THE STATE OF SOUTH CAROLINA
In The Court of Appeals



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APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

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W.C.C. File No.: 1607281

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Willie Carroll Powell, Employee, ..... Appellant,

v.

Johnsonville Mechanical Contractors, Inc., Employer, and Bridgefield Casualty Insurance Company c/o Summit, Carrier, ..... Respondents.

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# BRIEF OF RESPONDENTS

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## STATEMENT OF THE CASE

This claim was initiated by Claimant Willie Carroll Powell by filing a Form 50 Request for Hearing dated December 7, 2016. Claimant alleged injury to his "low back with referred pain/numbness to his right leg" from a work accident that occurred on May 3, 2016. (R. p. 179). Respondents Johnsonville Mechanical Contractors, Inc. and Bridgefield Casualty Insurance Company c/o Summit denied the claim, explaining that they were "investigating whether or not Claimant aggravated prior conditions in this alleged accident." (R. p. 180).

The parties entered into a Consent Order in January 2017 in which Respondents agreed, among other things, to send Claimant to Dr. Bill Edwards for an Independent Medical Examination ("IME") for his back, and to Dr. Patrick Denton for an IME for his right leg. (Consent Order, filed Jan. 24, 2017, R. pp. 175-178).

The parties filed Pre-Hearing Briefs and APA submissions and were heard by Hearing Commissioner T. Scott Beck on March 30, 2017. In their Pre-Hearing Brief, Respondents admitted the injury to Claimant's right leg but denied a compensable injury to his back. (R. p. 183). Although Claimant's initial Pre-Hearing Brief and APA submissions contained the results of an October 3, 2016 MRI of his lower back, as well as an October 20, 2016 IME performed by Dr. Steven C. Poletti of Southeastern Spine Institute, (R. pp. 184-187), Claimant filed an Amended Pre-Hearing Brief on March 28, 2017 that omitted any reference to his back. (R. pp. 189-192). At the March 30, 2017 hearing, Claimant took the position that he had withdrawn his request for a determination of the compensability of his back. (R. pp. 198-203).

Commissioner Beck issued a Decision & Order on May 12, 2017 noting that Respondents had agreed to pay temporary total disability benefits for a period when Claimant had been suspended from light duty without pay based on a report that he had been sleeping on the job.[1] Defendants also stipulated that "Claimant sustained a compensable injury to the right leg," and agreed "to authorize medical treatment with either Dr. David Stickler or Dr. Patrick Denton." Based on the stipulations entered into the record, Commissioner Beck found that "the back injury claim is held in abeyance," and ordered "authorized causally-related medical treatment with Dr. Stickler and/or Dr. Denton." (Decision & Order, filed May 12, 2017 ("2017 Order"), R. pp. 3-7).[2]

On August 18, 2017, Claimant filed another Form 50 Request for Hearing, alleging compensable injury to his "right calf/leg, back and hands" and seeking additional medical treatment for all body parts. Claimant also alleged that Respondents' "adjuster has refused to authorize" certain medical treatment/tests and stated that, "[i]f Claimant pays for treatment recommended he seeks reimbursement from the [Respondents]." (R. p. 181). Respondents filed a Form 51, admitting the compensable injury to Claimant's right leg only and denying all other body parts. Respondents indicated that whether Claimant was entitled to additional medical care was "TBD after Deposition of Dr. Patrick Denton." (R. p. 182).

The parties filed their Pre-Hearing Briefs and APA submissions on November 20, 2017. Claimant continued to assert injury to "his back and right leg/radiculopathy (numbness and tingling in foot and toes," and to seek additional medical care for his back

[1] *See* R. p. 98, line 16 – p. 99, line 2; p. 107, lines 3-24.
[2] *See also* R. pp. 201-203 (Commissioner Beck confirming, over Respondents' objection, that the back was being held in abeyance per Claimant's request).

and leg, asking that Dr. William Naso be designated as his authorized treating physician. Claimant also indicated he was seeking the "[i]mposition of penalties for adjuster's denial of medical treatment to which Claimant is entitled under the Act" as well as reimbursement for an MRI and an appointment with Dr. Naso. (Supp. R. pp. 231-237). Respondents continued to deny that Claimant's back was compensable. (R. p. 194).

Prior to the scheduled hearing, Claimant filed a Motion for Attorney's Fees, pursuant to S.C. Code Ann. § 42-3-175(A)(1), arguing that an authorized physician had ordered an MRI of Claimant's lumbar region and had referred Claimant to Dr. Naso, both of which Respondents failed to authorize. (R. pp. 195-196). However, at the November 30, 2017 hearing before Hearing Commissioner Aisha Taylor, Claimant's counsel withdrew his motion. (R. p. 30, lines 15-18; p. 32, lines 5-11 ("as you interpret that motion – it's not important to me anyway. I'll with draw that .... That's withdrawn")). The Commission subsequently denied Claimant's Motion for Attorney's Fees stating "[t]here is no prior order that [Respondents] failed to comply with. The medical treatment at issue has been denied by [Respondents] pending outcome of merits hearing." (Motion Order, dated Dec. 4, 2017, R. p. 178).

