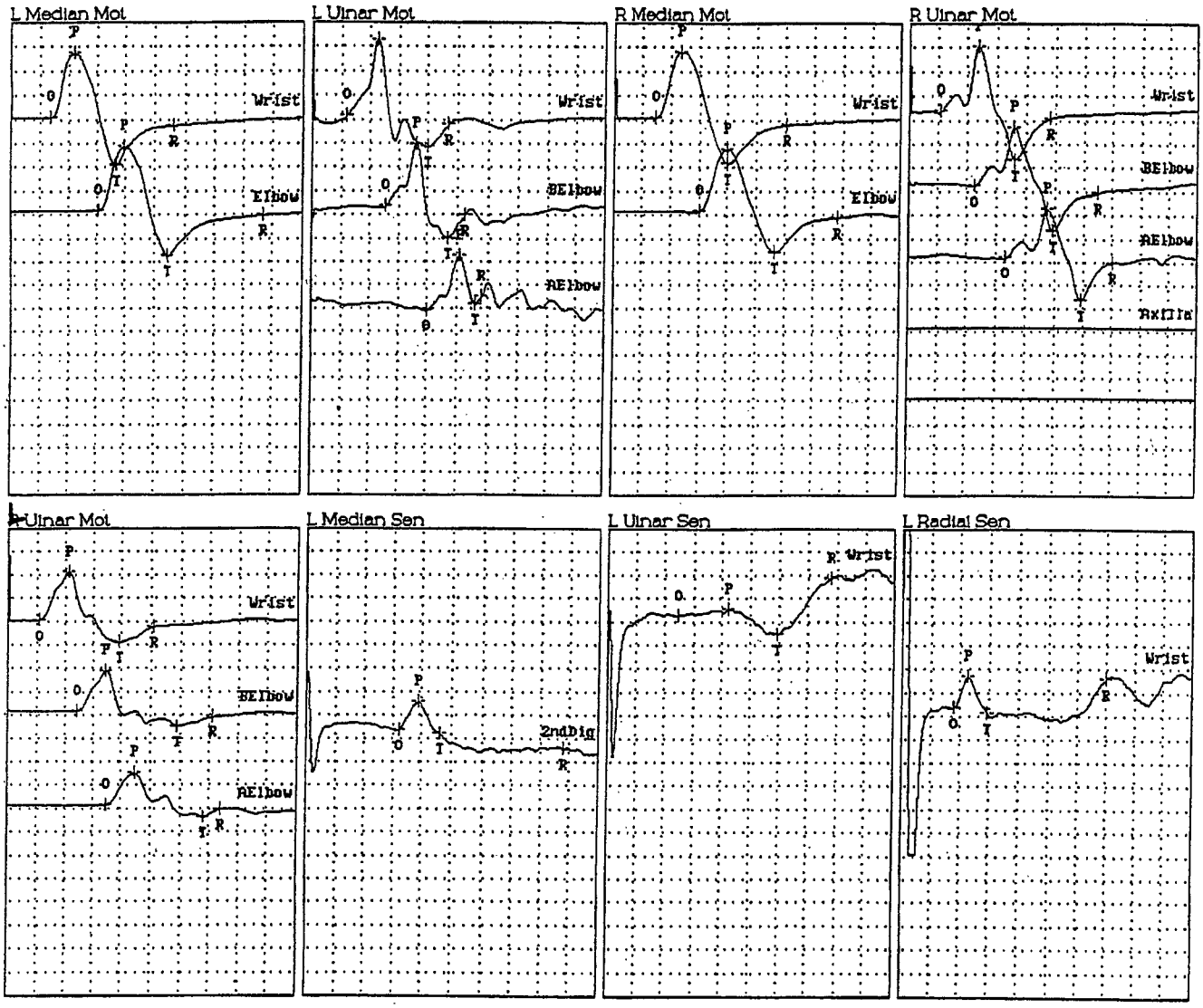
(1) Mild bilateral focal median neuropathy at the wrists, consistent with carpal tunnel syndrome.
(2) Left focal ulnar neuropathy at the elbow consistent with cubital tunnel syndrome versus tardy ulnar palsy. There is evidence of de-enervation occurring in the left first dorsal interossei muscle. This indicates that the focal ulnar neuropathy is severe and causing ongoing de-enervation at this time.

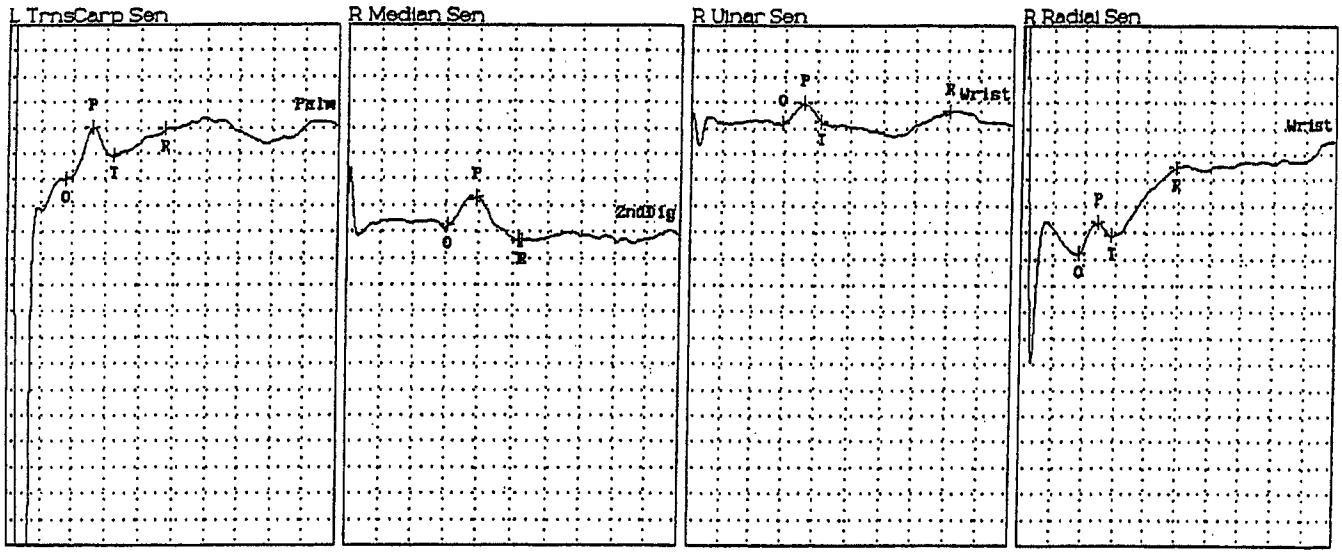
C. GREGORY KANG, M.D.
Physiatrist

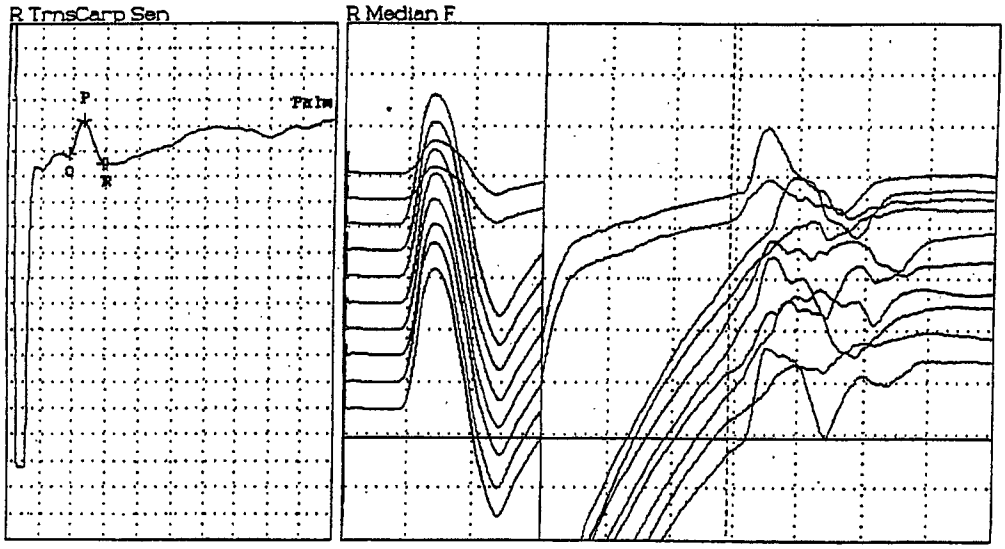
CGK/ajw

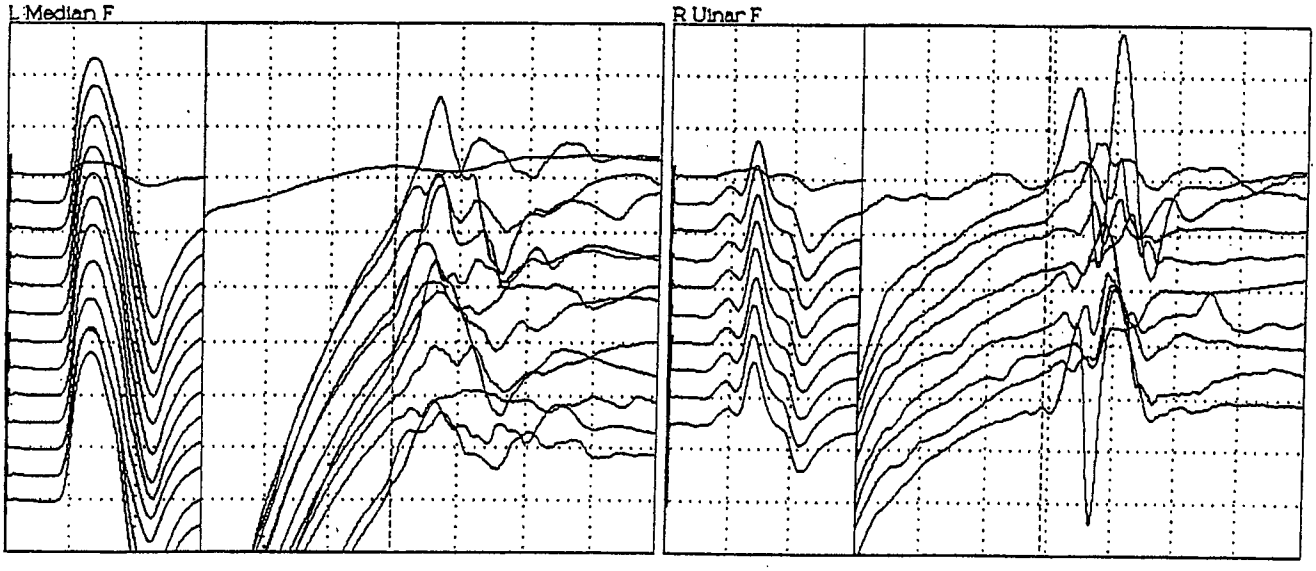
Pain, Spine, and Sports Medicine

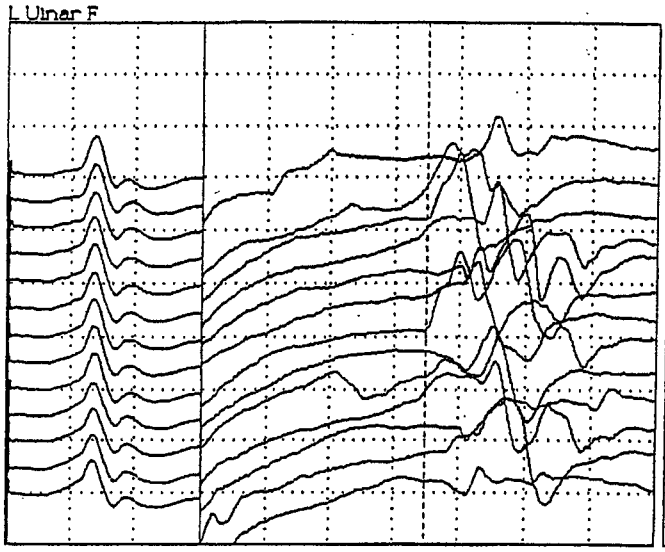
Patient: Chavis, Gilbert R.	**Age/DOB:** 47 / 12-7-1954	**Physician:** C.G.Kang,MD.
Sex: Male	**Height:** 5'5"	Tech DJB
	Weight: 190 lbs	**Ref Phys:** J.Wilkins,MD.

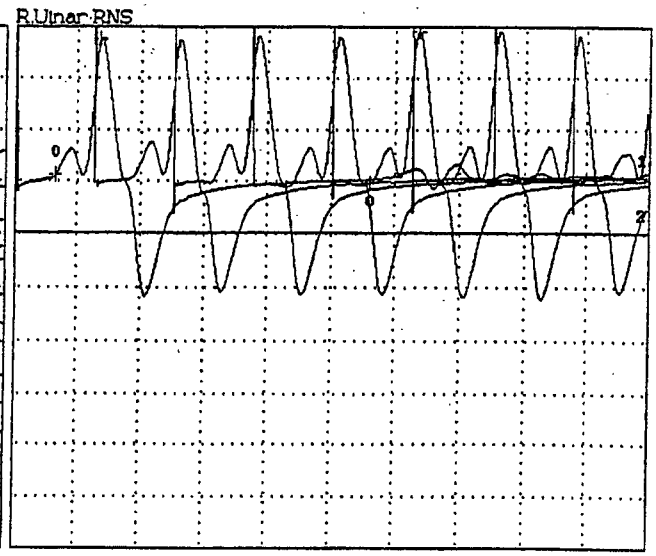


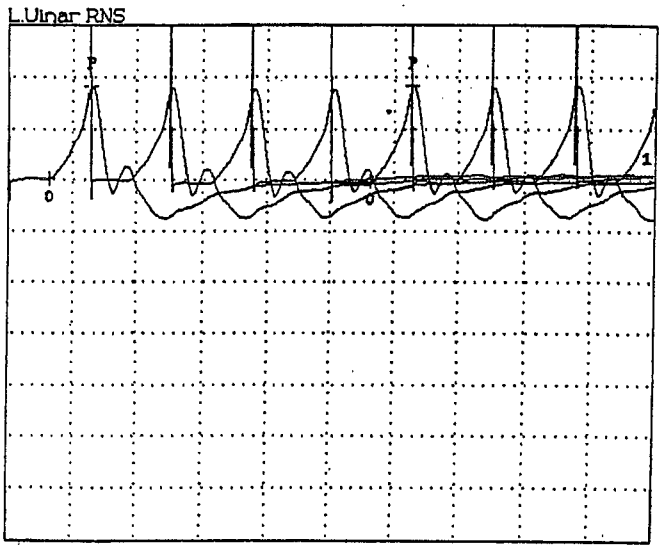

L TrnsCarp Sen
R Median Sen
R Ulnar Sen
R Radial Sen
Wrist


R TrnsCarp Sen
R Median F


L Median F
R Ulnar F







Nerve Conduction Report:

Motor Nerves

Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
L Median	APB					O-P (mV)					0			
	Wrist	4.13	<4.2			13.13	>5.0			Elbow-Wrist	5.06	26.00	51.4	>50.0
	Elbow	9.19				13.37								
L Ulnar	ADM					O-P (mV)					0			
	Wrist	3.47	<4.2			3.22	>3.0			BElbow-Wrist	4.13	20.50	49.7	>53.0
	BElbow	7.59				2.64				AElbow-BElbow	4.36	16.50	37.8	>53.0
	AElbow	11.95				2.34								

Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
R Median	APB					O-P (mV)					O			
	Wrist	4.50	<4.2			13.61	>5.0			Elbow-Wrist	4.50	23.00	51.1	>50.0
	Elbow	9.00				13.09								
R Ulnar	ADM					O-P (mV)					O			
	Wrist	3.28	<4.2			5.38	>3.0			BElbow-Wrist	3.52	20.00	56.9	>53.0
	BElbow	6.80				4.92				AElbow-BElbow	3.14	16.00	50.9	>53.0
	AElbow	9.94				4.16								
L Ulnar	ADM					O-P (mV)					O			
	Wrist	3.33	<4.2			4.06	>3.0			BElbow-Wrist	3.98	21.00	52.7	>53.0
	BElbow	7.31				3.46				AElbow-BElbow	3.14	10.00	31.8	>53.0
	AElbow	10.45				2.69								

Sensory Nerves

Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
L Median	Wrist					P-T (μV)					P			
	2ndDig			3.88	<3.4	10.20	>10.0			2ndDig-Wrist	3.88	14.00	36.1	>40.0
L Ulnar	5thDig					P-T (μV)								
	Wrist	NR		NR										
L Radial	IDI					P-T (μV)					P			
	Wrist			2.27	<2.7	15.73	>18			Wrist-IDI	2.27	10.00	44.1	>40.0
L TrnsCarp	Wrist					P-T (μV)					P			
	Palm			2.58	<2.2	11.15	>10			Palm-Wrist	2.58	8.00	31.0	40
R Median	Wrist					P-T (μV)					P			
	2ndDig			3.92	<3.4	12.66	>10.0			2ndDig-Wrist	3.92	14.00	35.7	>40.0
R Ulnar	5thDig					P-T (μV)					P			
	Wrist			3.58	<3.45	7.41	>15.0			Wrist-5thDig	3.58	14.00	39.1	>40.0
										Wrist-5thDig	3.58	-----	-----	>40.0
R Radial	IDI					P-T (μV)					P			
	Wrist			2.42	<2.7	4.93	>18			Wrist-IDI	2.42	10.00	41.3	>40.0
R TrnsCarp	Wrist					P-T (μV)					P			
	Palm			2.33	<2.2	26.32	>10			Palm-Wrist	2.33	8.00	34.4	40

F/H Report:

