THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

T. SCOTT BECK, COMMISSIONER, CHAIR
SUSAN S. BARDEN, COMMISSIONER
DERRICK L. WILLIAMS, COMMISSIONER

Appellate Case No. 2011-204487

W.C.C. File No.:0810190

Bobby Baker, Employee/Claimant .... Appellant,

vs.

Hilton Hotels Corporation, Employer, and
ACE American Insurance Company, Carrier/Defendants .... Respondents.

FINAL BRIEF OF RESPONDENTS

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STATEMENT OF ISSUES ON APPEAL

I. Whether the Hearing Commissioner and Appellate Panel properly found Claimant did not suffer a physical brain injury or any resulting physical brain damage based upon the greater weight of the evidence?

II. Whether the Hearing Commissioner and Appellate Panel properly found Claimant was not entitled to lifetime benefits as the greater weight of the evidence did not support a finding of physical brain damage?

STATEMENT OF THE CASE

Claimant has appealed the Decision and Order of the Appellate Panel of the South Carolina Workers' Compensation Commission finding Claimant did not suffer a physical brain injury or any resulting physical brain damage. (R. pp. 18-24).

On May 6, 2008, Claimant was injured after a piece of ceiling tile fell and struck him on his head during the course and scope of his employment with Hilton Hotels Corporation. The Employer and Carrier immediately admitted the claim and began providing medical and indemnity benefits.

Claimant filed a Form 50 Request for Hearing on July 7, 2010 alleging injuries to his head, spine, left leg and right leg. He alleged he was permanently and totally disabled as a result of his work related injury and also alleged he sustained physical brain damage pursuant to S.C. Code Ann. §42-9-10(c). (R. p. 25). This claim was heard before the single commissioner on January 4, 2011.[1] (R. p. 38). Subsequently, the single commissioner issued a Decision and Order dated March 2, 2011, which awarded Claimant permanent and total disability benefits pursuant to §42-9-30(21) based on his back injury, but denied Claimant's request for a finding of physical brain damage and entitlement to lifetime benefits. (R. pp. 4-17).

Claimant appealed the single commissioner's finding that he did not suffer physical brain damage to the Appellate Panel of the Workers' Compensation Commission. Oral Arguments were held before the Appellate Panel on June 21, 2011. The Appellate Panel upheld

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[1] This claim was originally set for a hearing on October 12, 2010; however, it was continued so the parties could perform additional discovery. This initial hearing date is significant because the expert report of Dr. L. Randolph Waid, which is so heavily relied upon by the Claimant, was completed less than two weeks prior to the original hearing date but over two years after the date of injury.

the Decision and Order of the single commissioner in its entirety by Order dated October 31, 2011. (R. pp. 18-24).

STATEMENT OF THE FACTS

On May 6, 2008, Claimant was injured after a piece of ceiling tile fell and struck him on his head during the course and scope of his employment with Hilton Hotels Corporation. The Employer and Carrier immediately admitted the claim and began providing medical and indemnity benefits.

Claimant initially presented to the emergency room at Grand Strand Regional Medical Center on May 6, 2008. He was not transported by ambulance. He was diagnosed with a scalp laceration and head contusion for which he received wound clips. An x-ray of his cervical spine read as, "no acute fracture" by the radiologist. Claimant was discharged home with instructions to follow up with his primary care physician for recheck within the next week. (R. p. 263). Claimant followed up with Doctors Care later that day. (R. pp. 491-92).

On June 14, 2008, Claimant presented to Grand Strand Regional Medical Center complaining of "lower back discomfort." Claimant's diagnosis was listed as "back pain" and he was discharged home with Percocet and Flexeril. Claimant was instructed to "follow up with orthopaedics for MRI of the back to further delineate." (R. p. 507).

Claimant presented to Doctors Care on June 16, 2008 with additional complaints of low back pain and was diagnosed as having a "low back strain." (R. p. 493). Claimant had an MRI of the lumbar spine performed on June 23, 2008 that revealed degenerative disc and facet joint disease with bilateral annular tears within the peripheral annular fibers at L4-5. Degenerative disc disease with an annular tear was also noted at the T11-12 level. (R. p. 509).

Claimant was referred to Dr. McCaffrey at Strand Regional Associates on June 26, 2008.[2] Prior to meeting with Dr. McCaffrey, Claimant completed a medical questionnaire wherein he indicated he "*never*" suffered from recurrent headaches, migraine headaches, fainting, dizziness or memory loss." (R. pp. 273-76). In his first meeting with the Claimant, Dr. McCaffrey noted,

> "[h]e suffered a very brief loss of conscious[ness] with a laceration to the occipital area requiring 12 stitches at Grand Strand Regional Medical Center. He went to Doctor's Care the next day and was told to go back to work. Unfortunately, he developed a bad upper respiratory infection. He was seen by his primary care physician and was in bed for two to three days after this accident. On 06/14/2008, he developed severe low back pain. He was seen at Grand Strand Regional Medical Center and given intravenous medication."