Commissioner Taylor issued her Decision & Order on May 22, 2018,[3] finding that Claimant's compensable "right leg injury is limited to that of the peroneal nerve in the right leg." She found that Claimant failed to meet his burden of proving a separate or independent injury to his back or right knee but that he was entitled to additional medical

[3] The Decision & Order is mistakenly dated May 22, 2017 but clearly was filed in May of 2018, as the hearing was held on November 30, 2017. The Certificate of Service of the Decision & Order is dated May 24, 2018.

care for his compensable right leg injury. (Decision & Order, filed May 22, 2018, R. pp. 8-18).

Claimant appealed to the Full Commission. An Appellate Panel of the Full Commission heard argument on September 18, 2018 and issued its Decision & Order on November 30, 2018 affirming the Hearing Commissioner's Decision & Order. In particular, the Commission found that Claimant sustained a compensable injury to the peroneal nerve in his right leg only. The Commission noted that Claimant had received "diagnostic evaluations including an EMG" as well as "an MRI of his lumbar spine, which showed some degenerative changes at L5-S1." Claimant also underwent an IME "with Dr. Denton who diagnosed Claimant with a neurological injury 'most likely to the peroneal nerve or at the tibial nerve peroneal nerve injection.'" Claimant was referred to Dr. Naso "with a diagnosis of 'peroneal nerve palsy with foot drop.'" The Commission also noted that Dr. Naso's medical opinion regarding Claimant's lower back was conditioned on facts that were not supported by a preponderance of the medical evidence. The Commission found Dr. Denton's deposition testimony to be persuasive. In contrast, the Commission assigned Dr. Poletti's[4] October 20, 2016 IME report little weight, finding it to be "out of proportion with the preponderance of the medical evidence as a whole." (Appellate Panel Decision and Order of the South Carolina Workers' Compensation Commission, filed Nov. 30, 2018 ("Commission Decision"), R. pp. 19-26).

Claimant timely appealed to this Court.

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[4] The Commission Decision incorrectly refers to the IME report as being by Dr. Johnson, another physician with Southeastern Spine Institute, as opposed to Dr. Poletti.

## BACKGROUND FACTS

### I. Medical Evidence.

Years before his work accident, on February 27, 2009, Claimant was seen at Pee Dee Family Practice after dropping a motor on his foot. (R. p. 208). He was seen again on July 26, 2010 after a four-wheeler accident. The "four-wheeler rolled on top of him hitting his right knee." Claimant was out of work and on pain medications for several weeks. (R. pp. 212, 214; Supp. R. pp. 227-229). He returned to Pee Dee Family Practice on October 24, 2014 complaining of severe arthritic discomfort, particularly right knee." (Supp. R. p. 230).

Approximately a year before his May 3, 2016 work injury, Claimant was seen by his family physician, Dr. Daniel D. DeCamps, (R. p. 89, lines 9-10), for "his chronic pain syndrome. He continues to have severe arthritic type severe discomfort, primarily in his lower back and his knees, right worse than the left." (R. p. 215). In August 2015, Dr. DeCamps saw Claimant again for a follow up "for his chronic pain syndrome. He had injured his back, has some marked pain in the right paralumbar area with increased muscle tone to palpation." (R. p. 216). Claimant was seen again in April 2016 for a "follow-up for his chronic pain syndrome to get a refill of his medications." (R. p. 217).

More than three weeks after his May 3, 2016 work accident, Claimant first sought medical treatment from Dr. DeCamps on May 27, 2016. Dr. DeCamps noted that Claimant "developed pain in his leg, both in his calf and his posterior thigh, some numbness down into his foot. He has been treating with Norco, but it is just not getting any better." Dr. DeCamps explained "he probably strained or popped one of his tendons

in this area," and treated Claimant "with hot soaks, Duexis samples t.i.d.," and Diazepam at night. (R. p. 112).

Claimant returned to Dr. DeCamps on June 8, 2016 reporting he was no better and, for the first time after his work accident, that he was "having some discomfort up into his back and even down into his left leg." Dr. DeCamps believed Claimant "probably has a tendon rupture and has developed a compensatory pain in his left side from walking differently." Dr. DeCamps ordered "an MRI of the proximal calf area to assess for tendon rupture," and placed Claimant on light duty. (R. p. 113). A venous ultrasound was performed of Claimant's right leg on June 22, 2016. (R. p. 207).

Approximately a month later, Claimant returned to Dr. DeCamps, who indicated Claimant was complaining of pain and numbness in his left hand as well. The MRI "showed compartmental syndrome suggestive of either muscle damage or nerve damage, and we are awaiting a neurological evaluation on this." (R. p. 114).

In response to a letter from Claimant's counsel seeking his opinion as to "whether or not Mr. Powell sustained a new injury to his right leg while he was carrying out his work duties on May 3, 2016," (R. pp. 205-206), Dr. DeCamps wrote a letter dated September 9, 2016, explaining that Claimant's "MRI scan suggests a compartmental process which could relate to myositis which is inflammation of the muscles or myopathy secondary to an intrinsic muscle disease or perhaps a nerve entrapment or neurological injury to the tibial nerve. On my last visit he was having neurological evaluation to help further delineate the cause and treatment for his condition. That is, his work-up is still in progress. However, I can state with a reasonable degree of medical certainty that the patient did suffer an injury to his right lower extremity and from his description of how it

occurred that his current symptoms in that area were as a result of his injury." (R. pp. 116-117).