Nerve	Muscle	Lat1 (ms)	Lat2 (ms)	Lat2 - Lat1 (ms)	Amplitude (μV)
R Median F	APB	29.53		29.53	

Nerve	Muscle	Lat1 (ms)	Lat2 (ms)	Lat2 - Lat1 (ms)	Amplitude (μV)
L Median F	APB	30.00		30.00	
R Ulnar F	ADM	29.45		29.45	
L Ulnar F	ADM	32.42		32.42	

EMG Report:

Side	Muscle	Nerve	Root	INS	FIBS	PSW	AMP	DUR	Poly	REC	IP	Comment
L	1stDorint	Ulnar	C8-T1	Inc	1+	1+	Nml	Nml	3+	Nml	C/CE	
L	APB	Median	C8-T1	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	Biceps	Musc	C5-6	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	fcu	ulnar	C7-8	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	PronatorTer	Median	C6-7	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
L	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
R	1stDorint	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
R	Biceps	Musc	C5-6	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	
R	PronatorTer	Median	C6-7	Nml	Nml	Nml	Nml	Nml	Nml	Nml	Nml	

RNS Report:

Nerve: R. Ulnar

Trial	Side	Amp 1 (mV)	Amp 5 (mV)	Amp Diff %	Area 1 (mVms)	Area 5 (mVms)	Area Diff %
1	Right	5.27	5.83	10.5	9.04	10.48	15.8
2	Right	-----	-----	-----	-----	-----	-----

Nerve: L. Ulnar

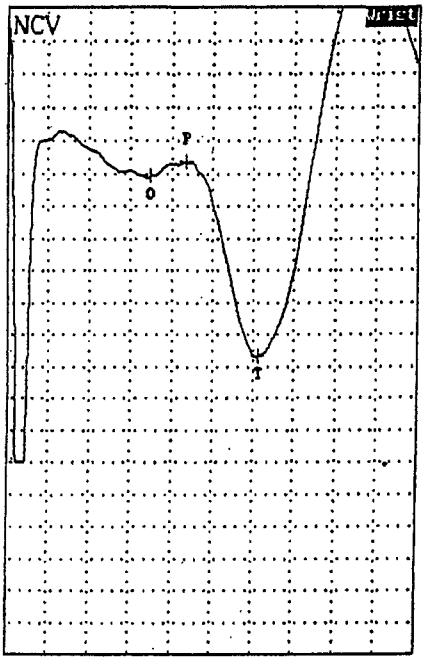
Trial	Side	Amp 1 (mV)	Amp 5 (mV)	Amp Diff %	Area 1 (mVms)	Area 5 (mVms)	Area Diff %
1	Left	3.61	3.72	3.1	6.74	7.07	4.9

Pain, Spine, and Sports Medicine

Patient: Chavis, Gilbert R.
Sex: Male

Age/DOB: 47 / 12-7-1954
Height: 5'5"
Weight: 190 lbs

Physician: C.G.Kang,MD.
Tech DJB
Ref Phys: J.Wilkins,MD.



Nerve	Site	Onset Lat (ms)	Norm Onset	Peak Lat (ms)	Norm Peak	Amplitude	Norm Amp	Area (mVms)	Duration (ms)	Seg Name	Delta (ms)	Distance (cm)	Velocity (m/s)	Norm Vel
						P-T (μV)					P			
L Ulnar Sen	5thDig													
	Wrist			4.33	<3.45	45.43	>15.0			Wrist-5thDig	4.33	14.00	32.3	>40.0
										Wrist-5thDig	4.33	-----	-----	>40.0

Site 5thDig	Elecl (mA)	PW (μs)	Gain (μV/div)	Hicut (Hz)	Locut (Hz)	Sweep (ms/div)
Wrist	51.0	150	7.50	2000	10.00	1.0

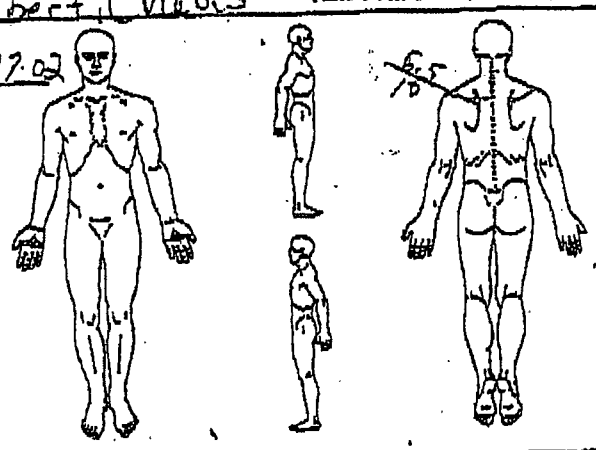
Mark Area of Pain

A: Ache B: Burn S: Sharp P: Pins & Needles N: Numbness ST: Stabbing

Rate Pain Scale, 1 to 10,(1 being mild & 10 being extreme)

Gilbert Chavis

Date: 8-27-02



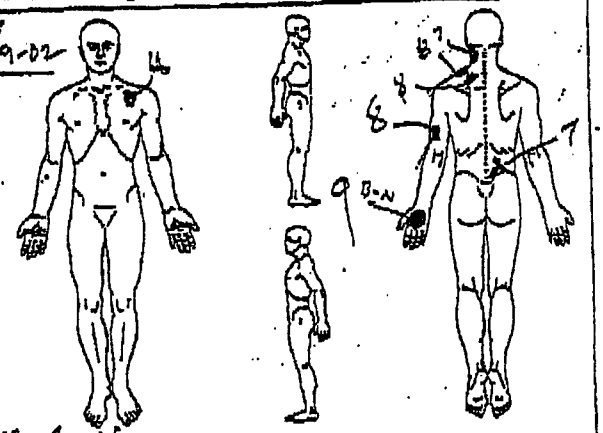
O

A

P

E.S. Chronic Pain L/Lec Thoracic

Date: 8-29-02



O Myofascitis

A

P Neurization

B.M.S: Chronic pt ICE

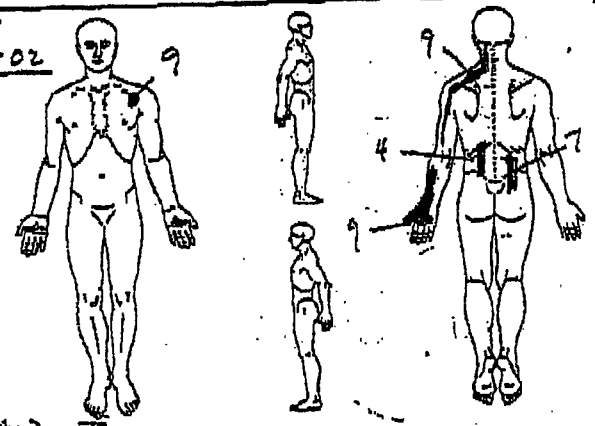
U.S. 1.6 W/cm²

Lumbar Hyperlordosis / L Sciatica

Lower abdominal stretches L x 5

Manual Therapy

Date: 9-3-02



O Myofascitis

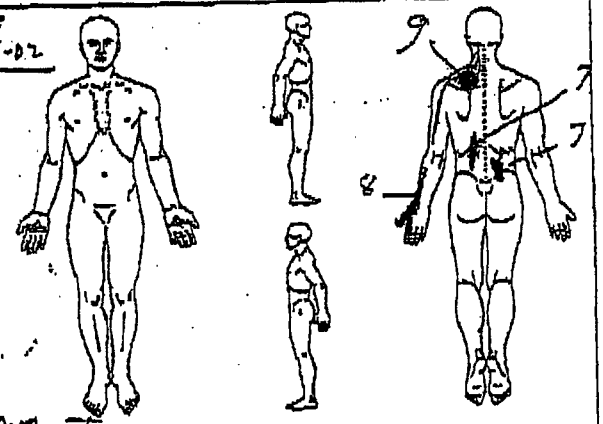
A

P

E.S. Chronic W/O TEMP

U.S. 1.6 W/cm²

Date: 9-5-02



O Myofascitis

A

P

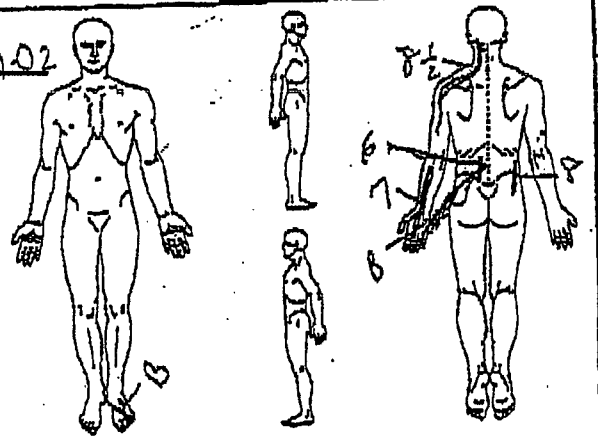
E.S. Unit (PRN) W/O TEMP

U.S.: 1.6 W/cm² 100%

Lumbar Hyperlordosis / Manual Therapy

Lower Extremity Stretches

Date: 9-9-02



O

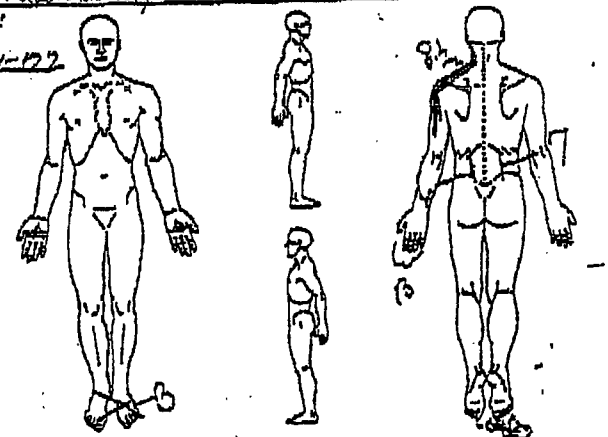
A

P

E.S. Chronic Pain NO Heat or Ice

U.S. 1.6 W/cm²

Date: 9-11-02



O

A

P

Chronic Stretches x4 / Lumbar Hyperlordosis

E.S. Unit (PRN) W/O Temp

U.S. 1.6 W/cm²

Manual Therapy

Pain, Spine & Sports Medicine

C. Gregory Kang, M.D. • Phone: (843) 232-8118

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Surfside Beach, SC 2957

PATIENT: GILBERT CHAVIS
DATE: 7/25/02

Brief History:
Gilbert returns for follow up. He states that the Duragesic still is not very effective. He has had to take 6 Roxicodone today. He reports exacerbation of pain in the left arm associated with paresthesias and radiating pain. It seems to begin in the left shoulder and go all the way down to the forearm and into the fingers. He has had these sensations chronically, but it seems to be worse at this time. He reports that the Topamax seems to be helping somewhat with the dysesthesias in the feet. The paresthesias in the hands and left arm is unchanged.

Examination:
He is in no acute distress. Biceps reflexes are 2+. Brachioradialis is 1+. Sensation is altered in the left arm. Slightly decreased strength in the left biceps, triceps, and rotator cuff muscles due to pain. Shoulder ROM is about 120 degrees of abduction. He has a positive impingement sign. He is also somewhat tender at the left AC joint.

Diagnostic Impression:
(1) Probable left shoulder impingement syndrome and AC joint dysfunction
(2) Left arm pain, unclear etiology, it could be due to cervical radiculopathy or radiation of pain emanating from the shoulder

Recommendations:
(1) We will schedule an EMG/nerve conduction study to evaluate symptoms in the arm.
(2) I will try to get the MRI report of the left shoulder from Coastal Orthopedics.
(3) Increase Duragesic to 100mcg q 3 d
(4) Gave Roxicodone 15mg q 8 h, #90 for breakthrough pain

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

PATIENT: GILBERT CHAVIS
DATE: 7/18/02

Brief History:
Mr. Chavis returns for follow up. He reports that the Duragesic seems to be helping with some of his pain, but not the pain in the left shoulder. That is still very painful, tight, associated with muscle spasms. The dysesthetic pain in the feet is somewhat better. He thinks it might be due to the Duragesic, but it is possible it could be the Topamax also. He is still requiring Roxicodone and that is the only medication that seems to be helping with the left shoulder pain at this time. He reports no significant side effects. He is having some difficulty with the Duragesic sticking to his skin at this time.

Examination:
Unchanged. He still has definite trigger points and tender points throughout the scapulothoracic muscles. He has no new changes neurologically.

Diagnostic Impression:
(1) Chronic cervical and scapulothoracic myofascial pain
(2) History of right rotator cuff tear, status post repair
(3) Dysesthetic pain hands and feet, slightly improved
(4) History of cervical disc bulge
(5) Chronic nonmalignant pain

Recommendations:
(1) Increase Duragesic to 75mcg/hr. We will give a 2 weeks supply.
(2) Roxicodone 15mg q 6 h for breakthrough pain, #60
(3) Topamax 50mg q hs
(4) Follow up in 2 weeks.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Jeffery Wilkins, MD

July 9, 2002

Jeffery Wilkins, MD

PATIENT: GILBERT CHAVIS
CHIEF COMPLAINT: CHRONIC PAIN

Dear Dr. Wilkins:

Thank you for kindly referring Mr. Gilbert Chavis.

HPI: He is a 47 year-old gentleman with a history of chronic neck and shoulder pain since 1998. He suffered an injury to the right rotator cuff. He initially underwent long term conservative treatment without much success. He reports that he eventually had an MRI which revealed a tear. He had arthroscopic surgery with improvement in function as well as some of his symptoms. He then developed some recurring pain in the shoulder as well as in the neck area. He had a 2nd opinion in Florence by Dr. Elvington who recommended evaluation at the Spine Institute in Mt. Pleasant. He had some type of spinal injection there in January of 2000. He apparently had a small CVA some time during that period. He thereafter developed some speech difficulties as well as some weakness in the left arm. He was seen by Dr. Grabowski in Conway, a neurologist, who eventually diagnosed him with a stroke. Currently most of Mr. Chavis' neurologic symptoms have resolved. He no longer has a speech problem or any residual weakness in the left arm. He does complain of dysesthesias and paresthesias in his hands and feet which he is convinced is due to the stroke.

He also reports concurrent development of pain in the left shoulder. He has been treated with physical therapy as well as trigger point injections with some success. He reports poor sleep. He also complains of migraine headaches.

He has been taking Roxicodone for quite some time for pain control.

PMH: 1) Diabetes mellitus 2) History of CVA

PSH: 1) Tracheostomy as an infant 2) Right shoulder arthroscopic surgery in 1999

ALL: 1) Codeine

MED: 1) Glucovance 2) Roxicodone 15mg q 4 h

SH: He does not smoke or drink. He lives in Conway, SC. He does not work. He used to work at AVX.

ROS: Currently no chest pain, shortness of breath, nausea, vomiting, fever, chills or night sweats.

PHYSICAL EXAMINATION:

General: Mr. Chavis was in no acute distress.

HEENT: Normocephalic head, atraumatic. Neck supple

Chest & Lungs: Cardiovascular regular rate and rhythm. Lungs clear. No rales or wheezes.

Abdomen: Soft and non-tender. Bowel sounds are present.

Skin: Intact.

Musculoskeletal: He had normal shoulder ROM bilaterally to abduction and forward flexion. It was somewhat tender with abduction. He did have a prominent AC joint region on the right side. He had trigger points along the scapulothoracic muscles primarily in the rhomboids, upper trapezius, and also in the teres minor.

Neurological: He did not seem to have any focal deficits. He had normal strength in the upper and lower extremities. Sensation was intact all four extremities. Reflexes 2+ equal and symmetrical. No clonus. No spasticity.

Diagnostic Impression:
(1) Chronic cervical and scapulothoracic myofascial pain on the left
(2) History of right rotator cuff tear, status post repair
(3) Right AC joint arthrosis
(4) Dysesthesias both hands and feet, unclear etiology, possibly related to diabetic neuropathy
(5) History of migraine headaches
(6) History of a cervical disc bulge by history

Recommendations:
(1) We will try a long acting narcotic. We will start Duragesic 50mcg/hr.
(2) Prescribe Roxicodone 15mg q 6 h for breakthrough pain
(3) Start Topamax 25mg q hs and slowly titrate to therapeutic doses. This is to address the dysesthesias in the feet and also may help with his migraine headaches.

(4) He would probably benefit from some physical therapy and also massage therapy to the neck and shoulder area to address his myofascial symptoms.

Thank you again for letting me see Mr. Chavis. I will keep you updated with any new developments.

With Kindest Regards,

C. GREGORY KANG, M.D.
Physiatrist

CGK/ajw

Diagnostic Imaging Report

SOUTH STRAND AMBULATO - 5050 HWY 17 BYPASS - MYRTLE BEACH,SC 29588
Phone #: 8438396066 Fax #: 8438392506

Name: CHAVIS,GILBERT R Loc: F.XOP Radiology No:

Dob: 12/07/1954 Age: 48 Sex: M Status: REG CLI Unit No: F000375088

Phys: KANGR - KANG,GREGORY C Acct: F01009947025

Reason For Exam: L/S Exam Date: 09/18/2003

Exams: 000603910 SPINE LUMBAR COMP W/OBLIQUES

Lumbar spine with obliques, September 18, 2003

Low back pain

AP, lateral, bilateral oblique and spot lateral views.

Minor degenerative findings are seen in the lower lumbar disk spaces. There is no acute or aggressive lesion. Slight degenerative sclerotic density is seen adjacent to the left SI-joint.

Impression: Minor degenerative findings in the lower lumbar disk spaces. Minimal sclerotic density is seen adjacent to the SI-joints, greater on the left side.

