THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Case No.: 2021-00683

Thomas Contreras, Employee, ...Appellant,

v.

St. Johns Fire District Commission, Employer, and
State Accident Fund, Carrier, ...Respondents.

FINAL BRIEF OF RESPONDENTS

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STATEMENT OF THE CASE

This matter arises out of a workers' compensation case. Appellant injured his right shoulder in the course and scope of his employment as a firefighter on October 8, 2008. Appellant filed a Form 50 in 2011 alleging an injury to his right shoulder, right upper extremity, right glenohumeral ligament, right clavicle, right scapula, right lateral deltoid, right bicep and right distal clavicle. (R. pp. 108-9). Respondents admitted an injury to the right shoulder only and denied all other body parts. (R. p. 115). In March of 2012, the parties entered into a consent order that the Claimant suffered an admitted injury to his right shoulder. (R. pp.1-2). In February of 2013, Appellant filed another Form 50 alleging an injury to his right shoulder, right upper extremity, right glenohumeral ligament, right clavicle, right scapula, right lateral deltoid, right bicep and right distal clavicle. (R. pp. 118-119). Respondents timely filed a Form 51 admitting an injury to the right shoulder only. (R. p. 120). A hearing was held in 2013 and as a result of that hearing, the Single Commissioner found that Claimant injured his right shoulder and right upper extremity.

The Single Commissioner also found that Claimant could not return to work as a firefighter. Additionally, the Single Commissioner also found that Claimant suffered a wage loss under §42-9-20. (R. pp. 3-35).

Respondents filed a Form 30 appealing the order of the Single Commissioner to the Full Commission. (R. pp. 121-2). The Full Commission reversed the order of the Full Commission and remanding the case back to the Single Commissioner for a determination under §42-9-30 to the right shoulder only. (R. pp. 36-52).

Appellant appealed the Full Commission's order the Court of Appeals. This appeal was dismissed as interlocutory. (R. p. 53). The case was then remanded back to the Single Commissioner. The Single Commissioner found that the Claimant suffered a 35% permanent partial disability (PPD) to his right shoulder. Furthermore, the Single Commissioner noted that the Commission was limited to only determining an award of permanency to the Claimant's right shoulder. (R. pp. 55-62). Appellant appealed to the Full Commission. (R. pp. 123-135). The Full Commission affirmed this award. (R. pp. 63-71). Appellant then appealed to the Court of Appeals. In 2019, the Court of Appeals remanded the case back to the Full Commission to make specific findings of fact regarding Appellant's right arm, right shoulder, and right clavicle. (R. pp. 72-5).

On April 27, 2021, the Full Commission issued an order awarding 35 % permanent partial disability benefits to the right shoulder and found that this award encompasses and includes any incidental effect on Claimant's right clavicle, right bicep, and/or right bicep tendon. The Full Commission specifically found that Appellant was not entitled to receive a separate award for his right arm or clavicle. A Motion to Reconsider was then filed to address the award of temporary partial disability and on June 4, 2021, the Full

Commission issued a modified award regarding the temporary partial disability award but did not modify the award for PPD. (R. pp. 76-104). Appellant then filed this appeal.

STATEMENT OF THE FACTS

Appellant injured his right shoulder in the course and scope of his employment on October 8, 2008. Appellant was employed as a firefighter and had risen to the rank of captain. (R p. 141). Appellant also worked at a bowling alley and had a route stocking vending machines. Appellant testified that he earned $9.18 an hour at the bowling alley. (R. p. 152). Appellant is also fluent in Spanish. (R. p. 161).

On October 8, 2008, the day of the injury, Appellant went to the ER with complaints to his right shoulder. (R. p. 558). Appellant was diagnosed with a soft tissue injury to his shoulder. Appellant then followed up with Atlantic Occupational Health for shoulder strain. (R. p. 298). On December 3, 2008, Appellant then went to Dr. Spearman, an orthopaedic surgeon, with complaints of right shoulder pain. (R. p. 297). Appellant's care was then transferred to Dr. Jaskwhich. On December 19, 2008, Dr. Jaskwhich noted that an MRI showed a superior labral tear with no evidence of rotator cuff tear. (R. p. 295). In 2009, Dr. Jaskwhich performed a right shoulder arthroscopic repair of superior labrum anterior-posterior (SLAP) tear on January 29, 2009. (R. pp. 264-5). On September 2, 2009, a second right shoulder arthroscopic surgery to address ongoing popping and discomfort in Appellant's shoulder was done by Dr. Jaskwhich. (R. pp. 262-263). The postoperative diagnosis of his second surgery was right shoulder arthroscopy with extensive debridement of suture, labrum, bursa and bone. (R. p. 262). On July 14, 2010, Dr. Jaskwhich noted that Appellant had right shoulder pain and assigned lifting restrictions but found that the Appellant was at MMI and assigned a 10% impairment rating to the right shoulder. (R. p. 282).