(R. p. 266). Claimant was diagnosed as having "low back pain with right leg radiation" and was referred for an EMG of the right lower extremity. Claimant was also diagnosed with a "closed-head injury with a left occipital laceration." Dr. McCaffrey noted that Claimant's laceration was completely healed and Claimant was having "no residual symptoms from this." (R. p. 268). In the "Mental Status" of his neurological evaluation, Dr. McCaffrey noted that Claimant was,

> "Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events.

(R. p. 268). Claimant continued to treat with Dr. McCaffrey from June 26, 2008 through March 11, 2009 when he was placed at maximum medical improvement with a finding of permanent and total disability "in reference to his low back pain, neck pain, and headaches." Claimant's mental status was assessed at each and every visit and was noted to be the same. (R. pp. 266-316). Dr. McCaffrey went on to complete an "Attending Physician's Statement of Disability"

[2] Appellant's Brief erroneously states Claimant's initial visit with Dr. McCaffrey was on May 26, 2008.

wherein he noted Claimant had a Class 5 Physical Impairment (severe limitation) and a Class 1 Mental/Nervous Impairment (no limitations). (R. p. 321).

Claimant treated with Dr. Jason C. Rosenberg at the Waccamaw Pain Management Center from September 10, 2008 through August 4, 2009. At his initial visit with Dr. Rosenberg on September 10, 2008, Claimant complained of "low back and right lower extremity pain." Claimant's mental status was described as "alert, oriented, cooperative, and follows commands well. Speech is clear and language is normal. Abstract function is normal. Attention and memory are normal." (R. p. 326). Claimant received a series of right L3 through S1 medial branch blocks and radiofrequency ablation procedures throughout the course of his treatment. Claimant's mental status was addressed during every visit and procedure and was noted to be "normal." (R. pp. 325-68).

Claimant was referred to pain management with Dr. Kang on November 4, 2009. Dr. Kang diagnosed Claimant with lumbar degenerative disc disease with lumbar facet syndrome and recommended a repeat radio frequency ablation and medical management of Claimant's pain medications. (R. p. 394). The last medical record from Dr. Kang prior to the hearing before the single commissioner was dated November 24, 2010. Dr. Kang placed Claimant at maximum medical improvement on June 8, 2010 with an 18% impairment rating to the lumbar spine. Dr. Kang gave Claimant clearance for sedentary type activity. In all of Dr. Kang's medical records from November 4, 2009 through November 24, 2010, it was noted that Claimant "shows no signs of cognitive impairment." (R. pp. 395-422).

At the request of his attorney, Claimant saw Robert E. Brabham, Ph.D. on July 20, 2010 for a psychological and vocational evaluation. Dr. Brabham noted Claimant's history of academic difficulties. Specifically, during the evaluation, Claimant described himself as "good

with my hands" but "retarded in the books." (R. p. 439). Claimant also noted that he had been "unable to handle the paperwork or financial aspects of his auto mechanics business in the past." (R. p. 439).

Again, per the referral of his attorney, L. Randolph Waid, Ph.D. evaluated Claimant on September 29, 2010 for a neuropsychological evaluation. Dr. Waid also noted Claimant's history of academic difficulties. During this examination, Claimant reported that "he has always been mechanical and good with his hands but not a 'good book learner.'" (R. p. 454). Interestingly, in his summary and case discussion, Dr. Waid, noted, "I believe it evident that the primary obstacle to Mr. Baker's ability to return successfully to role functioning are the residuals from the orthopaedic injury…." (R. p. 458).

Finally, Claimant was evaluated by Robert E. Deysach, Ph.D. on December 4, 2010 at the request of the Employer/Carrier. On the Wechsler Abbreviated Scale of Intelligence (WASI), Claimant was noted to have a Full-2 estimated IQ of 62, which places him in the "Mildly Handicapped" range. (R. p. 463). Dr. Deysach agreed with Dr. Waid that the "primary obstacles" of Claimant's inability to return to a competitive job market are the "residuals from the orthopedic injury." (R. p. 466). Of importance, Dr. Deysach noted cognitive deficits were documented but "the data indicate that these deficits are basically developmental (i.e., existing before the accident) rather than the result of physical brain damage from the accident." Specifically, Dr. Deysach noted,

> "In other words, up to the present, the patient has been able to compensate for his intellectual shortcomings by his physical competencies and a strong work ethic (e.g., working two full time jobs before his accident). The accident and his failure to return to productivity has made more salient to him and his family that he has significant deficits in the area of language and math (i.e., skills critical for activities of daily living)."

(R. p. 466). Lastly, Dr. Deysach noted it was reasonable to conclude Claimant did suffer an injury to the head with brief and mild-post concussive symptoms but "the data do not appear to support the presence of an acquired brain injury." (R. p. 467).

Both the Claimant and his wife testified at the January 4, 2011 hearing before the single commissioner. Prior to his injury, Claimant was employed with Hilton Hotels Corporation for approximately four years in the maintenance department. (R. pp. 89-90). His job duties included HVAC repair, plumbing, carpentry and general inspections of hotel rooms. (Id.) While working for Hilton Hotels, he was also employed as an automobile mechanic at Hardwick's Lube-It in Conway, South Carolina. (R. p. 91). Prior to working for Hilton Hotels, Claimant ran his own automobile mechanic business with his wife. Claimant testified that in running his business, he would run the day-to-day operation of the shop, while his wife handled the book keeping and other administrative duties. (R. pp. 92-93).

