THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

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SC Court of Appeals

Appellate Case No.: 2018-000965

Victor G. Benjamin, Claimant, ... Appellant,

v.

Rexam Beverage Can Company d/b/a Rexam Beverages, Employer,
and Hartford Insurance Company of the Midwest, Carrier, ... Respondents.

BRIEF OF APPELLANT

Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1320 Richland St.
Columbia, SC 29201
(803) 779-4000
stephen@samuelslawfirm.net

Jeff C. Chandler
CHANDLER LAW FIRM
Bank of America Building
2501 North Oak Street
Myrtle Beach, SC 29577
(843) 448-4357
jeffcchandler@aol.com

ATTORNEYS FOR APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. Whether the Workers' Compensation Commission erred in denying Victor Benjamin's claim for lifetime compensation when the Commission found as a fact that "Claimant's injuries to his . . . brain (for initial closed head injury and resulting headaches and seizures) . . . render him permanently and totally disabled," and the evidence to support this finding was Dr. Sandoz's opinion that Benjamin sustained a 54% whole person impairment for " physical brain damage the severity of which renders him incapable of returning to any form of gainful employment."

2. Whether the Workers' Compensation Commission committed legal error in holding Victor Benjamin failed to prove he is an incomplete quadriplegic pursuant to § 42-9-10(C), when the Commission disregarded binding precedent by adopting its own definition of quadriplegia contrary to the definition of incomplete quadriplegia set out in Reed–Richards v. Clemson University, 371 S.C. 304, 638 S.E.2d 77 (Ct. App. 2006).

3. Whether the Workers' Compensation Commission erred failed to follow § 42-15-60, when it denied medical treatment ordered by the attending physician who opined Victor Benjamin "require[s] the use of a motorized scooter to aid him with ambulation due to the injuries he sustained in the 06-15-2011 work accident."

STATEMENT OF THE CASE

This workers' compensation appeal arises out of an accident suffered by the Appellant, Victor Benjamin, on June 15, 2011. Benjamin's Employer, Rexam Beverage Can Company, and its Carrier, Hartford, accepted liability and began providing benefits. The parties disputed the extent of Benjamin's injuries. Employer and Carrier are the Respondents in this appeal.

Appellant commenced this claim by filing a Form 50 (Request for Hearing) on April 3, 2012, alleging he sustained work-related injuries to his brain, right upper extremity, right shoulder, left shoulder, back, and psyche. Respondents filed a Form 51 (Employer's Answer to Request for Hearing) on May 3, 2012. Respondents admitted injury to the back, psyche and right upper extremity, but denied physical brain injury, and/or injuries to the left shoulder and right shoulder. On July 12, 2012, the parties entered into a Consent Order providing for treatment and ongoing temporary disability compensation.

Benjamin received treatment from a number of doctors under workers' compensation, including Dr. Sandoz (neurologist), Dr. Deal (psychiatrist); Dr. Bergmann (psychologist); and Dr. Lozanne (neurosurgeon). Dr. Lozanne performed surgery to decompress Benjamin's spinal cord injury on February 18, 2013.

Benjamin's condition worsened following the surgery. He obtained treatment on his own with Dr. Poletti. Dr. Poletti performed a second surgery on Benjamin's spinal cord on February 13, 2014.

On February 19, 2014 – five days after the operation – Benjamin filed a Form 50 seeking to transfer care from Dr. Lozanne to Dr. Poletti. Respondents filed a Form 51 denying the transfer.

A hearing was held before Commissioner Susan Barden on June 23, 2014. On September 17, 2014, Commissioner Barden issued a Decision and Order denying the transfer of care.

On May 3, 2016, Appellant filed a Form 50 seeking lifetime compensation and treatment for physical brain damage and incomplete quadriplegia. On June 2, 2016, Respondents filed a Form 51 denying that Appellant was entitled to lifetime compensation.

A hearing was held on August 16, 2016 before Commissioner Aisha Taylor. On July 21, 2017, Commissioner Taylor issued a Decision and Order. The Single Commissioner found "Claimant's injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures) and psyches render him permanently and totally disabled." She denied the claim for lifetime compensation, finding Benjamin (1) failed to prove physical brain damage; (2) failed to prove he was quadriplegic; and (3) failed to prove a mobility scooter ordered by Dr. Sandoz for his gait and balance difficulty was causally-related to his spinal cord injury. [R. pp. 48 - 73].

Appellant timely filed his Form 30 (Notice of Appeal) on August 3, 2017. Oral argument was held on October 16, 2017. The Appellate Panel affirmed in a Decision and Order issued on April 24, 2018.

This appeal followed.

STATEMENT OF THE FACTS

This appeal from the Workers' Compensation Commission arises out work-related injuries suffered by the Appellant, Victor Benjamin, on June 15, 2011.

Victor Benjamin was employed as an equipment operator with Rexam for 29 years. Rexam manufactures beverage cans.

Benjamin was injured when a metal object dislodged from a piece of equipment, fell about 35 feet, and struck him in the skull. He sustained right forearm lacerations, a comminuted skull fracture, traumatic brain injury, and spinal cord injury.[1]

Benjamin was knocked unconscious. After being aroused in the ambulance, he was taken to McLeod Regional Medical Center, where he was admitted to the intensive care unit by the neurosurgeon, Dr. William Naso. [R. p. 111]. After undergoing surgery for the arm lacerations, he was released on June 17, 2011. [R. pp. 111-21].

Benjamin returned to Dr. Naso on June 24, 2011 with "significant headaches . . . lightheadedness and dizziness . . .", along with neck discomfort radiating into his right arm. [R. pp. 123-4]. A follow up on August 3, 2011 recorded "trouble with headache and short-term memory issues." [R. p. 127].

Beginning on September 16, 2011, Benjamin began receiving medical treatment for his brain and spinal cord injuries from Dr. George Sandoz, a neurologist. As to the closed head injury, Dr. Sandoz documented "confusion, headaches, incoordination, irritability, loss of consciousness."

As Benjamin showed signs of brain damage, Dr. Sandoz referred him to Dr. Leonard Goldschmidt for neuropsychological testing "due to multiple complaints of sensorimotor, cognitive

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[1] Respondents "admit that Mr. Benjamin suffered a compensable injury to the neck, psyche and right upper extremity but deny that he sustained physical brain damage, injuries to the lower back, left shoulder, right shoulder, left lower extremity and/or right lower extremity." [R, p. 953, lines 14-19].

and emotional difficulties." [R. p. 252]. Benjamin first saw Dr. Goldschmidt on October 18, 2011. The neuropsychological testing suggested:

> that Mr. Benjamin was experiencing several cognitive deficits and behavioral deficits that were consistent with his closed head traumatic brain injury; these deficits were primarily concerning memory attention, and executive functioning. [R. p. 253].

Dr. Goldschmidt diagnosed Benjamin with "Cognitive Disorder, Not Otherwise Specified (Likely Secondary to a Closed Head Traumatic Brain Injury)", "Closed head brain injury and chronic pain secondary to work-related accident of 6/2011" and "Coping with decreased cognitive and behavioral functionality." [R. p. 253]. Over the course of the next year and a half of treatment, Dr. Goldschmidt consistently diagnosed Benjamin with "Dementia due to Remote Closed TBI with Behavioral Disturbance." [R. pp. 257 - 397].