** Electronically Signed by GARY L. RIKE MD on 09/18/2003 at 1519 **
Reported and Signed by: GARY L. RIKE, MD

CC: GREGORY C KANG

Dictated Date/Time: 09/18/2003 (1401)
Technologist: JACKIE SELLECK, RT
Transcribed Date/Time: 09/18/2003 (1433)
Transcriptionist: FRAD.WSP
Electronic Signature Date/Time: 09/18/2003 (1519)
Printed Date/Time: 09/19/2003 (0751)

PAGE 1 DEPARTMENT COPY

Patient name: GILBERT CHAVIS Date: 2/16/05
Weight 210 lbs., BP: 130/90, Pulse: 88, RR: 14 Temp:
Chief Complaint:

flu c lab ordered

ROS: Fever, Chills, Dizzyness, Vertigo, Headache, Vision change, Productive cough, Sore throat, Sinus or ear pain, Chest pain, Shortness of breath, DOE, Edema, Heartburn, Reflux, Abdominal pain, Nausea, Vomiting, Diarrhea or bloating, Urinary frequency, Urgency, Polyuria, Hesitancy, Back or other pain +/or tenderpoints, Dysuria, Nocturia, Black tarry stools, BRBPR, Numbness, Tingling, Weakness, Fatigue, Difficulty sleeping, Weight loss or weight gain, Hair loss

__ROS otherwise negative

Physical Exam:
__appears stated age, without acute distress
__the patient is in some acute distress

Skin:
__Warm & dry, no rashes or jaundice
__AK, seborrhea dermatitis, vitiligo, nevi
__scars c/w previous surgery
__nail changes, clubbing
__cyanosis, hyperpigmentation

Breasts:
__No masses, dimpling, discharge, adenopathy
__tissue changes c/w fibrocystic ds
__Mass, size_____, location_____

__vulva, cervical, vaginal
__Cervical / vaginal mucosa without lesions or errythema
__atrophic / friable mucosa, discharge
__Adnexal tenderness, enlargement
__prolapsed bladder/uterus, cyst/mass

Rectal:
__Tone
__Mass
__Stool hemoccult
__external/internal hemorrhoids

Prostate:
__Not enlarged, no masses, non-tender
__enlarged, mass, nodule, tenderness

Back:
__Non-tender, curvature WNL
__paravertebral muscular tenderpoints
__spinal tenderness
__scoliosis
__cervical/thoracic kyphosis, lordosis

Extremities:
__No cyanosis, edema, clubbing
__Peripheral pulses intact x 4 extremities
__1-2-3-4+RUE, LUE, RLE, LLE edema
__decreased RUE, LUE, RLE, LLE pulses
__dermatitis, rash, ulcer, excoriations
__deformity consistent with RA, DJD
__[illegible]sis, clubbing, onychomycosis
__[illegible]er hemorrhage / Beau's lines

Psychological:
__Appropriate affect / A&O x 3
__depression, anxiety, confusion, memory impairment

HEENT:
__PERRLA, EOMI, Sclera anicteric
__Discs sharp, good venous pulsations, arcus senilis, cataracts
__TM's clear, with good cone of light
__No errythema or cobblestoning of pharynx
__Thyroid not enlarged, no carotid bruits
__errythema / cobblestoning of pharynx
__tonsillar enlargement / exudate, poor dentition
__errythema / boggy nasal mucosa, PND
__bulging / retraction / injection of Rt/Lt TM, canal edema
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__Rt/Lt ant / post / cervical / submandibular adenopathy

__thyroid enlarged / goiter / nodule / mass
__JVD / HJR is noted, Rt/Lt carotid bruits

Lungs:
__Symmetrical respirations / clear to auscultation B/L
__stridor / bronchial breath sounds
__dullness to percussion

__Rt/Lt wheezes / rhonchi / crackles / rales B/L
__prolonged expiratory phase
__decreased breath sounds, Rt/Lt / in bases

Heart:
__RRR w/o murmur, nl S1, S2, no S3, S4 or rub
__+ rub / + thrill, +S3, +S4, +click
__grade_____/VI murmur at LSB, RSB, apex
__with radiation to the carotid arteries / apex / axilla
__irregular rate / rhythm / ectopic beats
__c/w AR, AS, MR, MS, TR, TS, PR, PS, MVP

Abdomen:
__Soft, non-tender, normal BS x 4 quadrants
__No masses, HSM, or abdominal bruits
__epigastric, RUQ, LUQ, RLQ, LLQ, CVA tenderness
__+ mass, + abdominal bruits, distension, peritoneal signs
__hyper/hypoactive / absent bowel sounds

Neurologic:
__CN II – XII grossly intact, no focal deficits
__Strength 5/5 x 4 extremities, DTRs 2/4 x 4 extremities
__Sensory is intact to pinprick / light touch
__weakness of prox./distal RUE, LUE, RLE, LLE
__decreased sensation of prox./distal RUE, LUE, RLE, LLE
__hyper/hypo reflexes of RUE, LUE, RLE, LLE

Winston Mc Iver, Jr, MD

Triple i/CliniForms
PROGRESS NOTES

Name GILBERT CHAVIS

Address _____ SS# _____ Page # ____

Phone (home) _____ (work) _____ Date of birth _____

Drug allergies _____

DATE	NOTES
2/16/05	

Name

Stable at present

SCD/DEB

Hyp Rx

Con Rx

A Dm - at Actos

C HTN - BP at Rx

3 HLD at goal

at Lipit

Triple i/CliniForms ©1999 FP031 800.969.7237

Norvasc:

First line? Second line? Third line?

Bottom line:

With no known drug interactions, excellent tolerability, and proven efficacy, NORVASC works well in virtually any kind of patient at any time.

Reductions you can count on™

NORVASC (amlodipine besylate)

The most common side effects versus placebo were edema (0.9% vs 2.4%), headache (7.3% vs 7.0%), fatigue (4.5% vs 2.8%), and dizziness (0.2% vs 3.4%). NORVASC is indicated for the treatment of hypertension and angina.

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Please see accompanying full prescribing information for NORVASC.

2/10

CAR NA HEALTH SPECIALISTS/LAB ATORY
4591 SOCASTEE BLVD.
MYRTLE BEACH, SC. 29588
PHONE: (843) 839-4802 FAX: (843) 839-4804

FINAL SAMPLE REPORT

Patient ID: 499730 Chart:
Patient Name: CHAVIS, GILBERT R.
DOB: 12/07/1954 Age:50 Sex: M
Comments:

Final Reported: 01/27/05 14:56
Doctor: WINSTON D MCIVER JR. MD
Location: CONWAY OFFICE
Phone: 843-347-5748

Lab No: 05027075 Drawn: 01/27/05 08:20 Tech: GLH Rec'd: 01/27/05 13:03 Tech: CMB
Comments: TESTOSTERONE SENT TO QUEST

PROCEDURE	NORMAL	ABNORMAL	UNITS	REFERENCE RANGE
COMPREHENSIVE METABOLIC PANEL				
GLUCOSE		137 +	MG/DL	70 - 100
BUN	19		MG/DL	7 - 25
CREATININE	1.0		MG/DL	0.4 - 1.2
BUN/CREATININE RATIO	19.0		CALC	
SODIUM	140		MEQ/L	133 - 145
POTASSIUM	4.2		meq/L	3.5 - 5.1
CHLORIDE	101		MEQ/L	98 - 108
CARBON DIOXIDE	29		MMOL/L	22 - 40
CALCIUM	9.2		MG/DL	8.4 - 10.5
TOTAL PROTEIN	7.6		G/DL	6.4 - 8.2
ALBUMIN	4.1		G/DL	3.2 - 5.0
A RATIO	1.2		CALC	1.1 - 2.5
TOTAL BILIRUBIN	0.46		mg/dl	0.00 - 1.00
ALKALINE PHOSPHATASE	82		IU/L	50 - 136
ALT (SGPT)	45		IU/L	30 - 65
AST (SGOT)	19		IU/L	15 - 37
L I P I D P R O F I L E				
CHOLESTEROL		217 +	MG/DL	120 - 200
TRIGLYCERIDES	135		MG/DL	0 - 200
HDL		29 -	MG/DL	45 - 85
VLDL CHOLESTEROL	27		CALC	5 - 40
LDL CHOLESTEROL		161.0 +	CALC	0.0 - 100.0
TOTAL CHOL/HDL RATIO		7.5 +	CALC	0.0 - 5.0

	MEN	WOMEN
1/2 AVERAGE RISK	3.4	3.3
AVERAGE RISK	5.0	4.4
2X AVERAGE RISK	9.6	7.1
3X AVERAGE RISK	15.0	11.0

LDL/HDL RATIO	5.6 +	CALC	0.0 -	3.6
	MEN	WOMEN		

Dr Cmd
Stay with 10g

CAROLINA HEALTH SPECIALISTS/LABORATORY
4591 SOCASTEE BLVD.
MYRTLE BEACH, SC 29588
PHONE: (843) 839-4802 FAX: (843) 839-4804

FINAL SAMPLE REPORT

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PROCEDURE	NORMAL	ABNORMAL	UNITS	REFERENCE RANGE
1/2 AVERAGE RISK	1.0	1.5		
AVERAGE RISK	3.6	3.2		
2X AVERAGE RISK	6.3	5.0		
3X AVERAGE RISK	8.0	6.1		

CAR NA HEALTH SPECIALISTS/LAB TORY
4591 SOCASTEE BLVD.
MYRTLE BEACH, SC 29588
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FINAL SAMPLE REPORT

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Comments: TESTOSTERONE SENT TO QUEST

PROCEDURE	NORMAL	ABNORMAL	UNITS	REFERENCE RANGE
S E N D O U T S **********				
TO REFERENCE LAB	SPECIMEN SENT TO REFERENCE LAB			

CAROLINA HEALTH SPECIALISTS/LABORATORY
4591 SOCASTEE BLVD.
MYRTLE BEACH, SC 29588
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Comments: TESTOSTERONE SENT TO QUEST

PROCEDURE	NORMAL	ABNORMAL	UNITS	REFERENCE RANGE
HEMOGLOBIN A1C				
A1c		7.8 +	%	4.8 - 6.0

HEMOGLOBIN A1C LEVELS ARE RELATED TO MEAN BLOOD GLUCOSE DURING THE PRECEDING 2-3 MONTHS. THE RELATIONSHIP TABLE BELOW MAY BE USED AS A GENERAL GUIDE.

A1C	APPROX. MEAN GLUCOSE
6%	120 MG/DL
7%	150 MG/DL
8%	180 MG/DL
9%	210 MG/DL
10%	240 MG/DL

EACH 1% INCREASE IN HGB A1C IS A REFLECTION OF

AN INCREASE IN MEAN GLUCOSE OF APPROXIMATELY 30 MG/DL

REFERENCES:

DCCT GROUP, NEW ENGL. J. MED: 329,997-986 (1993)
SANTIAGO, J.V., DIABETES, 42, 1549-1554 (1993)

160-175

Quest Diagnostics®

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT742111D
REQUISITION: 0001295
LAB REF NO:

COLLECTED: 01/27/2005 08:20
RECEIVED: 01/27/2005 14:41
REPORTED: 01/28/2005 12:22

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 50
GENDER: M
SS: 248-04-2224

REPORT STATUS **Final**

ORDERING PHYSICIAN
MCIVER,WINSTON D

CLIENT INFORMATION
7187233
CAROLINA HLTH SPEC/CONWAY
CONWAY PRIMARY CARE CENTER
235 SINGLETON RIDGE RD
CONWAY, SC 29526-9136

Test Name	In Range	Out of Range	Reference Range	Lab
TESTOSTERONE, TOTAL	468		241-827 NG/DL	AT

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

Patient name: Gilbert Chavis
Weight 213 lbs., BP: 134/81, Pulse: 76, RR: 14 Temp: Date: 12/28/04
Chief Complaint: Flu

ROS: Fever, Chills, Dizzyness, Vertigo, Headache, Vision change, Productive cough, Sore throat, Sinus or ear pain, Chest pain, Shortness of breath, DOE, Edema, Heartburn, Reflux, Abdominal pain, Nausea, Vomiting, Diarrhea or bloating, Urinary frequency, Urgency, Polyuria, Hesitancy, Back or other pain +/or tenderpoints, Dysuria, Nocturia, Black tarry stools, BRBPR, Numbness, Tingling, Weakness, Fatigue, Difficulty sleeping, Weight loss or weight gain, Hair loss

Physical Exam:
__appears stated age, without acute distress
__the patient is in some acute distress

Skin:
__Warm & dry, no rashes or jaundice
__AK, seborrhea dermatitis, vitiligo, nevi
__scars c/w previous surgery
__nail changes, clubbing
__cyanosis, hyperpigmentation

Breasts:
__No masses, dimpling, discharge, adenopathy
__tissue changes c/w fibrocystic ds
__Mass, size_____, location_____

GYN:
__Vulva, cervical, vaginal
__Cervical / vaginal mucosa without lesions or errythema
__atrophic / friable mucosa, discharge
__Adnexal tenderness, enlargement
__prolapsed bladder/uterus, cyst/mass

Rectal:
__Tone
__Mass
__Stool hemoccult
__external/internal hemorrhoids

Prostate:
__Not enlarged, no masses, non-tender
__enlarged, mass, nodule, tenderness

Back:
__Non-tender, curvature WNL
__paravertebral muscular tenderpoints
__spinal tenderness
__scoliosis
__cervical/thoracic kyphosis, lordosis

Extremities:
__No cyanosis, edema, clubbing
__Peripheral pulses intact x 4 extremities
__1-2-3-4+RUE, LUE, RLE, LLE edema
__decreased RUE, LUE, RLE, LLE pulses
__dermatitis, rash, ulcer, excoriations
__deformity consistent with RA, DJD
__ cyanosis, clubbing, onychomycosis
__linter hemorrhage / Beau's lines

Neurological:
Appropriate affect / A&O x 3
Depression, anxiety, confusion, memory impairment

HEENT:
__PERRLA, EOMI, Sclera anicteric
__Discs sharp, good venous pulsations, arcus senilis, cataracts
__TM's clear, with good cone of light
__No errythema or cobblestoning of pharynx
__Thyroid not enlarged, no carotid bruits
__errythema / cobblestoning of pharynx
__tonsillar enlargement / exudate, poor dentition
__errythema / boggy nasal mucosa, PND
__bulging / retraction / injection of Rt/Lt TM, canal edema
__Rt/Lt AV nicking / copper wiring / papilledema
__Rt/Lt ant / post / cervical / submandibular adenopathy

__thyroid enlarged / goiter / nodule / mass
__JVD / HJR is noted, Rt/Lt carotid bruits

Lungs:
__Symmetrical respirations / clear to auscultation B/L
__stridor / bronchial breath sounds
__dullness to percussion

__Rt/Lt wheezes / rhonchi / crackles / rales B/L
__prolonged expiratory phase
__decreased breath sounds, Rt/Lt / in bases

Heart:
__RRR w/o murmur, nl S1, S2, no S3, S4 or rub
__+ rub / + thrill, +S3, +S4, +click
__grade_____/VI murmur at LSB, RSB, apex
__with radiation to the carotid arteries / apex / axilla
__irregular rate / rhythm / ectopic beats
__c/w AR, AS, MR, MS, TR, TS, PR, PS, MVP

Abdomen:
__Soft, non-tender, normal BS x 4 quadrants
__No masses, HSM, or abdominal bruits
__epigastric, RUQ, LUQ, RLQ, LLQ, CVA tenderness
__+ mass, + abdominal bruits, distension, peritoneal signs
_____hyper/hypoactive / absent bowel sounds

Neurologic:
__CN II – XII grossly intact, no focal deficits
__Strength 5/5 x 4 extremities, DTRs 2/4 x 4 extremities
__Sensory is intact to pinprick / light touch
__weakness of prox./distal RUE, LUE, RLE, LLE
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Winston Mc Iver, Jr, MD

Triple i/CliniForms
PROGRESS NOTES

Name Gilbert Chavis SS# Page # 2

Address

Phone (home) (work) Date of birth

Drug allergies

DATE	NOTES
18.98.04	

BS stim T
5 CA/Leo
Stop QC
cont Lyr

DDx
BS stim >200
Min T Actos to 45mg QD
+
Cont Glipizide 10g BID
+
Glucophage 500g BID
(2) Chr Pa Synd
F/u c Dr Kang
(4) HTN
(7) ED - Hx of ↓ testerone
F/u c Dr Gange
(↓ loss (penile implant)

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What are your patients taking for relief of
intermittent heartburn?
For free samples, www.zantac75.com
Zantac 75 is indicated for the relief and prevention of heartburn associated with acid indigestion and sour stomach
Distributed by Pfizer Consumer Healthcare, Morris Plains, New Jersey 07950 USA © 2003 Pfizer ZAN4355/05
Pfizer
Too Much
Too Little
Zantac 75

Patient name: GILBERT CHAVIS
Weight 213 lbs., BP: 130/86, Pulse: 80, RR: 15 Temp: Date: 10.9.04
Chief Complaint:
EST PRIMARY PHYSICIAN

ROS: Fever, Chills, Dizzyness, Vertigo, Headache, Vision change, Productive cough, Sore throat, Sinus or ear pain, Chest pain, Shortness of breath, DOE, Edema, Heartburn, Reflux, Abdominal pain, Nausea, Vomiting, Diarrhea or bloating, Urinary frequency, Urgency, Polyuria, Hesitancy, Back or other pain +/or tenderpoints, Dysuria, Nocturia, Black tarry stools, BRBPR, Numbness, Tingling, Weakness, Fatigue, Difficulty sleeping, Weight loss or weight gain, Hair loss

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Triplei/CliniForms
PROGRESS NOTES

Name GILBERT CHAVIS
Address _____ SS# _____ Page # ___
Phone (home) _____ (work) _____ Date of birth _____
Drug allergies _____

DATE	NOTES
12-9-04	

ABS
Scan
Eye AC
MRI

(1) Hyperglycemia - see #3

(2) Dermatitis
foot (heels)
moisturize

(3) DM - Hold Insulin
ct Glyburide + Glipizide
+ add ACAN 30g

(4) Chlamydia Syph - Place Referral

(5) HTN - pt on ACEI
(cut on ACE - minimal pitting edema)

(6) ED
Sildenafil
Viagra

NOW AVAILABLE
NEW Ketek
Aventis
Aventis Pharmaceuticals Inc.