Appellant's care was then transferred to Dr. DeMarco. On the new patient information form, Appellant stated that he was there for treatment to his right shoulder. (R. p. 254). Dr. DeMarco first saw the Appellant on August 6, 2010. The chief complaint listed was right shoulder injury. On October 11, 2010, Appellant underwent surgery for right shoulder thickening of middle glenohumeral ligament and superior coracohumeral ligament, right shoulder intra-articular synovitis, right shoulder type 1 super labrum anterior to posterior tear, right shoulder subacromial impingement syndrome and bursitis and right shoulder acromioclavicular joint osteoarthrosis. (R. pp. 260-1).

Appellant's last surgery was on March 29, 2012. Appellant contends that this specifically was intended to alleviate arm pain. Prior to the surgery on March 19, 2012, the parties agreed to a consent order that Appellant had an admitted injury to his right shoulder and was to return to Dr. DeMarco for more surgery. The consent order does not mention the arm, bicep or clavicle. (R. pp. 1-2). It seems logical that had the Appellant felt that this surgery was really intended for his arm as opposed to his shoulder that the consent order entered into mere weeks before surgery would address the arm and any other body part the Claimant felt was related to his workers' compensation claim. The preoperative diagnosis for the March 2012 surgery was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions, right shoulder subacromial impingement with adhesions and right shoulder long head of biceps tendinopathy. The post operative diagnosis was right shoulder coracoid impingement, right shoulder intra-articular synovitis and adhesions, right shoulder subacromial impingement with adhesions and right shoulder long head of biceps tendinopathy. (R. p. 258).

Dr. DeMarco's notes after the March 2012 surgery show that the follow up care was for the right shoulder. (R. pp. 227-230). Appellant returned to Dr. DeMarco for post-surgical follow up on June 26, 2012. Dr. DeMarco noted that the visit was in follow up to his shoulder and examined the Appellant's shoulder. The assessment and treatment was for Appellant's shoulder. (R. p. 225-226).

Appellant was last seen by Dr. DeMarco on August 7, 2012. This visit reflects that Claimant's shoulder was examined and the assessment and treatment was again noted for shoulder pain. Dr. DeMarco also stated that:

> At this point the patient is at MMI and has permanent partial restrictions of less than 40 pounds no overhead lifting with both hands and no more than 20 pounds with his right arm overhead. Less than 50 pounds of two handed carrying and pushing and pulling. He can do a medium level job. He has a permanent partial impairment of 9%. 3% for biceps atrophy, 3% for loss of internal rotation, 2% for loss of forward flexion and 1% for pain muscles spams. I do not predict any further surgical intervention in the next year however if he regresses with his pain he may need repeat corticosteroid injections, anti-inflammatories and/or physical therapy.

(R. pp. 223-224). Dr. DeMarco completed two 14B's during the tenure of his treatment of the Appellant. On the May 16, 2011 Form 14B, Dr. DeMarco indicated that Claimant injured his right shoulder. (R. p. 220). On the second 14B completed by Dr. DeMarco on September 4, 2012, he again indicated that Claimant injured his right shoulder. On the September 4, 2012, the 14B stated that Claimant had a 9% impairment rating to the right upper extremity which converted to a 15% impairment rating to shoulder, but the 14B does not have two separate ratings for two different body parts. (R. p. 569). There is no treatment in the record after August 7, 2012.