Claimant saw Dr. Stickler on July 21, 2016 for "possible tibial nerve dysfunction." Dr. Stickler noted that Claimant "was at work working on a pipe and had [his] legs wrapped around it leaning back to fix the pipe above him and when he sat up he felt something in his right leg 'pop'." Dr. Stickler indicated that Claimant's MRI "findings are nonspecific but could be related to a primary neurogenic process. The examination today was very difficult to interpret with reported inability to cooperate with just about all motor testing limited secondary to pain. I was unable to determine the presence of pathologic weakness given these limitation[s] .... His complaints are greater that [sic] what would be expected for a focal tibial neuropathy or even lumbar radiculopathy with more recent complaints in both hands." Dr. Stickler assessed and treated Claimant for pain in his right leg. Claimant "initially stated he did not want to consider EMG" but finally agreed to the test. (R. pp. 218-219).

Dr. Stickler scheduled an EMG for August 9, 2016 in order "to evaluate for lower extremity neuropathy versus lumbar radiculopathy." However, the EMG was inconclusive, or "non-diagnostic" because Claimant "was unable to tolerate conduction studies and even low level stimulation produced large amplitude movements with the inability to relax the muscles of the leg that equally limited the sensory conduction studies." (R. pp. 220-221). Because the EMG could not be completed, Dr. Stickler requested an MRI of the lumbar spine. (R. p. 223).

Claimant had an MRI of his lower back performed at Lake City Community Hospital on October 6, 2016. (R. pp. 132-133).

On October 20, 2016, Claimant saw Dr. Poletti at Southeastern Spine Institute for an IME. Dr. Poletti opined that he thought Claimant had injured his right knee in the May 3, 2016 accident and "that this disc disruption at the L5-S1 level most likely was the direct result of his work-related accident in 2016." Dr. Poletti recommended that Claimant "should potentially consider an epidural injection for the low back." (R. pp. 134-135).

Claimant was seen by Dr. Edwards for an IME on February 2, 2017. Dr. Edwards reviewed the October 3, 2016 MRI of Claimant's lumbar spine, noting that it "demonstrates mild degenerative changes at L4-5 and L4/S1 with a small central disc bulge at L5/S1. No significant compressive pathology." Dr. Edwards opined that Claimant's "spinal condition is not relevant. There is no impairment associated with his lumbar spine. These are degenerative changes that were not caused by his industrial accident." Dr. Edwards also reviewed the June 2, 2016 MRI of Claimant's right lower extremity and diagnosed Claimant with "[n]euralgia right leg status post mild compartment syndrome right leg." He explained that, "[n]o specific treatment is indicated for this and hopefully symptoms will continue to improve though [Claimant] understands there is no way to determine this with any reasonable medical certainty." Dr. Edwards opined that Claimant was at MMI for his right lower extremity, provided an 8% impairment and indicated no restrictions and/or further treatment were necessary. (R. pp. 224-226).

On March 1, 2017, Dr. Denton conducted an IME "with regards to [Claimant's] right knee." Dr. Denton concluded that Claimant "has a neurologic injury most likely to the peroneal nerve or at the tibial nerve peroneal nerve junction." Dr. Denton believed

further evaluation, including an EMG nerve conduction study, would be helpful. Dr. Denton stated, "[b]ased on his history of his injury I wonder if he did not compress the peroneal nerve against the pipe that he was hanging from. I think his workup should be continued with either neurology or possibly neurosurgery for peripheral nerve injury." (R. pp. 136-138).

On June 27, 2017, Dr. Denton referred Claimant to Dr. Naso for evaluation and treatment with a diagnosis of "peroneal nerve palsy with foot drop." (R. p. 140). Respondents attempted to schedule Dr. Denton's deposition in order to clarify the purposes of the referral, (R. p. 165), but were unable to arrange for the deposition until November 1, 2017.

Nonetheless, Claimant went to see Dr. Naso on his own on October 11, 2017. Dr. Naso reviewed the October 2016 MRI of Claimant's lumbar spine noting twice that it "is relatively unremarkable. There is a mild disc protrusion to the right at L5/S1." Dr. Naso recommended conservative treatment to the lower back, including physical therapy and injections. (R. pp. 167-169).

In response to a letter from Claimant's counsel seeking his expert medical opinion with regard to Claimant's lower back, Dr. Naso explained that, "[i]f it is true that the patient developed at the time of his injury or shortly thereafter pain that began in the low back radiating down the right leg into the foot and if it is true that he did not have these symptoms pre-injury, then it would be my opinion that his work-related injury is directly related to his symptoms. I would agree with Dr. Denton that it would be helpful for the patient to obtain a nerve conduction study and EMG of the right lower extremity to help sort these issues out further." (R. p. 170).

At his deposition, Dr. Denton testified that he was treating Claimant for the "injury to the [peroneal] nerve which is one of the nerves in the lower leg that splits behind the knee and goes around to the front of the leg." (R. p. 57, lines 19-25). He confirmed that his referral to Florence Neurosurgery and Dr. Naso was for the peroneal nerve related to the leg and not due to "any disk bulges, stenosis, anything of that nature." (R. p. 58, line 21 – p. 59, line 16). He agreed that, since his specialty was for leg injuries, he would defer to Dr. Edwards' evaluation of Claimant's back. (R. p. 59, lines 17-20; *see also* p. 118, lines 16-20). Dr. Denton clarified that any nerve blocks he would have provided to Claimant "would be blocking that [peroneal] nerve." (R. p. 60, lines 13-15). Dr. Denton also agreed that the injury Claimant described to him was to the leg and that, although the peroneal nerve is a branch of the sciatic nerve, it joins the sciatic nerve in the hip, before it reaches the lower back. (R. p. 65, line 23 – p. 67, line 6).