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CHS/ENDOCRINOLOGY
945 82nd Parkway
Myrtle Beach, SC 29572
Ph: (843) 497-3005, Ext: 607
FAX: (843) 497-5451

Paul D. Bunn, M.D. **Private line:** (843) 449-7356

Patient name: Gilbert Clavis
Date of exam: 02/23/04
DOB: 12/07/54

HISTORY OF PRESENT ILLNESS: Problem # 1 his hypogonadism; he tells me that the Androgel isn't working any better than the Testim did. I want to re-measure his testosterone value today. It may well be that we need to increase his dose, but before I do that I would like to make sure that we are dealing with a low testosterone value. Problem # 2 his wife no longer sleeps with him; he snores so badly that he keeps her awake. I am sure he probably has an element of sleep apnea. Unfortunately of course the testosterone therapy makes this worse. I have asked him to go ahead and get a sleep study and we may well need to have him see someone about his sleep apnea.

REVIEW OF SYSTEMS: His weight continues to go up. Today he weighs 218 pounds. Blood pressure is borderline at 130/90.

PHYSICAL EXAM:

GENERAL:	Awake, alert and oriented. In no distress.
HEENT:	PERRLA. EOMI. Neck without bruit or hum.
LUNGS:	Clear. There is no wheezing and no rales or rhonchi.
CARDIAC:	Unremarkable. Regular rate and rhythm. No murmur, rub or gallop.
ABDOMEN:	Obese.
EXTREMITIES:	His hands look a little puffy. He has no pitting edema.

DISPOSITION:

1. As above.
2. We will check testosterone level, basic metabolic panel.
3. We will see if we can schedule him for a sleep study.
4. I will modify his Androgel if needed after I see the results of his laboratory studies.

Paul D. Bunn, M.D.

PDB/krv

497449562 > Dr Shore

CHS/ENDOCRINOLOGY
945 82nd Parkway
Myrtle Beach, SC 29572
Ph: (843) 497-3005, Ext: 607
FAX: (843) 497-5451

Paul D. Bunn, M.D. **Private line:** (843) 449-7356

Patient name: Gilbert C[illegible]avis
Date of exam: 12/08/03
DOB: 12/07/54

HISTORY OF PRESENT ILLNESS: Problem # 1 his testosterone deficiency; I measured his testosterone last time. He is taking Testrin. His testosterone is exceedingly low. It looks to me as if it is not working at all. Problem # 2 he has hypogonadotrophic hypogonadism; he has essentially no gonadotropins. I am going to get an MRI on him. I have reviewed this with him.

REVIEW OF SYSTEMS: His diabetes still is not under good control, although he is better today.

DISPOSITION:

1. Get the MRI and I will follow-up with him after that. After we see what it is, we will have to change him to Androgel rather than Testrin.

Paul D. Bunn, M.D.

PDB/krv

CHS/ENDOCRINOLOGY
945 82nd Parkway
Myrtle Beach, SC 29572
Ph: (843) 497-3005, Ext: 607
FAX: (843) 497-5451

Paul D. Bunn, M.D. **Private line:** (843)-499-7356

Patient name: Gilbert Clavis
Date of exam: 11/25/03
DOB: 12/07/54

HISTORY OF PRESENT ILLNESS: Problem # 1 is a low testosterone. This is a gentleman now 48-years-old who is referred by Dr. Shore specifically for hypogonadism.

History reveals that he has a number of medical problems. The first of these is his Type 2 Diabetes, actually he has seen my partner on one occasion for this. He is now seeing Dr. Nicol for same. His diabetes is associated with a past history of hypertriglyceridemia. It is also associated with exogenous obesity. Currently for his diabetes he is on Metformin and Avandia. His diabetes is not under good control. He brought me his sugars over the last several days and both fasting and p.m. sugars are running in the 200-250 range.

In addition to this medical problem, he has also had a stroke. This occurred as a result during a cervical pain injection procedure for cervical disc disease.

In terms of his testosterone deficiency, it was diagnosed in summer of 2002 by Dr. Sloan over in Conway. I do not know what the evaluation was at that time. He notes that his total testosterone was low. He doesn't know any other laboratory studies. Initially he was placed on Testosterone injection every two weeks by her and he tells me that his symptoms at that time which included fatigue and inability to attain and maintain an erection did improve. However, his symptoms recurred.

He went to see Dr. Shore, apparently was sent there for consideration of a prosthetic device. He has decided against that. Dr. Shore took him off the testosterone injections and put him on a gel, he doesn't know the name of it. I presume it is an Androgel like formulation. He has been on it at least the last two weeks. He tells me that he has not received any benefit from same. He also relates that he has tried a fair amount of Viagra and occasionally it will work but most of the time it does not.

SOCIAL HISTORY: He is the father of two children. He has an older son and an 18-year-old daughter. She currently is enrolled in Coastal Carolina University. He use to work at AVX, now he is disabled and doesn't work. He doesn't use alcohol or tobacco.

CURRENT MEDICATIONS:

1. Neurontin.
2. Metformin.
3. Triamterene/HCTZ.
4. Lipitor.
5. Avandia.
6. Remeron.
7. Nexium.
8. Viagra.
9. Roxicodone.

FAMILY HISTORY: Showed that his father had diabetes and an aneurysm. Mother had lung cancer. He has two brothers, one of whom has diabetes. He has five sisters, one of whom has cancer.

PHYSICAL EXAM:

GENERAL:	Shows a gentleman looking about his stated age. He has exogenous obesity. Awake, alert and oriented. In no distress.
HAIR:	Pattern and texture are normal.
HEENT:	PERRLA. EOMI. Fundi don't show evidence for diabetic retinitis. I don't see any evidence for optic atrophy. Oral pharynx benign. Neck supple. No jugular venous distention. I don't find goiter.
LUNGS:	Clear. No rales, rhonchi or other adventitious sounds.
CARDIAC:	Unremarkable. He has a regular rate and rhythm without murmur, rub or gallop.
ABDOMEN:	Is significantly obese without palpable mass or hepatosplenomegaly.
GU:	External genitalia are normal. There are no masses in the testis.
EXTREMITIES:	Without edema.

DISPOSITION:

1. At this point, I want to measures levels to include FSH, LH, testosterone and prolactin. I will follow-up with him about that.
2. I have scheduled him a return appointment to see me in two months. Prior to that time however, I will adjust his medication if needed.

Paul D. Bunn, M.D.

PDB/krv

CHS/ENDOCRINOLOGY
945 82nd Parkway
Myrtle Beach, SC 29572

Donald Eagerton, M.D., F A.C.E., F.A.C.P.

Ph: (843) 497-3005
Fax: (843) 692-0233

INITIAL EVALUATION

Patient Name:	Gilbert Chavis
DOB: 12/7/54	SSN: 248-04-2224
Date of exam:	08/01/02

HISTORY OF PRESENT ILLNESS: Patient is a 47 year old Native American male who is sent here by Dr. Scott of Doctor's Care for evaluation and treatment of diabetes. In the interim he has started seeing a Dr. Sloan in Conway. Apparently there have been some labs drawn within the last two months but I do not have those results available. Mr. Chavis still wants me to see him in regards to his diabetes. He has had problems getting his glucose under control for quite some time. His blood sugars will range anywhere from 53 to 220. He has not been feeling well for the last several months. He is starting to feel a little bit better after he was discovered to have testosterone deficiency and has been getting replacement injections from Dr. Sloan.

PAST MEDICAL HISTORY: 1) Type II diabetes, 1988. 2) Hypertriglyceridemia with value as high as 1,000 in the past. 3) CVA that occurred during a cervical pain injection procedure. 4) Cervical disc disease. 5) GERD. 6) Probable testosterone deficiency. 7) Questionable increased liver enzymes. 8) Tracheostomy at age 10 months. 9) GI adhesions. 10) Rotator cuff tear, 1998.

FAMILY HISTORY: Father died at 73 with Type II diabetes and an aneurysm. Mother died at 62 of lung cancer. Has two brothers, one with Type II diabetes. He has five sisters, one has cancer. He has one son and one daughter who are healthy.

SOCIAL HISTORY: No alcohol or tobacco. Works at AVX metal processing. I believe he is getting workers compensation right now.

ALLERGIES: CODEINE.

CURRENT MEDICATIONS:
1. Roxicodone 15 mg q 4 hours.
2. Duragesic patch.
3. Glucovance 5/500 one b.i.d.
4. Topamax ? dose.
5. Zantac p.r.n.

REVIEW OF SYSTEMS: Several years ago his triglycerides were 1,000. These levels were drawn at work. He was sent immediately to the doctor who told him that he needed to "watch what he was eating". He was never placed on any medication for the triglycerides. He was

REVIEW OF SYSTEMS: (continued)
diabetic at the time. He doesn't follow any particular type of diet plan. He usually only eats two meals per day. The first meal is around 10:30 in the morning and the second meal is around 6:30 at night. Breakfast is usually eggs and toast with or without sausage and milk. In the evening he eats his big meal which may be fried chicken, grilled steak, chicken-bog, pizza, etc. He doesn't count carbohydrates or pay any attention to that aspect of his diet. He likes to drink sweet tea and still does so at times. He does not get any scheduled exercise. For the past four months, he says that he has been too weak to walk. Now that he has been started on testosterone replacements, he is starting to feel a little bit better. As far as he knows he has not had any history of retinopathy or nephropathy from diabetes. He does have neuropathy which may or may not be related to his other medical problems. He has not seen the ophthalmologist in three years or more. He does not have any vision problems right now. No cardiac or pulmonary symptoms. No GI symptoms. After his CVA he had some voice problems. He still stutters a little bit but not too bad. He has damage in his left hand and he has paresthesias in both arms, left worse than the right and in both legs. He did not bring a glucose logbook with him today. This morning he drank Crystal Light and ate three cookies. He felt shaky with a glucose of 94 currently.

He went to see Dr. Sloan about two months ago. Was complaining of weakness, fatigue, malaise, decreased libido and erectile dysfunction. Testosterone values apparently were low. I'm not sure what other workup has been done. He has been started on testosterone injections every two weeks. He has been told that this will change over to once a month later on. He is starting to feel considerably better.

PHYSICAL EXAM:

GENERAL:	Well-developed, well-nourished male in no acute distress.
VITAL SIGNS:	Height: 5' 5". Weight: 197 pounds. Pulse: 108. Blood Pressure: 134/94.
HEENT:	NCAT, PERRLA, EOMI. Pharynx is without lesions or exudates. Neck without JVD, bruits or nodes. Scar from tracheostomy. Thyroid is normal size and shape without nodules. Fundi with sharp discs and no obvious retinopathy.
HEART:	Regular rate and rhythm without a murmur.
LUNGS:	CTAP.
ABDOMEN:	Soft. No hepatosplenomegaly.
EXTREMITIES:	No clubbing, cyanosis or edema.
NEUROLOGICAL:	Complains of paresthesias in the arms and the legs. Sensation in the feet appear grossly intact. Motor appears to be 5/5. Gait is intact.
SPEECH:	Seems fairly good although he does tend to stutter a little.
SKIN:	There is a Duragesic patch on his chest.

ASSESSMENT AND PLAN:

1. Type II diabetes. Uncertain control. Will try to get labs from his other doctors' office. The most obvious problem as far as I can see is the inappropriate diet. First of all, there is no regard to carbohydrate content. There is no regard to fat content which is extremely important with his triglyceride problem. He eats two meals per day most of the time. The timing of the meals is not steady. Therefore, he is getting erratic effects from the glyburide component of his Glucovance and I would not be surprised to see numbers as erratic as he is stating. I do not know what the overall control is because I don't have the results of the recent labs and also there is no home glucose monitoring data. We decided for him to get on a regular regimen with three meals a day and a diet that is more consistent with an ADA plan. He will continue the Glucovance at the same dose. He will check blood sugars q a.c. and q h.s. for awhile and contact me next week with this information for further adjustment. Hopefully, we will be able to get him on an exercise regimen in the near future which should help as well.

   He has some basic misunderstandings about diabetes in general. We explained the basics of Type II diabetes including insulin resistance, insulin deficiency, the role of diet and exercise and the mechanisms of actions of his current medications. We talked about potential long term complications. He was instructed to see an ophthalmologist now and every year. We need to check for early diabetic kidney changes. I'm not sure what neuropathic features are from diabetes and what are from other medical problems. He was given some handout information and his questions were answered.
2. Probable testosterone deficiency. Again, this is based upon his history. Will try to get notes from his other physician. If he does have testosterone deficiency, we will need to make sure that he has been evaluated for primary versus secondary causes of this so that the evaluation and treatment can be appropriate. I also talked about the possibility of using patches or creams as opposed to injections for this problem. Again, I will wait until I get some more information before we discuss this further.
3. Hyperlipidemia. History of triglycerides as high as 1,000. I doubt seriously that his triglycerides now are anywhere the control they need to be if he is not taking any medications for them. I reminded him that this is essential to control in order to reduce the risk of cardiovascular disease. Will get a lipid profile before return.
4. Elevated blood pressure. No diagnosis of hypertension yet. We need to repeat some blood pressure readings and check urine microalbumin to determine if he needs an ACE inhibitor at this point.
5. History of a CVA which may have been related to a misadventure from a cervical injection as opposed to cerebrovascular disease in and of itself.

ASSESSMENT AND PLAN: (continued)

6. History of elevated LFTs. Will try to get some records.
7. Chronic pain syndrome. Follow-up with other physicians.
8. Return in two months with Hemoglobin A1C, lipids, Panel-7, LFTs and microalbumin.

Donald Eagerton M.D.

Donald Eagerton, M.D., F.A.C.E., F.A.C.P.

DE/wge

cc: Dr. Scott, Doctor's Care
Dr. Sloan, Conway

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LIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT424475U
EQUISITION: 0004463
AB REF NO:

OLLECTED: 02/23/2004 10:00
ECEIVED: 02/23/2004 14:40
EPORTED: 02/27/2004 02:15

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 49
GENDER: M
SS: 248-04-2224

REPORT STATUS **Final**

ORDERING PHYSICIAN
BUNN,PAUL D

CLIENT INFORMATION
7187235
CAROLINA HLTH SPECIAL/82ND
THE MEDICAL COMPLEX
945 82ND PKWY
MYRTLE BEACH, SC 29572-4610

Test Name	In Range	Out of Range	Reference Range	Lab
TESTOSTERONE, FREE AND TOTAL				
TESTOSTERONE, TOTAL	749		ng/dL Reference Range: 260-1000	EZ

This test was developed and its performance characteristics determined by Quest Diagnostics Nichols Institute. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. Performance characteristics refer to the analytical performance of the test.