STANDARD OF REVIEW

The Administrative Procedures Act ("APA") provides the standard for judicial review of decisions by the Commission. Pierre v. Seaside Farms, Inc., 386 S.C. 534,

540, 689 S.E.2d 615, 618 (2010); Lark v. Bi-Lo, Inc., 276 S.C. 130, 133-134, 276 S.E.2d 304, 306 (1981). Under the APA, this court can reverse or modify the decision of the Commission if the substantial rights of the appellant have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. S.C. Code Ann § 1-23-380(5)(d), (e) (Supp. 2011); Transp. Ins. Co., v. S.C. Second Injury Fund, 389 S.C. 422, 427, 699 S.E.2d 687, 689-90 (2010).

The Commission is the ultimate factfinder in worker's compensation cases. Shealy v Aiken Cnty., 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). As a general rule, this court must affirm the findings of fact made by the Commission if they are supported by substantial evidence. Pierre, 386 S.C. at 540, 689 S.E.2d at 618. "Substantial evidence is that evidence which, in considering the record as a whole, would allow reasonable minds to reach the conclusion the Commission reached. " Hill v. Eagle Motor Lines, 373 S.C. 422, 436, 645 S.E.2d 424, 431 (2007). "The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission's finding from being supported by substantial evidence." Id. Indeed, the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Moore v. City of Easley, 322 S.C. 455, 472 S.E.2d 626 (1996). An appellate court may not substitute its judgment for that of an agency as to the weight of the evidence on questions of fact unless the agency's findings are clearly erroneous in view of the reliable, probative, and substantial evidence on the record. Rodney v. Michelin Tire Corp., 320 S.C. 515, 466 S.E.2d 357 (1996).

ARGUMENT

The overwhelming evidence shows that that there is substantial evidence to affirm the order of the Full Commission.

1. The Appellate Panel was correct in finding the that the right arm is not a separate compensable body part.

Appellant's allegation that the "fourth and final surgery was specifically to address the long head of the biceps" and that it was a "separate surgery" for Claimant's arm is a complete misstatement of the facts and evidence. (Appellant's brief, p. 10). Appellant cites Dr. DeMarco's surgical note from March 29, 2012 to support this allegation; however, this allegation is clearly just a lifting of a select few words from Dr. DeMarco's final surgical note. Dr. DeMarco's records when read in their entirety confirms that the fourth and final surgery was for the shoulder. As opposed to just lifting a few carefully chosen words, the record must be reviewed in full.

At the November 22, 2011 appointment, Dr. DeMarco confirmed that this visit and surgery recommendation was for the Claimant's shoulder. As noted under chief complaint, the reason for the Claimant's appointment with Dr. DeMarco was for shoulder pain that flared up after doing yardwork. Under plan, Dr. DeMarco noted that the surgical recommendation was "absolutely the last thing that can be done in the shoulder, after doing a tenodesis, a coracoid decompression, I told him whatever pain or discomfort is left in the shoulder he will have to live with." (R. p. 234). Surgery was done on March 29, 2012. The pre -operative diagnosis was: right shoulder coracoid impingement; right shoulder intra-articular synovitis and adhesions; right shoulder subacromial impingement with adhesions; right shoulder long head of biceps tendinopathy. The post operative diagnosis was right shoulder coracoid impingement; right shoulder intra-articular synovitis

and adhesions; right shoulder subacromial impingement with adhesions; right shoulder long head of biceps tendinopathy. (R. p. 54). Under procedure's performed all of the procedures listed are to the right shoulder. There is no treatment or surgery to the arm.

On page 7 of Appellant's brief, Appellant quotes a part of the medical record dated November 22, 2011 to assert that the fourth surgery was specifically for arm pain. This portion of the note is misleading and as a complete reading of the note clearly indicates that the Claimant's last surgery was for his right shoulder.