Claimant completed the 9th grade but dropped out in the 10th grade so he could work to buy a car. Claimant testified he made poor grades in school and was even held back in the first grade. He did not like school and admitted to being distracted a lot and having problems with reading, spelling and math. (R. p. 123). Claimant received no other formal education beyond the 9th grade.

Claimant testified he could not remember exactly what happened to him on the date of injury. All he remembered was waking up on the floor of a hotel room he was inspecting. (R. pp. 106-07). He was later told that a piece of ceiling tile had fallen on his head. Claimant was driven to the hospital by his supervisor where he was treated for a scalp laceration. He received several staples in his scalp, and was told to follow-up with his family physician to have the staples removed. (Id.) Claimant admitted that he did not inform the ER physician about any

other problems and that he did not receive nor request any diagnostic tests or studies regarding the potential for physical brain damage. (R. p. 109). Claimant went to Doctors Care the day after his injury for a follow-up appointment and was released to return to work. Claimant admitted he did not mention any problems with memory or physical brain damage at this visit. (Id.)

Claimant testified he was unable to return to work as recommended by the Doctors Care physician due to a bad respiratory infection. (R. p. 110). He went to the emergency room about one month after the injury due to severe back pain. (Id.) He followed up with Doctors Care for his back pain and was eventually referred to Dr. McCaffrey, a neurologist with Strand Regional Specialty Associates. (R. p. 111). Claimant testified that Dr. McCaffrey took him out of work because of his back pain. (Id.) He continued to treat with Dr. McCaffrey for over a year. Claimant testified that he began to develop headaches after his injury and he informed Dr. McCaffrey of this. (Id.) Dr. McCaffrey provided Claimant with medication for his headaches. Claimant admitted he never discussed anything regarding memory difficulties or brain damage throughout the course of his treatment with Dr. McCaffrey. (R. pp. 112-15).

Claimant testified Dr. McCaffrey placed him at maximum medical improvement in March 2009. (R. p. 116). Claimant recalled attending an FCE where he had to perform a lot of different exercises. Claimant acknowledged he received a 14% impairment rating to his spine as a result of his FCE performance and he recalled telling the examiner he would like to return to work if he was physically able to do so. (R. p. 117). Claimant admitted that he never mentioned anything to the FCE examiner about memory loss or cognitive problems. (R. p. 118).

After the FCE, Claimant began pain management with Dr. Gregory Kang. Claimant testified he treated with Dr. Kang for over a year and continues to treat with him. Claimant

testified Dr. Kang has been able to give him the most pain relief. (Id.) Again, Claimant admitted he never mentioned anything with regard to memory problems and cognitive difficulties to Dr. Kang. (R. p. 119). Claimant acknowledged he received over two years of medical treatment without any discussion of or treatment for memory problems, cognitive difficulties or brain damage. (R. p. 122).

Claimant's wife, Peggy Baker, testified on his behalf. When asked to describe the type of problems her husband was having, she testified Claimant used to work 80 hours per week and that he is no longer able to do that. (R. p. 62). She also testified he used to take care of the home and do the yard work and he was not physically able to do this anymore. (Id.) Mrs. Baker testified her husband started forgetting things a lot and was oftentimes confused. (R. p. 64). She stated he "was not the same" mentally and physically and her husband usually lies around the house and watches television. (R. p. 63).

Mrs. Baker testified she was allowed to participate in her husband's medical treatment and attended approximately 95% of all of his medical appointments. She testified she was allowed to ask questions and get clarification from all of the treating physicians and that she was never barred from an examination room. (R. pp. 78-79).

STANDARD OF REVIEW

The South Carolina Administrative Procedures Act establishes the substantial evidence standard for judicial review of decisions by the Commission. S.C. Code Ann. §1–23–380 (Supp. 2010); Lark v. Bi–Lo, Inc., 276 S.C. 130, 134–35, 276 S.E.2d 304, 306 (1981). Under the substantial evidence standard of review, this court may not "substitute its judgment for that of the Commission as to the weight of the evidence on questions of fact, but may reverse where the decision is affected by an error of law." Stone v. Traylor Bros.,

360 S.C. 271, 274, 600 S.E.2d 551, 552 (Ct. App. 2004). "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 conclusions the administrative agency reached in order to justify its actions." Brought v. South of the Border, 336 S.C. 488, 495, 520 S.E.2d 634, 637 (Ct. App. 1999). In workers' compensation cases, the Appellate Panel is the ultimate fact finder. Shealy v. Aiken Cnty, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). The Appellate Panel is reserved the task of assessing the credibility of the witnesses and the weight to be accorded evidence. Id.

Appellant erroneously misapplies the standard of review in the relevant issue on appeal. The issue before the Court is not whether the Claimant asserted a physical brain damage within the meaning of the Act, but whether the Appellate Panel erred in finding Claimant did not suffer a physical brain injury, which is a factual question, not a legal one.