FREE TESTOSTERONE			Reference Range: 1.0-2.7	
TESTOSTERONE, FREE	202.9		pg/mL Reference Range: 50-210	

erforming Laboratory Information:

Z QUEST DIAGNOSTICS/NI 33608 ORTEGA HWY SAN JUAN CAPISTRANO CA 92675 Laboratory Director: R.E. REITZ,MD

Labs are fine
Stay same meds

Paul D Bunn

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CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT4248028
REQUISITION: 0003145
LAB REF NO:

COLLECTED: 11/25/2003 08:3)
RECEIVED: 11/25/2003 17:2)
REPORTED: 11/26/2003 12:37

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 48
GENDER: M
SS: 248-04-2224

REPORT STATUS **Final**

ORDERING PHYSICIAN
BUNN,PAUL D

CLIENT INFORMATION
7187235
CAROLINA HLTH SPECIAL/82ND
THE MEDICAL COMPLEX
945 82ND PKWY
MYRTLE BEACH, SC 29572-4610

Test Name	In Range	Out of Range	Reference Range	Lab
FSH	1.5		1.4-18.1 MIU/ML	AT
LH	2.4		1.5-9.3 MIU/ML	AT
PROLACTIN	3		2-18 NG/ML	AT

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

med tests

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SPECIMEN #	TYPE	PRIMARY LAB	REPORT STATUS	PG
254-695-0524-0	S	BN	FINAL	1

XI N 02 FAX

TIME 1153 ADDITIONAL INFORMATION

CC:1

CD: 01071035638

CLINICAL INFORMATION 09-13-02 11:35

PHYSICIAN I.D. EAGERTON D | PATIENT I.D. | TVOL

DOB: 12/07/54 FASTING N

PATIENT INFORMATION 843-347-5748

CHAVIS, GILBERT

SEX: M AGE (YEARS): 047/09

ACCOUNT UPIN: F84861
CAROLINA HEALTH SPEC - 82 PKWY 39710185
82ND PARKWAY 00
945 82ND PARKWAY 00
MYRTLE BEACH , SC 29572-
843-449-7938 SCW

PATIENT ADDRESS
616 MCKINLEY WAY
Conway , SC 2952[illegible]6-

DATE OF COLLECTION	DATE RECEIVED	DATE REPORTED	
09/11/02	09/11/02	09/13/02	1265

TEST	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
BASIC METABOLIC PANEL (7)					
Glucose, Serum		214 H	mg/dL	65 - 109	BN
BUN	13		mg/dL	5 - 26	BN
Creatinine, Serum	0.9		mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	14				
Sodium, Serum	137		mmol/L	135 - 148	BN
Potassium, Serum	4.4		mmol/L	3.5 - 5.5	BN
Chloride, Serum	99		mmol/L	96 - 109	BN
Carbon Dioxide, Total	23		mmol/L	20 - 32	BN
HEPATIC FUNCTION PANEL (7					
Protein, Total, Serum	8.1		g/dL	6.0 - 8.5	BN
Albumin, Serum	4.4		g/dL	3.5 - 5.5	BN
Bilirubin, Total	0.8		mg/dL	0.1 - 1.2	BN
Bilirubin, Direct	0.20		mg/dL	0.00 - 0.40	BN
Alkaline Phosphatase, Serum	94		IU/L	25 - 150	BN
AST (SGOT)	24		IU/L	0 - 40	BN
ALT (SGPT)	39		IU/L	0 - 40	BN
LIPID PANEL					
Cholesterol, Total	160		mg/dL	100 - 199	BN
Triglycerides		183 H	mg/dL	0 - 149	BN
HDL Cholesterol		31 L	mg/dL	40 - 59	BN
VLDL Cholesterol Cal	36		mg/dL	5 - 40	
LDL Cholesterol Calc	92		mg/dL	0 - 99	
MICROALB/CREAT RATIO, RANDOM UR					
Creatinine, Urine	244.8		mg/dL	Not Established	BN
Microalbum.,U,Random	31.7		ug/mL		BN
Microalb/Creat Ratio	12.9		ug/mg creat	0.0 - 30.0	
Hemoglobin A1c					
Hemoglobin A1c		7.8 H	%	4.5 - 5.7	BN
					BN

(Factors such as duration of diabetes, adherence to therapy and the age of the patient should also be considered in assessing the degree of blood glucose control)

The following ranges may be used for interpretation of results:
HgbA1c degree of glucose control:
>8% Action suggested*
<7% Goal of Diabetic Therapy**
<6% Normal

*High risk of developing long term complications such as retinopathy, nephropathy, neuropathy, cardiopathy, etc. **Some danger of hypoglycemic reaction in type I diabetics. Some glucose intolerant individuals and "sub-clinical" diabetics may demonstrate HgbA1c

REPORT

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SPECIMEN #	TYPE	PRIMARY LOC	REPORT STATUS	
254-695-0524-0	S	BN	FINAL	PG 2

TIME 1153 ADDITIONAL INFORMATION
CC:1
DOB: 12/07/54
CD= 01071035638 FASTING N

PATIENT INFORMATION 843-347-5748
CHAVIS, GILBERT
SEX: M AGE (YRS/MOS.): 047/09
ADDRESS 616 MCKINLEY WAY
Conway , SC 29526-

DATE OF COLLECTION	DATE RECEIVED	DATE REPORTED	
09/11/02	09/11/02	09/13/02	1265

XI N 02 FAX
CLINICAL INFORMATION 09-13-02 11:35
PHYSICIAN ID EAGERTON D PATIENT ID TVOL
ACCOUNT UPIN: F84861
CAROLINA HEALTH SPEC - 82 PKWY 39710185
82ND PARKWAY 00
945 82ND PARKWAY 00
MYRTLE BEACH , SC 29572-
843-449-7938 SCW

levels in this area.

HgbA1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

LAB: BN LABCORP BURLINGTON DIRECTOR: FRANK HANCOCK, MD
1447 YORK COURT BURLINGTON, NC 27215-2230

FOR INQUIRIES, THE PHYSICIAN MAY CONTACT: BRANCH: 000-000-0000 LAB: 888-200-5439
LAST PAGE OF REPORT

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SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
171-695-0316-0	S	BN	COMPLETE	Page #: 1

ADDITIONAL INF ORMATION

SS#248042224 FAST NG: N
PHONE: 843-347-5748 >OB: 12/07/1954

PATIENT NAME	SEX	AGE(YR./MOS.)
CHAVIS,GILBERT	M	47 / 6

PT. ADD.: 616 MCKINLEY WAY
CONWAY SC 29526-0000

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
6/20/2002	8:43	6/20/2002	6/21/2002	7:40	5568

CLINICAL INFORMATION
CD-91055414502

PHYSICIAN ID.	PATIENT ID.
SAUNDERS H	6927

ACCOUNT: CONWAY ADULT MEDICINE
HENRY V SAUNDERS
908 BELL ST
CONWAY SC 29526-0000
ACCOUNT NUMBER: 39096593

TEST	RESULT		LIMITS	LAB
COMP. METABOLIC PANEL (14)				
BUN	12	mg/dL	5 - 26	BN
Creatinine, Serum	.9	mg/dL	.5 - 1.5	BN
BUN/Creatinine Ratio	13			
Sodium, Serum	143	mmol/L	135 - 148	BN
Potassium, Serum	4.7	mmol/L	3.5 - 5.5	BN
Chloride, Serum	103	mmol/L	96 - 109	BN
Carbon Dioxide, Total	27	mmol/L	20 - 32	BN
Calcium, Serum	9.0	mg/dL	8.5 - 10.6	BN
Protein, Total, Serum	7.4	g/dL	6.0 - 8.5	BN
Albumin, Serum	4.2	g/dL	3.5 - 5.5	BN
Globulin, Total	3.2	g/dL	1.5 - 4.5	
A/G Ratio	1.3		1.1 - 2.5	
Bilirubin, Total	.9	mg/dL	.1 - 1.2	BN
Alkaline Phosphatase, Serum	109	IU/L	25 - 150	BN
AST (SGOT)	23	IU/L	0 - 40	BN
ALT (SGPT)	36	IU/L	0 - 40	BN
LIPID PANEL WITH LDL/HDL RATIO				
Cholesterol, Total	161	mg/dL	100 - 199	BN
VLDL Cholesterol Cal	31	mg/dL	5 - 40	
LDL Cholesterol Calc	97	mg/dL	0 - 99	
LDL/HDL Ratio	3.0	ratio units	.0 - 3.6	

	LDL/HDL Men	LDL/HDL Women
1/2 Avg.Risk	1.0	1.5
Avg.Risk	3.6	3.2
2X Avg.Risk	6.3	5.0
3X Avg.Risk	8.0	6.1

FRUCTOSAMINE

Reference Range is for non-diabetics.

	Male	Female
1- 5 mons.	1 - 177	1 - 5
6-11 mons.	2 - 7	2 - 5

Results are F agged in Accordance with Age Dependent Reference Ranges

Continued on Next Page

Chart 8

GRAND STRAND SLEEP DISORDERS CENTER

Polysomnography Exam

PHYSICIAN: BUNN
PATIENT: CHAVIS, GILBERT R.
ID: 1010850715 DATE: 2004/03/15 EXAM No.: SLEEP00970

COMMENTS:

The exam started at **08:54 PM** and ended at **03:28 AM**, with a sleep latency of **25.00** minutes and a REM latency of **51.00** minutes.

Total sleep time was **331.00** minutes, with a sleep efficiency of **83.80%**.

The sleep stage percentages were **11.59%** stage 1, **61.96%** stage 2, **4.31%** stage 3 and 4, and **20.51%** REM.

The total amount of time in stage Wake was **63.00** minutes and there were **124** arousals during the exam.

There were **0.9** Periodic Leg Movements per hour.

The Apnea index was **10.2** /hour, and the Hypopnea index was **20.3** /hour.

There were **168** respiratory events consisting of **168** obstructive, **0** mixed, and **0** central events. The average duration of the respiratory events was **15.15** seconds, and the maximum duration was **35.50** seconds.

The body position that was most common during respiratory events was **LEFT SIDE**.

The average baseline for oxygen desaturations was **92%** and the minimum oxygen desaturation was **67%**.

TECH COMMENTS: PT WAS ORDERED TO HAVE A DIAGNOSTIC PSG. PT HAD MODERATE OBSTRUCTIVE APNEA, SEVERE OBSTRUCTIVE PARTIAL APNEA, MILD PLMS, MODERATE AROUSALS AND SEVERE SNORING NOTED DURING THIS STUDY. PT HAD SEVERE DESATURATIONS IN REM SLEEP. AROUSALS AND PLMS APPEAR TO BE EVENT RELATED. ALL STAGES OF SLEEP WAS ACHIEVED. EKG APPEARED SR WITH SOME TACHYCARDIA. PT HAD A SCORE OF 5 ON THE SLEEPINESS SCALE. PT STATED THAT HE DID NOT SLEEP VERY GOOD AT ALL. TECH TOLD PT THAT HE WAS ASLEEP FOR MOST OF STUDY AND PT STATED THAT THERE WAS NO WAY THAT HE SLEPT THAT GOOD. PT WAS SURE THAT HE WAS AWAKE FOR MOST OF STUDY.
MICHELLE THORN PSGT.

STRAND SLEEP DISORDERS CE.

General Information

Name: CHAVIS, GILBERT R.
ID: 1010850715
Sex: Male
Age: 49 [12/07/1954]
BMI: 516
Height: 65
Weight: 218
Date: 03/15/2004
Physician: BUNN
Technician: MICHELLE THORN PSGT
Record Number: SLEEP00970
Scored By: MICHELLE THORN PSGT

Medication Information

GEMFIBROZIL, LIPITOR, ROXICODONE, NEURONTIN, BEXTRA, MITFORMIN, GLIPIZIDE, AVANDIA, ST. JOSEPH, CENTRUM, ANDROGEL, NEXIUM, TRIAM, VIAGRA

Sleep Disorder

HYPERSOMNOLENCE WITH SLEEP APNEA

Comments

PT IS LITTLE NERVOUS. CONCEIED ABOUT BEING ABLE TO FIND SOMETHING OUT.

Sleep Stage Information

Lights Out: 08:54 PM
Lights On: 03:28 AM

		Overall	Supine	Prone	Side	Unknown
Time	Recording	6h 35.0m	2h 45.0m	0h 0.0m	2h 34.5m	1h 15.5m
	Sleep	5h 31.0m	2h 19.5m	0h 0.0m	2h 21.0m	0h 50.5m

		Stage 1	Stage 2	Stage 3	Stage 4	REM	Sleep Onset	Sleep Efficiency
Latency	Actual	25.0m	28.0m	69.0m	74.5m	51.0m	25.0m	83.8%
	Normal					71.7m	10.0m	91.0%

Minutes	Wake	Stg1	Stg2	Stg3	Stg4	REM	MT
Total	63.0	39.0	208.5	13.5	1.0	89.0	1.0
Supine	25.0	10.5	90.0	9.0	0.0	30.0	0.5
Side	13.0	25.5	76.5	0.0	0.0	39.0	0.5
Prone	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Unknown	25.0	3.0	42.0	4.5	1.0	0.0	0.0

% of Minutes	Wake	Stg1	Stg2	Stg3	Stg4	REM	MT
Total	15.9	11.8	63.0	4.1	0.3	20.8	0.3
Normal	6.3	8.1	58.6	5.7	3.4	24.3	
Supine	18.2	7.5	64.5	6.5	0.0	21.5	0.3
Side	8.4	18.1	54.3	0.0	0.0	27.7	0.3
Prone	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Unknown	33.1	5.9	83.2	8.9	2.0	0.0	0.0

Respiratory Information

				Subtotal	Supine	Side	Prone	Unknown
Apnea	TOT	56	Total	56	27	29	0	0
			REM	25	19	6	0	0
			NREM	31	8	23	0	0
	OBS	56	REM	25	19	6	0	0
			NREM	31	8	23	0	0
	MIX	0	REM	0	0	0	0	0
			NREM	0	0	0	0	0
	CEN	0	REM	0	0	0	0	0
			NREM	0	0	0	0	0

				Subtotal	Supine	Side	Prone	Unknown
Hypopnea	TOT	112	Total	112	54	55	0	3
			REM	34	18	16	0	0
			NREM	78	36	39	0	3
	OBS	112	REM	34	18	16	0	0
			NREM	78	36	39	0	3
	CEN	0	REM	0	0	0	0	0
			NREM	0	0	0	0	0

			Total	Obstructive	Mixed	Central
RDI	30.45	Apnea	10.15	10.15	0.00	0.00
		Hypopnea	20.30	20.30		0.00

	Total	Supine	Side	Prone	Unknown
Position RDI	30.45	34.84	35.74	0.00	3.56
REM RDI	51.30				
NREM RDI	24.86				

Desaturation Information

	<100%	<90%	<80%	<70%	<60%	<50%	<40%
Supine	68	46	18	2	0	0	0
Prone	0	0	0	0	0	0	0
Side	73	34	9	0	0	0	0
Unknown	2	1	0	0	0	0	0
Total	143	81	27	2	0	0	0

Desaturation Threshold Setting: 3%
Minimum Duration Setting: 10 seconds
SaO2 Nadir: 67%

Longest event was 35.5 sec obstructive Hypopnea with an SaO2 of 85%.
Lowest SaO2 was 67% associated with 17.1 sec obstructive Apnea.

Awakening/Arousal Information

of Awakenings (>1.5 mins): 6
Norms: 4.7
Wake After Sleep Onset: 39.0 minutes

		Arousals	Index (#/hr)
Arousal Assoc.	Apneas	58	10.5
	Hypopneas	36	6.5
	LM	47	8.5
	Snore	0	0.0
	Spontaneous	10	1.8
	Total	124	22.5

EKG Rates

		Avg	Max	Min
EKG	Awake	84	114	71
	Asleep	84	106	69

Detected: Tachycardia

Myoclonus Information

		LM	Index (#/hr)
PLMS	Total LM during PLMS	31	5.6
	LM with Microarousals	18	3.3

	LM not in PLMS	LM	Index (#/hr)
LM	With Microarousal	29	5.3
	With Awakening	5	0.9
	With Resp. Event	11	2.0
	Spontaneous	11	2.0
	Total	46	8.3

GRAND STRAND REGIONAL MEDICAL CENTER
809 82 PARKWAY
MYRTLE BEACH, SC 29572

SLEEP STUDY REPORT

PATIENT: CHAVIS,GILBERT R
DOB: 12/07/54 AGE: 49 SEX: M
DATE OF ADMISSION:
ACCOUNT #: F01010650715

MEDICAL RECORD NUMBER: F000375088

PROCEDURE DATE: 03/15/2004
DATE STUDY RECEIVED:

REFERRING PHYSICIAN: Bunn
SCORING PHYSICIAN: Retalis

CLINICAL HISTORY: Excessive daytime somnolence/hypersomnolence.

METHODS: The patient underwent an overnight sleep study monitoring EEG, EOG, and mylohyoid EMG for sleep staging. Airflow was monitored with oral and nasal thermistors. Thoracic and abdominal pneumographs were used to access respiratory effort. A microphone was used to measure actual snoring resonance. Oxygen saturation was recorded using a pulse oximeter. EKG and anterior tibial EMG were also monitored. The standard chart speed for polysomnography was used (10 mm/sec).

RESULTS: The study began at 8:54 p.m. and ended at 3:28 a.m. The total recording time was 395 minutes and the time spent asleep was 331 minutes. The Sleep Efficiency Index was 84%. Latency to Stage 1 was 25 minutes. Latency to Stage REM from onset of sleep was 51 minutes. The following distribution of sleep stages was observed: Awake, 16%; Stage 1, 12%; Stage 2, 63%; Stages 3 T 4 (Slow Wave), 4%; Stage REM, 21%.

There were 168 apneas/hypopneas recorded during the study for a Respiratory Disturbance Index (RDI) of 30 events per hour. These were 100% obstructive, 0% central and 0% mixed in nature. During REM sleep, 51 events were observed (per hour). These ranged 10-35 seconds in duration with oxygen saturations from 67%. During NREM sleep, 25 events were recorded (per hour). These averaged 10-32 seconds in duration with oxygen saturations ranging from 75%. There were EEG arousals associated with apneic events. The SaO2 baseline for the entire study was 92%.

The EKG portion of the tracing exhibited normal sinus rhythm with tachycardia. Periodic Limb Movements of Sleep were present. Severe snoring was heard in positions.

IMPRESSION:

1. The patient demonstrated severe obstructive sleep apnea with sleep fragmentation, arousals and desaturations to 67%.

2. The electrocardiogram demonstrated normal sinus rhythm with tachycardia to 114 beats per minute.

3. Moderate periodic limb movements of sleep were observed with 31 events recorded and 18 associated arousals.

4. There was rapid onset of rapid-eye-movement sleep. Clinical correlation is recommended.

5. Severe snoring was observed without associated arousals.

Respiratory events occurred with near-equal frequency in the supine and lateral positions. Positional therapy is not likely to be of benefit.

Respiratory events occurred more frequently during rapid-eye-movement sleep with a Respiratory Disturbance Index of 51 events per hour.

The patient scored low on the Epworth sleepiness

GRAND STRAND REGIONAL MEDICAL CENTER
809 82 PARKWAY
MYRTLE BEACH, SC 29572

SLEEP STUDY REPORT

PATIENT: CHAVIS,GILBERT R
DOB: 12/07/54 AGE: 49 SEX: M MEDICAL RECORD NUMBER: F000375088
DATE OF ADMISSION:
ACCOUNT #: F01010850715

scale consistent with mild symptomatology.
9. Strongly suggest therapeutic intervention.

"Signed Copy on File"

D 03/22/2004 21:33:15
T 03/22/2004 23:41:35/366 Job #: 1948963/Doc #: 1377622

RETALIS,PHILIP P

Electronically Signed by PHILIP P RETALIS on 03/23/04 at 0822

SLEEP STUDY REPORT

OPEN MRI & CT OF MYRTLE BEACH

OPEN MRI & CT OF MYRTLE BEACH
900 21st Avenue North
Myrtle Beach, SC 29577
(843)916-1700 fax (843)916-9460

PATIENT NAME: Chavis, Gilbert
DATE OF BIRTH: 12/07/54
REFERRING PHYSICIAN: Dr. Bunn

DATE OF EXAM: 12/15/03

MRI OF THE BRAIN AND PITUITARY WITH AND WITHOUT CONTRAST

INDICATION: Hypogonadotrophic hypogonadism.

