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THE STATE OF SOUTH CAROLINA
In the Supreme Court

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APR 26 2013

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

S.C. Supreme Court

Opinion No. 5082
SC Ct. App. filed February 13, 2013
Withdrawn, Substituted and Refiled March 27, 2013

Thomas Lee Brown, ... Petitioner,

v.

Peoplease Corporation and
ARCH Insurance Company c/o Gallagher
Bassett Services, Inc., ... Respondents.

APPENDIX

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Appellate Panel
Commissioner Derrick L. Williams
Commissioner Avery B. Wilkerson, Jr.
Commissioner T. Scott Beck

WCC File No. 0809238

Thomas Lee Brown, ... Appellant

v.

Peoplease Corporation and
ARCH Insurance Company c/o Gallagher
Bassett Services, Inc., ... Respondents.

FINAL BRIEF OF APPELLANT

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SC Court of Appeals

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STATEMENT OF ISSUES ON APPEAL

- I. BASED ON A REVIEW OF THE RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE IN THE RECORD AS A WHOLE, DID THE COMMISSION ERR AS A MATTER OF LAW BY NOT GRANTING THE APPELLANT LIFETIME MEDICAL CARE FOR THE PROBLEMS HE HAS WITH HIS LOW BACK? 7
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STATEMENT OF THE CASE

This matter was commenced with the filing of a Form 50 on July 13, 2010 in this accepted workers' compensation case wherein the Claimant (the Appellant in this Court) requested an award for permanent and total disability benefits with lifetime medical care for all problems related to that injury. (R. p. 23). After the filing of a responsive Form 51 by Peoplease/Bulldog Hiway Express denying that the Claimant was totally and permanently disabled and entitled to lifetime medical care (R. p. 25), this matter was set for hearing before the Honorable David W. Huffstetler on October 22, 2010. Pursuant to Commission Regulations and the Administrative Procedures Act, the Claimant filed his Pre-Hearing Brief, Notice of Witnesses, and APA Submissions on October 7th setting forth the issues for decision by the Commissioner and the documentary evidence that would be placed into the Record at the hearing in support of the Claimant's position. (R. p. 27). On October 12, 2010, the Defendants (the Respondents in this Court) filed their Pre-Hearing Brief and Notice of Witnesses and APA Submissions. (R. p. 169). Subsequently on October 14th, the Defendants filed an "Amended" Pre-Hearing Brief specifically listing Ms. Monica Reese as a witness and noting that wage information from similar

employees of Peoplease may be introduced concerning the average weekly wage and compensation rate issue. (R. p. 182). This matter was then heard by Commissioner Huffstetler on October 22, 2010, who issued his notes for Decision on October 25th and his Decision on November 23, 2010. (R. p. 385; p. 1). On December 6, 2010, the Claimant filed a Form 30 - Request for Review by the Full Commission. (R. p. 186). The Claimant submitted his Brief to the Full Commission on February 14, 2011 and after a responsive Brief was filed by the Defendants on March 1, 2011, a hearing was held on the Request for Review (erroneously referred to by many as an appeal hearing), on March 21, 2011. (R. p. 189; p. 203; p. 318). Subsequently the Judicial Director issued a Request for Proposed Order simply noting a Full Affirmation of the Hearing Commissioner's Decision by the Appellate Panel and requesting Defense Counsel to draft a proposed Order making Findings of Fact and Conclusions of Law consistent with that Finding. (R. p. 399). A proposed Order was submitted on May 27, 2011 and by letter dated June 3, 2011, Counsel for the Claimant/Appellant filed objection to the proposed Order on the basis that it went beyond the directions of the Commission and a renewed objection to any party writing

the Consensus Order of the Appellate Panel in any case. (R. p. 402; p. 410).

Subsequently, the Appellate Panel Decision as drafted by Defense Counsel was issued by the Commission Panel on June 29, 2011 and Notice of Intent to Appeal and Exceptions were filed with the Court on July 27, 2011 and this appeal follows. (R. p. 14; p. 208). The Claimant/Appellant then filed a Motion for Leave to Submit Additional Evidence pursuant to the S.C. Administrative Procedures Act and to stay the appeal pending in this Court pending a remand to the S.C. Workers' Compensation Commission for consideration of that additional evidence. (R. p. 219). By Order of the Honorable Daniel G. Pieper dated November 2, 2011, that Motion was denied on which there is no reconsideration pursuant to this Court's Rules and the briefing in this case then followed. (R. p. 12).

STATEMENT OF FACTS

Mr. Brown requested a Hearing for a determination that he was entitled to an award for total and permanent disability based on either or both that he had sustained a greater than 50% loss of use of his back; and/or based on his total loss of earning capacity. Subsequently when he filed his Pre-hearing Brief due to the fact that more than one (1) doctor had expressed the opinion that he needed

additional medical care before being determined at maximum medical improvement, he alternatively plead that while he had filed requesting an award for total and permanent disability that he would request either the additional medical care as recommended before an Award or a Decision that he was entitled to an Award for total and permanent disability with accompanying lifetime medical treatment to include the recommended medical care. (R. pp. 112-114; p. 116; pp. 119-120). In his Form 50 (Request for Hearing) and in his Pre-hearing Brief, Mr. Brown listed that he had sustained injuries and medical problems resulting from the accident to his neck/back/arm and head, and an aggravation of his pre-existing diabetic condition. (R. p. 27; p. 23).

After the hearing, the Hearing Commissioner awarded Mr. Brown total and permanent disability benefits on the basis that he had sustained a total and permanent loss of earning capacity under S.C. Code §42-9-10 and §42-1-120, and based on his total and permanent disability he was awarded lifetime causally related medical care for treatment of his cervical spine and diabetes. However, the Commissioner found as a fact in Findings in Fact #3:

"In reference to the award simply being based under §42-9-30 for the loss of use of the back, the case of McLeod v. Piggly Wiggly calls the back a much more complicated area of the body and calls for expert medical opinions in those

kinds of cases. There is no specific medical report that ties the lumbar problems to the injury at work." (Emphasis added). (R. p. 9).

Based on this finding the Hearing Commissioner did not award Mr. Brown lifetime medical care for his lower back.

Mr. Brown had also requested a review of the average weekly wage and resulting compensation rate and the Hearing Commissioner found that exceptional circumstances existed to determine the applicable average weekly wage and compensation rate. He determined that an average weekly wage of \$740.38 with a resulting compensation rate of \$493.84 should apply based mainly on the testimony of the defense witness, Ms. Monica Reese. In his notes requesting a proposed Order, the Commissioner wrote:

"Let's start with average weekly wage. Ms. Reese testified the top-end for truck drivers at Peoplease (**through Bulldog**) is \$38,500 per year. Average weekly wage looks to the future. If the past is a predictor of the future, then the Claimant would reach that level, as he earned more than that prior to his employment at Peoplease. There is no documentary evidence to support the Claimant's testimony of having been promised .50 cents per mile. He could not even identify who told him that. The documents on a co-worker are only for one employee. So, I accept the testimony from Ms. Reese and use that number to calculate the average weekly wage." (Emphasis added). (R. pp. 385 & 386; see also: pp. 2-5).

Mr. Brown had requested however that the average weekly wage be increased at least to \$887.55 with a

compensation rate of \$591.73; which is based on his full year of income from his employment with the company that he was with prior to going with Bulldog Hiway Express. He also argued that since the evidence established that his reason for changing work was that he could make more money, was closer to home and would be paid at a higher rate of pay per mile (.50/mile per his testimony, \$1.00/mile per company records) and since his income during his weeks with Bulldog showed an ever increasing rate of pay that based on this evidence at a minimum his average weekly wage should be \$795.90 with a resulting compensation rate of \$530.63; which is based on his income for 52 weeks prior to the injury - 36 weeks with his former employer and his ever increasing weekly income for 16 weeks with Bulldog. (R. pp. 160-168).

The Decision of the Hearing Commissioner finding the Claimant totally and permanently disabled and entitled to lifetime medical treatment for his neck and radicular symptoms and aggravation of diabetes has not been appealed and is the law of the case. Further the finding that the evidence establishes that exceptional circumstances exists for the determination of the average weekly wage and the resulting compensation rate and the compensation rate that was applied in this matter was not appealed. Thus, the

application of the law and the finding of exceptional circumstances have also become the law of the case and at a minimum the compensation rate as set out by the Commissioner is the law of the case.

The decision of the Commissioner in refusing to grant the Claimant lifetime benefits for treatment of his low back and the basis for that decision that, "there is no specific medical report that ties the lumbar problems to the injury at work," have been appealed. The facts that support an award of medical care for the low back and the fact that the Record contains no contrary evidence to support the Commission's denial of benefits are set out hereinafter under Argument I. Again, the decision by the Commission that as a matter of law exceptional circumstances exists has not been appealed. However, the Appellant did and is appealing whether the exceptional circumstances in the Record establish that an even higher compensation rate should have been applied.

ARGUMENTS

- I. BASED ON A REVIEW OF THE RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE IN THE RECORD AS A WHOLE, THE COMMISSION ERRED AS A MATTER OF LAW BY NOT GRANTING THE APPELLANT LIFETIME MEDICAL CARE FOR THE PROBLEMS HE HAS WITH HIS LOW BACK.

A review of the evidence establishes that the Hearing Commissioner inadvertently overlooked or disregarded all of

the undisputed evidence in the Record that the Appellant's low back problems were caused by and stemmed from the accident. The Appellant would simply ask the Court to review the Record and based on that review of the undisputed evidence amend the award as a matter of law to include lifetime medical care for his low back.

While it is axiomatic having been decided numerous times by this Court and the Supreme Court that any Court of an appellate nature reviewing a decision of the S.C. Workers' Compensation Commission may not substitute its judgment for that of the Agency concerning the weight of the evidence and that the Commission is the ultimate fact-finder and that the Commission's decision on the facts is conclusive if supported by the evidence, the test is whether the Decision of the Commission is supported by substantial evidence. As this Court and Supreme Court have repeatedly held, substantial evidence is not a mere scintilla of evidence nor is it evidence that may be viewed blindly from one side or the other, but it is evidence which considering the Record as a whole would allow reasonable minds to reach the same conclusion that the Administrative Agency reached in order to justify its decision. However, with that said, the Decision of the Commission may and should be reversed where the substantial

rights of the Claimant have been prejudiced because the administrative findings of the Workers' Compensation Commission are clearly erroneous in view of the substantial evidence on the Record as a whole. Mullinax v. Winn Dixie Stores, Inc., 318 S.C. 431, 458 S.E.2d 76 (S.C. App. 1995). Where the evidence is susceptible of but one reasonable inference or where there is an absence of evidence to support the decision of the Commission, the question becomes one of law for the Court rather than one of fact for the Commission and the Decision should be reversed. Massey v. W.R. Grace & Co., 286 S.C. 434, 334 S.E.2d 122 (1985); Grayson v. Carter Rhoad Furniture, 317 S.C. 306, 454 S.E.2d 320 (1995), affirmed as modified, 312 S.C. 250, 439 S.E.2d 859 (S.C. App. 1993).

Again, the substantial evidence in the Record in this case establishes that the Claimant's low back problems were caused by the accident. There is medical opinion evidence specifically finding and stating the low back problems are related. There is absolutely no evidence contrary to that in the Record and the Court should reverse the Decision as a matter of law and award Mr. Brown medical care for his low back.

The Court's review will show that following the accident, Mr. Brown initially was referred to and was seen

by Dr. Denise Algood and had to go to the Emergency Room at the Regional Medical Center on July 6, 2008, wherein the doctor recorded the mechanism of injury was,

"complaint occurred by vehicle",

and a history,

"pt (patient) was in mvc (motor vehicle accident) two months ago when he developed the pain. He does a lot of heavy lifting at work, which he believes has exacerbated the pain. . . . Also reports shooting pain down both legs with some numbness. . . ."

The doctor's final diagnosis was primary, "lumbar strain, sciatica". The treatment included medications, x-rays and on discharge Mr. Brown was referred to Dr. Abu-Ata (R. pp. 61-65).

The Appellant was then seen by Dr. Abu-Ata on July 10th and Dr. Abu-Ata's assessment was,

"This is a 58 year old male patient with history of neck and back trauma after a motor vehicle accident after which he is complaining of intermediate frequent neck and back pain in addition to bilateral arm and leg numbness, foot and hand numbness." (Emphasis added).

Based on his findings he had MRIs performed of both the cervical and lumbar spine for evaluation of the cervical and lumbar spine and disc especially since there was, "the history of back trauma". (R. p. 59; 69-70). When Dr. Abu-Ata received the results of the cervical spine MRI due to the severe condition of the Appellant's condition in that

area, he made an emergency referral to Dr. Scott Boyd, neurosurgeon, who recorded a history that,

"Mr. Brown is a very pleasant 58 year old truck driver who says that on May 2nd he was involved in a motor vehicle accident and shortly thereafter developed severe neck and back pain. He denies any previous problems with his neck or back. His greatest problem seems to be the neck which is radiating down to his arms bilaterally." (R. p. 95).

Due to the severe condition and problems that Mr. Brown was having with his cervical spine, Dr. Boyd immediately scheduled him for a three (3) level cervical spine fusion and on September 15, 2008 expressed the opinion that it was his opinion to a reasonable degree of medical certainty that the problems that he had with:

"his neck and back and his need for medical care either stem directly from the automobile accident on May 2, 2008 or the accident aggravated and caused to become symptomatic a pre-existing condition in his neck and back which resulted in need for medical care."

That opinion was expressed in reference to the problems that the Appellant had reported in his initial consultation with Dr. Boyd. (R. p. 90). After that, treatment was concentrated on treatment of Mr. Brown's cervical spine wherein he had to have not one (1) but two (2) separate cervical fusion surgeries and was placed on chronic pain medication to control the problems that he had with his neck. There was never any question that the treatment that

was needed for his back, separate and apart from his neck or that all the problems that he was having with his back in any area, were related to the automobile accident nor was any treatment ever not authorized. All of his medical care was paid for by the Respondents.

In addition, On April 4, 2009, Mr. Brown underwent an independent medical evaluation by Dr. Blake Moore who found that he had suffered injuries in the motor vehicle accident on May 2, 2008 and had ongoing problems with his back and neck at that time. Dr. Moore expressed the opinion that given the mechanism of the injury and the temporal relationship that the problems that he was having with his neck and back were related to the automobile accident and he expressed his opinion to a reasonable degree of medical certainty. (R. p. 112).

Also in preparation for his request for an award, Mr. Brown underwent an independent medical evaluation conducted by Dr. Leonard Forrest with the Southeastern Spine Institute who noted all of the treatment to the cervical spine and then noted that, "I do not see any studies to the lumbar spine." Dr. Forrest went on to state the following opinion:

"It is certainly most likely that Mr. Brown's ongoing symptoms including those in the neck and upper extremities as well as the low back

and lower extremities are the result of the automobile accident of May, 08. . . . Despite having a three level fusion, in my opinion further evaluation at this time is needed. Mr. Brown is not at maximum medical improvement. . . .

With regard to the back and related leg symptoms, this almost certainly seem to be related to the motor vehicle accident for the same reason as stated above, but has not been evaluated adequately at this point. It continues to be a problem for him. I would recommend a MRI and then he will most certainly need treatment for the back related component of his symptoms also." (R. p. 119).

As noted, all of the treatment in reference to the problems with his low back and legs has been authorized and paid for by the Respondents and the Appellant veribly believes that the Hearing Commissioner overlooked the opinions that were expressed in reference to the low back again because the major part of the medical care was directed towards the severe condition and the multiple surgeries that he had to have concerning his neck. The Appellant simply asks that the Court review the evidence and amend the Award to include lifetime medical care for his problems with his low back based on the undisputed evidence.

II. BASED ON THE EXCEPTIONAL CIRCUMSTANCES IN THE RECORD,
THE COMMISSION ERRED AS A MATTER OF LAW BY NOT RAISING
THE COMPENSTION RATE TO \$591.73.

The decision of the Hearing Commissioner as affirmed by the Commission finding that exceptional circumstances existed for a determination of the average weekly wage has not been appealed (and is the law of the case) nor do the Respondents contest the increased compensation rate applied by the Commissioner. The Appellant filed this limited appeal simply to request that the Commission and now this Court review the circumstances in the Record as a matter of law and under those circumstances increase the compensation rate to \$591.73 to compensate for his future lost earning capacity.

Whether or not, "exceptional circumstances" exist and the compensation rate they justify as defined in the Statute just as whether the facts constitute an injury by accident as defined in the Act is a matter of law for decision by the Courts. Booth v. Midland Trane Heating & Air Conditioning, 298 S.C. 251, 379 S.E.2d 730 (S.C. App. 1989) (holding that whether or not exceptional reasons existed under the facts is a matter of law for the Court. Sturkie v. Ballenger Corp., 268 S.C. 536, 235 S.E.2d 120 (1977) (holding that while the determination as to whether or not an accident occurred is for the Commission, a

determination as to whether or not those facts constitute an accident as defined in the Act is a matter of law for the Court.)

Under the Act and specifically S.C. Code §42-1-40, the objective of wage calculation is to arrive at a fair approximation of the injured worker's probable future earning capacity; his disability reaches into the future, not the past and that loss as a result of the injury must be thought of in terms of its impact on his or her probable future earnings. Sellers v. Pinedale Residential Center, 350 S.C. 183, 564 S.E.2d 694 (S.C. App. 2002). Also, as the Court stated in Sellers, the Workers' Compensation Statute that concerns the determination of an average weekly wage and resulting compensation rate sets forth different methods for calculating the injured worker's average weekly wage and provides, "an elasticity or flexibility with a view towards always achieving the ultimate objective of reflecting fairly a Claimant's probable future earning loss." As the Supreme Court stated in Stephenson v. Rice Services, Inc., 323 S.C. 113, 473 S.E.2d 699 (1996) and as restated by this Court in Pilgrim v. Eaton, 391 S.C. 38, 703 S.E.2d 241 (S.C. App. 2010), the overriding goal in a workers' compensation case under the Act is to compensate the injured worker for the reduction in his or her earning

capacity or earning power caused by the work-related injury.

Therefore, having found that exceptional reasons existed for increasing the claimant's average weekly wage, the Appellant would submit that the Commission erred by failing to apply the appropriate legal standard which our Appellate Courts have held is to be applied to that determination, that being to arrive at a fair approximation of what Mr. Brown's probable future earning capacity would have been, and not as the Commission did to determine just what his future earnings would have been with his employer. His disability will reach into the future, not into the past and his loss must be thought of in terms of its impact on probable future earnings and he is to be compensated for that loss to the extent possible under the Act. [In conjunction with this argument, the Appellant would ask the Court to rule on the submission of the documentary evidence that he sought to add to the Record in Argument #4 and consider/review the Hearing Commissioner's Decision and the impact of that evidence as to the basis for that Decision; i.e. reference to Appellant's failure to produce such documentary evidence in support of his testimony.]

The Record establishes that Mr. Brown had been employed by Boyd Brothers, where he made a lot more money

than with the Respondents. He testified that he left Boyd Brothers for several reasons: the first of which was to come off the road and be able to run more local routes; and the second was that he could make more money per mile according to what he was being told by the employer, Bulldog Hiway Express. Mr. Brown testified that he was told when he began work for Bulldog that he would make .50 cents per mile. He also produced documentary evidence concerning his claim in the form of paychecks with Bulldog which not only confirmed his testimony but further established that he was paid as much as a \$1.00/mile. (R. pp. 160-163). The Respondents presented the testimony of Ms. Monica Reese concerning the rate of pay and the average weekly wage of people that worked for Bulldog but nothing contrary to his testimony on earning capacity. (R. p. 356, ll. 13-25; p. 362, ll. 4-22).

In his Findings of Fact concerning the average weekly wage and applicable compensation rate, there is actually no evidence set out. However, in the Statement of the Case the Hearing Commissioner noted Mr. Brown's testimony concerning one of the reasons for taking the job with Bulldog, that being that he would make .50 cents per mile. However concerning that testimony the Commissioner noted

that, "he did not produce any witness to that effect nor did he produce any documentation to that effect." (R. p. 4).

He then noted that Ms. Reese disagreed with the mileage rate and testified that the drivers for Bulldog, "did not make .50 cents per mile" and then testified as to the maximum rate at which they were paid. However, no documentary evidence was put in to support her testimony.

After noting again that there was no documentation "to support the Claimant's testimony of being promised .50 cents per mile nor did he identify the exact person that told him that", and after noting that he had considered the evidence presented by the Claimant, "concerning his past wages" and how much more he had made before working for Bulldog, the Commissioner then based his decision on Ms. Reese's unsupported testimony concerning what an employee and top producer would make considering all the employees. He established the average weekly wage and raised the compensation rate to what he would have made as a top producer for the employer.

Mr. Brown had testified that when he left Boyd Brothers that he was being paid approximately .39 cents per mile and that Bulldog was offering him .50 cents per mile and that that was going to increase his pay. (R. p. 335,

11. 16-19). Also, in support of his claim, Mr. Brown submitted various paychecks from his employer. (R. pp. 160-162). Those paychecks were admitted without objection and showed that Bulldog was paying Mr. Brown \$1.00 per mile. On the paycheck found at p. 126, the Appellant was paid for 474.2500 miles at the rate of \$1.00 per mile for a total of \$474.25. On the paycheck (R. p. 162), the Appellant was paid for 368 miles at \$1.00 per mile for a total of \$368.00 and on the other paycheck (R. p. 160), the Appellant was paid for 177.5 miles at \$1.00 per mile for a total of \$177.50. Obviously, this supports the Appellant's testimony that he was to be paid .50 cents or more per mile and that is one of the reasons he went to Bulldog, Inc. There is no contradictory documentary evidence in the Record on the mileage rate. The Record contained evidence of his far higher income at Boyd Brothers and that based on his prior income, his average weekly wage was \$887.55 with a resulting compensation rate of \$591.73.

On the attachment to Appellant's Pre-Hearing Brief concerning the average weekly wage and compensation rate, he set out a detailed analysis of the evidence that would be and was presented and the basis upon which he would request that the Commission find exceptional reasons and increase the compensation rate. (R. p. 28). The

Respondents' initial Pre-Hearing Brief filed on October 12th, ten (10) days before the hearing, only referenced the average weekly wage and compensation rate as reflected on the Commission Form 20 and there is absolutely nothing further concerning the average weekly wage or compensation rate. (R. pp. 169 & 22). Then on October 14th, eight (8) days before the hearing, the Respondents' Pre-Hearing Brief was amended to include the name of Ms. Monica Reese as a representative who may testify for the Respondents and to note that, "wage information from similar employees of Peoplease may be introduced regarding the average weekly wage and compensation rate." However, there is absolutely nothing in that amended Pre-Hearing Brief to place the Appellant on notice that the fact that he would be paid .50 per mile would be challenged. There was nothing to notify him that he needed to submit any additional documentary evidence to support his testimony in that regard.

There is no question that the Hearing Commissioner based his decision in part on the failure of the Appellant to provide documentary evidence to support his testimony, (it is interesting to note that he didn't require Ms. Reese or refer to the fact that she did not submit any supporting documentation in support of her testimony), and while stating that he took into consideration the Appellant's

excellent past work history and the far greater amount of income that he made with Boyd Brothers, which he did not project into the future as is required by our Appellate Court decisions, the Commissioner only raised the compensation rate to what Mr. Brown would have made with the Respondent Employer. He did not establish or address what his loss of earning capacity was in the future. Under the circumstances in the Record and specifically his income with Boyd Brothers the Commission erred as a matter of law by not applying the correct legal standard and establishing his future loss of earning capacity which at a minimum was \$887.55 with a resulting compensation rate at a minimum of \$591.73.

III. THE COMMISSION ERRED AS A MATTER OF LAW BY NOT PERFORMING ITS JUDICIAL AND ADMINISTRATIVE FUNCTION BY WRITING ITS APPELLATE PANEL ORDER AND MAKING ITS OWN FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION AND INSTEAD ALLOWING A PARTY TO WRITE THE ORDER AND MAKE FINDINGS, CONCLUSIONS AND A DECISION FOR THE COMMISSION.

On April 4, 2011, Judicial Director Virginia L. Crocker issued a document entitled, "SC Workers' Compensation Commission, Request for proposed Decision and Order", noting that the Panel had reached a decision and requested Counsel for the Defendants, to, "please prepare a proposed Order and submit it to the Judicial Department within 30 days of this Notice." Thereafter Respondent's

Counsel submitted a proposed Order which went outside of the specific directions of the Commission and made detailed Findings of Fact and legal conclusions not contained anywhere in the Record of the Commission.

S.C. Code §42-17-40 and §42-17-50 require that in the decision of the Hearing Commissioner or the Commission, the Commission shall include, "a Statement of Facts, Rulings of Law and other matters pertinent to the questions at issue." Commission Review Regulation 67-709 implementing S.C. Code §42-17-50, in addition to generally requiring that the Commission make, "Findings of Fact or Conclusions of Law," specifically sets forth under Reg. 67-709(e)(2) that,

"The Commissioners together shall agree upon a modification if any and record their Findings of Fact and Conclusions of Law on a vote sheet." (Emphasis added).

It is clearly the intent of our Statutes and Regulations that the Commission whether it is reviewing a decision of a Hearing Commissioner or is making a decision upon remand from our Appellate Courts, is required to make its own Findings of Fact and Conclusions of Law as part of its Fact Finder and Administrative Judicial responsibilities.

In addition to the requirements set out in the workers' compensation statutes and the Commission's own Regulations, our S.C. Supreme Court held (as reaffirmed on

numerous occasions in its subsequent decisions), in the case of Drake v. Raybestos-Manhattan, Inc., 241 S.C. 116, 127 S.E.2d 288 (1962) that the,

"Duty to determine factual issues is solely on the Commission and the Courts have no authority to determine such issues except in jurisdictional matters, and such duty requires that not only must Findings of Fact be made upon essential factual issues but they must be sufficiently definite and detailed to enable the Appellate Court properly to determine whether the Findings of Fact are supported by the evidence and that the law has been properly applied to them." (Emphasis added).

Here again, the Court has specifically held that it is the responsibility of the Commission for the Commission to make its Findings of Fact and Conclusions of Law and to set those out in the Record in its Orders.

Further, in addition to the requirements of the Workers' Compensation Act, the Commission's own Regulations and our case law, the S.C. Administrative Procedures Act specifically requires under S.C. Code §1-23-340 and 350 that the Agency (the Workers' Compensation Commission; the Agency responsible for making decisions in workers' compensation matters), must make a final decision containing, "Findings of Fact and Conclusions of Law separately stated." S.C. Code §1-23-340 further provides that where the majority of the officials of an Agency, the Commissioners in this case, who render a Decision did not

hear the case that the parties should be given an opportunity to present briefs and oral arguments on the Exceptions or Finding of the Agency. That Section further and more importantly provides specifically that, "the proposal" for Decision, "shall contain a statement of the reasons therefore and of each issue of fact or law necessary to the proposed Decision, prepared by the person who conducted the hearing or one who has read the Record." (Emphasis added). There is no question that the Administrative Procedures Act, the Commission's Regulations and the statutes and our case law all contemplate that the Commission, especially in the appellate process shall prepare its own Order and make its own detailed Findings of Fact and its own Conclusions of Law. In this case, for the Commission Panel to state that it has made a decision and to tell the Respondent's Attorney to fill in the blanks as to what its Findings of Fact and Conclusions of Law are, is to abdicate the responsibility of the Commission to make and "prepare" its own specific Findings of Fact and Conclusions of Law and to deny Mr. Brown the most fundamental of due process requirements. (Emphasis added). For the Appellants' Counsel to be allowed to draft the Order for the Commission in this situation also prevents the Court, the Appellant or anyone else from being able to

have an understanding of the basis upon which the Commission made its Decision. The law does not contemplate a party setting forth the party's Findings of Fact and Conclusions of Law (the Respondent in this case), or that any party should be requested to draft an Order of an appellate nature, especially a multimember consensus Order, but instead contemplates the Commission making its decision and for the Appellate Courts reviewing it to know what the Agency's decision is and what the basis for that decision was from that review.

Finally, Appellants' counsel would submit that he knows of no situation involving any administrative or judicial appellate tribunal, and particularly a multimember tribunal requiring a consensus opinion, where a party is allowed to write the decision and make findings of fact and conclusions of law for the body. This process clearly abdicates the responsibility of the Commission and denies the Appellant due process of law especially in the appellate process involving a review of that decision. The decision of the Commission should be reversed based on this error of law.

IV. THE HONORABLE JUDGE DANIEL G. PIEPER ERRED AS A MATTER OF LAW BY DENYING THE APPELLANT'S MOTION FOR REMAND TO BE ALLOWED TO SUBMIT ADDITIONAL EVIDENCE PURSUANT TO S.C. CODE §1-23-380(3).

Judge Pieper in his Order on the Motion that the Appellant filed denied the Motion on the basis that the evidence Appellant sought to be admitted was not material and that the Appellant did not present any good reason for his failure to present the evidence during the hearing before the Single Commissioner and the Appellate Panel.

First, as to the basis as to whether or not this evidence is material, Judge Pieper either misunderstood or overlooked the fact that the Hearing Commissioner specifically noted and based his ruling not granting a higher average weekly wage and compensation rate on the fact that the Claimant's testimony that he was to be paid .50/mile was not supported by any documentary evidence. The Appellant would ask the Court for its insight and a decision on what evidence could be more relevant or material on that finding by the Commission than a document that actually sets forth evidence specifically supporting and confirming the Appellant's testimony which had been disregarded or discredited by the Commission for not having supporting evidence. The Appellant has no problem with meeting the standard applied by Judge Pieper and again

would submit to the Court clearly that a review of the evidence and the Decision of the Hearing Commissioner on this issue will clearly set forth why there cannot be any more material evidence than that which is sought to be admitted in this case.

Second, as to the Appellant's failure to present this evidence at the hearing before the Single Commissioner or the Appellate Panel as is set forth in Argument II, the Appellant in his Pre-Hearing Brief had set forth a very detailed explanation of the evidence that he would submit at the hearing on the issue of his request for an increase for exceptional reasons in the average weekly wage and resulting compensation rate. (R. p. 28). The Respondents' first Pre-Hearing Brief did not even mention the average weekly wage and resulting compensation rate issue. It was not until 7 days before the hearing that the Appellant was made aware that there was any contest whatsoever as to this issue. In that amended Pre-Hearing Brief filed by the Respondents, there is absolutely no mention that there would be any evidence put into the Record concerning any contest to the mileage rate. Therefore, there was absolutely no notice to the Appellant that his testimony in

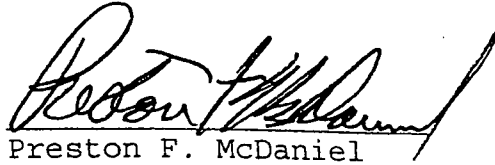
this regard would be challenged in any way or fashion. In fact, the Defendants did not, and the Appellant would like to reiterate, did not put in any documentary evidence contrary to that sought to be admitted as additional evidence. They in fact put in no documentary evidence on the mileage rate. The only thing that was submitted concerning the mileage rate was the unsupported testimony of Mr. Brown (which Mr. Brown would submit was actually supported), and the unsupported testimony of Ms. Reese about what Bulldog Peoplease drivers were paid. There is absolutely nothing in the Record to place the Appellant on notice that his veracity would be challenged or that he would need to support his credibility with documentation. Also as is set forth in the Motion, the Appellant did not know that the documentation that is sought to be admitted as additional evidence was in his possession at the time of the hearing. It was only later at a subsequent hearing in preparation for that hearing that he in fact found the card going through records concerning bills. The Appellant would ask the Court for a review on this basis and he believes the Court will find he has put forth valid and sufficient cause for having not produced this document or knowing that he needed to produce such a document at the hearing. Again, there is no question that the Hearing

Commissioner took exception with his testimony specifically because he did not have this document at the hearing. It would be very interesting to know what the Commissioner would say in reference to both Ms. Monica Reese's testimony and the Claimant's testimony had Mr. Brown happened to have had this card in his wallet that day and what the Commissioner would now say about the Claimant's testimony as compared to Ms. Reese's. At a minimum, the Appellant hopes that this Court will grant him the opportunity to submit that evidence to somebody and will overturn the Decision of Judge Pieper. As this Court knows, the Decision denying the Motion is not appealable and can only be addressed in this appeal in this fashion.

CONCLUSION

For all the foregoing reasons, the Appellant would request that the Court grant him lifetime medical benefits for his low back problems stemming from the accident and that the Court increase the compensation rate to that requested or remand this case to the Commission to take further evidence and apply the appropriate legal standard and to make a further ruling as to whether or not the compensation rate should be increased from that to which it was increased to \$591.79 or even greater based on the evidence submitted before the Commission.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Preston F. McDaniel", written over a horizontal line.

Preston F. McDaniel

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April 9, 2012

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS COMPENSATION COMMISSION

Appellate Panel

Commissioners: Derrick L. Williams, Avery B. Wilkerson Jr., T. Scott Beck

WCC File No. 08-0238

Thomas Lee Brown, Employee/Claimant,

Appellant,

Peoplease Corp., Employer, and
Aetna Insurance Company

s/o Gallagher Bassett Services, Inc.

Respondent.

FINAL BRIEF OF RESPONDENTS

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In support of Respondents

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STATEMENT OF ISSUES ON APPEAL

- I. Whether the Commission properly held that The Commission properly denied medical treatment for Claimant's lower back?
- II. Whether the Commission correctly held that Claimant's weekly compensation rate should be \$493.84?
- III. Whether the Commission committed error in the manner in which its Decision and Order was drafted?
- IV. Whether this Court did not err in denying Claimant's motion to submit additional evidence pursuant to S.C. Code 1-23-380(3)?

STATEMENT OF THE CASE

Appellant Thomas Brown ("Claimant") suffered a work-related injury on May 5, 2008 when a passenger vehicle drove under the truck he was driving, causing the truck to "jolt" when he put on the brakes. At the time of his accident, Claimant was employed by Peoplease Corp. to drive a truck for Bulldog Trucking (jointly referred to herein as "Bulldog/Peoplease"). Claimant had begun working for Bulldog/Peoplease a little over three months before his accident occurred.

Following his accident, Claimant was treated for pain in the cervical region of his neck/back, including two surgeries. (R. pp. 79-107, 115-116). In addition, following the accident Claimant's diabetes worsened to the point that he is now insulin dependent. (R. pp. 36-56) (R. p. 324, lines 2-7). These injuries have been admitted. Claimant's authorizing treating doctor is Dr. Scott Boyd and his family doctor, who treats his diabetes, is Dr. Algood. (R. p. 323, lines 19-24).

Claimant testified that he had been offered a pay rate of fifty-cents per mile by Bulldog; however, he could not identify who from Bulldog may have told him that. (R. p. 335, lines 11-19) (R. p. 363, lines 12-22). Although Claimant testified about his earnings through Bulldog, he acknowledged that he was actually paid by Peoplease. (R. p. 338, lines 9-13). He also testified that another reason he switched from his prior employer, Boyd Brothers, to Bulldog/Peoplease was that Bulldog/Peoplease was more local and would allow him more time at home. (R. p. 336, lines 5-6) (R. p. 340, line 20 – p. 341, line 21). In addition, he would not have to do as much heavy lifting/loading working for Bulldog/Peoplease as he did with Boyd Brothers. (R. p. 341, line 22 – p. 342, line 4).

Ms. Monica Reese, corporate counsel for Peoplelease, testified that she reviews every employment contract and completes the Form 20 for every workers' compensation claim. (R. p. 347, line 24 – p. 350, line 7). In this case, she reviewed the payroll of every driver who is in a similar position to Claimant, which included the payroll for about 60 drivers. She testified that, extrapolated out over a year, Claimant's wages would be approximately \$26,000 for the year, which is a fair average of what Peoplelease drivers working for Bulldog earn. (R. p. 350, lines 8-21) (R. p. 357, lines 1-10). The high end of salary that drivers in Claimant's class would earn is forty-two cents per mile, or approximately \$38,500 per year. (R. p. 356, lines 13-25) (R. p. 359, line 12 – p. 360, line 8 (explaining the category of similarly situated employees)). Specifically, Ms. Reese testified that Bulldog/Peoplelease does not pay any drivers in Claimant's classification more than forty-two cents per mile and that she did not know of anyone who would have told him he would make fifty cents per mile. (R. p. 362, lines 5-22).

Claimant was sixty years old at the time of the hearing before the Single Commissioner. (R. p. 323, lines 17-18).

A hearing was held before Single Commissioner David W. Huffstetler on October 22, 2010. Following the hearing, Commissioner Huffstetler requested that Claimant's counsel draft an order including several specified points and rulings. (R. p. 385). Although Claimant's counsel drafted an order, Commissioner Huffstetler made changes to that order so that it complied with his intended ruling. (Email from Kellie Lindler to Scott Garrett, Esq. and Preston F. McDaniel, Esq., dated November 23, 2010, R. p. 387 (forwarding message from Commissioner Huffstetler indicating he "made numerous changes to the proposed order"))).

Commissioner Huffstetler found that Claimant was permanently disabled as a result of the combination of the injury to his cervical spine and the aggravation of his diabetes, and awarded lifetime causally-related medical care for those two injuries. (Order and Award of the Single Commissioner, R. pp. 8-9, November 23, 2010 ("Single Commissioner Order")). He also ruled that exceptional circumstances exist for determining an average weekly wage compensation rate that is fair and reasonable to all parties concerned. (R. pp. 3, 8). Commissioner Huffstetler found that there was "no documentary evidence to support Claimant's testimony of having been promised 50 cents per mile," and Claimant "did not identify the exact person that told him that at the time of employment." (R. p. 4). Consequently, Commissioner Huffstetler accepted the testimony of Ms. Reese with respect to the determination of the average weekly wage issue. (R. pp. 4-5, 8-9). Finally, Commissioner Huffstetler found that the lumbar issues alleged by Claimant were not supported by substantial evidence in the record. (R. p. 9).

Claimant timely appealed to the Full Commission, arguing that Claimant should be entitled to lifetime medical care for his lower back and that his average weekly wage and compensation rate should be raised. The Full Commission heard oral argument on March 21, 2011 and issued its order on June 29, 2011 affirming the Single Commissioner's factual findings and conclusions of law. (Decision and Order of the Full Commission, R. pp. 18-21, dated June 20, 2011 ("Full 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, 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 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. 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). Furthermore, it is the Commission's prerogative to believe or disbelieve expert testimony. *See* Pack v. South Carolina Dept. of Transp., 381 S.C. 526, 536, 673 S.E.2d 461, 466-67 (Ct. App. 2009) (observing that the "Commission need not accept or believe medical or other expert testimony, even when it is unanimous, uncontroverted, or uncontroverted").

ARGUMENTS

I. The Commission properly denied medical treatment for Claimant's lower back.

The Commission did not award Claimant lifetime medical treatment for his lower back. (Full Commission Decision, p. 19). Relying on McLeod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 471, 313 S.E.2d 38, 41 (Ct. App. 1984), holding that the back is "a much more complicated area of the body," which requires expert medical opinions, the Full Commission affirmed the Single Commissioner's determination that Claimant failed to carry his burden of proving a causal link between his work-related accident and any lower back symptoms he might be experiencing. In short, "[t]here is no specific medical report that ties the lumbar problems to the injury at work." (Full Commission Decision, R. p. 19) (Single Commissioner Order, R. p. 9).

Appellant argues that there is undisputed evidence in the record linking his lower back problems to his work-related accident. Appellant's arguments are misplaced. First,

the emergency room notes from July 6, 2008 that Claimant quotes, (App. Br. pp. 10-11), state quite clearly that, "History [was] obtained from patient." (R. p. 63). Thus, the statement that, "pt was in a MVC 2 months ago when he developed the pain," (R. p. 61), was *Claimant's* version of events as recorded by the emergency room staff. Clearly, a medical record merely recounting a history provided by Claimant does not constitute independent medical evidence establishing causation. While in certain circumstances, statements by a claimant at a hearing where he or she is subject to cross-examination might support such a causal link, such unsubstantiated statements by Claimant to a medical provider where there is no ability to test their veracity cannot establish causation.¹ Furthermore, although the emergency room notes indicate "Lower back pain after MVC," they also state, "Patient denies back pain." (R. p. 63). Thus, the evidence Claimant relies on is insufficient to establish causation and, at best, is internally inconsistent.

Second, Claimant notes that he was referred to Dr. Abu-Ata. (App. Br. p. 11). However, Dr. Mahmoud Abu-Ata treated Claimant solely for his cervical neck/back problems. Dr. Abu-Ata, relying again on Claimant's "description of his pain," ordered an MRI done of both Claimant's cervical and lumbar areas of his back. (R. pp. 69-70). Those tests were performed on July 25, 2008, (R. pp. 57-60), after which all of the

¹ In addition, the suggestion that Claimant "does a lot of heavy lifting at work," (R. p. 61), is contradicted by Claimant's own testimony that one of the reasons he took the job with Bulldog/Peoplease was that he would not have to do the loading and unloading which he had done when he worked for his prior employer, Boyd Brothers. (R. p. 341, line 29 – p. 342, line 4).

treatment provided to Claimant was to the cervical area. (R. pp. 67-68, 79-107, 115-116).²

Next, Claimant quotes extensively from Dr. Boyd's medical notes. (App. Br. pp. 11-12). Claimant points to medical records from Dr. Boyd that indicate he was treating Claimant for "back and neck pain," (R. p. 95), and in particular Dr. Boyd's checking of "yes" to the question, "Is it your opinion to a reasonable degree of medical certainty that the problems [Claimant] has with his neck and back and his need for medical care either stem directly from the automobile accident of May 2, 2008 or the accident aggravated and cause to become symptomatic a pre-existing conditions in his neck and back which resulted in the need for medical care?", (R. p. 90), as evidence supporting a causal link between Claimant's lower back pain and his job-related accident. However, other medical records reveal that Dr. Boyd used the terms "neck" and "back" interchangeably to refer to Claimant's cervical area. Dr. Brown advised Bulldog that, "Mr. Brown is having **back** surgery 09/02/08." (R. p. 93 (emphasis added)). The September 2, 2008 surgery, performed by Dr. Boyd, was an anterior cervical discectomy and fusion. (R. pp. 105-106). Thus, the fact that Dr. Boyd checked "yes" to a question framed by Claimant's attorney is inherently ambiguous. Claimant's counsel may have intended for the word "back" to refer to Claimant's lower back, but it is not how Dr. Boyd used the term in other medical records, so his meaning on this form is unclear at best. Because Dr. Boyd was only treating Claimant for his cervical problems and provided absolutely no treatment to Claimant's lower back, it is more likely that he was answering the

² Note that Claimant recounts that due to his severe cervical condition, he was "an emergency referral to Dr. Scott Boyd . . ." (App. Br. p. 11). There was no similar referral to deal with any lower back issues and no subsequent treatment.

questionnaire with regard to the cervical area of Claimant's back than that he was opining on an area he had never treated. (R. pp.79-107).