ARGUMENT

I. THE APPELLATE PANEL PROPERLY FOUND CLAIMANT DID NOT SUFFER A PHYSICAL BRAIN INJURY OR ANY RESULTING PHYSICAL BRAIN DAMAGE BASED UPON GREATER WEIGHT OF THE EVIDENCE.

The hearing commissioner properly denied Claimant's allegation of a physical brain injury or resulting physical brain damage as this claim was not supported by the greater weight of the evidence. As stated in Claimant's brief, it is axiomatic in workers' compensation cases in South Carolina that the claimant bears the burden of proof to establish the existence of a compensable injury. Herndon v. Morgan Mills, 246 S.C. 201, 143 S.E.2d 376 (1965). In this case, the Claimant submitted 197 pages of medical evidence as well as his own testimony and that of his wife. Based on all of the evidence submitted as a whole, Claimant's allegation of

physical brain damage was not supported by the greater weight or preponderance of the evidence.

A. The Hearing Commissioner and Appellate Panel properly determined the record lacked sufficient evidence to support a finding of physical brain damage.

At the hearing, Claimant testified he could not remember exactly what happened to him on the date of injury. All he remembered was waking up on the floor of the hotel room he was inspecting. (R. p. 94, ll. 17-24; p. 106, ll. 24 – p. 107, ll. 8). Medical records from the emergency room at Grand Strand Regional Medical Center on the date of injury show a diagnosis of a scalp laceration and head contusion for which Claimant received wound clips. (R. p. 263). An x-ray of his cervical spine was read as "no acute fracture" by the radiologist and Claimant was discharged home with instructions to follow up with his primary care physician within the next week. (Id.). From May 6, 2008 through June 16, 2008 Claimant received medical care at both Doctors' Care and Grand Regional Medical Center with complaints of "lower back discomfort and received diagnosis of back pain and low back strain." (R. pp. 491-93; p. 507). Claimant had an MRI of the lumbar spine performed on June 23, 2008, which revealed degenerative disc and facet joint disease with bilateral annular tears at L4-5 and T11-12. (R. p. 509).

Claimant was referred to Dr. McCaffrey at Strand Regional Associates on June 26, 2008. Prior to meeting with Dr. McCaffrey, Claimant completed a medical questionnaire wherein he indicated he "*never*" suffered from recurrent headaches, migraine headaches, fainting, dizziness or memory loss." (R. pp. 273-76). In his first meeting with the Claimant, Dr. McCaffrey diagnosed Claimant as having "low back pain with right leg radiation" and referred him for an EMG of the right lower extremity. Claimant was also diagnosed with a "closed-

head injury with a left occipital laceration." Dr. McCaffrey noted that Claimant's laceration was completely healed and Claimant was having "no residual symptoms from this." (R. p. 268). In the "Mental Status" of his neurological evaluation, Dr. McCaffrey noted that Claimant was,

> "Oriented to person, place, and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events."

(R. p. 268). Claimant continued to treat with Dr. McCaffrey from June 26, 2008 through March 11, 2009 when he was placed at maximum medical improvement with a finding of permanent and total disability "in reference to his low back pain, neck pain, and headaches." Claimant's mental status was assessed at each and every visit and was noted to be the same. (R. pp. 266-316). Dr. McCaffrey went on to complete an "Attending Physician's Statement of Disability" wherein he noted Claimant had a Class 5 Physical Impairment (severe limitation) and a Class 1 Mental/Nervous Impairment (no limitations). (R. p. 321).

On March 22, 2010, one year after Claimant's last visit, Dr. McCaffrey completed a medical questionnaire wherein he stated he agreed with the certified disability examiner's impairment ratings of 14% to the lumbar spine and 5% impairment to sexual dysfunction. On October 12, 2010 (the day of the originally scheduled hearing and over eighteen months after Claimant's last visit) Dr. McCaffrey filled out a second questionnaire from Claimant's attorney wherein he checked the line for "YES" when it asked whether he agreed Claimant sustained a permanent physical brain injury. (R. pp. 323-24). It should be noted these last two questionnaires were sent along with records of others "experts" not authorized by the employer or carrier. It should also be noted Dr. McCaffrey's response to the brain injury questionnaire is in direct contrast to the ten visits over the course of nine months wherein Dr. McCaffrey noted claimant was "[O]riented to person, place and time. No difficulty with short or long term

memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient has no difficulty in discussing current events." (R. pp. 266-316).

After Claimant's last visit with Dr. McCaffrey in March 2009, he began treatment for long term pain management with Dr. Kang starting November 4, 2009 through the present. Dr. Kang diagnosed Claimant with lumbar degenerative disc disease with lumbar facet syndrome and recommended a repeat radio frequency ablation and medical management of Claimant's pain medications. (R. p. 396). Claimant continues to receive medical treat from Dr. Kang. The last medical record from Dr. Kang is dated November 24, 2010. Dr. Kang placed Claimant at maximum medical improvement on June 8, 2010 with an 18% impairment rating to the lumbar spine. Dr. Kang gave Claimant clearance for sedentary type activity. In all medical records from November 4, 2009 through November 24, 2010, it was noted that Claimant "shows no signs of cognitive impairment." (R. pp. 392-422).

