THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION APPELLATE PANEL

WCC File No. 0906322

Henry Thomas Brown, ... Claimant/Appellant,

v.

Peoplease Corporation. ..... Employer/Respondent,

and

Arch Insurance Company c/o
Gallagher Bassett Service, Inc. ..... Carrier/Respondent.

RESPONDENTS' FINAL BRIEF

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STATEMENT OF ISSUES ON APPEAL

I. WHETHER COMMISSION DENIED CLAIMANT DUE PROCESS OR VIOLATED EITHER THE ADMINISTRATIVE PROCEDURES ACT OR S.C. CONST. ART. I, § 22?

II. WHETHER SUBSTANTIAL EVIDENCE SUPPORTS THE COMMISSION'S FINDING OF FACT THAT CLAIMANT REFUSED MEDICAL TREATMENT?

STATEMENT OF THE CASE

This claim has been the subject of three separate hearings and appeals before the Workers' Compensation Commission. Claimant Henry Brown suffered a work-related injury to his lower back on May 5, 2009. At the time he was injured, he was employed by Peoplease Corporation ("Employer") and leased to Carolina Cargo. Employer and its insurer, Arch Insurance Company c/o Gallagher Bassett Services, Inc. (jointly, "Respondents") accepted the claim and began providing medical treatment.

In the first hearing, the Single Commissioner denied Claimant Temporary Total Disability ("TTD") benefits from the date Claimant stopped working for reasons unrelated to his injury. (Decision and Order of Single Commissioner Williams, dated October 5, 2009, R. pp. 1-12). The Commission affirmed and adopted the decision of the Single Commissioner, which stated that, "if Claimant is written out of work completely at some point in the future as a direct result of his work injury, he will be entitled to TTD benefits at that time." (Decision and Order of the Full Commission, dated February 25, 2010, R. pp. 13-18). There was no appeal of the February 25, 2010 Full Commission Decision.

Claimant filed a second request for hearing seeking TTD from October 28, 2009 and continuing. This request was based on a questionnaire provided to his treating physician, Dr. S. Taylor Jarrell, dated October 28, 2009, which in turn was based on a sworn affidavit provided by Claimant to Dr. Jarrell. In that affidavit, Claimant falsely stated that Respondents would not authorize physical therapy. (Decision and Order of Single Commissioner Beck, dated June 30, 2010, R. pp. 19-30). The Single Commissioner found that, because Dr. Jarrell's opinion was based on false statements in

the affidavit, Claimant was not entitled to TTD. The Single Commissioner further found "Claimant's tactics in this matter to be extremely suspect and akin to legal gamesmanship ..." and assessed hearing costs against Claimant. Claimant appealed to the Full Commission which, again, affirmed and adopted the Single Commissioner's decision in its entirety. (Decision and Order of the Full Commission, dated December 1, 2010, R. pp. 31-36). There was no appeal of the December 1, 2010 Full Commission Decision.

The third proceeding before the Commission, which generated this appeal, is discussed below.

FACTS

Immediately following Claimant's May 5, 2009 work-related injury to his lower back, Respondents began providing medical treatment. (R. pp. 81-125, 130-145). Claimant first saw Dr. Jarrell on August 13, 2009. (R. pp. 151-153). At that time, Dr. Jarrell noted that Claimant's goal was to avoid surgery, and stated "I think he needs to return to physical therapy for a good 3 to 4 months." (R. p. 153).

Claimant did not see Dr. Jarrell again until March 25, 2010, at which time Dr. Jarrell noted that Claimant had been approved for physical therapy "but he only went for about a month." Dr. Jarrell further noted that Claimant:

> is still quite miserable. At this point it would be reasonable to offer a two-level transforaminal lumbar interbody fusion **but he is not interested in surgery at this point**. We will repeat his physical therapy and see him back after that is done to reevaluate. I did talk to him about the surgery.

(R. pp. 154-155) (emphasis added). Dr. Jarrell indicated that, as of March 29, 2010, Claimant was to remain out of work until he completed his course of physical therapy and was re-evaluated. (R. pp. 156-157).

Claimant saw Dr. Jarrell again on July 15, 2010, at which point Dr. Jarrell noted that Claimant was "still hesitant to undergo surgical treatment" and suggested that he see a pain management doctor. (R. pp. 158-159). On a September 17, 2010 visit to Dr. T. Kern Carlton, a pain management doctor, Claimant confirmed that "he does not want to have surgery." Dr. Carlton noted that "[a] **two-level fusion was suggested, but the patient was not interested in pursuing this** on the visit of March 25, 2010. Additional physical therapy was recommended. He was then referred for pain management." (R. p. 203) (emphasis added). Dr. Carlton concluded that Claimant "wants to avoid surgery. He is not a good candidate for epidural steroid injections. He has failed to improve with physical therapy. At this point, I would recommend a functional restoration program ... I encouraged him to lose weight and reviewed with him his diet and his exercise regimen." (R. p. 204).