Similarly, it is unclear whether Dr. Blake Moore, who performed an independent medical review on April 4, 2009, was referring to the cervical or lumbar region of Claimant's back when he stated that there was a causal connection between Claimant's "back and neck pain," and his workplace incident. In any event, although Dr. Moore evaluated Claimant and reviewed his medical records, there would have been no medical records chronicling any treatment to the lumbar region for him to review, as there has been no medical treatment to Claimant's lower back. Furthermore, Dr. Moore's statement re causation again are based on the Claimant's "report" only, and certainly not on any medical treatment records in the file, as there were none. Thus, his comments and conclusions regarding Claimant's back are speculative because they are not based on medical records, and the Commission properly declined to credit them any weight. *See Pack*, 381 S.C. at 536, 673 S.E.2d at 466-67.

In fact, Claimant admits that Dr. Leonard E. Forrest stated in his September 15, 2010 medical evaluation that, "I do not see any studies of a lumbar spine." (App. Br. p. 13) (R. p. 119). Claimant then relies on Dr. Forrest's statements regarding the lumbar spine, despite acknowledging that there were no studies indicating the etiology of Claimant's lower back complaints – again, only statements made by Claimant himself. Furthermore, Dr. Forrest only stated that Claimant's lower back problems "**certainly** seemed to be related to the motor vehicle accident for the same reason as noted above, **but has not been evaluated adequately at this point.**" (R. p. 119) (emphasis added). First, this is not a statement to a reasonable medical degree of certainty. Second, Dr.

Forrest acknowledged that the lower back had not been adequately investigated. Therefore, even combined, the few medical references in the record to Claimant's lower back are insufficient to prove the causal link he bears the burden of proving. Thus, the Commission's statement that, "there is no specific medical report that ties the lumbar problems to the injury at work," is supported by substantial evidence in the record and should be upheld by this Court.

At the hearing, although invited by his counsel to state that his accident caused lower back problems, Claimant only stated only that the pain goes up and down but he could not pinpoint the origin of his back pain:

Q: And, then, but you also reported problems with your low back. What kind of problems are you having with your low back?

A: Well, that's been ongoing, **the pain it goes up and down my back.**

Q: Does some of it emanate from your low back, though, and does it start there?

A: Well, **it seems like it starts from the back of my neck and goes down** and then sometimes it varies also. It be coming up, it feels different all the time. **I really couldn't pinpoint in particular.**

(R. p. 334, line 16 – p. 335, line 1) (emphasis added). Thus, even Claimant was unable to definitively pinpoint the source or cause of his lower back pain.

In addition, contrary to Claimant's assertions that "treatment was [n]ever not authorized" for Claimant's back, and that "[a]ll of his medical care was paid for by the Respondents," (App. Br. pp. 12, 14), there simply has been no medical treatment to Claimant's back. Claimant testified that he has had absolutely no surgery or any medical treatment on his lower back. (R. p. 342, lines 17-23). Respondents have not refused to pay for treatment to Claimant's lower back precisely because there has not been any medical treatment for Claimant's lower back. The referral to Dr. Abu-Ata was for

treatment of his cervical pain, not for any lower back problems. All of the treatment authorized and paid for by Respondents has been to Claimant's neck and cervical injuries, which include the upper, or cervical, region of his back, and for his diabetes.

In the end, the Commission is given discretion to weigh and consider all the evidence, both lay and expert, when deciding whether causation has been established." Tiller v. National Health Care Ctr. of Sumter, 334 S.C. 333, 339-40, 513 S.E.2d 843, 846 (1999). As such, the Commission is entitled to believe all, part or none of a witness's testimony. Holcomb v. Dan River Mills/Woodside Div., 286 S.C. 223, 225, 333 S.E.2d 338, 340 (Ct. App. 1985). Concomitantly, once admitted, expert testimony is to be considered just like any other testimony. Tiller, 334 S.C. at 340, 513 S.E.2d at 846. The record is replete with evidence of treatment provided for Claimant's cervical injury and the aggravation of his diabetes. (R. pp. 36-56, 66-107). In contrast and as set forth above, the evidence of his lower back problems is tenuous, speculative, contradictory and unsupported by any treatment records. Thus, the Commission's findings of fact that Claimant suffered only a work-related cervical injury and aggravation of his underlying diabetic condition, and that "[t]here is no specific medical report that ties the lumbar problems to the injury at work," are supported by substantial evidence in the record and should be upheld by this Court.

II. The Commission correctly held that Claimant's weekly compensation rate should be \$493.84.

Section 42-1-40 provides "four alternative methods for the commission to use to calculate the average wage." Pilgrim v. Eaton, 391 S.C. 38, 44, 703 S.E.2d 241, 244 (Ct. App. 2010). The standard method of determining average weekly wages is to take the, "total wages paid for the last four quarters immediately preceding the quarter in which

the injury occurred . . . divided by fifty-two or by the actual number of weeks for which wages were paid, whichever is less.” S.C. Code Ann. § 42-1-40. The second and third methods provide two different methods to calculate the average weekly wage where employment prior to the injury was less than 52 weeks. Id. The fourth method is employed, “[w]hen for exceptional reasons the foregoing would be unfair, **either to the employer or employee**, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.” S.C. Code Ann. § 42-1-40 (emphasis added). Clearly, the method chosen must be fair to both the employer as well as the employee, and must be supported by substantial evidence in the record.

In this case, the Commission found that exceptional reasons exist under Section 42-1-40 for it to calculate Claimant’s average weekly wages. As a result, the Commission determined Claimant’s average weekly wage, not at the rate he was earning through Bulldog/Peoplease, nor at the rate he had made over the prior 52 weeks at both Boyd Brothers and Bulldog/Peoplease, nor at the wage he alleges he was promised by someone at Bulldog but, instead, at the top rate a driver in his class could ever earn with Bulldog/Peoplease. (Commission Decision, R. pp. 18-20) (Single Commissioner Order, R. pp. 3-5, 9-10).

The Commission did not apply an incorrect legal standard to its average weekly wage calculation, as is suggested by Claimant. It is accepted that, “the objective of wage calculation is to arrive at a fair approximation of the claimant’s probable future earning capacity,” because the disability “reaches into the future, not the past.” Sellers v. Pinedale Residential Ctr., 350 S.C. 183, 191, 564 S.E.2d 694, 698 (Ct. App. 2002). That

said, Claimant was 60 years old at the time of the hearing before the Single Commissioner, in contrast to the claimant in Sellers, who was sixteen years old when he was injured, and had realistic plans to become a master electrician like his father. 350 S.C. at 191-92, 564 S.E.2d at 698-99. Furthermore, the Commission did look to Claimant's future earning capacity with his employer. A printout of Claimant's actual weekly wages was admitted into evidence and shows Claimant's wages went up and down, varying from between \$700 per week to \$400 per week, but did not gradually increase over the time he worked for Bulldog/Peoplease. (R. p. 338, line 14 – p. 339, line 17) (R. p. 383). Ms. Reese testified that Claimant's average wage based on what he had earned during the time he worked for Employer extrapolated out to \$26,000 per year. Instead of using that figure to base his average weekly wage, the Commission looked to the future and assumed Claimant would eventually earn the highest amount a driver in his situation could earn at Employer to arrive at the average weekly wage of \$740.38, with a corresponding compensation rate of \$493.84. (Commission Decision, R. p. 19). Thus, the Commission did, in fact, take into account possible future earnings and wage increases when it calculated Claimant's average weekly wage.³

Here, there is no evidence supporting Claimant's alleged promise of a fifty-cents per mile wage other than his testimony, which is both unreliable⁴ and flatly contradicted by other testimony in the record. The Commission's factual finding as to Claimant's

³ Claimant inexplicably also takes the Commission to task for not basing his average weekly wage, at least in part, on "specifically his income with Boyd Brothers . . ." (App. Br. p. 22). Under the exceptional reasons provisions, the "statute provides an elasticity or flexibility with a view toward always achieving the ultimate objective of reflecting fairly a claimant's probably future earning loss." Sellers, 350 S.C. at 191, 564 S.E.2d at 698 (emphasis added). Thus, the Commission exercises discretion and flexibility in reaching an average weekly wage calculation that is fair to both the claimant and the employer. Despite Claimant's admonitions that this should be a "forward looking" calculation, he criticizes the Commission for not basing it, in part, on his past employment with Boyd Brothers.

⁴ As noted above, Claimant could not remember who at Bulldog told him he would make fifty cents per mil. (R. p. 335, lines 11-10) (R. p. 363, lines 12-22).

average weekly wage is supported by substantial evidence in the records. Ms. Reese testified that she reviews every employment contract with Bulldog/Peoplease and completes the Form 20 for every workers' compensation claim. (R. p. 347, line 24 – p. 350, line 7). In this case, she reviewed the payroll of every driver who is in a similar position to Claimant, which included the payroll for about 60 drivers. She testified that, extrapolated out over a year, Claimant's wages would be approximately \$26,000 for the year, which is a fair average of what Peoplease drivers working for Bulldog/Peoplease earn. (R. p. 350, lines 8-21) (R. p. 357, lines 1-10). The high end of salary that drivers in Claimant's situation would earn is forty-two cents per mile, or approximately \$38,500 per year. (R. p. 356, lines 13-25) (R. p. 359, line 12 – p. 360, line 8). Specifically, Ms. Reese testified that Peoplease does not pay any drivers in Claimant's classification more than forty-two cents per mile and that she did not know of anyone who would have told him he would make fifty cents per mile. (R. p. 362, lines 5-22).

Claimant makes much of the fact that, two days after Bulldog/Peoplease filed their Pre-Hearing Brief with the Commission listing witnesses and evidence, they filed an amended Pre-Hearing Brief naming Ms. Reese as a possible witness. Claimant complains that he was not notified that his assertion that he was promised a fifty-cents-per-mile wage would be challenged or that he would have to support his testimony with evidence. (App. Br. pp. 20-21). However, claimants generally must prove their entitlement to compensation and should be expected to present all of their evidence to the hearing commissioner. Regulation 67-612(J) provides that, “[a]ll available evidence and testimony shall be presented at the scheduled hearing or a party must move for an adjournment according to R. 67-613.” S.C. Code Regs. § 67-612(J). Claimant did not

move either for an adjournment or to have the record held open so that he could supplement it with substantiating evidence. Second, Respondents indicated that they were presenting a witness to testify on the average weekly wage and Form 20, so Claimant clearly knew there would be some dispute concerning average weekly wage. Finally, even if Claimant was caught unaware that a challenge would be made to his claim of being promised a fifty-cents-per-mile wage, the only evidence he presented at the hearing was that he “understood” that was what he would be paid, he but could not identify who told him that or who had hired him. (R. p. 363, lines 12-22). Such testimony is hardly reliable evidence on which the Commission could base a wage determination.

In addition, there is no evidence in the record that he was promised that he would earn fifty cents per mile. Despite his claims otherwise, the “documentary evidence” consisting of Claimant’s paystubs do not support his argument that he was told he would make fifty cents per mile OR that he was paid \$1.00 per mile. (App. Br. pp. 17-18). The paystubs appearing at R. pp. 160-162 are not entirely legible. However, what they do indicate is that the payment on the check was calculated at a “Rate” of \$1.00 for “Hours” of work. For instance, the June 27, 2008 paystub reflects 177.50 hours, not miles, paid at a rate of \$1.00 per hour. (R. p. 161). The February 1, 2008 paystub reflects 368 hours, not miles, paid at a rate of \$1.00 per hour. (R. p. 162). Thus Claimant’s argument that the record contains evidence showing he was paid at \$1.00 per mile is not supported by the evidence and should be disregarded.

In the end, the goal of the average weekly wage calculation is “to arrive at a fair approximation of the claimant’s probable future earning capacity,” Bennett v. Gary Smith

Builders, 271 S.C. 94, 98, 245 S.E.2d 129, 131 (1978), but not a windfall to the claimant. See, Brunson v. Wal-Mart Stores, Inc., 344 S.C. 107, 112, 542 S.E.2d 732, 734 (Ct. App. 2001) (holding that an average weekly wage based on dual employment status, when the claimant only intended to work two jobs for a short period of time, was “grossly unfair” to the employer). In this case, there is substantial evidence in the form of Ms. Reese’s testimony to support the Commission’s finding as to Claimant’s average weekly wage and, therefore, that finding should be upheld on appeal.

III. The Commission committed no error in the manner in which its Decision and Order was drafted.

Claimant correctly notes that the Full Commission requested that counsel for Employer draft a proposed Order and submit it to the Judicial Department of the Workers’ Compensation Commission. However, what Claimant fails to note is that the Commission also, “reserve[d] the right to modify and/or delete any or all portions of the submitted Decision and Order.” (R. pp. 399-400). Thus, the Commission plainly reserved the right to correct any errors or omissions in the orders submitted to it.⁵

Claimant’s assertion that the proposed order, “made detailed Findings of Fact and legal conclusions not contained anywhere in the Record of the Commission,” (App. Br. p. 22), is baseless. As can be seen by a simple comparison of the Single Commissioner Order and the Full Commission Decision, the findings of fact and conclusions of law are practically identical. (Single Commissioner Order, R. pp. 8-11) (Full Commission Decision, R. pp. 18-21).

Furthermore, there is no evidence that the Commission violated any of its statutory duties (under either the Workers’ Compensation Act or the Administrative

⁵ And, in fact, the Single Commissioner did just that – he revised the proposed order submitted to him by Claimant’s counsel. (R. p. 387).

Procedure Act) in issuing the Full Commission Decision in this case. Although Claimant cites S.C. Reg. 67-709.E(2), mandating that the Full Commission shall decide together whether to modify the Single Commissioner's findings of fact or conclusions of law, there is no evidence whatsoever in this record that the Commission did not do precisely that. The Commission Decision recites the history of the proceeding and notes that it has considered all the proffered testimony, all documentary evidence, "the Record on Appeal, the Commission's file and Appellate Briefs," and determined "that all of the Hearing Commissioner's Findings of Fact and Conclusions of Law are correct as stated." (Full Commission Decision, R. pp. 17-18). Not only did the Full Commission adopt the Single Commissioner's Findings of Fact and Conclusions of Law but, as noted above, its Decision restates those findings and conclusions almost verbatim. (Full Commission Decision, R. pp. 18-21). There is no evidence that the Commission did not completely fulfill its duty to determine the factual issues in this case, and to set them out in its Decision.⁶

The Commission's request for a proposed order did not direct counsel for Bulldog/Peoplease to "fill in the blanks as to what its Findings of Fact and Conclusions of Law are," as Claimant suggests. (App. Br. p. 25). Instead, the Commission's request advised that it found "a FULL AFFIRMATION of the Single Commissioner's Decision and Order." (R. pp. 399-400). In addition, the Commission's request directed counsel to "make sure the Appellate Panel Decision and Order recites the specific Findings of Fact and Rulings of Law of the Single Commissioner's Decision and Order," (R. p. 400),

⁶ For example, there is no evidence that a "majority of the officials" of the Full Commission hearing panel did not hear the case, as is suggested by Claimant. (See App. Br. p. 24) (Hr'g Tr. of Full Commission Hearing, Panel A, before Commissioners Beck, Williams and Wilkerson, on March 21, 2011, R. pp. 366-381).

which counsel did. Even if, solely for the sake of argument, counsel had misstated the Single Commissioner's factual findings or legal conclusions, the Full Commission clearly reserved its right to modify and/or delete any or all portions of the submitted Decision and Order." (R. p. 399). Therefore, there simply is no basis for Claimant's allegations that the Commission somehow abdicated its duty to make its own findings of fact and conclusions of law.

There are numerous cases where the Full Commission adopts the Single Commissioner's order, either verbatim or with modifications. There is nothing inherently wrong in the Commission doing so. *See, e.g., Trotter v. Trane Coil Fac.*, 393 S.C. 637, 644, 714 S.E.2d 289, 292 (2011) (noting that "the Commission unanimously upheld the commissioner's order and adopted the findings of fact and conclusions of law contained there in full"). Furthermore, because the Full Commission Decision contains all the specific findings of fact necessary to its legal conclusions, and those findings are sufficiently detailed to permit appellate review, it is not deficient in that respect. *See, e.g., Airco, Inc. v. Hollington*, 269 S.C. 152, 160, 236 S.E.2d 804, 808 (1977); *Nettles v. Spartanburg Sch. Dist. # 7*, 341 S.C. 580, 590, 535 S.E.2d 146, 151 (Ct. App. 2000).

Finally, despite having drafted the decision for the Single Commissioner, Claimant's counsel now alleges that such a process abdicates the Commission's responsibility and denies Claimant due process. Although Claimant apparently attempts to distinguish his drafting the Single Commissioner Order from the request to Bulldog/Peoplease's counsel to draft the Full Commission decision by limiting his complaint to "any administrative or judicial appellate tribunal, and particularly a multimember tribunal requiring a consensus opinion," it is a distinction without

difference. A decision by a judicial decision maker – whether a single commissioner, a single judge or a panel of the same – must comport with appropriate statutory standards, which the Full Commission Decision in this case does.

The Commission committed no error in requesting a party to submit a proposed order in this pursuant to its directive, and this Court should so hold.

IV. This Court did not err in denying Claimant's motion to submit additional evidence pursuant to S.C. Code 1-23-380(3).

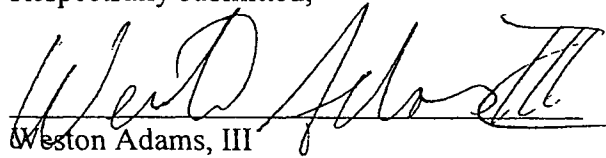
This Court properly denied Claimant's motion to submit evidence outside of the record considered by the Commission. Claimant made all the same arguments in his earlier Motion that he now raises in his Brief, (Claimant's Motion Pursuant to S.C. Code § 1-23-380(3) for leave to submit additional evidence and to Stay the Appeal Filed in this Matter Pending Further Hearing of the S.C. Workers' Compensation Commission, dated July 27, 2011, R. pp. 219-245), which this Court rejected. (Order, dated November 2, 2011, R. pp. 12-13). Claimant has already raised and argued this issue to this Court, and has been denied. He should not be allowed a second attempt at circumventing the Commission's evidentiary requirements set forth in S.C. Code Regs. §§ 67-612(J) and 67-707.

For all the reasons stated above and in Bulldog/Peoplease's opposition to Claimant's motion, (Respondents' Return in Opposition to Appellant's Motion for Leave to Submit Additional Evidence and to Stay the Appeal, August 4, 2011, with attachments, R. pp. 246-317), Bulldog/Peoplease submit that this Court should dismiss Claimant's argument on this point. In short, the evidence that the Claimant now wishes to admit is not material and Claimant has not presented any good reasons why he could not have presented this evidence during the hearing before the Single Commissioner.

CONCLUSION

For the reasons set forth herein, Appellants respectfully request that this Court affirm the Commission Decision in its entirety.

Respectfully submitted,



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March 28, 2012

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Appellate Panel
Commissioner Derrick L. Williams
Commissioner Avery B. Wilkerson, Jr.
Commissioner T. Scott Beck

WCC File No. 0809238

Thomas Lee Brown, ... Appellant,

v.

Peoplease Corporation and ARCH Insurance
Company c/o Gallagher Bassett Services, Inc., ... Respondents.

RECORD ON APPEAL

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ORDER AND AWARD

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0809238

THOMAS LEE BROWN,

Employee/Claimant,

v.

PEOPLELEASE CORP.,

Employer,

and

ARCH INSURANCE COMPANY c/o
GALLAGHER BASSETT SERVICES, INC.,

Carrier,

Defendant(s).

HEARING:

Date: October 22, 2010

Location: Walterboro, South Carolina

APPEARANCES:

Claimant represented by
Preston F. McDaniel, Esquire

Defendant(s) represented by
Scott B. Garrett, Esquire

PURPOSE OF HEARING:

This matter came before the Commissioner
on a Form 50 and 51

COMMISSIONER:

David W. Huffstetler

ELECTRONICALLY FILED:

November 23, 2010

STIPULATIONS

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

STATEMENT OF THE CASE

At the time for Hearing, pursuant to the Administrative Procedures Act and the Rules of this Commission, the parties have made records and reports from the following a part of the Record without objection: Dr. Denise Algood, Family Health Center; Orangeburg Regional Medical Center; Dr. Mahmoud Abu-Ata, Neurology & Pain Clinic; Dr. Scott Boyd, Columbia Neurosurgical Associates; Lexington Medical Center; Dr. Blake Moore; Dr. Brian Cuddy, Charleston Neurosurgical Associates; Dr. Leonard Forrest, Southeastern Spine Institute; Columbia Rehabilitation Clinic; Ms. Harriett Fowler, Vocational Expert; Claimant's Payroll and Tax Records; Social Security Disability Award; and Carolina Therapy Solutions. In addition, at the hearing various exhibits were offered and a ruling as to those exhibits is set forth in the Record; those exhibits that were admitted were considered and those exhibits which were excluded were not. Testimony was taken from the Claimant, Mr. Thomas Lee Brown, and Ms. Monica Reese for the Employer, Bulldog/Peoplease (hereinafter "Bulldog"), on the issue of the compensation rate.

First, as to the compensation rate, the evidence establishes

that the Claimant had only been working for Bulldog for a short period of time prior to the injury; a period of approximately 16 weeks. Due to the shortness of time with the employer, his income expectations and his immediate previous income as a truck driver, the Claimant took the position and asserted to the Commission that exceptional circumstances exists for the Commission to determine an average weekly wage and resulting compensation rate that is fair and reasonable to all parties. Based on my review of the evidence submitted, I agree with the position of the Claimant to the extent that exceptional circumstances exists for this Commission to determine an average weekly wage and resulting compensation rate that is fair and reasonable to all parties concerned. I also note for the Record that our Appellate Courts have ruled that the average weekly wage looks to the future. The Claimant submitted evidence which established that prior to going to work for Bulldog that he worked for Boyd Brothers Trucking throughout the entire year of 2007 and that, assuming he worked the entire 52 weeks during that year, based on his income as reported, on this W-2 he would have an average weekly wage of \$887.55 with a resulting compensation rate of \$591.73. He testified that the reason that he left Boyd Brothers to work with Bulldog was to have routes that were closer to home and because he would be making more money per mile. He testified that he was told when he began work for Bulldog that he

would make 50 cents per mile. However, he did not produce any witness to that effect nor did he produce any documentation to that effect. He also presented evidence and testimony to the effect that his weekly pay was ever increasing after he went to work with Bulldog. It was his intent to obtain more favorable runs as he continued his employment and that as you ran more favorable runs his salary would increase.

Ms. Monica Reese disagreed as to the mileage rate at which drivers were paid and testified that drivers did not make .50 cent per mile and then testified as to the range at which they were paid. She also testified that she had reviewed all the drivers salaries with Bulldog and that the top drivers were making \$38,500.00 per year. Based on this evidence, the average weekly wage determination looks to the future and assuming the past is a predictor of the future, then the Claimant would reach that level as he earned more than that prior to his employment with Bulldog. Therefore, there is no documentary evidence to support the Claimant's testimony of having been promised 50 cents per mile and he did not identify the exact person that told him that at the time of employment. The documents on a co-worker that was presented by the Employer is only for one (1) employee so I accept the testimony from Ms. Reese and the testimony and evidence presented by the Claimant concerning his past wages and have determined that a fair determination of the applicable

average weekly wage and resulting compensation rate is to calculate the average weekly wages based on the salary and income that a top producer for Bulldog would be making per year, or \$38,500.00 per year, which results in an average weekly wage of \$740.38 with a resulting compensation rate of \$493.84.

Next, in reference to the disability that the Claimant has suffered as a result of this injury, testimony was taken from the Claimant, and it appears based on a review of the testimony of the Claimant, the medical evidence, the physical therapist's functional capacity evaluation, and the vocational evaluation evidence, the evidence establishes that Mr. Brown is 60 years old and has a high school education. Following high school, he was in the Army, which is classified as a very heavy physical demand category under the DOT (Dictionary of Occupational Titles). After leaving the Army, he worked as a cook in both skilled and unskilled jobs until he went to work for Oakridge Associated Universities in Oakridge, Tennessee as a shipping and receiving clerk and truck driver. In 2000, after obtaining his commercial driver's license, he has worked as a truck driver from 2000 to 2008.

The Claimant testified that he could not return to any of the jobs in which he had a background and experience and that in his opinion he had lost over 60% of the use of his back to do work requiring the physical use of his back. He testified

extensively as to the problems that he is having from his injuries which include two (2) separate cervical spine fusions resulting in fusing his back from the C3-4 level through the C5-6 levels of the spine. Dr. Scott Boyd, the authorized treating physician, stated that the Claimant's cervical spine injury alone has a 27% whole person impairment under the AMA Guides and that he has been left with cervical myelopathy with resultant problems including coordination. His problems with coordination and gait stance are noted throughout the records and the evaluations of the various doctors involved. Dr. Boyd also opined that due to his cervical spine fusions and the results that in his opinion Mr. Brown cannot safely operate a truck; specifically including his range of motion problems and the cervical myelopathy with resultant problems of coordination. The Claimant confirmed and demonstrated that he cannot move particularly in one direction (range of motion), and actually has to have a person in the car to assist him in looking safely in that direction. He avoids any type of heavy traffic or complicated traffic situation due to that problem and only drives without somebody with him when absolutely necessary.

One of the functional capacity evaluations submitted addresses the opinion of the physical therapist as to the work category into which he most appropriately fits. In the opinion of that physical therapist Mr. Brown only qualifies for the full

range of jobs that fall in the sedentary work category under the Dictionary of Occupational Titles and does not fit into the category of either light duty or medium duty physical demand jobs.

In addition to the limitations that Mr. Brown has due to the injury to his neck, Mr. Brown, prior to the time of this accident, had been diagnosed with diabetes which was controlled simply taking oral medication. Since the accident and specifically after the surgeries, Mr. Brown has become an insulin dependent diabetic and is excluded from driving a truck or any commercial vehicle due to being insulin dependent. The authorized treating physician, Dr. Denise Algood, stated the opinion which is concurred in by Dr. Moore that Mr. Brown's diabetic condition was aggravated by the physical stress placed on Mr. Brown by his injuries and the surgery necessary to correct those injuries and that that aggravation of his diabetes has resulted in a heightened level of care wherein he became an insulin dependent diabetic. The Claimant testified concerning his diabetes and the treatment and the amounts of insulin and the number of times per day that he has to inject insulin at this time. Therefore, the undisputed evidence is that the injury and its aftermath aggravated his diabetic condition causing him to become an insulin dependent diabetic and causing all of the severe conditions and problems and treatment he has at this time

due to that condition.

In addition to the testimony concerning his physical limitations and his diabetic condition, the professional vocational opinion evidence that was submitted by and through Mr. Harriet Fowler, who opined the Claimant is unable to return to gainful employment. This opinion is not refuted by other expert opinions.

Wherefore, after review of the testimony and evidence submitted and as summarized above, I find that the Claimant has established by a preponderance of the evidence that he is permanently and totally disabled, based on the combination of his cervical injury and aggravation of his underlying diabetes.

FINDINGS OF FACT

1. That this is an admitted accident and that the only issues before this Commissioner are a determination of the disability award to which he is entitled as a result of his injuries sustained as a result of the accident and as to the average weekly wage and resulting compensation rate which will apply in this matter..

2. I find that exceptional circumstances exists to determine a fair and reasonable average weekly wage and resulting compensation rate for all parties involved and which will properly represent the Claimant's loss of earning capacity into the future. The average weekly wage of \$740.38 with a resulting

compensation rate of \$493.84 should apply.

3. That the Claimant has requested an award for total and permanent disability benefits based on either a total loss of earning capacity and/or for having lost more than 50% of the use of his back. In reference to an award simply being based under \$42-9-30 for the loss of use of the back, the case of McLeod v. Piggly Wiggly calls the back a much more complicated area of the body and calls for expert medical opinions in those kinds of cases. There is no specific medical report that ties the lumbar problems to the injury at work. The Claimant suffered a cervical injury with multi-level fusions and aggravation of his underlying diabetes.

4. That based upon the decision that the Claimant is totally and permanently disabled, he is entitled to lifetime causally-related medical care his cervical spine and diabetes.

5. That the Claimant is currently receiving weekly temporary total disability benefits. Based on the decision that the Claimant's condition is total and permanent and that he is entitled to an Award for such, the Claimant shall continue to receive weekly benefits at the compensation rate of \$493.84 per this Award until the balance of the 500 weeks of compensation is paid. A lump sum request was withdrawn by the Claimant at the time of the hearing. Such lump sum request may be renewed and decided by the Commission at a later date and is subject to

subsequent order of the Commission. The attorney's fees and costs in this matter may be requested and taken off the back end and paid in a lump sum.

6. That Mr. Brown was determined to have reached maximum medical improvement per the determination of Dr. Scott Boyd on April 19, 2010.

CONCLUSIONS OF LAW

Pursuant to S.C. Code §42-17-40, the following Conclusions of Law apply in this case.

1. That under §42-1-40, the determination is made as to the average weekly wage and resulting compensation rate.

2. That under §42-9-10 and §42-1-120, the determination is made as to the Claimant's entitlement to an award for total and permanent disability for total loss of earning capacity.

3. That under §42-15-60, the determination is made as to the Claimant's entitlement to medical care and based on the decision that he is entitled to an award for total and permanent disability, the Claimant is entitled to lifetime, causally-related medical care for his cervical spine and diabetes.

ORDER AND AWARD

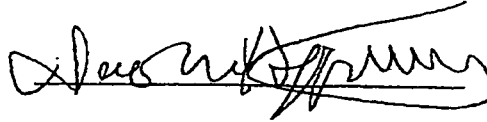
THEREFORE IT IS ORDERED that the Defense shall pay the Claimant benefits consistent with permanent and total disability.

IT IS FURTHER ORDERED that the Defense shall provide the

Claimant with lifetime, causally-related medical treatment for his cervical spine and diabetes.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

A handwritten signature in black ink, appearing to read 'David W. Huffstetler', written over a horizontal line.

David W. Huffstetler, Commissioner

CERTIFICATE OF SERVICE

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

November 23, 2010

By: Kellie Lindler, Administrative Assistant to Commissioner Huffstetler

The South Carolina Court of Appeals

Thomas Lee Brown,

Appellant,

v.

Peoplease Corporation and Arch
Insurance Company c/o Gallagher
Bassett Services Inc.,

Respondents.

Appellate Panel
South Carolina Workers' Compensation Commission
Trial Court Case No. 2011-WC-08-09238

ORDER

Appellant has filed a Motion for Leave, asking this Court to remand the case to the Appellate Panel for the submission of additional evidence pursuant to section 1-23-380 (3) of the South Carolina Code (Supp. 2010). Appellant asks this Court to hold this appeal in abeyance pending remand to and review by the Appellate Panel.

After careful consideration, we deny the motion. Section 1-23-380(3) permits this Court to grant leave for a moving party to present additional evidence before the Appellate Panel if the additional evidence is material and the moving party had good reasons for the failure to present it to the Appellate Panel. Evidence is material when a "logical or rational connection [exists] between the fact sought to be presented and a matter of fact" at issue in the case. Gause v. Livingston, 251 S.C. 8, 13, 159 S.E.2d 604, 607 (1968); see also Black's Law Dictionary 638 (9th Ed. 2009) (defining material evidence as "[e]vidence having some logical connection with

the facts of consequence or the issues"). This Court finds the additional evidence the Appellant seeks to present to the Appellate Panel is not material, and Appellant has presented no good reasons for his failure to present the evidence during the hearing before the single commissioner and the Appellate Panel. Appellant shall serve and file his Initial Brief and Designation of Matter within thirty days of the date of this order.

AND IT IS SO ORDERED.

Daniel G. Pieper J.

Columbia, South Carolina

FILED

cc: Preston F. McDaniel, Esquire
Scott B. Garrett, Esquire
Weston Adams, III, Esquire
Virginia Crocker, Judicial Director

APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 0809238

THOMAS LEE BROWN, EMPLOYEE,
CLAIMANT/APPELLANT,

vs.

PEOPLEASE CORPORATION, EMPLOYER,

AND

ARCH INSURANCE COMPANY c/o
GALLAGHER BASSETT SERVICES, INC., CARRIER,
DEFENDANTS/RESPONDENTS.

Appellate Panel Review held in
Columbia, South Carolina on March 21, 2011.

APPEARANCES: Claimant/Appellant represented by Preston F. McDaniel, Esquire
of Columbia, SC.

Defendants/Respondents represented by Scott B. Garrett, Esquire
of Columbia, SC.

STATEMENT OF THE CASE

This claim arises out of an admittedly compensable injury which occurred on May 2, 2008. The parties were heard by the Single Commissioner on October 22, 2010 in Walterboro, South Carolina on the Forms 50 and 51. The Claimant maintained that he was permanently and totally disabled as a result of the work-related accident. Specifically, the Claimant maintained that he sustained injuries to his cervical spine, lumbar spine, bilateral upper extremities, and an aggravation of his underlying diabetic condition in his capacity as a truck driver with the Employer. In addition, the Claimant also sought a determination for a deviation in the calculation of his average weekly wage.

The Defendants admit the Claimant sustained a compensable injury by accident arising out of and in the course of his employment on May 2, 2008 resulting in an injury to his cervical spine with an aggravation to the Claimant's underlying diabetic condition. The Defendants denied that the Claimant sustained injuries to the lumbar spine or bilateral upper extremities, and that the Claimant was not entitled to an award of permanent and total disability benefits on the basis that the medical records do not support such a finding. Both parties agreed that the Claimant reached maximum medical improvement on September 28, 2010.

In an Order dated November 23, 2010, the Single Commissioner determined that the Claimant sustained a compensable injury to his cervical spine with aggravation of his underlying diabetic condition. The Single Commissioner further ordered that the Claimant is entitled to an award of permanent and total disability with lifetime, causally-related medical care as a result of loss of earning capacity pursuant to Section 42-9-10 and Section 42-9-120 of the Act. The Single Commissioner further determined that the

Claimant's average weekly wage is \$740.38 with a corresponding compensation rate of \$493.84.

In reaching his Order, the Single Commissioner found and ruled as follows:

IT IS HEREBY ORDERED that the Defendants shall pay the Claimant benefits consistent with permanent and total disability.

IT IS FURTHER ORDERED that the Defendants shall provide the Claimant with lifetime, causally-related medical treatment for his cervical spine and diabetes.

Within the statutory period, counsel for the Claimant filed an Application for Review in this case setting forth his reasons, copies of which were furnished to all interested parties prior to the scheduled oral argument presented before the Appellate Panel on March 21, 2011.

By appeal, Claimant respectfully submitted the Hearing Commissioner erred in the following:

1. That the Hearing Commissioner erred by not specifically awarding the Claimant lifetime medical care for his low back and legs where the undisputed facts are that the Defendants did not contest that the Claimant has sustained injury to and/or which affected his low back and legs and where the uncontested medical evidence from the authorized treating physicians establishes that from the date of the accident forward he was treated for problems with his low back and legs and where those and other doctors stated the opinions that these injuries and need for treatment to these body parts stemmed from the work-related automobile accident.

2. That the Hearing Commissioner erred as a matter of law by failing to designate the previously authorized treating physicians as the physicians to continue to provide treatment at least until such time as the Defendants specifically designate and/or provide medical care through physicians of their choice for his continuing problems under the award of lifetime medical benefits to effect a cure or provide relief from the Claimant's disabling symptoms stemming from the accident.

3. That the Claimant requests a review by the Commission on the specific and limited issue as to whether or not the average weekly wage and resulting compensation rate as awarded by the Commissioner should be further raised to an average weekly wage of \$887.55 with a resulting compensation rate of \$591.73, which is based on the uncontested evidence of a full year of employment with his previous employer prior to the Claimant coming to work with the Employer and further based on the pay stubs that were submitted into the record which supports the testimony of the Claimant that he was to make at least \$.50/mile and is contrary to the testimony of the Employer representative that the maximum rate was \$.38/mile wherein those pay stubs reflect that he was to be paid \$1.00/mile, specifically as set out on pages 125, 126 and 127 of the Claimant's APA submissions.

All proffered testimony has been taken. Such, together with all documentary evidence, has been delivered to the individual members of the Appellate Panel and have since been under study and consideration.

In the Appellate Review, the Appellate Panel shall, pursuant to S.C. Code Ann. §42-17-50 (1989), review the award, weigh the evidence as presented at the initial

hearing, and, if good grounds be shown therefore, make its own findings of fact and reach its own conclusions of law consistent with or inconsistent with those of the Hearing Commissioner.

Thus, the Appellant and Respondents were present for oral argument on March 21, 2011 before the Appellate Panel. Therefore, based upon all submitted documentary evidence, the Record on Appeal, the Commission's file and Appellate Briefs, the Appellate Panel, by and through its statutory and inherent power, entered into its decision pursuant to S.C. Code Ann. §42-17-50. After careful review of the instant case, the Commission, by unanimous vote, has determined that all of the Hearing Commissioner's Findings of Fact and Conclusions of Law are correct as stated. Accordingly, the Appellate Panel has stated that the following Findings of Fact and Conclusions of Law shall become the law of the case and, therefore, the Decision and Order of the Hearing Commissioner is **AFFIRMED** in its entirety.

FINDINGS OF FACT

After hearing able arguments from counsel for the parties, a reading of the parties' respective Motions and Responses and Briefs, and a thorough analysis of the applicable statutes and regulations, the Appellate Panel concludes that Commissioner Huffstetler's Findings and Conclusions in his Order dated November 23, 2010, are correct as stated. Specifically, we the Appellate Panel find the following as fact:

1. That this is an admitted accident and that the only issues before this Appellate Panel are a determination of the disability award to which the Claimant is entitled as a result of his injuries sustained as a result of the accident and as to the average weekly wage and resulting compensation rate which will apply in this matter.

2. We find that exceptional circumstances exist to determine a fair and reasonable average weekly wage and resulting compensation rate for all parties involved and which will properly represent the Claimant's loss of earning capacity into the future. The average weekly wage of \$740.38 with a resulting compensation rate of \$493.84 should apply.

3. That the Claimant has requested an award for total and permanent disability benefits based on either a total loss of earning capacity and/or for having lost more than 50% of the use of his back. In reference to an award simply being based under Section 42-9-30 of the Act for loss of use of the back, the case of McLeod v. Piggly Wiggly calls the back a much more complicated area of the body and calls for expert medical opinions in those kinds of cases. There is no specific medical report that ties the lumbar problems to the injury at work. The Claimant suffered a cervical injury with multi-level fusions and aggravation of his underlying diabetic condition.

4. That, based upon the decision that the Claimant is totally and permanently disabled, he is entitled to lifetime, causally-related medical care to his cervical spine and diabetes.

5. That the Claimant is currently receiving weekly temporary total disability benefits. Based on the decision that the Claimant's condition is total and permanent and that he is entitled to an award for such, the Claimant shall continue to receive weekly benefits at the compensation rate of \$493.84 per this award until the balance of the 500 weeks of compensation is paid. A lump sum request was withdrawn by the Claimant at the time of the hearing. Such lump sum request may be renewed and decided by the Commission at a later date and is subject to subsequent Order of the Commission. The

attorney's fees and costs in this matter may be requested and taken off the back end and paid in a lump sum.

6. That the Claimant was determined to have reached maximum medical improvement per the determination by Dr. Scott Boyd on April 19, 2010.

CONCLUSIONS OF LAW

In view of these Findings of Fact, and as provided in the South Carolina Code of Laws, we the Appellate Panel conclude the following as matters of law:

1. That under Section 42-1-40, the determination is made as to the average weekly wage and resulting compensation rate.

2. That under Section 42-9-10 and Section 42-1-120, the determination is made as to the Claimant's entitlement to an award for total and permanent disability for total loss of earning capacity.

3. That under Section 42-15-60, the determination is made as to the Claimant's entitlement to medical care and, based on the decision that he is entitled to an award for total and permanent disability, the Claimant is entitled to lifetime, causally-related medical care for his cervical spine and diabetic condition.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Appellate Panel hereby **ORDERS, ADJUDGES AND DECREES:**

IT IS HEREBY ORDERED that the Defendants shall pay the Claimant benefits consistent with permanent and total disability.

IT IS FURTHER ORDERED that the Defendants shall provide the Claimant with lifetime, causally-related medical treatment for his cervical spine and diabetic condition.

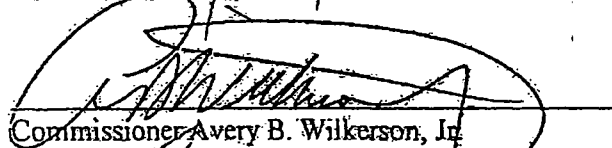
AND IT IS SO ORDERED.

The Hearing Commissioner's Order is **AFFIRMED IN FULL** by the Appellate Panel of the South Carolina Workers' Compensation Commission.

S.C. WORKERS' COMPENSATION COMMISSION



Commissioner Derrick L. Williams



Commissioner Avery B. Wilkerson, Jr.



Commissioner T. Scott Beck

CERTIFICATE OF SERVICE

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

By Valerie Deller on June 29, 2011

Preston F. McDaniel
Scott B. Garrett
Clyde C. Dean Jr

Margy Sowell League
Latonya Edwards

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

File # _____
Carrier File # 003289-000282-wc-01
Carrier Code # 170
Employer FEIN 43-0991710

THOMAS BROWN				PEOPLELEASE CORPORATION			
Claimant's Name		SSN		Employer's Name			
				3390 BUFFALO AVE N. CHARLESTON, SC 29418			
Address	City	State	Zip	Address	City	State	Zip
Home Phone #		Work Phone #:		GALLAGHER BASSETT SERVICES			
		SANDRIA EARLES		Insurance Carrier		803 547-8038	
		Preparer's Name		Phone #			

A. Total Wages Paid

1. Check Applicable Method: Date of injury: 05/02/08
- ☐ Report of earnings of injured employee based on four completed quarters.
- ☒ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
- ☐ Report of earnings of similar employee: Injured employee did not work sufficient time before alleged injury. Hire Date: _____
- ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)
2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.
- | Quarter | Ending Date | Total Wages Paid | |
|---------|-------------|------------------|-------------------------------|
| 1st | 4/5/08 | 7,395.50 | |
| 2nd | 4/26/08 | 2,039.50 | |
| 3rd | | | |
| 4th | | | |
| | | | Total Paid 2. <u>9,435.00</u> |
3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. 0.00
4. Add lines 2 and 3. TOTAL WAGES PAID: 4. 9,435.00
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 16

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5). AVERAGE WEEKLY WAGE: 6. 589.69

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. 393.14
8. The compensation rate is as follows (choose one):
- ☐ When average weekly wage (line 6) is less than \$75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8;
- ☐ When the estimated compensation rate (line 7) is less than \$75.00 and average weekly wage (line 6) is more than \$75.00, the compensation rate is \$75.00. Enter \$75.00 on line 8.
- ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
- ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8: _____
- ☒ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. 393.14

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

Claimant's Name: Thomas Brown SSN: _____ Employer's Name: Bulldog Hiway Express d/b/a Peoplease Corp.
Address: _____ Address: Post Office Box 40247
City: _____ State: _____ Zip: _____ City: Charleston State: SC Zip: 29423
Home Phone: _____ Work Phone: _____ Insurance Carrier: Arch Insurance Company
Preparer's Name: Preston F. McDaniel Law Firm: McDaniel Law Firm Preparer's Phone #: 803-771-7211

Complete each information blank. To request a hearing, check box 13b, indicate the kinds of benefits claimed by checking the box(es) at line 6, 7, 8, and 9 and file this form in duplicate.