**II. Lay Evidence.**

Claimant testified at the November 30, 2017 hearing that he was 51 years of age. (R. p. 37, lines 24-25). Prior to his work injury, he had worked for Johnsonville Mechanical for a total of 15 years. (R. p. 38, lines 1-6). He testified that, prior to his May 3, 2016 accident he was not having any difficulty with his lower back, right leg or thigh. (R. p. 39, lines 16-19).

Claimant initially testified that he first noticed he was having back pain "[p]robably two or three days" after his accident. "It gradually went up my leg into my back." (R. p. 40, lines 11-14). He then stated it was "[p]robably three or four days" after the accident before he noticed pain in his lower back. (R. p. 41, lines 1-5).

On cross-examination, Claimant acknowledged that he has had pain in his back since May 8, 2015 and that, as of April 2016, he was presenting to Dr. DeCamps for chronic pain syndrome. (R. p. 45, line 9 – p. 46, line 8). Claimant also acknowledged that, although additional nerve conduction, EMG studies have been authorized for his leg, he has elected to not have any such further testing performed. (R. p. 47, line 21 – p. 48, line 4).

At his prior January 6, 2017 deposition, Claimant testified that he had had surgery on his right knee in 2001, that he injured his right knee when he wrecked a four wheeler in 2014, (R. p. 85, lines 1-20), and that he had pulled a muscle in his back in 2015. (R. p. 83, lines 18-24). At the time of his work accident, he was taking Norco, prescribed by Dr. DeCamps, for his right knee pain. (R. p. 87, line 5 – p. 88, line 6).

Claimant described his May 3, 2016 work accident at his deposition, indicating that he was working on a high line and "had to lean back like this here to fit a piece or tube steel and it was way up. When he got it tacked off, I went to pull up something popped in the back of my leg right above my ankle in here." (R. p. 91, lines 14-24). He testified that, "immediately at the accident," the pain was in his "leg from [his] knee down." He first stated that the pain started traveling up his leg to his lower back "[p]robably a couple of days after the accident." He immediately clarified that "[i]t was a gradual pain, and it just gradually moved and I'd say a couple of weeks." (R. p. 92, line 19 – p. 93, line 2; *see also* p. 102, line 11 – p. 103, line 3 (confirming that the pain did not start in his lower back until "two or three weeks" after his accident)).

Claimant acknowledged that, at his first visit, he did not tell Dr. DeCamps about any pain in his back. (R. p. 93, lines 10-16). When asked why he did not tell Dr. Stickler about any back pain, Claimant responded, "I don't know." (R. p. 94, lines 8-13).

## STANDARD OF REVIEW

Judicial review of a Commission decision is directed by the substantial evidence rule of the Administrative Procedures Act, S.C. Code Ann. § 1-23-380(5) (Supp. 2015). Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981). A reviewing court should affirm the decision of the Full Commission unless it is clearly erroneous in view of the substantial evidence of the whole record. Lark, 276 S.C. at 136, 276 S.E.2d at 307. The reviewing court may not substitute its own judgment for that of the Full Commission as to the weight of the evidence on a question of fact, but may reverse if the decision is affected by an error of law. S.C. Code Ann. § 1-23-380(5). The Administrative Procedures Act "mandates that the commission take the evidence, judge the credibility and weight of that evidence, and from that judgment determine the facts of the case." Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 381, 440 S.E.2d 401, 403 (Ct. App. 1994).

Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the same conclusion the administrative agency reached in order to justify its action. Pierre v. Seaside Farms, Inc., 386 S.C. 534, 540, 689 S.E.2d 615, 618 (2010). "The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission's finding from being supported by substantial evidence." Clade v. Champion Labs., 330 S.C. 8, 11, 496

S.E.2d 856, 858 (1998). Instead, the findings of the Full Commission are presumed correct and can be set aside only if unsupported by substantial evidence or based on an error of law. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 186, 414 S.E.2d 162, 163 (1992). It is not within the appellate court's purview to reverse findings of the Full Commission which are supported by substantial evidence. Broughton v. South of the Border, 336 S.C. 488, 496, 520 S.E.2d 634, 637 (Ct. App. 1999). Where there is a conflict in the evidence, either by different witnesses or the testimony of the same witness, the factual findings of the Commission are conclusive. Anderson v. Baptist Med. Ctr., 343 S.C. 487, 492-93, 541 S.E.2d 526, 528 (2001).

## ARGUMENTS

### I. Claimant has abandoned certain arguments on appeal.

To the extent Claimant raised issues and/or arguments in his Form 30 to the Full Commission that he has not argued in his opening brief, they should be deemed abandoned for purposes of this appeal. Emerson Elec. Co. v. South Carolina Dept. of Rev., 395 S.C. 481, 489 n.6, 719 S.E.2d 650, 654 n.6 (2011) (declining to consider argument raised for the first time in a reply brief); Simmons v. SC Strong, 402 S.C. 166, 173 n.2, 739 S.E.2d 631, 634 n.2 (Ct. App. 2013) (argument not preserved for appellate review where it was raised for the first time in a reply brief); Lister v. NationsBank of Delaware, N.A., 329 S.C. 133, 494 S.E2d 449 (Ct. App. 1997) ("an appellant may not use the reply brief to argue issues not argued in the appellant's initial brief").