On October 5, 2010, Claimant was sent for an initial psychological evaluation with Dr. W. Brian O'Malley, Ph.D., who specifically noted that Claimant "declined spinal fusion preferring to manage his pain conservatively." (R. p. 206). Claimant continued to explore treatment with Dr. Carlton through the end of October 2010. (R. pp. 208-211).

On a return visit on November 11, 2010, Dr. Jarrell noted that Claimant had been through physical therapy and tried pain medications but still appeared "to be quite miserable with pain." At that point, Dr. Jarrell again recommended that Claimant proceed forward with "an L4-5 L5-S1 fusion." (R. pp. 160-163).

Instead of simply proceeding forward with the surgery, and consistent with Claimant's previous, repeated statements that he wanted to avoid surgery, Claimant

requested a second opinion. (R. p. 332, lines 5-7) (Decision and Order of Single Commissioner Huffstetler, dated July 27, 2011, R. p. 38) ("2011 Single Commissioner's Order").[1] Respondents accommodated this request and sent him to Dr. Alfred Rhyne for a second opinion regarding surgical options. Claimant was examined by Dr. Rhyne on December 15, 2010. Dr. Rhyne noted that, "[i]n the past [Claimant] stated that he does not want to have any type of surgical intervention," and had been "leery of pursuing any type of surgical intervention." Dr. Rhyne recommended either a series of epidural injections and "a work conditioning type of program" or, alternatively, a different surgical procedure from the one recommended by Dr. Jarrell. (R. pp. 213-214). Respondents contacted Claimant's counsel and requested that he discuss the options set out by Dr. Rhyne with Claimant, and then let them know "which course of treatment [Claimant] prefers. Once he has made a decision, [Respondents will] notify Dr. Rhyne and we'll get him set up for that treatment." (R. p. 241). Respondents were clearly prepared to move forward with whichever treatment option Claimant chose at this point in time.

However, instead of simply proceeding with the surgery, on December 29, 2010, Claimant requested a third opinion from a doctor of his own choosing, Dr. Boyd. (R. p. 242 (counsel for Claimant stating that, "[a]t this point, I do not know what surgery is best for my client. How does the Carrier feel about a third opinion tie-breaking opinion from Dr. Boyd in Columbia")). Respondents responded that they were willing to provide a

[1] Although Claimant now erroneously claims that Respondents requested the second opinion, (App. Br. p. 2), Claimant did not appeal this particular finding, (*see* Claimant's Form 30, dated August 8, 2011, R. p. 279), which is not, therefore, preserved for appeal. Green v. City of Columbia, 311 S.C. 78, 427 S.E.2d 685 (Ct. App. 1993) (only issues listed on application for review to the Full Commission are preserved for appeal).

third, tie-breaking opinion, but that it would be from a doctor of their own choosing. (R. pp. 243-244).

Claimant's counsel indicated that he opposed having Respondents select the third doctor. Claimant's counsel argued that, since Respondents had picked the first two doctors, Claimant "should get at least a say in the third." (R. pp. 245-246). Respondents advised that, they might "agree with [him] if our 'choice' of doctors was saying that your client is completely fine and doesn't need any kind of surgery, that is not the case here. **Both doctors have recommended surgery, and we simply need someone to break the tie regarding which surgery**." Respondents further indicated that, if Claimant wished to consult a doctor of his own choosing, he was free to do so at his own expense. (R. pp. 247-248) (emphasis added). Respondents subsequently set up an appointment for Claimant to see Dr. Charles C. Kanos, and advised Claimant's counsel of this appointment on January 13, 2011.[2] (R. p. 249). On the following day, January 14, 2011, Claimant's counsel filed a form 50 seeking a hearing. (Claimant's Form 50 dated January 14, 2011, R. p. 61).[3] On January 18, 2011, Respondents indicated to Claimant's counsel that, "[i]f your client knows which surgery he wants, you haven't told us and thus, there is no way for us to provide it. If he has made a decision about surgery, please let us know and we can schedule it. We're seeking a third opinion at your client's request and now you file a Form 50." (R. p. 250).

[2] Respondents initially selected Dr. Lucas to provide the third opinion; however, Dr. Lucas had refused to see Claimant, as he had "nothing to offer him." (R. p. 249). Consequently, Respondents set up an appointment with Dr. Kanos.

[3] Note there is an apparent typographical error on the Form 50 which makes it appear to be dated November 14, 2011. In any event, this request for a hearing was withdrawn the morning of the scheduled hearing.

In a January 25, 2011 follow-up email, Respondents sought clarification as to "what the issue is [regarding Claimant's filing the Form 50] since we agreed per your request to have your client seen for a third opinion. If he knows that he wants to proceed with surgery with either Dr. Rhyne or Dr. Jarrell, please let me know and we can schedule that. **The only reason surgery has not been authorized is because he wanted to get a third opinion before making a decision.** If there are no other issues, we will ask for costs/fee[s] associated with this hearing." In response, Claimant's counsel indicated that Claimant "would prefer to stick with Dr. Jarrell." (R. pp. 251) (emphasis added). Respondents requested clarification as to whether Claimant was "now ready to undergo the surgery?" to which Claimant's counsel merely replied, "[Claimant] is ready to proceed with Dr. Jarrell." (R. p. 252).