Benjamin underwent a psychological and vocational evaluation with Dr. Robert Brabham, a psychologist, on July 30, 2015. In a 14-page report, Dr. Brabham recorded:

> There are many symptoms and complications associated with a Traumatic Brain Injury/Damage. These may include headache, confusion, blurred vision, ringing in the ears, ease of fatigue, change in sleep patterns, behavioral or mood changes, memory problems, trouble with concentration and attention, onset of seizures, and numbness of loss of physical coordination, including episodes of balance difficulties/falls. Mr. Benjamin has experienced all of these symptoms. [R. p. 687].

Regarding specific impairment, Dr. Brabham assessed Benjamin with impairments based on the *Clinical Dementia Rating Scale*. "He is quite compromised in his attention/concentration, speed of mental processing and multitasking." Dr. Brabham assigned a 22% impairment rating of the whole person based on memory loss and moderate difficulty in handling some activities.[2] [R. pp. 687-8].

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[2] It should be noted that Dr. Brabham based his 22% impairment rating solely on clinical dementia – which is within his qualifications as a psychologist. He did not rate the same impairments rated by Dr. Sandoz. Dr. Sandoz assigned a 54% whole person impairment rating based on 4% for the headaches, 29% for the neurological effects, and 34% for the seizures – all of which were within his area of expertise as a neurologist.

Benjamin treated extensively with Dr. Lawrence Bergmann and Dr. Roger Deal for psychological issues arising out of his brain injury. Although neither doctor specifically opined on the severity of the brain injury in their treatment notes, they consistently document issues related to brain damage.

In his initial note on June 6, 2012, Dr. Bergmann notes the referring diagnosis of "Dementia Due to Remote Closed TBI with Behavior Disturbance and PTSD." [R. p. 406]. He recorded Benjamin "continues to experience irritability and anger, cognitive symptoms, sleep difficulties with nightmares, and depressed mood related to pain and physical limitations . . . His cognitive symptoms include headaches, lack of balance, and ringing in his ears." [R. pp. 406-7].

On June 25, 2013, Dr. Bergmann documented Benjamin's continuing anger and frustration, recording "We discussed the impact of head injury on feelings especially anger. I reminded him that after a head injury, being more irritable is to be expected and that it is important that he work to be aware of and control his anger." [R. p. 444]. These symptoms never changed or improved. On March 15, 2016, Dr. Bergmann noted he was continuing the "[s]ame basic approach with providing information about head injury and anger and then focusing on better management." [R. p. 742].

The clearest evidence of physical brain damage comes from Dr. Sandoz, Benjamin's treating neurologist. Dr. Sandoz treated Benjamin for both his brain injury and spinal cord injury. Dr. Sandoz began providing care for Benjamin on September 16, 2011 – three months after the accident. He continues to provide care with the last visit in the record dating from October 1, 2015. [R. pp. 129-227, 765-821].

Throughout the course of his treatment, Dr. Sandoz documented myriad permanent impairments due to the traumatic brain injury. On July 15, 2014 (three years after the accident), Dr. Sandoz, documented "Associated symptoms include clumsiness, confusion, gait disturbance, hearing

loss, incoordination, irritability, loss of consciousness, lucid intervals, memory difficulty, personality changes, restlessness, seizures, speech difficulty, stiff neck, unusual behavior and weakness." [R. p. 193]. On June 19, 2015, Dr. Sandoz assigned a 54% whole person impairment rating for the traumatic brain injury, writing:

> From the neurological standpoint, the patient has been complaining of a headache. This headache, after evaluation of the AMA Guidelines Sixth Edition, the patient has 4% impairment of the whole body. The patient has also has suffered a traumatic brain injury with late effect of this injury associated with the headaches, seizure, posttraumatic stress disorder, and lumbar pain. From the injury that the patient has suffered a traumatic brain injury, the patient suffers a 29% impairment of the whole body. Utilizing a combined value chart, this translates to 54% impairment of the whole body. [R. pp. 218-9].

At the time of the trial, more than three years had passed since the accident. Due to the brain damage, Benjamin still suffers from "clumsiness, confusion, gait disturbance, hearing loss, incoordination, irritability, loss of consciousness, lucid intervals, memory difficulty, personality changes, restlessness, seizures, speech difficulty, stiff neck, unusual behavior and weakness." [R. p. 193]. He remains physically and mentally incapable of returning to any kind of work that he has ever done.

Benjamin also suffers from significant problems due to his spinal cord injury – for which he has been diagnosed as an incomplete quadriplegic by three doctors and with "an incomplete spinal cord injury" by the fourth.

On November 1, 2012, Dr. Sandoz's partner, Dr. Eugene Giddens, recommended spine surgery, specifically "anterior cervical discectomy and fusion at C3 through C6 and plating." The surgery was needed due to "Cervical myelopathy with signal changes in the cord." [R. p. 147].

On November 12, 2012, Benjamin obtained a second opinion from Dr. Steven Poletti. Dr. Poletti diagnosed him with "myelomalacia in his cord" and spasticity. Physical examination showed a number of signs consistent with spinal cord damage, including "positive Babinski, upgoing toes,

hyperreflexia, positive Hoffman's sing, sever stenosis at C3-4 with myelomalacia." Dr. Poletti opined "this C3-4 myelomalacia and cord contusion necessitates posterior cervical fusion." [R. p. 572].

Respondents sent Benjamin for a third opinion with Dr. Karl Lozanne on January 22, 2013. Dr. Lozanne disagreed with Dr. Poletti and Dr. Giddens about the need to decompress C3-4 "despite the fact there is some spinal cord signal change at this level." Dr. Lozanne recommended "anterior cervical discectomy and plated fusion at C4-5, C5-6 and C6-7. [R. pp. 705-6]. Dr. Lozanne advised Benjamin the "surgical procedure . . . is not one that is going to result in complete recuperation of spinal cord function." [R. p. 629]. He performed the operation on February 18, 2013. [R. pp. 631-4].

On a follow up seven months after the surgery, Dr. Lozanne recorded:

> The initial improvement that was made after surgery is no longer present. He feels that his imbalance has persisted. He ambulates with the use of a cane . . . From a cervical spine perspective, I recommend continued out of work status. I explained to Victor that *the surgical procedure was not intended to repair his spinal cord* but rather to provide a decompression in hopes of getting continued improvement. [R. p. 707].

Despite these ongoing signs of spinal cord damage, Dr. Lozanne did not recommend further treatment.

Benjamin returned to Dr. Poletti on January 21, 2014. Dr. Poletti noted an updated MRI showed "edema changes in his spinal canal at the C3-4 level and he has signs of spastic cervical myelopathy." Dr. Poletti ordered posterior decompression, laminectomy and fusion at the C3-4 level. [R. p. 579]. Benjamin underwent the second fusion surgery on February 14, 2014.