In addition to Drs. McCaffrey and Kang, with whom Claimant treated consecutively for over two years prior to any mention of a physical brain injury, Claimant also treated with Dr. Rosenberg at Next Step Pain Management, Dr. Jeffrey C. Wilkins, Dr. William S. Edwards, Dr. John D. Steichen. Not one of these treating physicians noted the occurrence of or any problems with Claimant's cognitive abilities or functioning which would result in treatment for a potential brain injury.

Based on the lack of medical evidence in the treating physicians' records, both the single commissioner and the Appellate Panel properly determined Claimant did not meet his burden of proving he sustained physical brain damage by a preponderance of the evidence. The Appellate Panel upheld the Order of the single commissioner by a unanimous decision with Commissioner T. Scott Beck writing the opinion, Commissioner Derrick L. Williams concurring, and

Commissioner Susan F. Barden, concurring with comments. In fact, Commissioner Barden's comments underline the inconsistencies in Claimant's alleged brain injury claim. Commissioner Barden noted,

> "Dr. McCaffrey's questionnaire answers are not supported by his own treatment notes. The symptoms appeared months (over one year) after the date of the injury. The proof is in the treatment notes.

(R. pp. 18-24).

B. Substantial evidence exists to support the Appellate Panel's determination that Claimant's did not sustain physical brain damage.

More important than the *absence* of treatment notes regarding physical brain damage or cognitive limitations is the *presence* of actual statements to the contrary. Each and every one of Claimant's treating physicians, from the emergency room physicians to Claimant's long-term pain management physician, reported normal cognitive functioning throughout the course of Claimant's medical treatment. It wasn't until Dr. Kang released Claimant at maximum medical improvement with an 18% impairment rating to the lumbar spine and a sedentary work restriction that Claimant made an appointment to see Dr. Brabham – over two years after the accident.

Claimant and his wife testified they attempted to bring up Claimant's decline in cognitive functioning on numerous occasions, but were rebuffed by the treating physicians. This is inconceivable on many grounds. First, as indicated above, the vast majority of Claimant's medical treatment notes specifically refer to normal cognitive functions and abilities. To assert that attempts were made to discuss cognitive limitations with the numerous treating physicians is to assert that all of the treating physicians *lied* in their medical narratives. Claimant was specifically asked about this assertion at the hearing, to which he replied, "That could go a lot of different ways." (R. p. 119).

Second, Claimant was initially transported to the emergency room by a co-worker on the date of his accident. There were no case workers involved and no adjusters. Only the emergency room physicians had contact with Claimant regarding the extent of his injuries. When Claimant followed up with Doctors' Care later that day and several times later for follow up visits, again there were no adjusters or case managers involved with the claim. Claimant and his wife, who testified she attended 95% of his medical visits, would have had ample time and opportunity to discuss all of Claimant's complaints including any decline in cognitive functioning. Claimant filled out medical questionnaires and had lengthy discussions prior to all of his initial visits with every specialist to whom he was referred. The initial medical questionnaire for the visit with Dr. McCaffrey was discussed above; however, Claimant actually filled out a questionnaire prior to each visit with Dr. McCaffrey wherein he was specifically asked whether he had any specific questions for the doctor. In most of the cases, Claimant left this particular question blank; however, on January 15, 2009, Claimant wrote "about my pain". (R. p. 313).

Claimant treated with Dr. Rosenberg from September 21, 2008 through August 4, 2009 wherein on multiple occasions, Dr. Rosenberg noted, "The patient is alert, oriented, cooperative and follows commands well. Speech is clear and language is normal. Abstract function is normal. Attention and memory are normal." (R. pp. 325-68). In addition, Dr. Rosenberg noted at each visit a long discussion was had with Claimant concerning his current situation. Additional notes regarding a review of Claimant's symptoms range from back pain, hemorrhoids, headaches, skin rash, decrease visual activity requiring glasses, constipation and swelling. (R. p. 343).

At the hearing, Claimant testified doctors told him, "We can't discuss it. We are only allowed to discuss your back. That's all the insurance company is allowing." (R. p. 129, ll. 6-10.) This testimony is not supported by the medical evidence. The variety of complaints discussed with Dr. Rosenberg makes it highly unlikely Claimant was told not to discuss any one particular complaint. In the same line of questioning, Claimant testified that the doctors and the case manager used the term, "They was not authorized to do anything with my head was the word." However, Claimant later acknowledged that Dr. McCaffrey gave him "some pills" for his headaches. (R. p. 130, ll. 15-24.) Even the single commissioner tried to rehabilitate Claimant's testimony by asking exactly what Claimant said to his various doctors:

COMMISSIONER:	I believe her – Ms. Taylor's question was did you talk about having anything like memory problems other than headaches, any problems that would be associated with your ability to reason or anything of that nature other than headaches? I mean, doctors generally write down what you say whether they are authorized to or not. I'm just – I was curious to know why in every case.
CLAIMANT:	I don't know. I'll be honest, I just don't know, because I tried.
COMMISSIONER:	You are sure in every case you said you were having what, and tell me what you told them you had.
CLAIMANT:	I'm having real bad headaches.
COMMISSIONER:	I know that's in some of the records.