Respondents advised that they would still provide for the third opinion as requested by Claimant, in order to "to see what his opinion is regarding the two types of surgery offered by Drs. Jarrell and Rhyne." Respondents made it explicit that, "[we] are NOT denying him any treatment with Dr. Jarrell – we are simply seeking a 'tie-breaker opinion' with Dr. Kanos." (R. pp. 254-255). Respondents confirmed that, once Claimant had been evaluated by Dr. Kanos, he would "simply need to choose how he wishes to proceed with his treatment." (R. p. 256).

Dr. Kanos evaluated Claimant on February 21, 2011. Instead of deciding which of the two surgeries would be best for Claimant, Dr. Kanos determined that Claimant was not a good candidate for surgery but, instead, would benefit from pain management, (R. pp. 217-219), which was conveyed to Claimant. (R. p. 257 (noting "your client indicated that he did not want to undergo surgery so this should be good news for him. We'll get

him set up for pain management"). Claimant's counsel initially responded that, "Claimant indicated he wanted to try pain management first. When that failed he indicated that he wanted to undergo surgery." (R. p. 258). When Respondents advised Claimant's counsel that Claimant had not tried pain management, (R. p. 259), Claimant's counsel responded, "I thought he did. Anyhow, last time I spoke with him he was ready to proceed with surgery." (R. p. 260). Employer authorized pain management treatment as recommended by Dr. Kanos. (R. pp. 262-269).

Claimant filed a new hearing request on May 1, 2011. In his Pre-Hearing Brief, Claimant indicated he was seeking an order authorizing surgical treatment as proposed by Dr. Jarrell as well as an assessment of fines and penalties against Respondents for "refusing to provide medical treatment recommended by the authorized treating physician." (*See* Claimant's Form 58, dated July 11, 2011, R. pp. 69-72). In their Pre-Hearing Brief, Respondents raised the issue of whether Claimant was entitled to specific medical treatment "**after refusing to undergo surgery as recommended by his authorized treating physician**," and instead seeking a second and third opinion. (Respondents' Form 58, dated July 18, 2011, R. p. 275) (emphasis added).

A hearing was conducted on July 26, 2011, after which the Single Commissioner David W. Huffstetler issued his decision ordering Respondents to provide Claimant with "additional medical care in the form of surgery as recommended by Dr. Jarrell." (Single Commissioner Decision, R. p. 40). The Single Commissioner also found that Respondents had "provided the Claimant with adequate and necessary medical care, including three medical opinions concerning the possible need for surgery," and that "Claimant requested a third, tie-breaking opinion and now [is] refusing to accept it." (R.

p. 39). He noted that Respondents have been "more than cooperative in trying to accommodate the Claimant in his medical care." He also found that Claimant's initial "refusal to accept the surgery recommended by Dr. Jarrell and now asking to undergo the same surgery from the same physician has prejudiced [Respondents] by extending payment of temporary total disability benefits by one year." (R. p. 40). The Single Commissioner explained that, "[t]he further delay was caused by the Claimant's insisting on a tie-breaker and then refusing to accept that opinion." Consequently, as a matter of equity, the Single Commissioner ordered Claimant to reimburse Respondents for 32 weeks of TTD (to be deducted from any future award for permanent disability), which reflects the amount of time from the second surgical opinion provided by Dr. Rhyne to the date of the hearing. (R. pp. 39, 41). Finally, the Single Commissioner ordered that, in the event Claimant fails to undergo the surgery with Dr. Jarrell, Respondents "may stop payment of those benefits effective the date the surgery was scheduled to be performed." (R. p. 41). On appeal, the Full Commission once again affirmed and adopted the Single Commissioner's decision in its entirety. (Decision and Order of the Full Commission, dated March 13, 2012, R. pp. 42-46) ("Commission Decision").

Claimant timely appealed to this Court.

STANDARD OF REVIEW

Judicial review of a Commission decision is directed by the substantial evidence rule of the Administrative Procedures Act ("APA"), S.C. Code Ann. § 1-23-380(A)(5) (Supp. 2010). 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 errors of law. S.C. Code Ann. §1-23-380(A)(5). 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." 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. Etheredge v. Monsanto Co., 349 S.C. 451, 456, 562 S.E.2d 679,681-82 (Ct. App. 2002). 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).

The Full Commission is the ultimate fact finder in workers' compensation cases. Ross v. American Red Cross, 298 S.C. 490, 492, 381 S.E.2d 728, 730 (1989). It is not within the appellate courts' 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 witnesses, 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).

ARGUMENT

I. The Commission did not deny Claimant due process or violate either the Administrative Procedures Act or S.C. Const. art. I, § 22.

Claimant alleges that, by ordering Claimant to reimburse Respondents for 32 weeks of total temporary compensation for refusal of medical treatment, the Commission erred because it failed to provide Claimant "notice, the opportunity to be heard, or the opportunity to present evidence on his behalf," and, therefore, "denied Mr. Brown due process, violated procedural requirement in the Administrative Procedures Act, and denied Mr. Brown the right to cure." (App. Br. p. 8). Claimant asserts similar rights under S.C. Const. art. I, § 22. (App. Br. p. 10). Respondents address each of these alleged errors below.