Benjamin continued his treatment for the spinal cord injury with Dr. Poletti and Dr. Sandoz. On May 27, 2015, Dr. Poletti placed Benjamin at maximum medical improvement (MMI). Dr. Poletti wrote: "this man had a serious or catastrophic neurologic injury. . . . This type of spinal cord edema or compression is what commonly would be referred to as incomplete quadriparesis or as a

form of incomplete quadriplegia." He assigned a 67% whole person impairment rating. [R. pp. 606-8].

On December 14, 2015, Dr. Sandoz also addressed impairment, opining "Mr. Benjamin sustained an injury to his spinal cord (myelomalacia) which would be referred to as incomplete quadriparesis or a form of incomplete quadriplegia." [R. p. 652].

Benjamin received an independent medical evaluation from Dr. William Mills on June 20, 2016. Dr. Mills stated "I would have to agree with Dr. Poletti and Dr. Sandoz as afar as his inability to return to gainful employment and with their diagnosis of incomplete quadriplegia." [R. pp. 675-7].

In response to the opinions on incomplete quadriplegia by Drs. Poletti, Sandoz and Mills, Respondents deposed Dr. Lozanne and arranged a follow-up examination after the deposition. In his deposition, Dr. Lozanne was asked to define "quadriplegia." He testified: "Yeah. So anytime we use the plegia as the suffix in neurosurgical speak, that's complete lack of movement. All right? So we use quadriplegia as a complete lack of movement in four extremities." [R. p. 897, lines 22-5]. After describing the difference in definition as one of semantics, Dr. Lozanne went on to distinguish incomplete and complete spinal cord injuries, testifying "Incomplete spinal cord injury is one in which the function below the level of injury is still present, whether it is motor or sensory." [R. p. 915, lines 17-9]. As to Benjamin specifically, Dr. Lozanne testified "Yes, this is an incomplete spinal cord injury. That is exactly correct." [R. p. 916, lines 2-9].

Dr. Lozanne did the follow up examination on July 22, 2016. He assigned a 53% whole person impairment rating for the cervical spine injury including cortical spinal tract impairment.

The case was tried on August 16, 2016. The Single Commissioner found "Claimant's injuries to his neck, right arm, brain (for initial closed head injury and resulting headaches and seizures) and psyche render him permanently and totally disabled." She denied the claim for lifetime

compensation, finding Benjamin (1) failed to prove physical brain damage; (2) failed to prove he was quadriplegic; and (3) failed to prove a mobility scooter ordered by Dr. Sandoz for his gait and balance difficulties was causally-related to his spinal cord injury. [R. pp. 48 - 73].

This appeal followed.

STANDARD OF REVIEW

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

"[T]he guiding principle undergirding our workers' compensation system [is] that the Act is to be liberally construed in favor of the claimant. The second is the equally compelling evidentiary principle that an award may not rest upon surmise, conjecture, or speculation." Hutson v. S.C. State Ports Authority, 399 S.C. 381, 732 S.E.2d 500 (2012). The Commission's decision "must be founded on evidence of sufficient substance to afford a reasonable basis for it." Wynn v. People's Natural Gas Co. of S.C., 238 S.C. 1, 12, 118 S.E.2d 812, 818 (1961).

The Commission is permitted to disregard medical evidence only when there is other competent evidence in the record to support their conclusion. Potter v. Spartanburg Sch. Dist. 7, 395 S.C. 17, 716 S.E.2d 123 (Ct. App. 2011). Where a finding is based on "the medical opinion of the single commissioner, adopted by the Commission," rather than on the opinion of a medical provider, the finding must be reversed as unsupported by substantial evidence. Burnette v. City of Greenville, 737 S.E.2d 200, 401 S.C. 417 (Ct. App. 2012). A conclusion by the Commission "based on rank speculation . . . cannot now be used as the basis for denying [an injured worker's] claim for lost wages. Hutson at 504, 732 S.E.2d 694.

ARGUMENT

1. Victor Benjamin has suffered severe and permanent physical brain damage and is legally entitled to workers' compensation benefits for life.

Victor Benjamin was struck in the head with a chunk of metal which fractured his skull, knocked him down, and knocked him unconscious. [R. pp. 111-4]. He suffered a traumatic brain injury leaving him with numerous permanent impairments including constant headaches, cognitive deficits, dizziness and seizures. [R. pp. 91, 95, 129-32, 136, 138-9, 150-66, 175-80, 183-95, 199-201, 218, 241-56, 444, 687-92, 746]. His treating neurologist, Dr. Sandoz, assessed Benjamin with a 54% impairment of the whole body for his traumatic brain injury, seizures and headaches. [R. p. 218].[3] Dr. Sandoz opined to a reasonable degree of medical certainty that Mr. Benjamin "has suffered physical brain damage the severity of which renders him incapable of returning to any form of gainful employment." [R. p. 652].

The Appellate Panel found "Claimant's injuries to his neck, right arm, *brain (for initial closed head injury and resulting headaches and seizures)* and psyche render him permanently and totally disabled." [R. p. 95, lines 1-7 (emphasis added)]. However, despite the overwhelming evidence, the Appellate Panel found "Claimant has failed to meet his burden of proving entitled [sic] to lifetime benefits on the basis of having sustained permanent and severe physical brain damage." [R. p. 93, line 18 - p. 94, line 6].

Benjamin proved he sustained permanent physical brain damage so severe as to render him permanently and totally disabled. [R. p. 95, lines 1-7]. This is confirmed by the consistent evidence

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[3] Dr. Sandoz assigned 4% for the headaches, 29% for the neurological effects, and 34% for the seizures. Using the combined value chart, these impairments translate to a 54% whole person impairment. AMA Guides to Permanent Impairment (6th Edition), pages 604-605. Dr. Sandoz's impairment ratings do not include the spinal cord injury, which was separately rated by Drs. Lozanne, Poletti, and Mills.

of severe physical brain damage, along with the Commission's finding that the brain injury with resulting headaches and seizures resulted in total disability. The Court should therefore reverse the Appellate Panel and enter an order for lifetime compensation based on physical brain damage.

A. The criteria established under the South Carolina Workers' Compensation Act for physical brain damage.

The Workers' Compensation Act provides that "any person 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 limitation and shall receive the benefits for life." S.C. Code Ann. § 42-9-10 (2007). In 2013, the South Carolina Supreme Court issued two landmark opinions defining "physical brain damage." In Sparks, the Court held "we conclude that 'physical brain damage' as used in § 42-9-10(C) is physical brain damage that is both permanent and severe." Sparks v. Palmetto Hardwood, Inc., 406 S.C. 124, 130, 750 S.E.2d 61, 64 (2013). In Crisp, the supreme court further explained lifetime compensation was predicated on "brain damage so severe that the person could not subsequently return to suitable gainful employment." Crisp v. SouthCo Inc., 738 S.E.2d 835, 401 S.C. 627 (2013).

Although the court defined "physical brain damage," our appellate courts have not yet applied the "permanent and severe" standard in a reported case.[4] As such, this is a case of first impression.