(R. p. 129, ll. 11-24).

Clearly, the single commissioner considered all of the evidence as a whole when determining Claimant did not meet his burden of proving a physical brain injury or physical brain damage by the greater weight of the evidence. As such the single commissioner properly denied Claimant's physical brain damage claim and the Appellate Panel properly affirmed the decision.

C. When reviewed as a whole, the Hearing Commissioner and Appellate Panel properly determined the conflicting expert reports did not support a finding of physical brain damage.

In an effort to overcome two years of medical treatment without reference to cognitive limitations or resulting physical brain damage, Claimant obtained vocational and psychological evaluations performed by Robert E. Brabham, Ph.D. and L. Randolph Waid, Ph.D. both reports of which are contradictory at best given Claimant's reported history. Both Doctors Brabham and Waid reported Claimant's history of academic difficulties. Specifically, Dr. Brabham noted,

> "He has a limited educational background, having completed high school through the 9th grade. He quit school during the 10th grade and went to work. Thus, at the age of 52, he remains a high school drop out. He noted a history of academic difficulties, failing the 1st grade and 'barely passing all others.' He acknowledged he was 'good with my hands' but described himself as having been 'retarded in the books.' He also noted he had been unable to handle the paperwork or financial aspects of his auto mechanic business in the past."

(R. pp. 438-39).

In his examination with Dr. Waid, Claimant reported "he has always been mechanical and good with his hands but not a good book learner." (R. p. 454). Dr. Waid went on to note Claimant was limited in his educational skills, which was confirmed via evaluation by Dr. Brabham who administered he wide range achievement test-4 revealing Mr. Bakers' reading/word recognition abilities to be at the 4.6 grade level with arithmetic at the 2.9 grade level and spelling at the 5.5 grade level. In his Summary/Case Discussion, Dr. Waid opined,

> "The current neuropsychological evaluation was revealing of an individual who has a history of educational deficiencies ... I believe it evident that the primary obstacle to Mr. Baker's ability to return successfully to role functioning are the residuals from the orthopaedic injury with resultant chronic pain, somatic symptoms, and balance/dyscoordination difficulties."

(R. p. 458).

Claimant was evaluated by Robert E. Deysach, Ph.D. on December 4, 2010 at the request of the Employer/Carrier. On the Wechsler Abbreviated Scale of Intelligence (WASI), Claimant was noted to have a Full-2 estimated IQ of 62, which places him in the "Mildly Handicapped" range. (R. p. 463). Dr. Deysach agreed with Dr. Waid that the "primary obstacles" of Claimant's inability to return to a competitive job market are the "residuals from the orthopedic injury." (R. p. 466). Of importance, Dr. Deysach noted cognitive deficits were documented but "the data indicate that these deficits are basically developmental (i.e., existing before the accident) rather than the result of physical brain damage from the accident." Specifically, Dr. Deysach noted,

> "In other words, up to the present, the patient has been able to compensate for his intellectual shortcomings by his physical competencies and a strong work ethic (e.g., working two full time jobs before his accident). The accident and his failure to return to productivity has made more salient to him and his family that he has significant deficits in the area of language and math (i.e., skills critical for activities of daily living)."

(R. p. 466). Lastly, Dr. Deysach noted it was reasonable to conclude Claimant did suffer an injury to the head with brief and mild-post concussive symptoms but "the data do not appear to support the presence of an acquired brain injury." (R. p. 467).

The Appellate Panel is given discretion to weigh and consider all the evidence, both lay and expert, when deciding whether causation has been established. Potter v. Spartanburg School District 7, 395 S.C. 17, 716 S.E.2d 123 (Ct. App. 2011). Thus, while medical testimony is entitled to great respect, the fact finder may disregard it if other competent evidence is presented. Id. Expert medical testimony is intended to aid the Appellate Panel in coming to the correct conclusion. Corbin v. Kohler Co., 351 S.C. 613, 624, 571 S.E.2d 92, 98 (Ct. App. 2002) (citing Tiller v. National Health Care Center, 334 S.C. 333, 513 S.E.2d 843 (1999)). The final determination of witness credibility and the weight to be accorded

evidence is reserved to the Appellate Panel. Shealy, 341 S.C. at 455, 535 S.E.2d at 442 (2000).

All three experts agree Claimant has significant pre-morbid or developmental cognitive/educational deficiencies and that Claimant's physical limitations secondary to his orthopaedic injury are the greatest factors prohibiting Claimant from returning to work. Despite this, only Dr. Deysach reaches the most logical conclusion in finding that although Claimant did suffer an injury to the head, he did not sustain physical brain damage. The conclusions of Dr. Brabham and Dr. Waid do not rely on the medical evidence or even the testing results (most of which point to developmental deficiencies), but instead rely on the subjective opinion of the Claimant and his wife who both acknowledge Claimant's pre-injury cognitive deficiencies.