Procedural due process "is flexible and calls for such procedural protections as the particular situation demands." Jones v. South Carolina Dept. of Health & Envt'l Contr., 384 S.C. 295, 316, 682 S.E.2d 282, 294 (Ct. App. 2009). Due process "requires (1) adequate notice; (2) adequate opportunity for a hearing; (3) the right to introduce evidence; and (4) the right to confront and cross-examine witnesses." Clear Channel Outdoor v. City of Myrtle Beach, 372 S.C. 230, 235, 642 S.E.2d 565, 567 (2007). In order to prevail on a claim that he was denied due process, Claimant must show he has been substantially prejudiced. Jones, 384 S.C. at 316, 682 S.E.2d at 294. S.C. Code Ann. § 1-23-320(A) requires administrative agencies to afford all parties "an opportunity for hearing after notice of not less than thirty days ..." Administrative agencies also must afford parties an opportunity "to respond and present evidence on all issues involved." S.C. Code Ann. § 1-23-320(E). Finally, the South Carolina Constitution provides that

administrative agencies must provide "due notice and an opportunity to be heard ..." S.C. Const. art. I, § 22.

The Commission did not deny Claimant adequate notice, an adequate opportunity for a hearing, the right to introduce evidence on all of the issues, or any other procedure to which he is legally entitled. As a result, the Commission did not commit any legal error under due process clause requirements, S.C. Code Ann. § 1-23-320, or S.C. Const. art. I, § 22.

A. Notice.

Claimant alleges that the Commission erred because it did not provide him notice. "This appeal is about lack of notice." (App. Br. p. 8). Claimant asserts that refusal of medical treatment and reimbursement of temporary compensation were not alleged in any of the relevant filings at the Commission and that, therefore, he lacked proper notice under due process clause requirements, S.C. Code Ann. § 1-23-320, and S.C. Const. art. I, § 22. (App. Br. pp. 9-10).

The due process clause only requires "notice reasonably calculated under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." Jackson v. Speed, 326 S.C. 289, 303, 486 S.E.2d 750, 757 (1997); *see also* South Carolina Dept. of Labor v. Girgis, 332 S.C. 162, 169, 503 S.E.2d 490, 493 (Ct. App. 1998) (noting that "[d]ue process does not require that notices of administrative proceedings 'be drafted with the certainty of a criminal pleading,' as long as the notice is sufficient for persons whose rights may be affected to understand the substance and nature of the grounds upon which they are called to answer") (citation omitted). The notice requirements embedded in S.C. Code Ann. § 1-

23-320 require at least 30 days notice and "a short and plain statement of the matters asserted."[4] Finally, S.C. Const. art. I, § 22 requires "due notice."

Claimant received adequate notice of the issue of failure to comply with medical treatment. First, although refusal of medical treatment was not raised in Respondents' Form 51, (Respondents' Form 51, dated June 3, 2011, R. pp. 67-68), that filing reserved Respondents' right to assert additional affirmative defenses. (Id.). *See* Hargrove v. Carolina Ortho. Surg. Assoc., 389 S.C. 119, 124, 697 S.E.2d 641, 643 (Ct. App. 2010) (upholding denial of claim on a ground not specifically set forth on the employer's Form 51 where the employer asserted a general denial of liability and reserved its right to assert additional applicable defenses). In addition, in their Pre-Hearing Brief, Respondents raised the issue of whether Claimant was entitled to the specific medical treatment he was seeking "**after refusing to undergo surgery as recommended by his authorized treating physician**," and after seeking a second and third opinion. (Respondents' Form 58, R. p. 275) (emphasis added).[5] Thus, the issue of failure to comply with the treatment provisions of the Act was clearly raised and constituted adequate notice to Claimant. *See* Jervey v. Martint Envt'l, Inc., 396 S.C. 442, 451, 721 S.E.2d 469, 474 (Ct. App. 2012) (finding that a pre-hearing brief amended a Form 50 or 51 and provided ample notice of issue to the other party).

[4] That section also provides that, "[i]f the agency of other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, **upon application**, a more definite and detailed statement must be furnished." S.C. Code Ann. § 1-23-320(B)(4) (emphasis added). Here, Claimant never submitted an application for a more definite and detailed statement.

[5] In addition, Claimant himself raised the issue of compliance with the medical treatment provisions of the Act by seeking an assessment of fines, penalties and hearing costs against Respondents for what he alleged was a refusal "to provide medical treatment recommended by the authorized treating physician." (Claimant's Form 58, R. pp. 69-72).

