

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC File No. 1315486

Court of Appeals Case No. 2019-001394

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SC Court of Appeals

Beverly Bequeath-Collom, Claimant.....Appellant.

v.

S.C. Department of Education, Employer,
and S.C. State Accident Fund, Carrier Respondents.

RESPONDENTS' FINAL BRIEF

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COUNTERSTATEMENT OF ISSUES

1. Whether substantial evidence supports the Commission's finding Respondents are not liable for the unauthorized medical treatment obtained by the Claimant using her personal health insurance and/or Medicare from April 11, 2014 through December 17, 2018.
 2. Whether substantial evidence supports the Commission's finding the Claimant is not entitled to Temporary Total Disability compensation for the two (2) or three (3) week period she was out of work following her unauthorized cervical fusion.
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STATEMENT OF THE CASE

This is a workers' compensation appeal by Beverly Bequeath-Collom ("Claimant" or "Appellant") from the Decision and Order of the Full Commission Appellate Panel ("Full Commission") filed on July 23, 2019, which unanimously affirmed the Decision and Order of the Single Commissioner, with amendments. This brief is submitted by the S.C. Department of Education and the S.C. State Accident Fund ("Defendants" or "Respondents") in response to Claimant's appeal.

The above referenced claim was heard before the Single Commissioner on January 18, 2018 in Columbia, South Carolina. By way of background, the Claimant sustained an admitted injury to her back on July 12, 2013. On this date, the Claimant slipped and fell in water in the school cafeteria, landing on her left hand and backside. At the time of the accident, the Claimant was employed with the S.C. Department of Education as an education associate. The Claimant retired on June 30, 2017. Following the accident, Respondents subsequently authorized medical treatment for the Claimant's lumbar strain, to include an orthopedic evaluation as well as physical therapy.

At a later date, the Claimant began to complain of neck pain that she alleged was causally related to her work injury. Respondents denied the Claimant's allegation and maintained that the Claimant's neck injury was not related to her July 12, 2013 work accident; however, Respondents continued to provide authorized treatment for the Claimant's compensable lumbar spine injury. The Claimant filed a Form 50 Hearing Request on April 21, 2014 alleging that she sustained an injury by accident resulting in injuries to her back and neck on July 12, 2013. She requested additional medical treatment for the same, to include a cervical fusion. Respondents timely filed a Form 51 admitting an injury to the Claimant's lumbar spine only and denying the alleged injury

to the neck on April 30, 2014. A Hearing was subsequently set for August 4, 2014. Prior to the scheduled Hearing, the parties entered into a Consent Order to allow time for additional discovery. The Consent Order was served on the parties on November 18, 2014.

The Claimant sought unauthorized medical treatment for her neck with neurosurgeon Dr. Mike O. Tyler, all of which was denied by Respondents. The Claimant paid for the unauthorized treatment through her personal health insurance with Blue Cross Blue Shield and/or Medicare. Dr. Tyler performed an unauthorized anterior cervical discectomy and partial corpectomy fusion on November 25, 2014. The Claimant did not request authorization for this procedure from Respondents prior to undergoing the non-emergent surgery and paid for the same with her private health insurance and/or Medicare. The claim was closed with the Commission on December 6, 2014 by way of Form 19.

The Claimant filed a second Form 50 Hearing Request on September 17, 2015, seeking retroactive reimbursement for the unauthorized cervical fusion performed by Dr. Tyler. Respondents timely filed a Form 51 on October 15, 2015, admitting an injury to the Claimant's lumbar spine only and continuing to deny the alleged injury to the Claimant's neck. Following the submission of Pre-Hearing Briefs by both parties, the Claimant ultimately withdrew her Form 50 Hearing Request on November 30, 2015. The Claimant reinjured her neck on February 16, 2016 while shopping for groceries. This subsequent accident was wholly unrelated to the Claimant's employment. The claim was closed for a second time with the Commission on February 22, 2016.

The Claimant filed a third Form 50 Hearing Request on May 24, 2016. Respondents timely filed a Form 51 once again denying the Claimant's alleged neck injury on June 23, 2016. A Hearing was subsequently scheduled for August 31, 2016 in Columbia, South Carolina. Prior to

the Hearing, the parties entered into a Consent Order to allow time for additional discovery. The Consent Order was served on August 16, 2016. Respondents took the Claimant's deposition on September 13, 2016 and the deposition of Dr. Tyler on September 28, 2016. The Claimant filed a fourth Form 50 Hearing Request on December 20, 2016 alleging injuries to her neck, back, and left arm stemming from her July 12, 2013 work injury. The Form 50 was returned due to improper service. The Claimant refiled the Form 50 Hearing Request on January 11, 2017. Respondents timely filed a Form 51 on February 9, 2017, admitting an injury to the Claimant's back only and denying all other injuries as alleged.