In a workers' compensation action, the existence of any conflicting opinions between the doctors is a matter left to the Commission. Harbin v. Owens-Corning Fiberglass, 316 S.C. 423, 450 S.E.2d 112 (Ct. App. 1994). The Appellate Panel may weigh and consider all of the evidence, both lay and expert, when determining whether causation has been established. Tiller v. National Health Care Center, 334 S.C. 333, 513 S.E.2d 843 (1999). In the present case, all of the medical opinions were taken into consideration by the Appellate Panel as it weighed and considered all of the evidence submitted on behalf of the parties as to whether Claimant suffered a physical brain injury resulting in physical brain damage. In this case, the Appellate Panel was presented with medical evidence from Claimant's emergency room physician, Doctors Care, Dr. McCaffrey's treatment notes and conflicting answers to medical questionnaires prepared by Claimant's counsel, a neurologist, and three psychologists. The Appellate Panel committed no error of law by relying on the strengths and weaknesses of the medical reports and the weight to afford the opinions, as it made its factual findings regarding physical brain

damage. This court has previously held it is not within its purview to "balance objective against subjective findings of medical witnesses, or to weigh the testimony of one witness against that of another. That function belongs to the Appellate Panel alone." Sanders v. MeadWestvaco Corp., 371 S.C. 284, 292, 638 S.E.2d 66, 71 (Ct.App.2006) (quoting Roper v. Kimbrell's of Greenville, 231 S.C. 453, 461, 99 S.E.2d 52, 57 (1957)). After a careful review of all of the evidence, both the single commissioner and the Appellate Panel properly determined Claimant did not meet his burden of proving he sustained physical brain damage.

D. The Hearing Commissioner and Appellate Panel properly relied on the Crisp case in addition to the evidence as a whole in finding Claimant did not meet his burden of proving physical brain damage.

Given the factual background of this claim and that of the claim in Crisp v. South Co., 390 S.C. 340, 701 S.E.2d 762 (Ct. App. 2010), the hearing Commissioner was correct to find that Crisp closely parallels this claim. Claimant Crisp was struck in the head, neck, back and right upper extremity by a bobcat bucket during the course of his employment. He was admitted to the hospital where he was treated for abrasions and bruises behind the back of his head and neck as well as injuries to his back and right hand. He sought additional medical treatment from several physicians regarding his headaches, neck and lower back pain and was diagnosed with cervical muscle strain, lumbar strain and fractures to his right hand. An MRI scan of Crisp's brain did not reveal any abnormalities. Id. at 341.

Crisp then went to see Dr. Robert Moss, a psychologist, who diagnosed him with a traumatic brain injury. Claimant was then evaluated by Dr. Thomas Collings, a neurologist, who diagnosed him with a closed head injury but noted the head injury appeared to be "very minor," and that Crisp did not sustain a significant head injury based on his medical records and the low frequency of headache complaints. Crisp was then seen by Dr. David Price, a

psychologist, who concluded there was no credible evidence Crisp sustained a brain injury. Id. at 342

The hearing commissioner in the Crisp case concluded Crisp sustained a head injury resulting in cognitive disorders to his brain but not a physical brain injury. This holding was affirmed by the full commission, but reversed by the Circuit Court. In reversing the Circuit Court's Order, the South Carolina Court of Appeals ultimately upheld the conclusion of the Commission by holding,

> "To the contrary, we conclude the record is replete with substantial evidence to support the Commission's finding that Crisp did not sustain a physical brain injury . . . . The medical records of the several physicians who treated Crisp following the accident support reversal of the Circuit Court's decision. The hospital's physicians did not note any symptoms commonly attendant to a physical brain injury during Crisp's treatment. The physicians who evaluated Crisp following surgery did not diagnose Crisp with a physical brain injury. In fact, [the] MRI scan did not reveal any abnormalities suggestive of a physical brain injury and [Dr. Kopera] specifically opined Crisp was neurologically in tact."

Id. at 345.

When compared to our claim, the underlying facts of both cases are nearly identical. Claimant was struck in the head by a piece of ceiling tile during his employment. He was admitted to Grand Strand Regional Medical Center and was treated for a scalp laceration and a head contusion for which he received wound clips. Claimant had an x-ray of his cervical spine, which was normal. Clamant sought medical treatment from several physicians regarding his lower back pain as well as headaches. Dr. McCaffrey evaluated Claimant and diagnosed him as having low back pain with right leg radiation. Claimant also treated with Drs. Rosenberg and Kang for low back and right lower extremity pain. Claimant was evaluated by Dr. Brabham, who diagnosed Claimant with a traumatic brain injury. This report was agreed to by Dr. Waid, who noted in his multi-axial assessment that Claimant had

a "mild head injury" (R. p. 458). Finally, Claimant was evaluated by Dr. Deysach who opined that although Claimant did sustain an injury to his head, it did not amount to a finding of a physical brain injury.