The Single Commissioner ordered reimbursement of TTD pursuant to Section 42-9-210,[6] which provides, in pertinent part, that "[a]ny payments made by an employer to an injured employee during the period of his disability ... which by the terms of this Title were not due and payable when made may, subject to the approval of the Commission, be deducted from the amount to be paid as compensation." S.C. Code Ann. § 42-9-210. This provision is permissive. *See* Schud el v. South Carolina Alcoholic Bev. Cont. Comm'n, 276 S.C. 138, 142, 276 S.E.2d 308, 310 (1981) (use of the term "may" in legislation confers discretion on an administrative agency and "indicates a recognition that there may be a number of variables inherent" in its decision). The only two requirements under section 42-9-210 are that the Commission approve the deduction and that the payments "were not due and payable when made." Both of those requirements are fulfilled in this instant case.

Section 42-15-60 addresses compliance with medical treatment and provides, in pertinent part, that:

> During any period of disability ... the employee shall accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown. The **refusal of an employee to accept any medical, hospital, surgical**, or other treatment or evaluation **when provided by the employer** or ordered by the commission **bars** the employee from further compensation until the refusal ceases **and compensation is not paid for the period of refusal** unless in the opinion of the commission the circumstances justified the refusal ..."

[6] Claimant incorrectly cites S.C. Code Ann. § 42-9-260(B)(6) as the basis on which the Commission ordered reimbursement of temporary total disability benefits. Neither the parties nor the Commission raised or relied on S.C. Code Ann. § 42-9-260(B)(6), which deals with an employer's right to apply to the Commission to stop payment of temporary total disability benefits, not reimbursement of benefits that have been paid when not due.

S.C. Code Ann. § 42-15-60 (emphasis added). This provision is couched in mandatory terms and is part of a claimant's obligation in order to obtain benefits under the Act.[7] In addition, this bar is automatic – the statute does not require any action by an employer – it simply requires that the Commission find that an employee refused medical treatment without good cause. For example, in Aaron v. Viro Group, 344 S.C. 321, 543 S.E.2d 574 (Ct. App. 2001), this Court explained the mandatory nature of S.C. Code Ann. § 42-15-80 (which is similar to S.C. Code Ann. § 42-15-60 in that it requires a claimant to submit him or herself to an independent medical examination), and stated that, "where a claimant refuses to submit to a physical examination upon the request of ... the employer and the court can find no justification for his refusal to submit to the examination, the mandatory provisions of [S.C. Code Ann. § 42-15-80] become operative and the claimant is not entitled to compensation for the period that elapsed between the time of his refusal and the time when such refusal ceased." 344 S.C. at 325, 543 S.E.2d at 576-77; *see also* Hill v. Skinner, 195 S.C. 330, 11 S.E.2d 386 (1940) (affirming the ruling of the trial court describing what is now codified at S.C. Code Ann. § 42-15-80 as mandatory, and becoming "operative" upon the claimant's refusal to submit to a medical exam). Here, the Commission found no justification for Claimant's refusal[8] and, therefore, he simply was not entitled to compensation during the period he was refusing medical treatment.

This Court should hold Claimant had adequate notice to satisfy due process concerns, the APA and the South Carolina Constitution.

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[7] Ultimately, the burden rests on a claimant to prove he or she is entitled to compensation under the Act. *E.g.*, Therrell v. Jerry's Inc., 370 S.C. 22, 30, 633 S.E.2d 893, 897 (2006); Clade v. Champion Labs, 330 S.C. 8, 11, 496 S.E.2d 856, 858 (1998) (the burden is on the claimant to prove that he or she is entitled to compensation, and that "such award must not be based on surmise, conjecture of speculation").

B. Opportunity to be heard.

Claimant alleges the Commission somehow denied him an opportunity to be heard; however, he does not specify how he was denied such an opportunity. To the extent that he alleges the lack of adequate notice deprived him of the opportunity to be heard, notice is discussed above.

Furthermore, Claimant was present at the hearing before the Single Commissioner. At that hearing, Claimant was able to testify fully and was not denied any opportunity to present evidence or testimony. He was represented by counsel at both the hearing before the Single commissioner and the hearing before the Full Commission. At the hearing before the Full Commission, Claimant's counsel specifically argued that the Single Commissioner had committed various errors in ordering Claimant to reimburse Respondents for 32 weeks of compensation that was paid during the time he refused medical treatment. (R. p. 349, line 3 – p. 350, line 16). *See* Jones, 384 S.C. at 317, 682 S.E.2d at 294 (finding sufficient opportunity to be heard where party had an opportunity to participate both in the initial hearing and in the appeal before the Administrative Law Court).

Therefore, This Court should hold that Claimant had sufficient opportunity to be heard.

C. Opportunity to respond and present evidence and argument on all issues involved.

Claimant argues that the Commission denied him an opportunity to respond and present evidence on his behalf on all issues involved, particularly on the issues of whether he refused medical treatment and reimbursement of temporary compensation.

[8] Claimant did not seek an order from the Commission finding that there was "good cause" for his refusal.