TECHNIQUE: Sagittal T1, axial T2, FLAIR images were performed. This was followed by sagittal and axial coronal T1 pre- and post-gadolinium sequences through the pituitary glands. Axial T1 post-gadolinium images were then acquired through the entire brain. The study was performed on a 1.5 Tesla closed magnet.

FINDINGS: The thin sections through the pituitary gland show no evidence for pituitary adenoma or macroadenoma. There is no mass within the suprasellar cistern. The cavernous sinus and optic chiasm are normal.

Images through the posterior fossa reveal a small area of previous infarction within the right cerebellar hemisphere within the posterior inferior cerebellar artery distribution. There is mild prominence to the subarachnoid space throughout the supratentorial and infratentorial compartment, consistent with mild age-appropriate atrophy. The ventricular system is of normal size and in the midline. There is no supratentorial mass or infarct seen. There are normal flow voids maintained within the internal carotid and basilar artery at the skull base. The visualized orbits and paranasal sinuses are remarkable for mild mucosal thickening within the ethmoid air cells on the right. Nasal septum is also seen to be deviated towards the left. Post-gadolinium images through the entire brain show no area of pathologic enhancement.

IMPRESSION:

1. THERE IS NO ADENOMA IDENTIFIED WITHIN THE PITUITARY GLAND.
2. THERE IS A SMALL OLD INFARCT IN THE RIGHT CEREBELLAR HEMISPHERE WITHIN THE PICA DISTRIBUTION.

Steven Epstein, M.D./ts
Dictated on 12/17/03

good MRI OK

Paul Bunn

Carolina Health Specialists

945 82nd Parkway
Myrtle Beach, SC 29572
Phone: (843) 497-5929
Fax: (843) 497-5451

Date: 10/18/04 **Time:** 3:59

Attn: Kathy Morris

Fax#: (803) 252-0709

Pages: 23 **(including this cover page)**

Sender: Deirdre

Remarks: Re. Gilbert Chavis

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Commited to Patient Care and Community Service

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9285

SPECIMEN INFORMATION
SPECIMEN: AT424475U
REQUISITION: 0004463
LAB REF NO:

COLLECTED: 02/23/2004 10:00
RECEIVED: 02/23/2004 14:40
REPORTED: 02/27/2004 02:15

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 49
GENDER: M
SS: 248-04-2224

REPORT STATUS Final

ORDERING PHYSICIAN
BUNN,PAUL D

CLIENT INFORMATION
7187235
CAROLINA HLTH SPECIAL/82ND
THE MEDICAL COMPLEX
945 82ND PKWY
MYRTLE BEACH, SC 29572-4610

Test Name	In Range	Out of Range	Reference Range	Lab
TESTOSTERONE, FREE AND TOTAL				
TESTOSTERONE, TOTAL	749		ng/dL Reference Range: 260-1000	EZ

This test was developed and its performance characteristics determined by Quest Diagnostics Nichols Institute. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. Performance characteristics refer to the analytical performance of the test.

FREE TESTOSTERONE				
TESTOSTERONE, FREE	202.9		pg/mL Reference Range: 1.0-2.7 Reference Range: 50-210	EZ

Performing Laboratory Information:

EZ QUEST DIAGNOSTICS/MI 33608 ORTEGA HWY SAN JUAN CAPISTRANO CA 92675 Laboratory Director: R.E. REITZ,MD

Labs are fine
Stay same meds

CHAVIS,GILBERT R - AT424475U

Page 1 - End of Report

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CAROLINA HEALTH SPECIALISTS/LABORATORY
4591 SOCASTEE BLVD.
MYRTLE BEACH, SC 29588
PHONE: (843) 293-6769 FAX (843) 293-6781

FINAL SAMPLE REPORT

Patient ID: 499730 Chart:
Patient Name: CHAVIS, GILBERT R.
DOB: 12/07/1954 Age:49 Sex: M
Comments:

Page: 1
Final Reported: 02/24/04 08:49
Doctor: PAUL D. BUNN MD
Location: MYRTLE BEACH OFFICE
Phone: 843-347-5748

Lab No: 04054055 Drawn: 02/23/04 10:00 Tech: NS Rec'd: 02/23/04 13:28 Tech: CDB
Comments: TESTOSTERONE FREE & TOTAL TO QUEST

PROCEDURE	NORMAL	ABNORMAL	UNITS	REFERENCE RANGE
BASIC METABOLIC PANEL				
**********				
SODIUM	138		MEQ/L	133 - 145
POTASSIUM	4.4		meq/L	3.5 - 5.1
CHLORIDE	103		MEQ/L	98 - 108
CARBON DIOXIDE	28		MMOL/L	22 - 40
CALCIUM	9.3		MG/DL	8.4 - 10.5
GLUCOSE		192 +	MG/DL	70 - 100

EFFECTIVE JANUARY 1, 2004

Carolina Health Specialists Lab will be changing the cut-point to detect impared fasting glucose from 110 to 100 mg/dl to comply with the November 2003 recommendations for the ADA

BUN	16		MG/DL	7 - 25
CREATININE	0.9		MG/DL	0.4 - 1.2
BUN/CREATININE RATIO	17.8		CALC	

Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.934.9205

SPECIMEN INFORMATION
SPECIMEN: AT4248048
REQUISITION: 00003143
LAB REF NO:

COLLECTED: 11/25/2003 08:30
RECEIVED: 11/25/2003 17:20
REPORTED: 12/02/2003 02:07

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 48
GENDER: M
SS: 248-04-2224

REPORT STATUS Final

ORDERING PHYSICIAN
BUNN,PAUL D

CLIENT INFORMATION
7187235
CAROLINA HLTH SPECIAL/82ND
THE MEDICAL COMPLEX
945 82ND PKWY
MYRTLE BEACH, SC 29572-4610

Test Name	In Range	Out of Range	Reference Range	Lab
TESTOSTERONE, FREE AND TOTAL				
TESTOSTERONE, TOTAL		97 L	300-890	EZ
			Reference Range: 260-1000	
			This test was developed and its performance characteristics determined by Quest Diagnostics Nichols Institute. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. Performance characteristics refer to the analytical performance of the test.	
% FREE TESTOSTERONE		2.39 *		
TESTOSTERONE, FREE		23.2 H	6.6-22.1	EZ
			Reference Range: 1.0-2.7	
SEX HORMONE BINDING GLOBULIN			22-77	EZ
			Reference Range: 50-210	

Performing Laboratory Information:

EZ QUEST DIAGNOSTICS/NI 31608 ORTEGA HWY SAN JUAN CAPISTRANO CA 92675-2042
Laboratory Director: D.A. FISHER,MD; R.E. REITZ, MD

Have him bring in the testosterone he is taking @ home Also see in office Pt. informed 12/8/03 9:10am 003

CHAVIS,GILBERT R - AT4248048

Page 1 - End of Report

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LabCorp™

SPECIMEN #	TYPE	PRIMARY LAB	REPORT STATUS	PG
1254-695-0524-0	S	BN	FINAL	2

TIME 1153 ADDITIONAL INFORMATION
CC:1

XT N 02

CLINICAL INFORMATION FAX 09-13-02 11:35

DOB: 12/07/54
FASTING N

CD# 01071035638

PATIENT INFORMATION 843-347-5748 SEX M AGE(YR/MOS) 047/09

CHAVIS, GILBERT
PT ADD 616 MCKINLEY WAY
Conway , SC 29526-

PHYSICIAN I.D. EAGERTON D PATIENT I.D. TVOL

ACCOUNT UPIN: F84861
CAROLINA HEALTH SPEC - 82 PKWY 39710185
82ND PARKWAY 00
945 82ND PARKWAY 00
MYRTLE BEACH , SC 29572-
843-449-7938 SCW

DATE OF COLLECTION	DATE RECEIVED	DATE REPORTED	
09/11/02	09/11/02	09/13/02	1265

TEST	RESULT	FLAG	UNITS	REFERENCE INTERVAL

levels in this area.

HgbA1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

LAB: BN LABCORP BURLINGTON DIRECTOR: FRANK HANCOCK, MD
1447 YORK COURT BURLINGTON, NC 27215-2230

FOR INQUIRIES, THE PHYSICIAN MAY CONTACT: BRANCH: 000-000-0000 LAB: 888-200-5439
LAST PAGE OF REPORT

CHAVIS, GILBERT REPORT 09/11/02

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SPECIMEN #	TYPE	PRIMARY LAB	REPORT STATUS	
254-695-0524-0	S	BN	FINAL	PG 1

TIME 1153 ADDITIONAL INFORMATION
CC:1

XI N 02
CLINICAL INFORMATION
FAX 09-13-02 11:35

DOB: 12/07/54
CD# 01071036638
PATIENT INFORMATION 843-347-5748 SEX M AGE (YRS/MOS.) 047/09
CHAVIS, GILBERT
PT ADD 616 MCKINLEY WAY
Conway , SC 29526-

PHYSICIAN ID EAGERTON D PATIENT ID TVOL
ACCOUNT UPIN: F84861
CAROLINA HEALTH SPEC - 82 PKWY 39710185
82ND PARKWAY 00
945 82ND PARKWAY 00
MYRTLE BEACH , SC 29572-
843-449-7938 SCW

DATE OF COLLECTION	DATE ENTERED	DATE REPORTED	
09/11/02	09/11/02	09/13/02	1265

TEST	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
BASIC METABOLIC PANEL (7)					
Glucose, Serum	214	H	mg/dL	65 - 109	BN
BUN	13		mg/dL	5 - 26	BN
Creatinine, Serum	0.9		mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	14				
Sodium, Serum	137		mmol/L	135 - 148	BN
Potassium, Serum	4.4		mmol/L	3.5 - 5.5	BN
Chloride, Serum	99		mmol/L	96 - 109	BN
Carbon Dioxide, Total	23		mmol/L	20 - 32	BN
HEPATIC FUNCTION PANEL (7)					
Protein, Total, Serum	8.1		g/dL	6.0 - 8.5	BN
Albumin, Serum	4.4		g/dL	3.5 - 5.5	BN
Bilirubin, Total	0.8		mg/dL	0.1 - 1.2	BN
Bilirubin, Direct	0.20		mg/dL	0.00 - 0.40	BN
Alkaline Phosphatase, Serum	94		IU/L	25 - 150	BN
AST (SGOT)	24		IU/L	0 - 40	BN
ALT (SGPT)	39		IU/L	0 - 40	BN
LIPID PANEL					
Cholesterol, Total	160		mg/dL	100 - 199	BN
Triglycerides	183	H	mg/dL	0 - 149	BN
HDL Cholesterol	31	L	mg/dL	40 - 59	BN
VLDL Cholesterol Cal	36		mg/dL	5 - 40	
LDL Cholesterol Calc	92		mg/dL	0 - 99	
MICROALB/CREAT RATIO, RANDM UR					
Creatinine, Urine	244.8		mg/dL	Not Established	BN
Microalbum.,U,Random	31.7		ug/mL		BN
Microalb/Creat Ratio	12.9		ug/mg creat	0.0 - 30.0	
Hemoglobin A1c					
Hemoglobin A1c	7.8	H	%	4.5 - 5.7	BN
					BN

(Factors such as duration of diabetes, adherence to therapy and the age of the patient should also be considered in assessing the degree of blood glucose control)

The following ranges may be used for interpretation of results:
HgbA1c degree of glucose control:
>8% Action suggested*
<7% Goal of Diabetic Therapy**
<6% Normal

*High risk of developing long term complications such as retinopathy, nephropathy, neuropathy, cardiopathy, etc. **Some danger of hypoglycemic reaction in type I diabetics. Some glucose intolerant individuals and "sub-clinical" diabetics may demonstrate HgbA1c

CHAVIS, GILBERT REPORT 09/11/02

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Quest Diagnostics

QUEST DIAGNOSTICS INCORPORATED
CLIENT SERVICE 770.936.9208

SPECIMEN INFORMATION
SPECIMEN: AT4248028
REQUISITION: 0003145
LAB REF NO:

COLLECTED: 11/25/2003 08:30
RECEIVED: 11/25/2003 17:20
REPORTED: 11/26/2003 12:37

PATIENT INFORMATION
CHAVIS,GILBERT R

DOB: 12/07/1954 Age: 48
GENDER: M
SS: 248-04-2224

REPORT STATUS Final

ORDERING PHYSICIAN
BUNN,PAUL D

CLIENT INFORMATION
7187235
CARDLINA HLTH SPECIAL/82ND
THE MEDICAL COMPLEX
945 82ND PKWY
MYRTLE BEACH, SC 29572-4610

Test Name	In Range	Out of Range	Reference Range	Lab
FSH	1.5		1.4-18.1 MIU/ML	AT
LH	2.4		1.5-9.3 MIU/ML	AT
PROLACTIN	3		2-18 NG/ML	AT

Performing Laboratory Information:

AT QUEST DIAGNOSTICS-ATLANTA 1777 MONTREAL CIRCLE TUCKER GA 30084 Laboratory Director: WILLIAM M MILLER, MD

CHAVIS,GILBERT R - AT4248028

Page 1 - End of Report

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STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOW-UP
Patient Name: Gilbert Chavis
Date of exam: 11/06/03
Account number:

CHIEF COMPLAINT: About 70% improvement.

HISTORY OF PRESENT ILLNESS: He is still having shoulder pain but he has about 50 to 70% improvement since his surgery and is very happy with the outcome. He still has the knee pain and the paresthesias in his hand but they are better since the injection. They just bother him a little bit in the morning now. He has been discharged from therapy. He is here for reevaluation.

He has been concerned lately because he has lost all of his libido. He has been receiving testosterone injections twice a month by Dr. Shore but that did not improve. He is on multiple medications now and did not have any problems prior to his stroke. He is not even having any success with Viagra.

REVIEW OF SYSTEMS: See above.

PHYSICAL EXAM:
LEFT SHOULDER: He has 4+ strength in flexion but 5+ abduction. Range of motion actively is 120 degrees of flexion, 50 degrees of extension, 130 degrees of abduction, 30 degrees of adduction, 50 degrees of external rotation and 50 degrees of internal rotation. Minimal tenderness over the AC joint.
LEFT HAND: Negative Phalen's and Tinel's today.

DIAGNOSTIC TEST(S): None.

ASSESSMENT:
1. Improved left shoulder pain and range of motion status post manipulation with SAD and Mumford.
2. Apparent left carpal tunnel syndrome which has improved.
3. Decreased sexual libido.

PLAN: We had a lengthy discussion concerning his problems. Counseling time exceeded 10 minutes of his 15 minute plus examination. I have recommended that he discuss this with Dr. Nicol and Dr. Kang and perhaps Remeron or the Roxicodone are to blame. This is certainly outside my area of expertise.

As far as his shoulder is concerned, I believe he is at maximum medical improvement. His impairment, using the range of motion model, is 10%. He merits a 10% impairment for his Mumford procedure or resection arthroplasty of his AC joint. He merits a 6% impairment for his flexion deficit. This combines to 24% left upper extremity impairment.

PLAN: (continued)
I have given him a wrist brace to wear for his left carpal tunnel syndrome. Hopefully that will give him some relief.

FOLLOW-UP: P.R.N.

Thomas J. Chambers, M.D.

TJC /wge

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOW-UP
Patient name: Gilbert Chavis
Account Number: 25139
Date of exam: 10/09/03

SUBJECTIVE: His range of motion overall is improving. With physical therapy and stretching, he has noted increased paresthesias in the ulnar distribution. He does have a history of ulnar neuropathy, status post decompression. What is most bothersome is pain that radiates from his shoulder, shooting down the forearm and into his thumb. It is sore at night. Paresthesias do not wake him at night.

PHYSICAL EXAM:

C-SPINE: Good forward flexion. Limited extension. Negative Spurling's. No midline tenderness.

LEFT SHOULDER: Elevation 130 degrees. Internal rotation lacks 3 levels compared to the left. Diffusely tender around the anterior cuff and acromioclavicular joint. He is tight in the posterior capsule. Negative impingement signs. Strength is good.

LEFT HAND: No diffuse intrinsic atrophy or weakness. Negative Phalen's. Positive Tinel's over the median nerve. Decreased grip strength.

RIGHT HAND: Excellent grip strength. Negative Tinel's. Negative Phalen's. No atrophy.

DIAGNOSTIC TEST(S): EMGs checked by Dr. Kang in December, 2002 did reveal evidence of left median motor latency in addition to focal left ulnar neuropathy, status post ulnar nerve decompression.

ASSESSMENT:

PLAN: Dr. Chambers feels that based on the EMG findings and his physical exam, that he is most symptomatic with his carpal tunnel syndrome. Under aseptic conditions, 1 cc of Betamethasone and 1 cc of Marcaine were injected into the carpal canal. Routine postinjection instructions were given. If this give him good relief, we will recommend left carpal tunnel release. In the meantime, he is considering having an epidural steroid injection performed by Dr. Kang with a posterior approach. We will have him continue physical therapy for his shoulder. Follow-up 4-6 weeks.

Erin Kirby, PA-C

EK/rcw

cc: **Dr. Gregory Kang**
Fax Number: 293-8869

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOW UP
Patient name: Gilbert Chavis
Date of exam: 09/22/03
Account Number: 25129.0

CHIEF COMPLAINT: Left arm and leg pain.

HISTORY OF PRESENT ILLNESS: Patient is a 48-year-old right-handed white male seen for follow up of left arm and leg pain. Since his last visit, he underwent left shoulder manipulation by Dr. Chambers under anesthesias and is doing physical therapy as well. His shoulder has significantly improved. He is now having paresthesias in the index finger and thumb of the left hand. He did undergo a nerve conduction study by Dr. Kang recently and was told that he suffers from carpal tunnel syndrome. He has also had worsening low back pain over the past one month.