> At this point, Mr. Contreras continues to complain persistently of long head biceps and bicipital groove pain. **There is approximately a 5 cm section of the long head of the biceps that we are unable to visualize arthroscopically on a routine arthroscopy; however, on selected patients with persistent pain in this area, we will go ahead take down the transverse ligament and the bursal sac in the area and visualize the long head of the biceps and certainly at this point do a biceps tenodesis on him. I would also do a coracoid decompression to take off the impingement that he is getting from his coracoid onto the anterior suscapularis and bicipital groove area.** He has failed injections, it has been over a year, he continues having pain, and the 1 thing about him is that he has been completely consistent with where his pain is, directly over the bicipital groove. We looked at his biceps in the intraarticular position. I pulled in as much of the biceps into the joint, and this is typically what we do, and in that region it appeared normal and so I did not decide to look further release anything. We did remove his previous sutures from his previous repair and did a bursectomy and decompression, an AC joint resection. This did help with some of the other pain, but he is left with biceps pain which now needs to be addressed. This is still a worker's comp injury as directly and causally related to his injury on 10/08/2008. **This is absolutely the last thing that can be done in the shoulder, and after doing a tenodesis, a coracoid decompression, I told him whatever pain or discomfort is left in the shoulder he will have to live with.** We will need to get clearance from worker's comp, and his postoperative course would be similar with physical therapy a couple times a week starting around 4-5 weeks postoperatively and going for about 6 or 8 weeks. If we can get this done, I will see him in the end of December for surgery. (R. p. 234). Emphasis added on portions omitted from Appellant's brief.

A reading of the complete treatment from November 22, 2011, clearly indicates that the upcoming surgery was for the ongoing issues in the right shoulder. Moreover, the actual surgery note from March 29, 2012 shows the surgery was in the right shoulder

joint. (R. pp. 258-259). A review of the physical therapy records following the Appellant's fourth and final surgery show that physical therapy was for the shoulder. (R. pp. 343-346). The medical records clearly support the Appellate Panel's order when read in its entirety as opposed to picking and choosing snippets from the records.

Appellant's diagram in his brief highlighting the bicep muscle is misleading. (Appellant's brief page 11). Appellant attempts to argue that the long head bicep tendinopathy is part of the arm. The diagram is completely outside of the record on appeal. No doctor was ever shown this diagram to confirm or explain whether the diagram shown is relevant or depicts any of Appellant's four surgeries. Furthermore, the diagram was not part of the record below or presented at the Single Commissioner hearing and should not considered as evidence. The inclusion of this picture in the record without any medical testimony to authenticate this diagram is misleading and should not be considered by the Court. Appellant's argument should be limited to the record made at the lower levels.

Additionally, there seems to be an assumption that just because the word bicep is used that this automatically means that the arm is involved. No medical testimony was elicited by either side and there is no evidence that use of the term long head of biceps tendinopathy refers to the arm or is a reference to the biceps muscle as alleged by Appellant. The medical records discuss the long head of biceps tendinopathy not the bicep muscle arguably two different body parts. The bicep muscle attaches to the shoulder and logically the term is being used as part of the shoulder. The operative note from March 29, 2012, gives a lengthy description of the procedure which is clearly a procedure on the Claimant's shoulder and references the bicep tendon as it attaches to the shoulder joint not as separate injury. (R. pp. 258-9). Furthermore, as noted in the

November 22, 2011, the pain and treatment were for the Appellant's shoulder. (R. p. 234).

As noted by the Full Commission, there are no diagnostics anywhere in the record of the right arm. However, there are several MRIs to the right shoulder along with MRIs to the hip, left foot, and lumbar spine and CT scan of the sinuses. (R. pp. 274-280). It would seem logical that if any medical treatment was provided for the Appellant's arm there would be some sort of diagnostic testing whether an x ray, CT scan or MRI of the arm but yet there is none in the record. In this case, the absence of evidence is in fact evidence.

Appellant also points to Dr. Hughes' opinion to support his claim of an injury to the right arm. Dr. Hughes saw the Appellant once for an IME for the right shoulder on October 6, 2011. (R. p. 217). The Full Commission order of 2021 did not find Dr. Hughes' opinion evidence of a right shoulder arm persuasive. (Finding of Fact 11; R. p. 95). Although medical evidence "is entitled to great respect," the Commission is not bound by the opinions of medical experts and may disregard medical evidence in favor of other competent evidence in the record. Potter v. Spartanburg Sch. Dist. 7, 395 S.C. 17, 23, 716 S.E.2d 123, 126 (Ct. App. 2011). Dr. Hughes only saw the Appellant once and proved no actual treatment. In fact, Dr. Hughes' prediction about what prediction would be needed was incorrect as on October 6, 2011, Dr. Hughes opined that Appellant would not have another surgery in the foreseeable surgery. In November of 2011, Appellant's fourth surgery was recommended and later performed in March of 2012. Appellant's reliance on this report is clearly misplaced.