[4] The issue was raised to the Court in Fragosa v. Kade Constr., LLC, 407 S.C. 424, 755 S.E.2d 462 (Ct. App. 2014). However, this Court never reached the merits of the permanent and severe standard, instead remanding to the Commission to determine if Fragosa had suffered a physical brain injury, and if so, to determine "whether such injury was of sufficient severity to reach the level of physical brain damage as contemplated in section 42–9–10(C)." Id. Following remand, the South Carolina Supreme Court reversed in an unpublished decision holding "Remaining faithful to *Crisp* and *Sparks*, we find an impairment rating of 46% for a traumatic brain injury sufficiently severe to implicate lifetime benefits for physical brain damage pursuant to section 42-9-10(C)." Fragosa v. Kade Constr., LLC, Op. No. 2018-MO-29 (S.C. Sup. Ct. filed August 29, 2018).

B. <u>Confusion resulting from the legislature's use of "physical brain damage" when the equivalent medical term is "traumatic brain injury (TBI)."</u>

An issue confounding the decisional law is the legislature's choice of the term "physical brain damage" in the statute – rather than the medical term "traumatic brain injury."[5] This has led to confusion because medical professionals use the term "traumatic brain injury" to refer to all brain injuries resulting in physical brain damage of varying severity. Consequently, the medical records used to prove physical brain damage in workers' compensation cases still use the medical term *traumatic brain injury* - sometimes modified as *physical brain injury.* The Supreme Court noted this "inartful phrasing" in <u>Crisp</u>:

> From this inartful phrasing onward, the circuit court, the court of appeals, and the parties in their arguments to the various tribunals and in their briefs have alternatively referred to Petitioner's brain injuries in terms of "physical brain injury" and "physical brain damage," despite the marked difference in the length of time compensation may be awarded when the injury is "physical brain damage" contemplated under section 42–9–10(C) of the South Carolina Code.

A similar problem occurred in <u>Therrell v. Jerry's Inc.</u>, 633 S.E.2d 893, 370 S.C. 22 (2006). In <u>Therrell</u>, the Supreme Court was faced with reconciling statutory terminology with medical terminology. The court observed: "We believe a factor driving much of the confusion on this issue is that the scheduled member statutes speak in a different language from medical service providers . . ." <u>Id.</u> In <u>Crisp</u>, the court noted no other state uses the term "physical brain damage." <u>Crisp v. Southco., Inc.</u>, 401 S.C. 627, 738 S.E.2d 835 (2013).

Appellant makes this point to aid the Court as it reviews the medical evidence in the record and to illustrate a significant flaw in the Commission's analysis. As in <u>Crisp</u>, <u>Sparks</u> and <u>Therrell</u>,

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[5] The term "Traumatic Brain Injury" is used elsewhere in statutory law to describe what is essentially "physical brain damage" in the Workers' Compensation Act. <u>See</u> S.C. Code Ann. Reg. § 43-243.1 (L)(1)(2011)(defining "traumatic brain injury" regulations for "Criteria for Entry into Programs of Special Education for Students with Disabilities.").

the parties and medical providers sometimes use "inartful phrasing" in describing Benjamin's physical brain damage as a physical brain injury or traumatic brain injury. Medical terminology is an issue because the Commission inexplicably held Benjamin's proof failed due to "the lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe as required by case law and the Act." [R. p. 99, lines 1-17].

C. Physical Brain Damage resulting from Traumatic Brain Injury.

According to the Centers for Disease Control, "[Traumatic Brain Injury] is generally categorized as mild, moderate or severe. Most TBIs are mild TBI (MTBI). MTBI refers to those in which the injury to the brain itself is diagnosed as mild at the time the person is initially evaluated."[6] "Injury severity is typically established within the acute to early subacute time frame but the long-term effects of TBI and resultant disability, if any, can only be established months to years post-injury."[7] Thus, while it is sometimes possible to determine the existence of physical brain damage early in the process, the fact some healing takes place – particularly within the first six months – and some damage takes time to manifest itself, means the twin determinations of permanent impairment and inability to work are properly made at MMI (as the Court held in Crisp).

Doctors make the initial classification of *brain injury* as mild, moderate or severe on the initial evaluation. Most classification systems "differentiate TBI on the basis of loss of consciousness (LOC), altered consciousness (AOC), post-traumatic amnesia (PTA), or Glasgow Coma Scale (GCS)."[8] For the injury to be classified as severe, most systems require that the patient

[6] Faul M, Xu L, Wald MM, Coronado V. Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths, 2002-2006. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.

[7] Muriel Deutsch Lezak et al., *Neuropsychological Assessment* 193 (5th ed. 2012).

[8] Department of Defense and Department of Veterans Affairs (2008). "Traumatic Brain Injury Task Force" http://www.cdc.gov/nchs/data/icd9/Sep08TBI.pdf

suffer a gross loss of consciousness for greater than 30 minutes.[9]

There is no definitive record of how long Benjamin was unconscious. He testified he did not remember the accident and its aftermath. Medical records confirm he was "amnestic to the event." [R. p. 115]. He testified "The only thing I can remember is getting in the back of the ambulance . . ." [R. p. 883, line 17 - p. 884, line 6]. It can reasonably be inferred that he was unconscious for a period of time approaching or exceeding 30 minutes.

Brain damage itself comes in various forms. *Focal brain damage* is damage to an identifiable part of the brain. Patients with focal brain damage suffer specific deficits while retaining normal brain function elsewhere. Such patients may suffer partial paralysis or lose the ability to speak, smell or otherwise function depending on the location of the damage. Focal brain damage occurs most often in strokes, penetrating head injuries, and injuries resulting in bleeding (hematomas). Sometimes the damage can be located on imaging studies; otherwise, neuropsychological testing can pinpoint the specific area of damage.

Cortical contusions (bruising) occur with the rapid acceleration-deceleration seen in falls and car accidents. These brain contusions usually involve the frontal and temporal lobes, as these areas are most susceptible to the damaging effects of the brain bouncing and twisting within the skull. Patients with frontal and temporal lobe lesions develop problems with regulation and control of goal directed activity, problem solving, and memory and learning. They often suffer personality changes which "are more likely to impede the patient's return to psychosocial independence than cognitive impairment or physical crippling."[10] Patients may also suffer an impaired sense of smell, reduced visual competency, hearing issues, and balance disorders.

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[9] Id.

[10] Muriel Deutsch Lezak et al., *Neuropsychological Assessment* 200-202 (5th ed. 2012).

Diffuse brain damage is a common result of closed head injuries. Although the skull protects the brain from penetration, the brain itself is damaged by the shearing effect. Brain tissue suffers widespread tearing at the cellular level known as *diffuse axonal injury.* "Probably most traumatic axonal pathology occurs as a result of secondary effects damaging the fine cytoarchitecture of the axon, referred to as *secondary axotomy*. These intracellular alterations evolve over time taking days to months for the full pathological effects to develop. They degrade the functionality of the axon and can even lead to cell death."[11]

Diffuse brain damage generally cannot be seen on conventional imaging studies, although some emerging technologies provide hope this may change in the future. Under the current state of the art, the effects of diffuse brain damage can be shown by cognitive behavioral level of functioning and neuropsychological testing.[12] Although the brain may appear to be superficially intact on conventional CT and MRI scans, patients suffer a constellation of impairments from degradation in the microstructure and integrity of axons and their connections. This type of damage compromises mental processing speed, attention, cognitive efficiency, high-level concept formation, complex reasoning abilities, and executive functions. Patients perform poorly on tasks requiring concentration and mental tracking, and on reasoning problems that must be performed mentally.