CURRENT MEDICATIONS:
1. Vioxx 25 mg p.o. q.d.
2. Lipitor 10 mg p.o. q.d.

ALLERGIES: CODEINE

PHYSICAL EXAM:

VITAL SIGNS: Height: 5'7". Weight: 216 pounds. Blood pressure: 140/90. Pulse: 100 regular.

HEENT: Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus or visual field cuts. Pupils are 6mm to 4mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motoric deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally. Funduscopic examination showed sharp discs bilaterally with no evidence of papilledema or hemorrhage. No evidence of cataracts.

NEUROLOGICAL EVALUATION:

MENTAL STATUS: Oriented to person, place and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient had no difficulty in discussing current events.

CRANIAL NERVES: Normal visual fields. Funduscopic examination benign. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation intact. Corneal reflex intact. Facial movement symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER: Power was 5/5 throughout except for 5-/5 strength of the left APB. There was no noted pronator drift. Muscle bulk and tone within normal limits. No evidence of cogwheel rigidity.

SENSORY: Decreased sensation below the medial nerve distribution of the left hand to pinprick and light touch. No sensory deficits to the right upper extremity or bilateral lower extremities to pinprick, light touch, temperature, vibration and proprioception.

CEREBELLUM: Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs: +2 in the upper extremities and knee jerks; +1 ankle jerks with downgoing plantars.

GAIT: Exam showed mild unsteadiness on tandem gait and standing on one leg. Romberg testing was negative. There were no frontal release signs.

IMPRESSION & PLAN:

1. Previous right CVA with left-sided weakness. Patient had no weakness on examination today except for his left APB. He will need to undergo left carpal tunnel syndrome release by Dr. Chamber.
2. Intermittent migraine headaches. These appear to be stable at present.

PLAN: I plan on seeing the patient for follow-up as needed.

Michael McCaffrey, M.D.

MM/krw

cc: Dr. Tom Chambers

STRAND REGIONAL SPECIALTY ASSOCIATES
POSTOPERATIVE VISIT
Patient Name: Gilbert Chavis
Date of exam: 8/22/03
Account number: 25129

DATE OF SURGERY: 6/25/03.

PROCEDURE: Left shoulder manipulation with SAD and Mumford.

SUBJECTIVE: He feels a little bit better. He has been going to therapy and his motion is improving. He still has the burning pain down into his thumb and index finger. He also occasionally has some numbness in his small and ring finger. That was resolved after his ulnar nerve transposition but seems to be coming back a little bit now.

He states that he did have some nerve studies done following his stroke by Dr. Kang. Dr. Kang told him at that time that he had some ongoing radicular findings.

PHYSICAL EXAM:
CERVICAL SPINE: Negative Spurling's. He is somewhat diffusely tender over the left paraspinals. Limited motion.
LEFT SHOULDER: He has 130 degrees of elevation. Internal rotation to L4. The wounds look good.
NEUROLOGIC EXAM: Strength is intact in all myotomes but somewhat globally diminished on the left versus the right. Light touch sensation is intact throughout. Negative Tinel's over the carpal tunnel. Negative Phalen's for median nerve compression but he does have some ulnar nerve symptoms with Phalen's. No intrinsic is noted. No thenar atrophy.

DIAGNOSTIC TEST(S): None.

ASSESSMENT:
1. Doing well status post left shoulder manipulation with decompression and Mumford.
2. I cannot rule out cervical radiculopathy versus regional pain syndrome following his stroke.

PLAN: This may just be a regional pain syndrome following his stroke but I think he needs to be evaluated by Dr. McCaffrey who has seen him in the past. It may be cervical radiculopathy but I will defer that to Dr. McCaffrey to sort out. His shoulder seems to be doing well. He does need to continue his therapy.

WORK STATUS: Unchanged.
FOLLOW-UP: Six weeks.

Thomas J. Chambers, M.D.
TJC/wge

STRAND REGIONAL SPECIALTY ASSOCIATES
POSTOPERATIVE VISIT
Patient Name: Gilbert Chavis
Date of exam: 7/25/03
Account number: 25139

DATE OF SURGERY: 6/25/03

PROCEDURE: Manipulation with SAD and Mumford.

SUBJECTIVE: They are working more aggressively with range of motion with him in therapy but he has now used up all of his pre-approved visits. They have not done any pulley work nor does he have one for home use. His pain is improving but he is still sore.

PHYSICAL EXAM: He has 110 degrees of elevation with internal rotation to his lumbosacral junction.

DIAGNOSTIC TEST(S): None.

ASSESSMENT: Progressing slowly status post manipulation with Mumford and decompression.

PLAN: I am going to have him change to our therapy clinic. I have given him a pulley for home use.

WORK STATUS: Unchanged.

FOLLOW-UP: Four weeks.

Thomas J. Chambers, M.D.

TJC/wge

STRAND REGIONAL SPECIALTY ASSOCIATES
POSTOPERATIVE VISIT
Patient Name: Gilbert Chavis
Date of exam: 7/3/03
Account number: 25129

DATE OF SURGERY: 6/25/03

PROCEDURE: Manipulation with subacromial decompression and Mumford.

SUBJECTIVE: He has been pretty sore but he is happy that he did it. He feels a difference. He has been going to therapy but has only gone three times so far. They have not been pushing him very hard in range of motion.

PHYSICAL EXAM: Passively I can get him to about 100 degrees today. Wounds look great.

DIAGNOSTIC TEST(S): None.

ASSESSMENT: Doing well.

PLAN: I want him to push harder in physical therapy. I have asked Liz to call Dr. Kang to talk to him about that. I also made it very clear to Mr. Chavis.

WORK STATUS: N/A.

FOLLOW-UP: Three to four weeks.

Thomas J. Chambers, M.D.

TJC/wge

OCEAN AMBULATORY SURGERY CENTER
OPERATIVE NOTE
Patient Name: Gilbert Chavis
Account number:

DATE OF OPERATION: 6/25/03

DATE OF DICTATION: 6/25/03

PREOPERATIVE DIAGNOSIS: Left frozen shoulder with AC joint degenerative joint disease and rotator cuff tendinitis.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Left shoulder manipulation with arthroscopic subacromial decompression and arthroscopic Mumford.

SURGEON: Thomas J. Chambers, M.D.

ASSISTANTS: None.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

SPECIMENS: None.

DRAINS: None.

INDICATIONS: Patient is a middle age white male with a long history of chronic pain syndromes. He is also a diabetic. He has increased pain and stiffness of his shoulder and, on examination, has a frozen shoulder. His examination suggested that the cause was tendinitis with AC joint degenerative joint disease and subacromial impingement. He presents now for elective shoulder manipulation with decompression and Mumford.

DESCRIPTION OF OPERATION: The patient was taken to the operating room and placed in the supine position on the operating room table. After administration of a general anesthetic, a shoulder manipulation was performed. He had good pops and had excellent range of motion at the completion of manipulation. No evidence of fracture was noted. He was then rolled into the right lateral decubitus position. He was prepped and draped in the usual fashion.

DESCRIPTION OF OPERATION: (continued)
A posterior portal was made and the sheath placed into the shoulder over a blunt trochar. An anterior portal was made under direct visualization. The intraarticular portion of the scope showed some unusual spurring of the anterior humeral head but was otherwise unremarkable for degenerative changes. There was no instability noted. The tearing of the capsule from the manipulation was seen. The subscapularis was normal. Biceps was normal. The supraspinatus showed some partial thickness undersurface tearing but did not appear to be full thickness.

Attention was turned to the subacromial space. A subacromial bursectomy was performed and it was quite thickened. The superior surface of the tendon was clearly intact to probing and visualization. An anterior bony decompression was performed without release of the CA ligament. I found no evidence of sub-CA ligament impingement. The AC joint was degenerative and that was skeletonized using the Arthrocare wand and the shaver. I then placed the bur in through the anterior portal and performed an arthroscopic Mumford procedure with excellent visualization noted. I did move the scope to the lateral portal for improved visualization of the distal clavicle. I completed the decompression. The wounds were then irrigated and closed. No significant bleeding was seen. Under direct visualization, I did place a pain catheter directly underneath the AC joint. The portals were then closed with 4-0 nylon sutures. The shoulder was injected with 20 cc of .5% plain Marcaine and then hooked to the pain catheter. The wounds were dressed with Xeroform, sterile gauze and ABDs. He was awakened and taken from the operating room in stable condition where he was noted to be quite comfortable.

Thomas J. Chambers, M.D.

TJC/wge

OASC
OCEAN AMBULATORY SURGERY CENTER

Patient: Gilbert Chavis

Physician: Chambers

Date: 6/20/03

Allergies: Codeine

History: 48 yo WM who has developed (L) shldr pain 2° to a work related injury 12-1-98. He initially injured the (R) arm, had it scoped & an ESI for Cervical HNP. Thereafter he developed (L) frozen shoulder syndrome. He is on chronic Narcotics. ΦNSAIDs Tried Not Due. Tried for relief

Past Medical History: CVA, DM, Borderline HTN, GERD, peripheral Neuropathy

Medications: Glucophage, Glucotrol, Avandia, Neurontin 400mg bid, Roxicodone 180mg QD, Nexium prn.

Social History: NS, Etoh - Φ

Review of Systems: ΦCP/SOB, Φfever/chills Φ hepatitis FSBG v'd 3x week ≈ 190 in AM. Ran out of Med for Reflux. (D) wound healing problems.

Diagnostics/Labs: —

Physical Examination

Vitals: 160/90, P-90, R-14

General: pleasant WM in NAD

Skin: WNL, Minor abrasion @ dorsum hand

HEENT: PERRL, NC, AT

Cardiovascular: RRRS, RM/G

Lungs/Chest: CTA (B)

Abdomen: Scaphoid, firm, NT

Genitourinary —

Extremities: ΦC/C/E LEs (B).

Musculoskeletal: (L) Shldr - (+) Atrophy, pflex - 120, Aflex - 100°, IR - 45 jcm, 5/5 EL + Supra strength, (+) impingement + Adjt. Pain

Neurologic: Alert + Appropriate, Short-term Memory slightly diminished.

Other: —

Diagnosis: (L) frozen shoulder

Procedure: (L) Shoulder Scope with decompression + possible distal clavicle excision. Update EKG Hrt Planned non

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOW-UP
Patient Name: Gilbert Chavis
Date of exam: 4/3/03
Account number:

CHIEF COMPLAINT: Left shoulder pain.

HISTORY OF PRESENT ILLNESS: He still has lots of shoulder pain. It is worse since my examination last week. He has had his MRI and is here today for follow-up.

PHYSICAL EXAM: Markedly tender over the left AC joint. Positive impingement sign. Positive crossed adduction.

DIAGNOSTIC TEST(S): Left shoulder MRI shows some mild tendinopathy but, for the most part, just marked AC joint degenerative changes are seen with some mild impingement. There is a lateral downsloping acromion.

ASSESSMENT: Left shoulder subacromial impingement with AC joint degenerative joint disease.

PLAN: I have recommended a SAD, particularly with his lateral downsloping acromion as well as Mumford. Discussed the risks, benefits and recovery. The risks include some ongoing pain, stiffness and infection. He would like to proceed.

Thomas J. Chambers, M.D.

TJC/wge

OPEN MRI & CT OF MYRTLE BEACH
OPEN MRI & CT OF MYRTLE BEACH
900 21st Avenue North
Myrtle Beach, SC 29577
(843)916-1700 fax (843)916-9460

PATIENT NAME: Chavis, Gilbert

DATE OF BIRTH: 12/07/54

HOME PHONE : 843-347-5748

REFERRING PHYSICIAN: Dr. Tom Chambers

MRI LEFT SHOULDER

DATE OF EXAM: 03/31/2003. There is a previous study available for comparison dated 03/12/2002.

HISTORY: 48 year old male with persistent left shoulder pain.

TECHNIQUE: The following sequences were obtained using a Siemens 1.0 Tesla closed unit: multiple coronal oblique T1, dual-echo with fat saturation, and STIR images of the left shoulder were obtained. In addition, multiple sagittal dual-echo along with axial gradient images of the left shoulder were obtained without the use of intravenous contrast material.

FINDINGS: The marrow signal within the left proximal humerus is unremarkable. There are mild hypertrophic changes present within the left acromial clavicular joint. There is a type II left acromion with mild lateral downsloping causing very mild narrowing of the left subacromial space. Specifically, there is mild diffuse thickening and hyperintense signal within the anterior portion of the distal left supraspinatus tendon without full thickness tear or retraction. The infraspinatus and subscapularis tendons are intact. The coracoacromial and coracoclavicular ligaments are unremarkable. The proximal biceps tendon is intact. The glenoid labrum is mildly blunted anteriorly without detachment.

IMPRESSION:

1. MILD TENDINOSIS WITHIN THE ANTERIOR PORTION OF THE DISTAL LEFT SUPRASPINATUS TENDON WITHOUT ROTATOR CUFF TEAR.
2. MILD DEGENERATIVE HYPERTROPHY WITHIN THE LEFT AC JOINT CAUSING 1-2 MM OF SUPERIOR EFFACEMENT AT THE DISTAL LEFT SUPRASPINATUS MUSCLE CENTRALLY.
3. TYPE II LEFT ACROMION WITH MILD LATERAL DOWNSLOPING WITHOUT SIGNIFICANT ANATOMICAL NARROWING OF THE LEFT SUBACROMIAL SPACE.

Jerome McCabe, M.D./nlg
Radiologist
Dictated on 04/01/2003

STRAND REGIONAL SPECIALTY ASSOCIATES
INITIAL EVALUATION
Patient Name: Gilbert Chavis
Date of exam: 3/25/03
Account number: 25129

CHIEF COMPLAINT: Left shoulder pain.

DATE OF INJURY: 12/1/98.

HISTORY OF PRESENT ILLNESS: Patient is a middle age right hand dominant male who was injured lifting a 95 pound pot at AVX. He subsequently had a right shoulder arthroscopy with rotator cuff debridement by Dr. Preslar. He also had a C5-6 HNP and had an epidural steroid injection where he apparently sustained some sort of neurologic complication. He describes it as a stroke. It affected his left side but has resolved for the most part. He has had pain in his left shoulder ever since. He has night pain. He has paresthesias down the dorsum of the forearm. He has pain with driving. He had an MRI a year ago. My evaluation is now requested by Dr. Kang.

CURRENT MEDICATIONS:
1. Glucotrol.
2. Glucophage.
3. Neurontin.
4. Roxicodone.
5. Zantac.
6. Avandia.

ALLERGIES: CODEINE.

PHYSICAL EXAM:
GENERAL: Otherwise healthy appearing middle age white male in no acute distress. Alert and oriented x 3
VITALS: Height: 5' 7" Weight: 201 Pulse: 90
LEFT SHOULDER: Markedly tender over the rotator cuff. Markedly positive impingement signs. Straight abduction of only 70 degrees with elevation to about 90 degrees. Markedly limited rotation. No focal atrophy. Tenderness over the AC joint. Distal neurovascular examination is intact.
RIGHT SHOULDER: There is marked thickening about the AC joint, but it is nontender. Full range of motion with good strength. Negative impingement.

DIAGNOSTIC TEST(S): MRI brought with the patient dated approximately a year ago, shows no obvious tearing. There is some rotator cuff tendinopathy and some AC joint degenerative changes.

ASSESSMENT: Ongoing left shoulder pain, quite likely a frozen shoulder with or without rotator cuff pathology and AC joint pathology.

PLAN: I think he is probably developing a frozen shoulder. I do think he probably has some AC joint problems. I'm not sure about his rotator cuff. I would like to check an MRI. I want this done on a 1.5 Tesla magnet for optimum diagnostic quality. If it is negative, I will plan on an examination under anesthesia with probable manipulation and arthroscopy. I think it is quite unlikely, given his excellent nonoperative care at this point, there is going to be anything else that I can do non-operatively.

WORK STATUS: N/A.

FOLLOW-UP: After MRI.

Thomas J. Chambers, M.D.

TJC/wge

STRAND REGIONAL SPECIALTY ASSOCIATES
Patient name: Gilbert R. Chavis
Account Number: A25129-1
Date of exam: 11/18/02

WORKER'S COMPENSATION EVALUATION

GENDER: Male
ETHNIC ORIGIN: Caucasian
DOB: 12/07/54
DATE OF EVALUATION: 11/18/02
DATE OF ACCIDENT: 01/25/00
DATE FIRST SEEN BY PHYSICIAN FOLLOWING THE ACCIDENT: 01/25/00
EXAMINING PHYSICIAN: Dr. Goltra in Mount Pleasant, SC
REQUESTING PARTY: Dr. Gregory Kang
DOCUMENTS PROVIDED: None

PAST MEDICAL HISTORY: Non-insulin dependent diabetes mellitus and migraine headaches.

PAST SURGICAL HISTORY: Tracheostomy at age 10 months old, skin tag removed off his scrotum in 1967, right shoulder surgery in 1999, left ulnar transposition in 2002.

PREVIOUS HOSPITALIZATIONS OTHER THAN SURGERY: Kidney stones in 2001 and 2002.

CURRENT MEDICATIONS: Glucotrol 10 mg p.o. q.d.; Glucophage 500 mg p.o. q.d.; Percocet 10/325 one p.o. t.i.d. p.r.n.; multivitamin q.d.

PREVIOUS ACCIDENTS, OUTCOMES OR DISABILITY RATINGS: The patient had 2 separate Worker's Comp injuries in the past, regarding his back in 1996 and shoulder in 1998.

PREVIOUS INJURIES TO SPINE, HEAD OR EXTREMITIES: The lower back and left shoulder in the past on Worker's Comp injuries.