In addition, any issues listed in Claimant's "Statement of Issues" on appeal that are not addressed in his opening brief are deemed abandoned and should not be considered by this Court. *See, e.g.*, Nationwide Mut. Ins. Co. v. Eagle Window & Door,

Inc., 424 S.C. 256, 270, 818 S.E.2d 447, 455 (2018) (explaining that South Carolina "appellate jurisprudence has clearly established that '[a]n issue raised on appeal but not argued in the brief is deemed abandoned and will not be considered by the appellate court'"). As noted above, Claimant cannot present new arguments in a reply brief. Emerson Elec., 395 S.C. at 489 n.6, 719 S.E.2d at 654 n.6; Simmons, 402 S.C. at 173 n.2, 739 S.E.2d at 634 n.2; Lister, 329 S.C. 133, 494 S.E2d 449.

Finally, a number of Claimant's arguments on appeal are either cursory and/or not supported by meaningful authority. A cursory and unsupported argument is deemed abandoned on appeal. In the Matter of the Care and Treatment of McCracken, 346 S.C. 87, 92, 551 S.E.2d 235, 238 (2001); *see also* First Sav. Bank v. McLean, 314 S.C. 361, 363, 444 S.E.2d 513, 514 (1994) (mere allegations without argument and legal support are deemed abandoned); Bryson v. Bryson, 378 S.C. 502, 510, 662 S.E.2d 611, 615 (Ct. App. 2008) ("[a]n issue is deemed abandoned and will not be considered on appeal if the argument is raised in a brief but not supported by authority"). This includes Arguments II, III, and IV. Mere citation to a statutory provision without any support for Claimant's "interpretation" of those provisions and/or their application to the facts of this case, is insufficient to preserve Claimant's arguments for appellate review. As such, they should be deemed abandoned.

However, out of an abundance of caution, Respondents address each of Claimant's arguments below.

## II. The Commission properly rejected Claimant's argument that an implied covenant of good faith and fair dealing entitles him to relief. (Argument I).

Claimant's first argument recites case law regarding the implied covenant of good faith and fair dealing without making any substantive argument as to how that applies to

this case. However, he appears to suggest that the implied covenant of good faith and fair dealing that exists between Johnsonville Mechanical and its workers' compensation insurer also extends to him, even though he is not a party to that insurance contract. Claimant, in essence, is proposing a novel theory of workers' compensation law that is not supported by either the Act or case law, and should be rejected.

First, the case on which Claimant relies, Nichols v. State Farm Mut. Auto. Ins. Co., 279 S.C. 336, 306 S.E.2d 616 (1983), involves first-party automobile insurance, not third-party insurance. The issue in Nichols was "whether this State should recognize an action for bad faith in an insurer's handling of a claim for first party benefits." 279 S.C. at 339, 306 S.E.2d at 618. Nichols relied on Gruenberg v. Aenta Ins. Co., 9 Cal. 3d 566, 510 P.2d 1032 (Cal. 1973), which also involved first-party insurance. The California court explained in Gruenberg that an "implied duty of good faith and fair dealing," arises "in every contract [including insurance policies] that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." 9 Cal. 3d at 573, 510 P.2d at 1036; *see also* 9 Cal. 3d at 577, 510 P.2d at 1040 (the "implied covenant" of good faith and fair dealing "arises from a contractual relationship existing between the parties"). Thus, the existence of the implied covenant presumes a contractual relationship between the parties. Here, there is no contractual relationship between Claimant and Johnsonville Mechanical's workers' compensation insurer.

And, while the implied covenant of good faith and fair dealing arises in third party insurance cases, it only applies between the insured and insurer. Tadlock Painting Co. v Maryland Cas. Co., 322 S.C. 498, 473 S.E.2d 52 (1996) involved the alleged bad faith refusal to pay a third-party claim under a commercial insurance contract. There, the

insurer's refusal to timely pay claims while it disputed the application of the deductible provision with its insured resulted in consequential damages to the insured (in the form of lost business). While the Supreme Court recognized in Tadlock that the implied covenant of good faith and fair dealing exists in third-party insurance contracts, it confirmed that the duty is owed between the contracting parties – the insurer and the insured – and not to the third party. 322 S.C. at 502 & n.4, 473 S.E.2d 52 at 54 & n.4 (emphasizing the special relationship between the contracting parties created by the contract of insurance).

The Supreme Court highlighted the requirement of a contractual relationship in two companion cases: Carter v. American Mut. Fire Ins. Co., 279 S.C. 367, 307 S.E.2d 225 (1983) ("Carter I") and Carter v. American Mut. Fire Ins. Co., 279 S.C. 368, 307 S.E.2d 227 (1983) ("Carter II"). In Carter I, the Supreme Court recognized the insured husband's right to sue the insurer for a bad faith refusal to pay benefits under a homeowner's insurance policy in which he was the sole named insured. However, his wife could not maintain a separate action against the insurer based on the implied covenant of good faith and fair dealing precisely because she was "not a party to nor a named insured under the insurance contract." Carter II, 279 S.C. at 370, 307 S.E.2d at 227. The same is true here. Assuming, solely for the sake of argument, there was a bad faith failure to pay certain claims or authorize certain treatment/tests, which Respondents explicitly deny, Johnsonville Mechanical would have the right to bring a bad faith claim against its insurer for any damages it suffered from such failure; however, Claimant, as neither a party to nor a named insured under the policy, would not. *See* Tadlock, 322 S.C. at 502 & n.4, 473 S.E.2d 52 at 54 & n.4; Carter II, 279 S.C. at 370, 307 S.E.2d at 227.