However, Claimant had ample opportunity to respond and present evidence on the issue of compliance with medical treatment and reimbursement of temporary compensation. As noted above, both Claimant and his counsel participated in the hearing before the Single Commissioner, where his counsel was free to ask him any questions and develop the record as he saw fit.[9]

Furthermore, Claimant's counsel was present and fully participated at the hearing before the Full Commission. As noted above, Claimant's counsel argued both his refusal of treatment and the reimbursement issue to the Full Commission. (R. p. 349, line 3 – p. 350, line 16). Assuming solely for the sake of argument but without conceding, that Claimant was unable to present evidence or testimony before the Single Commissioner regarding his refusal of medical treatment or the reimbursement of temporary compensation, he could have requested that the Full Commission receive additional evidence, but failed to do so.

It is revealing that, although Claimant's counsel argued to the Appellate Panel that he was denied an opportunity to present evidence, (R. p. 349, lines 17-19), he did not request that the Commission take any additional testimony or allow him to present additional evidence. The "commission is the factfinder in a workers' compensation case and has the authority to receive further evidence." Solomon v. W.B. Easton, Inc., 207 S.C. 518, 415 S.E.2d 841 (Ct. App. 1992); *see also* S.C. Code Ann. § 42-17-50 (the Full Commission may, "if good grounds be shown therefore, ... receive further evidence, rehear the parties or their representatives and, if proper, amend the award"); *see also* S.C.

[9] As Claimant was the only witness before the Single Commissioner, the right to confront and cross-examine witnesses does not appear to be an issue in this case. There is no issue here of missing portions of a transcript, or a denial of the opportunity to effectively examine or cross-examine any witnesses, as was the case in Adams v. H.R. Allen, Inc., 397 S.C. 652, 726 S.E.2d 9 (2012).

Code Reg. § 67-707, which provides that "[w]hen additional evidence is necessary for the completion of the record in a case on review the Commission may, in its discretion, order such evidence taken before a Commissioner."

Claimant has not proffered any explanation of, or even hinted at what this evidence might have consisted of or might have shown. Instead, as was the case in Jackson, Claimant has failed to show how his presentation to the Single Commissioner or the Commission, "would have been altered" had he specifically been apprised that the Single Commissioner was contemplating ordering a reimbursement of total temporary compensation for refusal of medical treatment. 326 S.C. at 304, 486 S.E.2d at 757. In short, Claimant has failed to show how he was prejudiced, let alone substantially prejudiced, by the procedure he received at the Commission. *See* Jones, 384 S.C. at 316, 682 S.E.2d at 294 (holding that, "to prevail on a claim of denial of due process, there must be a showing of substantial prejudice"). Any deficit in the record on this issue is due to his own failure to fully develop his case.

Thus, even if, solely for the sake of argument, Claimant's procedural rights were violated at the Single Commissioner level, any error was remedied by the subsequent hearing before the Appellate Panel. *See* Ross v. Medical Univ. of S.C., 328 S.C. 51, 67, 492 S.E.2d 62, 71 (1997) (finding pretermination procedures failed to comply with minimum due process standards, but "the error was remedied by the subsequent Committee hearing" on appeal). In fact, although "Article I, § 22 requires an administrative agency [to] provide notice and an opportunity to be heard, [it] does not require notice and an opportunity to be heard **at each level** of the administrative process. It mandates notice and opportunity to be heard **at some point before the agency makes**

its final decision." 328 S.C. at 68, 492 S.E.2d at 71 (emphasis added); *see also* Majors v. South Carolina Sec. Comm'n, 373 S.C. 153, 160, 644 S.E.2d 710, 714 (2007) (same). In Clear Channel, the petitioner argued that its due process rights had been violated because it "neither received notice of the nonconformity issue nor had a meaningful opportunity to be heard." In rejecting this argument, the Court held that adequate notice was provided because the petitioner clearly knew the nonconformance issue was being raised prior to the appellate hearing before the zoning board of appeals, where it affirmatively argued the issue. The Court concluded that, "[t]he record shows Petitioner had both notice of the nonconformity issue and an opportunity to be heard. Petitioner's due process rights, therefore, were not violated." 372 S.C. at 235, 642 S.E.2d at 568. The same is true here.

It is also telling that, despite his vociferous claims of denial of due process and violations of the APA and the South Carolina Constitution, Claimant does not seek a remand for an opportunity to present additional evidence and for a fair hearing and, in essence, provide him with the process he alleges he is due. Instead, he simply wants his benefits reinstated. (App. Br. p. 12). Claimant would have this Court make the factual finding that he is entitled to the temporary benefits during the time he was refusing medical treatment, which is beyond this Court's appellate role. Pack v. South Carolina Dept. of Transp., 381 S.C. 526, 534, 673 S.E.2d 461, 465 (Ct. App. 2009) (holding that "questions of fact are decided solely by the Commission, and the court reviewing the Commission's decision lacks authority to determine factual issues, except in jurisdictional matters").