A claim for worker's compensation benefits is made based on the following grounds: Date of Injury or Illness: 5-2-08
☒ Injury ☐ Illness ☐ Repetitive Trauma

- 1a. The claimant sustained an injury to neck/back (Part(s) of Body Injured) on 5-2-08 (Month/Day/Year) in Colleton county, state of South Carolin
1b. Body part(s) affected are: neck/back/arm/head
Briefly describe how the accident occurred: Claimant was driving southbound on I-95 when another vehicle collided with is truck causing injury to his neck/back; accepted claim.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the Employer on 5-2-08 (Month/Day/Year) in the following manner:
Verbally reported over the telephone to Jerry & John, Safety Manager; accepted claim
☒ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for: _____
☒ (b) additional medical examination and treatment for: continuing neck/back/arm pain; lifetime medical care
☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: Claimant is currently receiving weekly TT benefits and would ask that those continue until claim is resolved or an Order of the Commission is issued on this issue.
☒ 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one):
☒ (1) General Disability: ☒ Total ☐ (2) Specific Disability: ☒ Total
☒ (3) Wage Loss ☒ Partial ☐ Partial
☐ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of: _____
10a. At the time of injury, the claimant was paid weekly wages of \$589.69, and demands accounting of days worked and wages earned as provided by law.
10b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident Same Employer
11a. Further grounds or unusual aspects of claim: Any and all other benefits applicable under the Act; Lifetime medical care.
11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident: Family Health Center, Orangeburg, SC; Orangeburg Regional Medical Center, Orangeburg, SC; Dr. Mohammed Alhatou, Orangeburg, SC; Dr. Boyd, Columbia Neurosurgical Associates, West Columbia, SC; Lexington Medical Center, West Columbia, SC; Dr. Blake Moore, Columbia, SC; Dr. Sweet, USC Specialty Clinics, Columbia, SC; Dr. Brian Cuddy, Charleston Neurosurgical Assoc., Charleston, SC; and Carolina Therapy Solutions, Columbia, SC
11c. To the best of your knowledge, did you have any prior permanent disability? None aware of, but subject to amendment upon further investigation.
If yes, describe: _____
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
☐ 13a. I am filing a claim. I am not requesting a hearing at this time.
☒ 13b. I am requesting a hearing. A \$25 fee is required.
14. Estimated time needed for hearing: 1 hour

I verify the contents of this form are accurate and true to the best of my knowledge.

Preston F. McDaniel
Preparer's Signature

Attorney for Claimant
Title

mcdaniellaw@hotmail.com
Email

July 13, 2010
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission Claims Department.



ATTORNEYS AT LAW

Reply To
SCOTT B. GARRETT
Direct Dial: (803) 227-2224
sgarrett@mgclaw.com
COLUMBIA

July 16, 2010

VIA HAND DELIVERY

Virginia Crocker, Judicial Director
S. C. WORKERS' COMPENSATION COMMISSION
1333 Main Street, Suite 500
Columbia, South Carolina 29201

RE: Thomas Brown v. Peoplease Corporation/ Bulldog Highway Express and Arch Insurance
Company c/o Gallagher Bassett Services, Inc.
Date of Accident: May 2, 2008
WCC File No.: 0809238
Our File No.: 2098.08421
Claim No.: 003289-000282-WC-01

Dear Ms. Crocker:

This firm has been retained to represent the employer and carrier in the matter referenced above. Please find enclosed the Form 51 on behalf of the employer and carrier in the above matter for filing in your office.

By copy of this letter, we are serving a copy of the Form 51 on the Claimant's attorney, Preston F. McDaniel, Esquire.

Very truly yours,

Scott B. Garrett

SBG/jjp

Enclosures

cc: Phillip S. Federigos, Esquire, Barnwell Whaley Patterson & Helms, LLC
Tara Potter, Gallagher Bassett Services, Inc. (via email only)
Monica L. Reese, Peoplease Corporation

SC Workers' Compensation Commission

333 Main Street, suite 500 • Post Office Box 1715
 Columbia, South Carolina 29202-1715
 803)737-5723



WCC File #: 0809238

Carrier File #: 003289-000282-WC-01

Carrier Code #: 170

Employer FEIN #: 43-0991710

Thomas Lee Brown

Claimant's Name SSN

Address City State Zip

(803) 873-5949

Home Phone #

Scott B. Garrett

Preparer's Name

Work Phone #

McAngus Goudelock & Courie

Law Firm

Peoplease Corporation

Employer's Name

210 Wingo Way, Suite 400

Mount Pleasant, South Carolina 29464

Address City State Zip

Arch Insurance Company c/o Gallagher Bassett Services, Inc.

Insurance Carrier

(803) 227-2224

Phone Number

Date of Accident: 5/2/08

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.
 The employer-insurance carrier in answer to the claim, respectfully shows:

1. It is **admitted** that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: _____
2. It is **admitted** that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: _____
3. It is **admitted** that the relationship of employer and employee existed at the time in question. The reasons for denial are: _____
4. It is **admitted** that at the time in question the employee was performing service growing out of and incidental to employment. The reasons for denial are: _____
5. It is **admitted** that notice of injury was given to the employer. The reasons for denial are: _____
6. It is **denied** that the employee needs/is entitled to additional medical care as a result of the injury. The reasons for denial are: _____
7. It is **denied** that the employee is entitled to temporary total disability for the period(s) of: _____
8. It is **denied** that the employee is permanently disabled. The reasons for denial are: _____
9. It is **denied** that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of **\$589.69** applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: _____
12. Estimated time needed for hearing: 1 hour

I certify that I have served this document pursuant to R.67-211 by delivering a copy to:

Preston F. McDaniel, Esquire
 The McDaniel Law Firm
 1315 Elmwood Avenue
 Columbia, South Carolina 29201

on the 16th day of July, 2010 by ☒ first class mail; ☐ personal service; ☐ certified mail.

I verify the contents of this form are accurate and true to the best of my knowledge.

G. Muriel George
 Preparer's Signature

Attorney for Employer/Carrier
 Title

sgarrett@mcclaw.com
 Email

July 16, 2010
 Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

WCC Form # 51 Revised 9/07

51**Employer's Answer to Request for Hearing**

McDANIEL LAW FIRM
ATTORNEYS AND COUNSELORS AT LAW
1315 ELMWOOD AVENUE
COLUMBIA, SOUTH CAROLINA 29201

Proudly representing injured workers
for over 25 years.

Preston F. McDaniel
OF COUNSEL:
Daniel E. Peagler, P.C.
Michael Johnson, P.C.

Telephone (803) 771-7211

Facsimile (803) 252-0709

October 7, 2010

Commissioner David W. Huffstetler
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

RE: Thomas Brown v. Peoplelease Corp.
WCC File No.: 0809238

Dear Commissioner Huffstetler:

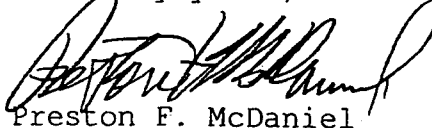
Please find enclosed a copy of the Claimant's Pre-Hearing Brief and Notice of APA Submissions and Witnesses in the above referenced matter.

By copy of this letter, with ~~enclosures~~, we are forwarding a copy of our Pre-Hearing Brief and APA submissions to opposing counsel on this date.

I hope this is sufficient for filing this matter with the Commission. However, if additional information is needed, please feel free to contact me at your convenience.

I look forward to seeing you at the hearing and to a resolution in the best interest of all parties concerned.

Sincerely yours,



Preston F. McDaniel

PFM/rdc

Enclosure
cc: Clyde C. Dean, Jr., Esquire
Scott B. Garrett, Esquire

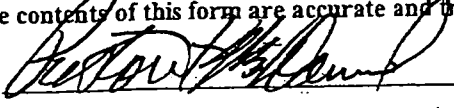
Claimant's Name: Thomas Brown SSN: _____ Employer's Name: Bulldog Hiway Express d/b/a Peoplease Corp.
Address: _____ Address: Post Office Box 40247
City: _____ State: _____ Zip: _____ City: Charleston State: SC Zip: 29423
Home Phone: _____ Work Phone: _____ Insurance Carrier: Arch Insurance Company
Preparer's Name: Preston F. McDaniel Law Firm: McDaniel Law Firm Preparer's Phone #: 803-771-7211

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury by Accident ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$ to be determined - see attached 2. AWW: \$ to be determined - see attached Date of Injury: 5/2/08
3. Type of injury and body part(s): neck/back/arm/hand; whole person due to the aggravation of the diabetic condition
4. Facts in controversy: See Attachment
5. Legal issues involved: See Attachment
6. Unusual aspects: _____
7. Witnesses (designate if expert)*: See Notice of Witnesses
8. Exhibits: Claimant requests that WCC File Number 0809238 be made a part of the Record; Claimant's earnings records may be submitted at the Hearing
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) Family Health Center, Orangeburg Regional Medical Center; Dr. Mohammad Abu-Ata Neurology & Pain Center; Dr. Scott Boyd, Columbia Neurosurgical Associates; Lexington Medical Center; Dr. Blake Moore; Dr. Sweet, USC Specialty Clinics; Dr. Brian Cuddy, Charleston Neurosurgical Assoc.; Carolina Therapy Solutions; DR. Leonard Forrest, Southeastern Spine Institute; Columbia Rehabilitation Clinic; and Harriet Fowler, Vocational Expert
10. Name, address, and specialty, if any, of the treating physician: Dr. Scott Boyd, Columbia Neurosurgical Associates, Columbia, SC; Dr. Algood, Family Health Center, Orangeburg, SC
11. Impairment rating(s); body part(s); physician and date of opinion: On 10/6/10 Harriet Fowler states that the Claimant is totally disabled as based on his age, education, significant restrictions/limitations, and his work history that he would be unable to obtain or maintain employment of any kind; On 9/20/10 Tracy Hill of Columbia Rehabilitation states the Claimant fits best into the sedentary category as he cannot do all the requirements in light or medium duty categories; On 9/15/10 Dr. Forest states that the Claimant has lost more than 50% of the use of his back to do work and states that he is not at MMI and needs additional treatment for neck and back; On 4/19/10 Dr. Boyd rates 27% whole person impairment; On 3/27/09 Dr. Denise Algood states that the aggravation to his diabetes was caused by the surgery and the physical stress put on the body due to the injuries sustained in the accident; and On 3/6/09 Dr. Blake Moore rates 36% to the whole person and also states that the Claimant is in need of additional treatment and is not at MMI and that the aggravation to his diabetes was caused by the surgery and pain which was as a result of this accident.
12. I am amending my form 50/51 in the following manner: #6 a - adding treatment for his diabetes in with the lifetime medical care; #10 a although the Claimant lists the AWW that the Form 20 shows, the Claimant is still asserting that AWW and Comp Rate are an issue.

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: 

Email: mcdaniellaw@hotmail.com

Date of Hearing: 10/22/10

Time Needed for Hearing: 1 hr.

On behalf of ☒ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.

*Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form #58.

PRE-HEARING BRIEF

Rev. Date 9/07

ATTACHMENT TO FORM 58

Thomas Brown v. Bulldog Hiway Express, d/b/a Peoplease Corp.

WCC FILE NO: 0809238

1 & 2. The Claimant requests that the Compensation Rate be based on his income for 52 weeks prior to the date of the injury. The evidence will show that the Claimant was working for Boyd Brothers prior to changing employment to go to work for Bulldog/Peoplease because Bulldog was closer to his home. He worked for Boyd Brothers throughout the entire year of 2007 and began work with Bulldog on January 7, 2008. The records from Boyd Brothers establishes that throughout the year of 2007 the Claimant made \$46,152.50 which gives him an AWW of \$887.55 with a resulting compensate rate of \$591.73. The Claimant then went to work for Bulldog on January 7, 2008 and the records of Bulldog indicate an ever increasing compensation rate while working for them. According to the pay stubs that will be placed into evidence from January 7 2008 through January 27, 2008 the Claimant had an AWW of \$486.96. From January 27, 2008 - March 29, 2008 it shows that the Claimant had an AWW of \$604.07 and then from March 29, 2008 - June 21, 2008 the Claimant had an AWW of \$644.11. Therefore, the evidence is clear that the Claimant's AWW was continuing to increase as he worked with Bulldog. According to the records the Claimant worked for Bulldog/Peoplease from January 7, 2008 - to the date of the accident on May 2, 2008 for a period of 16 weeks during which time the Claimant made \$9,434.00 with a resulting AWW of \$589.69 and a resulting compensation rate of \$393.15. Since the Claimant worked for a period of 16 weeks prior to the date of the accident with Bulldog that would leave 36 weeks to complete 52 weeks prior to the date of the accident. At the AWW of \$887.55 that would mean that during that 36 week period he would have income of \$31,951.80 and when that is added to the amount of money he made for the 16 weeks with Bulldog in the total amount of \$9,435.00 that means for the period of 52 weeks prior to the date of the accident he made \$41,386.80. Dividing that amount by 52 weeks equals an AWW of \$795.90 with a resulting compensation rate of \$530.63. The Claimant would submit that this is an appropriate AWW for the Claimant based on his work for both the employer and another employer for 52 weeks prior to the date of the accident. The evidence also establishes clearly that the Claimant had an ever-increasing AWW the longer he worked for Bulldog. Therefore, this is an appropriate AWW which fairly represents the AWW that the Claimant would be making but for the injury. AWW and Comp Rate are determined under §42-1-40 and R. 67-1603.

4. a. While Claimant filed for a PTD award since Dr. Forrest's opinion is that he is not at MMI, Claimant's entitlement to continuing medical care for back/leg/arm/hand and aggravation of pre-existing diabetes per Dr. Algood and Dr. Blake Moore;
- b. Claimant's entitlement to continuing temporary total disability benefits and for the difference in the compensation rate as stated above for all periods of TT that have previously been paid;
- c. If the Commission determines that further medical care will not tend to lessen the period of disability, then Claimant's entitlement to an award for total and permanent disability based on:
 1. The facts will establish Claimant's injury is not limited to a single member and therefore, his entitlement to an award for total loss of earning capacity. The Claimant is 60 years old; his work restrictions are limited light-limited medium duty; he has a background and experience in heavy duty types of work; his educational background is high school with some technical college; he has physical limitations on the use of neck/back, arm and hand and has impairment ratings due to his physical limitations. Based on all of the above, the services he can perform are so limited in quality, quantity or dependability that a reasonably stable job market for them does not exist and he has suffered a total loss of earning capacity.
 2. Having lost 50% or more of the use of his spine (back/neck).
- d. Claimant's entitlement to lifetime medical care for his neck/back, arm and hand as well as for medications and treatment for the aggravation to his pre-existing condition of diabetes;
- e. While it is the Claimant's position that he is entitled to an award for permanent total disability, in the alternative if the Commission does not find the Claimant to be totally and permanently disabled, then the Claimant's entitlement to an award for permanent residual disability to his neck/back, arm and hand as well as the whole person due to the worsening of his diabetic condition;

f. While it is the Claimant's position that he is entitled to an award for permanent total disability, in the further alternative, the Claimant has permanent partial loss of earning capacity as he is severely restricted to the type of work he can now perform which will greatly decrease his earning capacity; and

g. The Claimant requests a lump sum award if a final conclusion of the case is reached, with appropriate Social Security Language.

5. IN CORRELATION WITH RESPONSES UNDER NUMBER 4:

a. §42-15-60 provides for the Claimant's entitlement to medical care;

b. §42-9-10 provides for the Claimant's entitlement to continuing temporary total disability benefits and §42-1-120 defines disability;

c. 1) §42-9-10 and §42-1-120 defines total disability under §42-9-10; Coleman v. Quality Concrete Products, Inc., 245 S.C. 645, 142 S.E.2d 43 (1965); Colvin v. E.I. Dupont DeNemours Co., 227 S.C. 465, 88 S.E.2d 581 (1955); Stephenson v. Rice Services, 323 S.C. 113, 473 S.E.2d 699;

2) §42-9-30(19) Linen v. Ruscon Construction Company, 286 S.C. 67, 332 S.E.2d 211 (1985); Lyles v. Quantum Chemical Company, 315 S.C. 440, 434 S.E.2d 292 (S.C. App. 1993); Bateman v. Town & Country Furniture, 287 S.C. 158, 336 S.E.2d 890 (S.C. App 1985);

d. Claimant's entitlement to lifetime medical care under §42-15 60 due to total & permanent disability, or under Dykes v. Daniel Construction Co., 262 S.C. 98, 202 S.E.2d 646; and Dodge v. Bruccoli, et al., 334 S.C. 574, 514 SE2d 593 (SC App 1999);

e. In the alternative, Claimant's entitlement to scheduled member awards under S.C. Code §42-9-30 for permanent residual disability;

f. Permanent loss of earning capacity as provided in §42-9-20; Bowen v. Chiquola Mfg. Co., 238 S.C. 322, 120 S.E.2d 99 (1961); Bennett v. Gary Smith Builders, 271 S.C. 94, 245 S.E.2d 129 (1978); and

g. Claimant's entitlement to a lump sum award pursuant to S.C. Code §42-9-301 and R. 67-1605 with language in the award that such lump sum as awarded by the Commission is being ordered to be paid in lieu of the Claimant's entitlement to payments of compensation being made on a per week basis spread over the Claimant's lifetime (as established by the South Carolina Mortality Table, S.C. Code of Laws §19-1-150) which payment method the Commission may order under SC Code of Laws §42-9 240:

"The first installment of compensation payable under the terms of our award...shall become due seven days from the date of such an award...Thereafter compensation shall be paid in installments weekly, except when the Commission determines that payment shall be made monthly OR in some other manner."

(Such language will be helpful to the claimant in avoiding any Social Security Setoff and is an Order of payment that can be made by the Commission).

Respectfully Submitted,



Preston F. McDaniel
Attorney for Claimant

10/5, 2010

STATE OF SOUTH CAROLINA)
COUNTY OF COLLETON)
) BEFORE THE
) SOUTH CAROLINA
) WORKERS' COMPENSATION COMMISSION
) WCC File No: 0809238

THOMAS BROWN,)
) Employee-Claimant,)
) v.)
) NOTICE OF WITNESSES AND
) WRITTEN REPORT(S)/PHYSICIAN
) OR OTHER EVIDENCE TO BE
) INTRODUCED ON BEHALF OF
PEOPLEASE CORP., as)
Employer and ARCH INS.)
CO., as Carrier,)
) CLAIMANT, THOMAS BROWN
) Defendants.)
)

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
SCOTT B. GARRETT, ATTORNEY FOR THE EMPLOYER/CARRIER

YOU ARE HEREBY NOTIFIED THAT THE Claimant, Thomas
Brown, pursuant to the provisions of the South Carolina
Workers' Compensation Act and South Carolina Code Section
1-23-330 (1976, as amended), herewith submits the following
reports/physician or other evidence on behalf of the
Claimant, to wit:

NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE	DATE OF REPORT(S)	PAGE #
Dr. Denise Algood Family Health Center	2/22/08-3/27/09	1-21
Orangeburg Regional Med. Ctr.	7/6/08-7/25/08	22-30
Dr. Mahmoud Abu-Ata Neurology & Pain Clinic	7/10/08-10/23/08	31-43
Dr. Scott Boyd Columbia Neurosurgical Assoc.	8/4/08-4/19/10	44-61
Lexington Medical Center	9/2/08-4/19/10	62-72
Dr. Blake Moore	4/4/09	73-79
Dr. Brian Cuddy Charleston Neurosurgical Assoc.	10/29/09	80-81
Dr. Leonard Forest Southeastern Spine Institute	9/15/10	82-85
Columbia Rehab, Clinic	9/16/10-9/20/10	86-98
Harriet Fowler, Voc. Expert	10/6/10	99-124
Payroll Records		125-129
Social Security Disability Award	7/3/10	130-133

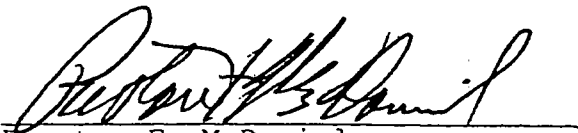
YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant:

The Claimant; any witness listed, named or called by the Defendants; and other lay witnesses to be named.

Respectfully submitted,



Preston F. McDaniel
Attorney for Claimant
1315 Elmwood Avenue
Columbia, SC 29201

10/7, 2010

CERTIFICATE OF SERVICE BY MAIL

I hereby certify that I have on this day served the following in the matter of Thomas Brown v. Bulldog Hiway Express d/b/a Peoplelease Corp. with a copy of the **Pre-Hearing Brief with APA Submissions** by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

Scott B. Garrett, Esquire
McAngus Goudelock & Courie
PO Box 12519
Columbia, SC 29211

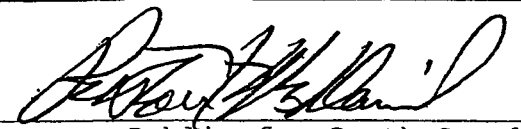
Commissioner David W. Huffstetler
SC Workers' Compensation Commission
PO Box 1715
Columbia, SC 29202

I also hereby certify that a regular communication by mail exists.



Robin D. Clary
Paralegal

SWORN TO BEFORE ME this
27th day of October, 2010.



Notary Public for South Carolina (L.S.)

My Commission Expires: 10/28/15

STATE OF SOUTH CAROLINA)
COUNTY OF COLLETON) BEFORE THE
WORKERS' COMPENSATION COMMISSION
WCC File No: 0809238

THOMAS BROWN,
Employee-Claimant,
v.

DATE OF HEARING: 10/22/10

PEOPLEASE CORP., as
Employer and ARCH INS.
CO., as Carrier,
Defendants.

APA SUBMISSIONS

Pursuant to South Carolina Code §1-23-330 and Commission Rule 67-612 Preston F. McDaniel, the Attorney for the Claimant, submits the following report(s) in support of and on behalf of the Claimant in this matter:

<u>NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE</u>	<u>DATE OF REPORT(S)</u>	<u>PAGE #</u>
1) Dr. Denise Algood Family Health Center	2/22/08-3/27/09	1-21
2) Orangeburg Reg. Med. Ctr.	7/6/08-7/25/08	22-30
3) Dr. Mahmoud Abu-Ata Neurology & Pain Clinic	7/10/08-10/23/08	31-43
4) Dr. Scott Boyd Columbia Neurosurgical Assoc.	8/4/08-4/19/10	44-61
5) Lexington Medical Center	9/2/08-4/19/10	62-72
6) Dr. Blake Moore	4/4/09	73-79
7) Dr. Brian Cuddy Charleston Neurosurgical Assoc.	10/29/09	80-81
8) Dr. Leonard Forest Southeastern Spine Institute	9/15/10	82-85
9) Columbia Rehab Clinic	9/16/10-9/20/10	86-98
10) Harriet Fowler, Voc. Expert	10/6/10	99-124
11) Payroll Records		125-129
12) Social Security Disability Award	7/3/10	130-133

Dr. Denise Algood
Family Health Centers, Inc.
3310 Magnolia Street
Post Office Box 1806
Orangeburg, SC 29115-1466

Preston F. McDaniel, Esquire
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

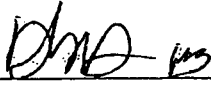
RE: Thomas Brown
DOB:
SSN:

Dear Mr. McDaniel:

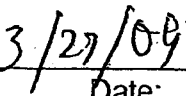
As you are aware, I was treating Mr. Brown for his diabetes prior to the work-related truck accident on May 2, 2008. I have reviewed my records and according to my records before, and even after the accident on June 23, 2008, ~~his diabetes mellitus was controlled with oral medication. Subsequent to that, on~~ November 18, 2008 I saw him at which time we changed him from oral medications to requiring insulin shots and so he has become an insulin dependent diabetes to control his diabetes. Following a cervical MRI on July 20, 2008 Dr. Alhatou referred the patient to Dr. Boyd who performed surgery involving a fusion of the C3-C4, C4-C5 and C5-C6 levels of his spine on September 2, 2008. Following this procedure when I saw him for a regular follow-up, I found that his condition and his diabetes had changed and he needed to be on insulin to control his diabetes.

I have reviewed the opinion from Dr. Moore and I concur in the opinion that most probably the physical stress placed on Mr. Brown by his injuries and the surgery necessary to correct those injuries aggravated his diabetes and required a heightened level of care wherein he has now become an insulin dependent diabetic.

I hope this provides you with that you need. If any additional information is needed, please advise.



Dr. Denise Algood



Date:

01

1 Note 3/16/2009 3:56:00 PM

Thomas Brown, Gender: M, DOB:
Algood, MD

Encounter Date and Time: 3/16/2009 03:56PM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: Lab results. M.E. Williams, MOA.

Tests

Results for: Lipid Panel

Ordered/ Test Name Performed	Ind Results	Units Range
---------------------------------	-------------	-------------

2/18/2009 Lipid Panel

2/19/2009

Cholesterol, Total H 237 mg/dL 100-199

Triglycerides 137 mg/dL 0-149

HDL Cholesterol 48 mg/dL >39

According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.

VLDL Cholesterol Cal 27 mg/dL 5-40

LDL Cholesterol Calc H 162 mg/dL 0-99

Comment SPRCS

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.

***** END OF RESULTS *****

Assessment

Hyperlipoproteinemia type II-B

Allergies

No Known Allergies.

Plan

Follow-up for re-examination PRN.

Vytorin 10 mg-40 mg tablet. SIG: once a day. Dispense: 30 tablet(s). Refill: 5. RENEWED WITH CHANGES BY DENISE ALGOOD.

Cholesterol/LDL in 6/08 was 204/135. Today's values show an increase compared to last year. Pt says he is taking his vytorin once a day and takes fish oil daily. Will increase Vytorin to 10/40 nightly and increase fish oil to bid. Recheck in 6 months.

Notes

Electronically Signed by: Denise Algood, M.D.

02

1 Note 2/26/2009 2:50:00 PM

Thomas Brown, Gender: M, DOB: ,
Cato, DPM

, Encounter Date and Time: 2/26/2009 02:50PM; Examiner: Lamar

Chief complaint

The Chief Complaint is: Diabetic footcare with c/o toenails to be trimmed. W. Wood, LPN.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.
Visit location: Podiatry, Orangeburg Family Health Center.

Past medical/surgical history**Diagnosis History:**

Hypertension.
Hyperlipidemia.
Diabetes mellitus

Therapeutic History:

Tonsillectomy.
past medical/surgical history [use for free text].

Personal history

Behavioral: Caffeine use DIET COKE 1-2 PER DAY. No previous history of smoking.

Drug Use: Not using drugs.

Home Environment: Native language English. The racial background is black.

Marital: Single.

Family history

8 children

Maternal history of:

Hypertension
Diabetes mellitus
Cancer.

Physical findings**Vital Signs:**

• Pain level 0 (0-10).

Dermatitis x2 posterior left leg.

Assessment

• Onycholysis was noted
• Diabetes mellitus
• Dermatitis

Nevus x2 measuring, #1 distal 0.5cm and #2 proximal 0.3cm in diameter.

Allergies

No Known Allergies.

Plan

• Manual nail debridement of six or more nails one

1) nail prophylaxis and debridement x10 2) referral to Dr Patricia McClerkin for E&M.

Notes

03

1 Note 2/18/2009 9:21:00 AM

Thomas Brown, Gender: M, DOB: ,
Algood, MD

, Encounter Date and Time: 2/18/2009 09:21AM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: 3 month DM/HTN.C/o feeling tired all the time.Pt. forgot to bring meds and need refill on tekturna and vytorin.MASburyLPN.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.
Visit location: Adult Medicine, Orangeburg Family Health Center.

° Normal appetite.

• A self-exam of the feet was performed - daily • A home blood sugar check was performed 1 x/day ° Blood sugar was above 80

Sees specialists: Podiatry

Current medication

Tekturna/hctz 300/12.5. SIG: every 24 hours SIG:

Vytorin 10 mg-20 mg tablet. SIG: once a day

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day

Glipizide 5 mg tablet. SIG: orally once a day

Glucotrol XL 5 mg tablet, extended release. SIG: 1 tab(s) orally once a day with meal (do not crush or chew)

Levemur 100 units/mL vial. SIG: 40 units subcutaneously 2 times a day

Diabetic equipment - 1 CC (U100) syringe. SIG: 2 times a day Length of need: 99/lifetime. Use as directed for diabetes

Valtrex 500 mg tablet. SIG: orally

Aspirin 81 mg tablet. SIG: orally

Personal history

Behavioral: Not smoking

Alcohol: Not using alcohol

Drug Use: Not using drugs

Habits: Not exercising regularly

Physical findings**Vital Signs:**

Vital Signs/Measurements	Value	Date
Temperature	97.9 F	2/18/2009
RR	20 per min	2/18/2009
PR	78 bpm	2/18/2009
Pain level (0-10)	0	2/18/2009
Weight	257 lbs	2/18/2009

• Blood pressure was 148/86 mmHg

Tests

Results for: Hemoglobin A1c

Ordered/ Test Name	Ind Results	Units Range
Performed		

2/18/2009 Hemoglobin A1c

2/18/2009

04

Hemoglobin A1c 6.1
***** END OF RESULTS *****
Results for: MICROALBUMIN, QUANTITATIVE, URINE

Ordered/ Test Name Performed	Ind Results	Units Range
11/18/2008 MICROALBUMIN, QUANTITATIVE, URINE		
11/19/2008		
Creatinine, Urine	46.8	mg/dL 22.0-328.0
Microalbum, U, Random	6.1	ug/mL 0.0-17.0
Microalb/Creat Ratio	13.0	ug/mg 0.0-30.0

***** END OF RESULTS *****

Assessment

- Benign essential hypertension
- Hyperlipoproteinemia type II-B
- Type II diabetes mellitus with complication
- Type I diabetes mellitus with complication

Allergies

No Known Allergies

Plan:

- Basic metabolic panel with total - 1 2/18/2009
calcium
- A hepatic function panel 1 2/18/2009
- A lipid profile
- Random blood glucose level 1 mg/dl 2/18/2009
- Hemoglobin A1c 1% 2/18/2009
- Follow-up for re-examination 3 months

Needs to increase physical exercise, eg daily walking program to improve physical stamina. Pt asks to come off insulin. His blood sugars are well controlled on current medication and insulin should be continued. Pt given one month sample supply of Tekturna, Vytarin and Diovan until mail order supply has arrived

Notes

Electronically Signed by: Denise Algood, M.D

05

1 Note 1/6/2009 2:28:00 PM

Thomas Brown, Gender: M, DOB:
Algood, MD

Encounter Date and Time: 1/06/2009 02:28PM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: HTN/DM f/u -- is now on the pt assistance program and need lotrel changed to tekturna.
M.E. Williams, MOA.

Current medication

GlipizIDE 5 mg tablet. SIG: orally once a day .
Glucotrol XL 5 mg tablet, extended release. SIG: 1 tab(s) orally once a day with meal (do not crush or chew) .
Levemir 100 units/mL vial. SIG: 40 units subcutaneously 2 times a day.
Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day .
Vytorin 10 mg-20 mg tablet. SIG: once a day .
Diabetic equipment - 1 CC (U100) syringe. SIG: 2 times a day Length of need: 99/lifetime. Use as directed for diabetes .
Lotrel 10 mg-20 mg capsule. SIG: orally once a day .
Valtrex 500 mg tablet. SIG: orally .
Aspirin 81 mg tablet. SIG: orally.

Physical findings**Vital Signs:****Vital Signs/Measurements**

Temperature

RR

PR

Blood pressure

Weight

Value

98.6 F

18 per min

80 bpm

120/80 mmHg

252.5 lbs

Assessment

- Visit for: a repeat prescription
- Benign essential hypertension
- Diabetes mellitus

Allergies

No Known Allergies.

Plan

- Follow-up for re-examination 3 months
- Tekturna/hctz 300/12.5. SIG: every 24 hours SIG: . Dispense: 90. Refill: 4.
Vytorin 10 mg-20 mg tablet. SIG: once a day . Dispense: 30 tablet(s). Refill: 11.
Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day . Dispense: 30 tab(s). Refill: 11.
Pt switched to Tekturna 300/12.5 and qualifies for PAP. He brings his diabetic log and blood sugars range from 88-110. There was one outlier on 12/31/08 of 178.

Notes

Electronically Signed by: Denise Algood, M.D.

06

1 Note 12/10/2008 3:15:00 PM

Thomas Brown, Gender: M, DOB: , Encounter Date and Time: 12/10/2008 03:15PM, Examiner: Lamar Cato, DPM

Chief complaint

The Chief Complaint is: 1st toenail on left foot has turned dark x 1 week. W. Wood, LPN.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient. Visit location: Podiatry, Orangeburg Family Health Center.

Past medical/surgical history**Diagnosis History:**

Hypertension.
Hyperlipidemia.
Diabetes mellitus

Therapeutic History:

Tonsillectomy.
past medical/surgical history [use for free text].

Personal history

~~Behavioral:~~ Caffeine use DIET COKE 1-2 PER DAY. No previous history of smoking.

~~Drug Use:~~ Not using drugs.

~~Home Environment:~~ Native language English. The racial background is black.

~~Marital:~~ Single.

Subjective

Pt. presents with chief complaint of thickened and painful nails bilateral lower extremities. States that they are causing difficulty with ambulation.

Family history

8 children

Maternal history of:

Hypertension
Diabetes mellitus
Cancer.

Physical findings**Vital Signs:**

• Pain level 0 (0-10).

Cardiovascular:

Arterial Pulses: • Posterior tibialis pulses were absent bilaterally. • Dorsalis pedis pulses were absent bilaterally.

Edema: ° No pitting edema. ° No nonpitting edema.

Musculoskeletal System:**Foot:**

General/bilateral: ° No mass on the foot. ° No calluses on the plantar aspects of both feet. ° No tenderness on palpation of the feet. ° No tenderness on palpation of the intermetatarsal spaces. ° Foot tenderness on palpation with no clicking sound on compression of the metatarsal heads. ° No pain was elicited by motion of the foot.

Toes:

General/bilateral: ° No swelling of the toes. ° No erythema of the toes. ° No warmth of the toes. ° No

tophus was seen on the toes. ° No deformity of the toes. ° No bone fragment protruding through the skin of the toes. ° No interdigital erythema of the toes. ° No interdigital maceration of the toes. ° No tenderness on palpation of the toes. ° No corns on the toes. ° No pain was elicited by motion of the toes.

Skin:

- Cool on the feet. ° Normal except as noted. ° Mobile. ° Showed no hyperkeratosis. ° Turgor was normal. ° Color and pigmentation were normal. ° Showed no erythema. ° Moisture was normal. ° No periungual nodules were seen on the toes. ° No fissures on the feet.

Injury / Incision Site: ° Toes showed no tissue injury.

Hair:

- Quantity and distribution were abnormal.

Nails:

- Nails: Toenails Lt foot 1, is affected. • Nail dystrophy was noted. • Subungual debris was noted. • Discolored.

Objective

Nails 1st left foot is thickened and elongated with subungual debris and onycholysis noted.

Assessment

- Diabetes mellitus
 - Dermatophytosis of the nails
- Onychomycosis 1st nail left foot.

Allergies

No Known Allergies.

Counseling/Education

Patient verbalized understanding of information and was given an opportunity to ask questions.

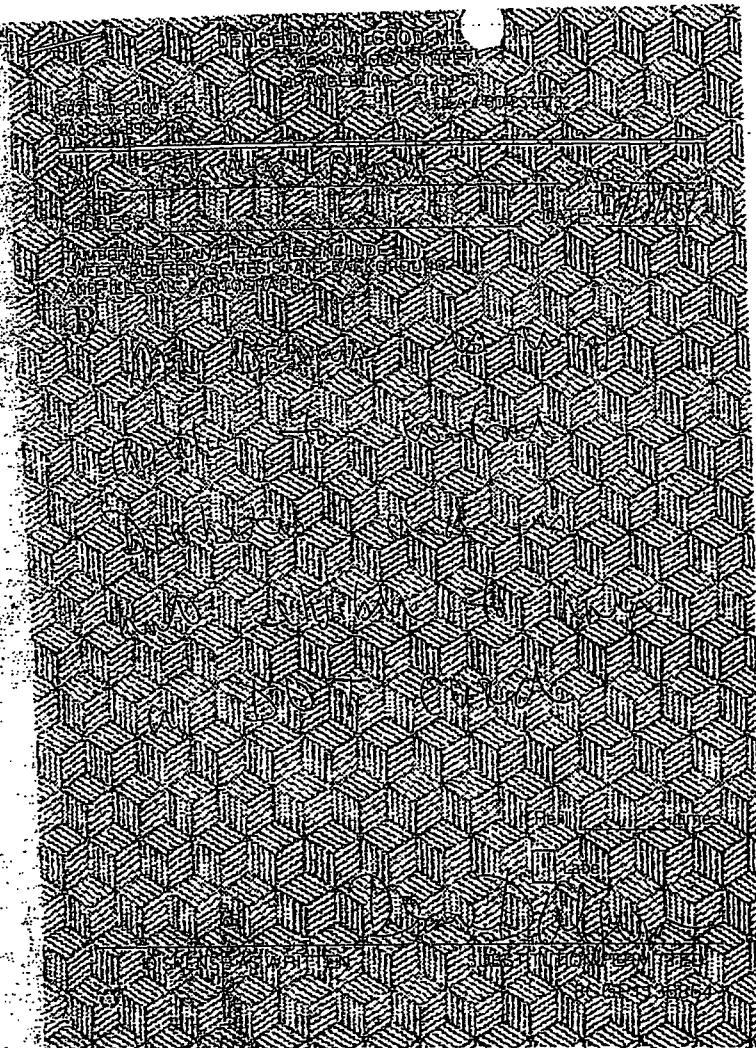
Plan

- Manual nail debridement of one to five nails
 - Follow-up for re-examination 3 months
- Rx: Tincture of Fungiod, 1 ounce bottle. Sig. apply 2x daily.

Notes

Electronically Signed by: Lamar Cato, D.P.M.

08



09

1 Note 11/18/2008 8:44:00 AM

Thomas Brown, Gender: M, DOB:
D. Algood, MD

Encounter Date and Time: 11/18/2008 08:44AM, Examiner: Denise

Chief complaint

The Chief Complaint is: 3 mos HTN/DM. Pts has no complaints. Rxs needed: M.E. Williams, MOA.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.
Visit location: Adult Medicine, Orangeburg Family Health Center.

- ° No symptoms.
- ° Normal appetite.
- A self-exam of the feet was performed - daily.

° No recent weight change ° No eye symptoms ° and No blurry vision ° No cardiovascular symptoms ° and
No chest pain or discomfort ° No pulmonary symptoms ° and No dyspnea ° No gastrointestinal symptoms °
Appetite not decreased ° Appetite not increased °, and No constant hunger ° No genitourinary symptoms ° and No
change in urinary frequency ° No dizziness ° No lightheadedness ° No tingling ° No burning sensation ° No
numbness

Current medication

Leveran 100 units/mL vial. SIG: 40 units subcutaneously 2 times a day.
Glucagon XL 5 mg tablet, extended release. SIG: 1 tab(s) orally once a day with meal (do not crush or chew)
Diabetic equipment - 1 CC (U100) syringe. SIG: 2 times a day Length of need: 99/Lifetime. Use as directed for
diabetes
Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day
Vytorin 10 mg-20 mg tablet. SIG: once a day
Lorrel 10 mg-20 mg capsule. SIG: orally once a day SIG:
Valtrex 500 mg tablet. SIG: orally
Glipizide 5 mg tablet. SIG: orally once a day
Aspirin 81 mg tablet. SIG: orally

Personal history

Behavioral: No coffee consumption, not smoking, no previous history of smoking, and not chewing nicotine-
containing substances.

Alcohol: Not using alcohol.

Drug Use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital Signs:**

Vital Signs/Measurements
Temperature
RR
PR
Pain level (0-10)
Weight

Value
98.1 F
18 per min
78 bpm
0
248 lbs

- Blood pressure was 134/80 mmHg.

Cardiovascular:

Arterial Pulses: ° Posterior tibialis pulses were normal. ° Dorsalis pedis pulses were normal.

Neurological:

Sensation: • Monofilament wire test of the foot was performed. ° No decreased response to tactile stimulation
of the leg/foot.

Skin:

- ° No ulcer was seen on the feet. ° No ulcer was seen on the toes of the right foot. ° No ulcer was seen on the toes of the left foot.

Nails:

- ° Normal (Toenails).

Assessment

- Benign essential hypertension
- Hyperlipoproteinemia type II-B
- Type II diabetes mellitus with complication

Allergies

No Known Allergies.

Vaccinations

- Received dose of influenza split virus vaccine for 3 years of age and above, for intramuscular use

Counseling/Education

- Inquiry and counseling about medication administration and compliance. Patient is taking 1 aspirin per day as instructed.

Plan

- CBC with partial differential
- Comprehensive metabolic panel
- Random blood glucose level
- Microalbumin level
- Follow-up for re-examination 3 months
- Glipizide 5 mg tablet. SIG: orally once a day. Dispense: 30 tablet(s). Refill: 11.
- Glucotrol XL 5 mg tablet, extended release. SIG: 1 tab(s) orally once a day with meal (do not crush or chew). Dispense: 30 tab(s). Refill: 11.
- Leverone 100 units/mL vial. SIG: 40 units subcutaneously 2 times a day Dispense: One month supply SIG: Dispense: 30 milliliter(s). Refill: 11.
- Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day. Dispense: 30 tab(s). Refill: 11.
- Lotrel 10 mg-20 mg capsule. SIG: orally once a day. Dispense: 30 capsule(s). Refill: 11.
- Vytorin 10 mg-20 mg tablet. SIG: once a day. Dispense: 30 tablet(s). Refill: 11.
- Diabetic equipment - 1 CC (UI00) syringe. SIG: 2 times a day Length of need: 99/lifetime. Use as directed for diabetes. Dispense: 200 syringe(s). Refill: 11.
- Diabetic log reviewed. Values range from 81-126. FBS today is 51 with an A1c of 11.3. Discussed pt's medication regimen and explained that he overall diabetes is not well controlled with an A1c this high.

Notes

Electronically Signed by: Denise Algood, M.D.

Reason for Visit

- Visit for: a repeat prescription.

1 Note 10/7/2008 9:09:00 AM

Thomas Brown, Gender: M, DOB: , Encounter Date and Time: 10/07/2008 09:09AM, Examiner: Denise D. Algood, MD

Chief complaint

The Chief Complaint is: DM/HTN - c/o that his sugar levels are going up and down. Had 2 ER visits this past weekend. M.E. Williams, MOA.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.
Visit location: Adult Medicine, Orangeburg Family Health Center.

° No symptoms.

° Normal appetite.