The result is confusion, perplexity, irritability, fatigue, and inability to do things as well as before the accident.

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[11] Muriel Deutsch Lezak et al., *Neuropsychological Assessment* 187 (5th ed. 2012).

[12] Recognizing the limitations of imaging technology in diagnosis diffuse brain damage, the supreme court declined to require proof of brain damage through an "objective diagnostic medium" such as CT or MRI scans. The court observed "there are essentially three ways to determine whether a person has sustained physical brain damage: (1) CT or MRI scanning; (2) cognitive behavioral level of functioning; and (3) neuropsychological testing." Crisp v. Southco., Inc., 401 S.C. 627, 738 S.E.2d 835 (2013). Benjamin proved physical brain damage both by his cognitive level of functioning (per Dr. Sandoz and Dr. Brabham) and neuropsychological testing (Dr. Goldschmidt).

D. The Commission erred in finding Benjamin had not met his burden of proving severe and permanent physical brain damage.

The Appellate Panel arbitrarily disregarded dispositive evidence, erred in its analysis and misapplied the test for physical brain damage. Victor Benjamin qualifies for lifetime compensation because he suffered severe and permanent physical brain damage – severe enough for the Commission to hold *inter alia* that "Claimant's injuries to his . . . **brain (for initial closed head injury and resulting headaches and seizures)** . . . render him permanently and totally disabled." [R. p. 95, lines 1-7 (emphasis added)].

Victor Benjamin's traumatic brain injury was so severe that his treating neurologist determined he merited a 54% impairment rating to the whole person. Dr. Sandoz went on to state "I hold the opinion he has suffered *physical brain damage* the severity of which renders him incapable of returning to any form of gainful employment." [R. p. 652 (emphasis added)].

Nowhere in the order of the Single Commissioner or the Appellate Panel is the impairment rating or opinion on physical brain damage mentioned – neither in the evidence of the case nor in the findings of fact. The Commission simply ignored it, as they overlooked virtually all the evidence of physical brain damage. Indeed, the Commission stated the evidence did not exist! This omission alone constitutes reversible error. While the Commission has authority to weigh *conflicting* evidence, it cannot *ignore* evidence. Everyone is entitled to his own opinion, but not his own facts.

The Supreme Court held entitlement to lifetime compensation is predicated on permanent and severe physical brain damage. Crisp v. SouthCo Inc., 738 S.E.2d 835, 843, 401 S.C. 627 (2013). The result is a two-part test: to qualify for lifetime compensation under section 42-9-10 (C), the employee must have suffered physical brain damage that is (1) permanent and (2) "so severe that the person could not subsequently return to suitable gainful employment." Id. at 842-843; Sparks v.

Palmetto Hardwood, Inc., 401 S.C. 619, 738 S.E.2d 831, 834 (2013)("we conclude that 'physical brain damage' as used in § 42-9-10(C) is physical brain damage that is both permanent and severe.").

In Benjamin's case, it is undisputed that his physical brain damage is permanent. Throughout the course of his treatment, Dr. Sandoz documented myriad functional deficits due to the traumatic brain injury. On July 15, 2014 (three years after the accident), Dr. Sandoz, documented "Associated symptoms include clumsiness, confusion, gait disturbance, hearing loss, incoordination, irritability, loss of consciousness, lucid intervals, memory difficulty, personality changes, restlessness, seizures, speech difficulty, stiff neck, unusual behavior and weakness."[13] [R. p. 193]. On June 19, 2015, Dr. Sandoz assigned a 54% whole person impairment rating for the traumatic brain injury, writing:

> From the neurological standpoint, the patient has been complaining of a headache. This headache, after evaluation of the AMA Guidelines Sixth Edition, the patient has 4% impairment of the whole body. The patient has also has suffered a traumatic brain injury with late effect of this injury associated with the headaches, seizure, posttraumatic stress disorder, and lumbar pain. From the injury that the patient has suffered a traumatic brain injury, the patient suffers a 29% impairment of the whole body. Utilizing a combined value chart, this translates to 54% impairment of the whole body. [R. pp. 218-9].

This is conclusive evidence that Benjamin sustained permanent damage to the brain. There is nothing at all ambiguous about it. "A permanent impairment, by definition, lasts for a lifetime." James v. Anne's Inc., 701 S.E.2d 730, 736, 390 S.C. 188 (2010). Impairment ratings are not made until the injured person reaches maximum medical improvement. "Maximum medical improvement is a term used to indicate that a person has reached such a plateau that in the physician's opinion there is no further medical care or treatment which will lessen the degree of impairment." O'Banner

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[13] Benjamin's condition contrasts dramatically with the employee in Sparks. In Sparks "the evidence failed to show that Petitioner had been dazed and confused after his head injury or suffered nausea, vomiting, cognitive impairments, or post-concussive headaches." Sparks v. Palmetto Hardwood, Inc., 401 S.C. 619, 738 S.E.2d 831, 834 (2013). Based on this evidence, the Supreme Court held Sparks had not suffered physical brain damage.

v. Westinghouse Elec. Corp., 319 S.C. 24, 28, 459 S.E.2d 324, 327 (Ct. App. 1995). It cannot be gainsaid that 54% to the whole person for a traumatic brain injury is a severe permanent impairment.

The second requirement for lifetime compensation is that the brain injury must be "so severe that the person could not subsequently return to suitable gainful employment." Crisp v. SouthCo Inc., 738 S.E.2d 835, 843, 401 S.C. 627 (2013). The severity analysis focuses on inability to return to suitable gainful employment. The Crisp court looked to section 42-9-400(d) for the Legislature's definition of "permanent physical impairment" as "any permanent condition . . . of such seriousness as to constitute a hindrance or obstacle to obtaining employment . . ." Crisp v. SouthCo Inc., 738 S.E.2d 835, 843, 401 S.C. 627 (2013), *quoting*, S.C. Code Ann. § 42-9-400(d)(2007).

Dr. Sandoz's opinion repeats this language almost verbatim. This element was established when the Appellate Panel found "Claimant's injuries to his . . . brain (for initial closed head injury and resulting headaches and seizures) . . . render him permanently and totally disabled." [R. p. 95, lines 1-7]. Once the Commission tied Benjamin's total and permanent disability to the brain injury, the inquiry was over – he had proven his case.

Despite the factual finding Benjamin had proven the elements for physical brain damage – a finding manifestly supported by substantial evidence – the Appellate Panel went on to make a legal conclusion that Benjamin failed to meet his burden of proof. The Commission held as a matter of law that Claimant failed to prove entitlement to lifetime benefits because of "the lack of any medical evidence stated to a reasonable degree of medical certainty that Claimant sustained brain damage that was permanent and severe as required by case law and the Act." [R. p. 99, lines 1-17]. Yet Dr. Sandoz stated exactly this point, giving the opinion to a reasonable degree of medical certainty that Benjamin "suffered physical brain damage the severity of which renders him incapable of returning to any form of gainful employment." [R. p. 652]. Unless the Commission simply overlooked Dr.