A Hearing was scheduled for April 3, 2017 in Columbia, South Carolina. Following the submission of both parties' Pre-Hearing Briefs, the Hearing was reset for April 25, 2017 in Columbia, South Carolina before Commissioner Aisha Taylor ("Single Commissioner"). During the Pre-Hearing Conference, the Single Commissioner ordered Mediation. The Single Commissioner's Order was served on the parties on May 8, 2017. Mediation took place on August 22, 2017; a settlement was not reached. Respondents filed a Form 21 seeking to pay permanency to the Claimant's lumbar spine on September 15, 2017. A Hearing was subsequently set for October 26, 2017 in St. Matthews, South Carolina before the Single Commissioner. Prior to the scheduled Hearing, the Claimant requested a postponement due to a long-standing trip. The Hearing was reset for January 18, 2018.

The Claimant sought a finding of compensability for both her neck and lower back, to include reimbursement from Respondents for the unauthorized medical treatment she obtained for her neck under her personal insurance and/or Medicare; specifically, she sought reimbursement for the cervical fusion performed by Dr. Tyler. Additionally, the Claimant contended she was entitled to temporary total disability ("TTD") benefits for the period she was out of work following

her neck surgery. Respondents maintained their denial of the Claimant's alleged neck injury. Defendants also took the position that they were not responsible for reimbursing the Claimant for the non-emergent, unauthorized medical care she sought on her own. Respondents contended the Claimant has reached maximum medical improvement ("MMI") as it related to her lumbar spine and sought a determination of permanent disability, if any, for the same. Finally, Respondents asserted the Claimant was not entitled to any temporary benefits based both on the denial of the cervical spine as a compensable part of the work accident; but also on the basis that there was no medical evidence documenting an inability to work by a medical provider, even if the cervical spine was a compensable part of the claim.

The Single Commissioner left the record open to allow the Claimant to submit post-Hearing evidence, if so desired, regarding impairment to the Claimant's cervical spine. The Claimant informed the Commission through counsel on February 13, 2018 that she wished to rely on the record as it currently stood and requested that the record be closed without the submission of any additional evidence. As such, the record was closed on February 13, 2018. Order instructions were sent to the parties on July 11, 2018. The Single Commissioner determined that the Claimant sustained compensable injuries to the lumbar and cervical spines only. Specifically, she determined that the Claimant aggravated her pre-existing cervical spine issues. The Single Commissioner also found that although the Claimant had a subsequent accident involving an injury to her neck in February 2016, the incident was not sufficient to break the chain of causation as to the Respondents' liability for the Claimant's cervical spine injury.

The Single Commissioner determined that Respondents were not liable for any unauthorized medical treatment related to the Claimant's neck from April 11, 2014 through December 17, 2018, the date of the Single Commissioner's Order. The Single Commissioner

opined that the medical treatment obtained by the Claimant through her own means was non-emergent and therefore not subject to reimbursement from Respondents pursuant to S.C. CODE ANN. § 42-15-60. The Single Commissioner found that the Claimant requested a Hearing on the issues of compensability and entitlement to medical treatment for her neck, but subsequently agreed to postpone the Hearing scheduled for August 4, 2014 vis Consent Order. Despite consenting to not go forward with the Hearing, the Claimant continued to seek unauthorized medical treatment for her neck. The Single Commissioner determined the Claimant had reached MMI for both her lumbar and cervical spine injuries. She assigned twenty (20%) percent permanent partial disability ("PPD") to the Claimant's back due to her lumbar and cervical spine injuries.

The Single Commissioner also found that the Claimant was not entitled to any additional medical treatment for her low back or cervical spine, outside of lifetime repair, replacement, or removal of her cervical hardware pursuant to S.C. CODE ANN. § 42-15-65. Finally, the Single Commissioner found the Claimant was not entitled to any TTD benefits. Within the statutory period, the Claimant filed a Form 30, Application for Review on December 31, 2018, setting forth her reasons for appeal. The Commission granted the Claimant an extension to file her Appellate Brief on February 19, 2019. The Claimant served her Appellate Brief on February 27, 2019. Respondents' timely served their Brief on March 11, 2019. Oral arguments were presented before the Full Commission on March 18, 2019 at 2:30 P.M. in Columbia, South Carolina. The Full Commission affirmed the Order of the Single Commissioner with Amendments on July 23, 2019. Within the statutory period, the Claimant filed her Notice of Appeal with the South Carolina Court of Appeals on August 19, 2019.