° No recent weight change ° and No recent weight change ° No eye symptoms ° and No blurry vision ° No cardiovascular symptoms ° and No chest pain or discomfort ° No pulmonary symptoms ° and No dyspnea ° No gastrointestinal symptoms °, Appetite not decreased °, Appetite not increased °, and No constant hunger ° No genitourinary symptoms ° and No change in urinary frequency ° No dizziness °, No lightheadedness °, No tingling °, No burning sensation °, and No numbness ° A self-exam of the feet was not performed - daily °, A home blood sugar check was not performed ___x/day °, Home sugar check was not low ° Was above 80

Current medication

Levemir 100 units/mL vial. SIG: 25 units subcutaneously 2 times a day

Diabetic equipment - 1 CC (U100) syringe. SIG: 2 times a day Length of need: 99/lifetime. Use as directed for diabetes

Lotrel 40 mg-20 mg capsule. SIG: orally once a day SIG:

Vytorn 10 mg-20 mg tablet. SIG: once a day

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day

Valtrex 500 mg tablet. SIG: orally

Oxycodone. SIG: every 6 hours

Hydrocodone. SIG: every 6 hours

Aspirin 81 mg tablet. SIG: orally

Personal history

Behavioral history: No coffee consumption, not smoking, no previous history of smoking, and not chewing nicotine-containing substances.

Alcohol: Not using alcohol.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

Vital Signs/Measurements

Temperature

RR

PR

Blood pressure

Pain level (0-10)

Weight

Value

98.5 F

18 per min

80 bpm

122/72 mmHg

0

239 lbs

Cardiovascular system:

Arterial Pulses: ° Posterior tibialis pulses were normal. ° Dorsalis pedis pulses were normal.

Neurological:

Sensation: ° Monofilament wire test of the foot was performed. ° No decreased response to tactile stimulation

of the leg/foot.

Skin:

- ° No ulcer was seen on the feet. ° No ulcer was seen on the toes of the right foot. ° No ulcer was seen on the toes of the left foot.

Nails:

- ° Normal (Toenails).

Assessment

- Type II diabetes mellitus with complication

Allergies

No Known Allergies.

Counseling/Education

- Inquiry and counseling about medication administration and compliance. Patient is taking 1 aspirin per day as instructed

Plan

- Random blood glucose level
- Hemoglobin A1c
- Follow-up for re-examination 6 weeks

Levemir 100 units/mL vial. SIG: 40 units subcutaneously 2 times a day Dispense: One month supply. Dispense: 30 mL. Refill: 5.

Glucotrol XL 5 mg tablet, extended release. SIG: 1 tab(s) orally once a day with meal (do not crush or chew).

Dispense: 30 tab(s). Refill: 5.

Pt says he got scared after checking his blood sugars at home and found his values in the 400's. His is now taking levemir 40 mg bid and the ED doctor added glucotrol 5 mg daily. A review of the pt's logs shows blood sugars now ranging from 88-230 (after lunch). Will have pt see Dr. Spittler for a diabetic eye exam.

Notes

Electronically Signed by: Denise Algood, M.D.

1 Note 9/23/2008 9:20:00 AM

Thomas Brown, Gender: M, DOB: _____
Algood, MD

Encounter Date and Time: 9/23/2008 09:20AM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: 3mon htn and diet controlled DM pt is also taking some pain pills due to having vertebrae surgery in Aug. by Dr. Boyd and also needs rx on all meds except pain meds. Pt is due to see neuro again in Oct. ts/pn.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.

PAIN LOCATION: __upper back

QUALITY: burning.

Medication(s) Taken: __oxycodone and hydrocodone

Visit location: Adult Medicine, Orangeburg Family Health Center.

PAIN RELIEVED BY: __

• Recent weight change.

Current medication

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day.

Lipitor 40 mg-20 mg capsule. SIG: orally once a day.

Vytorin 10 mg-20 mg tablet. SIG: once a day.

Valtrex 500 mg tablet. SIG: orally.

Oxycodone. SIG: every 6 hours.

Hydrocodone. SIG: every 6 hours.

Aspirin 81 mg tablet. SIG: orally.

Personal history

Behavioral history: No coffee consumption and not smoking. A previous history of smoking. Not chewing nicotine-containing substances.

Alcohol: Not using alcohol.

Drug use: Not using drugs.

Physical findings**Vital signs:**

Vital Signs/Measurements	Value
Temperature	98.3 F
RR	16 per min
PR	80 bpm
Blood pressure	132/80 mmHg
Pain level (0-10)	6
Weight	235 lbs
Height	76 in

Tests

Results for: Hemoglobin A1c

Ordered/ Test Name	Ind Results	Units	Range
Performed			

9/23/2008 Hemoglobin A1c

14

1 Note 7/31/2008 2:25:00 PM

Thomas Brown, Gender: M, DOB: , Encounter Date and Time: 7/31/2008 02:25PM, Examiner: Bismarck Amoah Apraku, MD

Chief complaint

The Chief Complaint is: Pt c/o pain in the neck and wants mole removed M.Jones-MOA.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.

PAIN LOCATION: neck.

QUALITY: burning.

DURATION: intermittent.

Medication(s) Taken: percocet.

Visit location: Adult Medicine, Orangeburg Family Health Center.

• Skin lesion(s):

Current medication

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day .

Lotrel 10 mg-20 mg capsule. SIG: orally once a day .

Vytorin 10 mg-20 mg tablet. SIG: once a day .

Valtrex 500 mg tablet. SIG: orally .

Aspirin 81 mg tablet. SIG: orally .

Physical findings**Vital signs:**

Vital Signs/Measurements

Temperature

RR

PR

Blood pressure

Pain level (0-10)

Weight

Height

Value

98.4 F

20 per min

84 bpm

146/88 mmHg

8

250 lbs

76 in

Standard Measurements:

• Patient was observed to be obese. • Symmetrical obesity (>30% over). • Centripetal obesity.

General appearance:

• Alert. • Oriented to time, place, and person. • Well developed. • In no acute distress.

Neck:

Carotid Arteries [See also Cardiovascular]: • Carotid arteries were normal.

Suppleness: • Neck demonstrated no decrease in suppleness.

Thyroid: • Showed no abnormalities.

Eyes:

General/bilateral:

Pupils: • Normal.

Ears:

General/bilateral:

External Auditory Canal: • External auditory meatus normal.

Tympanic Membrane: • Normal.

Hearing: • No hearing abnormalities.

Pharynx:

• Normal.

Lungs:

1 Note 6/25/2008 11:30:00 AM

Thomas Brown, Gender: M, DOB:
Algood, MD

, Encounter Date and Time: 6/25/2008 11:30AM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: Labs reviewed. will discuss at NOV. No change in treatment.

Allergies

No Known Allergies.

Plan

- Follow-up for re-examination - PRN

Notes

Electronically Signed by: Denise Algood, M.D.

1 Note 6/23/2008 8:20:00 AM

Thomas Brown, Gender: M, DOB: , Encounter Date and Time: 6/23/2008 08:20AM, Examiner: Denise D. Algood, MD

Chief complaint

The Chief Complaint is: 3MONTHS DM AND HTN FOLLOW UP—PT C/O PAIN IN THE LEFT SIDE OF THE NECK. Pt completed the Pt Health Questionnaire today on June 23, 2008 M.N.JONES-MOA.

History of present illness

Thomas Brown is a 58 year old male. Source of patient information was patient.
QUALITY: sharp PAIN ON THE LEFT SIDE OF HIS NECK.
Visit location: Adult Medicine, Orangeburg Family Health Center.

Physical findings**Vital signs:**

Vital Signs/Measurements

Value

Temperature

98.7 F

RR

20 per min

PR

82 bpm

Pain level (0-10)

5

Weight

251 lbs

Height

76 in

Blood pressure was 122/80 mmHg.

Assessment

- Visit for: a repeat prescription
- Neck sprain
- Benign essential hypertension
- Hyperlipoproteinemia

Allergies

No Known Allergies.

Plan

- A hepatic function panel
- A lipid profile
- Follow-up for re-examination months

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day . Dispense: 90 tab(s). Refill: 5.

Lotrel 10 mg-20 mg capsule. SIG: orally once a day . Dispense: 90 capsule(s). Refill: 5.

Vytorin 10 mg-20 mg tablet. SIG: once a day . Dispense: 90 tablet(s). Refill: 5.

Was in a MVA in 4/08 and has occasional neck pain. Should take motrin as needed.

Will contact about labs.

Notes

Electronically Signed by: Denise Algood, M.D.

9/23/2008

Hemoglobin A1c 14.0
greater than 14.0

***** END OF RESULTS *****

Results for: F.S. Glucose

Ordered/ Test Name Performed	Ind Results	Units Range
---------------------------------	-------------	-------------

9/23/2008 F.S. Glucose

9/23/2008

F.S. Glucose H 418 mg/dl 64 - 112

***** END OF RESULTS *****

Assessment

- Hyperlipoproteinemia type II-B
- Type II diabetes mellitus with complication

Allergies

No Known Allergies.

Counseling/Education

• Inquiry and counseling about medication administration and compliance. Patient is taking 1 aspirin per day as instructed.

Plan

• Random blood glucose level
• Hemoglobin A1c
• Follow-up for re-examination 2 weeks
Diabetic equipment - 1 CC (U100) syringe. SIG: 2 times a day Length of need: 99/lifetime. Use as directed for diabetes. Dispense: 200 syringe(s).
Levemir 100 units/mL vial. SIG: 25 units subcutaneously 2 times a day Dispense: One month supply. Dispense: 10 milliliter(s). Refill: 5.
Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day. Dispense: 30 tab(s). Refill: 5.
Lotrel 10 mg-20 mg capsule. SIG: orally once a day SIG: Dispense: 30 capsule(s). Refill: 5.
Vytorin 10 mg-20 mg tablet. SIG: once a day Dispense: 30 tablet(s). Refill: 5.
FBS 418, A1c-14.0. Pt says he has not had his blood sugar checked in many months. Has lost about 20 lbs but attributed this to exercise. Will start levemir 25 units bid and refer him to Dr. Anadu.

Notes

Electronically Signed by: Denise Algood, M.D.

° Respiration rhythm and depth was normal. ° Chest was normal to percussion. ° Clear to auscultation.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.

Heart Sounds: ° Normal.

Murmurs: ° No murmurs were heard.

Arterial Pulses: ° Equal bilaterally and normal.

Edema: ° Not present.

Abdomen:

Auscultation: ° Abdominal auscultation revealed no abnormalities.

Percussion: ° Abdominal percussion was normal.

Palpation: ° Abdominal palpation revealed no abnormalities.

Neurological:

Mental Status Findings: ° Mental status was normal. ° Mood was euthymic.

Speech: ° Normal.

Sensation: ° No sensory exam abnormalities were noted.

Motor: ° A motor exam demonstrated no dysfunction.

Reflexes: ° Normal.

Skin:

- Lesions: • Multiple skin lesions. • Papules were seen. • Lesions on the neck. • Axillary lesions. • Left axillary lesions. • Lesions on the trunk. ° General appearance was normal.

Assessment

- A skin tag was seen

Allergies

No Known Allergies.

Plan

- INJECTION - LIDOCAINE HCL - IV - 10 MG
- Electrosurgical destruction of skin tags
- Follow-up for re-examination 3 months.

Patient in today for removal of skin tags. The skin tags were removed with a surgical fine tip cautery under sterile conditions, after informed consent. patient tolerated procedure well. wonds were dressed with neosporin ointment. daily neosporin dressing advised.

Notes

Electronically Signed by: Bismarck Amoah-Apraku, M.D.

1 Note 2/22/2008 8:24:00 AM

Thomas Brown, Gender: M, DOB: ,
Algood, MD

Encounter Date and Time: 2/22/2008 08:24AM, Examiner: Denise D.

Chief complaint

The Chief Complaint is: DM/HTN EVAL – WOULD LIKE TO HAVE SAMPLES IF AVAILABLE.

History of present illness

Thomas Brown is a 57 year old male. Source of patient information was patient.
Visit location: Adult Medicine, Orangeburg Family Health Center.

- Blurry vision ° No eye symptoms
- Normal appetite
- Tingling ° No dizziness ° No lightheadedness ° No burning sensation ° No numbness
- A self-exam of the feet was performed - daily

• No cardiovascular symptoms ° and No chest pain or discomfort ° No pulmonary symptoms ° and No dyspnea ° No gastrointestinal symptoms °, Appetite not decreased °, Appetite not increased °, and No constant hunger ° No genitourinary symptoms ° No change in urinary frequency

Personal history

Behavioral history: No coffee consumption, not smoking, and no cigarette smoking. No previous history of smoking.

Alcohol: Not using alcohol.

Drug use: Not using drugs.

Habits: Exercising regularly.

Physical findings**Vital signs:**

Vital Signs/Measurements	Value
Temperature	97.9 F
RR	18 per min
PR	72 bpm
Blood pressure	160/82 mmHg
Pain level (0-10)	0
Weight	254 lbs

General appearance:

- Alert. • Oriented to time, place, and person. • Well developed. • In no acute distress.

Eyes:**General/bilateral:**

Retina: • A fundoscopic exam through dilated pupils was performed 2/22/2007.

Lungs:

- Respiration rhythm and depth was normal. • Clear to auscultation.

Cardiovascular system:

Heart Rate And Rhythm: • Normal.

Heart Sounds: • Normal.

Murmurs: • No murmurs were heard.

Arterial Pulses: • Equal bilaterally and normal.

Edema: • Not present.

Neurological:

Sensation: • Monofilament wire test of the foot was normal.

Assessment

- Benign essential hypertension
- Hyperlipoproteinemia
- Type II diabetes mellitus without complication

Allergies

No Known Allergies.

Counseling/Education

• Inquiry and counseling about medication administration and compliance . Patient is taking 1 aspirin per day as instructed.

Plan

- Random blood glucose level
- Glycosylated hemoglobin
- Follow-up for re-examination 4 months

Diovan HCT 25 mg-320 mg tablet. SIG: 1 tab(s) orally once a day . Dispense: 90 tab(s). Refill: 5.

Lotrel 10 mg-20 mg capsule. SIG: orally once a day . Dispense: 90 capsule(s). Refill: 5.

Vytorin 10 mg-20 mg tablet. SIG: once a day . Dispense: 90 tablet(s). Refill: 5.

Notes

Electronically Signed by: Denise Algood, M.D.

07/12/2008
** FINAL **

Exam Date: 20080725142159
MRI CERVICAL SPINE W/O CONTRAST
Patient: BROWN, THOMAS LEE
MRN: 0000454233
Account: 0820700280

CLINICAL HISTORY: NECK PAIN DOWN LEFT ARM.

DATE OF EXAM: 07/25/2008.

TECHNIQUE:

MRI evaluation was carried out utilizing a 1.5 Tesla magnet. Multiple T1, T2, and proton density MR images of the cervical spine were obtained in the axial and sagittal planes.

OVERVIEW:

Overview images of the cervical spine demonstrate grossly normal alignment of the vertebral bodies. There is essentially normal marrow signal throughout the visualized cervical and upper thoracic spine, without obvious acute osseous abnormality. The paraspinous soft tissues and brachial plexus also appear essentially unremarkable. Images of the lung apices reveal no gross abnormality.

There is, however, a scoliotic curvature of the upper thoracic region which appears primarily convex to the right.

SPINAL CORD:

The spinal cord is identified from the craniocervical junction through the upper thoracic region. There is moderate impingement on the cord at several levels related to disc protrusion as well as hypertrophic changes posteriorly. This has led to quite marked narrowing of the cervical canal which measures 3.3 millimeters at the C3-4 level, 4.0 millimeters at the C4-5 level, 4.4 millimeters at the C5-6 level. This has resulted in moderate flattening of the cord at these levels but no gross myelopathic change is appreciated at this time.

INTERVERTEBRAL DISCS:

C2-3: There is mild loss of disc signal without significant disc protrusion or obvious compressive sequelae.

C3-4: There is loss of disc signal and disc height with mild to moderate broad-based disc protrusion impinging upon the spinal cord as described above. There is also extension of protruded disc material into the neural foramina in association with moderate intraforaminal osteophyte formation resulting in moderate to moderately severe bilateral foraminal stenosis.

C4-5: There is loss of disc signal and disc height with mild to moderate broad-based disc protrusion associated with circumferential osteophyte formation and extending into the neural foramina bilaterally although more markedly on the left. This resulted in narrowing of the cervical canal with impingement and flattening of the spinal cord as well as moderately severe to severe bilateral foraminal stenosis.

C5-6: There is loss of disc signal with mild loss of disc

** FINAL **

Exam Date: 20080725142159
MRI CERVICAL SPINE W/O CONTRAST
Patient: BROWN, THOMAS LEE
MRN: 0000454233
Account: 0820700280

height. There is mild to moderate broad-based disc protrusion, again associated with circumferential osteophyte formation extending into the neural foramina bilaterally. Again, there is impingement and flattening of the spinal cord with moderately severe bilateral foraminal stenosis.

C6-7: There is loss of disc signal with mild to moderate broad-based disc protrusion extending into the neural foramina in association with mild to moderate intraforaminal osteophyte formation. There is again moderately severe bilateral foraminal stenosis.

~~C7-T1: Evaluation of the intervertebral discs demonstrates~~
essentially normal disc signal and disc height. There is no significant disc protrusion identified. The neuroforamina are patent.

OPINION:

Moderately severe degenerative disc/osteophyte disease of the cervical spine. There are disc bulges at most levels, associated with circumferential osteophyte formation and with hypertrophic lamellar changes at several levels. This has resulted in gross narrowing of the cervical canal with impingement and flattening of spinal cord and with varying degrees of predominantly moderately severe to severe foraminal stenosis at multiple locations as discussed in detail above.

Dr Abuatta was informed of these findings by phone.

69420: wcf

Dictating Physician: JEREMY W. YOUNG, M.D.

Signing Physician: JEREMY YOUNG, M.D.

23

** FINAL **

Exam Date: 20080725142249
MRI LUMBAR SPINE W/O CONTRAST
Patient: BROWN, THOMAS LEE
MRN: 0000454233
Account: 0820700280

CLINICAL HISTORY: LOW BACK PAIN DOWN BOTH LEGS.
DATE OF EXAM: 07/25/2008.

TECHNIQUE:

MRI evaluation was carried out utilizing a 1.5 Tesla magnet. Multiple T1, T2, and proton density MR images of the lumbar spine were obtained in the axial and sagittal planes.

FINDINGS:

OVERVIEW:

Overview images of the lumbar spine reveal essentially normal alignment of the vertebral bodies. There is unremarkable marrow signal identified throughout the visualized osseous skeleton. The paraspinous soft tissues appear essentially within normal limits.

THORACIC SPINE:

Images through the lower thoracic region reveal no substantial abnormality. The visualized disc spaces demonstrate normal signal characteristics and normal height without evidence of disc protrusion. The distal thoracic cord also appears unremarkable, with the conus medullaris located at approximately L1.

LUMBAR SPINE:

L1-2, L2-3, L4-5 and L5-S1: There is essentially normal disc signal and disc height, without evidence of disc protrusion or compressive sequelae. The neural foramina are grossly patent. L3-4: There is mild degenerative loss of disc signal and disc height. There is mild broad-based disc protrusion, extending, however, more markedly into the neural foramen on the left with some additional extraforaminal protrusion also noted. There is mild contact on the transiting L4 nerve roots with mild displacement on the left side. There is also moderately severe left-sided foraminal stenosis with likely early entrapment of the exiting left L3 nerve root.

OPINION:

Mild to moderate degenerative disc disease at L3-4. There is broad-based disc protrusion although eccentric towards the left and extending through the left neural foramen. There is contact on the transiting L4 nerve roots with mild displacement on the left. There is also likely entrapment of the exiting left L3 nerve root.

69427: wcf

PRINTED BY DS92361 DATE 8/12/2008
Dictating Physician: CLEREMY W. YOUNG, M.D.

Signing Physician: DALLAS LOVELACE III, M.D.

EMERGENCY RECORD

TRIAGE (Sun Jul 06 2008 11:33 KBA)

PATIENT: NAME: Thomas L Brown, AGE: 58, GENDER: Male, DOB:

TIME OF GREET: Sun Jul 06 2008 11:23, LANGUAGE: English, RACE: Black,

STATED PAIN GOAL: 0, ED - wait: NA - patient taken directly to room,

Suicide Assessment: Z- None above- No Assessment needed, SSN:

ZIP CODE: , KG WEIGHT: 115.2 (est.), HEIGHT: 193cm,

PHONE: , MEDICAL RECORD NUMBER: 0000454233, ACCOUNT NUMBER:

0818800043, ADMITTING: Unknown Ed Physician, ATTENDING: Unknown Ed

Physician, PRIMARY CARE: ALLGOOD, IBEX NUMBER: 20080706113346ADT.

PREVIOUS VISIT ALLERGIES: Nka.

ADMISSION: URGENCY: Fast Track, TRANSPORT: Ambulatory, DEPT: Emergency,
BED: FT 19.

VITAL SIGNS: BP 142/70, Pulse 76, Resp 20, Temp 97.9 O, Pain 6, O2 Sat -.

COMPLAINT: BACKPAIN.

TRIAGE ASSESSMENT: Pain education sheet given, INVOLVED IN MVC 5/2/08 WITH
INTERMITTENT BACK PAIN INCREASING IN SEVERITY THIS AM; C/O NECK TO LOW
BACK PAIN; MAEW; C/O INTERMITTENT NUMBNESS IN LEGS, Pain level 6 Hurts
Even More, using faces pain scoring, Quality is dull., Quality is
intermittent.

MEDICAL/EDUCATIONAL ASSESSMENT: Traumatic injury GCS: 15, Traumatic injury

RTS: 12- Patient has had the pneumonia vaccine, had the flu vaccine,

Communication Problem: No, Cultural Barrier: No, Religious Barrier: No,

Physical Impairment: No, Psychological Problems: No.

IMMUNIZATIONS: Immunizations up to date, Last tetanus shot received less
than 5 years ago.

KNOWN ALLERGIES

Nka.

HPI BACK (12:19 BMC)

TIME: Patient assessed at: 11:50.

CHIEF COMPLAINT: Patient presents for the evaluation of lower, back pain.

HISTORY: History obtained from patient.

MECHANISM OF INJURY: Complaint occurred by vehicle.

TIME COURSE: Onset of symptoms reported as gradual, Onset was 2 months ago

.. Patient currently has symptoms. Complaint is intermittent.

ASSOCIATED WITH: Numbness is present, Motor weakness is not present. No
bowel incontinence, bladder incontinence, Able to void, No abdominal
pain, fever, Sciatica is present, both, No tingling, dysuria.EXACERBATED BY: Patient's condition exacerbated by movement, walking,
lifting.NOTES: pt was in mvc 2months ago when he developed the pain. he does a lot
of heavy lifting at work, which believes has exacerbated the pain. he
has been taking alleve as recommended by dr allgood, but pain
continues. also reports shooting pain down both legs with some
numbness. denies fever, ivda, bowel/bladder incontinence.

PAST MEDICAL HISTORY (Sun Jul 06 2008 11:33 KBA)

MEDICAL HISTORY: History of hypertension, .

SURGICAL HISTORY: History of tonsillectomy.

PSYCHIATRIC HISTORY: No previous psychiatric history.

SOCIAL HISTORY: Denies smoking, Denies consumption of alcohol, Lives at

Name: Brown, Thomas L Age: M58 MedRec: 0000454233 AcctNum: 0818800043

of 4

The Regional Medical Center*3000 St. Matthews
Rd*Orangeburg, SC*29118*803-395-2204

TRMC HEALTH
EMERGENCY RECORD

home with family.

FAMILY HISTORY: Family history includes hypertension.

ROS

CONSTITUTIONAL (12:19 BMC): Negative constitutional review of systems. No fever.

CARDIOVASCULAR (12:19 BMC): No diaphoresis, chest pain, orthopnea, dyspnea on exertion.

RESPIRATORY (12:19 BMC): No SOB.

GI (12:20 BMC): No abdominal pain.

GENITOURINARY MALE (12:20 BMC): No incontinence, dysuria.

MUSCULOSKELETAL (12:23 BMC): Historian reports back pain.

NEUROLOGIC (12:23 BMC): Historian reports paresthesias. No paralysis.

NOTES (12:24 BMC): pt does report having more urgency with urination, but no loss of control. he also c/o difficulty getting an erection since the injury.

PHYSICAL EXAM

CONSTITUTIONAL (12:25 BMC): Vital Signs Reviewed.

HEAD (12:25 BMC): Atraumatic, Normocephalic.

NECK (12:25 BMC): Normal ROM. No meningeal signs, Cervical spine nontender.

CARDIOVASCULAR (12:26 BMC): RRR. Heart sounds normal. Normal S1 S2.

ABDOMEN (12:33 BMC): Assessment includes:. Abdomen is nontender. No pulsatile masses. Normal rectal exam.

BACK (12:34 BMC): Assessment includes:. No CVA tenderness, There is midline tenderness. in the lower back area, There is paraspinal tenderness.

There is paraspinal tenderness in the lower back. Pain with straight leg raise, on the left, at 40 degrees, on the right, at 40 degrees.

NEURO (12:35 BMC): GCS is 15. No focal motor deficits, focal sensory deficits.

DIAGNOSIS (13:26 BMC)

FINAL: PRIMARY: lumbar strain, sciatica, ADDITIONAL: .

MEDICATION SERVICE

Percocet 5/325 (12:06 BMC): Order: Percocet 5/325 : 2 tab(s) : By mouth
Notes: back pain

Ordered: Sun Jul 06 2008 12:06

Ordered by: Brian Chung

Entered by: Brian Chung Sun Jul 06 2008 12:06

Documented as given by: Rendie Kaigler R.N. Sun Jul 06 2008 12:08

MEDICATION , Time given: 1208, Given in amount and via route as prescribed, Amount given: 2TABS, Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Emotional support needed and given, Patient tolerated procedure well, Administered by RK, Patient in position of comfort, Side rails up, Cart in lowest position, Family at bedside.

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PRINTED BY DS92361 DATE 8/12/2008
Follow Up (13:04 JNZ) - Decreased pain, On a scale -10 patient rates pain as 4. No signs or symptoms of allergic reaction noted, Advised not to ambulate without assistance. Patient in position of comfort. Side Name: Brown, Thomas L Age: M58 MedRec: 0000454233 AcctNum: 0818800043 Prepared: Sun Jul 06 2008 19:21 by Page: 2 of 4

The Regional Medical Center*3000 St. Matthews Rd*Orangeburg, SC*29118*803-395-2204

TRMC HEALTH
EMERGENCY RECORD

rails up, Cart in lowest position, Family at bedside, Call light in reach.

RADIOLOGY INTERPRETATION (13:22 GEM)

BACK: Interpretation of the Lumbar spine x-ray shows, no fracture, no subluxation, DDD and DJD worse at L5-S1, lumbar straightening query spasm.

INTERPRETER: Preliminary review of x-rays by Radiologist.

DOCTOR NOTES (13:25 BMC)

TEXT: pain improved with percocet, no fract or sublux on xray. will give followup with neuro, dr alhatou.

NURSING ASSESSMENT: BACK (12:07 RK)

TIME ASSESSED: Patient was assessed at 1207.

CONSTITUTIONAL: Patient arrives ambulatory with steady gait to treatment area. History obtained from patient. Patient appears comfortable.

Patient is cooperative, alert and oriented x 3. Patient appears in no acute distress, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink.

BACK: Patient denies back pain. Patient is able to ambulate normally, Patient denies parasthesias, Patient denies CVA tenderness, extremity weakness, Patient complains of pain to entire back.

NECK: Patient has full range of motion to neck, Trachea midline, Patient's neck nontender. No lymphadenopathy noted to neck.

SAFETY: Side rails up, Cart in lowest position, Family at bedside.

ORDERS

Special Teaching, Needs, Educ, Pediatric by RK for BMC on Sun Jul 06 2008 12:08 Status: Active.

PO, topical meds 1-3 by RK for BMC on Sun Jul 06 2008 12:08 Status: Active.

L-Spine by BMC for BMC on Sun Jul 06 2008 12:08 Status: Done by DRS Sun Jul 06 2008 12:33 Comment: lower back pain after mvc.

LEVEL II by RK for BMC on Sun Jul 06 2008 13:42 Status: Active.

VITAL SIGNS (Sun Jul 06 2008 11:33 KBA)

VITAL SIGNS: BP: 142/70, Pulse: 76, Resp: 20, Temp: 97.9 O, Pain: 6, O2 sat: -.

DISPOSITION

PATIENT (13:26 BMC): D/C VS Reviewed: Yes, Nurses Notes Review: Yes, Meds. reconcilled: yes, Radiology Results: documented, Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable. Patient Flag: .

PRESCRIPTION (13:28 BMC)

Percocet 5/325: Tablet : 325 mg-5 mg.: Oral=Quantity: ***1*** Unit: TAB
Route: Oral Schedule: every 4-6 hours Dispense: ***15***

NURSING PROCEDURE: TRANSPORT TO TESTS (12:30 RK)

Name: Brown, Thomas L. Age: M58 MedRec: 0000454233 AcctNum: 0818800043
Prepared: Sun Jul 06 2008 19:21 by Page: 3
of 4

The Regional Medical Center*3000 St. Matthews
Rd*Orangeburg, SC*29118*803-395-2204

TRMC HEALTH
EMERGENCY RECORD

TIME: Procedure was performed at 1230, Patient transported to X-ray, via
cart, accompanied by nurse, Emotional support needed and given. Patient
tolerated procedure well.

SAFETY: Side rails up, Cart in lowest position, Family at bedside.

NURSING PROCEDURE: NURSE NOTES (13:04 JNZ)

TIME: Patient returned from x-ray, in no apparent distress. Patient states
decreased pain, Patient resting quietly, Family at bedside.

NURSING PROCEDURE: NURSE NOTES (13:05 JNZ)

TIME: PT REPORTS PAIN DECREASING, PAIN 4/10.

NURSING PROCEDURE: DISCHARGE NOTE (13:32 RK)

TIME: Procedure was performed at 1332, Patient discharged home, Patient
ambulates without assistance, Transported via friend/family driving.
Patient unaccompanied, Discharge instructions given to patient, Above
Person(s) verbalized understanding of discharge instructions and
follow-up care, Patient treated and evaluated by physician, discharged
by physician.

INSTRUCTION (13:27 BMC)

DISCHARGE: LUMBOSACRAL STRAIN - WITH X-RAYS, SCIATICA .

PHARMACY: PERCOCET.

FOLLOWUP: 1, M.I. Alhatou The Neurologic and Pain Clin 2850 Pelham Ct.
Orangeburg SC 29118 531-8500.

ADMIN

DIGITAL SIGNATURE (12:07 RK): Kaigler R.N., Rendie.

(12:30 RK): Kaigler R.N., Rendie.

(13:32 RK): Kaigler R.N., Rendie.

(16:10 KBA): Andrews R.N., Karen.

(19:17 JNZ): Zeigler, RN, Jennifer.

CURRENT MEDICATIONS (11:34 KBA)

Lotrel: 10/20MG DAILY; OUT LAST PM.

Diovan HCT: 320/25 MG PM; RAN OUT THIS AM.

KEY:

BMC=Chung, Brian GEM=Morgan, Gerard JNZ=Zeigler, RN, Jennifer

KBA=Andrews R.N., Karen RK=Kaigler R.N., Rendie

Name: Brown, Thomas L Age: M58 MedRec: 0000454233 AcctNum: 0818800043

** FINAL **

Exam Date: 20080706130400
XR SPINE LUMBOSACRAL, AP & LAT
Patient: BROWN, THOMAS LEE
MRN: 0000454233
Account: 0818800043

CLINICAL HISTORY: BACK PAIN.

DATE OF EXAM: 07-06-08. COMPARISON: NONE.

AP, lateral, and spot views of the lumbar spine were obtained.

FINDINGS:

There is abnormal straightening of the lumbar spine. Vertebral body height and alignment are otherwise preserved. No acute fracture or listhesis are noted. There is disc height loss most notably at L5-S1. The posterior elements appear intact although degenerated, most notably at L5-S1. No other significant abnormality noted.

IMPRESSION:

1. Lumbar straightening, query muscle spasm.
2. Lumbar discogenic and posterior facet degenerative changes, worse at L5-S1. If there are radicular symptoms, consider MRI.

62526: rsb

Dictating Physician: GERARD ERIC MORGAN, M.D.

Signing Physician: GERARD MORGAN, M.D.

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DATE 10-23-08

THE NEUROLOGIC AND PAIN CLINIC

28501
Orange, CA 92668

PHONE (803) 551-8500

NAME
Mohammed

ADDRESS

Mohammed Al-Halabi, M.D.
SC Lic. No. 22951
DEA No. BA6915283
NPI No. 1124059245

Mahmoud Abu Ali, M.D.
SC Lic. No. 22809
DEA No. BA023585
NPI No. 1841216901

(Please Label Contents) Mg No Sig Rep

Please advise Mohammed on 10/23/08 to 11/18/08
has been under doctor's care could not give
a full time has been up and down with
Dr. Abu Ali

DISPENSE AS WRITTEN
GROVE PARK PHARMACY

SUBSTITUTION PERMITTED

536-0007

Drive-Thru Window

Dr. Mohammed Alhatou
Dr. Mahmoud Abu-Ata
2850 Pelham Court
Orangeburg, SC 29118
(P) 803-531-8500
(F) 803-533-5585

DATE: September 11, 2008
PATIENT: Brown, Thomas
MR#: 90755

HISTORY: Mr. Brown comes today for a follow up. He had the spinal surgery for his cervical spine with cervical fusion after his MRI showed severe degenerative disc disease with multiple disc bulges and spinal current stenosis as well as impingement on the spinal cord. Since the surgery he said that he had been doing fine. He feels much better and stronger. His pain is much better but he has some tingling and numbness as well as some mild pain in his fingers and some mild neck stiffness. He's doing regular exercise and daily walking and he denies any bowel or bladder dysfunction, denies any speech or swallowing problems, denies any headaches or double vision, denies any lower back pain, denies any falls. He said that the current pain medications are helping.

PHYSICAL EXAMINATION: BP – 164/88, heart rate – 76. He is conscious, alert, and oriented X 3. Fluent speech, intact comprehension, supple neck, no cervical tenderness. Chest is clear. Heart regular. Abdomen is soft, extremities with no edema. Cranial nerves II – XII are intact. Motor: good strength in the upper and lower extremities. Sensation: slightly decrease to pin prick in the tips of the first three digits of both hands. DTR's symmetrical +2 in the upper and lower extremities. Gait is steady. Romberg is negative. Coordination: no ataxia. His labs showed elevated homocysteine and he was started on Foltex tablets twice a day and his hemoglobin A1C was 6.6%. Other labs were reviewed with him in details.

ASSESSMENT PLAN:

1. Degenerative spine disease with severe cervical stenosis status post surgery – currently doing fine, continue regular exercise and walking. Avoid heavy weight lifting, avoid frequent bending or pushing. Continue same medications.
2. Hyperhomocystenemia – continue Foltex.
3. Patient has hypertension and said that he's running out of his medications and asked me to prescribe his medications until he sees his family health center physician next month. I gave him a Rx for Lotrel 10/40 once a day for 1 month, Vytarin 10/20 once a day for 1 month and Dyovan 320/250 one tablet once a day for 1 month. I will have him come back for follow up in about 2 – 3 months.

Mahmoud ABU-ATA, MD
MA/ja

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Dr. M. Alhaton
2850 Pelham Court Orangeburg, SC 29118
803-531-8500 FAX - 803-531-7654

CERTIFICATE TO RETURN TO WORK OR SCHOOL

Patient Name: Thomas Brown

Was under my care from 8/1/08 to 10/1/08

And will be able to return to work/school on nowhere at this time.

Return appt 9/1/08 @ 9:30am

Comments/Restrictions: patient will be excused from work
for 2 months unable to drive. Restrictions may apply
and changes after next appt above. Thank April

~~William M. Alhaton~~ 8-1-08
Provider Signature Date

Dr. Mohammed Alhatou
Dr. Mahmoud Abu-Ata
2850 Pelham Court
Orangeburg, SC 29118
Tel: (803)531-8500
Fax: (803)533-5585

DATE: July 10, 2008
PATIENT: Brown, Thomas
MR#: 90755

REASON FOR VISIT: Evaluation for neck pain, back pain, arm and leg numbness.

HISTORY: Mr. Brown is a 58 year old right handed nice gentleman who is 6'4" tall who had history of hypertension, hypercholesterolemia and border line diabetes who said that he had been doing fine up until this past May, 2 months ago, when he had a car accident. He said he was looking in the mirror and the car hit his vehicle from behind. He said that his body jerked, his neck went forward and backward and he started to have neck and back pain then. He was told he had lumbar strain, he was having some spasms in the neck and back and since then he had been having nearly daily pain in the neck and back. He described his pain as intermittent, feels as spasms in the neck, middle and lower back. At times it goes to the shoulders and to the thighs. He also complains of numbness, tingling in the hands and the feet and in the thighs. He denies any weakness in the arms or legs. Denies any bowel or bladder dysfunction. He said that his pain is positional and is worse with activity. He denies any headache, no double vision, no blurry vision, no speech problems, no swallowing difficulties, no head trauma, no passing out or seizures. No falls, no walking problems, no dizzy spells, no seizures. No vertigo, no hearing loss, no fever, no chills, no night sweats, no nausea or vomiting. He said that he had X-rays for his spine that were negative. He was prescribed Percocet and Aleve both of which are helping his pain and he's happy with the current pain control.

REVIEW OF SYSTEM: As prescribed in history of presenting illness.

For past medical history, surgical history, family history, social history, medications, please refer to the front page of the chart.

PHYSICAL EXAMINATION: BP - 116/72, heart rate - 72. He is conscious, alert, and oriented to time, place and person. Fluent speech, intact comprehension, repetition, and naming. Head and neck exam: normocephalic, non-traumatic, supple neck, no bruits. Chest is clear to auscultation bilateral. Heart regular rate and rhythm. Abdomen is soft and non-tender, extremities with no edema. He had no spine tenderness. Negative straight leg raising test. Cranial nerves II - XII are intact to detailed exam. Motor: normal tone and bulk, good strength in the upper and lower extremities, 5/5. Sensation: intact to pin prick and light touch, position and vibration all 4 limbs. DTR's symmetrical +1 upper and lower extremities. Babinski: both toes are

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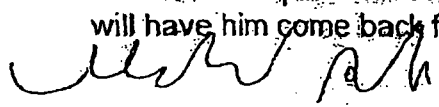
DATE: July 10, 2008
PATIENT: Brown, Thomas
MR#: 90755

Page 2..

down-going. Gait is steady. Romberg is negative. Coordination: intact finger-to-nose test and heel-to-shin test bilateral.

ASSESSMENT:

This is a 58 year old male patient with history of neck and back trauma after a motor vehicle accident after which he is complaining of intermittent frequent neck and back pain in addition to bilateral arm and leg numbness, foot and hand numbness. He was diagnosed with borderline diabetes. I'm not sure if his numbness, tingling sensation is due to small sensory fiber mild peripheral neuropathy related to the border line diabetes. However, his neurological exam is normal. I did a nerve conduction study / EMG for him that was normal and that showed no evidence of cervical or lumbosacral peri-radikulopathy, plexopathy or large fiber sensory neuropathy or motor neuropathy. These findings were discussed with him. I think the description of his pain is musculoskeletal and may suggest muscle spasms, however, I would like to do an MRI of the C-spine and lumbosacral spine for evaluation of cervical and lumbosacral spine and disc disease especially with the history of back trauma. His pain is currently well controlled with the current regiment which he is getting through his PCP. For work up of peripheral neuropathy, I would like to check hemoglobin A1C, protein electrophoresis immunofixation, B-12, thyroid function, ESR, RPR, and homocysteine. I will schedule him for the MRI of the C-spine and lumbosacral spine and suggested regular exercise and suggested physical therapy. I will have him come back for follow up in 8 weeks.



Mahmoud ABU-ATA, MD
MA/j5

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MOHAMMED ALIATOU, M.D.

The Neurology and Pain Clinic
2850 Pelham Court
Orangeburg, SC 29118
(803) 531-8500

Patient ID: THOMAS90755

Name: Thomas Brown

Address:

City:

Study Date: 10 Jul 08 10:45

Gender: Male

Date of Birth:

Age: 58

Referring Physician: Dr. Chung

Patient History:

This is a 58 year old male patient with neck pain, back pain, arm and leg numbness.

Interpretation:

Sensory nerve conduction studies showed normal bilateral median, ulnar, radial sensory and sural responses.

Motor nerve conduction studies showed normal bilateral median, ulnar, peroneal and tibial responses.

Needle exam of selected muscles of the lower and right upper extremities is normal.

Conclusion:

This is a normal study; there is no electrophysiologic evidence of cervical or lumbosacral radiculopathy, plexopathy, motor or large fiber sensory neuropathy.



Mahmoud Abu-Ata, M.D.