The time period between the date of injury to the first neuropsychological testing in the Crisp claim was approximately 21 months – almost two years. In our claim, the time period between the date of injury to the first neuropsychological testing was approximately 26 months – just over two years. Both records were void of any neurological or cognitive deficiencies, with the exception of headaches, for approximately two years. Both cases have a flurry of psychological testing and new complaints of cognitive limitations just prior to the hearing date. In both cases, the hearing commissioner looked at all of the medical evidence and lack of medical evidence as a whole in finding there was not a substantial evidence in the record to support a finding of a physical brain injury or resulting physical brain damage. The procedural posture of the two cases is irrelevant. Evidence is substantial if, considering the record as a whole, it "would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its actions." Taylor v. S.C. Dept. of Motor Vehicles, 368 S.C. 33, 36, 627 S.E.2d 751, 752 (Ct. App. 2006). Based on the above, the hearing commissioner did not err in finding that Crisp closely parallels this case and that Claimant did not meet his burden of proving he sustained a physical brain injury.

II. THE HEARING COMMISSIONER AND APPELLATE PANEL PROPERLY FOUND CLAIMANT WAS NOT ENTITLED TO LIFE TIME BENEFITS AS THE GREATER WEIGHT OF EVIDENCE DID NOT SUPPORT A FINDING OF PHYSICAL BRAIN DAMAGE.

The hearing commissioner properly denied Claimant's physical brain damage claim as it was not supported by a greater weight or preponderance of the evidence. As such, the hearing commissioner properly determined Claimant was not entitled to lifetime benefits pursuant to S.C. Code Ann. §42-9-10(C).

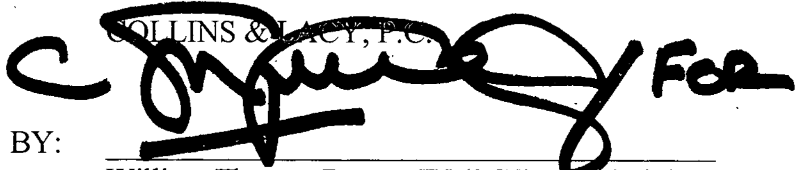
In order to receive lifetime benefits pursuant to the Act, any person determined to be totally and permanently disabled who as a result of a compensable injury has suffered physical brain damage shall receive benefits for life. S.C. Code Ann. §42-9-10(C). Here, the Appellate Panel found Claimant was permanently and totally disabled as a result of his back injury pursuant to S.C. Code Ann. 42-9-30(21). The Appellate Panel found there was not substantial evidence in the record to support a finding of physical brain damage. Contrary to Claimant's assertion, neither the Appellate Panel nor Dr. Deysach found that Claimant suffered "physical brain damage in the form of a concussion." The Appellate Panel relied on Dr. Deysach's opinion that although Claimant had post-concussive symptoms, the data did <u>not</u> support a finding of physical brain damage. As such, there was no finding of physical brain damage and thus, Claimant is not entitled to lifetime benefits. As Claimant failed to meet his burden of establishing a claim of physical brain damage by a preponderance of the evidence, the hearing commissioner properly found he is not entitled to lifetime benefits under the Act.

CONCLUSION

Based on the foregoing arguments, the Decision and Order of the Appellate Panel of the Workers' Compensation Commission should be AFFIRMED.

Respectfully submitted,

COLLINS & LACY, P.C.



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February 14, 2013

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

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SC Court of Appeals

T. SCOTT BECK, COMMISSIONER, CHAIR
SUSAN S. BARDEN, COMMISSIONER
DERRICK L. WILLIAMS, COMMISSIONER

Appellate Case No. 2011-204487

W.C.C. File No.:0810190

Bobby Baker, Employee/Claimant .... Appellant,

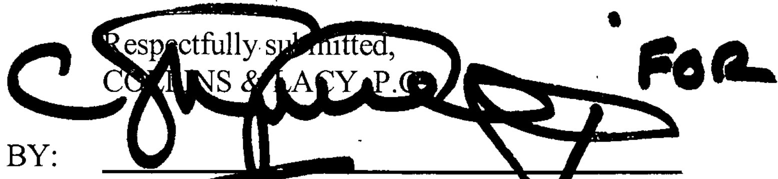
vs.

Hilton Hotels Corporation, Employer, and
ACE American Insurance Company, Carrier/Defendants .... Respondents.

CERTIFICATE OF COUNSEL

The undersigned certifies that the Final Brief of Respondents in the above-captioned matter complies with Rule 211(b), SCACR and with the August 13, 2007 Order from the South Carolina Supreme Court entitled "Interim Guidance Regarding Personal Identifiers and Other Sensitive Information in the Appellate Court Filings."

Respectfully submitted,
COLLINS & LACY, P.C.



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PROOF OF SERVICE

I hereby certify that I served the Final Brief of Respondents, Certificate of Counsel and Proof of Service upon Appellant by placing a copy in the United States mail, postage prepaid, to counsel of record, Luke A. Rankin, Esquire P.O. Box 919, Conway, South Carolina, 29528 on February 15, 2013.

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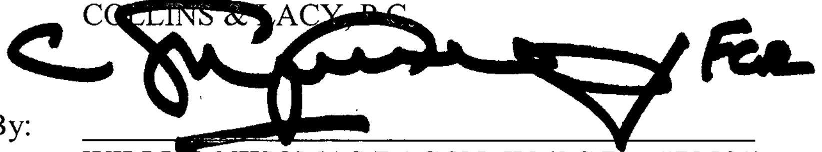

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