STATEMENT OF FACTS

The Claimant, age 71, initially presented to Doctors Care on July 9, 2013 with complaints of a week-long history of lower back pain. (R. 169). Doctors diagnosed the Claimant with a back strain, prescribed pain medication, referred the claimant to physical therapy, and assigned light duty work restrictions. (*Id.*). Respondents authorized physical therapy for the Claimant's lower back. The Claimant followed-up with Doctors Care on July 25, 2013 and reported an improvement in her back symptoms. (R. 175). The Claimant reported to Doctors Care for three subsequent visits; these records do not reflect any mention of neck pain by the Claimant. (R. 169-188). The Claimant completed sixteen (16) sessions of physical therapy at Progressive Physical Therapy. (R. 190-256). She was ultimately referred to Dr. David A. Scott of Moore Orthopedics. The Claimant initially presented to Dr. Scott on October 11, 2013. (R. 257-262). Although she complained of ongoing lower back pain, she made no mention of any neck pain. (*Id.*).

Dr. Scott ordered additional physical therapy. (R. 257). Aside from the Claimant's physical therapy records, she did not mention any neck pain to authorized treating physician Dr. Scott until December 16, 2013. (R. 264). Although the Claimant related her neck pain to the July 12, 2013 work injury, she began treating with Dr. Scott for her neck pain under her personal health insurance. (R. 267). An unauthorized MRI of the Claimant's cervical spine revealed degenerative changes at levels C5-C6 and C6-C7. (R. 269). Dr. Scott referred the Claimant to Dr. John Clavet for further evaluation of her neck pain. (R. 271). This referral was denied. On January 27, 2014, the Claimant declined to schedule any follow-up appointments with Dr. Scott, stating her lumbar spine was feeling better. (*Id.*).

The Claimant obtained unauthorized care for her alleged neck symptoms with Dr. Clavet from January 31, 2014 through July 11, 2014. (R. 272-283). She ultimately began treating with

Dr. Tyler under her personal health insurance. (R. 310). Dr. Tyler diagnosed the Claimant with chronic cervical radiculopathy due to cervical disc disease at both C5-C6 and C6-C7. (R. 303-304). He recommended surgery and performed the unauthorized anterior cervical discectomy and partial corpectomy fusion on November 25, 2014. (R. 309-312). Dr. Tyler released the Claimant from his care on May 13, 2015. (R. 149).

The Claimant submitted an affidavit from Dr. Tyler in which he opined she experienced no symptoms related to her cervical complaints prior to her work injury and she became symptomatic shortly thereafter. (R. 326-327). Respondents deposed the Claimant on September 13, 2016. She testified that she landed on her left hand and backside after slipping and falling at work on July 12, 2013. (R. 37). She stated that her back hurt initially after the fall. (R. 40). She confirmed that she continued to work for the remainder of the day on the date of her injury. (R. 41). She stated that she told her supervisor she was "fine" following the injury. (*Id.*). She confirmed that she sought medical treatment for her neck through her private insurance with Blue Cross Blue Shield. (R. 50, 55). She testified she elected to see a neurosurgeon for the first time approximately one year after her work-related injury. (R. 54).

The claimant testified that she never asked Respondents to authorize or pay for the surgery Dr. Tyler performed. (R. 56). She admitted boxes fell onto the surgical site on her neck while grocery shopping in February 2016. (R. 57-58). She testified that she missed two (2) or possibly three (3) weeks from work following the unauthorized surgery. (R. 63). She explained that she used her sick leave during this time. (*Id.*). She stated she is slowly returning to ballroom dancing. (R. 64). She testified she is not currently having any problems with her left arm. (R. 69-70). Respondents deposed Dr. Tyler on September 28, 2016. Dr. Tyler testified that he based his opinion noted on his affidavit solely on the history provided by the Claimant. (R. 83). He

explained that he takes his patients at “face value” and that it is not his job to assess their level of honesty. (*Id.*). He confirmed the Claimant suffered from pre-existing cervical issues. (R. 85).