Sandoz's opinion – unlikely given how much emphasis it received from both parties – the Commission must have arbitrarily disregarded it.

This approach to fact finding is simply not allowed. A hearing officer "may not arbitrarily substitute his own hunch or intuition for the diagnoses of a medical professional." Marbury v. Sullivan, 957 F.2d 837, 840-41 (11th Cir. 1992) (Johnson, J., concurring). The Commission cannot base a decision on its own lay medical opinion contravening the uniform medical opinions of the doctors – particularly in complex medical cases. Burnette v. City of Greenville, 737 S.E.2d 200, 401 S.C. 417 (Ct. App. 2012)(a finding of fact based on a commissioner's own lay medical opinion is not substantial evidence and must be reversed). To do so is to resort to rank speculation. See Hutson v. S.C. State Ports Authority, 732 S.E.2d 500, 399 S.C. 381 (2012)(reversing Appellate Panel's conclusion because "rank speculation" cannot outweigh competent evidence of disability).

In the instant case, there is no evidence contradicting Dr. Sandoz's assessment regarding Benjamin's physical brain damage. Dr. Naso documented "significant headaches . . . lightheadedness and dizziness . . ." [R. pp. 123-4]. Dr. Brabham documented "many symptoms and complications associated with a Traumatic Brain Injury/Damage." [R. p. 647]. Dr. Goldschmidt diagnosed Benjamin with "Dementia due to Remote Closed TBI with Behavioral Disturbance." [R. pp. 257-397]. The evidence confirms Benjamin suffered severe permanent physical brain damage in the industrial accident.

The decision below should be reversed as it is based on speculation and arbitrarily disregards dispositive evidence. The evidence is overwhelming that Benjamin suffered permanent physical brain damage of such severity that he is unable to return to suitable gainful employment. He met his burden of proof. The Court should find he is entitled to receive lifetime compensation under Section 42-9-10(C) as a matter of law.

2. Victor Benjamin was rendered an incomplete quadriplegic and is legally entitled to workers' compensation benefits for life.

The Workers' Compensation Act provides "that any person determined to be totally and permanently disabled who as a result of a compensable injury is . . . a quadriplegic . . . is not subject to the five-hundred-week limitation and shall receive the benefits for life. S.C. Code Ann. § 42-9-10 (C)(2007). In Reed–Richards v. Clemson University, this court held a diagnosis of *incomplete paraplegia* resulting in total disability supported an award of lifetime compensation. Reed–Richards v. Clemson University, 371 S.C. 304, 309, 638 S.E.2d 77, 80 (Ct. App. 2006).

Benjamin produced evidence from numerous doctors opining that he was an incomplete quadriplegic. [R pp. 606-7, 652, 675, 677]. Despite this evidence, the Commission held "based on the preponderance of the evidence as a whole, we find Claimant has failed to meet his burden of proving entitlement to lifetime benefits pursuant to Section 42-9-10(C) on the basis of 'incomplete paraplegia' [sic]." [R. p. 97, lines 14-20].

In reaching this finding, the Commission misapplied Reed-Richards and held an incomplete quadriplegic is not a quadriplegic. As Reed-Richards is binding precedent on the Commission, this is an error of law.

A. The criteria established under the South Carolina Workers' Compensation Act for lifetime compensation for a person permanently disabled and quadriplegic.

The Workers' Compensation Act provides that a totally disabled injured worker qualifies for lifetime compensation if the injury results in the worker becoming a quadriplegic. S.C. Code Ann. § 42-9-10(C) (2007). The Legislature did not distinguish between *complete* and *incomplete* paraplegia. In Reed-Richards, this Court affirmed the Commission's award of lifetime compensation for *incomplete* paraplegia.

The employer in Reed-Richards appealed, arguing that paraplegia means "you have total and full and complete loss of use of your lower extremities." The Court rejected this "lay person's definition," holding it was correct to interpret "the term 'paraplegic' to include a diagnosis of incomplete paraplegia." Reed–Richards v. Clemson University, 371 S.C. 304, 309, 638 S.E.2d 77, 80 (Ct. App. 2006).

The Court emphasized the holding was not judicial legislation.[14] Rather, the Court grounded its opinion on the definition of incomplete paraplegia promulgated by The American Spinal Injury Association (ASIA). Per the International Standards of Neurologic Classification of Spinal Cord Injury, *paraplegia* is "impairment or loss of motor and/or sensory function in the thoracic, lumbar, or sacral segments of the spinal cord secondary to damage of neural elements within the spinal canal." Id. The Court held this definition was consistent with the legislative purpose underlying the Act. Id. As the supreme court has stated, "Common sense indicates that a compensation law passed to increase workers' rights (because their common law rights were too narrow) should not thereafter be narrowly construed." Pierre v. Seaside Farms, Inc., 386 S.C. 534, 689 S.E.2d 615 (2010), *quoting* Pelfrey v. Oconee County, 207 S.C. 433, 440, 36 S.E.2d 297, 300 (1945).

In the instant case, the issue is *quadriplegia* rather than *paraplegia*. The legal analysis and definitions involved are essentially the same. ASIA defines quadriplegia as:

> Tetraplegia (preferred to "quadriplegia"): This term refers to impairment or loss of motor and/or sensory function in the cervical segments of the spinal cord, secondary to damage of neural elements within the spinal canal. Tetraplegia results in

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[14] In 2007, one year after Reed-Richards was published, the Legislature enacted substantial amendments to § 42-9-10; 2007 Act No. 111, Pt I, Section 17, eff July 1, 2007. The fact the Legislature made no changes to the definition of paraplegia and quadriplegia confirms that Reed-Richards accurately carried out the Legislature's intent. See Wigfall v. Tideland Utilities, Inc., 354 S.C. 100, 580 S.E.2d 100 (2003)(as the Legislature is presumed to be aware of the appellate court's interpretation of its statutes, Legislative "inaction is evidence the Legislature agrees with this Court's interpretation.").

> impairment of function in the arms as well as in the trunk, legs and pelvic organs. International Standards of Neurologic Classification of Spinal Cord Injury, (Revised 6th Ed. 2000).

The essential difference is that quadriplegia involves spinal cord damage in the cervical spine rather than the lumbar spine, thus affecting all body parts below the level of injury including the arms.

B. The Commission erred in finding Benjamin had not met his burden of proving entitlement to lifetime benefits on the basis of "incomplete quadriplegia."

In holding Benjamin did not meet his burden, the Commission focused on the deposition testimony of Dr. Karl Lozanne. The Commission held:

> we find Dr. Lozanne testified the suffix "plegia" refers to a complete lack of movement and that "paraplegia is the complete inability to move your legs. . . . After review of Dr. Poletti's medical note diagnosing Claimant with "incomplete quadriparesis or a form of incomplete quadriplegia", Dr. Lozanne testified the phrase "incomplete quadriplegia" was inappropriate in this instance and that claimant suffered from cervical myelopathy – spinal cord dysfunction that has led to some symptoms – including difficulty with balance. [R. p. 92, lines 3-11(internal citations deleted)].

This finding is legally incorrect because the Commission adopted a definition of incomplete quadriplegia which conflicts with Reed-Richards.