The record is full of actual treatment notes and records from Dr. DeMarco however the crux of Appellant's argument relies on a check the box questionnaire prepared by

Appellant's attorneys. This questionnaire is the only time Dr. DeMarco mentions the right arm. However, the overwhelming substantial evidence does not support the statements made in questionnaire. As noted in the Potter case, the Commission can disregard medical evidence if other competent evidence in the record exists. Finding of Fact 8(r) in the Full Commission's order provides an explanation as to why the Full Commission did not accept these statements. (R. p. 93). In the actual treatment notes, none of the treatment notes categorize Appellant's injury as an arm injury or reference any limitations on Appellant's arm. The notes consistently categorize this injury as a shoulder injury with treatment to the shoulder.

The Full Commission was correct in finding that the right shoulder was the situs of the injury. (FOF 8(a); R. p.87). Appellant initially went to the emergency room for this incident on October 8, 2008 and where an x-ray to his right shoulder was done. Appellant was then referred to Atlantic Occupational Health where he was diagnosed with shoulder strain. Appellant was seen by Dr. Spearman on December 3, 2008 for right shoulder pain from lifting weights. (R. p. 297). Dr. Spearman recommended an MRI to his right shoulder. Dr. Jaskwhich then started to treatment Appellant after the MRI. Dr. Jaskwhich noted that the MRI showed a superior labral tear with no evidence of a rotator cuff tear. (R. p. 295). A right shoulder arthroscopy, debridement and possible repair of the labrum was scheduled. (R. p. 295). On June 1, 2009, it was noted that he was back for follow up to his right shoulder and was released to full duty. (R. p. 291). On June 26, 2009, Appellant returned with a "hot spot" in his shoulder and his shoulder had popped. (R. p. 291). On August 5, 2009, it was noted that Appellant has daily pain in his shoulder and a second surgery was recommended to ensure that labrum is fully repaired. (R. p. 290). A second MRI of the shoulder was done. (R. p. 266). Surgery was done on January 29,

2009, by Dr. Jaskwhich. (R. pp. 264-265). On October 1, 2009, another surgery was done by Dr. Jaskwhich. (R. p. 262-3). On February 24, 2010, Appellant was released to full duty. (R. p. 284). On May 5, 2010, Appellant returned with ongoing pain in his right shoulder. Under treatment plan, it was noted that they "talked a little bit about what may be going with this shoulder." (R. p. 284). On July 14, 2010, Dr. Jaskwhich placed Appellant at MMI and assigned a 10% impairment rating to the right shoulder. (R. p. 282). As discussed earlier in this brief all of the Dr. DeMarco's surgeries were to the Appellant's shoulder including the fourth and final surgery in March of 2012.

Appellant relies on Hutson v State Ports Auth., 390 S.C.108, 700 S.E.2d 500 (Ct. App. 2010) *reversed* 399 S.C. 381, 732 S.E. 2d 500 (2012), to support his claim that his right arm should be found compensable. In Hutson, the claimant had an admitted injury to the back and documented radicular symptoms in his leg. Hutson, who was a crane operator, was adamant that he would be able to successfully run a restaurant. The Commission found that Hutson failed to establish his wage loss for a finding under § 42-9-20 and made an award solely to the back under §42-9-30. The Commission also found that the claimant's leg was affected by his back injury. This issue was not appealed. The real issue in Hutson was whether there was enough evidence to support a wage loss based on Hutson's testimony that he wanted to open a restaurant. However, there is a notable difference between Hutson and the case at bar, in Hutson, there was medical evidence presented to support that Hutson was having issues with his leg. In the case at hand, Appellant has not presented any medical evidence to support his claim that his upper extremity was injured. Hutson does not stand for the proposition that the mere testimony from the claimant that an injured body part creates pain or tenderness in other body part automatically creates a two-body part case. There must be actual objective

medical evidence to support this contention. On the final treatment of Dr. DeMarco, it was noted that the "the upper extremity was grossly neurologically and vascularly intact." (R. p. 223). Thus, there is no objective evidence to show that Claimant's right arm was injured.