The Claimant testified on her own behalf at the Hearing before the Single Commissioner. She stated that following the accident, she remained working for the Employer and that her salary remained the same. She stated that she did not miss any time from work as a result of her lumbar spine treatment and missed approximately two (2) or three (3) weeks from work following her cervical surgery, for which she used sick time for the period outside of the Christmas break. She returned to work full duty following her cervical surgery. At the time of the Hearing, no physician had assigned any impairment rating to the Claimant’s cervical or lumbar spine.

Per the Full Commission Decision and Order dated July 23, 2019, the Commission determined the greater weight of the evidence indicated the Claimant sustained compensable injuries to her lumbar spine and cervical spine as a result of her work-related accident. Specifically, the Commission found the Claimant aggravated her pre-existing cervical spine issues. The Commission determined that although the Claimant had a subsequent incident wherein boxes fell on her neck while grocery shopping in February 2016, the incident was not sufficient to break the chain of causation as to the Respondents’ liability for the Claimant’s cervical spine injury. Further, the Commission found Respondents are not liable for medical treatment for the Claimant’s neck from April 11, 2014 through December 17, 2018 as the medical treatment was non-emergent and therefore not subject to reimbursement pursuant to S.C. CODE ANN. § 42-15-60.

The Commission found the Claimant requested a Hearing on the issue of compensability and entitlement to medical treatment for her neck, but subsequently agreed to postpone the Hearing scheduled on August 4, 2014 via a Consent Order. The Commission determined that the Claimant nevertheless continued to seek unauthorized medical treatment

despite agreeing not to go forward with a Hearing in order to determine whether or not she was entitled to the same. The Commission determined the Claimant is at MMI for both her lumbar spine and cervical spine injuries. Further, the Commission determined the Claimant sustained a twenty (20%) percent permanent impairment rating to her back due to her lumbar and cervical spine injuries. The Commission determined the Claimant is not entitled to any additional treatment for her low back and is entitled only to lifetime repair, replacement, or removal of her cervical hardware pursuant to S.C. CODE ANN. § 42-15-65. Finally, the Commission determined the Claimant is not entitled to any period of TTD benefits as no physician has taken her out of work during any period of her treatment, whether authorized or unauthorized.

STANDARD OF REVIEW

The Administrative Procedures Act ("APA") governs review of decisions of the South Carolina Workers' Compensation Commission by the Court of Appeals. S.C. CODE ANN. § 1-23-380 (Supp. 2006); Lark v. Bi-Lo, Inc., 276 S.C. 130, 136, 276 S.E.2d 304, 307 (1981). Under the APA, the decisions of the South Carolina Workers' Compensation Commission may be reversed, modified, or remanded if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are affected by error of law. S.C. CODE ANN. § 1-23-380(A)(6)(d)(Supp. 2006).

Furthermore, decisions of the Workers' Compensation Commission may be reversed, modified or set aside if unsupported by reliable, probative, or substantial evidence on the whole record. Ellis v. Spartan Mills, 276 S.C. 216, 218, 277 S.E.2d 590, 591 (1981); Lark, supra.; S.C. CODE ANN. § 1-23-380(A)(6)(e). "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 conclusion the administrative agency

reached in order to justify its action.” Etheredge v. Monsanto Co., 349 S.C. 451, 562 S.E.2d 679 (Ct. App. 2002)(quoting Miller v. State Roofing Co., 312 S.C. 452, 454, 441 S.E.2d 323, 324-25 (1994)); Broughton v. South of the Border, 336 S.C. 488, 495, 520 S.E.2d 634, 637 (Ct. App. 1999). As the South Carolina Supreme Court observed,

a decision of the Workers’ Compensation Commission will not be overturned by a reviewing court unless it is clearly unsupported by substantial evidence in the record. Substantial evidence is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached to justify its action. Quantitatively, substantial evidence is something less than the weight of the evidence.

Howell v. Pac. Columbia Mills, 291 S.C. 469, 471, 354 S.E.2d 384, 385 (1987)(internal citations omitted). Finally, a decision may be reversed or modified if arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. S.C. CODE ANN. § 1-23-380(A)(6)(f).

ARGUMENT

I. Substantial evidence supports the Commission’s finding respondents are not liable for the unauthorized medical treatment obtained by the Claimant using her personal health insurance and/or Medicare from April 11, 2014 through December 17, 2018.