In his deposition, Dr. Lozanne was asked to define "quadriplegia." He testified: "Yeah. So anytime we use the plegia as the suffix in neurosurgical speak, that's complete lack of movement. All right? So we use *quadriplegia as a complete lack of movement in four extremities.*" [R. p. 897, lines 22-25].

Dr. Lozanne's definition is almost identical to the lay definition rejected in Reed-Richards: "you have *total and full and complete loss of use of your lower extremities*." As with the lay person's definition, Dr. Lozanne's definition contradicts the entire concept of incomplete quadriplegia adopted in Reed-Richards. It also contradicts the definition promulgated by ASIA and used by all other physicians in this case.

The Commission has no legal authority to redefine and reject this Court's holding on incomplete quadriplegia. As an administrative agency, the Commission is bound by the pronouncements of this Court and the South Carolina Supreme Court. Reliance on Dr. Lozanne's definition of quadriplegia was reversible error.

Perhaps acknowledging that it was exceeding its authority, the Appellate Panel tried to distinguish Reed-Richards. The Commission wrote:

> We find the Reed-Richards case is distinguishable from the present case. In Reed-Richards, the Court of Appeals affirmed Claimant's lifetime benefits based on the grounds that there was substantial evidence in the record to support the finding by the Commission. In that case, the only medical opinion in evidence was that of Dr. Shallcross, who opined Claimant had incomplete paraplegia. There were no other medical opinions on the issue in the record and as such, there were no other medical opinions on which the Commission or the Court could rely. [R. p. 98, lines 7-13].

It is true that in Reed-Richards there was no medical testimony stating there was no such thing as incomplete quadriplegia. And, if Dr. Lozanne's opinion had been part of the record instead of Dr. Shallcross's, it is theoretically conceivable the Court could have ruled differently and defined quadriplegia as "complete lack of movement in four extremities." However, that was not the case. The Reed-Richards definition of incomplete quadriplegia remains binding authority on the Commission. Merely because one doctor refuses to follow the legal definition – dismissing it as "literally semantics" – does not permit the Commission to disregard binding authority.

In fact, Dr. Lozanne agrees with Benjamin's other doctors in everything but the terminology. He testified "Yes, this is an incomplete spinal cord injury. That is exactly correct." [R. p. 916, lines 7-9]. Dr. Lozanne's impairment ratings were consistent with the ratings assigned by Benjamin's treating orthopaedic surgeon, Dr. Steven Poletti. Dr. Lozanne assigned a whole person impairment rating for the cervical fusion of 28% under DRE Category IV. For the spinal cord injury, he assigned

a cortical spinal tract impairment of 19% and 19% for "bilateral upper extremity involvement" and "station and gait." The combined whole person impairment rating equaled 53%.[15] [R. pp. 711-2].

Dr. Poletti was Benjamin's treating orthopaedic surgeon at the time of the trial. He took over surgical care from Dr. Lozanne when Benjamin required the second cervical fusion. Dr. Poletti assigned the same 28% whole person impairment rating for the cervical fusion. For the spinal cord injury, Dr. Poletti assigned a 39% whole person impairment rating based "station and gait disorders and impairment to both his upper and lower extremity." The total combined impairment was 67% to the whole person. [R. pp. 606-8].

As to incomplete quadriplegia, Dr. Poletti opined to a reasonable degree of medical certainty that:

> Suffice it to say this man had a serious or catastrophic neurologic injury. He has signs and symptoms of upper and lower extremity weakness. This type of spinal cord edema or compression is what commonly would be referred to as incomplete quadriparesis or as a form of incomplete quadriplegia. He has a disabling problem that will prevent him from walking normally or using his hands normally for fine motor activities. He is obviously permanently disabled from any type of employment and meets what I would describe as the necessary criteria for pursuing Social Security disability. [R. pp. 606-8].

Dr. Sandoz treated Benjamin for the neurological deficits from the spinal cord injury for years. Dr. Sandoz did not address an impairment rating for the incomplete quadriplegia. He opined:

> Mr. Benjamin sustained an injury to his spinal cord (myelomalacia) which would be referred to as incomplete quadriparesis or as a form of incomplete quadriplegia. He

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[15] The impairment ratings in this case are *whole person impairment ratings*. In Clemmons, the South Carolina Supreme Court converted the whole person impairment ratings assigned by the doctors to regional impairment ratings. For example, Dr. Drye's whole person rating of 25% was converted to a 71% regional impairment to the spine. The Court then noted there were no ratings lower than 70% in the record, thus the Commission's award of 48% loss of use to the back was not supported by substantial evidence. Clemmons v. Lowe's Home Ctrs., Inc., 803 S.E.2d 268 (S.C. 2017). If the same conversions were made in the instant case, the impairment ratings would exceed 100% (if that were possible!). Benjamin's whole person impairment ratings of 53% and 67% for the spinal cord injury are substantially more severe than Clemmons.

> has and does suffer from a progressive loss of use of his upper extremities and is unable to use his hands normally for fine motor activities. He is unable to ambulate normally due to this condition and walks with an altered gait using a four prong cane for stabilization and balance. [R. p. 652].

A second orthopaedic surgeon, Dr. William Mills, provided an independent medical evaluation on June 20, 2016. He agreed with Dr. Poletti and Dr. Sandoz in both their impairment ratings and "their diagnosis of incomplete quadriplegia." [R. pp. 675-7].

Once Dr. Lozanne's semantical definition of quadriplegia is removed from the equation – as it must be to remain faithful to Reed-Richards – the case becomes much more clear cut. Three qualified medical doctors explicitly opined Benjamin is an incomplete quadriplegic. In declining to recognize the term *incomplete quadriplegia*, Dr. Lozanne volunteered that his disagreement on terminology is "literally semantics." [R. p. 915, lines 7-8].

Dr. Lozanne went on to distinguish incomplete and complete spinal cord injuries, testifying "Incomplete spinal cord injury is one in which the function below the level of injury is still present, whether it is motor or sensory." [R. p. 915, 17-9]. This description mirrors the ASIA definition of incomplete quadriplegia: "impairment or loss of **motor and/or sensory** function in the cervical segments of the spinal cord, secondary to damage of neural elements within the spinal canal." International Standards of Neurologic Classification of Spinal Cord Injury, (Revised 6th Ed. 2000) (emphasis added).

Dr. Lozanne's testimony that Benjamin has an "incomplete spinal cord injury" for which he assigned a separate impairment rating is tantamount to an opinion that Benjamin is an incomplete quadriplegic. [R. p. 916, lines 2-9]. Once substance over semantics is considered, it becomes apparent that all four doctors effectively opine that Benjamin is an incomplete quadriplegic under the ASIA definition and Reed-Richards. As the evidence is all one way, it was error for the Commission to hold Benjamin failed to meet his burden of proof.

This Court has the authority to reverse the Commission's findings when they are controlled by an error of law or unsupported by substantial evidence. See, e.g. Clemmons v. Lowe's Home Ctrs., Inc., 803 S.E.2d 268 (S.C. 2017). In this case, there are two reversible errors. The first is the Commission failed to follow the binding precedent when it refused to apply the definition of incomplete quadriplegia adopted in Reed-Richards. The second is that there is no substantial evidence to support a finding that Benjamin is not an incomplete quadriplegic. Therefore, the Court should reverse the Commission and find that Benjamin proved he is a quadriplegic entitled to receive lifetime compensation as a matter of law.