Moreover, even if an implied covenant could be presumed between Claimant and Johnsonville Mechanical's insurer, which Respondents deny, the California Supreme Court held in Gruenberg that the insurance adjusting agent and employees of the defendant insurer "were not parties to the agreements for insurance; therefore, they are not, as such, subject to an implied duty of good faith and fair dealing." 9 Cal. 3d at 576, 510 P.2d at 1039. Claimant's assertions of malfeasance are directed at "the adjuster in this case," and as such, would not be covered by the ruling in Gruenberg in any event.

And, while South Carolina often follows North Carolina workers' compensation precedent, *e.g.*, Munn v. Nucor Steel, 336 S.C. 28, 31, 518 S.E.2d 289, 290 (Ct. App. 1999), neither that fact nor the North Carolina case on which Claimant relies, Gallimore v. Daniels Constr. Co., 78 N.C. App. 747, 338 S.E.2d 317 (N.C. Ct. App. 1986), does anything to advance his case. In Gallimore, the employee suffered a work-related injury and entered into a Compromise Settlement Agreement with his employer and its insurer ("defendants") under which they agreed to pay all of the medical bills incurred by the employee through May 31, 1983. When the employee needed further medical care, the defendants delayed approval of the treatment until after May 31, 1983. The North Carolina Court of Appeals pointed to the Compromise Settlement Agreement between the parties (the employee, on one hand, and the defendants, on the other) and held that the issue was whether the defendants had breached the duty of good faith and fair dealing that is implied in every contract or agreement. What was key in Gallimore and what distinguishes that case from the instant case is that there, the employee entered into a signed settlement agreement with the defendants, the employer and the insurer, which served as the basis of the duty and breach, whereas, here there is no settlement agreement

between Claimant and Respondents. Patently, the covenant of good faith and fair dealing in Gallimore did not arise out of the contract of insurance between the employer and the insurer but out of a separate settlement agreement they entered into with the employee. Even the portions of Gallimore Claimant cites in his brief acknowledge this: "the issue in this case is ... the conduct of defendants in view of the intent of the **compromise agreement**." 78 N.C. App. at 319, 338 S.E.2d 317 at 751 (emphasis added).

Logically, if such an implied covenant extended to third parties in general, and to workers' compensation claimants in particular, there would be no need for Section 42-3-175 of the Act, which authorizes a claimant to bring an action before the Commission for attorney's fees if it is determined the employer "or an adjuster, without good cause, failed to authorize medical treatment ... when ordered to do so by the commission." Contrary to Claimant's arguments on appeal, the Act provides a remedy in cases where the insurer and/or its adjuster fails to authorize medical treatment when ordered. In this case, however, Claimant forfeited his right to seek sanctions for the very behavior he now alleges injured him. (*See* R. p. 30, lines 15-18; p. 32, lines 5-11 (Claimant's counsel withdrawing his motion for attorney's fees pursuant to Section 42-3-175)).

In addition, where an employer fails to provide ordered medical treatment, the Commission has awarded and South Carolina courts have upheld payment of past medical expenses pursuant to S.C. Code Ann. § 42-17-60. *See* Clark v. Aiken County Gov't, 366 S.C. 102, 113, 620 S.E.2d 99, 104-105 (Ct. App. 2005) (the Commission is empowered by Section 42-15-60 of the Act to override an employer's choice of providers and to order payment of medical bills where appropriate); Gattis v. Murrells Inlet VFW #10420, 353 S.C. 100, 111, 576 S.E.2d 191, 196 (Ct. App. 2003) (confirming that the

Commission has authority to order payment of past medical bills where appropriate). In appropriate cases, the Commission has approved and courts have upheld authorization of medical care by a provider that a claimant has sought out on his or her own. Clark, 366 S.C. at 114, 620 S.E.2d at 105 (upholding Commission decision to order employer to pay for treatment the claimant sought on his own). The Commission did not do so in this case because no treatment had been ordered to Claimant's back and, as is explained below, Respondents are under no obligation to arrange or pay for Claimant to prove his case.

**III. The Commission properly found that Claimant failed to prove a compensable injury to his back and/or that Respondents denied him any medical treatment ordered by the Commission. (Arguments II, III & IV).**

While Claimant poses the propositions that insurance adjusters and rehabilitation professionals serve two different roles, citing general insurance law and an unrelated Commission regulation, and that an insurance adjuster has a natural "conflict of interest," his remaining arguments appear to be that the adjuster on this case thwarted his attempts to prove his own case and, as a result, he should be allowed a *de novo* hearing and appointment of Dr. Naso as the authorized treating physician. However, it is axiomatic that it is Claimant's burden to prove "the facts that will bring the injury within the workers' compensation law, and such award must not be based on surmise, conjecture or speculation." Clade, 330 S.C. at 11, 496 S.E.2d at 858. Specifically, Claimant, not Respondents, bears "the burden of proving the conditions under which [he] worked caused the injury to [his] back." Id.