S.C. CODE ANN. §42-15-60 outlines the Claimant’s entitlement to causally related medical treatment, and the Carrier/Employer’s right to direct the same. An Employer is liable for the causally related medical expenses that will tend to lessen the Claimant’s period of disability, or “incapacity because of injury to earn the wages which the employee was receiving at the time of the injury in the same or any other employment.” Williams v. Boyle Construction Company, 252 S.C. 387, 166 S.E.2d 550 (1969). An exception to the Carrier/Employer’s right to direct the Claimant’s medical treatment is if the Claimant requires emergency treatment and the Carrier/Employer has failed to provide adequate medical care. S.C. CODE ANN. §42-15-60 states

“[i]f an emergency, on account of the employer’s failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the injured employee, the reasonable cost of such service shall be paid by the [E]mployer, if ordered by the Commission.”

At no time during the history of this claim have Respondents ever authorized any treatment for the Claimant’s cervical spine. In fact, the Respondents repeated denial of this requested treatment caused the Claimant to file a Form 50 on April 21, 2014 requesting additional medical treatment for the back and initial treatment for the neck, to include a cervical fusion. Respondents timely filed a Form 51 admitting an injury to the Claimant’s lumbar spine only and denying the alleged injury to the neck on April 30, 2014. A Hearing was subsequently set for August 4, 2014. Prior to the Hearing, and more importantly prior to the Claimant proceeding with the unauthorized fusion with Dr. Tyler, the parties entered into a Consent Order to allow time for additional discovery.

The Claimant has failed to produce any form of evidence showing that the unauthorized procedure performed by Dr. Tyler on November 25, 2014 was in any way an emergency procedure. At no time during his deposition on September 28, 2016 did Dr. Tyler ever claim the fusion was an emergency procedure. Respondents should not be penalized for the Claimant’s failure to avail herself of the rights provided to her by the South Carolina Workers’ Compensation Commission, to include the right to litigate the denial of the Claimant’s alleged injury to the cervical spine. After being informed in writing that Respondents would not authorize any treatment for the cervical spine, to include the requested fusion, the Claimant elected to enter into a Consent Order to cancel the scheduled Hearing, and in turn cancel her opportunity to litigate the denial of her cervical spine injury prior to willfully electing to proceed with unauthorized treatment.

The Claimant chose to proceed with the surgery using her private health insurance. The Full Commission did not allow the Respondents to “escape responsibility” for paying for unauthorized medical treatment as alleged by the Claimant; the Claimant failed to avail herself of her rights under the Act and instead sought retroactive reimbursement for a procedure not recommended by an authorized treating physician or approved by Respondents. The Full Commission correctly determined that the Respondents are not liable for the unauthorized medical treatment obtained by the Claimant using her personal health insurance and/or Medicare from April 11, 2014 through December 17, 2018. The Claimant has wholly failed to introduce any evidence proving the unauthorized treatment she received was emergent in nature taking it outside of the scope of the boundaries provided in S.C. CODE ANN. §42-15-60. Accordingly, substantial evidence in this case supports the Commission’s finding that the Respondents are not liable for the unauthorized medical treatment obtained by the Claimant.

II. Substantial evidence supports the Commission’s finding the Claimant is not entitled to Temporary Total Disability compensation for the two (2) or three (3) week period she was out of work following her unauthorized cervical fusion.

No one disputes the fact that the Claimant underwent a “serious” neurosurgery on November 25, 2014. The Claimant has failed to introduce any medical record from an authorized treating physician, or even an unauthorized treating physician taking the Claimant out of work following her non-emergent, unauthorized surgery. The only mention of work from Dr. Tyler comes from his February 11, 2015 record which notes the Claimant is back to work; he does recommend that she “hold off” on snow skiing for at least twelve (12) to eighteen (18) months. There is no mention in the record that snow skiing is in any way related to the Claimant’s employment. Furthermore, the Claimant was paid via sick leave and/or vacation time during the de minimis time she missed from work following the unauthorized surgery, as she testified to at the Hearing. Accordingly,

substantial evidence in this case supports the Commission's finding that the Claimant is not entitled to TTD benefits for the time period she allegedly missed from work following her unauthorized surgery.

CONCLUSION

Based upon the foregoing, the Respondent respectfully requests the Court of Appeals to affirm the Decision and Order of the South Carolina Workers' Compensation Commission.

(signature page to follow)

Respectfully submitted,

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CERTIFICATE OF COUNSEL

Counsel certifies that the Final Brief of Respondents complies with Rule 211(b), SCACR.

Respectfully submitted,

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