SOCIAL HISTORY: He is a nonsmoker, nondrinker. He denies recreational drug use or history of addiction. He has been married to his 4th wife 16 years. He has 2 children and 2 dependents. His wife works for Horry County in finance.

CHEMICAL EXPOSURE: None

HOBBIES: None

PETS: None

HIGHEST EDUCATION LEVEL: GED

SPECIAL JOB TRAINING: None

PRIOR MILITARY SERVICE: None

ALLERGIES: CODEINE

TRAVEL HISTORY: The eastern/souther US.

FAMILY HISTORY: His mother died at age 62 from cancer. His father died at age 65 from unknown reasons. He has 5 sisters and 4 brothers. One of his brothers is 56 years old and recently had cataracts removed. He has a son who is 26 and a daughter 17 alive and well. He has 1 grandson who is 2 years old alive and well.

OCCUPATIONAL HISTORY: He has been disabled since 2000 secondary to left sided weakness from his previous CVA.

MOST RECENT JOB: Working at AVX as a paste processor. This job did require a jumpsuit, earplugs and safety glasses.

LAST DATE WORKED: 01/24/00. He is not working at present secondary to his previous CVA.

INJURY HISTORY: He had a back injury lifting something in 1996 and was evaluated by Dr. Wilkins at that time. He also had a shoulder injury in 1998 while lifting something at work and was evaluated by Dr. Kang.

HISTORY OF PRESENT ILLNESS: This 47 year old right handed white male states that on 01/25/00 while at Disk Imaging in Mount Pleasant, SC at the approximate time of 1:15 p.m. bodily injury occurred in the following manner. The patient was undergoing a selective nerve root block by Dr. David Goltra at Disk Imaging in Mount Pleasant, SC. He had an episode of loss of consciousness during this injection and awoke with left sided weakness and dysarthria. He was taken to Cooper River Medical Center and admitted at that time. He stayed over night but requested to go home the following day. He was seen by Dr. Groblewski approximately 2 days later for continued left sided weakness and dysarthria. Symptoms lasted for the next 6 to 8 months and he has been disabled since then secondary to left sided weakness.

CHIEF COMPLAINT AT PRESENT:

1. Previous right CVA with left sided weakness - Unfortunately I do not have any of his previous records or MRI in reference to his CVA. He has intermittent paresthesias of the left arm and left foot which can become burning in nature. Prior to his epidural/selective nerve root block, he was having pain in both arms which has been improving in the right arm over the past 1 year. He notes that supination of the left wrist will exacerbate the numbness and pain in his left hand. He does not know of anything that decreases his discomfort. This problem has been improving in his right arm, but not left arm. He does have a previous Worker's Comp injury to his left shoulder. He denies injuring this area of his body before. This problem with left sided numbness and weakness has been diagnosed as a CVA.

REVIEW OF SYSTEMS:

GENERAL:	Negative
DERMATOLOGICAL:	Negative
HEENT:	Negative
BREASTS:	Negative
PULMONARY:	Negative
CARDIOVASCULAR:	Negative
GI:	Negative
GU:	Negative
NEUROLOGICAL:	See HPI.
RHEUMATOLOGICAL:	See HPI.
ENDOCRINE:	Negative

PRIOR LAWSUITS: The patient has had a previous lawsuit in 1996 from his first Worker's Comp injury and in 1998 with his second Worker's Comp injury. His lawyer is Bruce Dew out of Columbia, SC.

NEGATIVE IMPACT TO THE INJURY: The patient has chronic pain in his left shoulder with weakness of his left side and is unable to work at present secondary to this.

PHYSICAL EXAM:

VITAL SIGNS:	Height: 5'5". Weight: 195. Blood pressure: 160/92. Pulse: 92 regular.
GENERAL:	The patient is a well-developed, well-nourished, well-groomed, white male in no acute distress examined in the office.

HEENT: Normocephalic, atraumatic. EOMI. No noted ptosis, nystagmus or visual field cuts. Pupils are 6 mm to 4 mm bilaterally to direct and consensual light. No afferent pupillary defects. No sensory or motoric deficits to the face. Tongue midline without fasciculations. Symmetrical palatal rise with good gag reflex. Hearing intact bilaterally. Funduscopic examination showed sharp discs bilaterally with no evidence of papilledema or hemorrhage. No evidence of cataracts.

NECK: The neck showed 5/5 strength of the flexors, extensors and lateral rotators. There were no carotid bruits or thyromegaly. There was no nuchal rigidity.

HEART: The heart has a regular rate and rhythm. S1 and S2 were auscultated. There were no murmurs, rubs or gallops.

RESPIRATORY: Trachea was midline. Lungs were clear to auscultation bilaterally with no rales, wheezes or rhonchi.

ABDOMEN: Abdomen was soft, nontender. There were normal active bowel sounds in all four quadrants. There was no evidence of hepatosplenomegaly. There was no guarding, rebound or rigidity.

EXTREMITIES: There was no edema, clubbing or cyanosis. There were +2 radial and dorsalis pedis pulses bilaterally.

NEUROLOGICAL EVALUATION:

MENTAL STATUS: Oriented to person, place and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient had no difficulty in discussing current events.

CRANIAL NERVES: Normal visual fields. Funduscopic examination benign. PERLA. EOMs full. No nystagmus. No ptosis. Facial sensation intact. Corneal reflex intact. Facial movement symmetric. Hearing intact bilaterally. Palate midline. Normal SCM/trapezius. Tongue midline.

POWER: Power was 5/5 throughout except for breakthrough weakness in all muscles tested in the left upper extremity secondary to pain. He had mild wasting of the interossei muscles of the left hand. There was no apparent pronator drift on examination.

SENSORY: Decreased sensation over the mid tarsal area of both feet to pinprick, light touch and temperature. He had decreased vibrational sense below the ankles. Normal sensation of the upper extremities.

CEREBELLUM: Examination showed finger-nose-finger and heel-to-shin testing intact bilaterally. Normal rapid alternating movements bilaterally.

DTRs: +2 in the upper extremities and knee jerks; +1 ankle jerks with downgoing plantars.

GAIT: Exam showed mild unsteadiness on tandem gait and standing on one leg. Romberg testing was negative. There were no frontal release signs.

IMPRESSION & PLAN:

1. Previous right CVA with left sided weakness - The patient has no definable weakness in his left lower extremity on examination today. I think some of his weakness, if not all of his weakness, in his left upper extremity is secondary to left shoulder pain. I recommend starting the patient on aspirin 81 mg p.o. q.d. He is on no stroke prophylactic medications at present. He may need a repeat MRI of the brain in the near future to evaluate for any recurrence of his right subcortical CVA versus new CVAs.
2. Intermittent migraine headaches - The patient may need to be on a prophylactic medication for this problem. I will hold on treating him with any triptan medications at this time secondary to his history of his previous CVA.

PLAN: I will see the patient in follow-up as needed. The patient was sent for an independent medical evaluation in reference to his previous CVA.

Michael McCaffrey, M.D.

MM/lhp

cc: Dr. Gregory Kang

901 EAST CHEVES STREET
FLORENCE, SOUTH CAROLINA 29506
(843) 662-5233

HAVIS, GILBERT R. (196-190 WC)
AGE FOUR (4)

Con't from page three (3)

RECOMM: This gentleman has a somewhat perplexing situation, given his previous history of a "stroke" from an epidural steroid injection done back in January. He appears to have made good recovery from this. I have told him, from my standpoint, there is no intervention required for this mild central disc bulge. He was cautioned however that some of his radicular symptoms conceivably could come from this and that he could not expect complete resolution of all of his symptoms from whatever type of shoulder surgery Dr. Elvington feels is required. He seems to have realistic expectations about this and I think it is appropriate for him to proceed with whatever Dr. Elvington recommends. (Edwards/dab)

6/2/00 Gilbert is still having significant pain. The majority of his pain is in the forearm and hand, not in the shoulder. After a long discussion with this I don't believe that anything I could do in his shoulder will make him better. It certainly won't make his hand feel better and this is the majority of his problem. He also has some neck pain. I have nothing to offer him Orthopaedically. I think this is related to the stroke and/or the injection. We will refer him back to Dr. Groblewski, give him some pain medication and some Neurontin to see if this will help him in the meantime but we will not make another appointment to see him back for me. He will be out of work until seeing Dr. Groblewski. (Elvington/km)

6/5/00 pg 1-4 faxed to Dr. Groblewski (km)
6-8-00 NCFAs X2 & update to Liberty Mutual (cg)
Update faxed Cheryl Furlish, RN
6-14-00 Report 5-25-00 & 6-2-00 faxed to Reshia Williams. Liberty Mutual. (cng)

12-08-00 Copy of report and patient's bill sent to Mr. Bruce G. Dew, Attorney-At-Law, 1417 Gregg Street, Columbia, S.C. 29201 (ck. For $15.00 received; ck. #3179) (dab)

12-08-00 Copy of report ~~left at front desk for pick up by the~~ mailed to the patient (dab)

PDOA
PEE DEE ORTHOPAEDIC ASSOCIATES

DEWEY N. ERVIN, M.D.
JOSEPH W. DUNLAP, JR., M.D.
W.S. (BILL) EDWARDS, JR., M.D.
ROBERT W. MOORE, M.D.
MICHAEL W. MENDES, M.D.

NIGEL A.R. WATT, M.D.
ROBERT E. ELVINGTON, JR., M.D.

A. CECIL BOZARD, JR., M.D., EMERITUS

W.N. (WILL) CINN, III, CMPE
EXECUTIVE DIRECTOR

Date May 25, 2000 Case # 196-190 WC

Name Gilbert R. Chavis Age 45 WM

Address 616 McKinley Way, Conway, S.C. 29526 Ref by Dr. Elvington

CC: Neck and right shoulder and arm pain.

HPI: This 45 year old, right handed, white male was kindly referred over by Dr. Elvington for evaluation of cervical disc bulge. This gentleman has had a remote work related injury to his right shoulder, in December of '98, that occurred at AVX. He had subsequent arthroscopic surgery elsewhere that has not lead to any significant improvement and Dr. Elvington has been consulted to determine if further surgical intervention may be of help. In the course of work-up, it was determined that he had a disc bulge at C-5-6 and given the radicular component of some of his symptoms, spinal evaluation was requested.

PMH: Past medical history has been previously noted. He is taking Tylox for pain intermittently.

PE: Five foot, five inch, 195 pound white male in no acute distress.

He has a surgical scar from a tracheostomy from early years. There are arthroscopic scars over the right shoulder. Shoulder motion is limited. He has some impingement signs and tenderness is noted about the subdeltoid region. He also has some mild tenderness in the right trapezius. No torticollis or loss of cervical lordosis. Gentle motion is tolerated well in all planes. Motor function in the upper extremities is normal. He has no reflex asymmetry and no long track findings.

X-RAY: Radiographic studies, plain films, show slightly decreased cervical lordosis otherwise normal.

MRI scan from 01-08 at Disc Imaging shows a central disc bulge at C-5-6. No significant compressive pathology is noted here.

CLINICAL IMP: Rotator cuff tear, right shoulder.
Cervical disc bulge C-5-6.

Con't on page four (4)

Name of Patient Gilbert Davis Date 4/2-4/6

Unable to return to work ✓ May return to light duty if available

May return to work on

Restrictions:
1) No lifting over lbs.
2) No repetitive bending, crawl, squat, stooping
3) No work involving use of hand.
4) No pushing/pulling
5) Cannot reach above shoulder
6) No climbing
7) No prolonged walking
8) Other:

May return with no restrictions on

Comments: Out of work until further notice

Diagnosis: (R) Shoulder Impingement

Return appointment date: 3wks Robert Elvington, M.D.

Return to Work Authorization

PATIENT/EMPLOYER'S COPY

Sent to Reesha 4/27

PEE DEE ORTHOPAEDIC ASSOCIATES, P.A.
P.O. DRAWER 1771
FflorENCE, S.C. 29503

HAVIS, GILBERT R. 196-190 WC
PAGE TWO (2)

4/24/00 Gilbert is back after a long hiatus. He has been referred back for workmans compensation for his shoulder. He apparently had some nerve compression in his cervical spine. He went for and ESI and from his statement he had some form of cerebral infarct. He's being followed by Dr. Growblewski, the Neurologist, in Conway. He's complaining of constant pain now from his neck into his shoulder and all the way into his middle finger. He has occasional numbness. Still some restricted motion in his shoulder. He did have the evidence of a rotator cuff tear or partial tear along with AC joint arthritis. We discussed an Arthroscopic look again. If he has a complete tear we will repair it, and I would plan on performing a distal clavicle excision. However, I am concerned about the pain into his hand. This is not caused by his shoulder. This may be some form of nerve root irritation from the injection, but I can't be sure. I would like for the patient to see Dr. Edwards for another opinion on his neck before we proceed anything further on his shoulder. I told him that fixing the shoulder would help his shoulder pain most likely, but it should not and would not do any benefit for anything below the elbow. If he has any cervical lesions this may complicate his rehab or may cause some shoulder pain that we cannot fix. He's aware of this and we are going to plan on getting him set up with Dr. Edwards. (Elvington/km)

4-25-00 Update faxed to Cheryl Furtick/WRA-Liberty Mutual Co.

4-27-00 Update for 4/24/00 re faxed to Cheryl Furtick, WRA-Liberty Mutual (Boy)

5-17-00 HCFA'd & Report to Liberty Mutual-Charlotte Cong)

PDOA
PEE DEE ORTHOPAEDIC ASSOCIATES

DEWEY N. ERVIN, M.D.
JOSEPH W. DUNLAP, JR., M.D.
W.S. (BILL) EDWARDS, JR., M.D.
ROBERT W. MOORE, M.D.
MICHAEL W. MENDES, M.D.

NIGEL A.R. WATT, M.D.
ROBERT E. ELVINGTON, JR., M.D.

A. CECIL BOZARD, JR., M.D., EMERITUS

W.N. (WILL) GINN, III, CMPE
EXECUTIVE DIRECTOR

Date 12-29-99 Case # 196-190 WC

Name CHAVIS, GILBERT R. Age 45 W M

Address 616 McKinley Way, Conway, SC 29526 Ref by

CC: Right shoulder pain.

HPI: This patient is a 45 year old white male who was injured on the job as a paste processor at AVX on 12-01-98 after picking up a heavy pipe. His shoulders extended and he felt a burning pain in his right shoulder. He is here for a 2nd opinion for further surgery. He is s/p arthroscopic rotator cuff debridement for a partial thickness tear. He also underwent a subacromial decompression by Dr. Presslar in August of 1999. He had failed injections and physical therapy previously. Prior to the surgery he had had some pain with overhead activities and with sleeping on his shoulder. Afterwards his pain improved some but he started to have popping in his shoulder and continued to have pain. He missed work for about 6 weeks after the initial surgery.

PE: On examination the patient has no atrophy in the shoulder. The scars are well healed. He has 165 degrees of abduction, 175 degrees of forward flexion. External rotation to 90 degrees with his shoulder in abduction and to 80 degrees of internal rotation. Good strength in his rotator cuff with resisted external rotation. He still has some impingement on impingement sign and is tender over his AC joint. His neck has good ROM without pain. He has good strength in both hands. No neurologic deficit. Good pulses bilaterally.

X-RAY: Of his shoulder shows the decompression but shows some degenerative changes at the AC joint. The MRI also shows some hypertrophy in the AC joint with no evidence of an increased tear of the rotator cuff.

IMP: Impingement right shoulder with AC joint arthritis.

RECOM: I did discuss this surgery with the patient and I have told him that this would probably help his pain. I would agree with Dr. Presslar. It should reduce his pain and give him a more functional shoulder. (Elvington/bj)

1-17-00 Report faxed to Michael Woodall-Liberty Mutual (bg)
, 18-00 HCFA & Report to Liberty Mutual, copy of report to pt. per telephone request for same. (bg)

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

RECEIVED
JUN 07 2013
SC Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Commons Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No.: 2012-213175

Gilbert Chavis, ... Employee,

v.

AVX Corporation, Employer, and Liberty Mutual Insurance, ... Carrier,

In Re: AVX Corporation and Liberty Mutual Insurance Company, ... Respondents,

v.

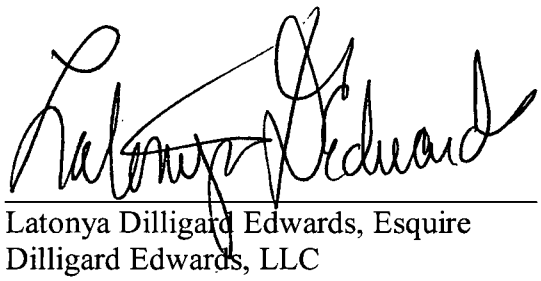
South Carolina Second Injury Fund,..... Appellant.

PROOF OF SERVICE

The undersigned employee of Dilligard Edwards, LLC, Attorney for the Appellant, does hereby certify that service of the **Appellant's Final Brief, Record on Appeal and Certificate of Counsel** to the South Carolina Court of Appeals in the above-captioned matter was made upon counsel of record for Respondents AVX Corporation, Employer and Liberty Mutual Insurance, Carrier, and the South Carolina Workers' Compensation Commission, by placing same in the United States Mail, first class postage prepaid, at the below listed address clearly indicated on said envelope on this 7th day of June, 2013, addressed as follows:

Kirsten L. Barr, Esquire
Trask & Howell, LLC
763 Johnnie Dodds Boulevard
Mount Pleasant, South Carolina 29465

The Honorable Virginia Crocker, Judicial Director
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715



Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
S.C. Bar #: 14593
(803) 750-2214 (phone)
(803) 750-2377 (fax)

ATTORNEY FOR THE SC SECOND INJURY FUND