3. The Commission erred in denying the mobility scooter prescribed by the authorized treating physician for the cervical spinal cord injury.

Appellant appeals the Commission's denial of a mobility scooter prescribed by Dr. Sandoz. The Commission found Benjamin failed to prove the need for the mobility scooter was related to his compensable injuries. This finding should be reversed as the evidence uniformly relates the need for the mobility scooter to Benjamin's work-related spinal cord injury.

Dr. Sandoz, the treating neurologist chosen by Respondents, wrote a prescription for a mobility scooter for Benjamin. [R. p. 227]. Dr. Sandoz opined Benjamin "require[s] the use of a motorized scooter to aid him with ambulation due to the injuries he sustained in the 06-15-2011 work accident." [R. p. 662]. The doctor stated "He is unable to ambulate normally due to [incomplete quadriplegia] and walks with an altered gait using a four prong cane for stabilization and balance." [R. p. 652]. Throughout his treatment notes, Dr. Sandoz documented problems with dizziness, balance, gait and ambulation beginning with the very first visit on September 16, 2011. [R. pp. 130, 148, 151, 160, 172, 176, 179, 184, 191, 193-4, 197, 199-200, 209, 215, 219-20].

Respondents refused to provide the mobility scooter, so it became an issue at trial. Appellant argued "Presently there is an issue with a prescription or an order for medical care to include a

mobility scooter. Causation has been provided by Dr. George Sandoz. He's indicated that the mobility scooter is because of the cervical cord injury." [R. p. 951, line 23 - p. 952, line 5].

The Commission denied the prescription for the scooter. The Appellate Panel held:

> We find Claimant is not entitled to a mobility scooter as there is insufficient evidence in the record causally-relating the need for the scooter to compensable injuries as outlined above. Specifically, Dr. Sandoz did not prescribe the mobility scooter until October 1, 2015 after Claimant alleged lower back and bilateral lower extremity symptoms associated with his 2011 work injury – claims which have been denied as noted above." [R. p. 95, lines 12-8].

The above finding references another finding wherein the Commission found:

> there is insufficient evidence in the medical record to support a finding that Claimant sustained an injury to his lower back (and any resulting radiculopathy to the legs) as a result of his work injury. [R. p. 94, lines 7-13].

The Commission's reference to a denied lower back injury and radiculopathy is a red herring. Appellant never alleged the need for the mobility scooter arose out of a lower back injury – nor was a lower back injury even pled. Counsel specifically argued at trial "that the mobility scooter is because of the cervical cord injury." [R. p. 951, line 23 - p. 952, line 5].

As to proving the need for the scooter arose from the cervical cord injury, each and every doctor documents Benjamin's gait and mobility problems arose from the cervical spinal cord injury. Dr. Poletti wrote " He has a *disabling problem that will prevent him from walking normally* or using his hands normally for fine motor activities." [R. pp. 606-8 (emphasis added)]. Dr. Mills noted "ongoing cervical cord dysfunction and residual symptoms [including] impairment of gait." [R. p. 676].

Even Dr. Lozanne records persistent difficulties with walking attributed to the spinal cord injury. At his initial evaluation on January 22, 2013 (nineteen months after the accident), Dr. Lozanne records "He has developed difficulties with his balance . . ." [R. p. 705]. Seven months after the first operation to decompress his spinal cord, Dr. Lozanne recorded:

> I explained to Victor that the surgical procedure was not intended to repair his spinal cord but rather to provide a decompression in hopes of getting continued improvement. He has been able to transition to the aid of a cane for ambulation, but is still feeling unsteady on his feet. There is some persistent abnormal sensation in the right upper and lower extremity at time, which he describes as coldness. I suspect that this is from the spinal cord abnormality." [R. p. 707].

On March 11, 2014, Dr. Lozanne wrote "He has a persistence of myelopathy with imbalance and numbness." [R. p. 649]. On August 21, 2014 – after he was no longer Benjamin's treating physician, Dr. Lozanne wrote: "He has a persistence of generalized imbalance as a manifestation of his spinal cord injury." [R. p. 650]. Respondents sent Benjamin back to Dr. Lozanne for a final evaluation on July 22, 2016. Dr. Lozanne gave Benjamin a 19% whole person impairment rating "for effect on station and gait" from a cortical spinal tract perspective. [R. p. 711-2].

The Act provides that the employer must furnish or cause to be furnished "an attending physician and *any medical care or treatment that is considered necessary by the attending physician*, unless otherwise ordered by the commission for good cause shown." S.C. Code Ann. § 42-15-60 (2007)(emphasis added). Respondents designated Dr. Sandoz as the attending physician. Once Dr. Sandoz opined Benjamin "require[s] the use of a motorized scooter to aid him with ambulation due to the injuries he sustained in the 06-15-2011 work accident," Respondents were required to provide it. [R. p. 662]. When the authorized treating physician states a mode of treatment or a medical device is *required* due to the work injuries, the statutory requirements have been met.

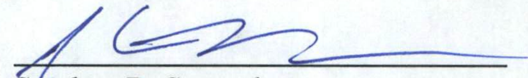
The Commission erred in failing to compel Respondents to provide the scooter. Benjamin proved he needed it to aid him with ambulation due to the work related spinal cord injury. The Commission misapprehended the medical evidence and misinterpreted the statute. See Burnette v. City of Greenville, 737 S.E.2d 200, 401 S.C. 417 (Ct. App. 2012)("the medical opinion of the single commissioner, adopted by the Commission," is not evidence and cannot form the basis of a finding).

Therefore, the Court should reverse and order Respondents to provide the mobility scooter and any other medical care or treatment considered necessary the treating physicians.

CONCLUSION

For the foregoing reasons, the Court should reverse the Appellate Panel and hold Victor Benjamin suffered total disability due to physical brain damage and incomplete quadriplegia. As such, he is not subject to the five hundred week limitation, and shall receive disability and medical benefits for life. The Court should also reverse the Appellate Panel on the denial of the mobility scooter prescribed by the attending neurologist.

Respectfully Submitted



Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1320 Richland Street
Columbia, SC 29201
(843) 448-4357

Jeff C. Chandler
CHANDLER LAW FIRM
Bank of America Building
2501 North Oak Street
Myrtle Beach, SC 29577
(843) 448-4357

Attorneys for Appellant

April 19, 2019
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Appellate Case No.: 2018-000965

Victor G. Benjamin, Claimant, ... Appellant,

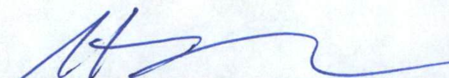
v.

Rexam Beverage Can Company d/b/a Rexam Beverages, Employer,
and Hartford Insurance Company of the Midwest, Carrier, ... Respondents.

CERTIFICATE OF COUNSEL

The undersigned certifies that this final Brief of Appellant complies with Rule 211(b), SCACR.

Respectfully Submitted



Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1320 Richland Street
Columbia, SC 29201
(803) 779-4000

Attorney for Appellant

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Columbia, South Carolina