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Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
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Peroneal R

Ankle	3.4 ms	7.5 mV		ms	mm	m/s
Fibula (head)	13.8 ms	6.0 mV	Ankle-Fibula (head)	10.4 ms	400 mm	38 m/s
Popliteal fossa	15.8 ms	5.3 mV	Fibula (head)-Popliteal fossa	2.0 ms	80 mm	40 m/s

Tibial R

Ankle	4.2 ms	5.9 mV		ms	mm	m/s
Popliteal fossa	16.2 ms	3.8 mV	Ankle-Popliteal fossa	12.0 ms	525 mm	44 m/s

Peroneal L

Ankle	3.7 ms	9.7 mV		ms	mm	m/s
Fibula (head)	14.4 ms	6.8 mV	Ankle-Fibula (head)	10.7 ms	405 mm	38 m/s
Popliteal fossa	15.7 ms	6.2 mV	Fibula (head)-Popliteal fossa	1.3 ms	75 mm	58 m/s

Tibial L

Ankle	4.6 ms	5.5 mV		ms	mm	m/s
Popliteal fossa	16.8 ms	4.6 mV	Ankle-Popliteal fossa	12.2 ms	510 mm	42 m/s

Median R

Wrist	3.6 ms	13.5 mV	Abductor pollicis brevis-Wrist	3.6 ms	72 mm	m/s
Elbow	10.6 ms	12.0 mV	Wrist-Elbow	7.0 ms	280 mm	40 m/s

Ulnar R

Wrist	2.8 ms	13.4 mV		ms	mm	m/s
Below elbow	8.2 ms	13.2 mV	Wrist-Below elbow	5.4 ms	305 mm	56 m/s
Above elbow	10.4 ms	12.7 mV	Below elbow-Above elbow	2.2 ms	145 mm	66 m/s

Median L

Wrist	3.6 ms	12.5 mV	Abductor pollicis brevis-Wrist	3.6 ms	70 mm	m/s
Elbow	9.8 ms	11.7 mV	Wrist-Elbow	6.2 ms	320 mm	51 m/s

Ulnar L

Wrist	2.7 ms	8.1 mV		ms	mm	m/s
Below elbow	8.9 ms	7.6 mV	Wrist-Below elbow	6.2 ms	325 mm	52 m/s
Above elbow	11.8 ms	6.9 mV	Below elbow-Above elbow	2.9 ms	150 mm	52 m/s

F-Wave Studies:

Nerve	M-Latency	F-Latency
Peroneal R	1.3 ms	69.0 ms
Tibial R	1.3 ms	66.3 ms
Peroneal L	1.4 ms	65.1 ms
Tibial L	1.3 ms	69.3 ms
Median R	3.8 ms	35.9 ms
Ulnar R	2.0 ms	37.9 ms
Median L	4.2 ms	33.9 ms
Ulnar L	3.1 ms	32.0 ms

Sensory Nerve Conduction:

Nerve and Site	Onset-Latency	Peak-Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Sural R							
Lower leg	3.3 ms	4.1 ms	8 μ V	Ankle-Lower leg	3.3 ms	140 mm	42 m/s
Sural L							
Lower leg	3.0 ms	3.8 ms	7 μ V	Ankle-Lower leg	3.0 ms	140 mm	47 m/s
Radial R							
Forearm	2.0 ms	2.6 ms	27 μ V	Anatomical snuff box- Forearm	2.0 ms	100 mm	38 m/s
Median R							
Wrist (Median)	1.7 ms	2.2 ms	41 μ V		ms	mm	m/s
Ulnar R							
Wrist (Ulnar)	1.7 ms	2.0 ms	10 μ V		ms	mm	m/s
Median L							
Wrist (Median)	1.4 ms	2.1 ms	63 μ V		ms	mm	m/s
Ulnar L							
Wrist (Ulnar)	1.3 ms	1.9 ms	15 μ V		ms	mm	m/s
Radial L							
Forearm	1.7 ms	2.3 ms	27 μ V	Anatomical snuff box- Forearm	1.7 ms	mm	m/s

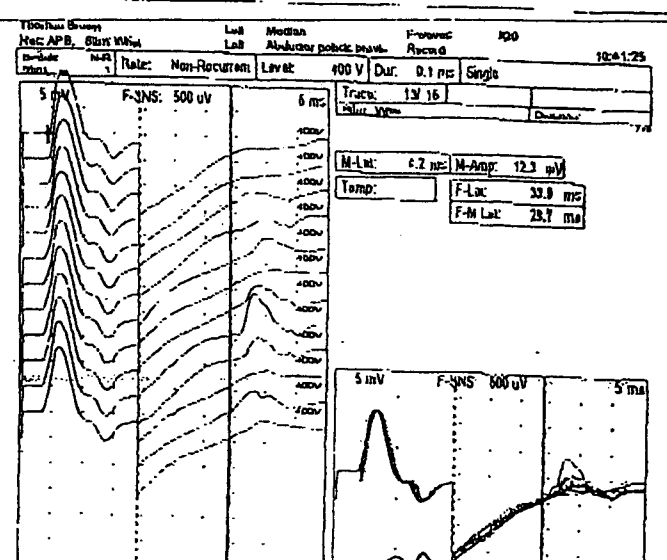
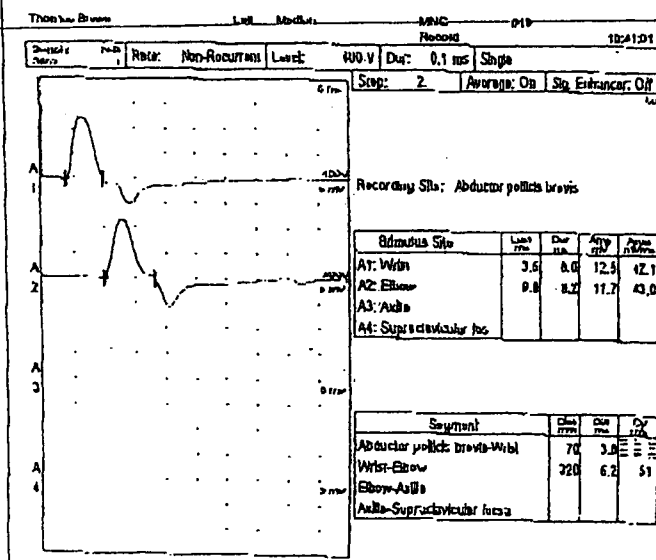
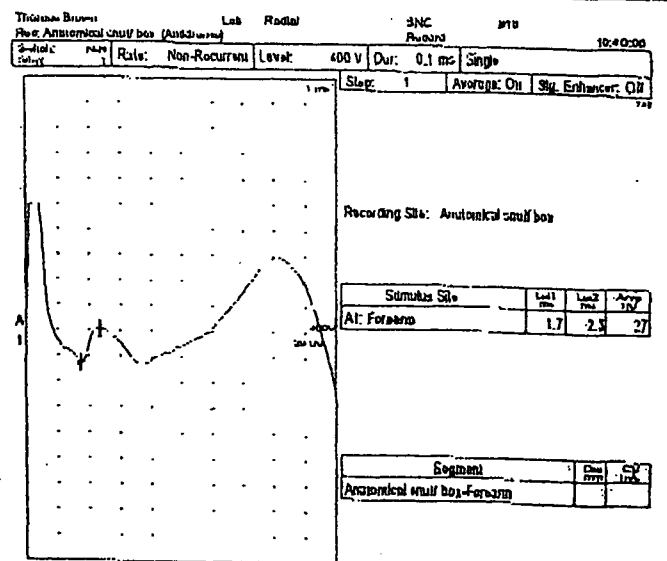
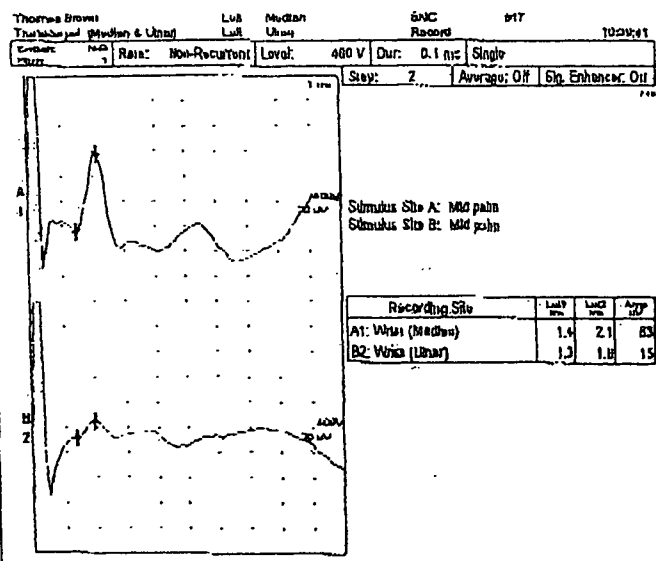
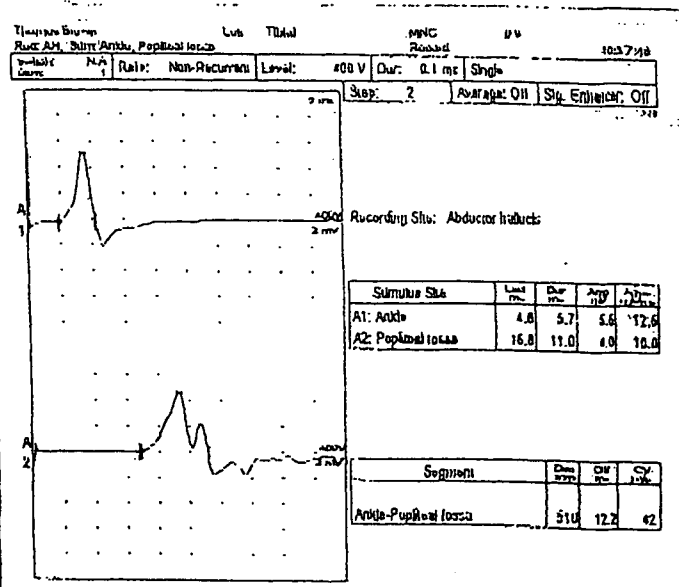
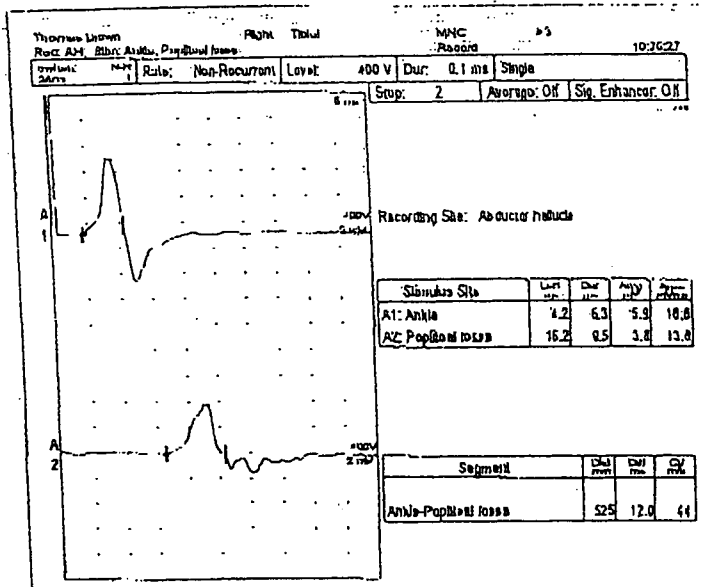
Needle EMG Examination:

Muscle		Spontaneous and/or Volitional Activity						Maximum Volitional Activity		
		Fib	Waves	Fasc	Poly	Atyp	Dur	Amp	Pattern	Effort
Tibialis anterior R	Normal									
Gastrocnemius (Medial head) R	Normal									
Vastus lateralis R	Normal									
Gluteus medius R	Normal									
Biceps femoris (short head) R	Normal									
Adductor magnus R	Normal									
Iliopsoas L	Normal									
Semitendinosus L	Normal									
Vastus lateralis L	Normal									
Tibialis anterior L	Normal									
Gastrocnemius L	Normal									
Gluteus medius L	Normal									
Cervical paraspinals L	Normal									
Cervical paraspinals R	Normal									
Lumbosacral paraspinal L	Normal									
Lumbosacral paraspinal R	Normal									
Deltoid R	Normal									
Biceps brachii R	Normal									
Triceps brachii R	Normal									
Abductor pollicis brevis R	Normal									
1st dorsal interosseous R	Normal									

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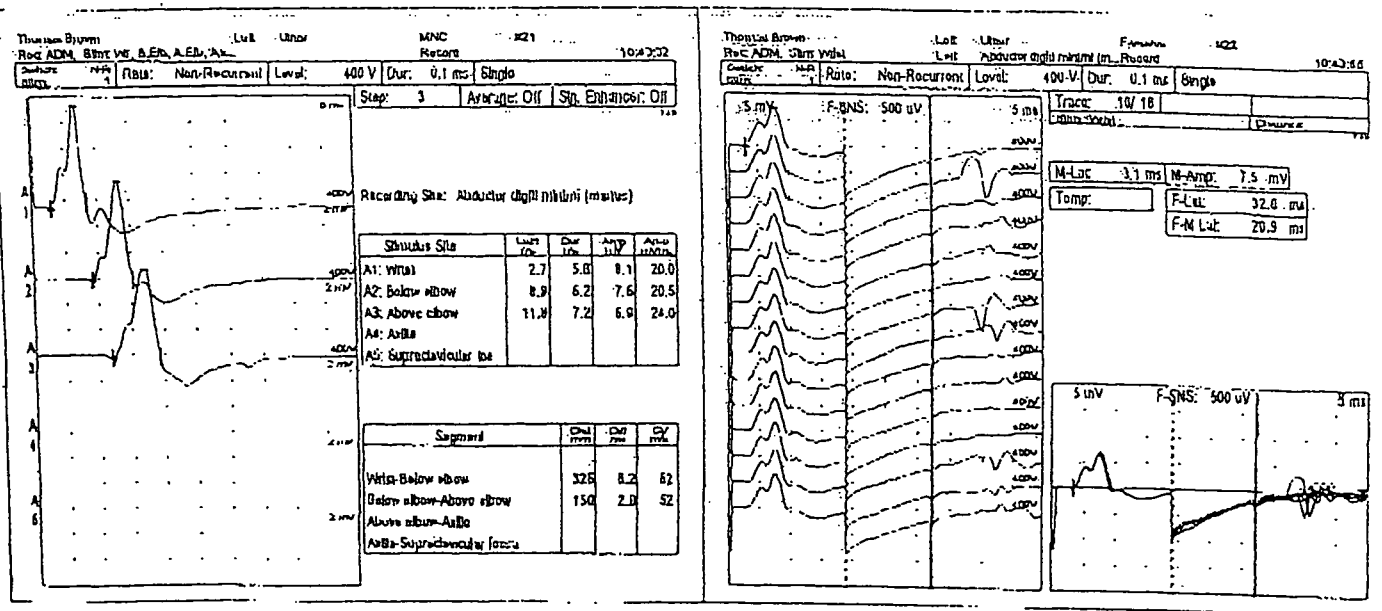
The Neurology and Pain Clinic

Orangeburg, SC

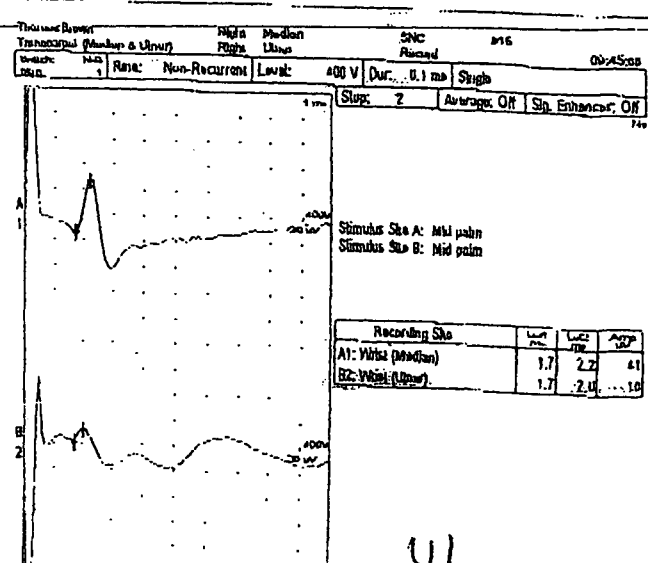
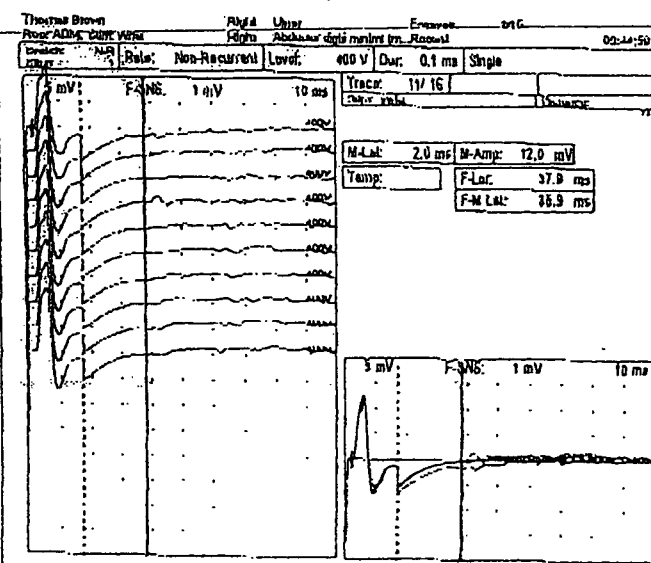
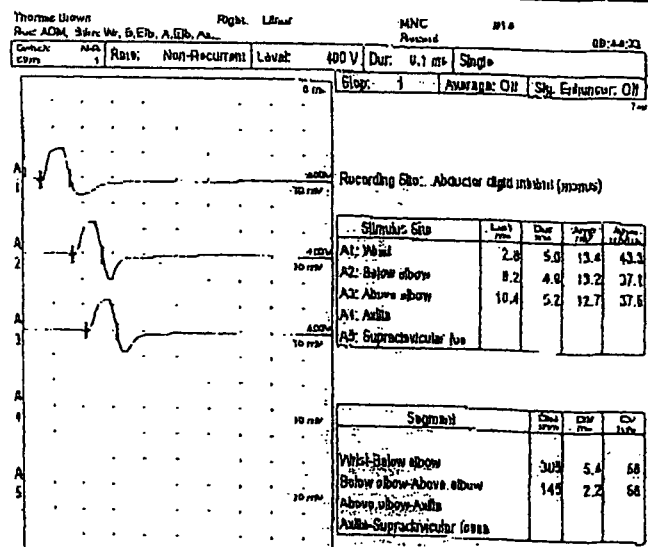
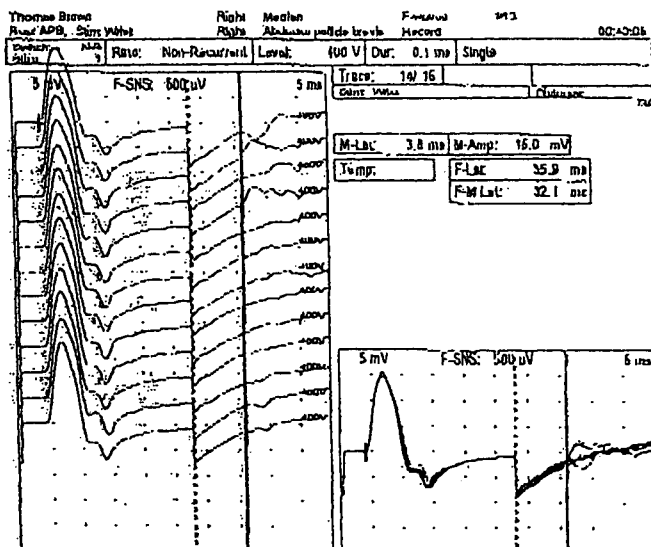
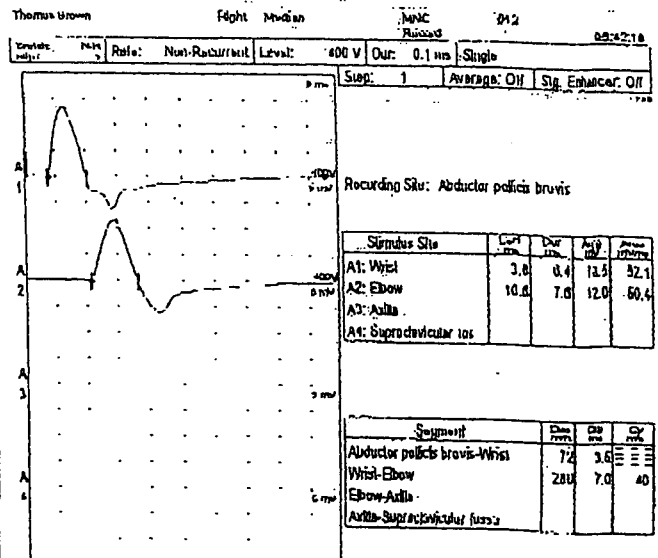
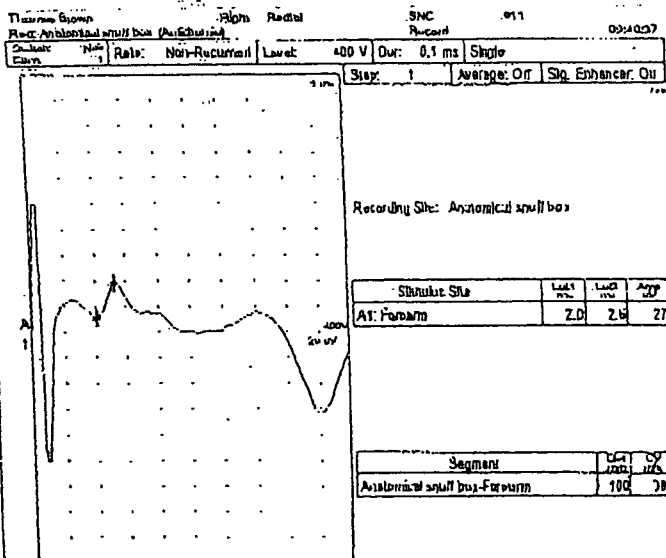


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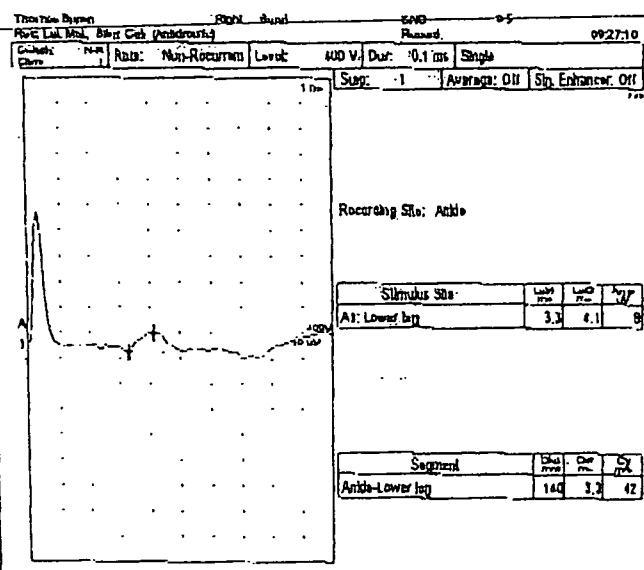
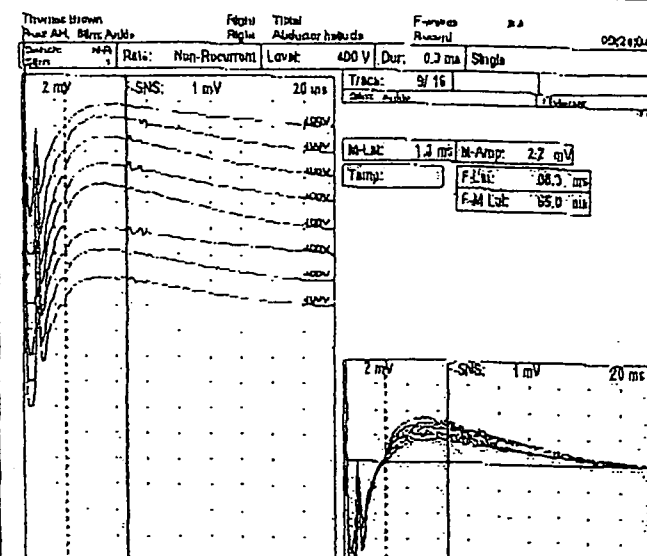
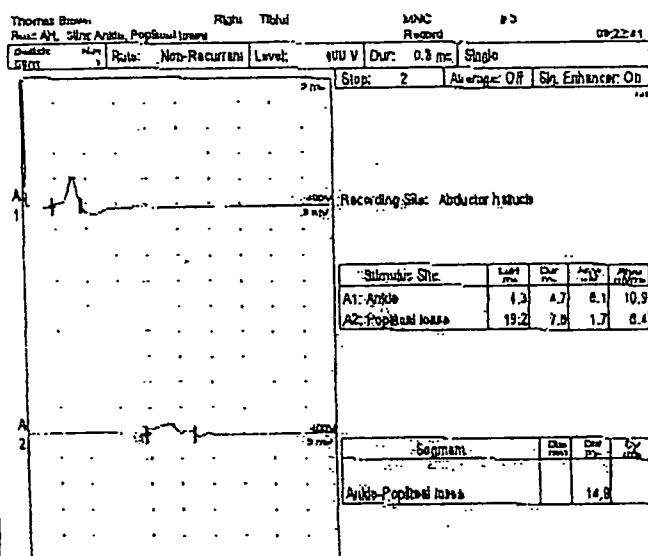
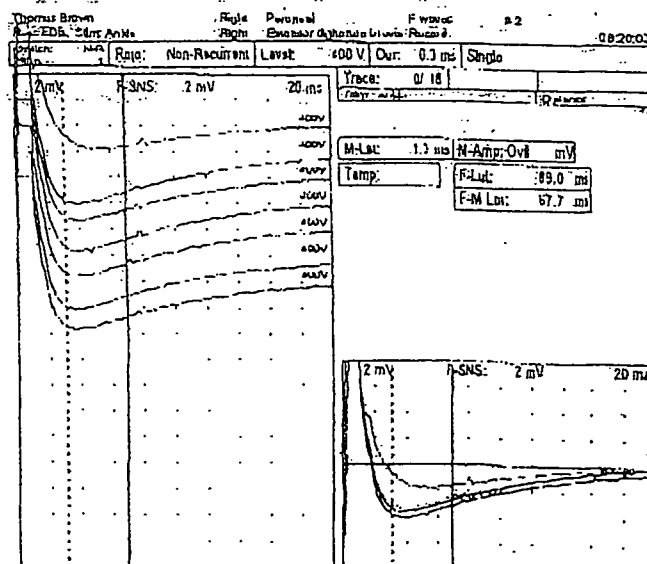
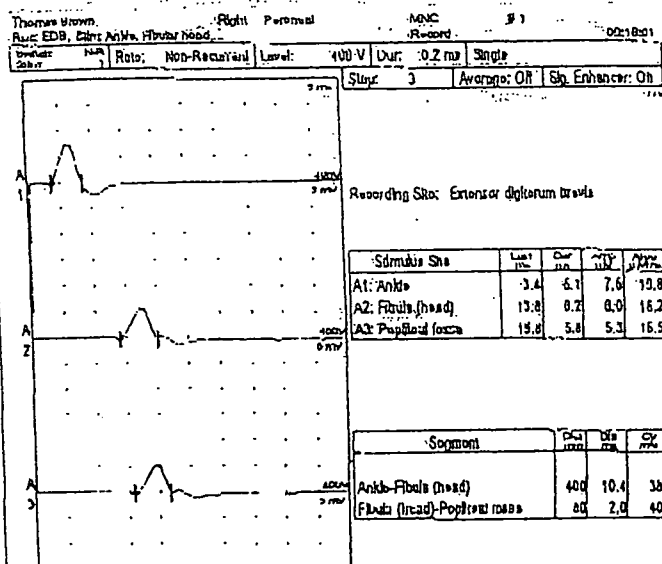


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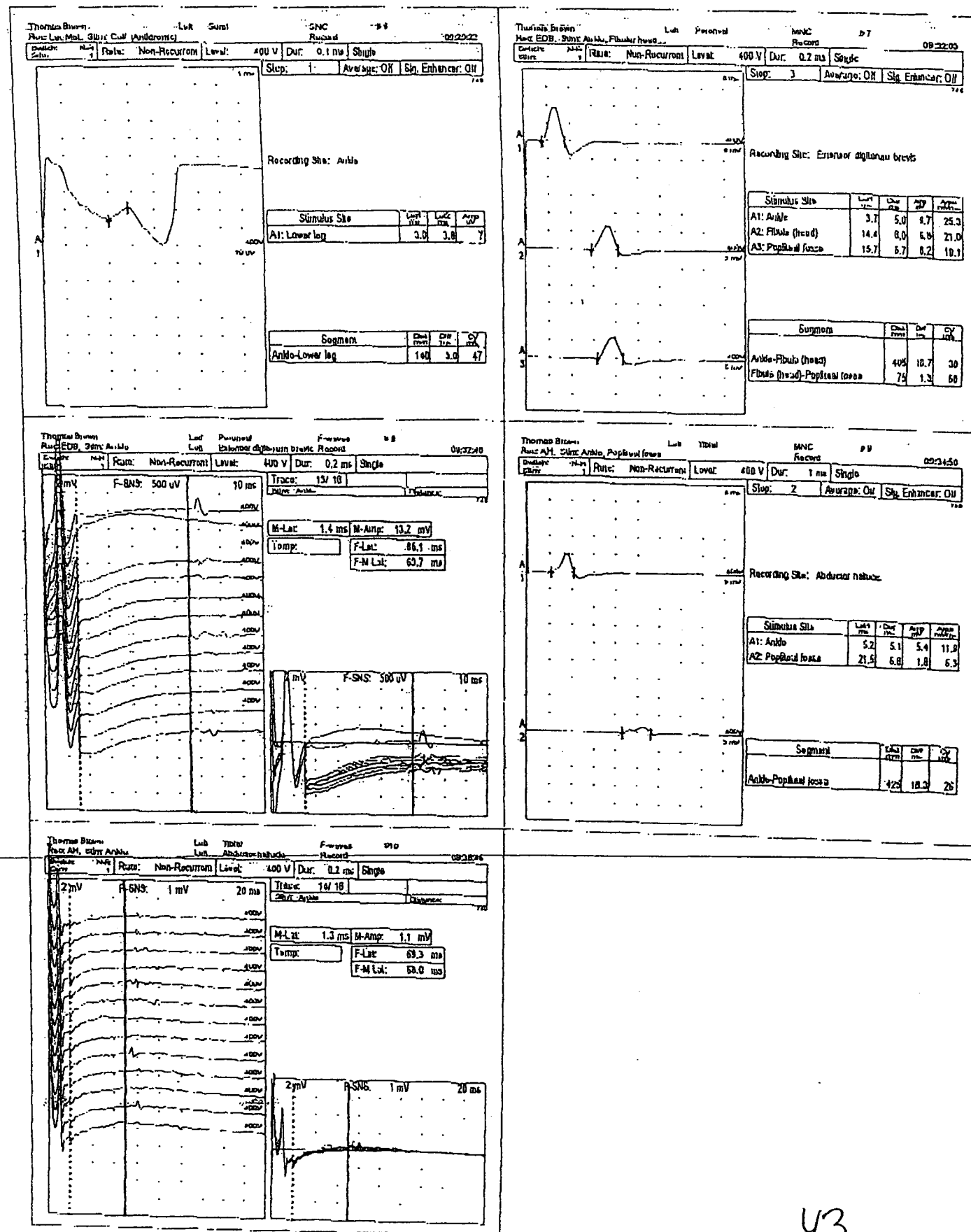


The Neurology and Pain Clinic

Orangeburg, SC



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www.columbianeurosurgical.com

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OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 4/19/10

Mr. Brown returns to the office for follow-up. He is over two months out from an anterior cervical discectomy and fusion at C6-7 for a disc herniation that was causing cord compression. He has had a chronic myelopathy and his myelopathy was made worse by this problem. He had an uneventful perioperative course. Initially he had pretty good improvement of his gait and upper extremity weakness but that now has stabilized. He really has not changed much since I last saw him six weeks ago. He is gradually increasing his activity but says that he still has difficulty with his gait and describes it as a "duck walk". He also continued weakness in his hands that is unchanged since his last visit. He also has significant restriction of ROM, particularly to the right.

On examination, his incision is well healed. He continues to have 4+/5 upper extremity weakness, particularly in his grips. Of note his last consult note indicated 5/5 power and that is an error. He does have a steady gait that is somewhat stiff. He has severely restricted ROM, particularly with rotation to the right.

IMPRESSION/PLAN: Mr. Brown has had some good improvement but by no means complete of his cervical myelopathy. He still has weakness, gait problems and restriction of ROM in his neck. I believe he is at maximum medical improvement at this point. I really do not believe that physical therapy or occupational therapy would help and at this point could actually reverse some of the gains that he has made. I will release him with a 27% impairment of the whole person based on AMA Guides. I have great concerns about him safely operating a truck considering his ROM issues and cervical myelopathy with resultant problems with coordination. He will probably require a Functional Capacity Evaluation in order to define his work restrictions.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MAH

CNAWT: 4040

44

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Randall G. Drye, MD Karl A. Lozanne, MD

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Pain Medicine

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Eva J. Rawl, MD

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(803) 794-3700 - (F) 794-0322

OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 3/8/10

Mr. Brown returns to the office for follow-up. He is a month out from an anterior cervical discectomy and fusion at C6-7. He had had a previous C5-6 fusion. He did very well with this surgery and does not report any significant swallowing problems or problems with his voice. He feels like his upper extremity paresthesias have improved although he still has some numbness and tingling in his hands. He has noticed some loss of range of motion in his neck particularly when turning to the right. He says that makes him difficult for him to drive.

On examination, his incision is well healed. He has 5/5 power throughout. He walks with a steady gait. He does have limited cervical ROM particularly to the right.

IMPRESSION/PLAN: Mr. Brown is coming along nicely. He has a chronic cervical myelopathy that is better since his recent surgery. I think it is too early for him to go back to work. I also do not want to put him through physical therapy as I think he would do better increasing his activity at his own pace. I have asked him to start walking more and doing some of his home exercises. I will see him back in four weeks with films at which time I hope we can put him at maximum medical improvement and makes some decisions about return to work.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MAH

CNAWT: 4040

45

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Spine and Neurological Surgery

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WORK STATUS INFORMATION

PATIENT WORK INJURY INFORMATION

THOMAS L BROWN

82313

Patient Name

Patient social security #

Chart #

BULLDOG HWAY EXPRESS

Employer Name

Insurance Carrier

3/10/2010

Case #

Date of Service

Date of Accident

Diagnosis code(s) and/or description of condition for which patient is being treated

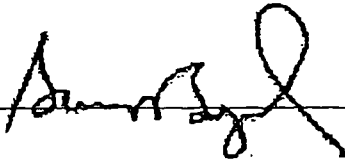
Remain out of work for 6 weeks

PHYSICAL LIMITATIONS

FOLLOW UP

Physician: SCOTT B. BOYD, MD

Signature:



46

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OFFICE CONSULTATION

Patient: Thomas L. Brown
Chart: 82313
Date: 4/14/09

HISTORY OF PRESENT ILLNESS: Mr. Brown is a patient of mine from Orangeburg who underwent a three level anterior cervical discectomy and fusion eight months ago for severe cord compression for multi-level disc disease. In fact his preop MRI reports a 3.3 mm spinal canal at C3-4 and 4 mm spinal canal at C4-5 and C5-6. C6-7 only had moderate changes with no cord compression. He did very well following that surgery and had improvement of his myelopathic symptoms. He returns today saying that he has a recurrence of some his preoperative symptoms and in many ways he seems worse. He describes pain across his shoulders radiating into his arms, left greater than right in terms of pain. He feels that he is becoming weaker in his hands, particularly on the right side. He says he occasionally experiences electric shocks going down his arms, particularly in his hands. He feels that his gait might be worsening where it had improved substantially after his last surgery. He also notes a muscular twitching in his right arm. He has only minimal neck pain.

PAST MEDICAL HISTORY: His history has changed since I last saw him in that he had been diagnosed with diabetes remotely but since his surgery he is now requiring Insulin for blood sugar control and also his hypertension has worsened.

CURRENT MEDICATIONS: Tekturra, Vytarin, aspirin, Diovan, Glucotrol, insulin, and Aleve.

FAMILY HISTORY AND REVIEW OF SYSTEMS: Well documented in the chart on the history form. That information has been reviewed and signed and is noncontributory except for the information included in the HPI.

PHYSICAL EXAMINATION: He is awake, alert, and oriented. He has some limitation of cervical ROM but no true Lhermitte's sign. He has 4/5 grip strength weakness bilaterally but pretty good biceps and deltoids. His lower extremity power is normal. He does have brisk lower extremity reflexes and a slightly spastic gait. He has visible fasciculations in his right arm.

RADIOGRAPHIC STUDIES: MRI of the cervical spine was performed today at Lexington Medical Center and I do not have the report, but his spinal canal is now patent with CSF completely surrounding his spinal cord at his operated levels from C3-C6. However, at C6-7 there is degenerative herniated disc causing cord compression. I do not appreciate any signal change at this level. This is a new finding from his preoperative MRI.

IMPRESSION/PLAN: Mr. Brown has a difficult problem. He had done reasonably well from a three level anterior cervical discectomy and fusion. Now he has new symptoms of worsening myelopathy and new findings on his new MRI scan of C6-7 stenosis mostly from disc herniation. This clearly represents a neurologic deterioration and, therefore, his new disc herniation is difficult to dismiss. I do not believe epidural steroid injections would help and I think physical therapy would be contraindicated. I believe instead he needs surgical decompression and fusion and I believe this would best be accomplished by an anterior cervical discectomy and

4/14/09

fusion at C6-7. Previous films have shown good early fusion at this operated levels so I believe I could amputate the lowest segment of his plate at C6 to allow room to apply a C6-7 instrumentation anteriorly. I think this is better than a posterior approach at this level. He understands and very much wishes to proceed.

The surgical procedure that has been offered was described in detail, and risks, benefits and alternatives were discussed. A model was used to demonstrate this, and the patient voiced an understanding. I have been careful not to guarantee relief of symptoms or improvement of the condition, but at this point surgery appears to be a reasonable option.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MH

CNAWT: 4041

48

fusion at C6-7. Previous films have shown good early fusion at this operated levels so I believe I could amputate the lowest segment of his plate at C6 to allow room to apply a C6-7 instrumentation anteriorly. I think this is better than a posterior approach at this level. He understands and very much wishes to proceed.

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Scott B. Boyd, MD

SBB/MH

CNAWT: 4041

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Eva Jane Rawl, MD

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OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 10/20/08

Mr. Brown returns today. He is now two months out from a three-level anterior cervical discectomy and fusion. He seems to be doing very well and says that he is continuing to improve. He has very little in the way of residual pain except for some right lateral neck pain that seems to be getting better as well.

On examination, his incision is well healed. He has good power throughout. He has surprisingly good cervical ROM and his gait is steady.

Plain films today show excellent positioning of his hardware and implants which I think are already showing early fusion.

IMPRESSION/PLAN: Mr. Brown is doing very well. I will see him back on an as-needed basis and we will allow him to return to work here in the next couple of weeks.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MH

CNAWT: 4040

Faxed To: Mahmoud Abu-Ata, MD

50

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OFFICE CONSULTATION

Patient: Thomas L. Brown
Chart: 82313
Date: 4/14/09

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WORK STATUS INFORMATION

PATIENT WORK INJURY INFORMATION

THOMAS L BROWN

82313

Patient Name

Patient social security #

Chart #

BULLDOG HWAY EXPRESS

Employer Name

Insurance Carrier

04/14/2009

Case #

Date of Service

Date of Accident

Diagnosis code(s) and/or description of condition for which patient is being treated

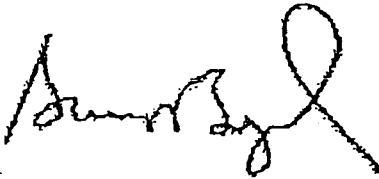
Remain out of work for pending surgery

PHYSICAL LIMITATIONS

FOLLOW UP

Physician: SCOTT B. BOYD, MD

Signature:



52

SCOTT B. BOYD, MD

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Phone: (803) 794-3700

Fax: (803) 794-0322

PERMISSION RETURN TO WORK/SCHOOL

This is to certify that: THOMAS L BROWN

is unable

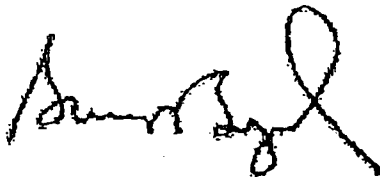
to return to work

on 10/20/ thru 11/14/08

Date: 10/20/2008

Physician: SCOTT B. BOYD, MD

Signature:



53

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WORK STATUS INFORMATION

PATIENT WORK INJURY INFORMATION

THOMAS L BROWN

82313

Patient Name

Patient social security #

Chart #

BULLDOG HWAY EXPRESS

Employer Name

Insurance Carrier

04/14/2009

Case #

Date of Service

Date of Accident

Diagnosis code(s) and/or description of condition for which patient is being treated

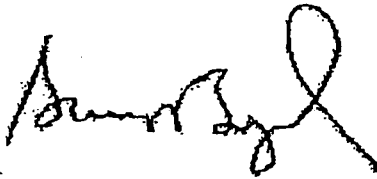
Remain out of work for pending surgery

PHYSICAL LIMITATIONS

FOLLOW UP

Physician: SCOTT B. BOYD, MD

Signature:



54

Dr. Scott B. Boyd, MD
Columbia Neurosurgical Associates
132 Sunset Court
West Columbia, SC 29169

Preston F. McDaniel, Esquire
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

RE: Thomas Brown
D/O/B: ; Chart No.: 82313

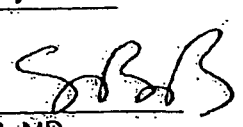
Dear Mr. McDaniel:

After review of the history given to you by Mr. Brown which included the history that, "On May 2nd he was involved in a motor vehicle accident and shortly thereafter developed severe neck and back pain. He denies any previous problems with his neck and back.." The following questions are now posed:

Is it your opinion to a reasonable degree of medical certainty that the problems that he has with his neck and back and his need for medical care either stem directly from the automobile accident of May 2, 2008 or the accident aggravated and caused to become symptomatic a pre-existing conditions in his neck and back which resulted in the need for medical care?

☒
yes

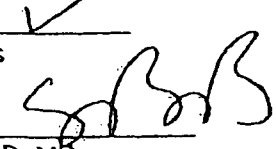
No


SBB, MD

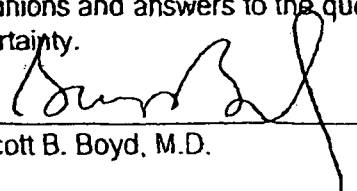
In reference to the current state of his treatment, based on a review of your August 25, 2008 note, you have scheduled him for neck surgery on September 2, 2008 and your opinion to a reasonable degree of medical certainty, is this treatment necessary as a result of his injuries received in the accident?

☒
yes

No


SBB, MD

I have reviewed the above referenced statements and they constitute my opinions and answers to the questions posed to a reasonable degree of medical certainty.


Scott B. Boyd, M.D.

9/15/08
Date

Page 1 of 1

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Randall G. Drye, MD

Pain Medicine

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OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 9/12/08

Mr. Brown returns today. He is two weeks out from a three level anterior cervical discectomy and fusion. His preoperative symptoms have improved significantly. He states he is 80% better. He still has a bit of posterior neck pain.

On exam his power is 5/5. His wound is healing nicely.

ASSESSMENT/PLAN: Mr. Brown is healing nicely following a three level ACDF. I would like to see him back in six weeks with films.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/GF/KB

CNAWT: 4040

Faxed To: Mahmoud Abu-Ata, MD

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OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 8/25/08

Mr. Brown returns today. He had a course of steroids and despite this he continues to report neurologic decline.

On examination, he shows signs of neurologic decline. His power is 4/5 in his arms bilaterally at all stations. He also has numbness in his legs.

IMPRESSION/PLAN: Mr. Brown has progressive cervical myelopathy and needs cervical decompression. I have recommended a three ACDF. The surgical procedure that has been offered was described in detail, and risks, benefits and alternatives were discussed. A model was used to demonstrate this, and the patient voiced an understanding. I have been careful not to guarantee relief of symptoms or improvement of the condition, but at this point surgery appears to be a reasonable option. He wants to proceed as soon as possible.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/CF/MH

CNAWT: 4040

Faxed To: Mahmoud Abu-Ata, MD

57

SCOTT B. BOYD, MD

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132 Sunset Court • W. Columbia, SC 29169

Phone: (803) 794-3700

Fax: (803) 794-0322

PERMISSION RETURN TO WORK/SCHOOL

This is to certify that: THOMAS L BROWN

is unable

to return to work

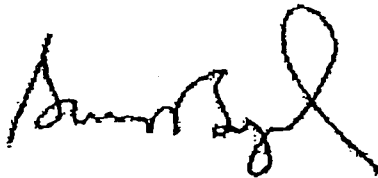
on 08/04/08

Mr. Brown is having back surgery 09/02/08. He will be out of work until approximately 3 weeks after surgery.

Date: 08/25/2008

Physician: SCOTT B. BOYD, MD

Signature:



58

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Randall G. Dye, MD

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Date: 08/25/2008

Dear THOMAS L BROWN,

You have been scheduled for a(n) Anterior Cervical Discectomy and Fusion on 09/02/2008 at 0930am.

You must be at the hospital by 0730am on the morning of your surgery.

Your surgery will begin approximately two hours after this time.

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT the night before your surgery.

If you take any ASPIRIN, PLAVIX, COUMADIN, LOVENOX or ANY OTHER BLOOD THINNER PRODUCTS, please stop taking one week prior to your surgery date. Your other medication will be reviewed by a nurse at the time of your pre-operative appointment.