Furthermore, it is both telling and unsurprising that Claimant was unable to find any case law to support his position that Respondents should have provided and/or paid for medical tests that he believes would have proven his claim that his back is

compensable. While Section 42-3-175 provides that, where a "claimant brings an action before the commission to enforce an **order authorizing medical treatment** ... and the commission determines that an insurer ... or an adjuster, without good cause, failed to authorize medical treatment ... **when ordered to do so by the commission**, the insurer ... or the adjuster must pay the claimant's attorneys; fees and costs of enforcing the order," S.C. Code Ann. § 42-3-175 (emphasis added), that section does not apply in this case for a number of reasons.

First, there was and is no order in place requiring Respondents to provide testing of or to pay for medical treatment to Claimant's back. In fact, Claimant fought at the March 30, 2017 hearing to not raise the issue of whether his back was compensable. (R. pp. 189-192) (R. p. 201, line 11 – p. 203, line 1). As Commissioner Beck pointed out at the hearing before the Full Commission, the 2017 Order "specifically was for the right leg because [Claimant] withdrew the back claim at that hearing .... So the medical, by default, could only be ordered for the right leg." (Supp. R. p. 238, line 14 – p. 239, line 4). Despite objections from Claimant's counsel to Commissioner Beck's interpretation of his own prior Order, Commissioner Beck subsequently asked counsel:

> COMMISSIONER BECK: Mr. Greene, how could it – how could it possibly mean to provide medical treatment for the back when you clearly withdrew the back at that hearing?
>
> MR. GREENE: How – he was not a maximum medical improvement. The issue – there was an issue as to the back, whether or not – and **you gave me the opportunity to further develop that claim**.
>
> COMMISSIONER BECK: That's right.
>
> MR. GREENE: All right.
>
> COMMISSIONER BECK: **Prove the compensability of it**.
>
> MR. GREENE: Yeah.

(Supp. R. p. 240, line 20 – p. 241, line 6) (emphasis added). Thus, while Claimant retained the right to develop evidence in order to attempt to prove that his back problems are compensable, neither Commissioner Beck nor the 2017 Order compelled Respondents to provide or to pay for testing to prove Claimant's case for him or for treatment to his back.[5] And while a physician, treating a claimant for one work-related body part may refer that patient for treatment of other body parts the physician notes as injured or diseased, that does not automatically make those other body parts compensable or obligate the employer (and/or insurer) to pay for that treatment to a non-related body part.

South Carolina and North Carolina precedent are in accord that reasonable and necessary medical expenses apply only to injuries and/or body parts that have been found to be compensable. *See* Munn, 336 S.C. at 31-32, 518 S.E.2d at 290, *citing* Errante v. Cumberland County Solid Waste Mgmt, 106 N.C. App. 114, 121, 415 S.E.2d 583, 586 (N.C. Ct. App. 1992) ("it is axiomatic that 'reasonable and necessary' worker's compensation awards for continuing medical expenses pursuant to Sections 97-29 and 97-25 contemplate only those reasonable and necessary expenses that are related to the *compensable* injury or injuries"). "It naturally follows that any medical treatment

[5] In fact, Claimant's counsel argued to the Full Commission, as he does on appeal, that Respondents somehow "prevented" Claimant from proving his back is compensable. (Supp. R. p. 242, line 22-25). Nothing could be farther from the truth. Respondents have not prevented Claimant from obtaining any evidence on his own in order to prove his case. They simply have refused to make his case for him. In fact, Claimant's counsel proposed to the Full Commission that the insurance adjuster was "trying to get even with me ever since" counsel wrote a letter to the adjuster's supervisor. (Supp. R. p. 243, lines 13-19). There was no evidence before the Commission of any such vendetta or motive behind the adjuster's handling of this case. Instead, the adjuster has handled this case professionally and ethically and within the terms of all prior orders of the Commission. (*See* Motion Order, dated Dec. 4, 2017, R. p. 178).

claimed under 42-15-60 must be causally related to the 'injury by accident' arising out of and in the course of employment." Munn, 336 S.C. at 32, 518 S.E.2d at 290; *see also* Hines v. Pacific Mills, 214 S.C. 125, 141, 51 S.E.2d 383, 390 (1949) (affirming circuit court finding that employer and workers' compensation insurer only were required to provide "medical and surgical attention necessary" to treat the compensable injury and were not required to treat a non-compensable body part); Brown v. Peoplease Corp., 402 S.C. 476, 483, 741 S.E.2d 761, 764-765 (Ct. App. 2013) (affirming denial of lifetime medical treatment to the claimant's lower back because it was not causally related to his workplace accident).

Second, as noted above, although Claimant filed a Motion for Attorney's Fees pursuant to 42-3-175(A)(1), Claimant's counsel withdrew his motion/request for attorney's fees at the hearing. (R. p. 30, lines 15-18; p. 32, lines 5-11 ("as you interpret that motion – it's not important to me anyway. I'll with draw that .... That's withdrawn")). As such, Claimant is bound by that concession on appeal. *See, e.g.*, Pope v. Heritage Comm., Inc., 395 S.C. 404, 430-431, 717 S.E.2d 765, 779 (Ct. App 2011); Smith v. Pearson, 210 S.C. 524, 530-531, 43 S.E.2d 479, 481-482 (1947) (finding party was bound by its counsel's prior statement). Thus, Claimant knowingly abandoned any complaint or remedy he had pursuant to Section 42-3-175.[6] As a result, Claimant is barred from making any argument based on Section 42-3-175 on appeal. *See, e.g.*, TNS Mills, Inc. v. South Carolina Dep't of Rev., 331 S.C. 611, 617, 503 S.E.2d 471, 474 (1998) ("[a]n issue conceded in a lower court may not be argued on appeal").