Finally, Claimant's reliance on United States v. Burke, 504 U.S. 229, 112 S. Ct. 1867 (1992), is entirely misplaced, as procedural due process was not even an issue in that Title VII discrimination case, which considered whether backpay that had been withheld unlawfully from plaintiffs constituted wages for purposes of the Internal Revenue Code. In his concurrence, Justice Scalia[10] explained that he would have resolved the issue on a basis different from any that was argued by any of the parties. After stating that, "[t]he rule that points not argued will not be considered is more than just a prudential rule of convenience; its observance, at least in the vast majority of cases, distinguishes our adversary system of justice from the inquisitorial one," he concludes that, "[e]ven so, there must be enough play in the joints that the Supreme Court need not render judgment on the basis of a rule of law whose nonexistence is apparent on the face of things, simply because the parties agree upon it – particularly when the judgment will reinforce error already prevalent in the system." 504 U.S. at 246, 112 S. Ct. at 1877. In short, the Court must be free to decide a case on a correct basis, even if neither of the parties raised it below. Here, however, Claimant was able to and did argue the refusal of medical treatment and the reimbursement issue before the Commission, making Justice Scalia's comments inapplicable to this case.

This Court should hold Claimant had an opportunity to respond and represent evidence to the Commission on all issues. Any failure by Claimant to fully develop the record is his own fault.

D. Right to Cure.

Citing S.C. Code Ann. § 42-9-260(B)(6), Claimant alleges he was denied "a right to cure." (App. Br. pp. 8, 11). However, even to the extent that S.C. Code Ann. § 42-9-

[10] Claimant incorrectly identifies this concurrence as having been written by Justice Souter.

260(B)(6) embodies a "right to cure," which Respondents do not concede,[11] and as noted above, that section was not raised or relied on by the parties below or the Commission. S.C. Code Ann. § 42-9-260(B)(6) addresses an employer's application to suspend payment of temporary disability payments. The Commission did not rely in any way on S.C. Code Ann. § 42-9-260(B)(6), (2012 Commission Decision, R. p. 45), and even Claimant admits that Respondents did not assert their rights under this provision. (R. p. 359, lines 17-21).[12]

In addition, there is no "right to cure" under S.C. Code § 42-15-60, on which the Commission did rely. Claimant knew or should have known that he was obligated to comply with the provisions of the Act, including S.C. Code § 42-15-60, in order to recover workers' compensation benefits. (*See* discussion above re the mandatory nature of S.C. Code § 42-15-60).

Therefore, this Court should reject Claimant's argument that he was denied any so-called right to cure.

E. The Commission did not violate S.C. Code Ann. § 1-23-320(I).

Claimant apparently misconstrues S.C. Code Ann. § 1-23-320(I) when he argues that all findings of fact relating to refusal of medical treatment and reimbursement of temporarily compensation should be removed from the Commission's Decision. S.C. Code Ann. § 1-23-320(I) requires that "[f]indings of fact must be based exclusively on the evidence and matters officially noticed." That statutory provision does not provide a

[11] Although S.C. Code Ann. § 42-9-260(C) provides that an employee whose benefits have been suspended may request a hearing to have them reinstated, this fall short of a "right to cure" asserted by Claimant.

[12] Claimant's assertions as to why Respondents did not file for a hearing to stop payment of benefits due to his refusal of medical treatment, (R. p. 347, lines 4-7; R. p. 360, lines 19-22), are pure speculation. Respondents have bent over backwards to attempt to provide Claimant with the appropriate treatment for his back injury but have been stalled and stymied by Claimant's repeated insistence that he did not want to pursue a surgical option.

notice requirement in the sense that findings of fact can only be made on issues for which the parties received an "official notice," as is suggested by Claimant. Instead, S.C. Code Ann. § 1-23-320(I) requires that each finding of fact in an administrative decision be based on the evidence in the record and, where appropriate, on matters or information officially noticed, as in the sense of taking judicial notice of a fact. *See* Weaver v. South Carolina Coastal Council, 309 S.C. 368, 374, 423 S.E.2d 340, 343 (1992) (discussing Section 1-23-320(I) in terms of judicial notice); Hendricks, 335 S.C. at 419, 517 S.E.2d at 706 (evaluating Section 1-23-320(I) in terms of evidentiary rules). As is discussed below, the Commission Decision is supported by substantial evidence in the record.

Therefore, this Court should find that S.C. Code Ann. § 1-23-320(I) is irrelevant to the case at hand.

II. Substantial evidence supports the Commission's finding of fact that Claimant refused medical treatment.

Substantial evidence supports the Commission's factual findings in this case which should be upheld on appeal. Not surprisingly, the evidence that supports the Commission's Decision was largely ignored by Claimant in his Brief. Immediately after the May 5, 2009 injury, Respondents began providing medical treatment to Claimant. (R. pp. 81-125, 130-145). Claimant repeatedly stated he did not want surgery. (R. pp. 153, 154-155, 158-159, 203, 206).