You will need to go to Lexington Medical Center 3 to 5 days before your surgery to have your pre-op workup completed. This will consist of simple lab work and possibly a chest x-ray or EKG.

Please call the following number to pre-register: Lexington Medical Center 791-2314

You will be prescribed pain medication post operatively. Please keep in mind that this is to be used short term, and we encourage you to start weaning yourself off by the time of your post op appointment -in our office.

Please feel free to call if you have any questions or concerns (803) 462-0423.

Sincerely,

59

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OFFICE CONSULTATION

Patient: Thomas L. Brown
Chart: 82313
Date: 8/4/08

HISTORY OF PRESENT ILLNESS: I am being asked by Mahmoud Abu-Ata, MD to evaluate the patient for a chief complaint of back and neck pain. Mr. Brown is a very pleasant 58-year-old truck driver who says that on May 2nd he was involved in a motor vehicle accident and shortly thereafter developed severe neck and back pain. He denies any previous problems with his neck or back. His greatest problem seems to be neck pain which radiates down into his arms bilaterally. He says that he feels that both arms are numb and he also has some occasional numbness in his legs. He feels weak in his arms and sometimes his legs feel "clumsy". He says his symptoms have been relatively stable over the last few weeks neither getting better or getting worse. So far he has tried nonsteroidals but that has not helped. He has not had physical therapy. He says when he turns his neck he senses a popping sound and also a burning pain with extension of his neck radiating out into his shoulders and arms. He is still working. He says overall he has gotten worse since his accident but again he has been relatively stable over the last week or so. He feels weak in his arms but he denies bowel or bladder dysfunction.

PAST MEDICAL HISTORY: Remarkable for hypertension but he is otherwise healthy.

ALLERGIES: NKDA

CURRENT MEDICATIONS: Aleve, oxycodone, Lotrel, Diovan, Vytarin, and aspirin.

SOCIAL HISTORY: He is not a smoker.

FAMILY HISTORY AND REVIEW OF SYSTEMS: Well documented in the chart on the history form. That information has been reviewed and signed and is noncontributory except for the information included in the HPI.

PHYSICAL EXAMINATION: The patient is seated on the exam table and appears generally healthy for age. The patient is awake, alert, and oriented. PERRL. Speech and language are normal, as are attention span and concentration. Affect is grossly normal, and fund of knowledge appears appropriate. Height is 6'4", weight is 254 pounds, and respirations are 14 and regular. Exam of the posterior cervical region reveals mild tenderness to palpation. There is some diminished cervical ROM. Tone in the upper extremities is normal without atrophy, fasciculations or abnormal movements. Spurling's sign is negative. There are no other mechanical signs noted. There is definite grip strength weakness at 4+/5. His other upper extremity groups are 5-/5 and symmetric. Sensation is intact to light touch and pinprick. DTRs are 1 to 2+ throughout and symmetric. Gait is steady. He may have a very subtle Hoffmann's sign on the left but he had downgoing toes bilaterally. I can observe some fasciculations in both hands.

60

RADIOGRAPHIC STUDIES: MRI of the cervical spine shows congenital stenosis that is now compounded by some ligamentum flavum hypertrophy and disc bulging with osteophytes that produces cervical stenosis throughout a wide segment of his cervical canal. This is most prominent at C3-4. I cannot tell if there is any signal change within his cord on this particular MRI scan.

IMPRESSION/PLAN: Mr. Brown has cervical stenosis. He is not overtly myopathic but I am concerned about the weakness in his upper extremities and his fasciculations. There is a very good chance that he will require surgery to decompress his cord but I am going to give him some Decadron today and see him back in two weeks to reassess. If he is no better then he will likely require surgery. I believe this would be best approached anteriorly so that we can stabilize as well as decompress and from that approach he would require at least a C3-4 and C4-5 ACDF and C5-6 may need to be included as well. I told him to call me back if there is any change in his condition prior to his next visit.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MH

CNAWT: 4041

Faxed To: Mahmoud Abu-Ata, MD

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29168
PHONE: (803) 781-2460

PATIENT: BROWN, THOMAS LEE

UNIT/MR NO: M000342882

AGE: 69

ACCT NO: H00045041989

DOB:

SSN:

SEX: M

REQ NO: 10-0053881

REPORT NO: 0419-0212

ADMITTING DR:

ROOM:

ORDERING DR: SCOTT B BOYD MD

PT LOCATION: HRAD

BOYSCO NS

REPORT STATUS: Signed

ORDERED BY: SCOTT B BOYD MD

LOCATION: REG CL1 HRAD

STUDY TYPE: 0419-0050 RAD/CERV SP 2 OR 3 VIEWS OR TRAUMA

DATE OF EXAM: 04/19/10

CLINICAL DATA: 59M, STATUS POST CERVICAL FUSION

CERVICAL SPINE:

FINDINGS: AP and lateral views show evidence of previous fusion procedures at both C-3 and C-5 and C6-7. This represents an interval change since 10/20/08 at which time fusion was continuous in one piece between the C-3 and C-6 levels. Alignment through the fused segments appears anatomic.

MAS

CHARLES G HOOD MD

REPORT STATUS: Signed

BOYD, SCOTT B, MD

ORDER#/PROCEDURE: 0419-0050 RAD/CERVTRA (72040)

EXAM TECH: ULM LEE

PT LOC/ROOM: HRAD/

REP RELEASED BY: HOOCHA RAD 04/19/10 1213

ADD RELEASED BY:

BROWN, THOMAS LEE

DISC DATE: 0

ED DISC DIAG: 00

Ordering Physician's Copy

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794-0322
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**LEXINGTON
MEDICAL CENTER**

2720 Sunset Boulevard
West Columbia, South Carolina 29169
803-791-2600

OPERATIVE NOTE

cc:

PATIENT: BROWN, THOMAS

LOCATION: HORSUM

ADM. #: H00043695956

M.R. #: M000342982

ADMITTED: 02/09/2010

Dictated: 02/09/2010 12:02 PM

DISCHARGED:

Transcribed: 02/09/2010 12:31 PM / wbj

PHYSICIAN: SCOTT B BOYD, MD

DATE OF BIRTH:

DATE OF PROCEDURE: February 9, 2010

PREOPERATIVE DIAGNOSIS: Cervical herniated disk.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURES

1. Anterior cervical disectomy, C6-7.
2. Anterior interbody fusion, C6-7.
3. Anterior plate instrumentation, C6-7.
4. Removal of anterior instrumentation, C5-6.
5. Application of intervertebral interbody implant.
6. Harvesting of morselized autograft.

SURGEON: Scott B. Boyd, MD

ASSISTANT: Jay N. Altemus, PA

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 20 mL.

OPERATIVE NOTE - H00043695956

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LEXINGTON MEDICAL CENTER

COMPLICATIONS: None.

DESCRIPTION OF PROCEDURE: The patient was taken to the Operating Room where he underwent uneventful induction of general anesthesia. He was prepped and draped in the usual sterile fashion over his anterior cervical area.

A right transverse incision was made sharply through the skin and then carried down through the platysma with the Bovie. An avascular plane was bluntly dissected between the sternocleidomastoid and strap muscles just medial to the carotid sheath. This brought the anterior cervical spine into view at the C6-7 level. The caudal extent of the old anterior cervical plate was identified and found to be nearly covered with calcification. This was burred down to reveal the lower 2 screws in the C6 vertebral body. Then, a carbide bit was used to amputate the plate just over the C5-6 interspace and this allowed removal of the 2 screws in the caudal section of the plate. This exposed the complete extent of the C6 body. Inspecting the C5-6 fusion, it was clearly fused.

Then, distraction posts were placed around the C6-7 interspace and a radical discectomy was performed. The disk space was distracted, but it did not distract very much. Midas Rex was used to bur down large posterior osteophytes particularly off the back of the C6 vertebral body, and the epidural space was entered with a microhook. A small Kerrison punch was then used to undercut the remaining osteophyte all the way across the disk space and then even out to the proximal foramina on both sides. This completed the decompression, so attention was turned to the fusion.

The end plates were prepared with the Midas Rex and then a 7-mm medium Cornerstone implant was chosen and packed with autograft which was harvested from the anterior lip of the C6 vertebral body. This implant was then gently tapped into the distracted disk space and it seated nicely. Then, a 14-mm Stryker titanium plate was chosen. Using 14-mm screws, these were passed through the plate and into the C6 and C7 vertebral bodies. Once this was done, this seemed to form a good solid and flush construct. The locking rings were engaged.

The wound was copiously irrigated with bacitracin irrigation and then closed in anatomic layers. A sterile dressing was applied and the operation was terminated. The patient was taken to the Recovery Room in good condition without apparent complications.

DATE _____ TIME _____ AM PM

SCOTT B BOYD, MD

Report Signed:
Report Signor:

OPERATIVE NOTE - H00043695956

Page 2 of 2

LEXINGTON MEDICAL CENTER

2720 Sunset Boulevard
West Columbia, SC 29169

ANATOMIC PATHOLOGY REPORT

Name : BROWN, THOMAS Loc: HNT4P1 Room: 498
Unit #: M000342982 Age: 59 Sex : M
Acct #: H00043695956 Doc: BOYD, SCOTT B, MD

Pat: BROWN, THOMAS (M000342982) Age/Sex: M Loc: 498 (DISC)

CoPath COLL: 02/09/10 00:00 REC: 02/09/10 12:18 PHYS: Boyd, Scott B., MD (
Inpatient Surgical Pat Intervertebral disc

(NOTE)

Patient Name: BROWN, THOMAS
MR#: M000342982
Specimen #L10-1609
Date Finalled: 2/11/2010

Specimen(s) Received
Cervical disc material

Clinical Information
Recurrent herniated nucleus pulposus (sgs)

Gross Description

Received is a 7.0 x 4.5 x 0.3 cm aggregate of grey-white irregularly shaped fragments of soft tissue admixed with bone and cartilage. RS-2 for decal. WT:sk 2/9/10

Microscopic Description

Sections show benign fibrobony, and fibrocartilaginous (disc) tissues with some myxocartilaginous tissue (consistent with portion of nucleus pulposus). These show focal reactively increased nuclear concentration, negative for suggestion of crystallosis; bone negative for any suggestion of abnormal bone turnover (no woven bone by polarized light exam...no increase in osteoblasts or osteoclasts),

Patient: H00043695956 BROWN, THOMAS

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and tissues negative for occult granulomatous pathology or malignancy.

That is, sections show the expected tissues, and they are negative for any surprise findings.

Finding/Reviews/Notes:

Diagnostic Opinion:

(FROM CERVICAL LAMINECTOMY AND DISCECTOMY SPINAL DECOMPRESSION)

TISSUES: BENIGN

FIBROBONY, DISC, AND NUCLEUS PULPOSUS TISSUE WITH REACTIVE CHANGES.

(722.0)

[ROJ:sk 2/10/10]

END OF REPORT

Patient: H00043695956

BROWN, THOMAS

66 Page 2 of 2

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER - IRMO
7035 ST. ANDREWS ROAD
COLUMBIA SC 29212
PHONE: (803) 407-4100

PATIENT: BROWN, THOMAS

AGE:
DCB:
SEX:

UNIT/MR NO: M000342982
ACCT NO: Y00003C54301
SSN:
REQ NO: 09-0006523
REPORT NO: 0422-0009

ORDERING DR: SCOTT B BOYD MD

PT LOCATION: IMRI
BOYSCONS

REPORT STATUS: Signed

ORDERED BY: SCOTT B BOYD MD
LOCATION: REG CLIMRI
STUDY TYPE: 0414-0003 IMRI/MRI CERVICAL W&WO CONTRAST

DATE OF EXAM: 04/14/09

CLINICAL DATA: 58M, HAND NUMBNESS. PAIN IN HER NECK AND
DOWN TO HER ARMS. PREVIOUS SURGERY.

SHOULDERS

MRI OF CERVICAL SPINE WITHOUT AND WITH CONTRAST ENHANCEMENT:

COMPARISON: None

TECHNIQUE: Sagittal T2 weighted, sagittal T1 weighted and axial gradient T2 weighted sequences were obtained. A 3-D volume sagittal T2 weighted sequence was performed. Axial images were reformatted from this data. An axial T1 weighted sequence was performed. Post gadolinium enhancement (20 cc of Multi-Contrast). Sagittal and axial T1 weighted sequences were obtained.

There are artifacts presumably related to metal hardware at C3 through C6 compatible with the history of fusion and anterior fixation.

The C2-3 disc space is unremarkable.

There is posterolateral osteophyte formation at C3-4. Presumed disc fusion material is noted in the disc. There is some mild thickening of the flava ligaments posteriorly with mild degenerative spinal stenosis at this level as seen on axial image 11 of series 4.

At C4-5, there is posterolateral osteophyte formation. There is also presumably some degree of mild degenerative spinal stenosis at this level.

At C5-6, there is posterolateral osteophyte formation. There is probable mild degenerative spinal stenosis at this level related to osteophyte formation and thickening of the flava ligaments.

There is mild diffuse disc bulge at C6-7 and some mild posterolateral osteophyte formation. There is thickening of the flava ligament posteriorly at this level with mild to possibly moderate degenerative spinal stenosis at this level.

There is suspicion of narrowing of the neural foramina bilaterally at this level related to disc bulge. No abnormal

enhancement is seen.

READING: 1. Mild to moderate degenerative spinal stenosis at C6-7 related to disc bulge, posterolateral osteophyte formation and thickening of the flava ligaments. There is probable narrowing of the neural foramina bilaterally at these levels related to disc bulge.

2. Mild degenerative spinal stenosis related to posterolateral osteophyte formation and thickening of the flava ligaments at C3-4, C4-5 and C5-6.

LM

LAYNE R CLEMENZ MD

REPORT STATUS: Signed

BOYD, SCOTT B, MD

ORDER#/PROCEDURE: 0414-0003 IMRI/CERVWWO (72156)

EXAM TECH:

PMKUB

PT LOC/ROOM:

IMRI/

REP RELEASED BY: CLELAY RAD 04/22/09 0901

ADD RELEASED BY:

DISC DATE:

ED DISC DIAG:

BROWN, THOMAS

Page 1 of 1

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: BROWN, THOMAS

AGE: 58

DOB: ~

SEX: M

UNIT/MR NO: M000342982

ACCT NO: H00036562288

SSN:

REQ NO: 08-0136854

REPORT NO: 1020-0597

ADMITTING DR:

ORDERING DR: SCOTT B BOYD MD

ROOM:

PT LOCATION: HRAD

BOYSCONS

REPORT STATUS: Signed

ORDERED BY: SCOTT B BOYD MD

LOCATION: REG CLI HRAD

STUDY TYPE: 1020-0124 RAD/CERV SP 2 OR 3 VIEWS OR TRAUMA

DATE OF EXAM: 10/20/08

CLINICAL DATA: 58M, FUSION.

CERVICAL SPINE:

COMPARISON: No comparison.

FINDINGS: AP and lateral views of the cervical spine show straightening of the normal lordosis. There is fusion anteriorly at C3-C4, C4-C5 and C5-C6 with interbody graft material present at each of these levels. There is a slight retrolisthesis of C4 on C5 and of C5 on C6. Facet disease is present.

IMPRESSION: Postoperative changes consistent with fusion at C3-C4, C4-C5 and C5-C6. There appears to be a very minimal retrolisthesis of C4 on C5 and C5 on C6.

MSA

REBECCA T NEWELL MD

REPORT STATUS: Signed

BOYD, SCOTT B, MD

ORDER#/PROCEDURE: 1020-0124 RAD/CERV/TRA (72040)

EXAM TECH: DSMHAR

REP RELEASED BY: NEWREB RAD 10/21/08 1407

ADD RELEASED BY:

DISC DATE: 0

ED DISC DIAG: 00

PT LOC/ROOM: HRAD/

BROWN, THOMAS

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OPERATIVE REPORT

PATIENT: BROWN, THOMAS	LOCATION: HORSUM
ADM. #: H00035692268	M.R. #: M000342982
ADMITTED: 09/02/2008	D: 09/02/2008 1:54 PM
DISCHARGED:	T: 09/02/2008 1:55 PM / alb
PHYSICIAN: SCOTT B BOYD, MD	DATE OF BIRTH:

DATE OF PROCEDURE: 09/02/2008.

PREOPERATIVE DIAGNOSIS(ES): Cervical herniated disk.

POSTOPERATIVE DIAGNOSIS(ES): Same.

PROCEDURE(S) PERFORMED

1. Anterior cervical disectomy at 3 levels, C3-4, C4-5, and C5-6.
2. Anterior interbody fusion at 3 levels, C3-4, C4-5 and C5-6.
3. Application of anterior plate instrumentation, C3, 4, 5 and 6.
4. Application of intervertebral interbody implants at 3 levels, C3-4, C4-5 and C5-6.
5. Harvest of morselized autograft.

SURGEON: Scott B. Boyd, MD.

ASSISTANT SURGEON: Coleman Fravel, PA.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 25 cc.

COMPLICATIONS: None.

DESCRIPTION OF PROCEDURE: The patient was taken to the Operating Room where he underwent uneventful induction of general anesthesia. He was prepped and draped in the usual sterile fashion over his anterior cervical area. A right transverse incision was made sharply through the skin and then carried down through the platysma with the Bovie. An avascular plane was developed between the sternocleidomastoid and strap muscles and bluntly dissected down to the anterior cervical spine. The C3 through C6 vertebral bodies were exposed and the longus colli was taken up with the Bovie on low-voltage settings. Then starting at C3-4, a radical disectomy was performed using curets and rongeurs down to the posterior disk space. There were large osteophytes, especially off the back of the C3 vertebral body that were burred down with the Midas Rex. After this was done, the posterior longitudinal ligament was carefully dissected using microinstruments and this allowed a small, 1-mm Kerrison punch access to the epidural space. The residual osteophyte was undercut and the posterior longitudinal ligament was taken. This nicely decompressed the central canal all the way across from foramen to foramen. Then attention was turned to the fusion and the endplates were prepared with the Midas Rex. A 6-mm medium Cornerstone implant was chosen and autograft was harvested from the anterior

OPERATIVE REPORT

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LEXINGTON MEDICAL CENTER

PATIENT: BROWN, THOMAS

ADML #: H00035692268

LOCATION: HORSUM

M.R. #: M000342982

lip of the C3 vertebral body. Autograft was packed into a 6-mm Cornerstone implant which was gently tapped into place. Then moving down to the C4-5 disk, in a similar fashion anterior osteophytes were taken down and a radical discectomy was performed. Again large posterior osteophytes were encountered and burred down with the Midas Rex. They were undercut with a small Kerrison punch all the way across the disk space to reveal the epidural space. This nicely decompressed the central canal and proximal foramen bilaterally. Fusion was then accomplished by preparing the endplates and then using another 6-mm medium Cornerstone implant that was packed with autograft. This was tapped into place and nicely countersunk. Then the 3rd disk level at C5-6 was taken down. There was a large anterior osteophyte covering the disk space. Again, after the discectomy was performed osteophytes were taken up with the Midas Rex and a small Kerrison punch. This decompressed the central canal and proximal foramen all the way across. Once this was done, a 3rd 6-mm medium Cornerstone implant was chosen and this implant seated nicely as well. Then a 45-mm Stryker titanium plate was chosen and using 14-mm screws throughout, the plate was attached to the anterior spine at C3, C4, C5 and C6. All 8 screws had excellent bony purchase and the locking rings were engaged. Final fluoroscopy showed good positioning of the hardware and the implants. By visual inspection this appeared to be a good solid and flush construct. Therefore, the wound was copiously irrigated with bacitracin irrigation. Hemostasis was obtained and then the wound was closed in anatomic layers. A sterile dressing was applied and the operation was terminated. The patient was taken to the Recovery Room in good condition without apparent complications.

SCOTT B. BOYD, MD

cc: MAHMOUD ABU-ATA, MD, Orangeburg, SC

OPERATIVE REPORT

PAGE 2 OF 2

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RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: BROWN, THOMAS

AGE: 58

DOB: 11

SEX: M

UNIT/MR NO: M000342982

ACCT NO: H00035692268

SSN:

REQ NO: 08-0113556

REPORT NO: 0904-0087

ADMITTING DR: BOYD, SCOTT B MD

ORDERING DR: SCOTT B BOYD MD

ROOM: 487-1

PT LOCATION: HNT4P2

BOYSCO NS

REPORT STATUS: Signed

ORDERED BY: SCOTT B BOYD MD
LOCATION: DIS IN HNT4P2 487
STUDY TYPE: 0902-0024 OR/FLUORO MORE THAN 1 HR

DATE OF EXAM: 09/02/08

CLINICAL DATA: 58M, CERVICAL HNP, PROCEDURE DONE IN OR

FLUOROSCOPY (MORE THAN 1 HOUR):

Fluoroscopy was provided by means of a portable image intensifier. No films were taken.

CDG

RADIOLOGY DEPARTMENT

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0902-0024 OR/FL2 (76001)

EXAM TECH: CLBRA
HNT4P2/487

PT LOC/ROOM:

REP RELEASED BY: RADDEP REF 09/04/08 0805

ADD RELEASED BY:

DISC DATE: 09/03/08

BROWN, THOMAS

ED DISC DIAG:

KINGSTREE SURGICAL ASSOCIATES
BLAKE H. MOORE, MD FACS
144 COLDSTREAM DRIVE
COLUMBIA SC 29212

(803)-749-7497
FAX: (803)-781-8970
EMAIL: BHMFACTS@hotmail.com

INDEPENDENT MEDICAL REVIEW:

PATIENT: THOMAS LEE BROWN

DOB:

ADDRESS:

SS#:

PHONE:

PREPARED FOR: PRESTON MCDANIEL, ESQ.

ADDRESS: 1315 ELMWOOD AVENUE
COLUMBIA, S.C. 29201

FAX: 803-252-0709

DATE: April 4th, 2009

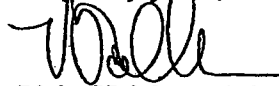
Dear Mr. McDaniel;

I had the pleasure of seeing your client, Mr. Brown, on 3/6/09, and I have prepared the following report in accordance with my exam and review of his records.

I enclose herewith and make as part of my report the standard worksheets for the calculation of disability ratings as per the recognized standard of the AMA Guidelines. In brief summary my exam reveals evidence of a 36% whole person impairment related to his workplace incident. Causality is established. If it is assumed that he is at MMI, he will still require further treatment and assessment. Full details of this process are provided in the body of this report.

If there are any questions, please feel free to contact my office accordingly.

Very truly yours,



Blake H. Moore, MD FACS

BROWN-PAGE 2

BACKGROUND:

Mr. Brown is a 58 year old male who indicates that he was injured when he was involved in an MVA as a restrained driver on or about 5/2/08. He hurt his back and neck, and reported numbness in his right hand. He has undergone an anterior multilevel cervical fusion. He reports ongoing pain, numbness, and weakness. He now reports difficulties with many basic activities of daily living, and loss of function. Independent medical review is requested so as to establish a disability determination as per standard guidelines.

MATERIALS REVIEWED:

In making this assessment I had the opportunity to meet with Mr. Brown on 3/6/09. X-Rays were made available for my personal review, and I concur with the radiologist's written reports. Medical records were received from the following sources and were reviewed:

- 1) Jeremy Young, MD
- 2) Dallas Lovelace, III, MD
- 3) Orangeburg Medical Center
- 4) Gerard Morgan, MD
- 5) Denise Algood, MD
- 6) Lexington Medical Center
- 7) Rebecca Newell, MD
- 8) Scott Boyd, MD
- 9) Columbia Neurosurgical
- 10) Neurology and Pain Clinic
- 11) Mahmoud Abu-Ata, MD
- 12) Mohamed Alhatou, MD

In review of same it appears that Mr. Brown has received generally competent and professional care to date.

PAST MEDICAL HX:

HTN
DIABETES
DYSLIPIDEMIA

PAST SURGICAL HX:

CERVICAL FUSION
TONSILLECTOMY

BROWN-Pg. 3

ALLERGIES

NKDA

MEDICATIONS:

INSULIN
DIOVAN
TEKTURNA-HCTZ
OXYCODONE
VYTORIN
ASA
NSAIDs

SOCIAL HX:

TOBACCO: Quit 1979
ETHANOL: DENIED
DRUGS OF ABUSE: DENIED.

FAMILY HX

CARDIAC: Mother
DIABETES: Brother
CANCER: DENIED

REVIEW OF SYSTEMS:

Complains of insomnia, hematochezia, melanic stool, hand and foot numbness, tremors, anxiety, depression, epigastric pain, dizziness, erectile dysfunction, polyuria, polydipsia, neck pain, back pain, and arthralgias.

HISTORY:

Mr. Brown was calm in recounting his history. His demeanor was appropriate and his hygiene and dress likewise appropriate. He appeared quite credible. He reported onset of back and neck pain following a work related MVA. After initial treatment by his family doctor, he was referred to Dr. Scott Boyd and he eventually underwent cervical fusion. He reports ongoing pain and numbness in both arms, albeit somewhat worse on the left. He is noted with a minimal pre-existing history of orthopaedic complaints. He reports an MVA circa 1985 where he sustained minor injuries as a passenger. He saw a chiropractor briefly. He returned to work with no limits and had no symptoms or treatment from 1985 until the index accident 5/2/08.

HISTORY-Continued:

He described a typical day in his life and how his problems affected him. He reports that sleeping is an issue 7 nights a week. He uses 3 extra pillows to prop his arms and neck. He reports that he needs help to get out of the tub as his arms are weak. He has problems dressing himself and reports problems with buttons, zippers and tying shoes or a tie. He has difficulty in parking a car as he cannot turn his head to visualize safely.

He reports that he is slow with chores and pain is limiting, particularly with repetitive type actions. He reports limited stamina. He reports that he cannot carry loads of any significance. He has hand weakness and cannot open jars.

He reports some basic limitations. He is limited in walking to ¼ mile. He can sit for 60 minutes and stand for 120 minutes at a time. He can climb 1 flight of stairs. He reports a maximal lifting limit of 30 pounds, with repetitive lifting limited to roughly 15 pounds by self description. He reports limited stamina with most tasks limited to 15 minutes or less. He is moderately limited in bending, twisting, stooping, kneeling and crawling.

He reports that his coital activity has decreased from four times weekly to once every 8 weeks. He reports that since his injury he has attempted coitus only 6 times. He and his girlfriend are limited in any sexual activity that requires him to support his weight on his arm as he describes pain and weakness. His physical activity has decreased as he has decreased or stopped jogging or fishing. He has problems picking up his 7 year old son and is generally unable to do so.

He reports a prior history of diabetes. He previously controlled his sugar with diet and exercise. He indicates that with "stress" of the accident and surgery, and a reported use of glucocorticoids he had developed blood sugars of up to 588, requiring a need to start insulin. The records reveal that his surgery was on 9/2/08. On 9/23/08 his blood glucose was noted to be 418 and his primary care physician Dr. Algood started him on insulin, demonstrating a time line consistent with causality.

He reports significant psychological stress. He reports anxiety in worrying about his future. He reports weight gain of 10 pounds. He reports insomnia and a loss of libido. He reports frustration. He reports relationship discord with frequent arguments with his girlfriend. He reports self isolation. He denied suicidal ideation.

He reports ongoing numbness in both of his hands. He reports ongoing weakness in both arms. He describes numbness and "shock" like sensations radiating from his neck to both hands. He reports significant symptoms in his left hand thrice a day, while his right hand is involved roughly twice a week.

EXAM:

Hgt: 6'4", Wgt: 259 lbs. BP: 181/119 P: 67 R: 20 O2Sat: 99% T: 97.6

HEENT: Conj.: Pink, Sclerae: Anicteric, No carotid bruit. (-)JVD

Lung: Clear to Auscultation.

Cor: Regular rate and rhythm, no murmur.

Abd: Soft, Nontender, No masses or organomegaly.

GU: Deferred.

Rectal: Deferred.

Upper Extremity: Shoulders/Elbows/Wrists-FROM. Tinnels and Phalens signs (-), Monofilament testing grossly normal.-complains of transient b/l arm numbness (R>L).

Strength: Pinch: Right-8 lbs., Left-9 lbs.; Grip: Right-82 lbs., Left-54 lbs.—Right hand dominant. Variability curves revealed normal effort and reliable data acquisition. Testing reveals a 30% left sided strength loss.

Lower Extremity: Normal gait; No edema. FROM at hip/knee/ankle.

Neuro: Cervical ROM-F-50, Ex-15, R Rot-40, R Lat-30, L Rot-45, L Lat 40; Thoracic-FROM; Lumbar: Flex-60, Ext-25, R Lat-25, L Lat-205, No radicular findings. Negative SLR, Normoreflexia. Able to stand on toes, Able to stand on heels. Monofilament exam grossly normal. About 5 degree dextro-kyphoscoliosis.

FINDINGS AND DISCUSSION:

Mr. Brown reports an incident whereby he was injured in an MVA circa 5/2/08. He reports on going back and neck pain. He reports ongoing hand numbness. He reports a change in his diabetic management from diet controlled to requiring twice daily insulin administration. Multiple questions are posed at this time. Firstly is the question of causality. Given the mechanism of the injury, and the temporal relations established there is a reasonable causal relationship to the incident and thus the workplace. This is opined to the standard of reasonable medical certainty. The mechanism described seems to be consistent with the trauma observed. He did note a minor history of orthopaedic trauma from an MVA more than 20 years ago for which he briefly sought chiropractic care. There was no interval treatment in that 20 year period. Accordingly, this can be stated to be an exacerbation of a pre-existing condition as a minimum.

Mr. Brown is a candidate for ongoing conservative care at this time including orthotic bracing, ongoing physical therapy/occupational therapy, pharmacotherapy, TENS provision and such to minimize his ongoing complaints of pain and weakness. Given his significant ongoing weakness, further OT and TENS trial are indicated for further rehabilitation. His weakness and loss of strength in his left arm is significant. A comprehensive long term pain management program is needed. Despite these issues, I believe that he will require ongoing evaluation. His employment situation is effected by his diabetes. While it is unlikely that any further surgical intervention will be required,

FINDINGS AND DISCUSSION-Continued:

his medical morbidities are not at MMI, while his orthopaedic issues are likely at MMI.

He self defined multiple limitations as noted supra and these reasonable accommodations should be honored as appropriate. If more specificity were required an FCE could be obtained. He appears capable of a sedentary level of activity given his observed exam and self reported problems. Given his age and morbidities he is a good candidate for vocational rehabilitation. He is unable to return to driving a truck given his insulin dependence at this time. He will require ongoing treatment of his diabetes before he can become eligible for resuming activities as a truck driver. Formal endocrinology referral should be strongly considered, particularly given the implications of adequate control towards his obtaining his trucking licensure.

Assignment of an impairment rating is as per the 5th and 6th Editions of the AMA Guidelines as noted herein. It should be explicitly stated that as per the AMA Guidelines an impairment rating may only be assigned once a patient has fully attained MMI. As he has not yet fully attained MMI, the following is provided as an academic discussion, and should be properly reassessed once he achieves this status.

His loss of strength as noted under the 5th Edition, and would represent a 10% UE rating, but is unable to be assigned as a loss of ROM is noted disqualifying same.

Regarding his low back pain the 5th Edition defines a DRE Lumbar Category II under Table 15-3 (pg. 384) and a 5% WP rater is defined. His MRI reveals broad based disc protusion at L3L4. Under the 6th Edition Table 17-4 (pg. 570) this defines a 9% adjusted WP rater based upon this MRI scan with non-verifiable radicular complaints. In this comparison the 6th Edition rater takes precedence.

His cervical disease is similarly assessed. Under the fifth edition an 18% rating is defined as a Class III disease under Table 15-5. Under the 6th Edition he has undergone a multilevel fusion. He has again Non-verifiable radicular complaints, but does demonstrate loss of strength. Table 17-2 (pg. 564) defines a 23% modified WP rating. Again the 6th Edition takes precedence.

He demonstrates an exacerbation of a pre-existing diabetes disorder as manifested by a need for Insulin following steroid therapy. It is a common clinical scenario where physical stress and the use of glucocorticoids will cause an exacerbation of diabetes and an increased burden in treatment. He demonstrated such a significant change. It can be stated with reasonable medical certainty that the combination of stress and the use of steroids resulted in the change in his condition from oral hypoglycemic to insulin requiring diabetes. Table 10-10 (pg. 234) defines a median 8% WP rating.

These potential ratable elements are summarized as below:

1) Lumbar	12% spinal	9% WP
2) Cervical	68% spinal	23% WP
3) DM	—	8% WP

FINDINGS AND DISCUSSION-Continued:

These raters are summed under the combined values tables (pgs. 604-606). Accordingly these elements sum to a total of a 36% impairment as to the whole person ($23+9+8=36\%$) under the rules of the AMA Guidelines.

I spent 2 hours in obtaining the history and exam of Mr. Brown. I spent 60 minutes reviewing his records. I spent an additional 2.5 hours in researching and preparing this report. I believe this to be a fair and accurate assessment of his current functional status.

Thus, this 36% whole person rating is the current best estimate of his functional capacity at this interval as per strict interpretation of the AMA Guidelines related directly or indirectly to his workplace trauma.

In terms of his ability to function he is at best limited to a sedentary level of function related to his injuries. When this is viewed against the spectrum of the multiple categories of function he has lost the ability to perform more than half of these categories of function. If his regional spinal impairments are summed using the same combined values table a summed 72% spinal impairment is determined ($68+12=72\%$).

If there are any further questions or concerns please advise accordingly.

RESPECTFULLY SUBMITTED



BLAKE H. MOORE, MD, FACS-4/4/09

CHARLESTON NEUROSURGICAL ASSOCIATES, L.L.C.

STEPHEN E. RAWE, M.D., Ph.D.
GEORGE H. KHOURY, M.D.
BRIAN G. CUDDY, M.D.
JOHN D. STEICHEN, M.D.
CYNTHIA W. ANDERSON, R.N., A.N.P.

10/29/2009

NAME OF PATIENT:

Brown, Thomas

D/O/B:

SS#:

REFERRING PHYSICIAN:

INDEPENDENT MEDICAL EVALUATION

HISTORY: Mr. Brown is a 59-year-old male who originally was seen by Dr. Mahmoud Abu-Ata for complaints of neck pain after a motor vehicle accident that was work-related in May 2008. He is driving a trailer truck and was struck from behind by another a car. He developed severe neck pain. During his evaluation, he also was complaining of intermittent numbness in to his arms bilaterally, occasionally with numbness into his legs as well as a feeling of fatigue and weakness in his arms and legs and a sensation of being clumsy. He is eventually was referred to Dr. Scott Boyd, a neurosurgeon in Columbia, after an MRI scan demonstrated a component of multiple levels of cervical stenosis, most prominent at the C3-C4 level. He underwent an anterior cervical discectomy and fusion with anterior instrumentation on 9/2/2008 at Lexington Medical Center from C3-C4 to the C5-C6 level. The patient had significant improvement in terms of his overall complaints, but because of continued neck complaints more recently as well as a followup MRI scan which demonstrated stenosis at the C6-C7 level causing cord compression, Dr. Boyd reviewed his MRI scan from 4/14/2009 and it demonstrated a C6-C7 level stenosis. He then recommended proceeding with an anterior cervical discectomy and fusion and stabilization at the C6-C7 level. He now comes for another opinion.

Past medical and past surgical history indicates history of diabetes and hypertension. He is on Tekturna HCT. He is on Aspirin, Diovan, and Levemir. Previous surgical history is as above including tonsillectomy as a child. He smokes one-half pack of cigarettes a day, two to three quarts of alcohol a day, and uses marijuana as well.

COMPREHENSIVE EXAMINATION reveals he is awake and alert. He has a well-healed surgical incision. He has -5/5 strength in the hand grips but 5/5 strength in his biceps, triceps, and deltoid. Lower extremity strength is 5/5. He has brisk reflexes at the biceps and knee and 1+ to 2+ at the triceps and ankle. There is a slight increase in tone in his upper and lower extremities. There is no Hoffmann's sign. No Lhermitte's sign.

80

RADIOGRAPHIC FINDINGS: From Lexington Regional Medical Center from 4/14/2009 demonstrating postsurgical changes at C3-C4, C4-C5, and C5-C6 with a well-decompressed spinal cord. There is focal stenosis at the C6-C7 level. Plain x-rays demonstrate interbody grafts and anterior instrumentation which are intact from C3 to C6.

MEDICAL DECISION MAKING: Focal stenosis at the C6-C7 level. I am in agreement with Dr. Boyd's recommendation for further treatment at the C6-C7 level. I believe this is a continued preexisting degenerative condition that has been aggravated by his work-related accident. Because of the extended period of time between his original MRI scan, there is a consideration of an updated MRI scan prior to the surgical procedure.

Brian G. Cuddy, M.D.

BGC/vhi

81

Thomas Brown

DOB: 6/11/50

Dear Dr. Forrest:

Please address the following issue in your report, or please provide an answer and opinion to the following question by completing this addendum

1. After reviewing the results of the FCE and after completing your evaluation and knowing the condition of Mr. Brown's' back/neck and knowing the U.S. Dept. of Labor's Dictionary of Occupational Titles physical demand work categories (of very heavy duty, heavy duty, medium duty, light duty and sedentary physical demand levels), in your opinion from a physical capacity standpoint and his physical ability to use his back to do full time work, has Mr. Brown lost more than 50% of the use of his back to do work with his back?

✓

Yes

LEF

LEF, MD (initials)

No

The above referenced opinion constitutes my opinion to a reasonable degree of medical certainty based on my treatment and knowledge of the condition of Thomas Brown.

LEF

Leonard E. Forrest, M.D.

9/15/10

Date:



SPINAL SURGERY
Donald R. Johnson, II, MD
Steven C. Palermi, MD
R. Blake Dennis, MD

Danny Butler, PA-C
Justin Swain, PA-C
Amanda Thurber, PA-C

CONSERVATIVE SPINE CARE
Leonard E. Forrest, MD
John F. Johnson, MD
G. Robert Richardson III, MD

PAIN MANAGEMENT
Mark D. Netherton, MD
Blane Richardson, MD
Virginia Blease, PA-C
Suzanne Livengood, PA-C

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CHARLESTON, SC 29407

(843) 763-2720

September 15, 2010

Preston F. McDaniel, Esquire
1315 Elmwood Avenue
Columbia, SC 29210

RE: BROWN, THOMAS
DOB:
Patient #310310

Dear Attorney McDaniel:

Today I had an opportunity to evaluate Mr. Thomas Brown. As you know, Mr. Brown is a 60-year old individual who has pain symptoms that are present in the neck and upper back as well as into both arms and his hands, left greater than right; Also in the low back and both legs and into his feet, left greater than right.

Mr. Brown relates the onset of these symptoms to a work related motor vehicle accident that occurred approximately 5/2/08. Mr. Brown indicates that he was the driver of an 18 wheeler. He indicates that a car came under his flat bed. He did not even realize that the car was under there. It felt like his brakes went on suddenly. It jolted him and then he had to struggle bring the tractor trailer under control. He ultimately found out that the car had gone under his vehicle. Mr. Brown indicates that immediately he was shaken, but he did not have any definite symptoms right then. However, within about three days he was experiencing symptoms in his neck and also in the low back. However, Mr. Brown indicates that his neck-related symptoms have always been worse than the low back related symptoms. Ultimately he had an initial surgery on his neck in September '08 and then a subsequent surgery in February '09. The sum total of this is that he has cervical fusion C3-4, C4-5 and C5-6.

Mr. Brown indicates that the cervical spine surgery did definitely ultimately help, but he is having considerable symptoms at the present time as noted above. This includes the neck and upper extremities as well as the low back and lower extremities as noted.

No prior history of any similar symptoms or problems before this incident in May '08.

83

BROWN, THOMAS

DOB:

Patient #310310

September 15, 2010

Page Two

No subsequent incident or injury since the time of the work-related motor vehicle accident in May '08.

Mr. Brown has not been able to return to work as a truck driver or otherwise since the accident.

On physical examination, Mr. Brown is pleasant and cooperative. He is generally overall healthy appearing. Examination reveals that there is some tenderness over the neck and upper back and also the low back. I do not find any definite weakness or definite neurologic deficit clinically in the upper extremities bilaterally or the lower extremities bilaterally.

I reviewed the scan findings. The most recent cervical study was done in April '09. There is metal artifact C3 through C6 noted consistent with fusion. There is disc bulge at C6-7. This is the level that is immediately below the fusion.

I do not see any studies of a lumbar spine.

Mr. Brown has symptoms that include his neck and upper extremities as well as the low back and lower extremities. The symptoms began within days following a work-related motor vehicle accident that occurred in May '08. He had no history of prior similar symptoms or problems and no history of any injury after the work incident in May '08.

It is certainly most likely that Mr. Brown's ongoing symptoms including those in the neck and upper extremities as well as the low back and lower extremities are the result of the motor vehicle accident of May '08. The cervical spine has been treated with ultimately a three-level fusion. However, he continues to have ongoing symptoms. Despite having had the three level fusion, in my opinion, further evaluation at this time is needed and Mr. Brown is not at maximum medical improvement. I would recommend getting a new MRI. He will almost certainly need some further treatment.

With regard to the back and related leg symptoms, this also certainly seems to be related to the motor vehicle accident for the same reason as noted above, but has not been evaluated adequately at this point. It continues to be a problem for him. I would recommend an MRI and then he will almost certainly need treatment for the back-related component of his symptoms also.

(continued)

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BROWN. THOMAS

DOB:

Patient #310310

September 15, 2010

Page Three

As for the functional loss for Mr. Brown, in my opinion, Mr. Brown has lost more than fifty (50%) percent of the use of his back as the result of the work-related motor vehicle accident of May '08.

If I can be of further assistance, or if you have any questions or comments, please do not hesitate to call or write.

Sincerely,

Leonard E. Forrest, MD

LEF/ten
T-9/16/2010

85.

Thomas Brown
DOB:

Dear Ms. Hill, PT:

I would appreciate it if you would provide answers and opinions to the following questions posed concerning the functional capacity evaluation and the results of that evaluation on Mr. Thomas Brown, which evaluation was performed on September 16, 2010:

1. In your opinion based on the functional capacity evaluation, can Mr. Brown perform the entire range of lifting requirements for jobs that are available in the physical demand level work in the sedentary work category under the Dictionary of Occupational Titles?

Yes

No

TH
TH (initials)

2. Is it your opinion that Mr. Brown can perform the full range of physical demand level work in the light duty category under the Dictionary of Occupational Titles, which requires him to lift at all levels twenty pounds (20lbs) on an occasional basis or in other words up to one hundred (160) times per day (one-third of an eight hour day - $480 \text{ minutes} \div 3 = 160 \text{ minutes}$)?

Yes

No

TH
TH (initials)

3. Based on the results of the FCE, is it your opinion that Mr. Brown is able to perform the entire range of lifting requirements in medium duty physical demand labor work classification, under the Dictionary of Occupational Titles which requires Mr. Brown to lift fifty pounds (50lbs) as often as one hundred sixty (160) times per day (1/3 of an 8 hour day (480 minutes) at one time per minute)?