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[6] In addition, the Commission subsequently denied Claimant's Motion for Attorney's Fees stating **"[t]here is no prior order that [Respondents] failed to comply with**. The medical treatment at issue has been denied by [Respondents] pending outcome of merits hearing." (Motion Order, dated Dec. 4, 2017, R. p. 178) (emphasis added).

Third, instead of thwarting Claimant's claim, Respondents and the adjuster in this case agreed to an IME of his right leg with Dr. Denton and to an IME of Claimant's back with Dr. Edwards. Dr. Edwards concluded, to a reasonable degree of medical certainty, that Claimant's "spinal condition is not relevant. There is no impairment associated with his lumbar spine. These are degenerative changes that were not caused by his industrial accident." (R. p. 224-226).

Fourth, contrary to Claimant's assertion on appeal, Dr. Denton was not designated as Claimant's authorized treating physician "in an attempt to determine the full extent and nature of [Claimant's] injuries." (App. Br. pp. 8, 9). Instead, Drs. Denton and Stickler were designated as authorized treating physicians for Claimant's causally-related injury, i.e., to his right leg. (2017 Order, R. pp. 4, 6) (*see also* Supp. R. p. 238, line 14 – p. 239, line 4; p. 240, line 20 – p. 241, line 6). Dr. Denton confirmed that he was treating **only** Claimant's leg, testifying that he was treating Claimant for the "injury to the [peroneal] nerve which is one of the nerves in the lower leg that splits behind the knee and goes around to the front of the leg," (R. p. 57, lines 19-25), and that any nerve blocks he would have provided to Claimant "would be blocking that [peroneal] nerve." (R. p. 60, lines 13-15). Dr. Denton further testified that he referred Claimant to Florence Neurosurgery and Dr. Naso for the peroneal nerve related to the leg and not due to "any disk bulges, stenosis, anything of that nature." (R. p. 58, line 21 – p. 59, line 16).

The bottom line is that Claimant failed to meet his burden of proving his back injury is compensable. The Commission's ruling on this issue is supported by substantial evidence including, but not limited to, the fact that Dr. Naso "opined that Claimant's lumbar MRI was 'relatively unremarkable,'" and that Dr. Naso's opinion with regard to a

possible causal link between Claimant's May 3, 2016 accident and his back was conditioned on two factual bases that are not supported by a preponderance of the medical evidence. (Commission Decision, R. pp. 24-25.

As noted above, Dr. Naso's opinion stated that, "**[i]f it is true** that the patient developed at the time of his injury or shortly thereafter pain that began in the low back radiating down the right leg into the foot **and if it is true** that he did not have these symptoms pre-injury, then it would be my opinion that his work-related injury is directly related to his symptoms." (R. p. 170) (emphasis added). First, Claimant did not report pain in his back for almost a month after his May 3, 2016 accident. (*See* R. p. 113; *see also* R. p. 92, line 19 – p. 93, line 2; p. 102, line 11 – p. 103, line 3). Second, Claimant had a history of back pain and injury over the year preceding his May 3, 2016 injury. (R. p. 89, lines 9-10) (R. pp. 215-217). Consequently, neither of the conditions outlined in Dr. Naso's November 14, 2017 letter are supported by the evidence, which renders his opinion non-probative. "[I]t is well settled that the probative value of expert testimony, based upon hypothetical factors, stands or falls on the existence or nonexistence of the facts upon which it is predicated." Chapman v. Foremost Dairies, Inc., 249 S.C. 438, 449, 154 S.E.2d 845, 851 (1967).

In addition, it is the Commission's role to weigh conflicting expert medical evidence. *E.g.*, Anderson, 343 S.C. at 492-93, 541 S.E.2d at 528. Here, although Dr. Poletti opined that Claimant's "disc disruption at the L5-S1 level most likely was the direct result of his work-related accident in 2016," (R. pp. 134-135), Dr. Edwards concluded the opposite, opining that "spinal condition is not relevant .... These are degenerative changes that were not caused by his industrial accident." (R. pp. 224-226).

As a result, the Commission's determination that Claimant's back injury is not compensable is supported by substantial evidence and should be affirmed on appeal. Rogers, 312 S.C. at 381, 440 S.E.2d at 403 (the APA "mandates that the commission take the evidence, judge the credibility and weight of that evidence, and from that judgment determine the facts of the case").

## CONCLUSION

For all the reasons stated herein, this Court should affirm the Commission Decision and dismiss this appeal with prejudice.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals



APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

W.C.C. File No.: 1607281

Willie Carroll Powell, Employee, ..... Appellant,

v.

Johnsonville Mechanical Contractors, Inc.,
Employer, and Bridgefield Casualty Insurance
Company c/o Summit, Carrier, ..... Respondents.

**CERTIFICATE OF COUNSEL**

The undersigned certifies that this Brief of Respondents Johnsonville Mechanical Contractors, Inc. and Bridgefield Casualty Insurance Company c/o Summit complies with Rule 211(b), SCACR. The undersigned also certifies that this Brief of Respondents complies with the South Carolina Supreme Court's April 15, 2014 Order re: Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings.

May 23, 2019

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