2. The Appellate Panel was correct in finding that the clavicle is not a compensable body part.

In Finding of Fact #7, the Full Commission correctly found that the Appellant did not suffer an injury to his clavicle. (R. pp. 81-7). Appellant's brief at times references the clavicle as injured body part but does not show any evidence supporting the clavicle as injured body part. The Appellate Panel was also correct in finding that the issue of compensability of the clavicle was not preserved on appeal. Issues not raised on appeal are not preserved for review. Rodney v Michelin Tire Corp., 320 S.C. 515, 466 S.E.2d 357 (1996). Appellant alleged the clavicle as an injured body part at Single Commissioner hearing in 2013. The order from the Single Commissioner found the right shoulder and arm compensable. Appellant did not appeal the failure to address the clavicle. When asked about the clavicle at the Full Commission hearing in 2013, Appellant's counsel agreed that the clavicle was no longer an issue in the case. (R. pp. 187-188). Had the Appellant wanted to preserve the issue of the whether the clavicle was compensable and felt that the Single Commissioner should have addressed it, he should have appealed this issue to the Appellate Panel.

As noted by the Full Commission order, the Claimant never identified the clavicle as being injured or painful. At the hearing in front of the Single Commissioner when asked to identify what body parts were injured, Claimant did not identify the clavicle or testify as to any injury to that part of his body. (R. p. 146)

Appellant seems to allege that that the terminology used describing the third surgery as a distal clavicle resection and right shoulder acromioclavicular joint means that the clavicle or collarbone is involved. There is no medical evidence to support this. The post-surgical note of October 20, 2010 lists the chief complaint as status post right shoulder SAD and excision of glenohumeral ligament with previous SLAP repair and debridement. (R. p. 242).[1] On January 21, 2011, Dr. DeMarco assigns an impairment rating of 7% to the right upper extremity which converts to an 11% shoulder impairment. This rating is prior to Appellant's fourth surgery. There is no mention of the clavicle or collarbone as being involved when Dr. DeMarco assigned an impairment rating following the third surgery. It is clear that there is no evidence to support the Appellant's claim that his clavicle was an injured body part. There is an overwhelming amount of evidence to support the Full Commission's findings that the clavicle was not injured.

3. The Appellate Panel was correct in finding that the Appellant's injury was limited to the right shoulder and §42-9-30.

The Appellate Panel was correct in finding that the injury is limited to the right shoulder and thus any award for disability should be made pursuant to S.C. Code §42-9-30. The evidence is clear that the Appellant injured his right shoulder. Appellant underwent four shoulder surgeries. All of four of the surgical reports, clear indicate that all four surgeries were that to the shoulder.

Additionally, there seems to be an assumption that because the word biceps is used that this automatically means that the arm is involved. No medical testimony was elicited by either side and there is no evidence that use of the term biceps refers to the

[1] SLAP stands for superior labrum anterior and posterior

arm. The biceps attaches to the shoulder and arguable the term is being used as part of the shoulder. The operative note from October 11, 2010, gives a lengthy description of the procedure which is clearly a procedure on the Claimant's shoulder and references the bicep tendon as it attaches to the shoulder joint not as separate injury. (R. pp. 260-261). Furthermore, as noted in the November 22, 2011, the pain was in the shoulder and the treatment was for the Appellant's shoulder. (R. p. 234). The rating from Dr. DeMarco states that Appellant has a 9% impairment to the shoulder and that this rating includes 3% biceps atrophy, 3% loss of internal rotation, 2% for loss of forward flexion and 1% for pain and muscle spasm. The reference to the biceps is included as part of the shoulder in the rating assigned by Dr. DeMarco.

Appellant argues that Singleton v. Young Lumber Co., 236 S.C. 454, 114 S.E. 2d 837 (1960) is applicable. Singleton stands for the proposition that in order for a claimant to obtain compensation in addition to a scheduled member, the claimant must show that some other part of his body is affected. In Simmons v. City of Charleston, 349 S.C. 64, 76, 562 S.E.2d 476, 482 (Ct. App. 2002), this court held that if there is substantial evidence presented that shows that the claimant suffers additional complications to another part of the body, other than the scheduled member, the claimant is entitled to proceed under the general disability statute. However, as noted by the Simmons court, there still must be a showing of substantial evidence to demonstrate that additional body parts were affected. Substantial evidence must be a higher standard than just having a doctor sign off on a "check the box" questionnaire. The substantial evidence in the record does not support a finding that more than one body part was affected. The overwhelming evidence in this case is that Appellant only injured his right shoulder. More importantly,

there is substantial evidence in the record to support the findings of the Commission's order and it should be affirmed.