Yes

No

TH
TH (initials)

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4. Based on the results of the functional capacity evaluation and your observations of the Claimant, including the difficulties he may have had or pain he experienced in performing the evaluation; in your professional opinion as a registered physical therapist which category does Mr. Brown best safely fit in referencing the physical demand classification system under the Dictionary of Occupational Titles published by the United States Department of Labor (please circle):

Below Sedentary

Sedentary

Light Duty

Medium Duty

TH

TH (Initials)

The above referenced answers and opinions are expressed by me based on my evaluation and observations of Mr. Thomas Brown during and resulting from the functional capacity evaluation that was performed on him by me as a registered physical therapist on September 16, 2010.

Tracy Hill, PT

9-20-10

Date:



Columbia
Rehabilitation
Clinic, Inc.

Date: September 16, 2010

Bruce D. Filler, MEd, P.T.
Director

Attn: Mr. Preston McDaniel
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, S.C. 29201

Re: Thomas Brown,

Mr. Brown was seen on September 16, 2010 for a Functional Capacity Evaluation.

Mr. Brown is a 60 year old male who sustained a work injury to his cervical and lumbar spine on May 2, 2008. The patient reported an initial pain level of "5" on a "0-10" pain scale in which "0" represents no pain and "10" represents maximal emergency level pain. The highest reported pain level during today's evaluation was "7" and this occurred with squatting.

The results of the Functional Capacity Evaluation performed on this date indicate that he can meet the demands of limited medium work with the exception of the one handed carry in which he qualifies for limited light work. He tolerates occasional walking, stairclimbing, kneeling, bending, twisting, and reaching. He does not tolerate occasional squatting. He can lift from 25 to 30 pounds at various heights on an occasional basis. He can carry 30 pounds with 2 hands. He can carry 18 pounds in the right hand and 18 pounds in the left hand. He can push 20 pounds loaded in a sled and can pull 20 pounds loaded in a sled. He has a self-reported sitting and standing tolerance of 180 and 120 minutes respectively. He has a self reported standing/walking tolerance of 120 minutes. He was observed to sit for a maximal time of 35 minutes and stand for a maximal time of 15 minutes. He was observed to stand/walk for a maximal time of 55 minutes.

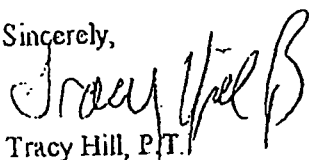
The patient's cervical and lumbar range of motion are limited. Please refer to the enclosed forms for range of motion measurements.

The results of the treadmill test place Mr. Brown in the average Classification of Aerobic Capacity. Mr. Brown's Functional Aerobic Capacity qualifies him for medium work.

Mr. Brown put forth a consistent effort during the evaluation. He qualifies for limited medium work with the exception of the one handed carry in which he qualifies for limited light work. He does not tolerate occasional squatting.

Thank you for this referral. If you have any questions, please call me at (803) 799-7007.

Sincerely,


Tracy Hill, P.T.

2362 Two Notch Road, Columbia, SC 29204, 799-7007
1 Wellness Blvd., Suite 204, Immo, SC 29063, 749-0808
1177 Sunset Boulevard, West Columbia, SC 29169, 794-3440
115 Blamey Drive, Columbia, SC 29223, 736-4845
185 - renab.com

88



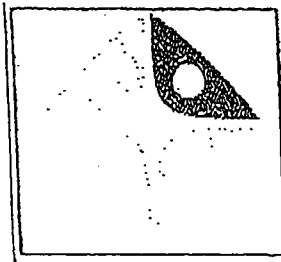
**Columbia
Rehabilitation
Clinic, Inc.**

PREPARED FOR:

Attn: Mr. Preston McDaniel
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, S.C. 29201

Tel: (803) 771-7211

FUNCTIONAL ABILITIES EVALUATION



Client Information

Client Name: Mr. Preston McDaniel

Address: 1315 Elmwood Avenue
Columbia, S.C. 29201

Injury Date: 10/1/99

Dominant Hand: Right

SSN: 123-45-6789

Date of Birth: 10/1/65

Gender: Male

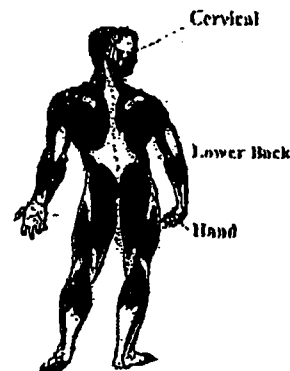
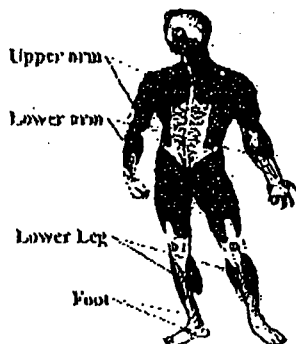
Height: 5'10"

Weight: 180 lbs

Start & Finish Date: 10/1/99

Evaluator: Tracy Hill

Areas of Complaint



General Location	Specific Location	Plane	Side	Pain Type	Pain Scale
Hand			Bilateral R>L	Tingling	5 - Moderate
Lower Arm			Bilateral R>L	Tingling	5 - Moderate
Neck (Cervical)			Central	Ache/burning/sharp	5 - Moderate
Upper Arm			Bilateral R>L	Tingling	5 - Moderate
Lower Back (Lumbosacral)			Central	Ache	3 - High Nominal
Foot			Bilateral	Tingling	2 - Nominal
Lower Leg			Bilateral	Tingling	2 - Nominal

Tracy Hill, PT
Physical Therapist

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

All testing was completed using the FOCUS System. Data Measurement was compiled through ODES products of Horizon Medical Inc.

89

Strength

Lower Extremity Manual Muscle Test

Sep 16, 2010 2:29:22 PM

Manual Muscle Testing of the lower extremities was performed and the results are as follows:

Hip Flexion: Bilat 4/5 Knee Extension: Bilat 5/5 Dorsiflexion: Bilat 5/5
Extensor Hallicis Long: Bilat 5/5 Eversion: Bilat 5/5

Strength

Upper extremity manual muscle test

Sep 16, 2010 2:31:25 PM

Manual Muscle Testing of the upper extremities was performed and the results are as follows:

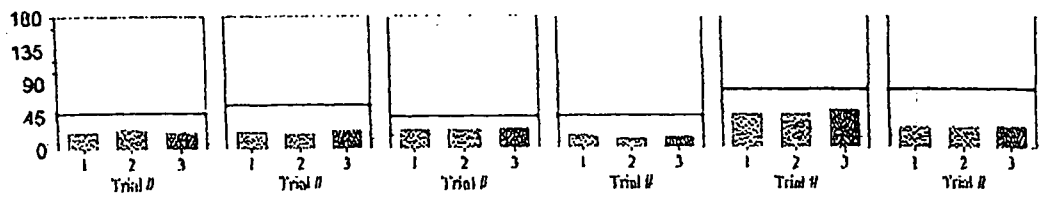
upper trapezius: Bilat 5/5 deltoid: Bilat 4/5 biceps: Bilat 5/5
triceps: Bilat 4/5 fingers: Bilat 5/5

Range of Motion

Cervical

Sep 16, 2010 2:14:46 PM

	Flexion	Extension	Left Lateral Flexion	Right Lateral Flexion	Left Rotation	Right Rotation
Normals:	50	60	45	45	80	80
Trial 1:	23	22	26	17	18	28
Trial 2:	27	21	26	13	47	28
Trial 3:	24	25	28	16	53	29
Average	24.7	22.7	26.7	15.3	49.3	28.3
Maximum	27.0	25.0	28.0	17.0	53.0	29.0
AMA Valid	YES	YES	YES	YES	YES	YES
% of Normal	49%	38%	59%	34%	62%	35%



Reference Information

American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition

90

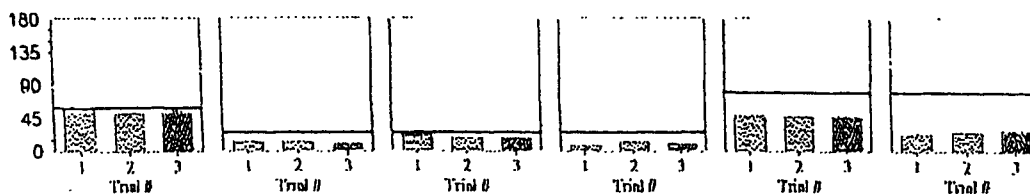


Range of Motion

Lumbar Range of Motion

Sep 16, 2010 2:17:39 PM

	True Lumbar Flexion	True Lumbar Extension	Left Lateral Flexion	Right Lateral Flexion	Left Straight Leg Raise	Right Straight Leg Raise
Normals:	60	25	25	25	80	80
Trial 1:	57	14	21	8	48	25
Trial 2:	52	13	19	14	47	26
Trial 3:	54	11	19	11	48	28
Average	54.3	12.7	19.7	11.0	47.7	26.3
Maximum	57.0	14.0	21.0	14.0	48.0	28.0
AMA Valid	YES	YES	YES	YES	YES	YES
% of Normal	90%	51%	79%	44%	60%	33%

Reference Information

American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition

Work Simulation Dynamic Bending

Sep 16, 2010 2:39:27 PM

The patient was asked to bend forward at the waist 25 repetitions. The results are as follows:

Work Simulation Dynamic Bending

Sep 16, 2010 2:40:26 PM

The patient was asked to bend forward at the waist 25 repetitions. The results are as follows:

dynamic bending: 25 repetitions

PRE HR 84 POST
HR 89Evaluator Comments

Mr. Brown was able to bend forward at the waist 25 repetitions.

Work Simulation Dynamic Rotation

Sep 16, 2010 2:43:04 PM

The patient was asked to rotate at the waist 25 repetitions. The results are as follows:

Dynamic rotation: 25 repetitions

PRE HR 88 POST
HR 85Evaluator Comments

Mr. Brown was able to rotate at the waist 25 repetitions.

91

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Mr. Thomas Lee Brown



Work Simulation Squatting

Sep 16, 2010 2:45:31 PM

The patient was asked to assume a squatting position for 2 minutes. The results of squatting are as follows:

squatting: 31 seconds

PRE HR 78 POST
HR 98Evaluator Comments

Mr. Brown was able to squat for 31 seconds. This test was terminated at the request of the patient secondary to complaints of increased lumbar/cervical pain and increased bilateral feet "tingling".

Work Simulation Kneeling

Sep 16, 2010 2:48:51 PM

The patient was asked to assume a kneeling position for 2 minutes. The results are as follows:

Kneeling: 2 minutes

PRE HR 88 POST
HR 93Evaluator Comments

Mr. Brown was able to kneel for 2 minutes.

Work Simulation Dynamic Reaching

Sep 16, 2010 3:15:17 PM

The patient was asked to transfer 1 lb weights from shoulder level to above head level for 5 minutes. The results are as follows:

Dynamic reaching: 5 minutes

PRE HR 92 POST
HR 103Evaluator Comments

Mr. Brown was able to reach for 5 minutes.

Work Simulation Stair Climbing

Sep 16, 2010 3:22:36 PM

The patient was asked to ascend/descend a series of 4 stairs for a total of 10 cycles. The results are as follows:

Time (min,secs)	Initial Heart Rate (bpm)	Final Heart Rate (bpm)	Stairs Ascended	Stairs Descended
2:15	92	105	40	40

Evaluator Comments

Mr. Brown was able to ascend/descend a series of 4 stairs for a total of 10 cycles. He used a step over step gait pattern and held onto handrails lightly.

92
P. 5

Work Simulation Floor to waist lift

Sep 16, 2010 3:30:11 PM

Floor to waist lifting results are as follows:

Floor to waist: 25 pounds

Physical demand level: medium

MAX HR 110

Evaluator Comments

Mr. Brown was able to lift 25 pounds with some difficulty noted. He did not want to attempt additional weight secondary to complaints of increased cervical and lumbar pain.

Work Simulation 12 inch to waist lift

Sep 16, 2010 3:40:33 PM

The patient was asked to lift from 12 inches off of the floor to waist height. The results are as follows:

12 inch to waist: 30 pounds

Physical demand level: medium

MAX HR 110

Evaluator Comments

Mr. Brown was able to lift 30 pounds. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

Work Simulation Waist to shoulder lift

Sep 16, 2010 3:50:50 PM

The patient was asked to lift from waist height to shoulder height. The results are as follows:

Waist to shoulder: 30 pounds

Physical demand level: medium

MAX HR 109

Evaluator Comments

Mr. Brown was able to lift 30 pounds with difficulty noted. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

Work Simulation Shoulder to overhead lift

Sep 16, 2010 4:00:14 PM

The patient was asked to lift from shoulder height to overhead height. The results are as follows:

Shoulder to overhead: 26 pounds

Physical demand level: medium

MAX HR 105

Evaluator Comments

Mr. Brown was able to lift 26 pounds with difficulty noted. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

Work Simulation Dynamic 2-handed carry

Sep 16, 2010 4:10:36 PM

The patient was asked to carry a box, using both hands, a distance of 30 feet. The results are as follows:

Dynamic 2-handed 30 pounds Physical demand level: medium
carry:

MAX HR 108

Evaluator Comments

Mr. Brown was able to carry 30 pounds. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

Work Simulation Dynamic 1-handed carry

Sep 16, 2010 4:20:54 PM

The patient was asked to carry a bucket, using 1 hand, a distance of 30 feet. The results are as follows:

Left-handed carry: 18 pounds Right-handed carry: 18 pounds

MAX HR 108

Evaluator Comments

Mr. Brown was able to carry 18 pounds in his left hand and 18 pounds in his right hand. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

Work Simulation Dynamic Push/Pull

Sep 16, 2010 4:30:20 PM

The patient was asked to push and pull a sled a distance of 30 feet. The results are as follows:

Push: 16.0 lb.fl. Pull: 16.0 lb.fl.

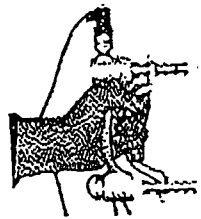
MAX HR

Evaluator Comments

Mr. Brown was able to push 20 pounds and pull 20 pounds loaded in a sled with some difficulty noted pulling. He did not want to attempt additional weight secondary to complaints of increased cervical pain.

94

Hand Grip Strength

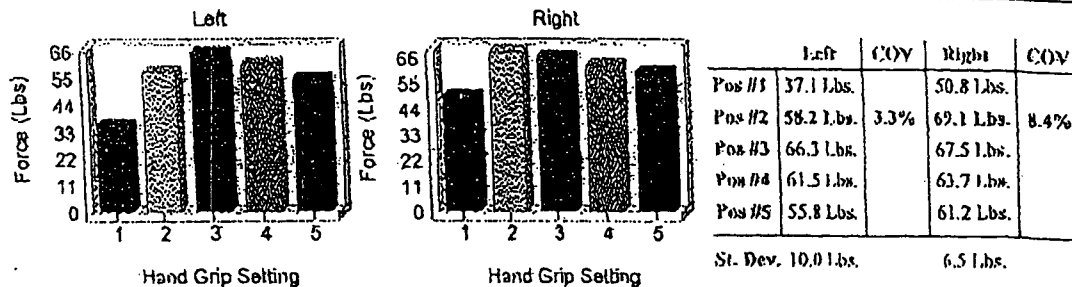


The hand dynamometer is set to each of the five available positions which vary the client's grip size. The results for each of the average maximum forces during each position are displayed by the corresponding bar graphs.

The JAMAR hand dynamometer was used in order to quantify grip strength and determine whether Mr. Thomas Lee Brown exerted consistent effort during grip strength testing. Mr. Thomas Lee Brown was tested using the modified maximum voluntary effort hand grip protocol. Mr. Thomas Lee Brown is right hand dominant. Normative data is based on the assumption that right and left hand dominant subjects, analyzed separately show little functional difference between their mean scores.^{1, 2}

Modified Maximum Voluntary Effort (MMVE)

Sep 16, 2010 1:58:44 PM



Using the Modified Maximum Voluntary Effort (MMVE) protocol over a range of five positions on the hand dynamometer, it is expected that the strength graphs obtained results in a bell-shaped curve^{3, 11, 12, 13} even in a disabled population or if the client's hand is injured^{2, 13} with the coefficients of variation at position 2 within the acceptable 15% or less limit.

The graph obtained for Mr. Thomas Lee Brown did demonstrate a bell shaped curve which may be an indicator of maximal effort and the coefficients of variation of the underlying data may be an indicator of consistent effort

¹ Stokes H. 1983. The seriously uninjured hand - weakness of grip. J Occup Med 25(9):683-684.

¹¹ Niebuhr B, Marion R. 1990. Voluntary control of submaximal grip strength. Am J Phys Med Rehabil 69(2): 96-101.

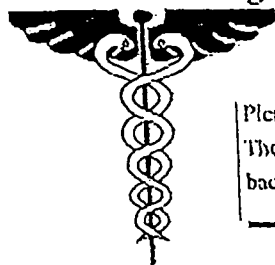
¹² Matheson L, Carlson R, Mienteyer L. 1988. Grip strength in a disabled sample: reliability and normative standards. Ind Rehabil Q 1(3):9, 17-23.

¹³ Hildreth D, Brendenbach W, Lisiter G, Hodges A. 1989. Detection of submaximal effort by use of the rapid exchange grip. J Hand Surgery 14A(4): 742-745.

95



The Waddell Signs



Sep 16, 2010

Please read:

The following tests are recommended to test for sincerity of effort in the case of lower back injuries. Please check whether the test is positive or negative.

1. Tenderness - Should be localized to a skeletal or neuromuscular structure.

Superficial Tenderness - provide light pinch to the skin over the lower back region. If there is widespread tenderness, this is considered non-physiological and is an indication of symptom magnification.

☒ Negative
☐ Positive

Non-Anatomic Tenderness - Perform deep palpation to the lumbar paraspinals. If there is tenderness which is widespread and not localized to any specific structures, then this is considered magnification of symptoms.

☒ Negative
☐ Positive

2. Simulation Tests - Give the patient the impression that a particular movement is being performed when it actually is not

Axial Loading - To perform this test apply a light downward pressure on the top of the patient's head while they are in the standing position. If increased lower back pain is reported then this is an indication of exaggeration of symptoms.

☒ Negative
☐ Positive

Simulated Rotation - With the patient in the stand position and feet together, rotate the pelvis and shoulders simultaneously by applying pressure at the level of the lower forearm. If the patient reports increased pain then this is considered symptom magnification.

☒ Negative
☐ Positive

3. Distraction Tests - Retesting of a positive finding in a way that the patient does not recognize or expect

Distraction Test - Perform a straight leg raise with the patient in the supine position. When the SLR shows marked improvement while performed on distraction (i.e. Patient seated) this is considered positive.

☒ Negative
☐ Positive

4. Regional Disturbances - Divergence from accepted neuroanatomy

Regional Disturbances - These are present as motor weakness or sensory loss involving widespread regions such as the entire leg or a quarter or half of the body.

☒ Negative
☐ Positive

5. Overreaction - Disproportionate verbalization, facial expression, muscular tension and/or tremor or sweating

Overreaction - A disproportionate response such as verbalizations, facial expressions, collapsing etc. can be indicative of symptom magnification.

☒ Negative
☐ Positive

If three or more of the categories are positive then the findings are clinically significant for non-organic low back pain.

Scoring: Clinically insignificant.

96



Sitting tolerance

Sep 16, 2010

The patient's self-reported sitting tolerance is as follows:

.....

Evaluator Comments

Mr. Brown has a self reported sitting tolerance of 180 minutes. He reports his sitting tolerance is limited secondary to complaints of increased cervical pain.

Standing tolerance

Sep 16, 2010

The patient's self-reported standing tolerance is as follows:

.....

Evaluator Comments

Mr. Brown has a self reported standing tolerance of 120 minutes. He has a self reported standing/walking tolerance of 120 minutes. He reports his standing/walking tolerance is limited secondary to complaints of increased cervical pain/pressure.

Cardiovascular Intake

Sep 16, 2010

Resting Rate (Min)	Systolic (mm Hg)	Diastolic (mm Hg)
70	132	72

Result	Normal Heart Rate	Normal Blood Pressure	Normal Blood Pressure
--------	----------------------	--------------------------	--------------------------

Single Stage Treadmill

Pre-Testing Heart Disease Questions

Test Date: Sep 16, 2010 2:55:33 PM

1. Have you ever had a heart attack?..... ☐ Yes ☒ No
2. Have you ever had heart surgery?..... ☐ Yes ☒ No
3. Have you ever had an abnormal electrocardiogram?..... ☐ Yes ☒ No
4. Do you have heart disease?..... ☐ Yes ☒ No
5. Have you been told by a physician you have had angina?... ☐ Yes ☒ No
6. Have you been told by a physician you
have had palpitations?..... ☐ Yes ☒ No
7. Have you had a stroke (CVA)?..... ☐ Yes ☒ No
8. Is your blood pressure (BP) 159/100?..... ☐ Yes ☒ No
9. Are you pregnant?..... ☐ Yes ☒ No

Initial Heart Rate Initial Blood Pressure
70 BPM 132 / 72

Stage	Speed	Heart Rate	Blood Pressure	Grade
1. Warm-Up	1mph	95 BPM	0/0	0%
2. Exercise	1mph	108 BPM	0/0	5%
3. Recovery	0mph	0 BPM	0/0	0%

Predicted Maximum VO ₂	24 ml/kg/min
	10 ml/kg/min
Predicted Max Met Level	3 METS
Functional Aerobic Capacity	Moderate work
Classification of Aerobic Capacity	Average

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Mr. Thomas Lee Brown

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**Harriet Fowler, CRC, M.Ed.
Vocational Rehabilitation Services**

2143 Marion Street

Columbia, South Carolina 29201

Tel: (803) 256-3213 Fax: (803) 256-2129 Pager: (803) 612-0818

Client: Thomas L. Brown

Employer: Bull Dog Highway

Address:

Express Trucking

North Charleston, SC

Telephone:

Date of Birth:

Date of Injury: 05/02/2008

SSN:

Date of Referral: 09/09/2010

Initial Evaluation

The following is a result of a request by Attorney Preston F. McDaniel of The McDaniel Law Firm, Columbia, South Carolina for a vocational evaluation. Mr. McDaniel's office provided medical records upon which the medical history was based and work history was a self-report by the client in an interview on 09/16/2010.

Educational/Vocational History:

The client graduated from Austin East High School, Knoxville, Tennessee in 1969 with approximately a "C average".

In 1969 the client entered the U.S. Army and worked as a ground-sensor communications signal specialist. This job is classified as very heavy in physical demand category and is low skilled (D.O.T. Ground-Sensor Specialist, 378.382-018). The client stayed in the Army for approximately two (2) years until 1971.

In 1971 the client began working with Mr. Steak Restaurant, Knoxville, Tennessee as a dishwasher. This job is classified as

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medium in physical demand category and is unskilled (D.O.T. Dishwasher, 318.687-010). He worked at this job for four (4) to five (5) months when he was promoted to grill cook/kitchen manager. This job is classified as medium in physical demand category and is skilled (D.O.T. Cook, Restaurant, 313.361-014; Kitchen Manager, 318.137-010). The client worked at this job for seven (7) years until 1978 when the restaurant went out of business in 1978. Ending pay was \$700.00/week.

In 1978 the client began working with Golden Pelican, Oak Ridge, Tennessee as a cook (steak and seafood)/kitchen manager. This job is classified as medium in physical demand category and is unskilled (D.O.T. Dishwasher, 318.687-010). This job is classified as medium in physical demand category and is skilled (D.O.T. Cook, Restaurant, 313.361-014; Kitchen Manager, 318.137-010). The client worked at this job for seven (7) years until 1985 when he continued in this job part-time until 2000. Ending pay was \$800.00/week.

In 1985 the client began working with Oakridge Associated Universities, Oak Ridge, Tennessee as a shipping and receiving clerk and truck driver driving straight/box truck. This job is classified as medium in physical demand category and is low skilled (D.O.T. Truck Driving, 905.663-014; Shipping and

Receiving Clerk, 222.387-050). The client worked at this job for fifteen (15) years until 2000 when he decided to attend truck driving school. Ending pay was \$800.00/week with "good benefits".

The client attended Tennessee Truck Driving School in White Pines, Tennessee and obtained his CDL in 2000.

From 2000 to 2008 the client worked as a tractor trailer driver with Swift Trucking, Covenant Trucking, J.B. Hunt Trucking, Boyd Brothers Trucking, and Bull Dog Highway Express Trucking from periods of six (6) months up to two (2) to three (3) years always leaving for better opportunities. This job is classified as medium in physical demand category and is semi-skilled (D.O.T. Tractor-Trailer Driver, 904.383-010). The client states that on 05/02/2008 a car drove under his truck which jolted him and he had to "really struggle to get control of the truck. Mr. Brown noted that the pain in his neck and low back became "worse and worse" and he saw his family physician and received medication but eventually noted he "ended up in the ER." Pay ranged from \$600.00/week up to \$800.00/week with average weekly wages of \$795.90 week in 2008, but he noted the last/full year prior to his injury average weekly wages were \$887.55/week.

Vocational Testing Results:

The client was administered the Wide Range Achievement Test-Revision 3 (WRAT-3) on 09/16/2010. He scored at fifth (5th) grade level spelling, at sixth (6th) grade level in reading, and fourth (4th) grade level in arithmetic.

Summary and Conclusions:

The client states that on 05/02/2008 a car drove under his truck which jolted him and he had to "really struggle to get control of the truck." Mr. Brown noted that his pain in his neck and low back became "worse and worse" and he saw his family practice physician and received medication but eventually noted he "ended up in ER." The client was seen at Trident Regional Medical Center, Orangeburg, South Carolina on 07/06/2008 where the client was noted to be an emergency "fast track" urgency. It was noted he had been involved in a motor vehicle accident on 05/02/2008 resulting in a "traumatic injury." It was noted that back pain had increased in severity since injury and that "heavy lifting at work" was felt to have exacerbated the pain as did "movement, walking, and lifting" (not at work). Pain was noted to be at a level 6 out of 10 from "neck to low back" and with "shooting pain down both legs" and with "intermittent numbness in legs." It was noted that Aleve prescribed by family physician did not relieve pain. Also noted was "urgency with urination"

and "difficulty getting an erection since the injury." Exam of lumbar spine revealed a positive straight leg raise test on both the left and right at 40 degrees and with pain; paresthesias; paraspinal, midline, and low back tenderness; "pain to entire back"; and Glasgow Coma Score of 15. Lumbar spine x-ray revealed spasming (per abnormal straightening) and both degenerative joint disease and degenerative disc disease, "worse at L5-S1." Radiologist recommended consideration of MRI if radicular symptoms were present which they were. The client was administered (and prescribed) Percocet which reduced the pain to a 4 over 10 level while at the hospital; and was referred to and ordered to see, Dr. Alhatou, neurologist at The Neurologic and Pain Clinic. ER noted past medical history prior to 05/02/2008 accident consisted of hypertension, tonsillectomy and "no previous psychiatric history."

The client was seen by Mahmoud Abu-Ata, M.D. at The Neurologic and Pain Clinic, Orangeburg, South Carolina on 07/10/2008 who noted the client had "been doing fine up until" the 05/02/2008 motor vehicle accident when he was hit from behind. It was noted that following the accident to that current date the client had had neck, middle and lower back spasming; "pain in the neck and back"; radiating pain from shoulders to thighs; numbness and/or tingling in the bilateral arms, hands, thighs, legs and feet.

(It was noted the client had borderline diabetes and Dr. Ata questioned whether the numbness and tingling might be symptoms of a neuropathy and thus performed an EMG/NCS on this date which revealed no neuropathy.) He noted pain was "worse with activity", but that Aleve and Percocet were helpful for pain relief. Dr. Ata ordered both a cervical and lumbar MRI, and physical therapy. (He noted past medical history consisted only of borderline diabetes, hypertension, and hypercholesterolemia.)

On 07/25/2008 the client underwent an MRI of the lumbar spine which revealed an L3-L4 broad-based disc protrusion extending into the neural foramen ("...more markedly...on the left") with "additional extra foraminal protrusion" with "contact on the L4 nerve roots with mild displacement"; L3-L4 "moderately severe left-sided foraminal stenosis with likely early entrapment of the exiting left L3 nerve root"; and L3-L4 degenerative disc disease.

The client also underwent a cervical MRI on 07/25/2008 which revealed "moderate impingement on the spinal cord at several levels related to disc protrusion as well as hypertrophic changes" which "led to quite marked narrowing of the cervical canal" which measured "3.3 millimeters at the C3-4 level, 4.0 millimeters at the C4-5 level, 4.4 millimeters at the C5-6

level" resulting "in moderate flattening of the cord at these levels"; C2-3 mild loss of disc signal; C3-4 "broad-based disc protrusion impinging upon the spinal cord with "extension of protruded disc material into the neural foramina in association with moderate intraforminal osteophyte formation resulting in moderate to moderately severe bilateral foraminal stenosis"; C4-5 "broad-based disc protrusion associated with circumferential osteophyte formation...extending into the neural foramina bilaterally although more markedly on the left" resulting "in narrowing of the cervical canal with impingement and flattening of the spinal cord as well as moderately severe to severe bilateral foraminal stenosis"; C5-C6 "broad-based disc protrusion, again associated with circumferential osteophyte formation extending into the neural foramina bilaterally." Again, there was "impingement and flattening of the spinal cord with moderately severe bilateral foraminal stenosis"; C6-7 "broad-based disc protrusion extending into the neural foramina...with mild to moderate intraforaminal osteophyte formation" with "again moderately severe bilateral foraminal stenosis." Radiologist summarized, "Moderately severe degenerative disc/osteophyte disease of the cervical spine. There are disc bulges at most levels, associated with circumferential osteophyte formation and with hypertrophic laminar changes at several levels. This has resulted in gross

narrowing of the cervical canal with impingement and flattening of spinal cord and with varying degrees of predominantly moderately severe to severe foraminal stenosis at multiple locations."

On 08/01/2008 Dr. Alhatou (a partner of Dr. Ata) wrote the client out of work and restricted him from driving from 08/01/2008 to 10/01/2008.

On 08/04/2008 and 08/25/2008 the client was seen by Scott B. Boyd, M.D. at Columbia Neurosurgical Associates in Columbia, South Carolina upon referral by Dr. Ata. It was noted the client had "severe" neck and back pain "shortly" after the 05/02/2008 auto accident with neck pain radiating "down into his arms bilaterally" with numbness and weakness in the arms (with measured strength reduced to 4 over 5 bilaterally "at all stations" in his arms). The client also reported a popping sound when turning his neck and also a burning pain radiating out into his shoulders and arms with extension of his neck. He was also noted to have occasional numbness in his legs with his legs feeling "clumsy." Exam did reveal "definite grip strength weakness at 4 plus over 5", diminished cervical range of motion, "subtle Hoffman's sign on the left, "fasciculations in both hands", and tenderness in the "cervical region." Dr.

Boyd noted that MRI of the cervical spine revealed, "stenosis...compounded by some ligamentum flavum hypertrophy and disc bulging with osteophytes" that produced "cervical stenosis throughout a wide segment of his cervical canal...most prominent at C3-4." He noted he was "concerned about the weakness in his upper extremities and his fasciculations." He noted on 08/04/2008 that the nonsteroidals the client had been taking had not helped and he prescribed steroidal, Decadron; but by 08/25/2008 noted continued "neurologic decline" upon exam despite Decadron. He diagnosed cervical stenosis and "progressive" cervical myelopathy. He noted no "previous problems with his neck or back" prior to the 05/02/2008 accident. He ordered spinal surgery but noted he was "careful" to "not guarantee improvement of the condition or relief of symptoms." Dr. Boyd noted on 08/04/2008 the client was working and wrote him out of work on that date.

On 09/02/2008 the client underwent anterior cervical discectomy at three levels, C3-C4, C4-C5, and C5-C6; anterior interbody fusion at three levels, C3-C4, C4-C5, and C5-C6; application of anterior plate instrumentation, C3, C4, C5, and C6; application of intervertebral interbody implants at three levels, C3-C4, C4-C5, and C5-C6; and harvest of morselized autograft by Dr. Boyd. Pre-operative diagnosis was cervical herniated nucleus

pulposus/disc; and surgery also revealed "large osteophytes, especially off the back of C3 vertebral body." Dr. Boyd also noted at C4-C5, "Again large posterior osteophytes were encountered." He then noted that at the "3rd disc level at C5-6... was a large anterior osteophyte covering the disc space". He also placed three 6 mm medium Cornerstone implants that were packed with autograft harvested from the anterior lip of the C3 vertebral body, a 45 mm Stryker titanium plate, and eight (8) 14 mm screws.

The client was seen by Dr. Boyd for follow-up on 09/12/2008 and 10/20/2008 who noted continued neck pain but the client reported being "eighty percent (80%) better"; however, x-ray of the cervical spine unfortunately revealed "a slight retrolisthesis of C4 on C5 and of C5 on C6" and "facet disease". Dr. Boyd released the client to be seen on an "as needed" basis, and allowed return to work on 11/14/2008.

On 10/23/2008 Dr. Ata ordered the client out of work from 07/10/2008 to 11/17/2008 and ordered no driving.

On 09/15/2008 Dr. Boyd noted that it was his opinion that the "problems" that the client had "with his neck and back and his need for medical care either stem directly from the automobile

accident of May 2, 2008 or the accident aggravated and caused to become symptomatic a pre-existing conditions in his neck and back which resulted in the need for medical care." He also noted that in "reference to the current state of his treatment" Dr. Boyd had scheduled him for neck surgery on September 2, 2008 and it was his opinion that "this treatment was necessary as a result of his injuries received in the accident."

On 04/04/2009 the client was seen by Blake H. Moore, M.D. in Columbia, South Carolina for an independent medical examination (IME). Dr. Moore noted the client reported symptoms of insomnia, hematochezia, melanic stool, hand and foot numbness, tremors, anxiety, depression, epigastric pain, dizziness, erectile dysfunction, polyuria, polydipsia, neck pain, back pain, and arthralgias and "appeared quite credible." He noted "onset of back and neck pain following a work related MVA" and that currently the client had "ongoing pain and numbness in both arms, albeit somewhat worse on the left," and current symptoms of sleep problem "seven (7) nights a week with use of three (3) extra pillows to prop his arms and neck"; arms weak to point of needing help to get out of the tub; "problems dressing himself" and "problems with buttons, zippers and tying shoes or a tie"; difficulty parking a car as he could not "turn his head to visualize safely"; slowness with chores as pain was limiting,

"particularly with repetitive type actions"; limited stamina; inability to "carry loads of any significance"; hand weakness and inability "to open jars"; limited in walking to ¼ mile; sitting limited to sixty (60) minutes and standing limited to one hundred twenty (120) minutes at a time; climbing limited to one (1) flight of stairs; maximal lifting limit of thirty (30) pounds; repetitive lifting limited to roughly fifteen (15) pounds; limited stamina with most tasks limited to fifteen (15) minutes or less; moderately limited in bending, twisting, stooping, kneeling, and crawling; "ongoing numbness in both of his hands" (right greater than left); ongoing weakness in both arms; "numbness and 'shock' like sensations radiating from his neck to both hands"; "significant" symptoms in his left hand thrice a day, and right hand roughly twice a week; "coital activity decreased from four (4) times weekly to once every eight (8) weeks"; limited in any "sexual activity that requires him to support his weight on his arm as he describes pain and weakness"; physical activity decreased as he has decreased or stopped jogging or fishing; and problems picking up his seven (7) year old son and "generally unable to do so." In addition, Dr. Moore noted, "He reports a prior history of diabetes. He previously controlled his sugar with diet and exercise. He indicates that with the "stress" of the accident and surgery and the use of glucocorticoids he had developed blood sugars of up

to 588, requiring a need to start insulin. The records reveal that his surgery was on 09/02/08. On 09/23/2008 his blood glucose was noted to be 418 and his primary care physician Dr. Algood started him on insulin, demonstrating a time line consistent with causality." Dr. Moore continued, "He demonstrates an exacerbation of a pre-existing diabetes disorder as manifested by a need for Insulin following steroid therapy. It is a common clinical scenario where physical stress and the use of glucocorticoids will cause an exacerbation of diabetes and an increased burden in treatment. He demonstrated such a significant change. It can be stated with reasonable medical certainty that the combination of stress and the use of steroids resulted in the change in his condition from oral hypoglycemic to insulin requiring diabetes." He also noted, "significant psychological stress" with "anxiety in worrying about his future" and weight gain of ten (10) pounds; insomnia and a loss of libido; frustration; relationship discord with frequent arguments with his girlfriend; and self-isolation. In relation to strength testing Dr. Moore noted pinch right eight (8) pounds, left nine (9) pounds; grip right eighty-two (82) pounds, left fifty-four (54) pounds; and the client was right hand dominant. Variability curves revealed normal effort and reliable data acquisition. This testing revealed a thirty percent (30%) left sided strength loss. He noted range of motion significantly

limited with cervical range of motion flexion 50 degrees, cervical extension 15 degrees, cervical right rotation 40 degrees, cervical right lateral 30 degrees, cervical left rotation 45 degrees, cervical left lateral 40 degrees; lumbar flexion 60 degrees, lumbar extension 25 degrees, lumbar right lateral 25 degrees, lumbar left lateral 20 degrees and about 5 degrees dextro-kyphoscoliosis. Dr. Moore summarized the client had ongoing back and neck pain; ongoing hand numbness; and change in his diabetic management from diet controlled to requiring twice daily insulin administration following 05/02/2008 injury. He continued, "Given the mechanism of the injury, and the temporal relations established there is a reasonable causal relationship to the incident and thus the workplace. The mechanism described seems to be consistent with the trauma observed. (He did noted a minor history of orthopedic trauma from an MVA more than twenty (20) years ago for which he sought chiropractic care. He noted, "a minimal pre-existing history of orthopedic complaints. He reports an MVA circa 1985 where he sustained minor injuries as a passenger. He saw a chiropractor briefly. He returned to work with no limits and had no symptoms or treatment from 1985 until the index accident 5/2/08." There was no interval treatment in that twenty (20) year period.) Accordingly, this can be stated to be an exacerbation of a pre-existing condition as a minimum." Dr.

Moore concluded, "Mr. Brown is a candidate for ongoing conservative care at this time including orthotic bracing, ongoing physical therapy/occupational therapy, pharmacotherapy, TENS provision and such to minimize his ongoing complaints of pain and weakness. Given his significant ongoing weakness, further OT and TENS trial are indicated for further rehabilitation. His weakness and loss of strength in his left arm is significant. A comprehensive long term pain management program is needed. Despite these issues, I believe that he will require ongoing evaluation. His employment situation is effected by his diabetes. While it is unlikely that any further surgical interventions will be required his medical morbidities are not at MMI, while his orthopedic issues are likely at MMI." In relation to work he noted, "He self defined multiple limitations as noted supra and these reasonable accommodations should be honored as appropriate. Given his age and morbidities he is a good candidate for vocational rehabilitation. He is unable to return to driving a truck given his insulin dependence at this time. He will require ongoing treatment for his diabetes before he can become eligible for resuming activities as a truck driver. Formal endocrinology referral should be strongly considered, particularly given the implications of adequate control towards his obtaining his trucking liscensure. If more specificity were required an FCE could be obtained. He appears

capable of a sedentary level of activity given his observed exam and self reported problems." In terms of his ability to function he is at best limited to a sedentary level of function related to his injuries. Dr. Moore noted in relation to rating that the client had not yet reached MMI thus his impairment rating at this point was "academic." Dr. Moore per the AMA Guides issued a nine percent (9%) whole person or twelve percent (12%) to the lumbar spine; twenty-three percent (23%) to the whole person or sixty-eight percent (68%) to the cervical spine; and eight percent (8%) to the whole person for his diabetes mellitus for a combined thirty-six percent (36%) whole person impairment rating. Dr. Moore concluded that the client had "lost the ability to perform more than half" of the "multiple categories of function." He opined, "If his regional spinal impairments are summed using the same combined values table a summed seventy-two percent (72%) spinal impairment is determined $(68+12=72\%)$."

On 04/14/2009 the client was again seen by Dr. Boyd who noted that prior to the surgery he performed the client had "severe cord compression" at multi-levels per his MRI ("3.3 mm spinal canal at C3-4 and 4 mm spinal canal at C4-5 and C5-6"); but now reported overall being "worse" since that surgery with "pain across his shoulders radiating in his hands, left greater than

right weakness in his hands "particularly on the right side"; occasionally electric shocks going down his arms, particularly in his hands; gait worsening where it had improved subsequently after his last surgery; a "muscular twitching in his right arm"; and "minimal neck pain". Dr. Boyd also noted "new symptoms of worsening myelopathy" and continued, "since his surgery he is now requiring insulin for blood sugar control and also his hypertension has worsened." He noted current medications of Tekturra, Vytarin, aspirin, Diovan, Glucotrol, Insulin, and Aleve. On exam he noted limitation of cervical range of motion; 4 out of 5 grip strength weakness bilaterally; slightly spastic gait; and "visible fasciculations in his right arm." The client then underwent a cervical MRI on this date which revealed osteophyte formation at C3-4; C3-C4 thickening of the flava ligaments posteriorly with mild degenerative spinal stenosis; at C4-5 degenerative spinal stenosis; at C5-6 osteophyte formation and degenerative spinal stenosis "related to osteophyte formation and thickening of the flava ligaments"; disc bulge at C6-7 and osteophyte formation and thickening of the flava ligament with mild to moderate degenerative spinal stenosis "related to disc bulge"; "probable narrowing of the neural foramina bilaterally at these levels related to disc bulge"; and mild degenerative spinal stenosis related to posterolateral osteophyte formation and thickening of the flava ligaments at

C3-4, C4-5 and C5-6. Dr. Boyd noted in review of this MRI (apparently with radiologist) in addition to above findings he noted the C6-C7 disc and osteophytes to be a "herniated disc causing cord compression" and "new symptoms of worsening myelopathy." Dr. Boyd noted, "This clearly represents a neurologic deterioration and, therefore, his new disc herniation is difficult to dismiss" and ordered surgery. He noted he was "careful not to guarantee relief of symptoms or improvement of the condition."

On 02/09/2010 Dr. Boyd performed anterior cervical discectomy, C6-C7; anterior interbody fusion, C6-C7; anterior plate instrumentation, C6-C7; removal of anterior instrumentation, C5-C6; application of intervertebral 7-mm medium Cornerstone interbody implant with a 14-mm Stryker titanium plate and 14-mm screws; and harvesting of morselized autograft. Preoperative and post-operative diagnoses were "cervical herniated disk" or "recurrent herniated nucleus pulposus."

On 03/08/2010 and 04/19/2010 the client was seen by Dr. Boyd who noted the client had had surgery for a C6-C7 "disc herniation that was causing cord compression" and chronic myelopathy which he noted was "made worse by this problem." At last appointment he noted that upper extremity paresthesias and strength had

shown some improvement but he remained with numbness and tingling in his hands; loss of range of motion in his neck" particularly when turning to the right making it "difficult for him to drive." It was noted he remained with difficulty with his gait and described it as a "duck walk"; "continued weakness in his hands"; and reduced strength at "4 plus over 5 in upper extremity weakness, particularly in his grip"; "severely restricted with range of motion particularly with rotation to the right"; and gait "somewhat stiff". Dr. Boyd summarized the client continued with cervical myelopathy problems including weakness, "gait problems and restriction of range of motion in his neck." He noted the client to be at maximum medical improvement and opined that physical therapy or occupational therapy at this point could actually reverse some of the gains that he has made." He noted the client had "a 27% impairment of the whole person based on AMA Guides." In relation to work he ordered the client out of work on 03/10/2010 and on 04/19/2010 he noted, "I have great concerns about him safely operating a truck considering his range of motion issues and cervical myelopathy with resultant problems with coordination" and noted a functional capacity evaluation would "probably" be required to "define his work restrictions".