Although Claimant's attorney sent Respondents letters dated November 23, 2010 and November 29, 2010 (R. pp. 225, 232), requesting surgery with Dr. Jarrell, he also immediately requested a second opinion regarding surgery. (R. p. 332, lines 5-7) (Single Commissioner Decision, R. p. 38). Dr. Rhyne, who provided the second opinion, dated December 15, 2010, noted Claimant did not want surgery and recommended Claimant be

provided either a different surgical procedure than the one Dr. Jarrell proposed or a series of epidural injections and a work conditioning type program. (R. pp. 213-214). Soon thereafter, on December 29, 2010, Claimant asked for a third "tie breaking" opinion in order to decide which surgery would be best for him. (R. p. 242). Respondents agreed to provide Claimant with yet another medical opinion. (R. p. 243). Rather than proceed with the third opinion that he requested and that Respondents arranged, Claimant "assume[ed] defendants were doing everything in their power to avoid authorizing surgery," (App. Br. p. 12), and filed a Form 50 request for hearing on January 14, 2011. Respondents responded expressing confusion about what Claimant really wanted – although at times he appeared to be asking for surgery, he had consistently stated he did not want surgery, (R. pp. 153, 154-155, 158-159, 203, 206), and had specifically requested a third, tie-breaking opinion. (R. pp. 242, 256). Although Claimant sent a letter requesting surgery with Dr. Jarrell again on January 25, 2011, (R. p. 251), Respondents understandably wanted to keep the appointment with Dr. Kanos in order to clarify, once and for all, exactly what treatment option Claimant wanted to pursue. (R. p. 254 (email from Respondent's counsel stating "[w]e would like to keep the appt just to see what his opinion is regarding the two types of surgery offered by Drs. Jarrell and Rhyne. We are NOT denying him any treatment with Dr. Jarrell – we are simply seeking a 'tie-breaker opinion' with Dr. Kanos")).

On February 22, 2011, Respondents advised Claimant that Dr. Kanos did not believe surgery would help his condition and that he had recommended a pain management treatment approach. "Your client indicated that he did not want to undergo surgery so this should be good news for him. We'll get him set up for pain

management." (R. p. 257). Even Claimant's counsel appears to have been confused, as he responded on February 22, 2011 that his "Client indicated he wanted to try pain management first. When that failed he indicated that he wanted to under go surgery." (R. p. 258). Respondents understandably were confused (again) about what Claimant wanted because he had not yet tried pain management. (R. p. 259). Claimant's counsel's response was simply, "I thought he did. Anyhow, last time I spoke with him he was ready to proceed with surgery." (R. p. 260). In light of Claimant's changing and unpredictable responses, and Claimant's repeated statements that he wanted to avoid surgery, Respondents authorized pain management to be set up through Dr. Kanos' office. (R. pp. 262-264). On March 1, 2011, Respondents informed Claimant that they were working to find a pain clinic close to his home. (R. pp. 265-267). In response, on March 3, 2011, Claimant sent the same letter requesting surgery that he had sent previously. (R. p. 233).

All the evidence in this case supports a finding that Claimant was unclear about what treatment he wanted, refused surgery, requested a second and then a third opinion, after which he chose the surgery the first surgeon had recommended. This process dragged on for a year, during which Respondents were paying total temporary disability benefits to Claimant as well as for the multiple medical opinions he sought. This is not the first time Claimant has attempted to gain advantage through mischaracterization regarding this injury. The evidence amply supports the Commission's finding that Claimant refused medical treatment by refusing "to accept the surgery recommended by Dr. Jarrell and now asking to undergo the same surgery from the same physician ..." (Commission Decision, R. p. 45). As a result, Claimant managed to extend payment of

TTD benefits for a year, which prejudiced Respondents. (Id.). However, the Commission did not order reimbursement of a full 52 weeks of TTD benefits, but only 32 weeks, representing the time between Dr. Rhyne's second opinion and the hearing date. Under the circumstances, this was more than fair to Claimant. In addition, because this resolution of a factual dispute is supported by substantial evidence in the record, this Court should uphold the Commission Decision. Anderson, 343 S.C. at 492-93, 541 S.E.2d at 528.

Finally, all other arguments arguably raised in Claimant's Notice of Appeal, but not addressed in his opening brief, have been waived on appeal because Claimant did not address them in his opening brief.

CONCLUSION

For all the reasons stated herein, this Court should uphold the Commission Decision and dismiss Claimant's appeal.

Respectfully submitted,

November 28, 2012

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION APPELLATE PANEL

WCC File No. 0906322

Henry Thomas Brown, ... Claimant/Appellant,

v.

Peoplease Corporation. ..... Employer/Respondent,

and

Arch Insurance Company c/o
Gallagher Bassett Service, Inc. ..... Carrier/Respondent.

CERTIFICATE OF COUNSEL

The undersigned certified that this Respondents' Final Brief complies with Rule 211(b), SCACR. The undersigned also certifies that this Final Brief complies with the South Carolina Supreme Court's August 13, 2007 Order re: Interim Guidance Regarding Personal Data Identifiers and Other Sensitive Information in Appellate Court Filings.

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PROOF OF SERVICE

I certify that on the 28th day of November 2012, I served the **Respondents' Final Brief** on Henry Thomas Brown by depositing a copy of it in the United States Mail, postage prepaid, addressed to his attorney of record:

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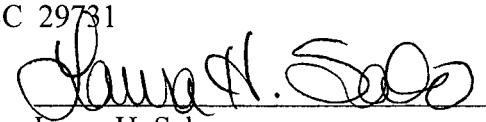

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