The 2021 Full Commission order explains in detail as to why this case is limited to only an award of PPD to the right shoulder under §42-9-30(14). No doubt in a lot of work compensation cases, the claimant could argue that they suffered a loss of earnings capacity; however, this in and of itself does not make a loss of earnings capacity case. The mere fact that the Appellant cannot return to work as a firefighter also does not make it a loss of earnings capacity case. If the Appellant only suffered an injury to one body part, then he is only entitled to an award under §42-9-30.

4. The 2021 Appellate Panel is not inconsistent with the 2014 Appellate Panel order.

Appellant is incorrect in their contention that the 2021 Appellate Panel oversteps the remand instructions from the Court of Appeals Full Commission erred in substituting its judgement for the 2014 Appellate Panel.

The Appellate Panel was instructed by the Court of Appeals to make specific findings regarding Appellant's right arm, right shoulder and right clavicle. In a 31-page order, the Appellate Panel made specific findings on each body parts. The 2021 order is not contradictory to the 2014 order of the Full Commission as alleged by Appellant. Specifically, Appellant compares Finding of Fact #8(r) in the 2021 order to Finding of Fact 29 in the 2014 order. Finding of Fact 8 addresses whether the Appellant's right arm is compensable, this Finding is seven pages long and has multiple subparts. Subpart (r) of this finding is addressing the check the box questionnaire completed by Dr. DeMarco that had multiple sub parts. Specifically, subpart (r) states:

> We considered Claimant's "check-the-box" questionnaires, sent by Claimant to the authorized treating physician, but note that these questionnaires were not part of

> or in response to or accompanied by any clinical treatment visit. We are mindful of the fact that these questionnaires do state that there was an injury and/or aggravation to the right biceps, but then qualify that statement by saying the affect is radiating pain and tenderness "into" the right biceps; the Appellate Panel finds this check-off response inconsistent with Claimant's subjective complaint to his vocational expert, whose 2011 report states that Claimant reported that his pain radiates upwards. The questionnaires are also inconsistent with Dr. DeMarco's 14B's to which we give great weight. (R. p. 93).

The Commission's findings are that that the portions in of the check the box questionnaire related to causation of the right biceps in inconsistent with the vocational report. This is the portion of the questionnaire that was specifically being discounted in the 2021 Order. The Appellate Panel is will within its review to weigh the evidence and discount parts of the reports as they believe was appropriate. [W]hile medical testimony is entitled to great respect, the fact finder may disregard it if there is other competent evidence in the record." Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 340, 513 S.E.2d 843, 846 (1999).

Finding of Fact 29 from the 2014 order states:

> That, we find that authorized orthopedic surgeon, Dr. James DeMarco, opined on "check the box" forms dated October 8, 2012, and October 24, 2012, that Claimant is in need of future medical care and treatment in the form of mediations, pain management clinic, injections, tens unit, repeat diagnostic imaging, physical therapy and follow up office visits as a result of his August 8, 2008, accident at work. He further opined that said medical treatment would tend to lessen Claimant's period of disability. Dr. DeMarco, does not opine on his 14-B issued on May 16, 2011, that Claimant will need future medical care and treatment; however, he opines differently on his October 8, 2012 and October 24, 2012, check the box reports and we give more weight to the opinions given in said reports given that they were provided at a later date than the 14-B, were provided closer to Claimant's hearing date and more accurately reflect Claimant's current condition and need for future medical care and treatment. (R. p. 50).

These findings are not inconsistent and contradictory. The 2021 order provides for future medical care for the Claimant's shoulder which is what FOF 29 in the 2014 order does. Thus, the 2021 Appellant Panel order did not upend the prior 2014 order as alleged by

Appellant's counsel. Both orders find the right shoulder compensable and reject that the clavicle, right arm or biceps as compensable body parts. Both orders find that the any award should be made under §42-9-30 and that an award under §42-9-20 is not appropriate. Both orders find that Appellant is entitled to Dodge medical. (Dodge v. Bruccoli, Clark, Layman, Inc., 334 S.C. 547, 514 S.E.2d 593 (Ct. App. 1999).