The client was seen by Brian G. Cuddy, M.D. of Charleston Neurosurgical Associates, Charleston, South Carolina on 10/29/2009 for an independent medical examination (IME). Dr. Cuddy noted medical history since accident and noted currently on exam minus 5 over 5 strength in hand grip and increase in tone in his upper and lower extremities. He reviewed 04/14/2009 MRI findings and concluded, "I am in agreement with Dr. Boyd's recommendation for further treatment at the C6-C7 level. I believe this is a continued preexisting degenerative condition that has been aggravated by his work-related accident. Because of the extended period of time between his original MRI scan, there is a consideration of an updated MRI scan prior to the surgical procedure."

Dr. Cuddy noted past medical history of diabetes and hypertension and medications of Hekturna HCT, Aspirin, Diovan, and Levemir, and previous surgical history of tonsillectomy as a child.

On 09/15/2010 the client was seen at Southeastern Spine Institute, Mt. Pleasant, South Carolina by Leonard E. Forrest, M.D. who noted the client was a 60 year old currently with pain symptoms "in the neck and upper back as well as into both arms and his hands, left greater than right; also in the low back and

both legs and into his feet, left greater than right." He noted medical history since accident with currently "considerable symptoms at the present time." Dr. Forrest noted, "No prior history of any similar symptoms or problems before this incident in May 2008. No subsequent incident or injury since the time of the work-related motor vehicle accident in May 2008." On examination he noted tenderness over the neck and upper back and also the low back. He also noted findings of MRI of April 2009 including disc bulge at C6-7, and noted he did not see any studies of the lumbar spine. He also opined, "It is certainly most likely that Mr. Brown's ongoing symptoms including those in the neck and upper extremities as well as the lower extremities are the result of the motor vehicle accident of May 2008. The cervical spine has been treated with ultimately a three-level fusion. However, he continues to have ongoing symptoms. Despite having had the three level fusion, in my opinion, further evaluation at this time is needed and Mr. Brown is not at maximum medical improvement. I would recommend getting a new MRI. He will almost certainly need some further treatment. With regard to the back and related leg symptoms, this also certainly seems to be related to the motor vehicle accident for the same reason as noted above, but has not been evaluated adequately at this point. It continues to be a problem for him. I would recommend an MRI and then he will almost certainly need

treatment for the back-related component of his symptoms also. As for the functional loss for Mr. Brown, in my opinion, Mr. Brown has lost more than fifty percent (50%) of the use of his back as the result of the work-related motor vehicle accident of May 2008."

On 09/16/2010 the client underwent a functional capacity evaluation at Columbia Rehabilitation Clinic, Inc., Columbia, South Carolina which revealed the client with significantly limited lumbar range of motion with straight leg raise tests positive or abnormal on both right (33% of normal) and left (60% of normal); true lumbar extension (51% of normal); and lumbar right lateral flexion (44% of normal). Testing also revealed cervical range of motion to be significantly limited with flexion (49% of normal); extension (38% of normal); left lateral flexion (59% of normal); right lateral flexion (34% of normal); left rotation (62% of normal); and right rotation (35% of normal). Testing revealed strength in upper extremities diminished with triceps and deltoid strength reduced to 4 over 5 on both sides. Lower extremity strength was also reduced with hip flexion at 4 over 5 on both sides.

Testing revealed the client not able to squat, even at the occasional level; limited to the occasional level only in

walking, reaching, stair climbing, kneeling, bending, and twisting. He was able to lift maximums of twenty-six (26) to thirty (30) pounds depending on height/levels lifted from. FCE evaluator noted lifting fell into the limited medium category, and noted the client's capacities fell into the limited medium category but this is not the case as the medium category per the D.O.T. requires "standing or walking for a total of approximately six (6) hours in an eight (8) hour workday in order to meet the requirements of frequent lifting or carrying objects." Also, light work per the D.O.T. "requires standing or walking for a total of approximately six (6) hours of an eight (8) hour day." The client is limited per this FCE to occasional level only in walking, i.e. maximum of 2.67 hours total in an eight (8) hour day. Thus, the client is also ruled out of light work, resulting in his limitation to sedentary work only-but with the significant limitation of only occasional reaching within the sedentary category which many/most sedentary jobs require. It should be noted that testing for maximum and consistent effort including Maximum Voluntary Effort testing, JAMAR hand dynamometer testing, bell-shaped curve graphing, and coefficients of variation revealed the client put forth maximum and consistent effort.

On 09/20/2010 in response to questions from the client's attorney, the FCE evaluator noted the client could "perform the entire range of lifting requirements for jobs that are available in the physical demand level work in the sedentary work category under the Dictionary of Occupational Titles" but could not perform light and medium category work. She also noted that the client falls into the sedentary physical demand category.

In conclusion, the client has a high school education but functions at fourth (4th) grade level in arithmetic, fifth (5th) grade level in spelling, and sixth (6th) grade level in reading. He has a very good thirty-nine (39) year work history including army private (two (2) years), dish washer (5 months), cook/kitchen manager (fourteen (14) years), shipping receiving worker/truck driver (fifteen (15) years), and tractor-trailer driver (eight (8) years). These jobs fall into the medium, and very heavy physical demand categories.

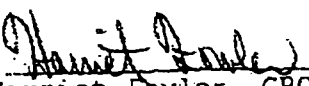
Therefore, given the client's limitations/restrictions, there is no job he previously held that he is now able to do. In order to determine jobs remaining within the client's current capacities, a transferable skills capacity analysis was performed. This occupational system analyzed the 12,741 job titles which exist in the United States economy as defined by

the Dictionary of Occupational Titles (D.O.T.). The D.O.T. is the official U.S. Department of Labor publication of jobs and respective requirements. All jobs were analyzed by computer against Mr. Brown's functional abilities, work history, and general educational development as inferred from his work history. Based on this objective extensive analysis there were no (0) job titles identified that would be within his current transferrable abilities.

A pragmatic look at the client's profile may assist in better understanding his severely restricted opportunities. The client could do few if any sedentary assembly jobs due to reaching limitations. The client would be unable to perform a sedentary cashier job at retail stores, grocery stores, pharmacies, etc. due to his fourth (4th) grade math level as usually at least a sixth (6th) grade level is required, and reaching limitations would also interfere. He could not be a sedentary taxi cab driver, chauffeur, delivery driver, etc. due to reaching restrictions. He could not be a fast food worker because of standing/walking restrictions. He could not be a file clerk due to spelling and reaching limitations as well as standing/walking limitations. He would be unable to perform a sedentary security guard job due to spelling limitations and possibly reading limitations as usually at least a sixth (6th) grade level of

spelling is required to complete incident reports and instructions manuals generally require reading levels above sixth (6th) grade. He would be unable to be a department store greeter due to standing limitations and reaching limitations could also interfere with this job as pushing carts and labeling items is also required.

The client is thus limited to a very, very narrow range of unskilled and semi-skilled sedentary jobs that do not require reaching beyond the occasional level that would pay between \$7.25/hour to approximately \$9.25/hour. The client has thus technically experienced approximately a seventy percent (70%) to ninety percent (90%) vocational loss and a large future wage loss given his pre-injury earnings of approximately \$22.19/hour. However, in actual practice it is more likely than not given his advanced age of sixty (60) (in spite of federal age discrimination laws), his education and functional academic levels, his significant restrictions/limitations, his work history and the job market that he would be unable to obtain or maintain employment of any kind.


Harriet Fowler, CRC, M.Ed.
Vocational Rehabilitation Manager

October 6, 2010
Date

Bulldog Hiway Express
PEOPLEASE CORPORATION

MESSAGE TO YOU

MESSAGE TO ALL EMPLOYEES

THOMAS L. BROWN

PEOPLEASE CORPORATION

DATE	EMPLOYEE NAME	DATE	STATUS	SSN	DATE	DATE
1010BROT	THOMAS L. BROWN	6/27/2008	Single	5	XXX-XX-3474	6/15/2008 6/21/2008
FILES	\$1.00 177.50 \$177.50	FICA	ADV	\$75.00	\$3,124.50	
ERDIE	\$52.00 \$52.00	MEDICARE	FEE	\$1.00	\$20.00	
		SOC SEC	GRN	\$24.99	\$499.80	
		FEDERAL	HL5C	\$34.54	\$276.32	
		STATE				
		SC		\$437.99		
		LOCAL				
TOTAL:	177.50 \$229.50	\$10.94	\$135.53			\$83.03
ACH Direct Deposit						Actual Deposit Amount
153201607 CHECKING Acct *****3560 Remainder of Netpay(\$83.03)						\$83.03
Total Deposits						\$83.03

THE FACE OF THIS CHECK HAS A COLORED BACKGROUND ON WHITE PAPER. THE BACK A UNIQUE CHECK IDENTITY BAR CODE AND A WATERMARK. HOLD AT AN ANGLE TO VIEW.

Bulldog Hiway Express
PEOPLEASE CORPORATION
210 Wingo Way Suite 400
Mt. Pleasant, SC 29464-1805

Wachovia Bank of SC, N.A.
Charleston, SC

03316873
67-776532

Date
June 27, 2008

Amount

Pay zero and xx / 100 Dollars

\$0.00

To
THOMAS L. BROWN

125
NON NEGOTIABLE

MESSAGE TO YOU

THOMAS L. BROWN

THE FACE OF THIS CHECK HAS A COLORED BACKGROUND ON WHITE PAPER. THE BACK A UNIQUE CHECK IDENTITY BAR CODE AND A WATERMARK. HOLD AT AN ANGLE TO VIEW.

Bulldog Hiway Express
PEOPLE'S CORPORATION
210 Wingo Way Suite 400
ML Pleasant, SC 29464-1805

Washington Bank of S.C., N.A.
Charleston, SC

Date
April 4, 2008

03225168
*67-776532

Amount
\$0.00

Pay zero and xx / 100 Dollars

To The THOMAS L. BROWN

*** VOID ***

126

NON NEGOTIABLE

Bulldog Hiway Express
PEOPLELEASE CORPORATION

MESSAGE TO YOU

MESSAGE TO ALL EMPLOYEES

THOMAS L BROWN

PEOPLELEASE CORPORATION									
01010BROT THOMAS L BROWN 2/1/2008 Single 5 XXX-XX-3474 1/20/2008 1/26/2008									
MILES	\$1.00	368.00	\$368.00	FICA		ADV	\$150.00	\$300.75	
PERDIE	\$260.00		\$260.00	MEDICARE	\$5.34				
				SOC.SEC	\$22.82				
				FEDERAL					
				STATE					
				SC	\$3.25				
				LOCAL					
TOTAL:								\$1,175.00	\$1,460.87
ACH Direct Deposit									\$446.59
D53201607 CHECKING Acct *****2560 Remainder of Nelpay(\$446.59)								Actual Deposit Amount	
Total Deposits:								\$446.59	

127

Bulldog Hiway Express
PEOPLEASE CORPORATION
210 Wingo Way Suite 400
Mt. Pleasant, SC 29464-1805

Wachovia Bank

N.A.

03158070
57-778132

Charleston, SC

Date

February 1, 2008

Amount

Pay

zero and xx / 100 Dollars

\$0.00

*** VOID ***

To The
Order Of

THOMAS L BROWN

NON NEGOTIABLE

128

This information is being furnished to the Internal Revenue Service. If you are required to file a tax return, negligence penalty or other sanction may be imposed on you if this income is taxable and you fail to report it.

Form W-2 Wage and Tax Statement 2007		896	7 Social security tips		1 Wages, tips, other comp 46152.50	2 Federal income tax withheld 5093.75
c Employer's name, address, and ZIP code BOYD BROTHERS TRANSPORTATION 3275 HWY 30 CLAYTON AL 36016-3003			8 Allocated tips		3 Social security wages 46152.50	4 Social security tax withheld 2861.46
			9 Advance EIC payment		5 Medicare wages and tips 46152.50	6 Medicare tax withheld 669.21
			10 Dependent care benefits		11 Nonqualified plans	12a See instructions for box 12
			13 Statutory employee Retirement Plan Third-party sick pay		14 Other 125P 3380.00	12b
e Employee's name, address, and ZIP code THOMAS L BROWN SC 29115-6278			b Employer identification number (EIN) 636006515		12c	
			a Employee's social security no.		12d	
15 State SC	Employer's state I.D. no. 25329056-7	16 State wages, tips, etc. 46152.50	17 State income tax 2409.57	18 Local wages, tips, etc.	19 Local income tax	20 Locality name

Copy C For EMPLOYEE'S RECORDS (See Notice to Employee on back of Copy B)

OMB No. 1545-0008

Dept. of the Treasury - IRS
Visit the IRS Web Site at www.irs.gov/w2

129

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Southeastern Program Service Center
1200 Rev. Abraham Woods, Jr. Blvd.
Birmingham, AL 35285
Date: July 3, 2010
Claim Number: 408-86-3474HA

660486 MC3M73 N3 2100
THOMAS L BROWN

You are entitled to monthly disability benefits beginning August 2010.

The Date You Became Disabled

We found that you became disabled under our rules on February 9, 2010. This is different from the date given on the application.

Also, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is August 2010.

What We Will Pay And When

- You will receive \$1,220.00 for August 2010 around September 15, 2010.
- After that you will receive \$1,220.00 on or about the third Wednesday of each month.
- ~~These and any future payments will go to the financial institution you selected. Please let us know if you change your mailing address, so we can send you letters directly.~~

The day we make payments on this record is based on your date of birth.

No payment is due at this time because of adjustments made to your benefits.

Other Disability Payments Affect Benefits

Your present workers' compensation payments of \$1,703.60 do not affect your Social Security benefits.

Enclosure(s):
Pub 05-10153
Pub 05-10058

130

C

See Next Page

408-86-3474HA

Page 2 of 4

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

You are due disability benefits because you are expected to be disabled under our rules for at least 5 full calendar months. Therefore, you should let us know if your health improves or you are able to return to work.

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "What You Need To Know When You Get Social Security Disability Benefits". It will tell you what must be reported and how to report. Please be sure to read the parts of the pamphlet which explain what to do if you go to work or if your health improves.

A provider of employment or vocational rehabilitation services may contact you about getting help to go to work. The provider may be a State vocational rehabilitation agency or a provider under contract with the Social Security Administration.

If you go to work, special rules allow us to continue your cash payments and health care coverage. For more information about how work and earnings affect disability benefits, call or visit any Social Security office and ask for the following publications:

- Social Security - Working While Disabled...How We Can Help (SSA Publication No. 05-10095).
- ~~Social Security - If You Are Blind-How We Can Help (SSA Publication No. 05-10052).~~

It is important that you let us know if:

- There is any change in the workers' compensation payment or in any public disability payment you receive, or
- You receive a lump-sum award or any additional payments which supplement your workers' compensation or public disability payments.

We have included your earnings from the railroad industry in figuring your Social Security benefit. If additional work in that industry together with your past railroad service totals 120 months or 60 months of railroad service after 1995, please notify any Social Security office promptly.

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SOCIAL SECURITY NOTICE

From: Social Security Administration

THOMAS LEE BROWN

Date: 06/24/2010

Claim Number: 408-86-3474

You must meet certain medical and non-medical requirements to be entitled to disability benefits.

We have found that you meet the medical requirements for disability benefits. An explanation of our finding is attached. Please read it carefully.

Doctors and other trained staff looked at your case and made this decision. They work for your state but used our rules.

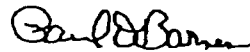
Please remember there are many types of disability programs, both government and private, which may use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in your case.

We have not yet made a decision about whether you meet the non-medical requirements, but we will make that decision soon. Then we will send you a second notice explaining our decision. After you receive this second notice you will have 60 days to appeal the determination we made about your claim for disability benefits.

If you have any questions about your disability claim or wish to appeal our findings, please do not get in touch with the Social Security Office until you have the second notice. The people at the Social Security Office will be better able to answer your questions when they have the information from both notices.

After you have received your second notice, you can call or write any Social Security Office to appeal our determination or to get answers to your questions. Most questions can be handled by telephone or mail. If you go to the Social Security Office in person, please take both notices with you.

Sincerely,



Paul D. Barnes
Regional Commissioner

cc:
RDO/351
Claim No.: J67180
1157D (2/04) LOC
SNO:

594

132

351/J67180

EXPLANATION OF DETERMINATION

Name of Claimant	NH's Name(if CDB or DWB Claim)	SSN	Type of Claim
THOMAS L BROWN			DIB

The following evidence, listed with receipt date, was used to decide this claim.

KINGSTREE SURGICAL ASSOCIATES, 06/17/10
LEXINGTON MEDICAL CENTER, 05/31/10
CHARLESTON NEUROSURGICAL ASSOC, 06/04/10
REGIONAL MED CTR-O'BURG/CALHOU, 06/02/10
DR SCOTT B BOYD MD, 06/10/10
NEUROLOGY AND PAIN CLINIC, 06/02/10
USC DIVISION OF NEUROSURGERY, 06/01/10
FAMILY HEALTH CENTERS INC, 06/07/10
Evidence Supplied By You

You said that you are unable to work due to a motor vehicle collision causing neck and back injuries, high blood pressure, diabetes, herpes and high cholesterol. You are currently not working.

You said that these conditions began on 5/02/08. The medical evidence shows that the earliest date you had a disabling impairment was 2/09/10 when you underwent a second neck surgery. Prior to this date, the limitations caused by your medical condition would have allowed you to do your past work as a truck driver as described in the national economy.

RDO/
SNO:

Form SSA-4268-C4 (1-85)

133



Thomas Lee Brown
Claimant's Name SSN
Address City State Zip
Home Phone #
Work Phone #
Scott B. Garrett
Preparer's Name

Peoplelease Corporation
Employer's Name
210 Wingo Way, Suite 400
Mount Pleasant, South Carolina 29464
Address City State Zip
Arch Insurance Company c/o Arrowpoint Capital Corp
Insurance Carrier
(803) 227-2224
Phone Number

A claim for workers' compensation benefits is made based on the following grounds:.

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Comp. Rate: \$393.14 2. AWW: \$ 589.69 Date of Injury May 2, 2008
3. Type of injury and body part(s): neck
4. Facts in controversy: What is the extent of permanent partial disability to the Claimant's neck pursuant to Section 42-9-30. The Defendants deny the Claimant is permanently and totally disabled. The Defendants deny the Claimant has sustained loss of more than 50% of the use of his back. The Claimant has been released by the treating physician and allowed perform medium to heavy duty work. This has been confirmed by the functional capacity evaluation. The Claimant's work history is varied and there are many jobs he has done before to which he could return.
5. Legal issues involved: See Number 4.
6. Unusual aspects: None anticipated.
7. Witnesses (designate if expert) Representatives of Peoplelease Corporation may be called to testify.
8. Exhibits: Excerpts from Claimant's personnel file may be introduced.
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)
Records of Dr. Scott Boyd dated 4-19-10 through 9-28-10 consisting of three pages; records of Carolina Therapy Solution LLC dated 6-10-10 through 6-14-10 consisting of five pages.
10. Name, address, and specialty, if any, of the treating physician: Dr. Scott Boyd, Columbia Neurosurgical Associates, P.A., 720 Rabon Road, Columbia, South Carolina 29203
11. Impairment rating(s); body part(s); physician and date of opinion: 27% loss of use to whole person from Dr. Boyd dated 9-28-10.
12. I am amending my Form 50/51 in the following manner: _____

I verify the contents of this form are accurate and true to the best of my knowledge.

SIGNATURE

Email: sgarrett@mqclaw.com

DATE OF HEARING: October 22, 2010

Time needed for hearing: 1 hour

On behalf of ☐ Claimant ☒ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0809238

THOMAS LEE BROWN,

Employee,

Claimant,

vs.

PEOPLEASE CORPORATION,

Employer,

AND

ARCH INSURANCE COMPANY C/O
ARROWPOINT CAPITAL CORP,

Carrier,

Defendants.

**NOTICE OF WITNESSES AND
WRITTEN MEDICAL REPORTS
TO BE INTRODUCED AS
DIRECT EVIDENCE ON BEHALF
OF DEFENDANT**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND PRESTON
F. MCDANIEL, ESQUIRE, ESQUIRE:

YOU ARE NOTIFIED that the Defendants, pursuant to the provisions of the South
Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws
(Cum. Supp. 1988) submit the following medical records and other documents as evidence:

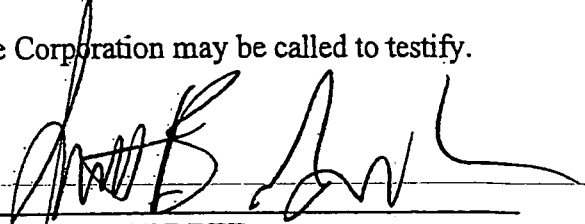
APA#	DOCTOR	PRACTICE	DATES	PAGES
1.	Scott S. Boyd	Columbia Neurosurgical Associates, P.A.	4-19-10 to 9-28-10	1-3
2.		Columbia Therapy Solutions, LLC	6-10-10 to 6-14-10	4-8

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise
oppose this evidence and, should you desire to exercise this right, you are to promptly schedule

the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants: representatives of Peoplelease Corporation may be called to testify.



SCOTT B. GARRETT
MCANGUS GOUDELOCK & COURIE, L.L.C.
Post Office Box 12519, Capitol Station
700 Gervais St. Suite 300
Columbia, South Carolina 29211-2519
(803) 779-2300
Attorneys for the Employer/Carrier

Columbia, South Carolina
October 12, 2010

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0809238

THOMAS LEE BROWN,

Employee,

Claimant,

vs.

PEOPLEASE CORPORATION,

Employer,

AND

ARCH INSURANCE COMPANY C/O
ARROWPOINT CAPITAL CORP,

Carrier,

Defendants.

**CERTIFICATE
OF
SERVICE**

The undersigned certifies that she is an employee at MCANGUS GOUDELOCK & COURIE, and that she has served, on the date set forth below, a copy of the document described below, in the above entitled action to the following persons, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

TO:

Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

Clyde C. Dean, Jr., Esquire
Dean Law Firm
Post Office Box 1405
Orangeburg, South Carolina 29116-1405

VIA HAND DELIVERY

**S. C. WORKERS' COMPENSATION
COMMISSION**

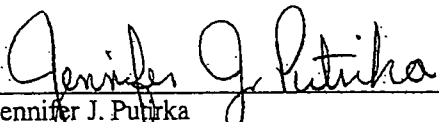
1333 Main Street, Suite 500
Columbia, South Carolina 29201

DOCUMENT:

Pre-Hearing Brief and Notice of Witnesses and Written
Medical Reports

DATE OF
MAILING:

October 12, 2010


Jennifer J. Putrka
Legal Secretary to Scott B. Garrett

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

www.columbianeurosurgical.com

Spine & Neurological Surgery

Thomas J. Holbrook, Jr., MD Scott B. Boyd, MD
William M. Rambo, Jr., MD Brett C. Gunter, MD
Randall G. Drye, MD Karl A. Lozanne, MD

720 Rabon Road
Columbia, SC 29209
(803) 462-0423 • (F) 462-0432

Pain Medicine

Steven B. Strick, MD
Eva J. Rawl, MD

132 Sunset Court
W. Columbia, SC 29169
(803) 794-3700 • (F) 794-0322

OFFICE VISIT

Patient: Thomas L. Brown
Chart: 82313
Date: 4/19/10

Mr. Brown returns to the office for follow-up. He is over two months out from an anterior cervical discectomy and fusion at C6-7 for a disc herniation that was causing cord compression. He has had a chronic myelopathy and his myelopathy was made worse by this problem. He had an uneventful perioperative course. Initially he had pretty good improvement of his gait and upper extremity weakness but that now has stabilized. He really has not changed much since I last saw him six weeks ago. He is gradually increasing his activity but says that he still has difficulty with his gait and describes it as a "duck walk". He also continued weakness in his hands that is unchanged since his last visit. He also has significant restriction of ROM, particularly to the right.

On examination, his incision is well healed. He continues to have 4+/5 upper extremity weakness, particularly in his grips. Of note his last consult note indicated 5/5 power and that is an error. He does have a steady gait that is somewhat stiff. He has severely restricted ROM, particularly with rotation to the right.

IMPRESSION/PLAN: Mr. Brown has had some good improvement but by no means complete of his cervical myelopathy. He still has weakness, gait problems and restriction of ROM in his neck. I believe he is at maximum medical improvement at this point. I really do not believe that physical therapy or occupational therapy would help and at this point could actually reverse some of the gains that he has made. I will release him with a 27% impairment of the whole person based on AMA Guides. I have great concerns about him safely operating a truck considering his ROM issues and cervical myelopathy with resultant problems with coordination. He will probably require a Functional Capacity Evaluation in order to define his work restrictions.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MAH

CNAWT: 4040

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.www.columbianeurosurgical.com

Spine & Neurological Surgery

Thomas J. Holbrook, Jr., MD	Scott B. Boyd, MD
William M. Rambo, Jr., MD	Brett C. Gunter, MD
Randall G. Dye, MD	Karl A. Lozanne, MD

720 Rabon Road
Columbia, SC 29203
(803) 482-0423 - (F) 482-0432

Pain Medicine
Steven B. Storick, MD
Eva J. Rawl, MD

132 Sunset Court
W. Columbia, SC 29169
(803) 794-3700 - (F) 794-0322

CHART NOTE

Patient: Thomas L. Brown
Chart: 82313
Date: 7/14/10

Mr. Thomas L. Brown underwent a Functional Capacity Evaluation at Carolina Therapy Solutions on 6/10/10. I have been provided with this study's report.

Mr. Brown appears to be able to function in the medium to heavy work range according to this evaluation. Further specifics are contained within the body of the report.

Mr. Brown appeared to put forth very good effort on this evaluation and, therefore, it is felt to be valid. I agree with this evaluation's findings.

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

Scott B. Boyd, MD

SBB/MAH. CNAWT: 4045

Faxed To: CNA Work Comp Dept.

South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov



82313
Physician's Statement

Claimant's Name: Thomas Brown Employer's Name: Peoplelease Corp.
Physician's Name: Dr. Scott Boyd Insurance Carrier: Gallagher Bassett
Practice/Clinic: Columbia Neurosurgical Assoc. SCWCC File No: _____
Preparer's Name: Tara Cook
Phone: (803) 462-3622

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 7-1-08

Date of first office visit: 8-4-08 Date of last visit: 4-19-10

Diagnosis or nature of injury or illness: T22.0

Body part(s) injured: neck Body part(s) affected: _____

Date of Maximum Medical Improvement: 4-19-10

Based on the AMA Guidelines, the claimant has sustained a 27 % loss of use to whole injured body part(s) and a _____ % loss of use to _____ other affected body part(s).

_____ The claimant is able to return to work without restriction.

X The claimant is able to return to work with the following restrictions:

medium to heavy

_____ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

X will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

_____ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Scott Boyd
Treating Physician

9-28-10
Date

Carolina Therapy SOLUTIONS, LLC
132B Sunset Ct
132B Sunset Ct
West Columbia, SC 29169

Date: 06/10/2010

Dear Dr. Boyd,

THOMAS L. BROWN was referred by you for evaluation of his overall functional capacity in a 4 hour FCE. You asked that his work ability be evaluated. We also assessed his effort level and reliability while performing the test. Attached are the FCE results.

Effort Level: In regards to his effort level, which underlines the ability for him to voluntarily perform work, he had good results:

Full effort on 13 of 13 tests, self-restricted on 0 tests, and refused on 0 tests.

Work Abilities: In brief summary, if he stays within his FCE limits and avoids poor body mechanics, Mr. Brown demonstrated his heaviest work abilities at each body level as follows with the corresponding DOT Physical Demand Category listed next to each:

<u>Mid-body up to 100 lbs</u>	(DOT Heavy Work)
<u>Low levels (below mid-body level) up to 50 lbs</u>	(DOT Medium Work)
<u>Shoulder levels up to 50 lbs</u>	(DOT Medium Work)

A more detailed breakdown of his limits is on the FCE Report. Further job-specific testing can be performed upon request.

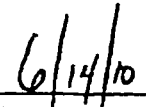
His job as a Truck driver has many variables, and if job-specific information is identified or a Job Function Description is requested, a test could be developed that would match his specific job. This would provide you with information on his abilities tested against the physical tasks of the job.

If further specific testing, return to work management, or functional rehabilitation to increase his abilities would assist, please let us know.

Thank you for this referral!



William Siebers, PT
SC Lic: 1787



Date 6/14/10

Carolina Therapy SOLUTIONS, LLC

132-B sunset Court

West Columbia, SC 29169

Ph 803-796-5116 Fx 803-796-5131

A DSI Work Solutions Provider

A DSI Work Solutions Provider

Client:	BROWN, THOMAS		
Report Date:		Evaluation Date:	08/01/2010
Address:			
Phone:		E-Mail:	

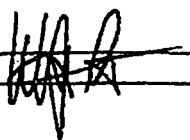
ABILITIES	OCCASIONALLY 1-25%	FREQUENTLY 26-50%	CONSTANTLY 51-100%	Functional Considerations/ Issues
1. Lift-Carry	100 lbs	50 lbs	20 lbs	Frequent rest breaks of a few minutes should be allowed at moderate and heavy levels.
2. From floor	50 lbs	30 lbs	10 lbs	
3. To shoulder	50 lbs	30 lbs	20 lbs	
4. Push/Pull	90 lbs / 119 lbs	45 lbs / 60 lbs	23 lbs / 30 lbs	
5. Hand Grip	R 95 lbs L 76 lbs	R 48 lbs L 38 lbs	R 24 lbs L 19 lbs	
6. Pinch Grip (3 pt)	R 16 lbs L 14 lbs	R 8 lbs L 7 lbs	R 4 lbs L 4 lbs	
7. Hand Coordination		X		
8. Sit			X	
9. Stand-Walk			X	
10. Bend-Reach			X	
11. Low Level Activity			X	Uses half kneel.
12. Elevated Activity			X	
13. Climb Stairs			X	Uses hand rail.
Note: *: Amount client was willing to do but self restricted before maximum could be determined R: Refusal to perform activity O: Tested but unable				
(Estimate for an 8 hour work shift) Ergonomic conditions including breaks must apply.				

Effort rating: Gave Full Effort on 13 tests of 13 tests
Self Restricted On 0 tests
Refused to perform 0 tests

Consistency: Consistent Performance demonstrated on 8 / 9 tests.

Referral Question: What are Mr. Brown's functional abilities?

- Recommendations:** 1) A job description was not available. However, he has the potential for full time work at the above indicated functional levels. Proper ergonomics would be necessary at these levels.
- 2) A Work Reconditioning/Work Hardening program may be of benefit for Mr. Brown to increase functional abilities.
- 3) Answering the referral question specifically could be done by doing specific Job Analysis for his current job or for future jobs and Job Function Matching could be performed. This clinic can provide Job Analysis and Job Function Matching. If further work conditioning is necessary, it can be provided as well.

Evaluator Signature		Date:	6/14/10
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Carolina Therapy SOLUTIONS, LLC

132-B sunset Court

West Columbia, SC 29169

Ph 803-796-5116 Fx 803-796-5131

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A DSI Work Solutions Provider

FCE HISTORY & PHYSICAL EXAMINATION

Name:	BROWN, THOMAS L.				
Address:					
City:		State:	SC	Zip:	
Home Phone:		Work Phone:			
Referred By:	Dr. Scott Boyd				

Physician: Dr. Scott Boyd

Specialty: Neurosurgery

Diagnosis: (1) Cervical HNP

ICD-9 Code: 722.0

Medications: Takes Alleve & oxycontin PRN, meds for HTN & hypercholesterolemia. Also takes aspirin, but reports MD is aware of taking this with Alleve.

Recent or pertinent surgeries: S/P cervical discectomy fusion C6-7 on 2/09/2010 for HNP with cord compression with myelopathy. Reports he had a previous ACDF C3-C6 in 09-03-2008.

Functional abilities and restrictions current: Reports he is able to drive, but has difficulty turning head to right due to stiffness/tightness and some pain at end-range rotation to right. Reports sleep disruptions due neck discomfort intermittently. He reports little overall difficulty walking, but avoids uneven surfaces. He goes to his local mall to walk for exercise regularly. He reports some difficulties with lifting due to UE weakness, L>R. Able to reach overhead, but prolonged reaching is more difficult.

Symptoms and discomfort: Reports weakness both arms & hands, particularly on left. Reports numbness left distal forearm & hand and right fingers. This is fairly constant.

Job at Time of Injury: Truck Driver of a flat bed truck

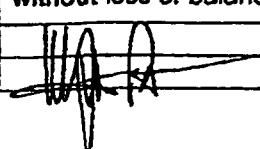
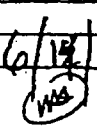
Work Status: Not working due to dysfunction

Type of Job at Injury:

- | | |
|--|--|
| ☐ Lift Under 10# | ☐ Mostly Standing/Walking Job |
| ☐ Lift 10-20# | ☒ Mostly Sitting Job |
| ☒ Lift 20-50# | ☐ Mixed Sit/Stand/Walk |
| ☐ Lift Above 50# | |
| ☒ Lifted at Waist Level | |
| ☒ Lifted at Shoulder Level | |
| ☐ Lifted from Floor | |

Reason for Referral:

- | | |
|---|--|
| ☐ As Part of a Work Rehabilitation Program | ☐ To Determine Status of Disability |
| ☒ Return to Work / Work Available | ☐ Medical-Legal Request |
| ☐ To Determine Work Status | ☐ Other |

Physical Date:	06/01/2010		
Worker / Client:	BROWN, THOMAS L.		
Blood Pressure:	133/81		
Resting Heart Rate:	81	Age adjusted maximum HR for test:	137 (Age 59)
Resting Heart Rate:	81	Age adjusted maximum HR for test:	137 (Age 59)
Body Part	Specifics		Strength and Motion Rating
Neck <u>ROM:</u>	<u>Limited:</u> Maj Mod Min Nil <u>Symptoms</u>	☐ Within Normal Limits ☒ Limit in motion ☒ Limited by weakness	
NW = Not Worsened	Flex X Ext X / X SBR X SBL X / X RR X / X RL X / X Posture: Moderately flexed MMT: 4+/5 throughout. Some discomfort on resisted sidebending, R>L, but not worsened. Symptoms increased as indicated above, but none worsened (eased when stopped).	Not Worsened Bilat lower neck stiffness, NW Pulls L neck, NW Pulls L neck, NW Stiff R neck, NW NW	
Back <u>ROM:</u>	<u>Limited:</u> Maj Mod Min Nil <u>Symptoms</u>	☒ Within Normal Limits ☐ Limit in motion ☐ Limited by weakness	
NW = Not Worsened	Flex X Ext X SBR X SBL X RR X RL X SGR X SGL X Posture: Moderately flexed MMT: 5/5 throughout. Seated SLR: Negative & symmetrical.	Not Worsened NW NW NW NW NW NW NW	
R-Upper Extremity	ROM WNL's. Strength on myotomal testing 5/5 throughout.	☒ Within Normal Limits ☐ Limit in motion ☐ Limited by weakness	
L- Upper Extremity	ROM WNL's. Strength on myotomal testing 5/5 throughout except elbow extension 5-/5, shoulder ER 4+/5.	☒ Within Normal Limits ☐ Limit in motion ☒ Limited by weakness	
R-Lower Extremity	ROM WNL's. Strength on myotomal testing 5/5 throughout. Able to fully squat without loss of balance.	☒ Within Normal Limits ☐ Limit in motion ☐ Limited by weakness	
L-Lower Extremity	ROM WNL's. Strength on myotomal testing 5/5 throughout. Able to fully squat without loss of balance.	☒ Within Normal Limits ☐ Limit in motion ☐ Limited by weakness	
EVALUATOR:			DATE: 6/17/10 

Summary:

1. Overall moderately limited cervical ROM but with only stiffness at end ranges and not worsened. With proper ergonomics, this did not affect functional abilities indicated in FCE.
2. Mild neck weakness apparent with some discomfort on lateral resistance during manual muscle testing. With proper ergonomics, this did not affect functional abilities indicated in FCE.
3. Mild weakness was noted left triceps & shoulder external rotators on manual muscle testing. This did not appear to affect functional abilities or symmetry of activities in FCE.
4. Numbness left distal forearm & hand and right fingers reported. On manual muscle testing, hand strength was 5/5 and grip strength was within one standard deviation of norms, but pinch strength & hand coordination were below norms.

5. Prolonged periods of rest needed between segments of the FCE before advancing to the next segment.

However, his HR was not able to return below 100-110 BPM between sets of lifts & carries without his having to sit for a short period of time before advancing to the next segment. This likely represents a deconditioning effect.

- 6.
7. Functional limitations in FCE are related to the following physical findings:

Test Item	Physical = Functional Findings
#2 Lift from Floor #3 Lift to shoulder	Prolonged periods of rest between segments of the FCE. HR was not able to return below 100-110 BPM between sets of lifts without his having to sit for a short period of time before advancing to the next segment.
#1 Lift-Carry #2 Lift from Floor #3 Lift to shoulder	Body mechanics had to be instructed & re-emphasized for safe performance.
#6 Pinch Grip	On manual muscle testing, hand strength was 5/5, but pinch strength with pinch dynamometer in both hands was weaker than norms. He showed no difficulties with hand weakness during lifting & carrying activities.
#7 Hand Coordination	Scored mildly below average standard scores on hand coordination tests bilaterally.

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Thomas Lee Brown

Claimant's Name SSN

Address City State Zip

Home Phone #

Work Phone #

Scott B. Garrett

Preparer's Name

Peoplelease Corporation

Employer's Name

210 Wingo Way, Suite 400

Mount Pleasant, South Carolina 29464

Address City State Zip

Arch Insurance Company c/o Arrowpoint Capital Corp

Insurance Carrier

(803) 227-2224

Phone Number

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Comp. Rate: \$393.14

2. AWW: \$ 589.69

Date of Injury May 2, 2008

3. Type of injury and body part(s): neck

4. Facts in controversy: What is the extent of permanent partial disability to the Claimant's neck pursuant to Section 42-9-30. The Defendants deny the Claimant is permanently and totally disabled. The Defendants deny the Claimant has sustained loss of more than 50% of the use of his back. The Claimant has been released by the treating physician and allowed to perform medium to heavy duty work. This has been confirmed by the functional capacity evaluation. The Claimant's work history is varied and there are many jobs he has done before to which he could return.

5. Legal issues involved: See Number 4.

6. Unusual aspects: None anticipated.

7. Witnesses (designate if expert) Representatives of Peoplelease Corporation may be called to testify. Monica Reese and other representatives of Peoplelease may be called to testify.

8. Exhibits: Excerpts from Claimant's personnel file may be introduced. Wage information from similar employees of Peoplelease may be introduced regarding the average weekly wage and compensation rate issue. Form 20/Wage Statements from similar employees may be introduced regarding the average weekly wage issue.

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) Records of Dr. Scott Boyd dated 4-19-10 through 9-28-10 consisting of three pages; records of Carolina Therapy Solution LLC dated 6-10-10 through 6-14-10 consisting of five pages.

10. Name, address, and specialty, if any, of the treating physician: Dr. Scott Boyd, Columbia Neurosurgical Associates, P.A., 720 Rabon Road, Columbia, South Carolina 29203

11. Impairment rating(s); body part(s); physician and date of opinion: 27% loss of use to whole person from Dr. Boyd dated 9-28-10.

12. I am amending my Form 50/51 in the following manner: _____

I verify the contents of this form are accurate and true to the best of my knowledge.

SIGNATURE

Email: sgarrett@mqclaw.com

DATE OF HEARING: October 22, 2010

Time needed for hearing: 1 hour

On behalf of ☐ Claimant ☒ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0809238

THOMAS LEE BROWN,

Employee,

Claimant,

vs.

PEOPLEASE CORPORATION,

Employer,

AND

ARCH INSURANCE COMPANY C/O
ARROWPOINT CAPITAL CORP,

Carrier,

Defendants.

AMENDED NOTICE OF WITNESSES
AND
WRITTEN MEDICAL REPORTS
TO BE INTRODUCED AS
DIRECT EVIDENCE ON BEHALF
OF DEFENDANT

TO: ~~SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND PRESTON~~
F. MCDANIEL, ESQUIRE, ESQUIRE:

YOU ARE NOTIFIED that the Defendants, pursuant to the provisions of the South Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws (Cum. Supp. 1988) submit the following medical records and other documents as evidence:

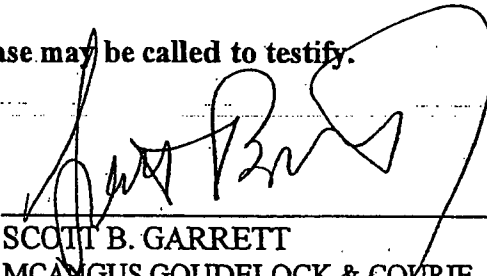
APA#	DOCTOR	PRACTICE	DATES	PAGES
1.	Scott S. Boyd	Columbia Neurosurgical Associates, P.A.	4-19-10 to 9-28-10	1-3
2.		Columbia Therapy Solutions, LLC	6-10-10 to 6-14-10	4-8

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule

the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants: representatives of Peoplelease Corporation may be called to testify. **Monica Reese and other representatives of Peoplelease may be called to testify.**



SCOTT B. GARRETT
MCANGUS GOUDELOCK & COURIE, L.L.C.
Post Office Box 12519, Capitol Station
700 Gervais St. Suite 300
Columbia, South Carolina 29211-2519
(803) 779-2300
Attorneys for the Employer/Carrier

Columbia, South Carolina
October 14, 2010

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0809238

THOMAS LEE BROWN,

Employee,

Claimant,

vs.

PEOPLEASE CORPORATION,

Employer,

AND

ARCH INSURANCE COMPANY C/O
ARROWPOINT CAPITAL CORP,

Carrier,

Defendants.

**CERTIFICATE
OF
SERVICE**

The undersigned certifies that she is an employee at MCANGUS GOUDELOCK & COURIE, and that she has served, on the date set forth below, a copy of the document described below, in the above entitled action to the following persons, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

TO:

Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

Clyde C. Dean, Jr., Esquire
Dean Law Firm
Post Office Box 1405
Orangeburg, South Carolina 29116-1405

VIA HAND DELIVERY

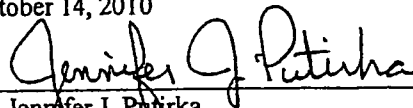
**S. C. WORKERS' COMPENSATION
COMMISSION**
1333 Main Street, Suite 500
Columbia, South Carolina 29201

DOCUMENT:

**Amended Pre-Hearing Brief and Amended Notice of
Witnesses and Written Medical Reports**

DATE OF
MAILING:

October 14, 2010


Jennifer J. Putirka

Legal Secretary to Scott B. Garrett