Finding of Fact #10 in the 2021 Appellate Panel order states:

> As to both the right arm and right clavicle, we give the greatest weight to the treatment records accompanied by a clinical visit, rather than to check the box questionnaires sent by Claimant and for which there was no accompanying clinical visit and/or narrative treatment note. For instance, in the last narrative treatment note from Dr. DeMarco of August 7, 2012 (the date of maximum medical improvement), Dr. DeMarco's "Assessment" was "Shoulder pain" (under this particular heading), and the "Treatment" heading lists only "Shoulder Pain" as well. As part of the impairment rating to the right shoulder, Dr. DeMarco assigned 3% for biceps atrophy and **1% for pain/spams** [emphasis added]. This appears to the Appellate Panel to be the extent of any incidental involvement regarding the arm with nothing specifically regarding the clavicle. (Record, pages 103-104 and 404-405). (R. p. 95).

This finding is not inconsistent with Finding of Fact #29 from the 2014 order which orders future medical treatment. Finding of Fact #10 in the 2021 order is one of many findings that detail as to why the Appellate Panel correctly found that the only compensable body was the right shoulder.

Appellant makes the conclusory statement in his brief that the Appellate Panel substituted its own medical opinion for the opinions of the doctors. (Appellant's brief p. 20). In Burnette v. City of Greenville, 401 S.C. 417, 737 S.E.2d 200 (Ct. App. 2012), the court found that prior orders were not supported by substantial evidence and reversed the Commission's findings. The Burnette court found that there was no evidence that the findings made by the commission originated from a medical provider and was forced to conclude that it was the medical opinion of the single commissioner. In the case at bar, the medical evidence clearly supports the findings of the Full Commission as

discussed at length in prior sections of this brief. The Full Commission wrote a lengthy order and with detailed findings to support Furthermore, it appears that the Appellant is substituting his opinion of that of the doctor's opinion by asserting that the fourth surgery was to alleviate arm pain. Appellant also tries to argue that the Appellant's opinion about the fourth surgery is medical evidence. (Appellant's brief pp. 6-7).

Appellant's statement that the medical evidence is unrefuted in part because there was no cross examination of doctors is shifting the burden of proof to the defense which is not appropriate.

5. The evidence does not support the Single Commissioner's findings on wage loss.

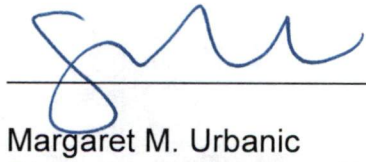
There is clearly substantial evidence to support the Appellate Panel's findings the case should be limited to an award under §42-9-20 for the right shoulder. However, if the court should reverse the Appellate Panel and find an award under §42-9-20 appropriate this case should be remanded for a recalculation of an award. The evidence from the Claimant is that he earned more at his hourly job at the bowling alley then what Claimant's vocational expert projected his earnings. Appellant testified that he earned $9.18 an hour and the vocational report estimated claimant's earnings of near minimum wage of $7.25 - $8.00 an hour. (R. p. 152; 213). The report also fails to consider the Appellant's skills of managing the vending machine routines, the administration and supervision of other firefighters in his role as firefighter captain. Furthermore, Appellant also admitted to being fluent in Spanish which is not mentioned in the vocational report and would arguably open up job possibilities for the Claimant. (R. p. 161). Despite the Claimant's testimony about his hourly rate at the bowling alley, the Single Commissioner used minimum wage from 2008 of $7.25 to calculate Claimant's loss of earning capacity. Additionally, the 2021

Full Commission order lowers the Appellant's average weekly wage in Finding of Fact 32 to $1,134.72. Thus, any award of wage loss should be recalculated with the newly determined average weekly wage of $1,134.72 and using the Appellant's hourly rate of $9.18 as opposed to minimum wage.

CONCLUSION

As there is an overwhelming amount of evidence, not just substantial evidence to support the findings of the Commission and the order of the Full Commission should be affirmed in its entirety.

Respectfully submitted,



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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

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MAY 09 2022
SC Court of Appeals

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Thomas Contreras, Claimant, ...Appellant

v.

St. Johns Fire District Commission, Employer, and State Accident Fund, Carrier,Respondent

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CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Final Brief complies with Rule 211(b), SCACR.

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May 6, 2022